TRAVELLING PSYCHIATRIC SERVICES

An Exploratory Study of the Services of the British Columbia Mainland Travelling Child Guidance Clinic

by

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ABSTRACT

The purpose of this thesis is to make an exploratory study of the British Columbia Mainland Travelling Child Guidance Clinic. One of the main goals is a more definitive statement and clarification of the current functions and services of the clinic.

The study includes:

(1) A description of travelling child guidance clinics generally, in terms of underlying theory and assumptions, historical development, and current problems and functioning;

(2) A brief description of the travelling child guidance services in Canada;

(3) A detailed description of the British Columbia Mainland Travelling Child Guidance Clinic:
   a. its historical development;
   b. its stated functions and goals;
   c. its operation "in the field."

The above includes material drawn directly from a sample of clinic files, which describes: the characteristic group of clients referred for individual service; problems seen by the referral sources as indicating the need of clinical assessment and help; the channels of referral and presentation to the clinic; the professional members of the community who, through attendance at case conference, come into direct contact with clinical concepts and knowledge about the understanding and treatment within the community of behavior disorders in children, and general mental health methods in the alleviation and prevention of further similar difficulties; and the recommendations made for such community treatment of the disorder. A questionnaire circulated to all Social Welfare Branches indicated the field offices' concept of the effectiveness and adequacy of clinical services.

The British Columbia Mainland Travelling Clinic has achieved a good beginning. Staff exigencies in both the clinic and the field have made ideal objectives impossible to achieve. The addition of another travelling clinic team together with more field personnel will alter this criticism. The success of any such undertaking will always depend on harmonious relationships among clinic staff, field health and welfare staff, and other citizens in the communities.

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* * *
An Exploratory Study of the Services of the British Columbia Mainland Travelling Child Guidance Clinic
CHAPTER I

THE EVOLUTION OF TRAVELLING CHILD GUIDANCE CLINICS

1. Introduction

The Research Division of the Department of National Health and Welfare, in its report of July, 1954, stresses repeatedly the importance of mental health education in Canada. In this connection, the contributions of the community clinics are noted in almost every section of the report. At one point, it states that "there can be little doubt that the most effective educational work is being done in the community clinics across Canada."¹ In summing up the future objectives of Canada's Mental Health program, it numbers as third amongst the five "desirable forward steps," "the better integration of psychiatric programs with other health services as community services, regardless of whether they are provided by a mental hospital or a general hospital or a clinic."²

Thus, more and more the mental health clinics are being accepted as an essential component of community

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¹ Department of National Health and Welfare, Research Division, General Series Memorandum No. 6, Mental Health Services in Canada, Ottawa, July, 1954, p. 146.
² Ibid., p. 189.
mental health services, and their contributions recognized. This study is concerned with a specific form of community clinic, the travelling child guidance clinic. In perusing the professional literature, it has been noted that stationary child guidance clinics are dealt with abundantly, but that the material on the travelling child guidance clinics serving large geographical areas is notably sparse. This invokes grave concern as to the general, and even professional, recognition of the potential value of the travelling child guidance clinic to the rural population it serves. This thesis has been undertaken in the light of this concern, and is specifically focussed upon the British Columbia Mainland Travelling Child Guidance Clinic stationed at Vancouver. The areas studied will include: the development of the travelling child guidance clinic and its "roots" in the mental hygiene movement as seen on this continent; its present goals, structure and function, particularly in relation to social welfare; a survey of existing travelling child guidance services in Canada; and a study of the historical development, and the current operation in the field of the British Columbia Mainland Travelling Clinic. It is hoped this exploratory study will promote greater understanding of the important role of the travelling clinic in rural communities; and that, as a result, a more definitive statement and clarification of the current functions
and services of the British Columbia Mainland Travelling Child Guidance Clinic will lead the way to further research in the interests of focussing future clinical program along most effective lines. Since this is a social work thesis, more emphasis will be placed on studying the social work aspects of general and specific clinic function, than upon the medical, psychiatric, psychological, or Public Health aspects, each of which, as will be discussed, plays an important role in the functioning of the clinic team.

Social work has always stressed health and welfare aspects of people's adjustment in extending its services to families. When there is disturbance in intra-family relationships or other stresses which threaten family breakdown, social workers are immediately alerted to their professional and social responsibility. Because some intra-familial relationships are grossly distorted and pathological, the medical, psychological and educational disciplines are also alerted. These human relations disciplines have developed special skills which certify their competence to deal effectively with several aspects of adjustment problems.

The Child Guidance Clinic structure has effectively combined the multi-discipline approach in combination with the concept of the whole child (physical, cultural, intellectual, personality, social and emotional
aspects), his total environment, and his reaction to it. The specialized knowledge of the professions concerned is brought to bear on the presenting situation, both within the clinic team—psychiatry, psychology, social work, public health nursing—for diagnostic, evaluative and treatment purposes; and, particularly in the case of travelling clinic, within the community, where a group of professional persons—teachers, doctors, public health nurses, judges, ministers—can do much toward creating an understanding, tolerant environment in which treatment, be it on any level, can be more constructively entered into and utilized. Social work has been closely interested in the development of psychiatry from a preoccupation with psychotic individuals and the classification of mental diseases, to the more constructive field of preventive psychiatry. This is evidenced in the psychiatric hospitals, mental hygiene clinics, child guidance clinics, and travelling child guidance clinics of today.

The child guidance clinic movement and the mental hygiene movement are closely interwoven. The mental health movement in Canada has generally paralleled the one in the United States, both in terms of time and objectives. A summary study of the steps leading to the present coordinated approach of the medical, psychiatric, nursing, psychological and social work professions as applied to children, in order to see and handle the child as an entity
rather than deal with fractional parts as a problem, is indicated as a base for understanding the present child guidance clinics, both stationary and travelling.

Definition of a Child Guidance Clinic

Stevenson and Smith have defined the child guidance clinic as follows:

The child guidance clinic is an attempt to marshal the resources of the community in behalf of children who are in distress because of unsatisfied inner needs, or are seriously at odds with their environment....Its service is rendered through the direct study and treatment of selected children by a team consisting of a psychiatrist, a psychologist, and psychiatric social workers, and also through focusing the attention of physicians, teachers, social workers and parents, on what is commonly called the mental hygiene approach to problems of child behavior.¹

The three-fold functions of a child guidance clinic are broadly indicated as follows:

1. The study and treatment of patients.

2. Seeking to interest other community agencies in the prevention of behavior and personality disorders in children and in promising methods of dealing with them when they occur.

3. Attempting to reveal to the community, through the first-hand study of individual children, the unmet needs of groups of children.²

Interest in the mental health of children has increased over the past thirty or forty years, during


which time

...knowledge of the emotional life of children has increased enormously, and the art of helping those who are in emotional difficulty has been greatly improved. Concurrently, the public's interest in these matters has grown. The challenge of the present moment is that of discovering some means by which the kind of help that is available to the few patients of the best clinics can be offered throughout the country.¹

The urban areas generally have, over the years, developed increasingly adequate services for children. The need for similar services to rural areas was also recognized, and community requests made an extension of clinic services necessary. As the child guidance movement gained impetus, the early "community clinics," connected with psychiatric hospitals, gradually developed into some form of travelling child guidance clinics. The demand for child guidance clinic services far exceeds the supply of trained personnel available to staff the needed clinics. One way in which the travelling clinics attempt to solve this situation and spread available services is through the building up of strong state central staffs to serve as headquarters for travelling clinic personnel.²

upon the consultative and community education aspects of the travelling clinics has also served to apply on a community wide basis its knowledge of the basic factors that enter into personality development. The British Columbia situation is a good example of this focus. The entire rural areas of the province are visited by two travelling clinic teams operating from the two stationary Child Guidance Clinics at Victoria and Vancouver. Their function is adapted to meet the current demand for and ability to use child guidance clinic services. One of their main objectives is to educate the local community to an awareness of the gaps in local social service structure, and to ways and means of filling these gaps.

In Canada, the travelling clinics are of particular importance in extending general mental health services to the non-urban areas. Geographically and population-wise, Canada is a large, undeveloped country, with large regions very sparsely populated. These areas must be serviced by the travelling clinic if they are to have services at all.

2. General Historical Background of Child Guidance Clinics

Child psychiatry has been concerned with that small group of children whose behavior deviates so much from the normal that they are considered insane. It has, however, shown increasing interest in the field of children's
emotional problems generally. Essentially, its evolution to this area of interest, encompasses the development of the theory that disorders of conduct and of psychic processes come from the same sources, and represent the individual's way of reacting to internal and external demands. According to this theory, mental adjustment is a function of the total human being, the result of physiological, psychological and situational factors; and psychiatry is "the scientific study of peculiarities of personality and of interpersonal relationships." This point of view represents the convergence of various lines of development, not only in psychiatry, but in psychology and philosophy as well. It means abandoning the distinction between mind and body, accepting the dynamic influences of emotions on human behavior, and admitting the ineffectiveness of attempting to control an individual's motivations by external compulsions.¹

The psychiatric principles basic to child guidance as practiced today, were profoundly affected by the contributions of Adolph Meyer, and of the psychoanalytic movement founded by Sigmund Freud.² Meyer's basic contribution was his emphasis on the uniqueness of each individual

¹ Witmer, op. cit., p. 4.
² The writer is mindful of eclecticism in the psychoanalytic movement—Rank, Adler, and the Neo-Freudians.
patient, and the consequent necessity of studying his total life history as well as his intellectual and physical equipment, if one is to understand the nature of his present disorder. From psychoanalytic theory came the concept of the dynamic influence of the emotions (the individual's own and those of the persons with whom he is in contact) on human behavior. The psychoanalysts showed behavior to be purposive but its motivation often non-rational and unconscious. Equally important, it was noted that each individual has a capacity for self-direction and that the most therapy and education can do is to provide the setting favourable to the development of latent abilities.¹ The chain of development that began in America with Meyer's insistence on studying the total individual rather than the functioning of specific organs, led logically to the presence of all types of problem children in psychiatric clinics. Meyer's hypothesis that mental activity represents the adaptation and adjustment of the individual as a whole, provided a basis on which the various schools of dynamic psychiatry could unite, and the whole range of human behavior became of interest to the psychiatrist. The history of the mental hygiene movement is an unfolding of the possibilities inherent in that concept. Better care for the psychotic individual, prevention of psychoses, prevention of other forms of social

and psychic maladjustment, led eventually to the conviction that these were unsatisfactory goals, and mental hygiene became a "positive program for life well-lived, for mental health because of its values and not because of what it avoids."¹

There appear to have been three major lines of development leading to present psychiatric services for children. First, there is the early work of mental hospitals and schools for the feeble-minded. In spite of the fact that psychiatrists in the latter part of the nineteenth century were chiefly concerned with problems of neuropathology and the classification of mental diseases, there was even then some interest in preventive work. As early as 1871, the California State Board of Health proposed the erection of a psychopathic hospital for the treatment of incipient mental disorders. It believed that much permanent insanity was due to the lack of early care. The clinic opened in 1897 under the direction of Dr. Walter Channing at the Boston Dispensary was more definitely preventive, and apparently marked the beginning of clinical work with children. It definitely foreshadowed more modern methods of studying patients. More or less through the influences of Meyer, other state hospitals in New York (1909) and Massachusetts (1910) began to offer clinic services. In addition to their interest in

¹ Ibid., p. 7.
prevention through early recognition and treatment of mental disease, use of the parole system and follow-ups, and of educational objectives, is noted.

With the shift in psychiatry to an interest in total behavior and in the social and emotional genesis of mental disorders, it was a natural step for clinics to seek to aid children who were socially maladjusted.¹ The Out-patient Department of the Boston Psychopathic Hospital accepted children as patients from the time of its opening in 1912. Generally, however, state hospital clinics rarely accepted children as patients before about 1920. The clinic opened in 1915 in Easton, Pennsylvania—the Allentown State Hospital—was the only other notable exception. One of its original purposes was to serve as a clearing house for the public schools of all children suspected of being in the exceptional class, securing for them diagnosis and prognosis, determining the degree and variety of mental weakness, and advising what environment and course of action will serve the interest of each individual child.² Many of the later state hospitals began their work on the basis of such an interest in educationally retarded children.

The second line of development leading to present psychiatric services for children is found in clinics for

² *Loc. cit.*
juvenile delinquents. Dr. William Healy's work in the Juvenile Court of Cook County, Illinois, provided the pattern on which the later child guidance clinics were partially modelled. What happened here is so well known that it needs no elaboration.

The third line of development of present psychiatric services for children is seen in the five year program (1922 to 1927) of demonstration child guidance clinics, financed by the Commonwealth Fund. The widespread public interest and enthusiasm for the treatment approach to personality and behavior difficulties had stimulated the National Committee for Mental Hygiene's interest in behavior problems of children, as a result of which they approached the Commonwealth Fund for the financing of this program.

In planning this demonstration clinic program, the National Committee drew upon the experience of the Illinois Institute for Juvenile Research, the Judge Baker Foundation, and two psychopathic hospitals. Precedent for including psychiatric social workers on the clinic staff was offered by the Boston Psychopathic Hospital and the Henry Phipps Psychiatric Clinic, both of whom differed from the Institute in serving the whole community rather than merely the court. The Committee had already taken part in the training of psychiatric social workers, and its clinical program was in a sense a putting into practice of much that had been
taught. Other demonstration clinics were established throughout the Eastern and mid-Western United States. It soon became apparent, however, that there were disadvantages to working wholly through the courts and that the most effective preventive work was to be done with children whose misconduct had not yet been adjudged legal delinquency. The later clinics were therefore established in connection with hospitals or schools, and referrals were sought from parents, teachers and social workers.

II. **Travelling Child Guidance Clinics—Development**

The specific nature of travelling child guidance clinics, and their genesis, is seen in the establishment of demonstration clinics, conducted from six months to two years, by a staff sent out from New York. These were held in seven widely scattered cities. Out of their experience certain conclusions emerged that form the basis for much of the child guidance work of today:

1. that child guidance should not be limited to any one diagnostic group, such as delinquents or "pre-psychotics," and that it has most to offer to children of adequate intelligence whose difficulties have not been of long duration;


3 *Loc. cit.*
(2) that the need for psychiatric help is not the only factor determining amenableability to treatment—however, emphasis was placed not on the significance of family attitudes in resistance to psychiatric help, but rather on the magnitude of the problem and the lack of community facilities to carry out the treatment program;

(3) that child guidance clinics cannot work apart from the community and must depend upon other social agencies and institutions for assistance in their work:
   a) that clinics should work with schools and social agencies and "interpret" child guidance to them;
   b) that the community has a part to play in the promotion of children's mental health;
   c) that the work of a clinic is seriously handicapped unless there are in the community fairly adequate facilities for the care of children with respect to education, health and recreation, and some special provisions for children who are mentally defective, or dependent, or delinquent. Without these resources, plans for environmental treatment could not be carried out effectively, nor could psychotherapy compensate for gross defects in the community situation. Equally or more important were found to be the attitudes of those in charge of such community agencies or institutions. Child guidance, accordingly, came to be regarded as a co-operative enterprise, one that drew upon many more than the clinic staff for its undertaking;

(4) It became clear that the demonstration clinics could not hope to cope with all the mental hygiene problems of children that would be brought to their attention. The clinics' policy of education and co-operative work was an attempt at the resolution of that dilemma. Most clinics therefore allotted a considerable proportion of their time to teaching the principles of mental hygiene to teachers, school nurses, court and other social workers, and to parents as well. Education of social workers
and others through case conferences, exchange of staff, and "co-operative work" was a more direct attack on the problem, it being expected that what these workers learned about the treatment of a few children could be applied to their work with the many who would otherwise need the clinic's help.¹

Thus we see a gradual movement toward current thinking about the mental health of children as a community responsibility in which the clinic shares. The travelling child guidance clinic is seen now as a community agency that defines its function beyond psychiatric diagnosis and treatment to participating consultative services to other health, welfare and educational agencies in the community. The effectiveness of travelling child guidance clinic practice is determined by the amount of effective participation between the child guidance clinic and the community. There must be mutual interaction.

¹ Public Welfare Aspects of Travelling Clinic

Travelling clinics have been studied recently by Jules Coleman and R.E. Switzer. Some of their general observations are extremely significant in understanding travelling clinic functions and limitations under certain circumstances. They state that the success of a travelling child guidance clinic is very much dependent on its ability to become engaged as a participant with the child welfare
agencies in the community. This type of clinic always directly relates its services to existing community resources. It has no independent therapeutic role. It derives whatever strength it may bring to the solution of problems from antecedent community activities that have been playing a supporting part and building up in the patient a readiness to move in the direction of change. The clinic contributes to change, in other words, by unveiling what is already potentially there.\(^1\) If a community lacks adequate schools, teachers, social workers, school and public health nurses, placement facilities, Juvenile Courts, maternal and child welfare and health programs, i.e., if the community is not already undertaking the multiple socially integrated activities that are necessary for the welfare of children—then the effectiveness of a visiting clinic is grossly reduced. Any results it does achieve are truly accidental, unpredictable and unexpected. Thus it can be seen that the travelling clinic is not only a medical unit with a medical tradition of treatment. Even more, it is a social agency with a constant, continuing, integrated relationship to the organized activity of the community.\(^2\)


\(^2\) Witmer, op. cit., p. 399.
The development of travelling child guidance clinics in Colorado seems a typical example of the way in which the travelling clinics generally arrive at their current function. In 1925, members of the staff of the Colorado Psychopathic Hospital participated in general medical and health clinics for both children and adults, in many communities throughout the state. These travelling clinics, or "community health conferences" continued till 1928, when separate travelling psychiatric clinics to five communities were established. Up to this point, the goals of the clinics were in the main educational. In 1936, these community clinics became monthly travelling child guidance clinics, as a result of the establishment of co-operative efforts between the mental hygiene clinics of the psychopathic hospital and the child welfare division of the State Department of Public Welfare. The general goals remained as before. Diagnosis, evaluation and interpretation to the referring person or agency were the major clinic functions. The way had also been paved for "psycho-social treatment," through public education and the encouragement of an accepting attitude toward psychiatry. In 1946, the emphasis shifted from education of the community to treatment of patients. This shift came largely through the one year's assignment of a child psychiatrist; and also through a new

1 Treatment of both psychological and social factors.
policy of treatment orientation. Among the difficulties encountered in the first year were the following:

(1) the securing of typical child guidance patients instead of examining children of low intelligence or those whose difficulty was due to organic causes;

(2) the giving of treatment service with proper follow-up instead of providing merely diagnostic service;

(3) overcoming the meager resources in the local community for handling problem children;

(4) the gaining of parental co-operation and community assistance. The program for overcoming those difficulties was centred on the child welfare worker and her already established relationships with other agencies.\(^1\)

In this way the psycho-social treatment process evolved, with its intimately related and mutually dependent administrative and clinic aspects.

\(\text{(2) General Description of Travelling Clinic Structure and Goals}\)

Generally, travelling clinics include a psychiatrist, and a psychologist, who travel to the clinic setting one to two days each month. The child welfare worker of each community visited completes the clinic team. The latter receives all referred cases; makes a pre-clinic home visit for Social History purposes; interprets the services of the clinic; helps the patient to decide whether he wishes to use the actual services; and makes the actual

\(\text{\textsuperscript{1}Ibid., p. 407.}\)
appointment. Cases are referred by schools, private physicians, courts and other social agencies, as well as by parents themselves. The frequency of clinic visits is usually determined by such limitations as distance, size of parent-clinic staff, the availability of suitable personnel, and pressures on the local social worker, particularly if this is a child-welfare worker, carrying her own caseload in addition to clinic cases. The presence of trained staff in the local community is necessary to carrying out the therapeutic function of the guidance clinic. Equally important is a consistent policy of community relations, in order to provide continuity of service. Even where a community has developed sound supporting services, a clinic still does not exist in the "splendid isolation of psychodynamic preoccupation," but must maintain constant concern for its relations to other agencies.¹ Coleman states that it is especially important to emphasize repeatedly the public health aspects of clinic function and their possibilities for the development of a preventive psychiatry. The influence teachers may have on the social and emotional development of children is recognized, and indicates the value in positive clinic relations with the school. Interpretative and co-operative work with social and health agencies is also valuable. The clinic may help the agency social worker in a more effective

¹ Ibid., p. 408.
use of her own professional responsibilities in working with disturbed clients, through offering a consultative program with the psychiatrist. In health agencies, the lack of psychiatric orientation in the training of public health nurses may be partially remedied through positive clinic relationship, and mutual professional respect. Thus we see indeed that the child guidance clinic, be it travelling or stationary, is a group of professional people who combine their specialized knowledge, and attempt to employ the resources of the community to meet the problems of children who have unsatisfied psychological needs, and who are poorly adjusted to their surroundings.

The work of the clinics, which will be studied in more detail in the following chapters, has proven that if preventive work with behavior and personality difficulties of children is to be handled effectively, the preventive attack must be directed toward helping parents, schools, health and social agencies to understand and deal with early cases. The purpose is to detect and treat children's difficulties at a stage when actual treatment in the community is still possible and community resources can be used preventively. Children are referred to the clinic because of disordered habits, troublesome personality traits, or unacceptable behavior—all outward manifestations of serious underlying disturbance in the mental, physical,
or social sphere, which are destroying the harmonious adjustment of the child to its environment. To understand and correct the basic factors causing these symptoms, is to strike at the roots of mental disease, delinquency, dependency, and other forms of social inadequacy and failure. In searching for these underlying causes it is impossible to separate the physical and mental aspects of the human personality and to treat them independently. The child guidance clinic therefore represents the fundamental unity in the many-sided aspects of human personality and behavior. The concepts of the whole child and the clinic team approach, are basic to its current function.¹

III. The Travelling Child Guidance Clinic Across Canada

(1) General Developmental Picture

As has been noted, the Mental Hygiene movement in Canada has generally paralleled, both in terms of time and objectives, the one in the United States. Certain historical trends related to the mental health aspects of the child guidance clinic movement in Canada have been noted in the 1954 report of the Research Division of the Department of Health and Welfare, mentioned earlier.²

¹ Byrne, Dr. U.P., Vancouver Child Guidance Clinic, lecture notes.
² Department of National Health & Welfare, Research Division, General Series Memorandum No. 6, Mental Health Services in Canada, Ottawa, July, 1954, p. 17.
(1) Change in the types of personnel employed, the degree of specialization increasing with the advances in scientific knowledge.

(2) An incipient change in public attitudes toward the mentally ill, and an emerging interest in their welfare, evidenced by the formation of voluntary organizations.

(3) A recognition that mental health services were a health problem, evidenced by the transfer of institutional administration to provincial mental health divisions.

(4) A gradual shift in emphasis in the direction of community services, including not only educational media, diagnostic and short term treatment, but the institutions themselves.

(5) Increasing participation by the federal government, acting in a consultative capacity and assisting through the provision of limited financial aid.

(6) A beginning of research into mental health problems.

As in other countries, prejudice and ignorance concerning mental illness have constituted a formidable barrier to progress. To eliminate such prejudice, emphasis has been placed on public mental health education, which today is a function not only of special agencies, but of every mental health worker in the field.¹ More and more, mental health clinics are being accepted as an essential component of community health services. Depending on their purpose, clinics are operated by various agencies including public health departments, municipalities or health units.

¹ Ibid., p. 4.
mental or psychiatric hospitals, children's hospitals
and child health centres, tuberculosis sanitarium, general
hospitals, school boards or voluntary organizations. Some
are full-time, others part-time, and some are held at
regular or irregular intervals; some are stationary clinics
while others are held by travelling clinic teams that move
from place to place on regular schedule or on request.¹

The "average" Canadian clinic team consists of a
psychiatrist, a psychologist, and a social worker. Mental
Health clinics in the larger hospitals are usually better
staffed and equipped to provide treatment. Smaller clinics
and travelling teams may provide only a screening service
for referred cases, and may give no treatment whatever, but
merely advise the source of referral concerning the pat­
ient's mental status, and concerning future therapy, and
places where such therapy may be obtained.²

Clinic services have expanded rapidly in Canada
since the inception of the National Health Program in 1948.
Although no specific mention is made of the Mental Health
Grant or the Professional Training Grant, there are few clin­
ics in any province that have not received substantial finan­
cial assistance toward expanding their work, either through

¹ Department of National Health and Welfare, Research Div­
ision, Mental Health Services in Canada, Ottawa, July, 1954,
p. 105.

² Loc. cit.
help in training or employing their personnel, or both. Many clinics are financed entirely through federal grants.

At the present time there is little uniformity in the types of mental health services provided for children in the several provinces or within any province; wide variations depend on the population of a community and on the sources available for referrals. All provinces provide some child guidance, but as yet, these services are limited chiefly to the more densely populated urban areas. As has been mentioned previously, the travelling clinics have gradually developed in an effort to extend clinical services into non-urban areas, but as yet, their services are generally confined to the diagnostic, screening and referral functions. A Child Guidance Clinic studies, assesses, and treats a variety of disturbances arising in children and in parent-child relationships.

Many of these clinics have been either established or substantially expanded since the inauguration of the National Health Program in 1948. The recent report on Mental Health Services in Canada, July, 1954, points up the increase both in facilities and in training of professional personnel; and the indications are that there is real progress being made in this area at the present time, due both to the increased federal financial aid, and to the results of current emphasis on community education along mental health lines. The present picture is an encouraging one,
boding well for future developments in mental health services. This report also acknowledges the role of mental health clinics in attaining present public interest and increased understanding of mental illnesses and of modes of prevention: "There can be little doubt that the most effective educational work is being done in the community clinics across Canada. This work has been mentioned indirectly in almost every section of this report. Medical personnel in clinics and hospitals, public health nurses, psychologists, social workers, and many others share in this work. Perhaps the recovered patient and his family play the greatest role in gradually breaking down the barriers of prejudice, for he is convincing proof that like physical ailments, his illness may also be cured."¹

(2) Survey of Current Travelling Child Guidance Clinic Services in Canada

In an effort to gain as clear a picture as possible of the extent of travelling child guidance clinic services in Canada, letters were sent to various clinics across Canada, and to the provincial directors of Mental Health Services.² A total of nineteen requests for information concerning:

¹ Ibid., p. 46.
² See Appendix A.
were sent out, to eighteen of which replies were received. 

