THE DEVELOPMENT AND GROWTH OF
THE CHILD GUIDANCE CLINIC OF GREATER WINNIPEG

BY

SHERMAN N. LANG

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SHERMAN N. LANG

A thesis submitted to the Faculty of Graduate Studies of
the University of Manitoba in partial fulfillment of the requirements
of the degree of

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ABSTRACT

The purpose of this study was to trace the factors which influenced the development and growth of the Child Guidance Clinic of Greater Winnipeg and to examine its function as a support service to the school divisions of Greater Winnipeg. This study focused on developments in the areas of administration, role and function of clinicians and delivery of services. Information was obtained through archival materials and interviews with Clinic staff.

This study is significant in that it provides a valuable educational document to school personnel, community agency personnel and parents involved with the services of the Child Guidance Clinic of Greater Winnipeg.
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACKNOWLEDGEMENTS</td>
<td>i</td>
</tr>
<tr>
<td>ABSTRACT</td>
<td>ii</td>
</tr>
<tr>
<td>LIST OF FIGURES</td>
<td>v</td>
</tr>
<tr>
<td>Chapter</td>
<td></td>
</tr>
<tr>
<td>I  INTRODUCTION</td>
<td>1</td>
</tr>
<tr>
<td>PURPOSE</td>
<td>2</td>
</tr>
<tr>
<td>SIGNIFICANCE</td>
<td>3</td>
</tr>
<tr>
<td>METHODOLOGY</td>
<td>3</td>
</tr>
<tr>
<td>DEFINITIONS</td>
<td>4</td>
</tr>
<tr>
<td>Child Guidance</td>
<td>4</td>
</tr>
<tr>
<td>Child Guidance Clinic of Greater Winnipeg</td>
<td>4</td>
</tr>
<tr>
<td>Unit</td>
<td>4</td>
</tr>
<tr>
<td>ORGANIZATION</td>
<td>4</td>
</tr>
<tr>
<td>II  HISTORICAL OVERVIEW</td>
<td>5</td>
</tr>
<tr>
<td>III REVIEW OF THE RELATED LITERATURE</td>
<td>13</td>
</tr>
<tr>
<td>SUMMARY</td>
<td>32</td>
</tr>
<tr>
<td>IV  DISCUSSION</td>
<td>33</td>
</tr>
<tr>
<td>INTRODUCTION</td>
<td></td>
</tr>
<tr>
<td>PROCEDURE</td>
<td>33</td>
</tr>
<tr>
<td>PARTICIPANTS</td>
<td>33</td>
</tr>
<tr>
<td>INTERVIEW DATA</td>
<td>34</td>
</tr>
<tr>
<td>Psychology</td>
<td>34</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>35</td>
</tr>
<tr>
<td>Reading</td>
<td>37</td>
</tr>
<tr>
<td>Social Work</td>
<td>40</td>
</tr>
<tr>
<td>Chapter</td>
<td>Page</td>
</tr>
<tr>
<td>---------</td>
<td>------</td>
</tr>
<tr>
<td>Speech and Hearing</td>
<td>42</td>
</tr>
<tr>
<td>Directorate</td>
<td>44</td>
</tr>
<tr>
<td>ANALYSIS</td>
<td>45</td>
</tr>
<tr>
<td>V SUMMARY AND CONCLUSIONS</td>
<td>47</td>
</tr>
</tbody>
</table>

REFERENCES .............................................................. 51

APPENDICES

| A | C. G. C. 1987 Budget ............... 55 |
| B | Criteria for Certification of School Clinicians .......... 57 |
| C | C. G. C. Referral Form .............. 62 |
| D | Correspondence ..................... 70 |
| E | C. G. C. Service Units ............. 76 |
# LIST OF FIGURES

<table>
<thead>
<tr>
<th>Figure</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Structure of C. G. C. 1951</td>
<td>9</td>
</tr>
<tr>
<td>2.</td>
<td>Structure and Working Agreement ... (1987)</td>
<td>10</td>
</tr>
<tr>
<td>3.</td>
<td>C. G. C. Staff by Year</td>
<td>49</td>
</tr>
<tr>
<td>4.</td>
<td>C. G. C. Cases by Year</td>
<td>50</td>
</tr>
</tbody>
</table>
CHAPTER I

INTRODUCTION

The Child Guidance Clinic of Greater Winnipeg is a joint education and mental health agency administered by the Winnipeg School Division No. 1. It is financed by contributions from the Provincial Department of Education and The Department of Health as well as the local school divisions which it serves (see Appendix A). There is no direct charge for services which are provided to children and adolescents attending public, private, parochial or specialized schools. Delivery of service is provided through multi-disciplinary teams or Units which include members from the Psychiatry, Psychology, Reading, Social Work and Speech and Hearing Disciplines. There is a total of twenty such Units. Seventeen of these Units are geographically located and these include nine teams in the Winnipeg School Division No. 1 as well as teams which operate in eight suburban school divisions including Assiniboine South, St. Boniface, Fort Garry, St. Vital, Norwood, River East, Seven Oaks and Transcona-Springfield. Four suburban divisions including Seven Oaks, St. Vital, Norwood and Assiniboine South do not include Reading Clinicians. They use in-school resources to carry out what historically has been the role of the Reading Clinician. Within the Winnipeg School Division No. 1 three additional Units provide services to children outside the regular, public school classroom situation. One Unit is assigned to work in private and parochial schools, another works with students in programmes for the mentally handicapped and the third provides services to programmes for hearing-impaired students.(see Appendix E) Services are provided in the French language to "Français" programmes in St. Vital, St. Boniface and Norwood School Divisions. French immersion programmes in these and other divisions are not necessarily serviced by French speaking clinicians. St. James-Assiniboia has operated independently from the Child Guidance Clinic since 1977. It provides similar services through its Educational Support Services. Units vary in size and make-up according to the needs of the geographic area or population they serve and are staffed accordingly. School divisions
serviced by the Child Guidance Clinic are represented on an advisory council which gives direction for the operation of the Clinic. While most referrals are made by school personnel, parents, social agencies, physicians and other professionals also refer. Self-referrals are accepted from students over the age of eighteen.