On the basis of the information received, the writer here presents the current Canadian picture regarding facilities for travelling psychiatric clinic services for children, in each of the ten provinces.

NEWFOUNDLAND

There are no travelling mental health clinics in Newfoundland at present. The Hospital for Mental and Nervous Diseases at St. John's, makes available in its out-patient department, consultative services to the Departments of Welfare, Education and Justice, as well as to general practitioners throughout the province. As yet, travelling clinic services are still undeveloped.

PRINCE EDWARD ISLAND

Travelling clinic services for children are as yet but a small part of this province's accelerated mental health program. At present, they are operating out of the Mental Health Clinic in Charlottetown, under the administration of the Division of Mental Health. It is stated that the travelling clinic will become more active, with the eventual establishment of branch offices in specified centres.
The stationary Mental Health Clinic, located at 101 Queen Street, Charlottetown, was opened March 16, 1952, on a part time basis, with Saturday mornings reserved for children. It functions as a diagnostic, consultative, therapeutic and educational unit. Cases are referred by the family or attending physician. The clinic is staffed by the professional staff from Falconwood Hospital, two miles distant, and includes: two psychiatrists (alternate afternoons), one psychologist and one social worker. An interesting aspect of this clinic is the close collaboration between the clinic and the Guidance Consultant, who has her office in the same setting. The services of the Guidance Consultant, sometimes referred to as the educational consultant or the liaison officer, emerged from the Forest Hill Village Project, an experiment begun in 1948 by the National Committee for Mental Health. The Committee was looking for a suitable community to carry out an idea they had to attempt to study and practice the ways and means to mental health, at the point in our society which seems most likely to yield results, the child. Since children are most accessible in schools and only understood within a network of relationships, the school in its community was the chosen field. The emphasis in this province's mental health program appears to have been upon an active educational program in the interests of laying a sound foundation amongst the health, welfare, and educational
personnel as to the understanding of general mental health
principles and use of mental health clinic services, when
they become available.

The Director of the Division of Mental Health
states that although the clinic is operating on a part-
time basis due to insufficient staff, this is expected to
be remedied by July, 1955. One of the staff psychiatrists,
currently specializing in child psychiatry at the Memorial
Guidance Clinic, Richmond, Virginia, will rejoin the clinic
at that time.

Excerpts from the 1952 Prince Edward Island de-
partment of Health and Welfare Annual Report indicate that
the Guidance Consultant's activities and the psychiatric
interviews form the bulk of the clinic's activities—the
former being involved in educational and community liaison
activities, the latter in therapy, but mainly with adults.
The psychologist does a limited amount of therapy in addi-
tion to her psychological testing; and the social worker's
activities include mostly history taking, plus a few
"interviews with mother in child guidance."

The emphasis upon the work of the Guidance Con-
sultant at this stage in the development of the province's
mental health services seems an appropriate one, particu-
larly when accompanied by efforts toward increasing the
professional training, and numbers of staff. The guidance
consultant, who was active in the Forest Hill Village
Project, acts as a liaison officer between the Department of Health and Education; her work is directed through the Department of Education, but is under the supervision of the Division of Mental Health. Her work consists essentially of school activities, such as human relations classes, interviews with teachers, parents, public health nurses, and social welfare workers, and of educational activities, as in the presentation of films, lectures, and talks to various groups, including Home and School Association, Women's Institutes, and Teacher Study Groups and Conferences.

It is recognized that Mental Health in the schools is new in this province and must, therefore, move slowly. In the meantime, the sound community education work, and the establishing of sound community relationships as a basis for future expansion of services as the need is felt by the citizens, should result in future effectiveness of mental health services.

The travelling clinic service in Prince Edward Island works most closely and effectively with the schools, and at its present stage of development stresses the educational aspect, utilizing the services of the guidance consultant in this respect.
NEW BRUNSWICK

There are no travelling psychiatric clinic services for children in New Brunswick at the present time.\textsuperscript{1} There are, however, three community mental health clinics, operated by the Department of Health and Social Services, at Saint John, Fredericton, and Moncton. For areas not served by the three clinics, a screening service is being developed. This consists of a clinical team of a psychologist and a social worker who periodically visit any centre where a group of cases has been assembled. This service began in 1952-3.\textsuperscript{2}

NOVA SCOTIA

There are no travelling child guidance clinics in Nova Scotia. The clinics that are operated are all fixed in one spot, and patients from outlying areas come to the clinic if possible.\textsuperscript{3} The "Mental Health Services in Canada" report indicates that Nova Scotia has the following mental health services: out-patient clinic and treatment and consultative services offered by the Victoria General Hospital in Halifax, the Halifax Mental Health clinic for children, and a stationary clinic at Digby, primarily for research purposes. In

\textsuperscript{1} Letter from New Brunswick Department of Health and Social Services, Mental Health Division.

\textsuperscript{2} Department of National Health and Welfare, Research Division, Mental Health Services in Canada, Ottawa, July, 1954, p. 108.

\textsuperscript{3} By letter, Chief, Neuropsychiatric Division, Department of Public Health, Nova Scotia.
addition, to extend services to points remote from Halifax, the province operates a field psychiatric clinic with headquarters in Sydney. This is staffed by a full-time psychiatrist and a psychiatric nurse. Services include consultation, education, and child guidance, mental testing, consultation to local courts and practising physicians and a limited treatment service.

**QUEBEC**

Quebec abounds in Mental Health Clinics, most of which are closely connected with the three major universities—Montreal, McGill, and Laval. These clinics include hospital clinics directed by universities, hospital clinics not directed by universities, and non-hospital clinics affiliated with universities. Of the wealth of clinics, however, only two provide travelling psychiatric services—the Verdun Protestant Hospital, a training hospital affiliated with McGill University, and The Mental Hygiene Institute, which is affiliated with, but not directed by McGill University.

The Verdun Protestant Hospital travelling psychiatric clinic was established as part of the treatment services of the Hospital, and was proposed to provide a screening of cases prior to admission, and a follow-up of those discharged. It was seen as a pilot project, and it was hoped that a treatment and consulting service, along with a program of public education, would find acceptance in
smaller communities. The project was financed through the Dominion Provincial Health Grants, and began operations for two full days every two weeks, in October, 1949, in Sherbrooke, a city of 50,000 population, 103 miles from Montreal. The clinic functions as part of a mental hospital service, with emphasis on treatment and preventive psychiatry. It began and continues to operate in close liaison with the local medical profession. Only physicians can refer patients to the clinic, and the confidential clinical reports go directly to the referring physicians. Once the clinic had opened, it was found that the examination of psychotic types was a minor need compared to the number of children and adults referred for therapy, but not hospitalization. The nitrous oxide technique was relied on heavily in attempting psychotherapy with patients seen only once every two weeks. It was found patients would gladly come 40 miles for such a "treatment," whereas they would find it difficult to come 10 miles for an "interview." Statistical information records a total of 76 patients, receiving 84 nitrous oxide treatments, and 232 "visits."

The clinic team is composed of a psychiatrist, assisted by a psychologist and a social worker, plus volunteers in various capacities. Free office and treatment facilities are provided by the Family Welfare Association and the Sherbrooke General Hospital. Psychological testing, social service histories, and case histories by the
referring family physician were utilized in arriving at a diagnosis, and suitable treatment planning. The public education program met with popular acceptance from the beginning, and is regarded as a major function of the clinic. It has done much to promote community acceptance and understanding of psychiatry as applied to the emotional problems of living. Included in the program were addresses, film showings, and discussion groups with service clubs, Home and School Associations, Women's Institutes, college undergraduates, and Nurses' Associations, in nine different communities. Professional education, not seen originally as a function of the clinic, became a by-product worth noting. Resident and visiting postgraduate students, medical and nursing, visited the clinic. Nursing instructresses and supervisors, and social service workers attended, as well as medical, nursing and theological groups from the community. Among other things this has proved a stimulus to further extra mural activities of the hospital staff within the area.¹

It was felt that the results of this pilot project, attempting to serve a large area at a considerable distance from the clinic headquarters, augur well for its successful operation in smaller communities nearby. Dr. Reed, the Medical Superintendent, commented by communication with the

We feel these visiting clinics are of distinctly limited use in therapy but quite valuable as an initial step in establishing psychiatric clinical services by demonstrating what can be done and by an active program of public education. I am inclined to be very critical of those travelling clinics which do not attempt therapy but limit their work to the examination of referred cases and then make suggestions and recommendations many of which cannot be followed.

The other travelling clinic service operates from The Mental Hygiene Institute, Montreal. This clinic travels to an institution for delinquent children from broken homes, who have to be placed in foster homes or institutions. It offers both a diagnostic and therapeutic psychiatric service, which includes psychological testing of the children, and gives consultation service to the Children's Service Centre of which this residential home is a part.  

These two travelling clinics are the only ones operating in Quebec at present.

ONTARIO

At the present time there are no travelling child guidance clinics in Ontario. There is, however, a network of mental health clinics serving the more densely populated parts of the province. The importance of mental hygiene in

1 Reed, Dr. Geo., Medical Superintendent, Verdun Protestant Hospital, communication with the writer.

2 By letter, Baruch Silverman, M.D., Director, Mental Hygiene Institute, 531 Pine Avenue, W., Montreal.
community health services was first officially recognized by the Ontario Department of Health in 1926, when the Out-Patient Department of the Psychiatric Hospital, Toronto, was opened. The organization of mental health clinics throughout the province was initiated in 1930. At the present time there are full-time clinics and travelling clinics operating in the districts served by the Ontario Mental Hospitals in London, Hamilton, Kingston, and Brockville. These serve, in addition to their own area, the population of twenty-two cities and towns remote from stationary hospital clinics. In addition to these four travelling clinic teams, Ontario had, in 1953, seven psychiatric units in general hospitals, seventeen community out-patient departments in mental hospitals, and six community clinics operated by municipal health departments chiefly for child guidance.¹

The travelling clinic units, composed of a team of three members, the psychiatrist, the psychologist, and the psychiatric social worker, have a regular schedule of clinics in surrounding general hospitals or public health units. All appointments for these clinics are made through the local medical officers of health. Cases are referred by: family physicians, public health and school nurses, teachers, social agencies, the clergy, and parents. While the great majority of the patients come willingly to clinic, there is a small

¹ Department of National Health and Welfare, Research Division, Mental Health Services in Canada, General Series Memorandum, No. 6, Ottawa, July, 1954, p. 117.
percentage of patients referred by juvenile, family, and magistrate's courts. The diagnostic process is similar to that of the British Columbia Mainland Travelling Child Guidance Clinic, which will be set forth in detail in Chapter II. The suggested treatment may be carried out by the referring physician or social agency as indicated in the reports they receive from the clinic. Some patients and/or relatives may be asked to return to the clinic for one or several treatment interviews.

The clinics make use of all the community social service facilities in helping patients with their interpersonal relationships. The clergy, the recreation directors, the boys', girls' and youth group leaders, and the public health nurses and social agencies are glad to cooperate in every way possible.

The problems presented are varied in number. Children's problems could be classified under such headings as: educational maladjustment, juvenile delinquency, habit disorders, nervousness, mental deficiency, home maladjustment, physical complaints, social maladjustments, and miscellaneous problems, in that order of frequency.

In addition to dealing directly with these problems, the clinics are also active in community education in mental hygiene. Through lectures to home and school associations, service clubs, groups of social workers, nurses, teachers and others, the clinic staff encourage the adoption
of modern attitudes towards mental abnormalities and seek to show the reasonableness of taking active steps to preserve mental health. Likewise, through conferences with small groups, the practicability of mental health procedures are being demonstrated and old prejudices are being broken down. ¹

The districts served by the travelling clinics are as follows:

The Ontario Hospital in Kingston serves Kingston, Belleville, Perth, Almonte, Renfrew and Penbroke. Services to Hamilton, Guelph, Wentworth, Simcoe, Milton, Brantford, Shelburne, and Dunnville are extended by the Ontario Hospital in Hamilton. Brockville, Ottawa, Cornwall, Alfred and Morrisburg are visited by Brockville Ontario Hospital team. The Ontario Hospital in London extends travelling clinic services to London, Sarnia, Woodstock, Chatham, Windsor, Stratford, and Owen Sound.

An extract from a letter received from Dr. G.E. Jenkins, Director, Mental Health Clinic, London, Ontario, gives a picture of the clinical schedules:

Our clinic holds a formal half-day session every Monday afternoon in Victoria Hospital, London, Out-patient Department, and in London we see return cases for therapy on Tuesdays and Fridays. In the past we have held clinics out of town at Chatham, twice a month, Windsor, twice a month, Owen Sound,

Sarnia, Stratford, and Woodstock, each once a month. Appointments for the out-of-town clinics are made either by the hospital admitting department if we hold a clinic in a hospital or by the Medical Officer of Health’s office if the clinic is held there, as it is in Chatham, Sarnia, Owen Sound and Woodstock. In many of the centers we have a great deal of help from the local Public Health Nurses in gathering histories, preparing patients for clinic, and in following up our recommendations. Owing to the wide area covered by this clinic, an area which extends 150 miles or so in both directions, we have not, up to now, had very much chance to carry on long-term therapy.

It would appear that, although these clinics operate from mental hospital bases, their functions, goals and liaisons more closely approximate those of child guidance, than is seen in the Quebec picture. There is a closer liaison with the local medical profession than is seen in British Columbia.

MANITOBA

There are no travelling child guidance clinics in Manitoba. Stationary child guidance clinics are operating in Winnipeg, Brandon, and Selkirk. A travelling clinic from Brandon provides clinical mental health services in Minnedosa, Neepawa, Dauphin, Virden, Rivers, Flin Flon, The Pas, and Souris.

Services provided include psychometric and clinical testing. The clinics are conducted by personnel from the Brandon Hospital for Mental Diseases. From the information available, there is no indication of the total activities of these clinics; but from the Mental Health Services in
Canada report, one gathers that staff limitations have curtailed the activity considerably.

SASKATCHEWAN

There are no travelling child guidance clinics operating in Saskatchewan at present. The Department of Public Health does, however, maintain three full-time mental health clinics located at Regina, Saskatoon, and Moose Jaw. Each employs two full-time psychiatrists, a psychologist, two social workers, and secretarial assistants. When available speech therapists are included. The stated functions of these clinics are:

1) To provide a consultative and diagnostic service to referring physicians and social agencies. There is rigid adherence to the policy of accepting only references from family physicians, except in the case of wards of the Department of Social Welfare. Public health nurses, teachers, social workers, and others wishing to refer psychiatric problems, may do so through the patient’s family physician.

2) Therapeutic services - selected patients, both children and adults, are given therapy on an out-patient basis.

3) Educational services - the clinic through its contacts with community agencies and other personnel, attempts to promote the acceptance of mental health principles. These contacts include public health nurses, social workers, teachers, and other community leaders. The educational
program takes the form of case conferences, seminars, and institutes.

Six part-time clinics are conducted weekly, twice monthly, or monthly, depending on need and facilities available, in Yorkton, Swift Current, Prince Albert, Weyburn, Assiniboia, and North Battleford.

They are staffed by personnel from the mental hospital, the Munroe Wing of the Regina General Hospital, and the full time mental health clinics. Their function is primarily diagnostic and consultative. All patients seen are referred by physicians or the department of Social Welfare. A few patients are carried on a treatment basis, although this is necessarily limited. The community contacts provide some basis for community education.\(^1\) In addition, out-patient services were provided by the psychiatric hospital in Regina, (the Munroe Wing), and a child guidance service was operated by the Regina School Board.

Of interest to this study are the teacher psychologists associated with the health regions—one in Weyburn, one in Swift Current, and one in Regina. These are teachers who have received a one year post-graduate training course in mental hygiene, conducted by the Canadian Mental Health Association, in co-operation with the University of Toronto. It is the responsibility of the teacher psychologists to conduct an in-service training program in mental hygiene with school teachers in their areas. The main purpose of this

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\(^1\) Department of Public Health, Province of Saskatchewan, *An Outline of Psychiatric Services*, June, 1954.
program is to help the teachers gain a better insight into the behavior of children, and by so doing, to promote the healthy growth and development of the children in their classrooms. The program is carried out through conferences with groups of teachers on individual children, and through individual informal discussions with each teacher on special problems she may have in her classroom.

ALBERTA

Alberta has had an active system of child guidance clinics since 1929. Their Provincial Guidance Clinics are carried on under the auspices of the Department of Public Health. The clinics began in 1929 in Edmonton, Calgary, and Lethbridge. The first Mental Hygiene Clinics in Alberta were initiated by Dr. Fitzpatrick who was then the Superintendent of the Provincial Mental Institute at Edmonton. This later became the Provincial Guidance Clinics. The professional staff of a psychiatrist, psychologist, and social worker were for many years borrowed from one of the Mental Hospitals. The Clinic Team travelled to the larger centres of population periodically and provided a diagnostic and consultation service for persons referred by the Medical practitioners, schools, and social agencies.

In 1947, the first Guidance Clinic with a full-time staff of psychiatrist, psychologist and social worker and stenographer-receptionist, was established in the city
of Calgary. This team was to provide service for the southern part of the province, visiting the cities of Lethbridge and Medicine Hat on regular schedules, and other centres on request.

In 1948, a Guidance Clinic with similar full-time staff was provided, with headquarters in the city of Edmonton, to service the northern part of the province.

The central part of the province is serviced by part time clinics, provided by the staff of the Provincial Mental Hospital at Ponoka and the staff of the Provincial Training School at Red Deer.

It is usual for regular clinics to be held at key or focal points in each zone. For example, in the northern zone (Edmonton) regular clinics are held every two months at Wetaskiwin, Vegreville, Vermilion, Holden, Wainwright, and Westlock, and twice a year at Athabasca, Two Hills, St. Paul, and Bonnyville. In addition, the clinic team from Edmonton visits the Peace River District for a series of clinics over a two week period each year.

The system of travelling clinics had been extended, by 1954, to include twenty-two centres. In addition to the three Regional Guidance Clinic Headquarters already established in Edmonton, Calgary and Red Deer, it is planned to locate other teams at strategic points, until there are five or six such in the province.
The functions of the clinics in the rural areas to which the clinics travel are essentially diagnostic and consultative in nature. The clinics work in close co-operation with Health Units, which provide health services to schools. In areas where there are no health units, the clinics work in close co-operation with school superintendents, school principals and teachers, as well as with medical practitioners and social agencies working with children, such as Well Baby Clinics, Child Welfare Departments, and Juvenile Courts. In 1952, of persons examined by the clinics:

- 45.4% were referred by schools
- 21.3% were referred by Community agencies
- 17.6% were referred by medical practitioners
- 12.4% were self-referred
- 3.3% came from other services.

The problems of persons examined by the clinics cover the whole range of personality difficulties. In 1952, 1,801 persons were examined or treated by the Guidance Clinics. Of these, 22.7% were mental defectives, 21.9% were education problems with adequate intellect, 11% were emotional disorders, 5.1% showed anti-social trends, 4.9% were disorders of speech, 4.3% were epileptic, psychotic, or involved in sexual difficulties, 4.2% were psychoneurotics.

The clinical procedure is similar to that in the British Columbia Mainland Travelling Clinic, except that the social history information is gained by the clinic social worker on the day of the full clinic examination. Conferences are held at the end of the clinic day with the referring
persons and clinic staff, in which the cases examined are reviewed and the recommendations for management of the problem are discussed. Written reports are also sent to the referral source, giving an outline of the problem, the child's abilities, and the recommendations for management of the problem.

In the follow-up studies, there has been substantial improvement in a large percentage of even those cases who were contacted only once, whereas 75% of those carried in treatment (at the stationary centres) have shown distinct benefit.

Public education in Mental Health is another function of the Alberta Guidance Clinics. A great deal of work is done in talks to home and school organizations, service clubs, women's organizations, lectures to teachers-in-training, and medical and nursing students. As a result, public acceptance of the clinic service and of psychological and psychiatric treatment of personality difficulties has increased.

In summary, it would appear that travelling child guidance clinics, as such, are at present operating only in Alberta and British Columbia. Mental Health clinics are seen in all provinces, under the provincial departments of mental health, in the form of clinics attached to a mental hospital service, and of community clinics. These clinics frequently offer travelling clinic services of a limited nature, and generally include some child guidance services.
In all, much emphasis is on public mental health education, as well as on the specific diagnostic, consultative and therapeutic functions of the clinics. These services are relatively new, and are still in the process of defining future goals and services and of awakening and determining the need of such psychiatric services in the communities served. The trend of community-clinic liaisons is directly related to the nature of the original source of the service, so that in some provinces the main liaison is with the local medical profession—notably in Quebec and Saskatchewan. In Manitoba, Alberta, and Ontario, the clinics are closely associated with the local physician and health departments, but also have close relationships with schools and with social agencies. In Prince Edward Island, an accelerated mental health education program utilizing the services of a guidance consultant, has placed emphasis on liaison with health, welfare, and educational personnel, particularly the latter, prior to the establishment of full travelling clinic facilities, when available.

Although British Columbia and Alberta are the only two provinces as yet utilizing travelling child guidance clinic teams, there are indications that the other provinces may, in time, either establish similar services, or substantially increase the proportion of existing travelling clinic services for children. Each province has an extensive public
and professional mental health education program which should result in further demand for psychiatric services for children.

IV. Travelling Child Guidance Clinics in British Columbia

Historical Background and Development to Date

Child Guidance Clinics, under provincial auspices, have been operating in British Columbia since July 15, 1932. The first clinic was opened on a part time basis, following a request by the Provincial Psychiatrist, Dr. A.L. Crease, to the National Committee for Mental Hygiene for help in a program of prevention of mental illness. The Committee was instrumental in obtaining the services of the first psychiatric social worker, Miss Josephine Kilburn. It was realized that though advanced work was being done with children in the fields of health, education and social welfare, these activities were, with a few exceptions, uncoordinated; each group limited its study to one phase of the child, treating him either as a mind to be educated, a physical organism to be safeguarded, a dependent to be supported, or an offender to be disciplined. In spite of the excellent work in the individual fields, there were obvious gaps, overlapping, and contradiction of methods. The need of coordinating the medical, psychiatric, psychological and social approaches to children's problems, of seeing the child as a whole rather than as just a specific problem, was recognized generally on
this continent. With this goal in mind, the original
Vancouver Child Guidance Clinic was established, at first
on a part-time basis.

The system of child guidance clinics now extends over
a wide area of the province, and includes two travelling
clinic teams with headquarters in the two stationary clinics
in Vancouver and Victoria; and currently covers a total of
twenty-four semi-rural centres.

The original clinic was held at 771 Hornby Street,
Vancouver, on a weekly basis. The Vancouver clinic staff
consisted of Dr. Crease and Miss Kilburn, plus a nurse and
stenographer from the Essondale Provincial Mental Hospital
staff. Miss Kilburn also did the psychometrics. An addi-
tional psychiatric social worker was included on clinic days.

Visits to Victoria for one full day a month were
initiated on September 2, 1934. Girls' and Boys' Industrial
School examinations were also begun in this year. The Vic-
toria clinics were increased in 1935 to two full days a month;
and in this year initial clinics were held in Nanaimo, Cour-
tenay, Alberni, and Chilliwack. A public health nurse was
appointed to the staff in 1936. The clinic was, by 1937,
operating practically full time in Vancouver, with a staff of
one psychiatrist, one psychologist (appointed in 1937), two
social workers and a public health nurse. The clinic was at
this time handling cases for other agencies on a diagnostic
basis with recommendations.
The services slowly expanded from this point. In 1939-1940, the travelling team was visiting New Westminster twice a month, alternating with Chilliwack. The need of widening the scope of the Child Guidance Clinic through extension of travelling clinic services and of its consultative and community education services was recognized throughout the war years. The Annual Reports reveal increased community recognition and constructive use of Clinic services in the early 1940’s. Referrals from private physicians, magistrates, and key members of social agencies, indicated that "the citizens, professional, and non-professional are realizing the value of a psychiatric service in the daily problems arising from their general contact with their fellowmen."¹

The educational aspects of clinic function increased, with considerable teaching and orientation being given to social service and nursing students, leading to their more mature understanding of the value of the Mental Hygiene program, and of the functions of the Child Guidance Clinic.

Field visitors in Social Welfare Branch, in those districts not served directly by the clinic, gradually, through correspondence, made more use of clinic services. The visitors, recognizing problems, prepared and forwarded

¹ Department of Provincial Secretary, Mental Health Service, Province of British Columbia, Annual Report, 1940-41, p. 119.
to Child Guidance Clinic Vancouver office full histories of these cases, requesting consideration and advice. Where it seemed essential for a complete examination, the patient was presented to the nearest local clinic. In this way, the clinic service did reach further afield. This incomplete service was recognized, however, as pointing to the necessity of full clinic facilities in certain areas of concentrated population. The Travelling Clinics maintained their contact throughout the war years with Victoria, Nanaimo, Courtenay, New Westminster, and Chilliwack. It was impossible to broaden clinical services to outside districts other than through correspondence; but correspondence with teachers, doctors, social workers, et cetera, throughout the province, indicated how acutely a full-time travelling clinic was needed, once the personnel was available. The establishment of such a travelling clinic became a major post-war goal.