Clinic services are provided by the five disciplines in an integrated fashion, in whatever combination is indicated, to children, their parents or guardians and school personnel. This integrated method of service delivery makes the Child Guidance Clinic of Greater Winnipeg, as an institution, unique on this continent (Downey, 1981). Unit teams deal with both learning and communication difficulties as well as problems of a behavioural or social/emotional nature. Other communities characteristically have a separate child guidance clinic, which is essentially a psychiatric service, while some of the other services are provided in the community or under the ægis of a particular school division. In Winnipeg, services operate out of a centralized clinic; the administrative aspect of the work is centralized while the delivery or services is decentralized. Clinical services are carried out mainly in the schools and the homes in the local community.

PURPOSE

The purposes of this study were to trace the factors which influenced the development and growth of the Child Guidance Clinic of Greater Winnipeg and to examine its function as a support service to the school divisions of Greater Winnipeg. This study dealt with three specific areas of change and development: 1) administrative structure and funding, 2) role and function of the Psychology, Psychiatry, Reading, Social Work and Speech and Hearing Disciplines and 3) method of delivery of services. Perceived effects of these changes were examined through interviews with Child Guidance Clinic of Greater Winnipeg staff familiar with its history. This study covered the thirty-six year history of the Child Guidance Clinic of Greater Winnipeg from its inception in 1951 to the present time as well as earlier, related services in the Winnipeg School Division No. 1 which ultimately led to the development of the Child Guidance Clinic of Greater Winnipeg.
SIGNIFICANCE

The Child Guidance Clinic of Greater Winnipeg is a school-oriented agency which deals with a variety of school-aged children's mental health and educational problems. This agency emphasizes the importance of involving school personnel and parents in the treatment of these problems. There is considerable reliance on teachers to identify problems initially and to monitor the effectiveness of treatment. The effectiveness of the clinician often depends on his or her relationship with school personnel and appropriate use of Child Guidance Clinic services by school personnel. It is felt by the present writer that a comprehensive overview of the Child Guidance Clinic of Greater Winnipeg will provide a valuable educational document to present and future educators using its services and will ultimately lead to a better understanding and more effective use of these services. It will also serve a similar purpose to new employees of the Child Guidance Clinic of Greater Winnipeg as well as parents and other agency personnel. This study could also provide information to institutions in other communities for which the Child Guidance Clinic of Greater Winnipeg could serve as a model as well as a resource for further research.

METHODOLOGY

Since no specific, comprehensive work on the Child Guidance Clinic of Greater Winnipeg has been written, it was necessary to obtain information for this study from relevant documentary materials such as annual reports, committee reports, articles and archival files. Perceived effects of major changes and developments in the functioning of the Child Guidance Clinic of Greater Winnipeg were obtained through structured interviews with staff members familiar with its history.
DEFINITIONS

Several terms will require definition to set the study in its proper context. They are defined as follows:

Child Guidance: Keir (1952, p. 5) has defined child guidance as "...giving expert advice or assistance to parents, educationists, and children themselves..."

Child Guidance Clinic of Greater Winnipeg: A school-based support system offering multi-disciplinary professional services in psychiatry, psychology, reading, social work and speech and hearing. It is a joint mental health and educational agency administered by the Winnipeg School Division No. 1. This agency serves all of the school divisions in Metropolitan Winnipeg with the exception of St. James.

Unit: An interdisciplinary team which includes representatives from psychiatry, psychology, reading, social work and speech and hearing disciplines serving a geographic or special needs population. These units vary in size and make-up according to the geographical area or population which they serve.

ORGANIZATION

Chapter II contains an historical overview of the Child Guidance Clinic of Greater Winnipeg. It traces developments in the Winnipeg School Division No. 1 prior to 1951 which eventually led to the formation of the agency in that year. This is followed by a discussion of the growth and development of the Child Guidance Clinic of Greater Winnipeg to its current status.

Chapter III is a review of the related literature. The area researched is the major patterns of development of child guidance clinics in North America and Europe.

Chapter IV is a discussion of the major changes and developments in the Child Guidance Clinic of Greater Winnipeg over the past thirty-six years. It deals with the interview procedure used to gain information and presents a discussion of the interview data.

Chapter V contains a summary of the study, draws conclusions and makes recommendations for further research.
CHAPTER II
HISTORICAL OVERVIEW

On July 1, 1987 the Child Guidance Clinic of Greater Winnipeg celebrated its thirty-sixth anniversary. During those thirty-six years it has grown from a professional staff establishment of twenty-nine to over 159. In 1986-1987, total annual cases handled was 11,365 or approximately eleven per cent of all children in the school system served. The creation of the Child Guidance Clinic of Greater Winnipeg in 1951 was actually the consolidation of services to schools which existed prior to that time.