There were two difficulties that needed to be overcome in meeting the needs of the province by extending and improving clinics, namely, geographic and personnel. It was felt that adequate coverage within the standards recommended by the American Psychiatric Association could be provided by four psychiatric teams. Each team would consist of one psychiatrist with special training in child psychiatry, two clinical psychologists, four psychiatric social workers, including a casework supervisor and necessary clerical help.
With the acquisition of additional trained personnel to complete four psychiatric teams, it was planned to station one team in Victoria to serve the Lower Mainland area, and the fourth team would act as a travelling team to cover the rest of the province. Thus a definite goal was established, in recognition of the geographic needs of the entire province. The need of making child guidance services more accessible to those outside of the concentrated urban population in the southwestern tip of the province was recognized as immediate. As personnel requirements were met, travelling clinic services expanded rapidly.

The stationary clinic moved in 1942 to its present location at 455 West Thirteenth Avenue. A Vancouver clinic social worker was, in 1944, placed in the Victoria Clinic on a full-time basis. During the period 1942-46, services continued at this level. Dr. Crease was not always at Child Guidance Clinic, but another psychiatrist attended in his absence. Usually he was accompanied by a psychiatrist from the Provincial Mental Hospital, particularly interested in orientation in child psychiatry.

The appointment of Dr. U.P. Byrne as Director of Clinics, in December, 1945, was the beginning of real expansion in both stationary and travelling clinics. With the appointment of the first interne in clinical psychology to the clinic, and the appointment of Dr. Gordon Kirkpatrick as the second clinical psychiatrist, the travelling clinics
were then free to really move, by reason of adequate staffing. The following initial clinics were held over the next few years to present date: 1946 - Penticton, Vernon, Nelson, Prince Rupert and Prince George, with full clinics at Children's Hospital also beginning; in 1947 - Cranbrook, Kamloops, Creston; 1948 - Salmon Arm, Trail; 1949 - Nakusp, Powell River, and Murrayville. The services consisted of preliminary introductive work primarily, mainly diagnostic, consultative, and educative, and were offered at the request of the community. Great interest was shown wherever the clinics were held. Once the initial contact was made, services were continued, as frequently as needed and requested by the community - generally once or twice yearly.

As demand for services increased, additional staff was required to meet the demand. The house next to 455 West 13th Avenue was purchased in March, 1949, thus enlarging clinical facilities considerably. The film "Friend at the Door" was released in 1949, and the ways in which Child Guidance Clinic could be helpful to the various social agencies were presented, for the first time by means other than word-of-mouth. The additions to the travelling clinic list continued, with Grand Forks, Dawson Creek, Vanderhoof, Kelowna, and Quesnel being visited initially in 1951. The more extensive use of travelling clinics in all the main centres of British Columbia made it necessary at this time to appoint a social worker to give full time to the work of the travelling
In addition, the travelling clinics on Vancouver Island were for the first time sent out from Victoria rather than Vancouver. Also in this year, the first pre-clinical conference was held at the University unit of the clinic. In response to a pressing demand for her services, a speech therapist was appointed on January 21, 1952. She covered Woodlands School and the Children's Hospital, in addition to her clinic caseload. She also was available, at the request of the community, on the travelling clinic. Full clinics were commenced at Child Health Centre, Western Society for Physical Rehabilitation Centre, and at the University of British Columbia unit. Dr. Valens was appointed in May, 1952, as full-time psychiatrist in Victoria. The Victoria Child Guidance Clinic was therefore staffed by a psychiatrist and a social worker on a full-time basis.

The first clinic was held at the Preventorium and at Terrace in July, 1953. Initial clinics were held in 1954 at Ladner, Ocean Falls, Campbell River and Fort St. John. Also, in 1954, construction was started on the long-awaited Child Guidance Clinic in Burnaby and upon its completion, adequate facilities will for the first time be available.

Table 1 presents the total travelling clinic activity for the year 1953-54, and indicates the extensiveness of the service.
### Table 1. Summary of British Columbia Mainland Travelling Child Guidance Clinic Activity, April 1, 1953 to March 31, 1954

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<th>Abbotsford</th>
<th>Chilliwack</th>
<th>Cloverdale</th>
<th>Cranbrook</th>
<th>Creston</th>
<th>Dawson Creek</th>
<th>Grand Forks</th>
<th>Haney</th>
<th>Kamloops</th>
<th>Kelowna</th>
<th>Leacher</th>
<th>Mission</th>
<th>Nelson</th>
<th>Penticton</th>
<th>Powell River</th>
<th>Prince George</th>
<th>Prince Rupert</th>
<th>Quesnel</th>
<th>Salmon Arm</th>
<th>Smithers</th>
<th>Terrace</th>
<th>Trail</th>
<th>Vernon</th>
<th>Williams Lake</th>
<th>TOTALS</th>
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<td>1</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>1</td>
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(a) Refers to the number of clinic days.

Source: Department of Provincial Secretary, Mental Health Services, Province of British Columbia, Annual Report, 1954, p. 237.
The preceding material gives a general picture of the British Columbia Travelling Clinics, and the expansion in the demand for Child Guidance Clinic services in the rural areas. All this did not "just happen," but came about through the co-operative and educative aspects of clinic function, and by meeting the community at the level of its request for service, gradually working toward more broad, constructive and realistic use of clinical services.

Purpose and Plan of the Study

The purpose of this thesis is to make an exploratory study of the British Columbia Mainland Travelling Child Guidance Clinic which operates out of Vancouver. One of the main goals is a more definitive statement and clarification of the current functions and services of the clinic. This is offered:

(1) as a base for further study;
(2) in the belief that "many problems disappear when the clinics can clearly set forth, for themselves and for the community, their concepts of their function."1

In order to understand the local travelling clinic's present functioning and stage of development, it is necessary to see it in perspective. A study of current literature will be made, therefore, as to the underlying theory and assumptions,

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1 Witmer, H. L., op. cit., p. 256.
the historical development, and current problems and functioning of travelling child guidance clinics generally on this continent. A survey of travelling child guidance clinic services in Canada will be presented, from material compiled from replies to letters¹ sent out to various clinics across Canada, and to the provincial directors of Mental Health Services.

The historical background and development to date of the local travelling clinic will be compiled through interviews with Dr. U.P. Byrne, clinical director, and through perusal of Annual Reports of the Clinic.²

The above material will serve as a background for the main body of the thesis—a study of the purposes of the local travelling clinic (Chapter II), and of its operation in the field (Chapter III). The former will include: the stated administrative and staff structure and functions of the British Columbia Mainland Travelling Child Guidance Clinic; the stated policy under which it operates in the field; the geographical areas and general social service structure of the rural communities serviced; and the types of cases the clinic sees as appropriate to its function.

¹ See Appendix A.
² Department of the Provincial Secretary, Mental Health Services, Province of British Columbia, Annual Reports, 1932-1954.
The material presented will be drawn directly from annual reports and other clinical documents, plus interviews with the clinic director and the heads of the various departments within the clinic.

A threefold approach to the study of the "clinic in operation" will be made, with emphasis upon indication of the general trends and community aspects of current travelling clinic function, rather than a detailed, analytical study of services rendered. First, a random sample case study of 50 cases seen during 1953 will be made. A questionnaire will be sent to all Social Welfare Branch field offices, through which all community requests for travelling clinic service are made. The writer will also include personal informal interviews with available field casework supervisors and social workers. These last two, in combination, will lead to a necessarily tentative assessment of the response of the field to the travelling clinic services. Any follow-up material available on clinic files of the sample cases studied will be utilised; and the general community education activities of the team members will also be presented.

On the basis of this material, the findings and implications of the present study in relation to future local travelling clinic practice will be drawn and presented. It is hoped this exploratory study will be followed by more detailed and comprehensive studies in areas of importance, as indicated in the course of the study.

1 See Appendix B.
CHAPTER II

THE PURPOSES OF THE BRITISH COLUMBIA MAINLAND
TRAVELLING CHILD GUIDANCE CLINIC

This chapter will present the stated administrative and staff structure and functions of the British Columbia Mainland Travelling Child Guidance Clinic. The stated policy under which it operates in the field will be discussed; also the geographical areas and general social services structure of the communities serviced. In addition, the types of cases the clinic sees itself as handling most effectively will be reviewed. The material presented is drawn directly from annual reports and other clinical documents, plus interviews with the clinic director and the heads of the various departments within the clinic. The resulting picture will therefore present the clinic purposes and goals, and the means employed to attain them—as seen from the viewpoint of the clinic itself.

I. Introduction.

1. General Description of the British Columbia Mainland Travelling Child Guidance Clinic

The British Columbia Mainland Travelling Child Guidance Clinic is one of the two travelling Child Guidance Clinics in British Columbia. It operates out of the station-
ary Child Guidance Clinic located in Vancouver at 455 West Thirteenth Avenue and is made up of a team of five professional people—a psychiatrist, a psychiatric social casework supervisor, two psychologists, and a public health nurse "with special training."

1 The team visits, at the request of the local Health or Welfare Departments or the Schools, all the larger centres on the British Columbia Mainland (currently twenty-four communities). As a team, each member has individual duties so that a child who is referred receives a complete social investigation, a thorough medical examination, a full psychological evaluation and educational survey, and a careful psychiatric study. The team combines psychiatry, psychology and social work, as applied to children, in order to see and treat the child as a complete person in an environment—i.e., the concepts of the "team approach" and the "whole child" are basic to the service extended by the clinic. The clinic carries on a program of primary and secondary prevention of behaviour and personality disorders in children, as is summed up in the Annual Report of the Provincial Mental Health Services:

Each patient highlights the conditions that contributed to his breakdown. The Clinic has the opportunity to help the related agencies in the community to perform their mental health functions more effectively. It does this through consultation with them in regard to individual cases, through designed educational activities such as lectures and staff discussions, and through, in appropriate cases, considering

1 This will be explained later in the staff breakdown.
personnel from these agencies as part of the clinic team working with the patient. Thus the nurse, teacher, social worker, probation officer and clergyman may become partners in the clinic team in an effort to meet the needs of an individual case.

In order to meet community demand for service, the clinic team works on a fixed schedule. Enabling the team to keep to their schedule and hence supply the demand emphasizes the importance of integrating clinical services with the existing community resources. Also, it points up the clinic's dependence for its effectiveness upon agency cooperation in preparing the social history material and the client prior to clinical evaluation, and in carrying out treatment recommendations appropriate to the individual case. It is impossible, with the present clinical personnel available and with trained staff shortages in the field, to meet community demand for individual psychiatric service. An essential part of the travelling clinic's service to the community lies, therefore, in its use of the individual case study, conference and consultation to enable local professional personnel to acquire added knowledge, skills and techniques for use in their general caseload as well as in the particular case under study. The travelling clinic has, also, a broader objective, that of explaining to the public at large, simple principles of mental health based on clinical findings. Each clinic represents a pilot project or experiment in which the factors that are responsible for the maladjustment of children are demonstrated. When alerted to its individual needs,
the community may then be encouraged and indirectly guided to embark upon a preventive program of recognizing and filling the gaps in existing local health, welfare, educational and recreational resources.

Specifically, the British Columbia Mainland Travelling Clinic operates as a special consultative group to handle diagnostic problems at the case level. These cases are then used, in conjunction with lectures and films to both professional and lay groups, to fulfill the Clinic's paramount function—its contribution to the total mental health needs of the community. **Its aim is to treat the problems presented, using the available community resources in the treatment; and through community education methods, to enable the community to meet more adequately its individual needs.**

2. **Policy and Procedure on Travelling Clinic**

All travelling clinics are arranged at the request of the Regional Administrator, or District Supervisor, of the Social Welfare Branch,¹ and at the request of the Public Health Units. The Schools, in particular instances where no health or welfare services exist, may ask the Clinic team to visit.

The agency requesting the clinic is responsible for the physical setting of the clinics. If the clinic is

¹ Provincial Department of Health and Welfare.
a joint one with the Health and Welfare Branches, then the District Supervisor of the Social Welfare Branch usually assumes this responsibility. Five rooms are needed for the duration of the clinic, and every effort is made to avoid interruption of interviews. The clinic staff make their own arrangements for their hotel accommodations.

The choice of cases should preferably be made after consultation and sharing of information between the Health and Welfare Branches. The Medical Health Officer or senior nurse is responsible for the attendance of patients and members of her own staff at clinics. Whenever possible, the Medical Health Officer should attend the conference. The District Supervisor assumes this responsibility for social workers and the children whom they are presenting.

Five copies of the travelling clinic schedule are forwarded to the person in the community who is responsible for making local arrangements for the travelling clinics. These are filled out and four copies are returned to the Vancouver Clinic at least a week in advance of the appointment date.

Four copies of the social and developmental histories for each patient (see Appendix C) to be examined by the travelling clinic team are submitted to the Vancouver clinic a week in advance of appointment.

The field health and welfare offices are informed of the above procedures prior to clinical examination. In
order to prepare the patient for the clinic experience, the health and welfare agencies also receive the following outline as a guide in preparing the client so that he may participate fully and gain maximum benefit from the clinical examination:1

No patient or relative should ever be introduced to the clinic without being fully prepared. He needs to be aware of why he is coming and what will happen when here, and also the part that he plays in making the best use of the clinic facilities. Patient and relative should know in advance that examination requires half a day.

The child should have no more excitement than necessary beforehand. For instance, a child coming to the clinic in the afternoon should not have dental work in the morning or attend a circus. Children coming from long distances should be in town a day or two before examination. Children under three years of age are always examined in the morning when rested, and if feasible, children under six years should also have morning appointments.

The following information about clinic procedure will be helpful in explaining the routine of the clinic to the child and his parents:

On arrival at the CQC, the child goes to the playroom where there are toys and books available for his amusement. He is seen by the psychologist, who gives the psychometric, personality, aptitude and other tests which are required. The child has a physical examination and is later interviewed by the psychiatrist. The child's parents or guardians are also interviewed by the psychiatrist either separately or together as the case may be. The psychiatrist always wants to see both parents whenever possible. During the child's presence in the clinic, his reactions are observed and recorded. The relationships between the child and his parents, between the parents themselves, between the child and other children in the playroom are also observed. The worker presenting the child to the clinic should remain with him as the

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1 Mimeographed material sent out to each local Health and Welfare unit from the stationary Vancouver clinic.
CGC staff cannot accept responsibility for supervising the children while in the waiting room. The presenting worker will be expected to attend and participate in the conference, at which all the findings with respect to the patient are presented. At this time, plans for treatment are discussed, the worker participating in the discussion, and it is then the responsibility of the worker interested in the case to implement the recommendations and treatment plan. The person referring the case has responsibility at conference for channelling the recommendations toward a plan which is within the range of available resources.

These conferences are scheduled at a conveniently arranged time to all concerned, usually after 4 p.m. The conferences are attended by the members of the clinic team, all available members of the Welfare Department and the Health Department, school representatives, particularly the teacher involved, and the probation officer if indicated. The purpose of the conferences is twofold:

1. Evaluation of the problem, with suggestions for its solution.

2. Teaching by case method, so that those attending learn to draw parallels, and apply the principles involved in other relevant situations.

Non-professional people do not attend these conferences. The material presented is screened according to those attending. In some cases, where intimate family details are significant, double conferences are held.

Attention should be drawn to the mutuality of responsibility in participation and contribution, of clinic

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1 Dr. Byrne, personal communication with the writer.
team members and the local professional person presenting
the case, in arriving at a workable treatment plan, geared
to the available local community resources and professional
services.

II. Stated Functions

The general objectives and functioning of the
Travelling Clinic have been discussed, the conclusion being
that "the Child Guidance Clinic's paramount function is its
contribution to the total mental-health needs of the com-
munity. It is both a social and health agency and therefore
occupies a unique mediative and coordinative role in further-
ing the concept of integrated community activity in behalf
of the welfare of the individual."¹ The travelling clinic
team is unable to cope with the pressure of needed in-
dividual treatments by individually directed efforts as
therapists. It therefore utilizes the professional and
non-professional channels within the community to promote
broad mental health education, and to awaken the community
to the individual needs existing in the related fields of
social service—health, welfare, education and recreation.

The stated function of the British Columbia Main-
land Travelling Child Guidance Clinic is as follows:²

¹Annual Report, Mental Health Services, Province of
²Ibid., 1947-8, p. 128.
To study the whole child; to give guidance to family and community in understanding the causes of children’s difficulties; to give guidance in understanding the basic needs of children; to give guidance to the child himself in the light of his needs.

This is accomplished by its specifically stated functions:

1. Diagnosis

This service is one in which the child and his situation has been studied in whole or in part, a psychiatric and psychosocial evaluation is made, and possible solutions to problems contained within these areas then presented. The Child Guidance Clinics, however, have no active part in the subsequent progress of the case. The value of this service depends on the responsible agency being adequately equipped to make the social study, to make use of the clinic’s findings, and to carry out the clinic’s psychiatric recommendations. In the diagnostic service, treatment is delegated by the clinics’ psychiatrists in conference to the referring agency.¹

Diagnosis is seen not as the beginning of treatment, but as one of several thoughtful steps in a treatment process which began with the first contact at intake. Treatment starts when somebody first realizes there is a problem and decides to do something about it. In the travelling clinic situation, the clinic is coming into a situation that has already been prepared, where the patient has had an opportunity to move toward a new experience. The clinic team contributes a skill which consolidates and fortifies the treatment movement which has already taken place. It provides the impetus and the stimulus, a supporting frame-

¹ Annual Report, 1947-8, p. 128.
work and appropriate understanding—but whatever it provides, the job of treatment is something which is done by the patient. This is particularly visible in the travelling clinic experience.¹

2. Consultation

The use of this service is undoubtedly one of the most encouraging developments in the whole service (of the clinic). A consultation service is one in which the clinics' services are given to any person interested in the child, but where there may be no actual contact on the part of the clinics with the child. Social and health workers have found it helpful to discuss the psychiatric problems of their clients with the psychiatrist and the other members of the clinics' teams. In offering this service the clinics assume a very important teaching role. Such teaching is of necessity focussed on the individual case presented by the agency and on the psychiatric aspects of that case. The teaching carried out in the consultative service brings psychiatric learning to interested professional groups which can be applied to the needs of other clients.²

The district social worker, for example, gains from the clinic psychiatrist added knowledge around the meaning of behaviour, and from the clinic social worker help around social casework techniques in utilizing this diagnostic information, both in the specific case and in her general professional practice. The teacher may request of the psychiatrist medical and psychiatric knowledge in

¹ Coleman, Dr. Jules C., "Relating the Professional Services of the Clinic to Other Professional Groups in the Community," Institute for Clinic Personnel of the Child Guidance Clinics and Institutions of the New York State Department of Mental Hygiene, March 20-24, 1950, published by State of New York Department of Mental Hygiene, Mental Health Commission, Albany, N. Y., p. 74.

understanding the child's behaviour in the school or in the classroom. She may turn to the clinic psychiatrist, psychologist or social worker for an understanding of how the resources in the school environment might be used to relieve the stresses there. The minister, in consulting with the psychiatrist about a specific case, may be helped to see ways in which the activities of the church may be used not only to strengthen the individual's spiritual resources, but also to strengthen his social and personal functioning. Then again, the minister and teacher may, in consultation with the clinic social worker, gain a clearer understanding of the family unit and the interaction among family members. In addition, they may turn to the social worker to enable not only the client, directly, but the teachers and ministers themselves in mobilizing community resources more productively.

3. Education
   a) Community Education

   The educational program of the travelling clinics is based on the promotion of sound mental health for everyone, particularly the growing child, his parents, and the family.

   The function of the Travelling Clinic in presenting the broad principles of mental hygiene to the community has been stressed. The tools used for this purpose are, first, consultations with parents who come to the clinic,
and secondly, those educative channels available to the team—lectures, films, panel discussion groups, and with professional groups, case studies. Both methods provide opportunities to give guidance to families and communities in understanding the causes of children's difficulties—i.e., the basic needs of children. They also provide opportunities to discuss the available resources within the community for preventive mental health; to encourage the active use of these resources; and to encourage planning for future facilities as needed to achieve a higher standard of family life.

On a team visit, each team member is prepared to present the viewpoint of mental hygiene whenever asked. The team members try to fit the educational program to meet local demand, and although they prefer to attend meetings in a group, in order to provide specific answers directed to each profession represented on the team, they do also, when requested, speak individually to their own professional group. The material presented is, of course, chosen according to the group being addressed. If the meeting is, for instance, one sponsored by the Parent Teachers Association, and open to the general public, the presentation centres around the general areas of Child Guidance Clinic description and function, and the needs of children generally. In a professional group, more technical aspects are discussed, which could be upsetting
to a lay group, but are stimulating and instructive to those members of the profession not in as close contact with more recent professional trends as are the team members.

b) Staff Education

In order to ensure that team members are sufficiently competent and knowledgeable to function as community consultants in the above ways, the stationary clinic in Vancouver, from which the Travelling Clinic team is drawn, carries on a continuous program of staff education. Through staff meetings, technical educative films, an extensive library, participation in conferences and professional organizations, the general staff members have access to current professional developments and practice. Educational grants to enable further professional training have been utilized by members of each profession, and maximum professional training is encouraged.

It is apparent that great emphasis has been placed on the use of the travelling clinic as a teaching unit. The background material relating to British Columbia Travelling Child Guidance Clinics¹ indicates that the pioneering stage of trying to stimulate the communities' desire for service has, for the most part, passed. The table presented in Chapter I re clinical services provided

¹ See Chapter I.
to the 24 communities visited is indicative of this. The problem that presents itself now is mainly that of educating the community according to its present level of development, and enabling it to find ways and means of making fuller use of the Travelling Clinic services. This will mean further clarification and interpretation of clinical services, and encouraging and stimulating the development of a more extensive, fuller community social service structure to facilitate the carrying out of preventive and treatment measures.

4. Research

This aspect of clinic function has unfortunately not yet been utilized to any significant extent. The pressures of the tight schedule necessary to cover the vast mainland area are in the main responsible for the lack of follow-up studies on individual cases. One of the immediate goals of the Vancouver clinic is the staffing of two travelling teams, in which case emphasis will be placed on determining areas of effectiveness of team services, the extent to which treatment recommendations have been followed, et cetera. The descriptive material, now being formulated through this thesis, must necessarily precede any analytical or qualitative social work research, which is important and necessary.
III. Areas Serviced

1. Geographical

The travelling clinic, during the fiscal year April 1st, 1953, to March 31st, 1954, visited twenty-four towns on the British Columbia mainland. The towns visited were:

1. Abbotsford  
2. Chilliwack  
3. Cloverdale  
4. Cranbrook  
5. Creston  
6. Dawson Creek  
7. Grand Forks  
8. Haney  
9. Kamloops  
10. Kelowna  
11. Ladner  
12. Mission  
13. Nelson  
14. Penticton  
15. Powell River  
16. Prince George  
17. Prince Rupert  
18. Quesnel  
19. Salmon Arm  
20. Smithers  
21. Terrace  
22. Trail  
23. Vernon  
24. Williams Lake

A total of 65 clinics were held, with Trail, Prince Rupert and Penticton making most use of the direct services of the team, with 7, 5 and 5 clinics, respectively. Haney, Kamloops, and Kelowna were next, with 4 clinics each, while Chilliwack, Nelson, Powell River and Prince George each held 3 clinics.

Several of these towns are close enough to Vancouver to be covered in a one-day visit. Others involve ten-day trips, with several communities being covered on the one trip. The total area serviced is the entire British Columbia Mainland, with the closest centre, Ladner, being about 10 miles from Vancouver, and the farthest,
Dawson Creek, being 670 miles from Vancouver.

Because of the extensive area covered, and the need of visiting several centres on one trip, the team frequently travels at night. This means that the members of the team hold clinics and attend conferences all day, record necessary data in the evening, and travel on to the next centre at night, only to go through the same routine again. In centres where the team stays more than one day, the evening is frequently taken up with the promotion of mental health by one of the channels previously mentioned.

In addition to these rural clinics, the travelling clinic also operates within the city of Vancouver. Regular visits are made to the Children's Hospital, Western Society for Rehabilitation of the Handicapped, Children's Health Centre at Vancouver General Hospital, School for the Deaf and Blind, and the Detention Home. Clinics have also been held at The Preventorium, and at St. Christopher's School for Boys in North Vancouver.

2. General Community Picture in relation to Social Service Structure

In the majority of communities visited, there is a local health unit and a local social welfare branch. It is the responsibility of these agencies to determine beforehand who shall present the cases to clinic, and carry out treatment recommendations, unless otherwise indicated by
clinical results. The health units are composed of the Health Unit Director, Senior Public Health Nurse, and Public Health Nurses. The Social Welfare Branches are composed of the district casework supervisor and social work-staff. The social workers may have either a Master of Social Work degree, a Bachelor of Social Work degree, or an in-service training course. The caseloads are heavy, and there is a continual shortage of trained workers. All this needs to be taken into consideration, in looking at the total picture of the communities visited. As much knowledge as possible of the existing conditions in the individual community is necessary to gauging clinical recommendations to the local scene.

A recent promising development in rural British Columbia is the formation, in each welfare district or health unit, of a local professional organization, generally known as a Child Guidance Council. In some areas, these are functioning well, whereas in others they are not yet properly established, and their value not recognized by the community.

These Councils consist basically of representatives of the local Welfare, Health and School staffs. Representatives of Social Welfare Branch include:

1. Regional Administrator, who must be sympathetic to the idea.

2. Casework supervisor - the main functioning person of the Welfare group.
3. Individual social workers, who present cases to the total group.

Representatives of the Health Department include:
1. Unit Director, who is usually active, and provides the necessary medical background.
2. Senior Public Health Nurse.
3. Public Health Nurse, who presents the case.

School representatives include:
1. Inspector, whose enthusiasm and sympathy are necessary to effective school participation.
2. Mental Health Coordinator, who is usually a senior teacher, with eight to ten years teaching experience, a suitable personality and an interest in mental hygiene. There are Mental Health Coordinators in Kamloops, Kelowna, North Vancouver, Burnaby and in Vancouver. These men are trained at University of Toronto, in a one-year course which combines the departments interested in mental health—Canadian Mental Health Association, Department of Psychology, Department of Sociology, School of Social Work, Institute of Child Study. Their function is to instruct the teachers in mental hygiene principles, and help them toward better understanding and handling of class behavior and personality problems. The Mental Health Coordinator is an invaluable entree into the body of teachers.
4. School Counsellor.
5. Teacher, on the individual case.

In some areas others, such as probation officers, are added to the group.

The representatives of the above groups meet on appointed evenings, to consider the child being brought to attention, by either the social worker, public health nurse, or the teacher. The problem is presented to the Council by the professional person who first recognized there was a problem, and saw the need of action. Those present combine their knowledge of the case, frequently finding more than one group aware of or involved in it. In this way, the Council acts somewhat as a Social Service Index in the community, coordinating and avoiding duplication of effort. At the meeting, they attempt to decide:

1. what is the problem?
2. what can be done about it?
3. who should do it?

The problem is handled according to the skills of the group. It uses the Travelling Clinic as a consulting group, who bring their skills to bear in the evaluation of the case, i.e., in the diagnosis and treatment planning of the case. The groups represented on the Council can solve a lot of the cases themselves, but when they recognize the existence of a psychiatric problem, they refer the case to Travelling Clinic. In certain circumstances, where it is difficult because of the closely knit structure
of the community, and the role the particular parents fill in it, to "tell the family," they get around this by referring the case to the Travelling Clinic. This professional rather than personal, approach is much more acceptable and "carries more weight" with many people. They will accept "the opinion of the experts," but may oppose the same opinion from a closer source.

It is the hope of the Travelling Clinic Director that as these groups acquire added skills through case studies and actual handling, they will, with their added techniques, be able to handle more and more of the community problems at the local level. The Travelling Clinic sees as a part of its job the encouragement of the use of these Child Guidance Councils in those districts where the local professional people have not yet appreciated their value.

IV. Staff and Administration

1. Administration

The Provincial Child Guidance Clinics of British Columbia are a division of the Provincial Mental Health Services, which operate under the Department of the Provincial Secretary. The Director of the Clinic, Dr. U. P. Byrne, is directly responsible to the Director of Mental Health Services, Dr. A. M. Gee. The Social Service Department of the Clinic is in a unique position, as its personnel
is employed by Social Welfare Branch of the Department of Health and Welfare. The Social Casework Departmental Supervisor is directly responsible to the Provincial Supervisor of Psychiatric Social Work, Miss Alice Carroll, as well as to Dr. Byrne, the Clinical Director. This provides an administrative link between the travelling clinic social casework supervisor, and the Social Welfare Branch personnel, which, potentially, should result in a close relationship between the clinic and the community.

2. Staff

The following is a breakdown of the qualifications and functions of each professional member of the clinic teams:

(a) Psychiatrist

The clinical psychiatrist must be a qualified medical practitioner, with one year rotating clinical internship, four years training and experience in psychiatry, and have passed the examination of a Specialist of Royal College of Physicians of Canada. He must possess personal requirements for Travelling Clinic work, since the psychiatrist occupies a key position in the team. He must be able to encourage and infuse team spirit through effective direction, and adequate supervision. Certain qualities of personality, a certain range of social and community interest and knowledge, and special abilities for getting along with people singly and in groups are
requisite. He must be versed in good public relations techniques in order to foster sound working relationships and integration with the lay and professional groups in the community. He should also be a fluent speaker, in order to lead in the presentation of sound mental health principles to the community; to awaken recognition of need and desire for improvement in community resources, and to interpret clinic function to the various community agencies and groups in the promotion of greater, and more productive, use of clinical services.

During the clinical examination, the psychiatrist, working within the team approach, has the responsibility of diagnosis, and the determination of the child's need for psychiatric treatment, as well as the responsibility for providing an evaluation of the child's physical condition. The latter, the first step in clinical procedure, is of great importance, in recognition of the effect of bodily illness upon behaviour. The psychiatrist notes, particularly,

1. coordination
2. hearing
3. vision
4. hand and eye dominance

since these, if present, give rise to certain specific difficulties in learning to write, spell, and read. Before determining the presence of an emotional basis to any of
these learning difficulties, it is necessary to rule out possible physical causes.

The psychiatrist formulates a general estimate of the child's

1. mental state
2. personality
3. adaptation
4. motivation—of child and parents

through the medium of interviews with the child and parents, and noting pertinent points in the Social History. He is chairman of the full clinic conference following clinical examination, in which summaries of:

1. social history
2. physical examination
3. psychological evaluation
4. educational status
5. general mental health

are presented. Although the whole team participates in and contributes toward the establishment of the diagnostic evaluation and formulation of treatment planning, it is the psychiatrist who is the final authority, and who carries the responsibility for these.

In addition to these, the psychiatrist also is available for consulting conferences with parents and workers, and other professional people within the community. In the community educational work of the Travelling Clinic, his role is a heavy one. He is available, at the request
of community groups, for lectures, discussions, participation in panels, and film presentations. This is a large and important aspect of travelling clinic service, as has been discussed previously.

(b) Psychologist

The stated professional requirements for the clinical psychologist are: (1) a Bachelor of Arts degree plus 5 years clinical experience; or (2) a Master of Arts degree plus 2 years experience. There are, however, very few psychologists with these qualifications available. In order to compensate for this shortage of qualified psychologists, a "clinical internship" was established. In line with this, there are currently three "grades" of psychologists:

1. Psychologist Grade I - known as a "clinical intern." This group includes those with a BA degree, with a major in psychology, who are gaining clinical experience through the clinical internship, generally of one year's duration.

2. Psychologist Grade II - known as a "Psychologist." This group includes those with the BA degree plus the one year's clinical experience.

3. Psychologist Grade III - includes those with a Master of Arts degree plus 2 years' clinical experience, or, those with a BA plus 5 years' clinical experience.
At present, there has been quite a staff turnover in the psychology department personnel, so that the majority of the psychologists on travelling clinic are either Grade II psychologists, or clinical internes.

Ideally, personal requirements for travelling clinic work, in line with the travelling clinic objective, include skill in the education and public relations aspects of the profession. The psychologist is usually closer to the schools and the educational programs and problems than are the other clinical workers, and may be very active in school-clinic relations.

The stated function of the Psychologists is to:

...apply the basic knowledge which they share with all psychologists plus additional skills in interviewing people and counselling them, and in evaluating tests that indicate intelligence, personality characteristics, emotional adjustment, and other individual differences.

In the clinical examination, the psychologist is first of all a specialist in the tools of psychology, and therefore responsible for the diagnostic psychological study. He (she) applies all the objective and projective procedures that will contribute to a building up of a picture of a person and how he functions. He adds to this his clinical insight and judgment, and arrives at conclusions that are helpful in treatment planning.

In general, the psychologist is responsible for a psychological assessment of:
1. the client's intellectual capacities, verbal and non-verbal, and specific strengths and weaknesses in intellectual functioning;

2. emotional factors interfering with intellectual functioning;

3. learning capacity in major educational areas;

4. achievement in the tools of learning;

5. the specifics of any learning disabilities;

6. directions for further education, or possible limits of further education;

7. aptitudes and interests;

8. motor coordination;

9. speech problems;

10. habits of work;

11. aspiration levels;

12. frustration tolerance;

13. remedial needs and many elements of personality.

The psychological study will give hints that may require medical study, or some special aspects of psychiatric study. Leads for the psychiatrist in exploring feelings, attitudes and relationships may emerge from the psychological study. Although the psychologist does not deliberately probe for these, she is alert to their manifestation.

The travelling clinic psychologist must be available for consultation purposes (mainly with school per-
sonnel) if requested, and for participation in discussions and panels with other team members. She, too, must be able to interpret Mental Health to professional and non-professional community groups, and to further the development of effective preventive programs within the community.

(c) Psychiatric Social Casework Supervisor

The professional requirements for the Travelling Clinic Casework Supervisor are:

...a Master of Social Work degree from a university of recognized standing; several years' experience in work related to the duties to be performed including some experience in collaborative work with other professional disciplines, preferably in a Child Guidance Clinic; sound knowledge of the dynamics of human behaviour; ability to interpret services of the Clinic and casework method to professional persons and to the general public; working knowledge of all Acts and Regulations pertaining to the work of Social Welfare Branch; knowledge of existing resources and services relating to mental health needs of families and children; ability to withstand the taking of long trips each month to various districts of the province; demonstrated or potential ability to supervise other social workers.¹

Personal requirements are again a determining factor in suitability for the position. Again the liaison, consultative and general community education aspects are of outstanding importance, since the casework supervisor takes a good deal of responsibility for the coordinating aspects of the clinic. By virtue of their specific training, social workers have a particular awareness of the

¹ Social Welfare Branch, personnel advertisement.
effects of agency functions and policies, and a knowledge of community structure, both as it should be and as it is. Since the social worker is from the beginning identified with social agencies, the casework supervisor on travelling clinic functions as the liaison person between the community social service resources and the clinic. He is, in particular, the team liaison person with Social Welfare Branch personnel.

The following job description study, worked out over the last year, clearly states the role of the Travelling Clinic Casework Supervisor.¹

1. **Administrative Responsibilities**

   a) Arranging Clinics. Discussions, arrangements and correspondence with personnel in the field regarding clinic function, available dates, and general preparation for such clinics.

   b) Integration of services to clients on Travelling Clinics, including planning and scheduling of team activities and promoting flow of work.

   c) Contributions to the over-all coordination and integration of team operations to promote the collaborative services to clients.

   d) Maintaining liaison with and encouraging cooperation of all existing community services in the field such as schools, health and welfare agencies, and other community groups.

   e) Reporting on work to the Supervisor (of Child Guidance Clinic Social Service Department) through consultation and statistics.

¹ Job descriptions study, Child Guidance Clinic staff, Vancouver, 1954.
2. **Supervisory Responsibilities**

   a) Discussion of cases with supervisors and workers in the field to promote implementation of recommendations. Further discussion may be requested through the field supervisor on a continuing case, and this may be handled through correspondence.

3. **Consultative Responsibilities**

   a) Contributing to findings, evaluation, diagnoses and treatment recommendations of clinic team.

   b) The interpretation of existing services and resources relating to mental health needs of families and children.

   c) Recording the social work participation in such cases.

4. **Caseload Responsibilities**

   a) Interviews on Travelling Clinics. Direct interviews with relatives and friends, and professional associates to procure data for the immediate use of the team for evaluation of the presenting problem and diagnosis.

   b) Responsibility for limited caseload as time permits.

   c) Recording of these casework activities.

5. **Educational and Interpretive Responsibilities**

   a) Participation in orientation, lectures, and discussion leadership on Travelling Clinics throughout the province to interpret services and mental health principles in professional and community groups.

6. **Staff Development Responsibilities**

   Contributing to staff meetings, committee work, and staff projects.

7. **Research Responsibilities**

   Participation in any surveys or research projects undertaken by Clinic, Social Welfare Branch, Mental Health Services, etc.
In practical working experience, the following is a resume of the casework supervisor’s activity during a typical travelling clinic day:

While the child is being examined by the psychiatrist, the social worker, having familiarized himself with the Social History material presented in advance by the local person referring the case, interviews one or both parents. In the process, he clarifies certain points in the history, for the benefit of the clinic team. He also formulates his social diagnosis of the situation, based on the Social History material, plus his own disciplined observations of the parents during a well-focussed casework interview. He notes: the strengths and limitations of the parents; their ability, based on their own past experiences and relationships, to give to the child; their general feelings around the child and around their own parents. He observes parents, evaluates what they can be expected to give in the light of their own experiences; he assesses the child and its social needs, and evaluates the strengths and limitations in the parent-child relationship. Drawing upon his dynamic understanding of family inter-relationships, of social situations in general, and of social resources, he then contributes, in the conference, towards the establishment of a diagnosis and a treatment plan.
In a routine clinical conference, the attendance ranges from about 7 to 30 professional people, including:

1. clinic team members.
3. Public Health Unit nurses and doctors.
5. Local physicians.
6. Probation Officers.
7. Other professional people involved in the particular case, such as ministers.

The clinic psychiatrist, who is chairman of the conference, gives his brief outline of the case and the problem, the psychologist gives the psychological report, and the Public Health Nurse gives her playroom and examining room observations. The clinic social worker presents his social evaluation, arrived at as described above. The psychiatrist then presents his psychiatric findings as derived from his interviews with the child, and with the parents. Next, the local school representative is asked for an evaluation of the child's adjustment at school, and any pertinent medical information is presented. A portion of the conference is a period of general discussion, with each person present contributing what he or she sees as helpful in understanding the specific situation. The psychiatrist draws the discussion and the team present-
ation together. He gives an evaluation of the problem, and asks for suggestions as to the help that can be given to relieve the current pressures. Where there are obvious lacks in available resources, the team may explain how other communities have increased their resources, how these resources are used, and their value to the community. The general community picture of social service resources is frequently examined. Often the ways and means of initiating community interest in establishing needed facilities are discussed. The clinic social worker is responsible for recording the conference discussion, members present, and the staff's treatment recommendations.

Following the conference, the clinic social worker contacts the local social worker and district supervisor, and clarifies points of discussion, plus the local social worker's role in treatment. These are further clarified in the doctor's report, which is sent to the local Social Welfare Branch or Public Health Unit office, following the travelling clinic's return to the Vancouver Stationary Clinic. The local social worker is encouraged to use the clinic social worker consultatively on this and future visits, and to inform the travelling clinic social worker of progress made in cases seen by the Clinic on other occasions.
In discussion with the current Travelling Clinic Casework Supervisor, who is newly appointed as of January 1, 1955, he pointed out the advantages of being known to the district as a Supervisor, rather than as a Caseworker, as formerly. The district supervisors feel free to discuss, with another supervisor, many of their supervisory problems. This leads to a better understanding of the capabilities of the District staffs, in turn leading to treatment recommendations geared to the resources, professional as well as material, of the community. The District Supervisors also have the opportunity of becoming acquainted with the latest Social Welfare developments in Vancouver, and in other Social Welfare Branch districts. The Travelling Clinic supervisor is, then, potentially one who integrates and coordinates the clinic services among the various Social Welfare Branch offices. This potentially strengthens working relationships and understanding between the districts, as well as between the district and the Travelling Clinic.

The present Travelling Clinic Casework Supervisor recognizes the importance of furthering the use of the available consultative services of the travelling clinic. In this connection, and in an effort to do some follow-up study of previous Travelling Clinic cases, he has initiated a program of contacting local personnel,
with a view to:

(a) future assessment of the amount of intensive contact local health and welfare personnel are able to give on individual cases;

(b) reality of clinic recommendations in terms of the local resources;

(c) correct use of Travelling Clinic services by local referring agencies;

(d) suggestions on treatment of patients and the mental health aspects in the particular situation.

As an example of this approach, he recently reviewed 47 cases with the Public Health staff in one of the centres visited. In the process, he was able to help the Public Health Nurse in her understanding of the relevant family relationships, and around appropriate handling of them. If this proves of value to the nursing staff, they will voluntarily repeat the experience on individual cases; and see the value, to themselves and to their patient, in keeping Travelling Clinic informed of progress in clinical cases. The broader objective of increasing the Public Health Nurse's understanding of the basis and treatment of personality and behavioural disorders is of course inherent in this approach. This would apply equally in the case of Social Welfare Branch cases.

The value of "knowing the community" is stressed by this travelling clinic casework supervisor, if most
effective clinical service is to be extended in all areas. He is planning to establish a file on each community visited, in which he will include; a list of the foster homes, adoption homes, institutions in each area; recreational facilities, service clubs, et cetera; plus the local school personnel, indicating receptiveness, understanding and participation in clinical services. This file will be of inestimable value in integrating clinical services with existing community structure, and will point up those areas which need particular emphasis, if the specific community is to fill adequately its social welfare needs, and ensure an adequate Mental Health program.

The reality of the tight clinical schedule--an average of 3-4 clinical examinations and conferences daily--has impinged upon the amount of participation in community education lectures and discussions. Its importance in fulfilling clinic function is recognized, but at present with one travelling team attempting to meet the demands for services of the entire British Columbia Mainland areas, the evenings are too often spent in travelling to the next town. The establishment, in the not too far distant future, of a second travelling team, will enable more participation in general community education activities.
(d) **Public Health Nurse**

Professional requirements for the Public Health Nurse on the travelling clinic team are an R.N. with Public Health training, and psychiatric experience. This special program of education is designed to help her as a professional person to achieve a body of knowledge and a philosophy about human behaviour, closely tied to nursing situations. On the travelling clinic team she is in effect the liaison between the rest of the clinic staff and the Public Health nurses and the Public Health Units in the community visited. She is the clinic consultant to the local Public Health Nurses; and since the Public Health Units, along with the Provincial Social Welfare Branch districts compose the bulk of the clinic's referral sources, the importance of her consultative role cannot be overestimated. She is in a position, through her understanding of and participation in the profession of nursing, to encourage understanding of appropriate use of the clinical services, and to give guidance around more effective preparation of social history material, preparation of the client for clinical examination, and guidance around the productive carrying out of treatment recommendations.

Her specific functions on the travelling team are: ¹

1. to observe the child in the waiting room and at play;

¹ Dr. Byrne, personal communication with author.
2. to prepare the child for the physical examination, and give assistance at the physical examination, including vision and audiometer tests;
3. to take specimens and do laboratory tests as indicated;
4. to operate moving picture projector during showing of mental health films to the community.
5. to take full part in the educational program;
6. to gather statistics and do statistical analyses of clinic services;
7. to handle all reservations for travelling clinic team.

As with the other team members, emphasis is placed on the community aspects of her role. It can be seen that each professional representative has a distinct role as consultant person on the team for the related professional group in the community. Each team member must also be able to interpret the mental health program and functioning of the clinic as a whole, when called upon to do so.

V. Types of Cases

The travelling clinic attempts, through education of referring sources in the various ways previously discussed, to encourage the presentation of children whose problems are of a nature that will benefit from clinical services. Here again, the use of case study and conference on individual cases, consultations around general and specific professional
practices, and lectures and film presentations to the general public, is invaluable in promoting maximum and most effective use of the travelling clinic. Through these mediums, in addition to education in the basic principles of growth, development and human relationships, the clinic clarifies the indications for referral to the clinic, stressing:

(a) multiplicity of symptoms;
(b) persistence of symptoms;
(c) inappropriateness of behaviour;
(d) indications of mental retardation.

The Social Welfare Branch Annual Report, 1948, states that:

...deviations in mental status, trait, conduct, or habit, do not of themselves necessarily constitute problems, nor do they always indicate the need for study by a child guidance clinic. It is rather when the aforementioned are not adequately dealt with, understood, or accepted within the family, or by the persons who are caring for the child, or when the aforementioned deviations cause present disharmony within the child or family or point to future unhappiness or harm and are found to extend beyond the remedial resources within the child's immediate environment that child guidance evaluation is indicated.

The types of problems referred to the travelling clinic, and felt to be appropriate, are wide in range and variety, and include:

1. **Primary Behaviour Disorders**

These include disorders of habit, personality, conduct, and neurotic traits. They are called primary because
they are not secondary to any pathological condition. The behaviour is therefore indicative of underlying emotional disturbance, and clinical evaluation as to the diagnostic significance of the symptoms, and recommendations as to treatment, help guide the local worker in her role of casework treatment, and appropriate use of community resources. Since primary behaviour disorders develop in the child in reaction to the influences of the environment, the social worker's knowledge about the dynamics of family relationships is of prime importance in arriving at a diagnostic assessment of the problem.

Thumb-sucking, nail-biting, enuresis, masturbation, et cetera, are included in the habit disorders.

The personality disorders include sensitiveness, seclusiveness, apathy, day-dreaming, excessive imagination and fanciful lying, moodiness, obstinacy, quarrelsomeness, selfishness, laziness, lack of ambition or interest, general restlessness, et cetera.

Among the conduct disorders are disobedience, teasing, bullying, temper tantrums, bragging or showing off, defiance of authority, seeking bad companions, keeping late hours, lying, stealing, truancy, destructiveness, cruelty to persons or animals, sex activity.
2. Dependent Children

These are the children who, because of some disaster in the home, are becoming or have become, social charges, i.e., they have become wards of the Supervisor of Child Welfare, and as such are dependent upon social agencies—Social Welfare Branch in the rural areas—for appropriate maintenance planning. Early clinical evaluation of the child's emotional adjustment is helpful to the rural professional worker in making plans appropriate to the individual child. In this way, adequate plans can be made for their care, based on the child's needs, and resources in the community to meet those needs. Much future difficulty can be avoided in this way. Adoption homes, foster homes, institutions, may be then chosen and prepared, in the light of the child's needs.

3. Exceptional Children

This group includes children who are either exceptionally bright, or retarded. These children frequently come into conflict with their environment. It is important that their abilities be evaluated, and adequate plans be formulated for them. Again, the travelling clinic, through its full clinical investigation, supplies the diagnostic base from which the rural worker proceeds. Consultations on future clinic visits are available when requested. The local worker may return for guidance around specific treatment techniques and problems, or around further understanding
of the basic motivation in the particular situation, and how to cope with it constructively. In these situations, the parents need help, first, around understanding the difficulties generally inherent in a child of this specific ability, or disability; secondly, in feeling free to express their feelings about the behaviour, and to gain acceptance of the naturalness of these feelings within themselves, thus relieving their guilt, and enabling them to move toward greater acceptance and understanding of the child; and thirdly, help around meeting the child's needs, as specifically indicated in this particular family and general environment.

Summary

The British Columbia Mainland Travelling Child Guidance Clinic operates as a special consultative group to handle diagnostic problems at the case level. These cases are then used, in conjunction with lectures and films to both professional and non-professional groups, to fulfil the clinic's paramount function—its contribution to the total mental health needs of the community. Its aim is to treat the problems presented, using the available community resources in the treatment; and through community education methods, to enable the community to meet more adequately its individual needs.

Cases are presented to the travelling clinic by local health and welfare personnel, and occasionally by
school personnel or probation officers. These local people prepare the social history, and send it in to the clinic team in advance of its visit. On the clinic day, the child referred receives a complete social investigation, a thorough medical examination, a full psychological evaluation and educational survey, and a careful psychiatric study. Following this, a case conference is held, at which the clinic team and interested local professional people participate. The purpose of the conference is twofold.

1. Evaluation of the problem, with suggestions for its solution;

2. Teaching by case method, so that those attending learn to draw parallels, and apply the principles involved in other relevant situations.

Clinic team members and local professional personnel are mutually responsible for participation and contribution toward a workable treatment plan, geared to the available local community resources and professional services. A written report is sent by the clinic doctor to the local referring agency, upon the clinic's return to Vancouver.

The stated functions of the local travelling clinic are diagnosis, consultation, community and staff education, and research.

Since community demand for individual psychiatric services can not be met under existing clinic and field
staff shortages of trained personnel, emphasis in the travelling clinic is upon the use made of the clinical diagnosis and case conferences, and upon the consultative and community education aspects of travelling clinic function. This shows up clearly in the description of the qualifications and functions of each team member. Skill in the community education and public relations aspects of the clinic are inherent in the individual personal qualities necessary for travelling clinic work. Each professional member of the clinic needs maximum professional training, in order to act as consultant to the community personnel in his or her professional capacity, when the occasion arises. Requisite also is the ability to interpret total clinic function to community groups and individuals. In addition to this, it is extremely important that all persons assigned to travelling clinic are interested in, and comfortable about, working with rural people, and have some means of intimate communication with them.

The travelling clinic attempts to encourage presentation to the clinic of those children whose problems are of a nature that will benefit from clinical services. The types of problems seen as appropriate referrals for clinical assessment and treatment recommendations are, broadly:

1. primary behaviour disorders;
2. dependent children;
3. exceptional children.
The broad clinical aim of helping the local professional groups detect and handle more and more of the community problems at the local level, is inherent in the entire clinical process. A most positive sign, and one that needs support and encouragement, is the gradual development in rural areas of British Columbia, of local professional organizations, known generally as Child Guidance Councils.
CHAPTER III

THE BRITISH COLUMBIA MAINLAND TRAVELLING CHILD GUIDANCE CLINIC IN OPERATION

I. Introduction

In the preceding chapter, the broad aim of the Travelling Clinic has been formulated as being:

...to treat the problems presented, using the available community resources in the treatment; and through community education methods, to enable the community to meet more adequately its individual needs.\textsuperscript{1}

It is with this broad aim that the present chapter is mainly concerned. The purpose of the material presented herein is to indicate the general trends of clinic operation within the communities at present utilizing its services. This thesis is seen as an exploratory study, with one of its goals a more definitive statement and clarification of the function the Travelling Clinic is currently fulfilling within the rural communities of the British Columbia Mainland, rather than a detailed, analytical study of services rendered.

A threefold approach to this study of the "clinic in operation" has been made, therefore, through:

1. Random sample case study of fifty cases seen during 1953 by the Travelling Clinic. The emphasis upon

\textsuperscript{1} Chapter II, p. 59.
the material thus collected directly from the clinic files, has been upon indicating broadly:

a. The characteristic group of clients being referred for individual services;

b. The problems seen by the referral sources as indicating the need of clinical evaluation and help in treatment planning;

c. The channels of referral and presentation of cases to the clinic;

d. The professional members of the communities, who, through attendance at case conferences, come into direct contact with clinical concepts and knowledge about the understanding and treatment within the community, of behaviour disorders in children, and general mental health methods in their alleviation; and in the prevention of further similar difficulties in other children;

e. The trend of recommendations made for such community treatment of the disorder.