Some of the first special education and school psychological testing in North America were initiated in Winnipeg in the early 1920's. Miss May Bere was appointed as "specialist in intelligence tests and educational measurement" as of September, 1920 (Baker, 1969). Miss Bere had gained work experience at the Judge Baker Foundation in Boston, serving under Dr. William Healy. The interdisciplinary approach proferred by Dr. Healy was reflected in Miss Bere's work. Dr. Crawford (1929), chief medical inspector of the Winnipeg School District, in describing the role of the psychologist to the Manitoba Educational Association in 1929 emphasized that the study of the subnormal child required the involvement of the teacher, the principal, the psychologist, the physician for physical defects and the school nurse who obtained family, developmental and social histories. A truant service was begun in 1928 at which time one teacher was relieved from classroom responsibilities to work part-time with truants. By the late 1930's the Winnipeg School District had established speech correction and visiting teacher programmes. The visiting teacher programme developed out of the existing truant service and subsequently evolved into the Social Work discipline. In 1935, when the Winnipeg School District established a Mental Hygiene Programme, the main foundation for what was to become the Child Guidance Clinic was laid (Downey, 1981). In that year, Miss Grace Dolmage, a special class teacher qualified to undertake mental testing, was hired to study the acute problems of retardation throughout the system. Miss Dolmage was assigned permanently to the Medical
Inspection staff serving as psychologist. In, 1936, through the combined efforts of the Winnipeg League for the Hard of Hearing, and the Winnipeg Kiwanis Club, the first audiometric survey was carried out.

In 1941, a Child Guidance Clinic was organized under the joint sponsorship of the City Health Department and the Winnipeg School Board. The formal organization of the Child Guidance Clinic consolidated the services of social work, psychology, speech therapy, public health nursing and part-time psychiatric consultation and had as its Coordinator Miss Grace Dolmage (Asselstine, 1959). With Philadelphia, Boston and Chicago, Winnipeg had one of the first school psychiatric services (Downey, 1981). In 1944, a psychologist began work in the area of diagnosis and remediation of learning difficulties and this eventually led to the establishment of the Reading Department four years later.

In 1946, Dr. Pincock, Provincial Psychiatrist, was arranging space for a "Child Guidance Youth Study" clinic to serve all school children in the Greater Winnipeg Area (Asselstine, 1959). Rather than having two clinics as previously planned, Dr. Pincock recommended to the Minister of Health that one coordinated clinic be set up to pool the resources of the City Health Department, the Winnipeg School District, the Provincial Department of Health and the suburban School Districts. Asselstine (1959, p. 2) states, "The combined arrangement was favoured because service rendered would be more efficient and over-all costs less." This matter was kept open for continued consideration by the Minister of Health.

In 1948, the "Reavis Report" recommended the coordination of all guidance services in connection with the Child Guidance Clinic (Reavis, 1948). An application for a federal mental health grant was approved in 1949. Dr. T.A. Pincock, then Manitoba Provincial Psychiatrist, in a letter to the Minister of Health gave the following reasons for consolidating and combining Child Guidance Work in the Winnipeg area: 1) economy of space, staff and time, 2) increased efficiency, 3) the files of all children can be centralized
and be made readily available, 4) the teaching possibilities for students of medicine, social work, public health nursing, teaching, psychology are enhanced, and 5) the main objective of discovering and managing behaviour disorders at an early stage in their development is accomplished. Dr. Pincock further noted that centralization under one authority was essential to success (Pincock, 1948).

On March 23, 1950 a joint presentation to the Minister of Health by the Superintendent of Winnipeg Schools and the City Medical Health Officer recommended the expansion of the Winnipeg Child Guidance Clinic to include Greater Winnipeg. The Minister of Health consented to a combined "Child Guidance Clinic of Greater Winnipeg" and agreed to submit the project to Ottawa requesting an additional grant not to exceed $35,000.

In April of 1951 the name of project 606-5-22 was officially changed to "Child Guidance Clinic of Greater Winnipeg" (Asselstine, 1959). From this point on the writer will use the terms "Child Guidance Clinic of Greater Winnipeg", "Child Guidance Clinic", "C. G. C". and "Clinic" synonymously. All of these terms are common local usage. On May 31, 1951 the Winnipeg School Board approved the extension of the Clinic to be operated under the ægis of the Winnipeg School Board and the provincial Department of Health and Welfare through the division of Psychiatric Services, with the cooperation of the Winnipeg City Health Department. The Child Guidance Clinic of Greater Winnipeg began its official operation in July, 1951 with Dr. James Asselstine, a psychiatrist, as Director. The Clinic was organized into six departments: Psychology, Social Work (Visiting Teacher), Reading, Speech and Hearing, Psychiatry and Clerical. It provided services to thirteen school divisions through its staff of twenty-nine (Asselstine, 1955). This structure remained until 1972.

In 1972, The Directorate of the Clinic was shifted from the Department of Health to the Department of Education. Mr. L. B. Fleischer, an educator, was appointed Director in 1973. The "Departmental Structure" was abandoned (see Figure 1.) and
replaced by the current "Unit System" where members of each professional discipline work together on a team along with an Area Service Director who is responsible for the administration of services to one or more geographical areas in a school division. The Area Service Director is also responsible for the supervision of staff members within his/her professional Discipline. The total Clinic remains under the direction of a Director and Assistant Director (see Figure 2.).

In June, 1972 a Clinic Advisory Committee was established after recommendation from members of the Provincial Government and certain local school divisions. School divisions requested more input into the operation of the Clinic and expressed a need for more consultative services available to the classroom teacher. The Advisory Committee consisted of representatives from the Superintendent's Department from each of the participating school divisions in Greater Winnipeg, a school trustee from each of the divisions, as well as representatives from the Department of Education and the Clinic itself. The stated purpose of this committee was to provide input into the formation of policy and the operation of the Clinic, to be a vehicle for discussion of concerns among the divisions, to be a consultative body to the administration and to provide the opportunity for the sharing of information concerning specific projects of Clinic services (C.G.C. Advisory Council, 1982). The Clinic Advisory Committee continues to operate in this way at the present time.