2. Questionnaire sent to all Social Welfare Branch field offices (see Appendix B), through which all community requests for Travelling Clinic services are made. The writer has used the replies to this questionnaire (fourteen were returned out of the twenty-four sent out), in combination with (3) below, to come to a necessarily tentative assessment of the response of the field to the Travelling Child Guidance Clinic services extended.
3. Personal informal interviews with available field casework supervisors and social workers.

It is recognized that at its present stage of development, and under the necessary operational pressures of time imposed by the limited number of clinic team members working throughout a vast geographical area, there are certain limitations in the clinic files which inhibit a comprehensive analytical study of individual case services. As has been mentioned previously, the clinic is aware of these gaps, and is hopeful of, in the near future, reducing the pressures upon the travelling teams, by the formation of a second travelling team. One of the main emphases, in addition to such relief of pressures and more frequent service as desired by the communities, will be on follow-up studies, with a sensitivity to future study of the effectiveness of current clinical practice, in relation both to the individual as a "case", and to the community as the focus.

The emphasis in this thesis is upon the community aspects of the Travelling Clinic service. It is the writer's impression that once these are more clearly defined, and broad function as well as specific function imbedded in the thinking of team members, referring agency members and professional persons within the referring communities, then and only then will clinical facilities be extended and utilized to the maximum benefit of all concerned—and particularly of the client being served—the individual within
II. The Travelling Clinic's Current Field of Operation

The question broadly posed in this part of our study, is: who is the travelling clinic reaching, and how? As has been indicated, we are concerned here not with the clinic's ability to perform its diagnostic function adequately in relation to each case; its ability to do so, and the process involved, have been clarified in Chapter II. We are concerned here, however, with the use made of such diagnostic services, i.e., with the diagnosis in action, in furthering community (professional and non-professional) understanding of children's needs, and use of clinical services, concepts and knowledge, toward creating a healthier, happier environment for the children of the community.

We have seen that the travelling clinic is set up as a very specialized service organization, doing a specialized job. In order to do that job effectively, it must be able to have the kind of patients that it can help. If the clinic is flooded with patients it cannot help, obviously it is not going to be able to do the job for which it was set up. According to Dr. Jules Coleman:

...when a clinic opens up for the first time in a community, the pattern of referral usually follows pretty much the same course....the first cases referred are very likely to be the defective children, and then, hard on their heels, the over-aggressive,

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1 Coleman, Dr. J.S., "Relating the Professional Services of the Clinic to Other Professional Groups in the Community," New York Institute of Child Guidance Clinics, 1950, p. 66.
delinquent behaviour problems, i.e., those problems which are causing the community the most woe. **It is the clinic's job to clarify its services with the agencies in the community.**

Coleman goes on to say that if the clinic feels its time is best spent with certain types of problems rather than others:

...in order to be able to work with such problems, they must do a great deal of interpretation with the agencies in the community representing the supporting services. Such interpretation does not mean explaining to the agencies what one wants, but is, rather, a process of demonstration or of interpretation through the use of case material. By inviting representatives of the agencies to come into conferences which the clinic holds, and by maintaining continuous contact over a period of time in a given community, I think that eventually the agencies begin to recognize they can get more help with some cases than with others. Then they will have a tendency to refer those cases for which the clinic can be of best service.

The following material, from the random sample of fifty cases seen during 1953 by the travelling clinic, will give an indication of the trends, in relation to the above material, in current travelling clinic practice throughout the British Columbia Mainland.

1. **The Children Referred for Travelling Child Guidance Clinic Evaluation in 1953**

The unit of study in child guidance is the individual child, with any services extended to parents and others in close contact with the child, being offered in his interests and with the focus upon his problem. Modification of family and community attitudes is, of course, an essential part of helping the child; but for statistical purposes emphasis is on the child as a unit, the family being viewed
as "environmental factors" amenable to modification through appropriate casework services.

In order to determine the general characteristics of the group of children being referred for travelling clinic evaluation in 1953, as seen in the case sample under study, let us look at them in terms of:

- age range
- sex
- status (home environment)
- intellectual ability
- community of origin.

This will present a general picture of the group of children currently being seen by the community as candidates for Travelling Clinic evaluation. It will indicate, as well, the medium through which the clinic is now working in its move toward increased community mental health knowledge and facilities in creating a happier, healthier environment for its citizens, both child and adult.

Table 2 shows the age range of the clients, and the proportion of each sex within the various age groups.

Table 2. Age Range and Sex of Clients in the Sample Study of Travelling Child Guidance Clinic Cases, 1953.

<table>
<thead>
<tr>
<th>Sex</th>
<th>Age in Years</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1-4</td>
<td>5-6</td>
</tr>
<tr>
<td>Boys</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Girls</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Total</td>
<td>6</td>
<td>3</td>
</tr>
</tbody>
</table>
The above table indicates that the tendency is for a larger proportion of boys to be referred to the clinic than girls, the ratio in the sample being 29:21, or, of the total, 58% boys to 42% girls.

The age of the children ranged from 3 to 17 years, with the age group 9 to 12 years accounting for 21 of the children, or 42% of the total studied. The remainder of the children were distributed relatively evenly above and below this concentration, with 14 (28%) falling in the 1 to 8 year age group, and 15 (30%) falling in the 13 to 18 year age group. The age distribution in boys was much more even than in girls, with 10 of the 29 cases being in the 1 to 8 year age range, 10 in the 9 to 12 year age range, and the remaining 9 cases in the 13 to 18 year age range. The age distribution of girls, on the other hand, was largely concentrated in the 9 to 12 year age group, which accounted for 11 of the total of 21 girls referred. Of the remaining 10 girls, 4 were younger than 9 years, and 6 were older than 12 years.

On the surface, this age distribution is a fairly typical one for a child guidance clinic caseload. It appears to indicate that although some children are recognized at an early age as having problems requiring clinical assessment and help, the majority are not referred as early as is in the best interests of the child. It would be interesting to study in greater detail the trend of Travelling Clinic referrals over the years, in order to ascertain a definite
trend in the referral age of the clients.

Table 3. General Family Backgrounds of Clients in the Sample Study of Travelling Child Guidance Clinic Cases, 1953.

<table>
<thead>
<tr>
<th>Natural child in own home with both parents</th>
<th>Natural child in own home with only one parent</th>
<th>Ward of Superintendent Child Welfare, in foster home</th>
<th>Child in Adoptive Home on Adoption Probation</th>
<th>Adoption Completed</th>
<th>T O T A L</th>
</tr>
</thead>
<tbody>
<tr>
<td>25</td>
<td>9</td>
<td>9</td>
<td>4</td>
<td>3</td>
<td>50</td>
</tr>
</tbody>
</table>

The outstanding indication in the above table is that one-half of the referrals were children from an outwardly physically normal home environment, insofar as they have not suffered the trauma of separation from their parents by death, illness or desertion. Of the remaining 25 children, 9 have suffered separation from one parent, but still have, at least nominally, the close contact and support of the other parent; 9 are children who are wards of the Superintendent of Child Welfare, placed in foster homes; and of the 7 children in adoptive homes, 4 were on adoption probation, and 3 had been legally adopted. The broad implication of this is that 32% of the children referred are those for whom social agencies have had sole responsibility in planning at some time in their lives, and who traditionally form a large proportion of child guidance clinic caseloads. These are the "dependent" children in whose welfare child guidance clinics have had a traditional
interest. The use of a sound mental health study ensures that the social agencies in whose charge these children are, because of some disaster in their own homes, will have at their command the knowledge of the child and his needs that is essential to suitable planning for his future well-being. There will be less chance of unsuitable, even damaging placements, if the available homes are evaluated in accordance with the child's needs and potential, and insofar as is possible, placements made with a view to the correlation of the needs of the child and of the future home.

The remaining 68% of the children are living in their own homes under the care of one or both parents, and presumably were referred because an adjustment problem was recognized and help sought in its solution. The implication is that these homes, on the whole, indicate supportive strengths for the child; and with the exception of the few instances in which removal of the child from his own home was recommended, their voluntary appearance at clinic is indicative of the parents' recognition of the problem, and their desire for professional help in its alleviation.

Table 4. Intelligence Ratings (as determined by clinical examination) of Clients in the Sample Study of Travelling Child Guidance Clinic Cases, 1953.

<table>
<thead>
<tr>
<th>Range</th>
<th>0-19</th>
<th>20-49</th>
<th>50-69</th>
<th>70-79</th>
<th>80-89</th>
<th>90-99</th>
<th>100-109</th>
<th>110-119</th>
<th>120-139</th>
<th>140+</th>
<th>Unable to Assess</th>
<th>Total</th>
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<tr>
<td></td>
<td>-1</td>
<td>8</td>
<td>3</td>
<td>12</td>
<td>11</td>
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<td>4</td>
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<td>-</td>
<td>5</td>
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<td>50</td>
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</table>
Table 4 indicates that of the 50 children studied, 23 (46%) fell within the slow normal (12 cases) and normal (11 cases) range, i.e., I.Q. 80-99. Of the remainder, 10 (20%) were in the bright normal and superior range of general intelligence—i.e., I.Q. 100-129; 12 children (24%) were in the lower range of intelligence; and 5 suffered a disturbance—physical, emotional or intellectual—of such severity that the intelligence potential could not be established. From this sample, it would appear then that of the 50 children seen, only 12 were children for whom institutional care would probably be indicated; 33 children (66%) were children who, with appropriate help, could function as responsible citizens, and who could, in all but the severely disturbed cases, respond to casework help; of the remaining 5 cases (10% of the total sample) institutionalization for either emotional, physical or intellectual disturbance of a gross nature would in all probability be eventually indicated. It would appear then, that of all the cases referred, 66% are potentially responsive to appropriate help within the community.

Finally, with regard to the semi-rural centres1 from which these children were referred, it was seen that they encompassed 23 of the 24 districts visited; and were concentrated in Vernon, Penticton, Cranbrook, Abbotsford, Trail and Kelowna.

1 Refers to the town and rural areas surrounding it whose activities are centred in the town.
In summary, the following trends appear:

1. More boys than girls tend to be referred to clinic — 58% boys to 42% girls.

2. The age of the children referred ranged from 3 years to 17 years, with 42% of the total sample falling in the 9-12 year age group, 28% in the 1-8 year age group, and 30% in the 13-18 age group — i.e., although some problems are recognized early, the majority are not referred for help as soon as is desirable;

3. 50% of the children referred are those living in their own home with both parents; 18% are from broken homes but still are living with one parent; and only 32% of the sample were children who are or have been dependent upon social agencies for care and planning. Presumably, then, 68% of the children were referred because a problem was recognized and help sought, and their parents would be actively involved in the solution of the problem. This would seem to indicate increasingly appropriate use of Travelling Clinic in preventive cases.

4. 66% of the children referred fell within the range of general intelligence which is potentially responsive to appropriate help within the community; only 24% were children for whom institutional care seemed indicated, and in 10% of the cases the severe degree of disturbance—physical, emotional, or intellectual—would quite probably not be responsive to treatment within the community, but does need assessment in order to plan appropriately.
These, then, are the general characteristics of the group of children currently being referred to the Travelling Clinic for diagnosis and treatment planning.

2. The Problems Seen by the Community as Indicating the Need for Clinical Assessment and Help

The classification of problems presented here represents not the clinical diagnosis of the problem, but rather the symptoms which appear as problems to the parents, to the social, health, recreational and educational institutions, and to the people of the immediate geographical area in which they arise. Special stress has been placed on studying the frequency of complaints as viewed by the referring sources (the community), since the value of any community service such as a Travelling Child Guidance Clinic is determined, in a practical sense, by what can be done to reduce the stresses which cause concern, not only for the child, but for the large number of citizens with whom he is in constant contact. Unless this is achieved, no matter how accurate the diagnosis of the problem may have been, it is of little value unless it is translatable into concrete aids toward the solution of the problem.

Social work and other human relations professions recognize that each "case" is of a complex, particular character. As such:

...an individual problem cannot be solved by label, that is, by the identification of one factor, or part of the factors in it, but must be diagnosed, that is, understood as a whole. While a problem must be understood as a whole, many individuals needs can be grouped
and met as classified. A case is a problem trying to solve itself. Its terms in social work are persons. A case is always somewhere between extremes, and always presents the question, not of which cause, but of which combination of causes. A case lends itself to classification, but not in one class only. A case demands respect for each person concerned in it. It presents persons in relation to each other, with equivalent rights and independent interests. The objective in a social case is not to arrive at a static or "right" conclusion, but to arrive at a condition in which tensions may be balanced or relaxed and desires satisfied or redirected. The case under study is arbitrarily limited in time, space, and substance, in order that change may be 'consciously effected', but the human situation is organic, and the organism and the organization will continue to move after the diagnosis is made, and the new element, whatever it may be, is put in.¹

The above quotation is a very timely one in relation to the writer's present necessity of reducing the many variables inherent in any given case situation down to workable, meaningful classifications for the purposes of social research. Keeping ever in mind Mary Cannon's description of the complexity and multiple causation inherent in any given problem, the writer has adapted the data available from the case sample under study:

(1) to the purposes of this thesis
(2) to the method of statistical presentation
used by the Child Guidance Clinics of British Columbia in their Annual reports.

The writer does not see these classifications in the light of criteria to be used in future research, but as adapted

particularly to the broad nature of this study, in such a way as to make possible general deductions about the trends in the present operation of the travelling clinic. Hence lies the value in studying the complaints being referred to the clinic, with a view to seeing what they are, their frequency, and the professional resources available and in use for meeting them. The aim of furthering the treatment of the problem within the local community must be kept in mind at all times.

For the purposes of this thesis, a "presenting problem" refers to those problems of which the referral source was aware, at the point of referral to the agency which presented the case to the Travelling Clinic team. As has been discussed, it is recognized that in any given case a child may present one or more of the problems listed in the classifications.

Figure 1 indicates the actual distribution of presenting problems per case.

The total number of presenting problems in this case count of 50, came to 92. Of the 50 cases studied, 22 listed two or more (up to 4) presenting problems: 5 cases listed 4 problems each; 10 cases listed 3 problems each; 7 cases listed 2 problems. Of the remaining 28 cases which listed only one presenting problem, 7 listed "mental retardation," and 4 listed "adoption evaluation," both of which are sufficient cause in themselves for referral for clinical evaluation. In the remaining 17 cases, the nature of the
### Figure 1: Distribution of Presenting Problems per Case in the Sample Study of Cases Seen by Travelling Child Guidance Clinics, 1953.

<table>
<thead>
<tr>
<th>Case No.</th>
<th>Mental Retardation</th>
<th>Disobedience (School)</th>
<th>Disobedience (Home)</th>
<th>Low Progress</th>
<th>Truancy</th>
<th>Adoption Evaluation</th>
<th>Day-dreaming</th>
<th>Running Away</th>
<th>Phobic Reaction</th>
<th>Depression and Elation</th>
<th>Lying</th>
<th>Stealing</th>
<th>Cruelty to Farm Animals</th>
<th>Epilepsy</th>
<th>Sexual Play with Other Children</th>
<th>Headaches</th>
<th>Masturbation</th>
<th>Exaggerated Interest in Fire</th>
<th>Inability to Concentrate</th>
<th>Enuresis</th>
<th>Nail-biting</th>
<th>Fighting at School</th>
<th>Irregular Sex Relationship</th>
<th>Spastic</th>
<th>Destructive Behaviour</th>
<th>Bizarre Behaviour</th>
<th>Anti-Social</th>
<th>Nightmares</th>
<th>Personality Difficulties due to Appearance</th>
<th>Obesity</th>
<th>TOTAL</th>
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problem indicated there would be other symptoms present also, of which the presenting agency was aware, even though the referral source may not have been. These single problem referrals included: slow school progress (2), day-dreaming, running away, phobic reaction, depression and elation, sexual play with other children, lying, disobedience at school, enuresis, irregular sex relationships, epilepsy, spasticity, stealing, nightmares, personality difficulties due to appearance, and bizarre behaviour. Each of these symptoms (or causes) indicates the presence of (or leads to) a problem in adjustment for the child; and therefore falls within the category of cases which are seen as valid clinic referrals (Chapter II, Types of Cases). This would indicate, on the basis of the cases studied, that the local referring agencies have a clear picture of which problems indicate the need of and would benefit most from referral for clinical evaluation and planning for treatment. In other words, the referrals now being made are on the whole appropriate to the service offered by the clinic, and fall within the group of problems seen by the clinic as valid referrals for evaluation.

Figure 2 presents the frequency with which these problems occur within the case sample studied. The bulk of the problems—66—fall within the main category of "Primary Behavior Disorders," which have been defined as occurring in "a person whose life shows the pattern of behaviour
<table>
<thead>
<tr>
<th>Presenting Problems</th>
<th>Frequency</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Primary Behaviour Disorders</strong></td>
<td></td>
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<tr>
<td>A. Habit Disorders</td>
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<tr>
<td>1. Tantrums</td>
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<td>2. Obesity</td>
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<td>3. Enuresis</td>
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<td>4. Nail-biting</td>
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<td>5. Masturbation</td>
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<td><strong>B. Personality Disorders</strong></td>
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<td>1. Anti-social</td>
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<td>2. Aggressiveness</td>
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<td>3. Inability to concentrate</td>
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<td>4. Depression and elation</td>
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<td>5. Daydreaming</td>
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<td>6. Due to appearance</td>
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<td><strong>C. Neurotic Disorders</strong></td>
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<tr>
<td>1. Nightmares</td>
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<td>2. Headaches</td>
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<tr>
<td><strong>D. Conduct Disorders</strong></td>
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<tr>
<td>1. Disobedience (School)</td>
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<td>2. Disobedience (Home)</td>
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<td>3. Destructiveness</td>
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<td>4. Stealing</td>
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<td>5. Lying</td>
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<td>6. Sex Offences</td>
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<td>7. Cruelty (farm animals)</td>
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<td>8. Exaggerated int. in fire</td>
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<td>9. Running Away</td>
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<td>10. Truancy</td>
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<tr>
<td><strong>TOTAL</strong></td>
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Figure 2. Frequency of Presenting Problems in the Sample Study of Cases Seen By Travelling Child Guidance Clinic, 1953.
designed to relieve unconscious tension through 'acting-out' in ways not well adapted to reality.\textsuperscript{1} Primary behavior disorders are always reactions to environmental influences\textsuperscript{2} and indicate a child in conflict with his environment, generally in such a way that the conflict is relatively easily detected, particularly since it is expressed in such a way as to be disturbing and upsetting to those around him.

Disobedience at school and home occur 13 and 14 times respectively, i.e., in 26\% and 28\% of the cases, and tantrums are seen in 14 of them. Disobedience, stealing, lying, tantrums—all are types of behavior which are incompatible with the mores of the local community, and which, when they appear in a child, are immediate cause for discomfort and alarm in parents, schools, and other community institutions. That they loom large in the clientele of a child guidance clinic is therefore to be expected. Similarly, enuresis, masturbation, daydreaming, sex offences (deviations) and cruelty to farm animals, each of which occur in 2 of the cases, are unacceptable to rural citizens, and are obviously indicative of maladjustment problems. Mental retardation (in 10 of the cases), and slow school progress (in 5) are also obvious and valid indications for referral to Clinic. Adoption evaluation


\textsuperscript{2} Ibid., p. 32.
(in 5 cases) is an accepted clinical service. The grouping
"other" includes extreme behaviour—phobic reaction (once)
and bizarre behaviour (twice)—and extreme physical disorders—
epilepsy (twice) and spastic (once)—all of which deviate from
the normal to such a degree as to be instantly recognizable as
posing a problem to the child, and to the community.

The greater proportion of problems referred for
clinical services are, therefore, within the group of dis-
orders which either cause discomfort or disturbance within
the community, or are sufficiently abnormal in manifestation
as to be immediately seen as deviations from the "normal."
They present problems in adjustment, and are therefore valid
requests for evaluation and help in planning for their
alleviation.

On examining the remainder of the presenting prob-
lems—those which occur only once in the cases studied— one
finds further representation from the group of conduct dis-
orders—destructiveness, exaggerated interest in fire, running
away, truancy. These also lie within the easily recognizable,
and upsetting group of behavior disorders.

The remaining problems, obesity, nail-biting, anti-
social behavior aggressiveness, inability to concentrate,
depression, and elation, personality difficulties due to
appearance, nightmares, headaches, represent 18% of the total.
These problems are not so obviously disturbing to citizens
as are the other 82%; and their inclusion within the clinic
referrals seems to indicate greater awareness of the basic principles of mental hygiene and increasing interest in the early detection and prevention of potentially unhappy—rather than merely upsetting—children and adults. Each of these symptoms, particularly when occurring in relation to other symptoms, indicates the wisdom of a full clinical investigation as to the origin of the disturbance. Since they are not as manifestly indicative of disturbance as, for instance, disobedience, stealing, or lying, they might easily go unnoticed in a community, were it not interested in the welfare of its children, and alerted to mental health concepts and danger signals.

It has been seen that, although the majority of problems presented for clinical evaluation fall within the group of disturbances which are readily manifest and upsetting to others generally, 18% of the cases present problems which indicate a deeper understanding of the principles of mental health and an interest in early prevention, rather than purely alleviation of troublesome symptoms. In other words, the rural communities at present utilizing travelling clinic, are still referring, as would be expected, the most troublesome and upsetting cases for clinical service. It would appear, however, that, presumably based on the help previously received with these situations, plus the greater general understanding of children's behavior and personality problems and needs through community mental health education
methods, there is a greater awareness of the value of prevention, and greater understanding of the more subtle aspects of mental ill health. The trend, based on the sample under study, appears to be moving toward using the clinic in a preventive way before gross problems appear. This trend needs to continue, in order that maximum effective use of clinic service is attained. This trend can be stated only tentatively; and in the interests of the focussing of future clinical program, a detailed study of cases over the years would definitely reveal the trend in referral of problems to the clinic, and would indicate areas in which further emphasis is indicated.

3. The Sources of Referral of These Problems to Clinic

Our next question is: where are these problems which are being referred to the travelling clinic first recognized as problems, and as such, in need of professional evaluation. The answer will indicate which groups within the various local communities under study have sufficient understanding of and interest in:

(1) children's needs and problems, and

(2) clinical services,

as to recognize the existence of the problem, and the value of clinical aid toward its solution.

In this connection, Morris Krugman has summed up the question at hand succinctly:

1 Krugman, Morris, Institute for Clinic Personnel of the Child Guidance Clinics and Institutions of the New York State Department of Mental Hygiene, p. 25.
The criterion for the success of a clinic is not the judgment of the clinic members, but the value placed upon the services of the clinic by the community. Sometimes a clinic will actually render valuable service, but the community has not been taken into its confidence and does not know about, or understand, this service.

The breakdown of presenting problems stated by the referral sources as shown in Table 5 will give general indications of awareness, value, and use of clinical services as perceived by those who make referrals to the clinic.

Table 5 indicates that of the cases being studied, 33% of the problems were referred by the schools, 21% by Social Welfare Branch, 17% by Public Health Unit, 17% by parents, 7% by doctors, 4% by probation officers, and 1% by Juvenile Court.

In the sample under study, the greater proportion, 60%, of school referrals involved conduct disorders—in the following distribution: disobedience at school (7 instances); disobedience at home (5); lying (3); stealing (2); and truancy (1). Personality disorders represented 13% of the school referrals, and involved 1 case each of: anti-social behavior; inability to concentrate; daydreaming; and personality disorder due to appearance. Slow school progress accounted for a further 13% of the school referrals, and occurred in 4 cases. Mental retardation in 2 instances was the reason for referral; tantrums were included in 1 case referral, as was bizarre behavior.
Table 5. Sources of Referral of Problems Presented in the Sample Case Study of Cases Seen by Travelling Child Guidance Clinic, 1953.

<table>
<thead>
<tr>
<th>Presenting Problems</th>
<th>Social Welfare Branch</th>
<th>Public Health Unit</th>
<th>Schools</th>
<th>Parents</th>
<th>Doctors</th>
<th>Probation Officers</th>
<th>Juvenile Court</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Primary Behaviour Disorders</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A. Habit Disorders</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Tantrums</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>2. Obesity</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>3. Enuresis</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>4. Nail-biting</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td>1</td>
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<tr>
<td>5. Masturbation</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>B. Personality Disorders</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>1. Anti-social</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td>1</td>
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<tr>
<td>2. Aggressiveness</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td>1</td>
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<tr>
<td>3. Inability to concentrate</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td>1</td>
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<tr>
<td>4. Depression and Elation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td>1</td>
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<tr>
<td>5. Daydreaming</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td>1</td>
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<tr>
<td>6. Due to Appearance</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td>1</td>
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<tr>
<td>C. Neurotic Disorders</td>
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<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>1. Nightmares</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td>1</td>
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<tr>
<td>2. Headaches</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>D. Conduct Disorders</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Disobedience (School)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3</td>
<td>1</td>
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<tr>
<td>2. &quot; (Home)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3</td>
<td>2</td>
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<tr>
<td>3. Destructive</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>4. Stealing</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td>1</td>
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<tr>
<td>5. Lying</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td>1</td>
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<tr>
<td>6. Sex Offences</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>7. Cruelty (Farm Animals)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>8. Exaggerated Int. in fire</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td>1</td>
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<tr>
<td>9. Running Away</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td>1</td>
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<tr>
<td>10. Truancy</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>2. Mental Retardation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td>1</td>
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<tr>
<td>3. Adoption Evaluation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>5</td>
<td>5</td>
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<tr>
<td>4. Slow in School</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>5. Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>TOTAL</td>
<td>19</td>
<td>16</td>
<td>30</td>
<td>16</td>
<td>6</td>
<td>4</td>
<td>1</td>
<td>92</td>
</tr>
</tbody>
</table>
The active recognition of travelling clinic services by the schools is a positive sign. The school is, for many reasons, a key institution in dealing with children's problems. It can frequently be used to meet some children's needs when the home fails to function. Even if the school can not adequately meet all needs, the school personnel can frequently be enlisted in a supportive program so that pressures on the child are lessened and substitutions provided. Even if no treatment program is possible, acquainting school personnel with the results of a diagnostic study often arouses sympathy and results in better handling.

The proportion of referrals by parents is also encouraging, but will hopefully increase. The parents are more likely to be receptive to clinical evaluation and indicated casework services, if they themselves have initiated the process. As clinical services become more accepted and integrated into the local community, this source of referral of problems would, we trust, increase, with more and more parents being involved right from the beginning in efforts toward the understanding and solution, or at the least, alleviation, of the problems involved.

In the case sample, 50% of parental referrals involved conduct disorders, and were distributed as follows: disobedience at school (twice); disobedience at home (twice); stealing, lying, sex offences, and exaggerated interest in fires (once each). A large percentage (40%) of the total habit disorders were referred by parents, and accounted for
25% of the total parental referrals. They included: tantrums (twice); obesity and masturbation, once each. Both cases in which neurotic disorders were included were referred by parents. One child was referred by parents who suspected mental retardation, and another child for problems resulting from a spastic condition.

The Social Welfare Branch workers referred problems accounting for 21% of the total presenting problems. It is interesting that more referrals were not made from this source, as one would expect. Further study of the trend of referral sources over the years would be illuminating, but with the materials at hand, one can only speculate as to the implications involved. Again, the greatest proportion of referrals involve conduct disorders—this time 42%—and again disobedience at home and school predominate, with each appearing in 3 cases. Lying and sex offences comprise the remainder of the conduct disorders referred. The total cases (5) referred for adoption evaluation came, as a matter of policy, through Social Welfare Branch. Three of the Social Welfare Branch referrals involved the serious deviations from the normal, including epilepsy and phobic reaction. One case in which a habit disorder (enuresis) and one in which a personality disorder (aggressiveness) was involved, formed the remainder of the Social Welfare Branch referrals.

The Public Health Units were referral sources for the same number of problems as were parents, thus coming
third in line of activity. Again the conduct disorders loomed large, forming 43% of this agency's referrals; but the distribution of problems was not as concentrated on disobedience as in the sources of referral already discussed. Instead, we find a scattering of problems, with 2 cases of disobedience at home, and one each of: disobedience at school, stealing, lying, cruelty to farm animals, and running away. Three of the cases of mental retardation were referred by the Public Health Unit, and one each of slow school progress, epilepsy, tantrums, and masturbation.

Physicians' referrals accounted for 7% of the presenting problems—not a large proportion, but a promising beginning of a trend that needs to be encouraged further, as doctors are in a position of confidence and trust with their patients and therefore in a position to recognize early symptoms of disturbance, and refer for evaluation and planning. Only 2 of these referrals were for mental evaluation, the others being conduct disorders (3), disobedience at home, destructiveness, cruelty to farm animals, and nail-biting (1).

In 4 instances, problems were referred by Probation Officers—mental evaluation, disobedience at home, stealing and enuresis comprising this group of referral problems.

There was only one instance of a Juvenile Court referral, involving stealing. It does, however, indicate at least a beginning recognition by the Court of the possibil-
ities of treatment and prevention rather than incarceration for early offences against the law.

In summary, then, problems tend to be recognized and referred by local community groups in the following order:

1. Schools
2. Social Welfare Branch
3. Parents, and Public Health Units
4. Doctors
5. Probation Officers
6. Juvenile Court

Emphasis in all groups is upon the problems falling within the group of conduct disorders, with particular emphasis on disobedience notable in school, Social Welfare Branch, and parental referrals. Personality disorders tend to be referred by the schools, neurotic disorders by the parents, and a large proportion of habit disorders likewise by the parents. All adoption evaluation cases are referred by Social Welfare Branch, also half of the problems indicating serious deviations from the normal, as discussed earlier. Schools understandably find slow school progress a cause for concern, and referred 4 out of 5 cases; the Public Health Nurse referred the other. Mental retardation tends to be referred mainly by Public Health Units, with schools and doctors a close second.
4. Channels of Presentation of Cases to Travelling Clinic, and of Carrying Out Treatment Recommendations

Generally speaking, the agency presenting the case to the clinic is, with a few exceptions, the one which follows up the clinical evaluation, and is active in treatment. In studying the question of the frequency with which certain agencies refer problems to travelling clinic, we can get a general picture of the extent to which the clinic is integrated into the communities. These agencies—health, welfare, and education—represent the supporting services within the community, and have as one of their important goals maximum contribution to the welfare of the individual to whom they offer services. It has been said that in any one day these supporting services successfully treat more psychiatric problems than all the psychiatrists in the country treat successfully in a year.\(^1\) The importance of the relationship between the clinic and these community institutions or agencies cannot be overstressed, since it is in the community that the actual preventive work is going to be done; and it is through our contact with these agencies that we are best able to apply, on a community-wide basis, our understanding of the basic factors that enter into personality development, and of where the stresses and strains are in the general environment. Conferences held with these referring agencies enable them to understand the

\(^1\) Coleman, Dr. J.C., "Relating the Professional Services of the Clinic to Other Professional Groups in the Community," New York Institute of Child Guidance Clinics Personnel, 1950, p. 66.
strengths and limitations of the clinic, and enable the clinic team to encourage the carrying out of treatment recommendations.

A study of which agencies tend to be more active in presentation of cases to clinic has a two-fold value:

(1) as an indication of which agencies are actively involved in treatment;

(2) as an indication of the agencies who, presumably, have found clinic referral helpful, and are therefore, likely to increase their use of travelling clinic.

Table 6. Frequency Distribution of Agency Case Presentation to Travelling Child Guidance Clinic, 1953, as Indicated in a Random Sample Case Study

<table>
<thead>
<tr>
<th>Social Welfare Branch</th>
<th>Public Health Unit</th>
<th>Schools (Mental Health Coordinators &amp; Counsellors)</th>
<th>Probation Officer</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>29</td>
<td>18</td>
<td>2</td>
<td>1</td>
<td>50</td>
</tr>
</tbody>
</table>

According to the above figures, Social Welfare Branch presented the largest proportion of cases to travelling clinic in 1953—58% of the cases in the sample. The Public Health Units came next, presenting 36% of the referrals in the sample; schools presented 2 (4%) of the cases, and probation officers only one case (2%).
A further study of the actual channels of referral, from the time the case is recognized as presenting a problem and referred for service, to its actual presentation at clinic, will give some general indication of the trends in referral and agency liaisons within the urban communities of British Columbia.

Table 7. Community Agencies Through Which the Referral Sources Contacted Clinic in Sample Study of Travelling Child Guidance Clinic Cases, 1953.
The above table indicates that of the 50 cases under study, the school referred 30%; Social Welfare Branch, 24%; parents referred 18%; Public Health Unit referred 12%; doctors, 10%; Probation Officers 4%; and Juvenile Court, 2%.

The schools, the main referral source, referred, of their 15 cases, 4 to Social Welfare Branch, 10 to Public Health Unit, and 1 directly to Clinic. Schools, therefore, tend to work predominantly through the Public Health Unit, but do refer a significant number through Social Welfare Branch. Where there are school counsellors, or Mental Health Coordinators, they do occasionally actually present the case to the clinic.

The Social Welfare Branch, second most frequent referral source, presented 11 of its 12 referrals directly to the travelling clinic, and 1 was presented through the Public Health Unit.

Parents, third referral source, referred 8 of their 9 cases through Social Welfare Branch, and 1 through the schools.

The Public Health Units, fourth referral source, presented 4 of their referrals directly to clinic, and 2 through Social Welfare Branch.

Physicians referred 5 cases, 2 through Social Welfare Branch, and 3 through Public Health Unit.

Probation Officers referred 2 cases, 1 directly, and 1 through the Social Welfare Branch.
The most obvious trends are for schools to refer largely through Public Health Units, and for parents to request help of Social Welfare Branch. Both Social Welfare Branch and Public Health Nurses tend to present their own case; but the Public Health Nurses seem more flexible in this respect, although the basis of referral to Social Welfare Branch for clinical presentation is not clear. Speaking generally, the writer feels that more interaction between Social Welfare Branch and Public Health Nurses would indicate more healthy community liaisons; however, here again, a detailed study of trends over the years in specific communities would be necessary before making any authoritative statement.

Doctors understandably work more through Public Health Units than through Social Welfare Branches, but the fact that 2 of 5 referrals were to Social Welfare Branch would seem to indicate a growing recognition by the local doctors of the value of social work services and focus in the treatment of behavior and personality disorders.

In Summary, Social Welfare Branch and Public Health Unit case presentations are predominant, with Social Welfare Branches presenting 58% of the total sample cases, and Public Health Units 36%. Schools and probation officers presented the remaining cases. Schools tend to refer mainly through the local Public Health Unit, and parents through the local Social Welfare Branch. Social Welfare Branch and Public
Health Nurses tend to present their own referrals. Doctors refer to both Public Health Nurses and Social Welfare Branches in a ratio of 3:2. Probation officers presented 1 case, referred another to Social Welfare Branch; and Juvenile Court referred 1 case to Social Welfare Branch for presentation to travelling clinic.

5. The Spreading of Clinical Understanding and Knowledge of Treatment of Children's Problems through the Use of Case Conference, i.e., Teaching by Case Method

There is general agreement on the fact that the most effective mental hygiene education stems from the clinical worker through the case approach. Case discussions, conferences and workshops with school personnel and allied human relations professions, on live cases, have been found to be much more effective than generalized lecture or discussion groups.¹ In the field operation of the British Columbia Mainland Travelling Child Guidance Clinic, the case conference is, as has been discussed previously, seen not only as giving specific understanding and help around a given case situation, but, equally as important, as increasing the understanding, insights and sensitivity of those in attendance toward other children with whom they are in daily or frequent contact. Increased awareness of gaps in local social service structure, may be more obvious in the study

¹ Krugman, M., Ph.D., article in New York Institute of Child Guidance Clinic Personnel, 1950, p. 27.
of a particular situation; and ways and means of filling these gaps are best implemented through those professional groups in general attendance at such conferences.

The importance of estimating to what extent the travelling clinic is currently making use of this most powerful educational channel is self-evident. In rural British Columbia, one of the main sources, if not the main source, of mental health education, is the travelling clinic. A study, therefore, of the use currently being made of its educational channels is doubly significant, not only in terms of more effective clinical operation, but equally in terms of the extent of increased general professional and public understanding achieved.

This part of our study is to determine, within the scope of the study sample, first, the extent to which professional groups are being included in case conferences; and secondly, which presenting agencies are most actively seeking the use of the case conference to further understanding and cooperation within the community, in the interests of general mental health.

In the 50 cases under study, conference attendance ranged from 2 persons to 13 persons, and totalled 284 persons, i.e., an average of 5 to 6 persons per case. Those professions represented were: social workers, public health nurses, public health doctors, mental health coordinators, school principals, school counsellors, school teachers, practicing physicians, probation officers, ministers, Victoria Order of
Nursing staff, and school inspectors. In studying the distribution of attendance per case conference, the emphasis was upon Social Welfare Branch (43%), and Public Health Nurse (32%), personnel, with school personnel (21%), third in number. These are the three professional groups most actively in contact with children and most actively involved in the detection and treatment of children's problems. This concentration upon these three groups bodes well for the preventive program, and is a positive sign. The implication is that more and more early problems will be recognized, and hopefully handled by these groups. The vast drop in the attendance of other professional people at case conferences, however, would appear to indicate that the potentialities of their active participation in the detection, referral, and even in some cases treatment, of children's problems have not been recognized by the local health and welfare agencies; or it may indicate non-acceptance by these professions of the mental hygiene approach; or, a third alternative might be that the competence of the clinic and local staff to deal with early symptoms is not yet fully accepted by other professional groups within the community. In any case, further concentration and effort at including these professions, particularly doctors, ministers, and upon occasion lawyers (none of whom appeared in the cases studied) in case conferences, and directing towards them interpretation of clinical services and help available within the community for the child
with a problem, is indicated in the interests of a stronger, more effective community mental health structure.

Social Welfare Branch presented 29 cases at Travelling Clinic (see Table 6), and a total of 159 persons were present at these conferences, i.e., an average of 5.1 persons per conference. Of these, 53% were social workers, 27% were Public Health Unit personnel, 17% were school personnel. The remainder included three probation officers, one minister, and no local doctors.

Public Health Nurses presented 19 cases to Travelling Clinic (see Table 6) and included in the case conferences were 108 persons, i.e., an average of 5.7 persons per conference—6 higher than Social Welfare Branch. Of these, 38% were Public Health Unit personnel, 30% were social workers, and 27% were school personnel. The remainder included 2 doctors, 2 probation officers, and 2 other professional persons.

In comparing conference attendance at cases presented by the Social Welfare Branch and the Public Health Unit, it appears that the Public Health Unit includes other professions—mainly social work and education—to a greater degree than does Social Welfare Branch. The latter tends to concentrate more on its own staff, who certainly should be included as much as possible; but a broader group of professions needs to be included as well, if maximum use is to be made of the conferences, as a means of interpreting
Table 8. Attendance at Travelling Clinic Case Conferences, 1953, in Relation to the Agency Presenting the Case.

<table>
<thead>
<tr>
<th>PRESENTING AGENCY</th>
<th>Public Health Nurse</th>
<th>Public Health Unit Doctor</th>
<th>Social Worker</th>
<th>Mental Health Coordinator</th>
<th>School Counsellor</th>
<th>Principal</th>
<th>Teacher</th>
<th>Doctor</th>
<th>Probation Officer</th>
<th>Other</th>
<th>T O T A L</th>
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</thead>
<tbody>
<tr>
<td>SOCIAL WELFARE BRANCH</td>
<td>38</td>
<td>5</td>
<td>85</td>
<td>1</td>
<td>7</td>
<td>2</td>
<td>17</td>
<td>3</td>
<td>1</td>
<td>159</td>
<td></td>
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<tr>
<td>PUBLIC HEALTH UNIT</td>
<td>30</td>
<td>11</td>
<td>32</td>
<td>3</td>
<td>7</td>
<td>19</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>108</td>
<td></td>
</tr>
<tr>
<td>PROBATION OFFICER</td>
<td>1</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>SCHOOL</td>
<td>4</td>
<td>1</td>
<td>4</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td>14</td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>73</td>
<td>17</td>
<td>123</td>
<td>3</td>
<td>10</td>
<td>10</td>
<td>38</td>
<td>2</td>
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children's needs and clinical services to the various community professional groups.

In summary, attendance at case conferences includes mainly Social Welfare Branch, Public Health Unit, and school personnel, Doctors, probation officers, ministers, and Victoria Order of Nurses are also included upon occasion, but more emphasis needs to be placed on their potential contributions both in a specific situation, and in the general community mental health programme. The Public Health Unit tends to include slightly more people in the conferences it calls, and to include a greater proportion of school personnel. The Social Welfare Branch, on the basis of this study, does not appear as well integrated into the community professional groups, as does the Public Health Unit. Of the 50 cases studied, in 7 of the cases there was no representative present from the Public Health Unit, and in 4, no representative of Social Welfare Branch. In 39 of the cases, however, there was at least a degree of collaboration on the cases, to the extent of attendance at conference. Only a detailed study by community would reveal the extent of collaboration. However, the general implication from the sample study figures is that Public Health Units and Social Welfare Branches do on the whole collaborate on their cases.

It is the writer's impression that more use of the case conference could be made by the field, once its full value and purpose is more clearly recognized.
6. The Trend of Clinical Recommendations for Treatment of the Problems Presented

As has been discussed earlier, emphasis in this study is not upon the diagnostic evaluation as such, but is rather upon the use made of it in terms of the available community resources. Since at the present time the agency presenting the case to clinic almost invariably does the follow-up and implements the recommended treatment, the question of the gearing of recommendations to the skills of the presenting agency arises. Ideally, again, one would hope to see, for example, cases in which disturbed family relationships are basic to the child's disturbance, being carried by the district social workers. This is the unique area of understanding and skill of the trained social worker, and as such is best handled by him. The Public Health Nurse, on the other hand, is best equipped, for example, to handle any problems of medical origin, or cases where it appears the parents may respond to counselling in connection with the care of children. Due to heavy caseloads and the lack of both numbers and skill of social workers in many areas, as well as local administrative difficulties, such a division of cases is not always feasible. In such circumstances, it is essential that the clinic team, in making its recommendations based on the clinical study and evaluation of the problem, know the conditions existing in the community, and offer suggestions for local treatment that are within the
range and skill of the local person who will be continuing with the client. The conference, and the following consultation with the corresponding clinic team member, should be directed along educative lines, increasing the local worker's understanding of the problem and of how to deal with it, within his ability. The referring agent must be taken at the level at which he is operating and be helped to move forward from there. It is again a recognized fact that more preventive work can be done through the cooperative agencies who are on the scene continuously, and even if they are not able to do quite as thorough a job as would be ideal, in the long run there is a positive gain, to the client, the agency, and the community.

Let us look at this problem, then, in terms of what recommendations are currently being made by the clinic, as indicated by the 50 sample cases.

Again, as in presenting problems, there is a multiplicity of recommendations per case, so that in the 50 cases, a total of 94 recommendations were made. This can be understood if one considers, for instance, the recommendation "removal from own home." This recommendation would in most cases be accompanied as well by "casework services to parents," and "casework services to child."

The 15 recommendations appear in the following frequency:

1. Casework services to parents - 50% of cases.
2. Further Travelling Clinic services - 28% of cases.
Table 9. Clinical Recommendations for Treatment in relation to the Agency Presenting the Case, as indicated in the Sample Study of Travelling Child Guidance Clinic Cases, 1953.

<table>
<thead>
<tr>
<th>Clinical Recommendations</th>
<th>Presenting Agency</th>
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<td></td>
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<td>Work closely with school</td>
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<td>1</td>
<td>4</td>
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<td>Further Travelling Clinic Services</td>
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<td>TOTAL</td>
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<td>40</td>
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3. Referral to teacher for remedial instruction or friendly support - 22% of cases.

4. Removal from own home to foster home - 16% of cases.

5. Casework services to child, and work closely with school, each in 14% of cases.

6. Institutional care - 12% of cases.

7. Group activity - 8% of cases.

8. Removal from foster home, referral to physician, special classes, adoption recommended, and adoption contra-indicated due to factors in child's background, each appear in 2 cases.

9. Child Guidance Clinic on a treatment basis, and adoption contra-indicated due to factors in present home, each appear in 1 case.

Of the 15 recommendations involved, "casework services to parents" appeared most frequently--in 25, or 50% of the cases. In 12 of these cases, Social Welfare Branch would be involved in treatment; Public Health Nurses would carry another 12 of them, and a probation officer was responsible for the remaining case. The recommendations appear appropriate in the case of Social Welfare Branch and Probation Officer cases, but that such a high proportion of such cases is currently carried by Public Health Units raises some question. Only further intensive study would clarify the picture; but within the scope of this study, the figures seem
to raise considerable question as to the wisdom of the current practice of the presenting agency carrying the case, and of the responsibility of the clinic to clarify this at conference. Even though it is not possible to provide social workers for the more intensive contact indicated in most child guidance clinic cases, the need of additional workers in the interests of the prevention of future difficulties does need to be pointed out administratively. Where it is not possible to assign cases to Social Welfare Branch, the Public Health Unit Nurse should be offered clinical consultation services periodically, in her carrying of those cases which involve problems in social relationships or in psychiatric areas.

The recommendation "casework services to child," although occurring in only 7 instances, presents a similar situation. Three of these cases were presented by Public Health Nurses, and raise questions identical to those discussed above.

In 14, or 28% of the cases, it was recommended that the child be seen again "for further Travelling Clinic Services." This could be for further evaluation, or could indicate the clinic's particular interest in following the progress of the case. As a rule, it has been left up to the agency involved to re-present a case when indicated; and the expression of continued clinical interest in the situation has been an indication of the severity of the situation, with possible change in plans indicated from time to time.
The even division of these cases between Social Welfare Branch and Public Health Nurses—8 to 6—seems to have no specific implication within the present study.

"Referral to teacher for remedial instruction or friendly support" is the next most frequent recommendation, occurring in 22% of the cases. It indicates both recognition of the role the school may play in the treatment of a disorder, and an attempt at furthering cooperation amongst the community health, welfare, and educational personnel. The Public Health Nurse is ordinarily in close contact with the schools, and of the 11 such recommendations of referral to the teacher, 5 were cases presented by the Public Health Unit. Four of the cases were ones on which Social Welfare Branch was active, and two were cases presented by either the Mental Health Coordinator, or the School Counsellor. This trend toward close cooperation with the school on appropriate cases is one which should be encouraged to continue and increase, for reasons discussed earlier.

In 8 cases, "removal from own home to foster home" was recommended, following the diagnostic study. Four of these cases were presented by Social Welfare Branch, 3 by Public Health Nurses, and 1 by a probation officer. Of the 3 cases presented by the Public Health Nurses, in one case the recommendation for removal also included that the "most effective handling would be on a team basis, with Public Health Unit and Social Welfare Branch." In the other 2 cases, no
such suggestion was made, and there was no Social Welfare Branch representative present at either conference. Presumably interpretation of the need for removal of the child and helping parents see this need, was left up to the Public Health Nurse, for reasons which were not apparent in the file. Due to lack of follow-up material, it was not possible to determine the final disposition of the cases.

The recommendation: "work closely with school," which appears in 7 cases—4 Public Health Nurse and 3 Social Welfare Branch—again is recognition and encouragement of the use of the potential resources of the school in helping a child in difficulty.

Recommendation for "group activity" appeared in 4 cases, 3 of which were presented by the Public Health Unit. This again is a recommendation more appropriate to a case being carried by a social worker. One would hope there would be use made by the Public Health Nurse of the Social Welfare Branch worker's knowledge of community resources, and of ways of presenting the particular resource so that the decision to participate is the child's, not the worker's.

The need for "special class" was pointed out in 2 Public Health Unit cases. In neither of these instances was there such a resource available; however, pointing up the lack, and the benefit of special class in this particular case, would serve as a means of drawing attention to, and fortifying the need of working toward the provision of the needed resource.
In 2 instances "removal from foster home" was recommended. "Adoption" was recommended in another 2 cases, and "adoption contra-indicated" was the recommendation in a further 3 cases, 2 because of "factors in child's background" and 1 because of "factors in present home environment." All these cases were as a matter of policy carried by Social Welfare Branch.

The main implication of this study regarding the recommendations of the clinic is that many of the cases do not seem to be carried by the agency best suited, by virtue of the specific training of its personnel, to give the service appropriate to the problem. Notable are the number of cases carried by the Public Health Nurse in which casework services to parent or child, or both, are recommended. The reason for this inappropriate division of cases is not readily apparent. However, the matter is of prime importance in a maximum use of clinical service in the interests of the community served. Knowing the chronic shortage of trained social workers in the field, this state of affairs is understandable. Presumably the handling of cases is decided beforehand by the local health and welfare agencies. It seems that it is the duty of the clinic to indicate those instances in which the case would best be carried by another agency. Whether this is followed or not is the responsibility of the agencies involved. The writer feels this is a very important issue, and that intensive study of the issues involved would be valuable.
Another implication is that the schools are being drawn into the total treatment plan in 40% of the cases. This is again a very encouraging aspect. Not only does this ease tensions for the specific child under study but, as has been said before, the teachers will, through the understanding gained in a particular case, gain in their understanding and approach to other children in similar difficulties.

From the recommendations, it appears that of the 50 sample cases, only 7 were seen as unresponsive to some degree of treatment within the community. Of these 7 cases, 6 were recommended for "institutional care" and 1 for "Child Guidance Clinic on treatment basis." In 14 cases, specific recommendation for further clinical services was made.

It would be of real value to determine the extent to which the clinical recommendations were followed out, and if not, why not. The present travelling clinic Social Work Supervisor is now devoting a part of his time in each community to discussing cases with the health and welfare staff, in order to determine the present status of the case, in terms of treatment, and the extent to which clinical recommendations were acted upon. In this connection, 15 of the 50 cases in the sample had follow-up material on the file. Briefly, of the 15 cases, 7 had been presented by Social Welfare Branch, 7 by Public Health Nurses, and 1 by Mental Health Coordinator. In all 7 Social Welfare Branch cases, the clinical recommendations had been followed out, and a degree of improvement seen.
The recommendations included: emphasis on home relationships; casework services to overcome resistance to committal to an institution; Children’s Aid Society Receiving Home for Child Guidance Clinic treatment; support and alleviation of pressures at school; continuance in adoptive home; casework services re parent-child relationship; and, adoption recommendation. Each of these recommendations is in line with the role and skill of the social worker---and was, therefore, carried out.

The situation in the 7 Public Health Nurse cases is quite different. Six verbatim illustrations will show this. On the other hand, the writer will also explain the overburdening of the Public Health Nurse which accounts for this. In only 1 of the 7 cases was the clinical recommendation followed through. In this case, "casework services" had been recommended and the case had been carried, or turned over (it was not clear which) to Social Welfare Branch. Improvement was seen in the case as a result. In 6 cases, however, clinical recommendations were not followed through, and in only two of these cases was any degree of progress indicated. The recommendations, and the follow-up reports, were as follows:

1. **Recommendation**: "Social Welfare Branch to give continuous support and good interpretation to family. Review in 1 year." **Follow-up report** indicated that "little follow-up needed, according to Public Health Nurse. Some improvement seen. Case closed."