Also in 1972, a committee of Child Guidance Clinic staff members developed task forces which communicated with The Psychological Association of Manitoba, the Manitoba Speech and Hearing Association, the Reading Council of Greater Winnipeg and the Manitoba Institute of Registered Social Workers in the direction of certification of school clinicians. Briefs were presented recommending certification to the Board of Teacher Education and Certification of the Department of Education. The Child Guidance Clinic task forces continued their work by concerning themselves with issues relating to the
payment of grants to school divisions as a means of encouraging and facilitating the employment of school clinicians (C.G.C. Annual Report, 1972). This eventually led to the issuing of School Clinician's Certificates by the Department of Education in 1978. All staff employees must have their credentials processed by the Department of Education for the purpose of being issued a certificate as a School Clinician. The Department of Education determines for each employee a grant placement based upon classification (C. G. C. Manual of Procedure, 1984). Criteria for certification are presented in Appendix B. Psychiatrists are certified by the Royal College of Physicians and Surgeons.

Thirty-six years ago the Child Guidance Clinic was one of the few resources available to children with special needs in the schools. Such developments as individualized programming, continuous progress, guidance counselling and resource teacher help for children reflect a shift in the educational system towards individualized, pupil-centered programming. The facilities of the school system, including the Clinic, have become resources for the child. From 1954 to 1973, the Clinic provided classes for emotionally disturbed children through its "Clinic Tutoring Service". This eventually evolved into the Learning Assistance Centre classes which currently provide educational and treatment programmes for emotionally disturbed children in the Winnipeg School Division No. 1. Clinic services are constantly being modified to focus on the assessment, remediation and follow-up of the the more complex problems in addition to providing consultative and ultimately preventative services to the child, school personnel and parents through parent groups, school inservices and involvement in early identification programmes. In the core area of Winnipeg, an inter-agency group has been established by the Clinic to facilitate communication among community agencies and the Clinic and to help prevent duplication of services. In addition, there has been a continuing growth and interest in the direction of research among Clinic staff.

With its close tie to the schools, Clinic staff are able to come in contact with virtually all children in the school system starting from an early age. This is an important
factor in the Clinic's attempt to fulfill its purpose of enabling all children to have an education and to develop to their fullest potential.
CHAPTER III

REVIEW OF THE RELATED LITERATURE

Literature related to the major patterns of development of Child Guidance Clinics in Europe and North America, particularly the United States of America and England, will be presented.

The literature presents several definitions of Child Guidance and Child Guidance Clinics which come from a variety of perspectives. Stevenson (1934) writes:

"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 - children whose development is thrown out of balance by difficulties which reveal themselves in unhealthy traits, unacceptable behavior, or inability to cope with social and scholastic expectations. Its service is rendered by 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. The essence of this approach is that behavior is studied objectively, as nearly as possible without prejudice, in the hope of discovering the causes - usually multiple - which produce it, and that an effort is made to modify it by eradicating or abating the causes rather than by precept or imposition of authority." (p. 1)

Watson (1960) presents the following definition:

"Child Guidance Clinics are the major setting for the diagnosis and treatment of emotionally disturbed children who do not require hospitalization. The most distinctive characteristic of these clinics is their day-to-day utilization of the services of specialists from various fields. Psychiatrists, clinical psychologists and psychiatric social workers are the nucleus of the team used for a multifaceted approach to their clinical tasks. In varying degrees and proportions other specialists are used, including pediatricians, remedial teachers and speech specialists. Through these specialists, child guidance clinics have relations with all major personal service institutions in their communities. Schools, hospitals, and other social agencies refer children, and in turn are utilized by the clinics in their diagnostic and remedial work." (p. 192)

Gardner (1953) points out that some child guidance clinics are community sponsored, some are affiliated with hospitals, others are affiliated with universities where several departments sponsor the clinic, and still others are part of a school system. This diversity of sponsorship as well as the fact that child guidance clinics are often closely related to
agency clinics such as those attached to juvenile courts, community clinics serving both adults and children, hospital out-patient clinics, and residential treatment centres have led Watson (1960, p. 193) to state, "The lines dividing these agencies from child guidance clinics are more than loosely agreed upon. This loose delimitation prevents a very accurate estimate of the number of child guidance clinics." MacLean (1966) states:

"In trying to solve the problems and guide the child, it is useful for the teacher or parent to have knowledge of and to take advantage of any services which may exist to help her when the need arises. One such agency at her disposal is the Child Guidance Service...Their purposes will differ according to the development of each area and country, but basically they are designed to investigate and observe children who are in need of help or who have problems whether from an intellectual, emotional or environmental point of view." (pp. 4-6)

As might be expected from the preceding definitions of child guidance clinics, there will be inevitable variations from clinic to clinic with a diversity of points of view and practices. However, basic themes which run throughout the definitions are that the population served is the school-aged child or adolescent and both mental health and educational services are provided by multi-disciplinary teams of professionals. Watson (1960, p. 194) states, "...the clinic maintains an emphasis on the child as the primary patient." Burt (1953, p.12) maintains, "In its original sense...the phrase 'child guidance' included giving guidance to normal as well as to abnormal children, to the ordinary school pupil as well as the 'difficult child'." Warren (1971) points out that clinics have adjusted their services to local needs and attitudes of the community which they serve.

The history of the inception and development of child guidance clinics sheds further light on their various perspectives of operation. The major countries of origin of child guidance clinics are the United States of America and England, and it is from these two countries that the preponderance of literature emanates.

A forerunner of the first guidance clinic appeared in 1896 when Lightner Witmer, a psychologist, founded the Psychological Clinic of the University of Pennsylvania (Watson, 1960). He had become interested in the educationally retarded and handicapped child because of challenges from school teachers in his university classes to
make psychology a useful field. The great majority of cases seen in his clinic came from the school system. Although less stress was placed upon them, non-school and emotional problems were also dealt with.