2. **Recommendation**: "School counsellor work with boy, social worker close contact with family. Review 1
Follow-up indicated "little contact since clinic examination. Main reason—the boy has finished school and therefore has not been the problem previously seen. Case closed."

3. **Recommendation**: "Casework with parents (rigid, punitive), encourage group activities, expression of hostility toward parents. Keep teacher alerted re progress to avoid school trouble." Follow-up indicated "Family not accepting of Child Guidance Clinic recommendations nor of Public Health Nurse services. Still tension in the home, but improved school progress."

4. **Recommendation**: "Remain at school with emphasis on socialization, not academic factors. Help mother accept retardation." Follow-up indicated "mother hostile to clinic. Refuses to return. Public Health Nurse feels she has accomplished little in helping mother with guilt feelings." In this instance, there was correspondence with the clinic director regarding further recommendations, and support to the Public Health Nurse for what she was able to accomplish.

5. **Recommendation**: "Father and mother be given continuous support and interpretation re basic emotional needs of children. Review in 1 year." Follow-up indicated that this recommendation had not been followed, but "rapid improvement at school since child moved into a room with a male teacher. Helped boy's relationship with his father. No reason further contact. Case closed."

6. **Recommendation**: "Male worker for boy. If possible, another worker for mother and sister re boy's needs. Explore resources for socialization." Follow-up indicated that "Public Health Nurse had continued with children and parents. Male worker not called in. Apparently child has shown great improvement, especially since July, 1953, when father returned home. Better relationships with father."

In 3 of the 6 cases, where referral to Social Welfare Branch had been recommended, the referral was either not made by Public Health Nurse or not picked up by Social Welfare Branch (1, 2, and 6 above). The reasons were not apparent. The result was inadequate service to the child, with premature closure of the case in 2 instances of the 3. In another case
(3, above), the situation definitely indicated need of casework services, and an understanding of dynamics and human relationships. The recommendations were along these lines— but directed toward the Public Health Nurse, who could not be expected to handle, within her specific knowledge and skill, this type of case. In (4) above, the recommendation was again directed toward the Public Health Nurse, and again casework skills were indicated and recommended—and again, little, if any, progress was made. In (5), casework services were once more recommended. In this instance, the Public Health Nurse called in the school, with resulting improvements in parent-child relationships.

It is not fair to the Public Health Nurse to burden her with a case-carrying responsibility in which clinic recommendations specify skills which require the knowledge and technique of another profession. Social workers and psychiatrists would be equally, if not more, distressed if they were asked to carry the burden of nursing care and nursing education, which might be required in their caseloads.

The one case carried by the Mental Health Co-ordinator met with a high degree of success. Recommendation was "Removal of academic pressures, and minimum of discipline till child doesn't over-react to it." Follow-up indicated "nightmares gone, child improved. Apparently a warm, accepting male teacher has been most helpful to this child." In other words, the recommendation was geared to the school function, and as such, it was workable.
Although this is much too small a number of cases to use as a basis for any conclusive statements, two factors stand out clearly, and indicate the extreme importance of further study, once the follow-up material is available. First, the cases in which progress was seen were, with two exceptions, those cases in which the recommendations had been appropriate to the role and function of the follow-up agency. Secondly, there seemed to be a tendency not to follow up suggestions of referral made following the diagnostic study. Both these factors seem to point to the need of further clarification of the role and function of the Public Health Nurse, and the role and function of the Social Welfare Branch; and the need of the local health and welfare agencies coming to an early decision, based on the needs of the case, as to who should carry the case. The other implication is that there are difficulties in the relationships between local agencies, and between these agencies and the clinic, which need "study, diagnosis, and treatment"—and a sound community organization approach.

7. The Extent of Direct Community Education Activities of the Travelling Clinic during 1953

The importance of awakening general community interest in, and awareness of, the aims and functions of a travelling child guidance clinic service, and of general mental health principles, has been discussed previously. One of the tasks of the clinic Public Health Nurse is to keep a record of the activities of the travelling clinic team, over and above the specific
case services. A study of her report for the year 1953 gives the picture of the broader channels of community education currently utilized in conjunction with the specific services discussed earlier in this chapter.

During 1953, from January 1st to December 31st, a total of 18 contacts were listed with various rural community groups, for the purpose of interpreting clinical function and discussing mental health generally. The types of activity included:

- lectures (6);
- film showing, followed by discussion (5);
- attendance at meeting of local professional groups (4);
- case presentation (1);
- workshop (1);
- symposium (1).

In one instance, the Public Health Nurse showed mental health films to a Registered Nurses Association meeting. Another time, the clinic team participated in a case presentation to a group of teachers. In 3 instances, the psychiatrist and the social worker led group discussions following showing of films to school personnel. In the other instances, the clinic psychiatrist was the main clinic participant. Generally the other team members were present also, to contribute their specific knowledge when indicated in the discussions which are encouraged following each type of presentation.
The groups with whom the clinic met in the above ways, included:

- teachers (6);
- medical staff of hospitals (3);
- health, welfare and education joint meetings (3);
- Parent-Teachers Associations (3);
- Local Council of Women (1);
- Registered Nurses Association (1);
- Young Adult Group, Young Women's Christian Association (1).

Frequently service clubs, such as Kiwanis, and special interest groups, such as the Society for the Advancement of Handicapped Children, are also included in clinical educational activities.

These contacts with local community professional and non-professional groups covered 16 of the 24 towns visited by the clinic. In Kelowna and Penticton, two different groups were addressed; but in the other 14 centres, only one contact per year was recorded, and in 8 centres, none. The picture was almost identical in 1954. It would seem that this very important medium of clinical contact with the general community is not being used as effectively as one would hope. It is an important area of clinic-community relations; and in the travelling clinic scene, particularly, its effective use can do much to help the professional groups and general citizens to see that the clinic, despite its transient nature, is
"theirs," to turn to for help and guidance in the areas outlined in the clinic program. It is recognized, again, that the current shortage of staff, and pressures of time, have entered largely into this limited number of group addresses, film showings, case presentations, et cetera. With the advent of the second travelling clinic team, one would hope to see more emphasis on achieving:

1. greater use of individual team members in these group contacts;

2. increase in quantity and scope of group contacts, particularly among non-professional groups, such as Parent-Teachers Associations, service clubs, Local Councils of Women, et cetera.

It seems to the writer that this is an extremely important area in the relationship between the local communities and the clinic, which to date, for reasons discussed, appears to have been only partially utilised. It would seem to be an important area to consider in planning for community service on a two-team rather than a one-team basis.

8. Clinical Services as Seen by Field Personnel

As has been stated previously, the criterion for the success of a clinic is not the judgment of the clinic members, but is rather the value placed upon its services by the community. In an effort to determine the community response to clinical services, questionnaires were sent out to all Social Welfare Branch field offices, through which all
requests for clinical evaluation and help are channelled. 
Fourteen questionnaires were returned, representing 15 dis-
trict offices throughout the British Columbia Mainland. The 
questionnaires were filled out by Social Welfare Branch dis-
trict supervisors, and represent, therefore, the opinions of 
Social Welfare Branch personnel only.

In these 15 offices, 102 cases were referred to 
the travelling clinic in 1952, and 162 in 1953—an increase 
of 59%. In 5 of the centres, the clinic visited once a year. 
Of these, 2 requested visits twice yearly. In 3 of the 
centres, 1 to 2 clinic visits per year were usual, and were 
sufficient. In 5 districts, visits were made twice yearly, 
which was sufficient in all but one district, where visits 
were requested 3 times a year. In another district, 2 to 3 
clinical visits per year were the usual, and were proving suf-
ficient. In still another district, close to Vancouver, visits 
were made by the clinic team "at request" (of the district 
office).

The cases most commonly referred for clinical 
evaluation by these 15 district offices were those involving:

1. Placement cases in which there is concern 
 about the emotional consequences to the child due to former 
dependency, broken home, or neglect. (9 times.)

2. Children in their own homes whose behaviour 
difficulties stem from a distinct break-up in parent-child 
relationship. (9 times.)
3. Patients who are retarded in their intellectual development. (9 times.) Also appearing frequently were cases in which:

4. Inability to cope with social or scholastic expectations (6 times.) was the cause for referral to clinic.

These cases which were referred most frequently, were also the ones in which the field personnel felt most help was given. Clinical evaluation and treatment recommendations were found to be most helpful (7 instances) in those cases involving placement (#1 above). In 6 instances, the field workers found clinical services most helpful in cases of children in their own homes whose behaviour difficulties were attributable to faulty parent-child relationships (#2 above). Cases of intellectual retardation, and of difficulty in coping socially or scholastically, each were seen as benefitting from clinical help in 5 instances (#3 and #4 above). In 2 instances, cases involving maladjustment stemming from a child's undesirable habits were seen as being most frequently referred to clinic; and in 3 instances, it was felt these cases were the ones in which clinic had been most helpful. Children who are retarded because of physical handicaps, and children who exhibit behaviour difficulties as a direct result of marital conflict, were both mentioned in 5 instances each, but were not seen either as occurring frequently or as being helped particularly through clinical service. Cases involving psychogenic disorders were merely mentioned in 2 instances,
but not seen specifically as either frequent or as benefitting from clinic referral. In one instance, they were seen as being referred frequently, and in one instance as having been helped most through presentation at clinic.

The above analysis of the questionnaire replies implies that there is not universal acceptance by Social Welfare Branch field personnel of the value of travelling clinic services. This comes out more clearly in response to the question, "on the average, to what extent did the clinical diagnosis help the social worker in over-all casework operation?" In 5 districts, it was seen as "extremely helpful"; in 2 districts, as "moderately helpful"; in 1 district as "of limited value"; but in no districts was it seen as "of no value." This response seems to indicate a degree of reservation on the part of many district workers as to the actual help the clinic is giving in their cases; and a feeling that more help could be expected than they are at present receiving. They are not, however, rejecting clinical help—note that in only one instance was the clinical diagnosis seen as "of limited value," and in no instances was it seen as "of no value." It is encouraging that in 5 districts, the experiences with the travelling clinic have been so positive as to merit being considered "extremely helpful."

Clinical conferences were found to be "very useful" by 10 of the district offices; "more use possible" was the verdict in 4 district; and in 1, they were seen as of "almost
no use." There was a close relationship between the way in which the clinical diagnosis and the clinical conferences were viewed by the districts. All 5 of the districts which indicated that the clinical diagnosis had been "extremely helpful" to the social worker in his over-all casework activity, also found the clinical conferences to be "very useful"; and indicated that other local professional persons were active participants in the conferences--and that all gained by their participation. Four of these 5 districts stressed "social service personnel" as the most important limiting factor affecting follow-up, and the other saw lack of "continuity of psychiatric consultation" as the main limiting factor.

In 5 of the 10 districts which found clinical conferences "very useful," the clinical diagnosis was seen as giving only "moderate" help to the social worker in carrying the case. In 4 of these districts, the "social service personnel" was seen as the most important limiting factor affecting follow-up; and in 1, "community resources" were felt to be the chief limitation. Here again, local professional people were included in the conferences, and their contributions to the over-all picture recognized.

Clinical diagnosis was felt to be "moderately helpful," and opinion regarding clinic conferences was that more use could be made of them, in 4 districts. In 3 of these districts, the follow-up of the cases presented was limited
mostly by the social service personnel, and in 1 "continuity of psychiatric consultation" was felt to be the most important limiting factor in follow-up activities on clinic cases.

One district reply quite frankly stated that the clinical diagnosis was of only limited value to the social worker in his over-all casework activity, and that the clinical conferences were of almost no use. It was interesting, however, that this district requested more frequent clinical visits than it was then receiving. It was felt that "conference is frequently limited because confidential causative material cannot be discussed in conference slanted toward community interpretation." The most important limiting factors affecting follow-up of cases examined by the clinic were lack of adequate social service personnel to do the job, plus the fact that there was "no available" psychiatric consultation. The district supervisor commented that "conferences between psychiatrist and supervisor on psychiatric consultation level and geared to treatment plan would be helpful."

The overall picture seems to be that clinical services are generally regarded as helpful, or as potentially helpful. Lack of stable and trained staff, and pressures of time and distance are the main limiting factors in utilizing the clinical services available. The varied opinions indicated in the questionnaire replies point out the value of effort toward knowing your various communities individually, as the general comments indicate that in some districts
clinical aims and purposes are well recognized, and used con-
structively; whereas in others there is misunderstanding as
to the role of the travelling clinic in relation to the Social
Welfare Branch, and the communities served.

The following verbatim list of general comments is
illuminating and self-explanatory:

1. In my opinion the clinic will become increasingly
useful as its function becomes better known in the
community. There have been only 3 clinic visits
to_______, in 1952,-3,-4. The community is just
now becoming aware.

2. Child Guidance Clinic fulfills a two-fold function
in rural areas. It is of direct benefit to the soc-
ial worker in providing a diagnosis and giving dir-
ection to the treatment plan. It also provides an
opportunity for interpretation of the services
provided through the Social Welfare Branch Field
Service, to other professional groups, and a chance
to enlist the cooperation of these people in planning
for and with the child and the family.

3. We would emphasize that the greatest weakness in this
service is our follow-up. The clinic conference gives
us much (usually) to work on, but time and inex-
perienced workers always seem to confine our efforts
to a great extent.

4. The main difficulty has been follow-up of suggestions
made by clinic—in view of lack of experienced social
workers. New untrained workers are often hesitant
about attempting intensive casework in the serious
behaviour problem type of case.

5. Better screening could be done in choice of cases for
clinic, with closer cooperation between Public Health,
Schools, and Social Welfare Branch. In______, have
recently organized a Child Guidance Council which
should help in this respect.

6. Parents at times ask that the doctor give them a
frank report. This is so often left to the social

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1 Extracts from questionnaire replies.
worker who has not enough experience in this phase of our work. Also suggest that Children's Registry curtail their referrals as we are finding the Public Health Nurses with more referrals than we can cope with.

7. Due to distance and lack of time it is difficult to follow up cases adequately.

8. We seem chronically unable to carry out the plan we agree to in the conference in most instances.

9. We find that if we have interpreted well that generally other interested persons have a great deal to contribute to understanding the case and to planning for the future. Occasionally we have an unfortunate experience.

10. The part the outside parties contribute seems limited. Usually much time is spent educating those in attendance—possibly this is the fault of the local welfare staff.

These comments indicate several pertinent points regarding the present travelling child guidance clinic service and its present stage of integration into the rural communities.

1. The various district offices are varied as to the degree of understanding they have of clinical services and functions.

2. There is difficulty in following up clinical recommendations, due to lack of trained social workers, and to pressures of time, distance and heavy caseloads—or is it due to clinical recommendations not geared sufficiently to the local scene, and not enough help to local workers regarding the practical as well as the ideal therapeutic aspects of the case?
3. Local professional people are included in conferences, but there seems some confusion as to their role, and the role of the clinic in adding to their knowledge and understanding of the case, as well as of clinical and local social work services in relation to it. The use of double conferences when indicated does not appear to be universally recognized.

4. The local offices are aware of current clinic limitations due to the "youth" of the service, but to date the positives outweigh the negatives. The field workers are looking hopefully to the clinic for guidance, and it is up to the clinic to find ways and means of giving it, in a usable manner.

The writer, in informal discussions with available branch supervisors and field workers, was further impressed with the fact that an intensive program of interpretation to field agencies of clinical functions and services, is indicated at this time. The travelling clinic is an established service now, but there is misunderstanding still on the part both of clinical staff and field staff, as to how to make maximum use of the services available; even, almost of what services are available. The infrequent visits of the clinic team, and the staff changes both in clinic and field personnel, have operated against the gradual establishment of sound clinic-community relationships, as embodied in interpersonal staff relationships between the clinic personnel.
Emphasis upon the sound relationship of the clinic to the rural communities it serves is therefore also strongly indicated, if the travelling clinic is to attain its rightful role as diagnostician, consultant, and mental health educator to rural areas. To date, the clinic's diagnostic service has dominated; but increasingly, various district workers are voicing their need of consultative services in the carrying out of clinical treatment recommendations. The broad community health education services of the travelling clinic are as yet, as has been noted, only partially recognized and utilized.

Generally speaking, appropriate cases are being referred for clinical evaluation and treatment recommendation; clinical conferences are being used both for teaching by case method, and for further interpretation to allied human relations professions in the local community around clinical functions and children's basic needs; social workers, Public Health Nurses, and school personnel are working together to an appreciable extent on individual cases and in general community mental health activities; but difficulty in follow-up of individual treatment recommendations seems to be interfering with positive acceptance of the clinic by the local community. Further understanding and acceptance of mutual limitations—by the clinic staff of the difficulties under which the field workers operate; and by the field workers of
the difficulties and limitations under which the travelling teams operate—would pave the way to clinical recommendations geared more closely to local conditions, and to more realistic expectations of clinic by the field. In view of the imminent expansion of the present one travelling clinic team into two travelling clinic teams for the same geographical area, the writer hopes that intensive research by individual community will be carried out as soon as clinical file material regarding follow-up reports is available. Such research would be an invaluable aid to determining future focus and planning for travelling clinic service.

Summary

The various approaches made in this chapter to the study of the local travelling clinic "in operation," indicated generally that the rural communities are referring cases to clinic which are appropriate to clinic function. A large proportion of these are amenable to treatment within the community. The greater proportion of problems referred fall within the group of disorders which either cause discomfort or disturbance within the local community, or are sufficiently abnormal in manifestation as to be immediately recognizable as deviations from the "normal." In 18% of the cases, however, problems were presented which seem to indicate a deeper understanding of the principles of mental health, and an interest in early prevention, rather than only in alleviation of
troublesome symptoms. Problems tend to be recognized and referred by local community groups in the following order: schools, Social Welfare Branch, parents and Public Health Units, doctors, probation officers, and Juvenile Court. Emphasis in all groups is upon the problems falling within the group of conduct disorders, with particular emphasis on disobedience notable in school, Social Welfare Branch, and parental referrals. Personality disorders tend to be referred by the schools, neurotic disorders by the parents, and a large proportion of habit disorders likewise by the parents.

Social Welfare Branch and Public Health Unit case presentations are predominant, with Social Welfare Branches presenting 58% of the total sample cases, and Public Health Units 36%. Schools and probation officers presented the remaining cases. Schools tend to refer mainly through the local Public Health Unit, and parents through the local Social Welfare Branch. The local health and welfare agencies tend to present their own referrals. Doctors refer to both Public Health Units and Social Welfare Branches, in a ratio of 3:2. Probation officers presented one case to Social Welfare Branch for presentation to travelling clinic. This presents a fairly positive picture of local community liaisons; but more referrals from local physicians, and more pre-clinic interaction between the local health and welfare units would be indicative of healthier community relationships.
Attendance at case conferences averages 5 to 6 persons per case, and includes mainly Social Welfare Branch workers, Public Health Unit and school personnel. Doctors, probation officers, ministers and Victoria Order of Nursing staff are also included upon occasion, but more emphasis needs to be placed on their potential contributions both in a specific situation and in the general community mental health program. In 39 of the 50 cases, both Public Health Unit and Social Welfare Branch personnel were in attendance, indicating that they do collaborate on most, but not all, of their cases. It is the writer's impression that, on the whole, more use of the case conference could be made by the field, once its full value and purpose is more clearly understood.

In studying clinical recommendations, it was implied that many of the cases do not seem to be carried by the agency best suited, by virtue of the specific professional training of its personnel, to carry out the treatment recommendations. Notable are the number of cases carried by the Public Health Nurses, in which casework services to parent, or child, or both, are recommended. Since the agency presenting the case is in most instances the one who will do the follow-up work on it, it would seem that the clinic has the responsibility of indicating those instances in which the case would best be carried by another agency; and, if this is not feasible, of gearing recommendations more closely to the professional skill of the presenting agency.
This issue was re-emphasized in the follow-up reports, which were available on 15 of the 50 cases studied. These indicated that the cases in which progress was seen were, with two exceptions, those cases in which the recommendations had been appropriate to the role and function of the follow-up agency. It also appeared that there was a tendency not to follow up on suggestions of referral made following the diagnostic study—i.e., at the case conference. Both these factors seem to point to the need of further clarification of the role and function of the Public Health Unit, and the role and function of the Social Welfare Branch; and the need of the local agencies coming to an early decision, based on the needs of the case, as to who should carry the case. The other implication is that there are difficulties in the relationships between local agencies, and between those agencies and the clinic, which need "study, diagnosis and treatment"—and a sound community organization approach.

In studying the amount of clinical activity expended, in 1953, on general community mental health education and knowledge about clinical services, it was found that such activity was limited. In only 16 of the 24 towns visited by the clinic team was any activity entered into, above and beyond the individual case study and conference; and then only one such contact per year was involved. In 8 towns, there was no such contact. Current pressures of time and travel impinge upon the clinic team's ability to participate extensively in
film showings, discussion groups, lectures and case presentations to various community groups; but it is felt that, when the second travelling clinic team is established, emphasis on this very important area of community education and interpretation, is indicated as an essential part of an extended clinical program.

The Social Welfare Branch questionnaire responses indicated that the clinic, although generally seen as helpful to the worker and to the community, is not yet completely accepted. The replies indicated specifically that appropriate cases are being referred for clinical evaluation and treatment recommendations; clinical conferences are being used both for teaching by case method and for interpretation to other professional groups within the community; social workers, public health nurses and school personnel are working together to an appreciable extent on individual cases and in general community mental health activities; but difficulty in the follow-up of individual treatment recommendations seems to be interfering with positive acceptance of the clinic by the local community.

The main implications of the above material are, first, that in the immediate future, emphasis upon the consultative and community education aspects of clinic function is indicated, since it appears these are not fully utilized at present; and secondly, the need is brought out repeatedly of knowing your communities individually, in order both to
gear recommendations to the local resources, and to promote sound community relationships, based on mutual understanding and respect.
CHAPTER IV

THE FINDINGS AND IMPLICATIONS OF THE PRESENT STUDY IN RELATION TO FUTURE TRAVELLING CHILD GUIDANCE CLINIC PRACTICE

It is important to understand any local phenomena in terms of its historical development, not only locally but continentally. Present problems can very often be understood more clearly in the light of the past, and seen more in perspective than if viewed only as a participant in the present situation. The present study, seen, as has been stated, as an exploratory one, and as laying the base for further needed research along more detailed analytical lines, has attempted to present the broad theoretical and historical background of travelling child guidance clinics on this continent, in Canada, and particularly in British Columbia. Against this background, we have studied carefully the present administration, functions and process of the British Columbia Mainland Travelling Child Guidance Clinic, and of its individual team members. Through a random sample case study of 50 cases seen by the travelling clinic in 1953, general trends in the present field operation of the clinic have been observed, with stress upon the community aspects of the service. Emphasis has been upon the use made of the clinical diagnostic study and evaluation, as a tool for increasing general
mental health knowledge, and as an aid to local professional people in their general as well as specific case handling, plus a strengthening of community liaisons. Replies to questionnaires sent out to the Social Welfare Branch field offices have been evaluated in an effort to assess the degree to which travelling clinic services are accepted and understood by, and integrated into the rural communities served.

In the course of this study, the writer has noted the paucity of research and descriptive material on travelling child guidance clinics as compared to the abundance of written material on the stationary clinics. There seems to be a tendency, in the perception and thinking of professional people generally, to overlook the very real value and importance—and potential—of the travelling clinic which services the rural population. Research and descriptive material done on welfare services tends to flourish on urban and industrial communities. This has its proper place in the scheme of welfare planning. However, when one looks at the geographical composition of the North American continent, one cannot overlook the fact that North America, despite its move toward greater urbanization and industrialization, is still an agrarian culture to a great extent. While this is conjecture, the writer wonders whether the biases and interests of the people doing the studies might favor the "more attractive" urban and industrial areas, and thus subtly bias the attitudes and responses of their readers. Thus the profes-
sional worker is conditioned to viewing any other area of social work or psychiatric activity, however important, as "incidental."

The writer, however, has come to the conclusion that the travelling clinic services, far from being "incidental" to the stationary clinic services, represent the most potentially productive area of child guidance, and require of those engaged in it, special skills over and above those required of the worker in an urban clinic. It is a particularly challenging field, requiring, as has been noted, the utmost in professional competence and skill, plus the ability to adapt to local staff and conditions. As yet, the entire field has just been tapped, and on the whole, the potential value of travelling clinic services not generally recognized. The study of travelling child guidance clinic services in Canada indicated that only in Alberta and British Columbia do they exist as such.

Other provinces, notably Prince Edward Island and Ontario, have mental health programs which seem headed in the eventual direction of the development of travelling child guidance services; but the remainder of the Dominion seems still in the process of evolution from seeing travelling clinic services as an aid to screening for admission to a mental hospital, toward seeing the potential preventive and educative value in child guidance to the rural communities visited. The province of British Columbia may well take pride in the fact that it has established a service indicative
of progressive thinking along social welfare lines. It is, however, a growing, developing service, and as such, periodic assessment of the trends in development are necessary to focussing the services of the clinic more nearly to the needs of the client—the citizens of the rural communities of the British Columbia Mainland. It is hoped the present exploratory study will be but the beginning of a series of more detailed studies. The writer is convinced that the potential role of the travelling clinic in encouraging the establishment of adequate rural and semi-rural mental health programs and facilities cannot be over-estimated. A positive start has been made, despite severe limitations and pressures of time, distance, and staff; and a doubling of available clinic staff and services is planned for the near future. The present assessment of trends in clinical operation and indications of future areas of emphasis is offered as potentially helpful in planning future clinical program. The writer at all times bears in mind the youth of the service, and the limitations under which both clinic and field have operated; and offers her own thinking, based on the material compiled and presented in this thesis, in an unbiased light, and with the interests of future progress in mind.