It is generally agreed that the first child guidance clinic was established in Chicago in 1909 (Stevenson, 1934, Watson 1960, Shakow, 1948, Witmer, 1935). Under the direction of William Healy, a psychiatrist, it was called the Juvenile Psychopathic Institute (Healy and Broner, 1948). Originally designed to study juvenile delinquency, children were referred who also presented personality, educational and non-court difficulties. Healy (1948, p. 26) states, "There was ample evidence in many cases that delinquency was tied up to school dissatisfactions, with truancy and then more serious conduct. These attitudes toward school life were most often based on deficiencies of accomplishment." The personnel in Healy's clinic reflected the team concept. Healy served as director and psychiatrist. There was a staff psychologist and social workers from cooperating agencies (Watson, 1960).

In 1917, Dr. Healy and his assistant in Chicago, Dr. Augusta Bronner, a social worker, migrated eastward to organize a clinic in Boston under the name of the Judge Baker Foundation. This later became the Judge Baker Center (Watson, 1953). In the same year, Dr. Herman Adler took charge of the clinic in Chicago. In describing their work Healy and Broner, (1948) state:

"...delinquency has by no means been our sole interest. Even in Chicago many cases showed problems other than delinquency; and in Boston, from the first, children were referred to us who presented personality, educational, and non-court behavior difficulties. Over the years and especially since 1929 when the Hyams fund enabled us to establish a special treatment unit, these other problems of childhood and adolescence have been taken in greater and greater proportion, up to over 80 per cent of our recent case load." (pp. 42-3)

They go on to state that remedial teaching and speech correction had later become part of their programme.

In comparing the work of Healy and Witmer, Shakow (1948, p. 233) states, "When Witmer became interested in in the medical aspects of a problem it seemed to be
mainly with the physical or neurological, whereas Healy's was primarily with the psychiatric." Witmer insisted on the need for a cooperative group or team of workers, each a specialist in the four main fields: psychological, social, educational and medical. Louttit (1939, p. 366) thus remarked, "Witmer's actual clinic organization and philosophy do not materially differ from the modern 'psychiatric' child guidance clinic." Witmer's study of the child eventually gave birth to what he later called "clinical psychology" (Shakow, 1948). In later years Witmer's clinic dealt with the problems of the superior child and with vocational guidance and speech disabilities.

In 1920, Henry W. Thurstone of the New York School of Social Work was asked by the Commonwealth Fund of America to formulate a plan for child welfare. An advisory committee, including representatives from the fields of psychiatry, psychology, education, social work and the juvenile court, was formed and drew up a report. A programme, planned to cover a five-year period, was formally adopted in November, 1921. Its purposes stated in the Commonwealth Fund's annual report for 1922 were as follows:

"1. To develop the psychiatric study of difficult pre-delinquent and delinquent children in the schools and the juvenile courts; and to develop sound methods of treatment bases on such study.
2. To develop the work of the visiting teacher whereby the invaluable early contacts which our school systems make possible with every child may be utilized for the understanding and development of the child.
3. To provide courses of training along sound lines for those qualified and desiring to work in this field.
4. To extend by various educational efforts the knowledge and the use of these methods." (Stevenson, 1934, p. 21)

The period from 1922 to 1927 was one in which the National Committee for Mental Hygiene on behalf of the Commonwealth Fund of America established demonstration clinics in a variety of cities and rural areas in the United States for the purpose of showing both the need and the work they could do (Stevenson, 1934; Watson, 1953, 1960). For the first time they were called "child guidance clinics".

The first demonstration clinic was begun in the spring of 1922 in St. Louis. Eight clinics were permanently established as a result, and many others were at least
partially stimulated by this effort (Watson, 1953). It was the announced intention from the very beginning that eventually expenses for their maintenance would be absorbed by the community in which they were located. The child guidance plan of organization called for the professional personnel to include at least a psychiatrist, a psychologist and a social worker. In referring to the demonstration clinics, Warren (1970) points out:

"These put into action the so-called team approach of psychiatrist, psychiatric social worker and psychologist to the child and family: a concept realized by Healy and towards which others have been groping. The procedure, whatever fun has sometimes been made of the 'team', is still of fundamental importance and has influenced the practice of psychiatry in general." (p. 242)

During the decade 1920-1930 an important shift of focus had been occurring. No longer was the delinquent of primary interest. Nor was there much concern with mental defectives, epileptics or neurological cases. Instead, emphasis was placed upon maladjustment in the school and the home, especially that centering around parent-child relationships. Watson (1953, pp. 336-337) states: "The clinics began to concentrate upon problems of the individual who may be spoken of as falling within the normal range of intelligence, the roots of which may in some measure be traced to emotional difficulties."

Meanwhile, similar developments in child guidance had occurred in Britain where the work originally centered in the schools. When school attendance was made compulsory in 1876, it became obvious that many children were apparently incapable of meeting the standards laid down by the Board of Education's code (Keir, 1952). In Great Britain, Child Guidance sprang from the early work of the school of "biological psychology" where Spencer, Bain, Galton and Sully all contributed to its development (MacLean, 1966). First attempts at the practical application of the assessment of children were made in Galton's anthropomorphic laboratory in 1884. Keir (1952, p. 7) states, "...it was Francis Galton who first advocated the scientific study of the individual child, primarily with a view to practical recommendations about his treatment at home and at school, and later as an aid to selecting a suitable career." Sully founded the Society for Child Study in 1883 and it was here that the first efforts were made to involve teachers and
educationalists. Louttit (1939) points out that like Witmer in the United States, Sully insisted on the need for a cooperative team of specialists in his work with children. His writings and addresses had a profound influence on psychology, both general and educational, in Great Britain. Burt (1953, p. 12) indicates, "In its original sense - as used, for example by Sully and his followers - the phrase 'child guidance' included giving guidance to normal as well as to abnormal children, to the ordinary school pupil as well as to the 'difficult child'."

In 1913 the first child guidance effort took the form of the appointment of a child psychologist, Cyril Burt, by the London County Council to work with problem school children (Watson, 1960). The appointment of Cyril Burt as Educational Psychologist was recognition of the importance of his work concerning the study of individual differences in children. History later revealed some serious indiscretions in Burt's research techniques. Nevertheless, he made some important contributions to the field of child guidance. He later became the chairman of the Executive Committee of the Child Guidance Council, an influential body which administered monies, granted scholarships for training and supervised the development of child guidance along the lines pioneered at the demonstration clinics in the United States (Hersov, 1986).

In Great Britain provision had occasionally been made for disturbed children in the early 1920's by voluntary bodies and local educational authorities which included the first child guidance clinic, the East London Child Guidance Clinic, under the directorship of Dr. Emmanuel Miller, a psychiatrist (Warren, 1971). Established in 1927, it was the first child guidance clinic in the country and according to the Jewish Health Organization the first in Europe. It was opened in Bell Lane, England (Renton, 1978). It was designed as a demonstration and training clinic along the lines developed in the United States by a founding staff who had travelled abroad to learn its principles. Hersov (1986, P. 782) indicates, "The clinic's objective was to train psychiatrists, psychologists and psychiatric social workers in child guidance methods with the basic principle of working together as a
team." Cyril Burt was honourary consultant to the clinic. In the first five years there were nearly 600 referrals. Renton (1978, p. 311) states, "Behavioural disturbances accounted for the majority as they do today."

With the help of the Commonwealth Fund of America, the Child Guidance Council was set up in England in 1928. This organization is now incorporated into the National Association for Mental Health. Through this organization certain key workers were sent to the United States to learn the new child guidance methods.

From 1927 onward child guidance clinics increased in numbers, often funded from voluntary sources or charity and fees from local educational authorities. There were few hospital-based child psychiatric clinics. Local educational authority child guidance clinics early on had the advantage over hospital-based clinics of being reasonably financially secure and this was critical for encouraging their development and spread (Warren, 1971).

The Second World War brought into prominence the problems of children evacuated from their families. Hersov (1986, p. 783) states, "They showed a variety of emotional and conduct disorders in response to the difficulties of adapting to new families, situations and customs, away from the support of their own families and neighbourhood...emotional disturbance was more protean and widespread than hitherto believed."

With the advent of the National Health Services in England in 1948 there was more financial support for the hospital-based services for children. There were two kinds of psychiatric services: child guidance clinics run by local educational authorities and hospital-based child psychiatric clinics. The Ministries of Health and Education were separately responsible for these. The local authority service, as a rule, had closer ties with the community and through the educational psychologists, with the schools. In either setting, clinical practice finally depended on the individual outlook of the staff (Warren, 1971). The child guidance clinics had closer links with the community and schools and
provided less formal and threatening settings in the homes where children and families could be treated. The hospital-based clinics, sometimes referred to as child psychiatric clinics, were in closer contact with other hospital services and could bring wider resources to bear on serious psychiatric disorders. The team approach was practiced in both settings. Hersov (1986, p. 784) writes, "The psychiatrist was master in his house in hospital but less sure of his ground in some local authority clinics. However, much good work was done in both, given the lack of knowledge in the field generally at the time."

Through the establishment of joint clinics with premises and staff provided by the local Educational Authority and the psychiatrist provided by the Regional Hospital Board, the gap between these two types of services was partially bridged. Warren (1971, p. 244) states, "This has since become a common and continuing pattern up and down the country, and to the surprise of some, this arrangement has generally worked quite well." Some Regional Boards have set up consultant posts, a post based on a joint child guidance clinic, but with some sessions in a pediatric hospital, or in a community home and so on (Warren, 1971). This is basically the situation which currently exists at the Child Guidance Clinic of Greater Winnipeg.

Watson (1960), in his discussion of the development of child guidance clinics, reports that other than Great Britain, most European countries have done little along these lines. Keir (1952) makes a brief presentation on the early development of services in several European countries. In Paris, impressed by the work of Galton and Sully, Binet published a series of papers on "La Psychologie Individuelle". This led him to the study of the mental development of children from both the intellectual and emotional aspects, and finally he devoted himself to the construction and revision of his celebrated scale of tests. Much of his work was carried out at the new "pedagogical laboratory" which he established in 1905. Binet, like Sully, came up with a comprehensive scheme for treating children in his report to the Minister of Public Instruction. This included a physical, medical, educational and psychological examination with reports on social conditions.
During the opening years of the twentieth century, the work of Meumann, Stern and Babtag in Germany, and of Claparede in Switzerland, did much to provide more adequate theoretical background for child study and child guidance.

In Northern Ireland, the child guidance service is apparently regarded as the responsibility of hospital and health authorities (Lancet, 1959). While in Scotland, child guidance has been established as an educational service. Moody (1952, p. 156) comments, "The result has been an educationally-oriented service in which psychiatry has played little or no part until recently." In summarizing her presentation on the development of child guidance services outside of Great Britain and the United States of America, Keir (1951, p. 18) states, "...but in these other countries, the practical applications remained long almost entirely neglected." No mention was made of Canadian developments.

In Canada, organized efforts in the field of child psychiatry began in March, 1923 with the establishment of a child guidance clinic in Montreal when the first attempts were made to combine the skills of psychiatry, psychology and psychiatric social work in a team approach to dealing with behavioural disturbances in children (Silverman, 1961). Prior to this, there had been considerable psychiatric interest in juvenile delinquency, mental deficiency and school failures in children. This was largely a part of general psychiatric activity in out-patient psychiatric clinics at the Toronto General Hospital and the Royal Victoria Hospital in Montreal. Silverman (1961, p. 239) goes on to state, "The impetus for this whole development was given by the formation, in April, 1918, of the Canadian National Committee for Mental Hygiene, now known as the Canadian Mental Health Association."