The material presented in the preceding chapters illustrates that the development of the local travelling child guidance clinic has historically been much like that
of those travelling clinics described in Chapter I. Local conditions and associations have gradually given it a distinctive character, particularly in its close liaison with social agencies, which does not appear as strongly in the other travelling clinic services studied. The general trend of evolution from a mental hospital setting, to child guidance, to travelling child guidance, as the strengths and values of psychiatric services in the everyday problems of living were more universally recognized, is clearly distinguishable. Its aim has been to "spread around" available psychiatric services and knowledge, and has been formulated as being:

...to treat the problems presented, using the available community resources in the treatment; and through community education methods, to enable the community to meet more adequately its individual needs.

In the process of achieving this, the travelling child guidance clinic has met with specific problems and has acquired specific characteristics which differentiate it from the stationary clinic from which it operates. While the stationary clinic is concerned with the psychological, psychiatric and social diagnoses of the children and their families, and the travelling clinic is also focussed on this, there is, however, another factor involved—and that is, a social assessment of the community. It has been stressed repeatedly, in the analysis of the material compiled herein, that one of the main problems at present confronting the
clinical team is, not the establishment of the clinical
diagnosis of the problem presented, but is, essentially,
how to make use of that diagnosis, how to present it in
terms meaningful and practicable to the local worker.
The present study has indicated pretty clearly that the
field agencies are, on the whole, referring problems approp­
riate to the service rendered by the travelling clinic.\(^1\) The
clinic team is competent to diagnose;\(^2\) but the fact remains
that the treatment recommendations are in many instances, not
proving practicable. Before looking at the implications of
this, let us study the total picture as revealed within the
scope of this study.

The analysis of the 50 clinic files indicated that
real progress has been made in educating the local workers
as to suitable cases for clinic. The general characteristics
of the group of children, and the nature of the problems
they presented, fell within those seen as suitable clinic
cases. Problems are recognized and referred by schools,
Social Welfare Branch, parents and Public Health Units,
doctors, probation officers, and Juvenile Court, in that
order of frequency. The majority of cases are presented
by Social Welfare Branch—58%—and Public Health Unit—46%,
with schools and probation officers presenting the remaining
6%. Schools tend to refer largely through Public Health

\(^1\) See Chapter III, p. 114.
\(^2\) See Chapter II, description of staff qualifications.
Units, and parents through Social Welfare Branch. Public Health Units and Social Welfare Branches tend to present their own cases; in this respect more interaction was seen as healthier. There was general community professional representation at conferences, with emphasis on Social Welfare Branch, Public Health Unit and school personnel. It was felt more effort was needed to include doctors, ministers, et cetera. The active participation of school personnel is viewed as extremely positive.

This part of the study presented on the whole a positive picture of community use of clinic service, and indicated considerable strengths within the communities, as to their present interest in mental health programs. When it came to an analysis of treatment recommendations, however, it seemed that the picture broke down considerably, with treatment recommendations not being as closely geared to the skills of the local person carrying the case, as would be desirable.¹

This implication was fortified in the questionnaire replies, which indicated that too frequently the recommendations are not applicable to the local conditions; and were, therefore, often by-passed completely. Personal interviews between the writer and available field casework supervisors and social workers also indicated this, and added the further suggestion that the field workers would appreciate consult-

¹ See Chapter III, analysis of follow-up reports.
ative services around the carrying of clinic cases.

In studying the direct use of such community education channels as lectures, film showings, case presentations, panel discussions, et cetera, around mental health principles and around use of clinical services, it was noted that only a nominal number of such contacts were listed on clinic records.

The writer noted, in addition, that on examining travelling clinic case records, they show the process of study and diagnosis well indeed; but that too often the record ends with this. One gets the impression of an incomplete service, with little sense of continuity, and not enough sense of relationship with the presenting agency and local community.

The implication is that at present the travelling clinic's total function within the communities it serves is not being fulfilled as adequately as it could be. Real gains have been made in the post-war years, and the travelling clinic has become a firmly established and increasingly recognized and accepted service throughout the province. The initial steps have been successfully completed, as is indicated by the appropriate case referrals, the broad local professional attendance at conferences, and the positive indications of growing community liaisons. The transient nature of the travelling child guidance clinic service does inevitably lead to difficulties in the relationship
between the clinic and the communities it serves, and emphasizes the necessity of knowing your community in its limitations and its strengths, and adapting available services to the local situation. From the material at hand—clinic files, field questionnaire replies, and ideas expressed by field personnel—this seems to be the point at which clinical services have become stalemated for the present. The writer feels that the difficulty encountered in the area of clinical recommendations is symptomatic of a more basic disturbance in the matter of the relationship of the clinic to the rural communities it serves, and that in the interest of future progress, this disturbance needs "study, diagnosis and treatment."

Any positive relationship must be based on mutual respect and understanding. In this case, the clinic must understand the community, and the community must understand the clinic. Through understanding, comes respect. This thesis is seen as an effort toward clarifying further the functions and services of the travelling clinic—both, as has been stated, for the clinic team and for the local referring agency personnel. Chapter II has hopefully achieved this end. The consultative and community education aspects of clinic function need particular emphasis in future community interpretation, and insofar as is possible under present clinic conditions, should be stressed, and their use encouraged.
Because the travelling clinic must work closely and cooperatively with a wide variety of rural and semi-rural communities in British Columbia, it would be very valuable to undertake brief records which indicate descriptive material about the individual community generally. In this way, the clinic workers would know of its existing strengths and of its limitations as well. This record would best be kept simultaneously by the travelling clinic and by the local social agency. It should help both agencies to use helpful resources more speedily and efficiently. It would also help both agencies recognize evident gaps in local resources more speedily. In this way, the broad role of the travelling clinic in aiding in the gradual progression of the community toward increasingly adequate social service and general mental health resources and attitudes, would ever be kept in focus. It would also help the referring community agencies feel the clinic's genuine interest and understanding of their problems; and would enable the clinic team, through an understanding of local conditions, to make clinical recommendations better adapted to local resources.

Emphasis in community interpretation upon the total clinic functions—diagnosis, consultation, community and professional education, and research (encouraging of follow-up reports on cases seen by clinic), would appear to be the immediate step necessary. The "other side of the coin" is the undertaking, presumably by the casework supervisor on the travelling team, of the compilation of
individual community files as to local resources, professional staff and general community attitudes, i.e., a social assessment of the community. This should result in better-focussed case conferences, more meaningful and understandable to the local workers present. In this event, the clinic will be consulted increasingly around general community conditions and resources, and will move toward its role as "community consultant" on mental health issues. In order to attain this, it is imperative that each clinic team member be interested in and able to work comfortably in an easy relationship with local professional people; and be ever aware of the role the clinic plays in the rural communities.

Since working relationships between the clinic and the community need to be more firmly established, the writer would suggest that insofar as is practicable, staff assigned to the travelling clinic be fairly permanent. If this is possible, there will be less chance of the team being viewed as alien to the local scene, or of the travelling clinic being viewed as an "incidental" service. Its extreme importance must be recognized both by clinic and by community, if it is to fulfil its potential role. At present, the social worker is the only member of the team permanently assigned to travelling clinic. The psychiatrist is generally the one currently taking his (or her) senior fellowship at the clinic, and is assigned to the travelling team for his six months' stay at the clinic. The psychologists currently rotate, but
the writer would suggest that, in order to stress continuity in staff relationships between clinic and community, they be assigned consistently to the same community.

The clinic's description of the functions of the various staffs seems fairly well worked out in its written statements of job descriptions. The effectiveness with which any staff member carries through his job responsibility depends to a large extent upon his own clarity about his defined responsibility, as well as his training and demonstrated professional competence. In the case of the travelling clinic, this includes, particularly, recognition of and ability to participate actively and effectively in the consultative and community education aspects of travelling clinic function—and in the fostering of positive community-clinic relationships.

A random sample case study of travelling clinic files was made in an effort to gain a broad picture of clinical activities in the field in 1953. Although the sample of cases studied was small, some rather expected findings nevertheless came out of its analysis. The sample indicated that more boys than girls tend to be referred to clinic--58% boys to 42% girls. The age of the children referred ranged from 3 to 17 years, with 42% of the sample falling in the 9 - 12 year age group, and 30% in the 13 - 18 year age group. This implies that although some problems are recognized early, the majority are not referred for help
as soon as is desirable. Half of the children referred were those living in their own home with both parents; 18% were from broken homes, but were still living with one parent; and 32% of the children were, or had been, dependent upon social agencies for care and planning. The majority of the children referred--66%--were within the range of general intelligence which is potentially responsive to appropriate help within the community. The problems being referred were on the whole appropriate to the service offered by the clinic, and fell within the group of problems seen by the clinic as valid referrals for evaluation. The greater proportion of problems referred for clinical services were those within the group of disorders which either cause discomfort or disturbance within the community. As would be expected, complaints of disobedience were the most numerous. The least numerous in terms of frequency included: severe habit disorders, severe personality disorders, severe neurotic disorders, and severe conduct disorders. The schools referred the most problems (33%), with Social Welfare Branch second (21%), and parents and Public Health Unit were third, with 17% each. Doctors referred 7%. Probation officers and Juvenile Court referred the least number of problems in the cases studied.

Although this is a small sample, the findings suggest a healthy distribution of referrals among local agencies, schools, parents and key establishments. Because
the family physician usually is in intimate contact with the residents in the community, one would expect to find a larger number of referrals by doctors, as the clinic service becomes integrated into and accepted by the rural communities. Social Welfare Branch and Public Health Unit case presentations are predominant, with Social Welfare Branch presenting 58% of the total sample cases, and Public Health Unit 36%. Schools and probation officers presented the remaining cases. Schools tend to refer mainly through the local Public Health Unit, and parents through the local Social Welfare Branch. Social Welfare Branches and Public Health Units tend to present their own referrals. Doctors refer to both Public Health Units and Social Welfare Branches in a ratio of 3:2.

Attendance at case conferences generally includes mainly Social Welfare Branch, Public Health Unit and school personnel. Doctors, probation officers, ministers, and Victoria Order of Nursing staff are also included upon occasion, but more emphasis needs to be placed on their potential contributions both in a specific situation, and in the general community mental health program. It is the writer's impression that more use could be made of the case conference, once its full value and purpose is more clearly recognized.

The main implication of the study of the clinical recommendations is that many of the cases do not seem to be
carried by the agency whose function, and training of personnel, is best adapted to the needs of the case. Notable are the number of cases carried by the Public Health Unit in which casework services to parent or child, or both, are recommended. The reason for this inappropriate carrying of cases is not readily apparent, although it may well be based on the chronic shortage of trained social workers in the field. Presumably the handling of cases is decided beforehand by the local health and welfare agencies. It seems that it is the duty of the clinic to indicate those instances in which the case would best be carried by another agency. Whether this is followed or not, is the responsibility of the agencies involved.

A very positive indication in the clinical recommendations is that the schools are being drawn into the total treatment plan in 40% of the cases.

Although the systematic collection of follow-up reports has just been initiated by the new travelling clinic casework supervisor, 30% of the sample cases already had such reports on file, as a result of these recent efforts. Although this is much too small a number of cases to use as a basis for any conclusive statements, two factors stand out clearly, and indicate the extreme importance of further study, once more complete follow-up material is available. First, the cases in which progress was seen were, with two exceptions, those cases in which the recommendations had
been appropriate to the role and function of the follow-up agency. Secondly, there seemed to be a tendency not to follow up suggestions of referral which were made following the diagnostic study. Both these factors seem to point to the need of further clarification of the role and function of the public health nurse, and the role and function of the Social Welfare Branch worker; and the need of local health and welfare agencies coming to an early decision, based on the needs of the case, as to who should carry the case. The other implication is that there are difficulties in the relationships between local agencies, and between these agencies and the clinic, which need "study, diagnosis, and treatment"—and a sound community organization approach.

A study of the activities of the travelling clinic team in general community mental health education and interpretation of clinical services, indicated that such activity was limited. Current pressures of time and travel impinge upon the clinic team's ability to participate extensively in the various channels of community education over and above the case study and conference. This limitation is recognized; but it is extremely important, in the light of the implications of this study, that emphasis be placed upon the area of community education and interpretation as an essential part of clinical program, once the second travelling team is established. As much emphasis as possible in the meantime would enable the clinic to
maintain the gains made, and to prepare the way for greater acceptance and use of total clinic functions, by the rural areas.

In the course of this study, certain aspects of the general trends of clinic operation were necessarily skimmed over lightly. Further detailed analytical study would be enlightening and helpful in focussing future clinical program more nearly to meet the needs of the local communities. Some of the possible areas of study which have been mentioned in the context of this thesis, are:

1. Trend of travelling clinic referrals over the years, with respect to the age, sex, general family backgrounds, and intellectual ability of clients.

2. Detailed study of cases over a period of years with regard to the types of problems referred to the travelling clinic.

3. Study of the extent to which clinic recommendations are followed up—and if not, why not.

4. Intensive research by individual community as to the total functioning and relationship of the travelling clinic to the community, with emphasis on follow-up reports.

5. Study of the specific role and function of the Public Health Nurse, and of the Social Welfare Branch worker, in carrying rural cases.

The travelling clinic has made an auspicious beginning. It has become an established part of the field
welfare services; and although, as this study has indicated, staff exigencies of field and clinic have made ideal objectives impossible to achieve, this situation will be partially remedied in the near future. With the establishment of a second travelling clinic team, more time and effort will be available to focus on areas indicated herein as needing immediate attention—community education and interpretation of total clinic function, with emphasis on the education and consultation aspects of the clinic; and fostering of sound community-clinic relationships based on the clinic knowing and respecting the community, in its strengths and in its limitations, and on the community knowing and respecting the clinic, in its strengths and limitations. The success of any such undertaking will always depend on harmonious relationships among clinic staff, field health and welfare staff, and other citizens of the communities served.
APPENDIX A

LIST OF CLINICS AND PROVINCIAL DIRECTORS
OF MENTAL HEALTH SERVICES CONTACTED

1. Child Guidance Clinic,
   710 - 14th Avenue,
   Calgary, Alberta.
   Director.

2. Child Guidance Clinic
   10523 - 100th Avenue
   Edmonton, Alberta.
   Dr. R. A. Schrag, Director.

3. Director,
   Child Guidance Clinic,
   Red Deer, Alberta.

4. MacNeil Clinic for Psychiatric Services,
   Saskatoon, Saskatchewan.
   Dr. Z. Selinger.

5. Dr. D.G. MacKerracher,
   Director, Mental Health Services,
   Department of Health,
   Parliament Buildings,
   Regina, Saskatchewan.

6. Dr. T.A. Pincock,
   Provincial Psychiatrist,
   Psychopathic Hospital,
   Winnipeg, Manitoba.

7. Dr. M. Houze, Director,
   Mental Health Clinic,
   Ontario Hospital,
   Brockville, Ontario.

8. Dr. H.R. Brillinger,
   Director,
   Mental Health Clinic,
   Ontario Hospital,
   Hamilton, Ontario.
APPENDIX A (Continued)

9. Dr. R.M. Billings, Director, Mental Health Clinic, Ontario Hospital, Kingston, Ontario.

10. Dr. G.E. Jenkins, Director, Mental Health Clinic, Ontario Hospital, London, Ontario.

11. Director, Mental Health Clinic, Ontario Hospital, New Toronto, Ontario.

12. Director, Mental Health Clinic, Ontario Hospital, Whitby, Ontario.

13. Dr. R.C. Montgomery, Director, Mental Health Division, Department of Health, Parliament Buildings, Toronto 2, Ontario.

14. Dr. Baruch Silverman, Director, Mental Hygiene Institute, 531 Pine Ave. W., Montreal, Quebec.

15. Dr. Geo. Reed, Director, Verdun Protestant Hospital, Verdun, P.Q. Travelling Clinic.

16. Dr. L.R. Vezina, Chief, Division of Psychiatric Hospitals, Ministry of Health, Parliament Buildings, Quebec, P. Q.
17. Dr. Clyde Marchall,  
Chief Neuropsychiatric Division,  
Department of Public Health,  
Halifax, Nova Scotia.

18. Dr. R.R. Prosser,  
Director,  
Mental Health Services,  
Department of Health and Social Services,  
Fredericton, New Brunswick.

19. Dr. A.J. Murchison,  
Director,  
Mental Health Division,  
Department of Health and Welfare,  
Falconwood Hospital,  
Charlottetown, Prince Edward Island.
January 9th, 1955.

Dear Dr. .......

As part of my work for the Master of Social Work degree, I am studying for my thesis the travelling child guidance clinic services currently available in Canada, with special reference to the Vancouver Travelling Child Guidance Clinic.

I have been unable to obtain the information which I need, and would like to enlist your aid in regard to your clinic, which I understand provides travelling psychiatric services for children. I trust this will not entail too much of your time, and that the necessary material may be readily available in annual reports or other statistical data.

Briefly, the areas of interest are:

a) clinic function (diagnostic, consultative, educational, therapeutic, et cetera)
b) area serviced

c) staff and administration
d) types of cases handled
e) tie-in with other social agencies

Any other comments you feel are indicated would be appreciated.

Would it be possible to receive this information on or before January 25th?

With thanks for your cooperation,

Yours truly,

(Mrs.) Phyllis Coyle, University of British Columbia School of Social Work.
APPENDIX B

The purpose of this enquiry is a brief review of the services offered through the Travelling Child Guidance Clinic from Vancouver. It would be greatly appreciated if you base your judgments on your experience in the last two years only. Please feel free to comment on any ways in which you think services might be improved.

Identifying Information

District Office ..................... Date ............... 

How often does the clinic visit ......................... 

Is there a need for more frequent visits .... How often ......... 

Approximate number of cases referred by the district office 

in 1952 ......................... in 1953 .........................

I. REFERRALS

In which type of cases have you found the clinic most helpful. (Mark with X the type(s) of cases which are most common. Mark with tick ( / ) the types of case(s) for which the clinic has been most helpful.)

<table>
<thead>
<tr>
<th>Type of Case</th>
<th>Number</th>
<th>Help</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Maladjustment stemming from child's undesirable habits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Inability to cope with social or scholastic expectations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Placement cases in which there is concern about the emotional consequences to the child due to former dependency, broken home, or neglect.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
4. Children in their own homes whose behaviour difficulties stem from a distinct break-up in parent-child relationship

5. Patients who are retarded in intellectual development

6. Patients who are retarded because of physical handicaps

7. Cases involving psychogenic disorders

8. Behaviour difficulties as a direct result of marital conflict

9. Other (Please specify) ........................................

II. Follow-up

1. On the average, to what extent did the clinical diagnosis help the social worker in over-all case work operation.
   A. Extremely helpful .... B. Moderately helpful ....
   C. Of Limited value .... D. Of no value ...........

2. What were the most important limiting factors affecting the follow-up. (Please explain factors where necessary):
   A. Community resources ... C. Social service personnel...
   B. Continuity of psychiatric consultation .... D. Other ..................

Suggestions ............................

III. CLINIC CONFERENCES AND COMMUNITY INTERPRETATION

1. Do you find clinic conferences (Check which)
APPENDIX B (Continued)

A. Very useful........... B. More use possible .......
C. Almost no use ........ D. Other (Specify) .........

2. Do you include other interested professional persons
   (e.g., public health nurses, teachers, school coun­
   sellors): Yes....... No ........

If the answer is yes, please comment on their part in
the conferences. ........................................
....................................................................
....................................................................

GENERAL COMMENTS ........................................
....................................................................
....................................................................
INTRODUCTION

The preparation of a social case history presupposes a case work relationship with the child and his family. Referral to Child Guidance Clinics should be a joint decision made by the child and the family and the social worker, after interpretation of the purpose and value of such examination has been done by the worker. The child and his family should be aware that Clinical examination is aimed at further understanding of the child's problem and that usually it is followed by a further "working together" of the family and the social worker.

Consequently, much of the information required for a social history will have been obtained during the social worker's early contact with the family, and an evaluation of the problem made.

An adequate social case history supplies to the Clinic team a revealing story of the child in his social setting. The plot centres around his difficulties which often come about through friction between his growth process and the demands of his environment. Whatever affects this growth process or the environment is of significance in the story. As far as possible a social history should give a clear impression of the child with respect to inheritance, rate of development, bodily health, home, background, parental attitudes, response to school life, adaption to family and other children, and adults.

The social history is not only descriptive, it also includes the social worker's evaluation and indicates the work already done and its effect. Four copies of the developmental and social history should be submitted at least a week prior to Clinic examination of all Vancouver Island and Travelling Clinic cases.
SOCIAL HISTORY OUTLINE

A guide to preparation of Social Histories for the Child Guidance Clinics.

NAME:

BIRTHDATE: STATUS: (Ward, Non-Ward, Etc.)

PARENTS: (FATHER) BIRTHDATE:
(MOTHER) ADDRESS:
(MAIDEN NAME)

TELEPHONE:

SOURCE OF REFERRAL: (By whom and how)

PROBLEM: (1) As stated and seen by parents, child, and any other closely involved persons.
What help are they asking for?
How long have parents, child, or others been aware of the problem(s)?
How do they feel about receiving help?

(2) Social worker's general picture of problem. Estimate client's awareness of the presenting problem and other problems seen by the social worker.
Reason for referral to Clinic at this time.
What specific help is desired by social worker.

DATE OF PREVIOUS EXAMINATION AT C.G.C., E.P.H., Etc. (Child or relatives)

FAMILY HISTORY

HOME SETTING: Pertinent and brief descriptive material of present home setting—economic and community status; housing; persons in home.

FATHER: (1) Identifying information—name; present age; place of birth; religion.

(2) Social and cultural background—others in family, ages; father's description of paternal grandparents; father's estimate of his adjustment to family, school, religion, and social groups; extent of education; work record, health; any serious illnesses or operations.

(3) Family relationships—father's feelings about and relationship to child, to wife, to others in family; father's attitude and contribution with regard to problem(s); How does he handle it?
FAMILY HISTORY

(4) Paternal relatives—information pertinent to child and parents' adjustment:

MOTHER: Information as for father (1), (2), (3).

(4) Maternal relatives—information pertinent to child and parents' adjustment:

MARITAL ADJUSTMENT: When, where, and how did parents meet? Courtship; Sexual adjustment.

STEP-PARENTS OR FOSTER HOMES: As above with dates child was with them and reasons for leaving. Indicate and evaluate relationships, adjustment, and the meaning of the experience to the child. (in chronological order)

SIBLINGS: Identifying information—name; date and place of birth, religion. How do they fit into the family, inter-personal relationships?

PERSONAL HISTORY

DEVELOPMENTAL FACTS:
Date, place of birth: Age weaned: Bladder control at:
Toilet training began: Bowel control at:
Teethed at: Walked at:
Talked at (words): (sentence formation):

DESCRIPTION OF DEVELOPMENT TO DATE: mother's health, attitudes and feelings about child during pregnancy; method of delivery; length of labour; birth injuries.

(1) Eating: Method of early feeding; Method of weaning, any early feeding, or present eating difficulties; Food fads or fussiness; Indigestion or any indication of gastro-intestinal disorder.

(2) Elimination: Method and attitudes in training child; Difficulties; Any indications of frequent constipation or diarrhea; Any incidents of enuresis; Soiling; Smearing; Any present unusual attitudes or habits regarding elimination.

(3) Sexual development: Interest in sexual information; Any incidents of exhibitionism; Sex play; Masturbation or intercourse (describe, including age and frequency, of such incidents); Extent of sexual knowledge;
PERSONAL HISTORY

From whom obtained;
Evidence of development;
Age of puberty;
Attitude toward it;
If menses established is it regular? Painful?
Has someone discussed puberty and sexual role with child?
Any indication of abnormal sexual behaviour?

(4) Physical development:
Has physical growth been normal?
Give incidents of illness, disease (ages) sequelae (disability, etc.)
Reactions of child and parents to serious illnesses;
Disabilities;
Operations and preparation of child for these (age);
Child's attitude to and estimate of present health;
Any over-compensation or over-concern.

PERSONALITY AND APPEARANCE:
Physical description;--any indications of nervous habits; fears; disturbances of sleep; recurrent or significant dreams.
General picture of the child's outstanding relationships and how he (she) uses these.
How does he (she) handle feelings and need such as anger, affection, dependency in relation to his (her) closest relationships. Attitudes to school, teachers, people in authority.

Interest and Recreation; adjustment to social groups, employment, particular friends of both sexes.
Ambitions and goals.
Estimate of child's insight, intelligence, humour.

SCHOOL RECORD:
Grade and teacher's report. Bureau of Measurements record if in Vancouver.

EVALUATION AND PLAN

Social worker's evaluation of case from work done by the presenting agency.
What has been done? How frequent are the contacts? How strong is worker-child relation?
What methods have been tried in working with child and parent(s)?
What has been tried by family members in dealing with problems? How successful?
What possible resources are there in family or community to help meet child's needs?
What are worker's suggestions for carrying on from the point?
Questions around which social worker would like discussion.

ALL HISTORIES SHOULD BE SIGNED BY THE SOCIAL WORKER AND FOUR COPIES SUBMITTED TO THE CLINIC.
Specific References

Books:


Articles:


Studies and Reports:


Department of National Health and Welfare, Research Division, General Series Memorandum No. 6, Mental Health Services in Canada, Ottawa, July, 1954.

Department of Provincial Secretary, Mental Health Services, Province of British Columbia, Annual Reports, 1932-1954.


Department of Health, Hospitals Division, Ontario Mental Hospitals and Mental Health Services, Annual Report, 1951.

Department of Public Health, Province of Saskatchewan, Public Health Annual Report, 1952-3.

Department of Public Health, Province of Saskatchewan, An Outline of Psychiatric Services, June, 1954.

Department of Public Health, Province of Alberta, Mental Health Services, 1953.