The Canadian Journal of Mental Hygiene in its first issue in April, 1919, states in its leading editorial that teachers and parents are becoming greatly concerned about the fact that the problem of the abnormal child in the school has not been properly solved in Canada and that special facilities are needed in the school system to cope with these difficulties. Repeated references are made to the difficulties under which the pioneers in
this field worked and the obstacles they had to surmount due to the fact that considerable time had to elapse before the general medical profession and the public at large developed an appreciation of the need for adequate facilities and trained personnel for this work.

The editor of The Canadian Journal of Mental Hygiene, Dr. Gordon S. Mundie, in association with Dr. B. Silverman, were involved in the development of the Montreal Child Guidance Clinic in 1923. Silverman describes the pattern of this clinical work as essentially that of the demonstration Child Guidance Clinics established by the National Committee for Mental Hygiene in the United States: to focus attention on the importance of treating behaviour disturbances in children as part of an over-all community mental health programme. The child guidance clinic in Montreal rapidly became a centre to which the schools, social agencies and the juvenile court brought their psychiatric problems.

In his review of child psychiatric services across Canada, Lapointe (1961) noted the existence of child guidance clinic facilities in several cities. In Halifax, facilities provided service, training and teaching. In Montreal, the child guidance clinic was involved with diagnostic problems as part of the Montreal Children's Hospital, Department of Psychiatry. In the province of Ontario, mental health clinics catered to children and mention is made of a recently opened child guidance clinic in London at that time. The Child Guidance Clinic of Greater Winnipeg was noted for the provision of comprehensive services to school-aged children through its five departments including psychiatry, psychology, reading, social work and speech and hearing. A child guidance clinic in Edmonton provided psychiatric, psychological and social work services. In Vancouver, the Division of Mental Hygiene of the Metropolitan Health Committee provided mental health services to the entire school population.

Clifford Scott, in his address to the Canadian Psychiatric Association in 1957, praised British child psychiatry. Scott (1958, p. 129) stated that Canada "...had much to learn by keeping in close touch with the developments across the water." He further
commented, "To equal achievements in Britain, Canada would require 100 child guidance clinics."

The close interrelationship between the development of child psychiatry and child guidance clinics is well documented in the literature. Keir (1952) points out that well before the close of the nineteenth century, child psychology had become a recognized branch of scientific research and teaching in Britain, on the Continent and in the United States. She goes on to state that unlike child psychology, child psychiatry is a subject of comparatively recent growth. Henderson and Gillespie's well-known *Textbook of Psychiatry* contained no chapter on "Child Psychiatry" until the 1932 edition. They explain that, at that time, the recent growth of child guidance had shown that this topic must be considered as an important part of the psychiatric domain. Keir (1952) indicates that even as late as 1920, psychiatric examinations carried out by the school medical officer in London were generally limited to measuring the size of the skull. In discussing the development of child psychiatry in the United States, Warren (1971, p. 252) states, "Before 1939, almost the only post-graduate opportunity for training in child psychiatry was a fellowship awarded by the Child Guidance Council in a Child Guidance Clinic." He points out that the term "child guidance" was used before the term "child psychiatry". In describing child psychiatry in Britain, Hersov (1986, p. 781) states, "The first epoch of its history began in the 1920's when clinical psychiatrists became members of the child guidance team." Stevenson (1948) stressed the importance of the National Committee for Mental Hygiene to protect the child guidance clinic and ensure a continuous flow of well trained child psychiatrists. He goes on to say that the establishment of the National Institute for Child Guidance in 1927 did much to bring the training of psychiatry to a higher degree of planning and design. Stevenson (1948, p. 78) states, "The significance of this training goes far beyond the child guidance field for it has become evident that it contains the fundamental of training for all extramural psychiatry."
The development of child guidance clinics also had a considerable effect on the development of the fields of social work and clinical psychology. Stevenson (1934, p. 125) states, "The rise of the clinics also has paralleled a rapid development in social work." Stevenson (1948) indicates that there was general concensus that the training of psychiatric social workers was becoming better formulated and the process of training was being given serious attention early in the child guidance programme. Shakow (1948) stresses the importance of Witmer's work in establishing university clinics and courses in clinical psychology in the universities. Tulchin (1948, p. 598) indicates that as a member of the the child guidance team the psychologist is no longer satisfied with the mere giving of tests, "...he clearly recognizes their limitations and knows that much more material is needed to gain even partial insight into the many problems which any case presents."

The multidisciplinary approach of the child guidance clinic is a recurring theme in the literature. Tulchin (1948) points out that the child guidance movement, in the evolution of its organization, clearly recognizes the need for the group attack on the intricate problems which it has to face. He goes on to state that whatever contribution the psychiatrist, social worker or psychologist may make when working alone, when they are working together their contributions present an entirely different gestalt which is worthy of investigation. Stevenson (1934, p. 2) reiterates this statement: "The clinics offer not merely one line of attack but a synthesis of techniques not often brought together elsewhere, and more effective in combination than they could be singly." Hartwell (1948) suggests that the psychiatrist, the social worker and the psychologist are so closely associated in their attempts to treat the problems of children, that it is not easy to separate the function of each. Miller (1968), a pioneer in child guidance, in his textbook Foundations of Child Psychiatry, indicates that the team approach was designed for the enlightenment of the psychiatrist. He questions whether the trained specialist should abandon the specific skills which he/she brings to the team so that there is a blurring of roles and a loss of precision in data gathering. In an earlier statement in reference to the
formation of the child guidance clinic, Stevenson (1934) suggested that no intensity of need could have produced such an organization until psychiatry, psychology and social work had arrived at a point in their respective developments where each had a substantial contribution to make to the task at hand, and at the same time was sufficiently appreciative of the contributions the other two could make to be able to work with them towards a common goal.

MacLean (1966) points out that although the specific team of workers in child guidance normally consists of psychologists, psychiatrists and social workers, in addition there may be pediatricians, speech therapists and others where and when required. Not every member of the team is involved in each investigation but the important aspect of the teamwork is that specialized opinion is available where required and appropriate personnel can be brought in when needed. Moody (1952, p. 159) states, "It is a truism to say that successful teamwork of any kind depends on good inter-personal relations. But nowhere is this more applicable than in the Child Guidance Service. Where the inter-personal relations are good the work goes well; where they are not good, it goes badly."

There are a number of controversial issues in the literature regarding child guidance clinics. As previously cited in this thesis by Gardner (1953), child guidance clinics have a number of sponsors and affiliations ranging from communities, hospitals, universities and school systems. The term "child guidance clinic", "child guidance centre", "psychological clinic", "psychoeducational clinic", "child psychiatric clinic" or "community mental health clinic" are all associated with the term "child guidance". As previously cited by Watson (1960), this prevents a very accurate estimate of the number of child guidance clinics in existence. MacLean (1966) suggests that the actual building in which the work is carried out, although sometimes designated "clinic", does not resemble a hospital clinic.

Keir (1952) and Burt (1953) make several references to the child guidance clinics in Great Britain where controversies have existed over whether the head should be a psychiatrist or psychologist. Both situations apparently exist. Dr. J. Asselstine (1959),
former Director of the Child Guidance Clinic of Greater Winnipeg stated that for the school-age child, the child guidance services should be provided by a clinic within the school system with a director who is a qualified psychiatrist. MacLean (1966) reports that the school psychological service and the child guidance service which are separate systems in some countries, are combined in many parts of Britain and function as part of the educational system. She points out that consideration of the child in all aspects of his/her environment of both home and school can be done more readily where the school service and clinic service are one in the educational system. She warns that subjecting the child to duplication of psychological services could lead to an artificial division of the child in school and the child at home.

Levy (1952, p. 488) states, "The weakness of the child guidance method, from the point of view of psychiatry, in the professional sense, has been its growing distance from hospital and clinic. Its direction is the court, the family case agency, the school and the general public. The psychiatrist has to battle for his clinic, for his right to give therapeutic service to his patients, and fend off demands for various educational functions outside his role." He goes on to indicate that the weakness of the team in the hospital is a lack of integration and separation of services so that the psychiatrist does not get sufficient value from his co-workers. Levy (1952, p. 489) goes on to state, "The child guidance integration tends to subordinate the the psychiatrist; the hospital integration keeps psychologist and social worker too subordinate." Warren (1971) states that the disadvantages of the isolation of the child psychiatrist in a child guidance clinic, away from other medical colleagues, have become better appreciated. As previously cited in this thesis, Warren points out that some Regional Boards in Great Britain have accordingly set up consultant psychiatric posts to overcome this disadvantage.

Sampson (1976, p. 13) states that treatment or therapy in child guidance is of interest to the educator for a variety of reasons. One of the most important of these derives from the fact that its methods are opposite those of teachers; "...it does not use instruction,
exhortation or correction to bring about changes in behaviour or remove symptoms, but relies entirely on attempting indirectly to restructure the mental outlook which is causing the child to deviate unacceptably." Sampson goes on to suggest that therapy, unlike most teaching and moral guidance, is based on individual diagnosis, so that the treatment chosen is matched, as far as possible, to each particular case in all its complexity. MacLean (1966) stresses the fact that no generalizations are possible in treatment as each child reveals a distinct background of his/her own. Thus, the factors causing the problem for each individual are unique. She states that no single technique or method which is rigid or mechanical can can solve problems, each peculiar to a particular personality.

In his discussion of therapy, Hersov (1986, p. 795) echoes a familiar theme: "The child guidance movement gave a particular emphasis to a style of intervention embodying a team approach to modifying environmental stresses." He points out that with the introduction of new techniques in treatment there was a change in the child guidance setting from long-term therapy without any specific goal other than gaining of "insight", to more focused therapy with more clearly defined goals, more often short-term. Kraemer (1987) indicates that whatever treatment a child may be having in a child psychiatry department or child guidance clinic, the parents are usually involved in some way. He states that what is done with and for them depends on the interest, orientation, training and availability of clinic staff. The cooperation and commitment of parents and child are of ultimate importance. Rubin et al (1972) describes therapy as a human endeavour with a long history, but one characterized by cycles and fads.

Traditional approaches in child guidance treatment, when indicated by diagnosis, was psychotherapy. For children this usually took the form of individual sessions or play-therapy. More recently, environmental treatment has also been employed. This includes giving advice to parents, arranging change of domicile or school for the child or introducing him/her to new experiences or interests. Moodie (1947) describes educational therapy as "the most definite and practical." He points out that individual
remedial teaching was, from the start, one of the treatment methods used by child guidance clinics in Britain.

Recent trends in therapy include the use of medication. Sampson (1976, p.22) states, "Very much in contrast to early practice, some child guidance clinicians are now taking considerable interest in the potentialities of drugs in child management. Drug prescriptions have already been a good deal applied in guidance in America." Hersov (1986) indicates that one of the differences between British and American child and adolescent psychiatry is that in Great Britain medication is prescribed less often. Taylor (1985) comments that the infrequency with which stimulants are prescribed in Britain has led to the withdrawal of certain drugs from the market. He indicates that Attention Deficit Disorder is diagnosed much more frequently in the United States and stimulants are widely used in treatment. Hersov (1986, p. 797) presents the following explanation: "Maybe the emphasis on psychosocial aetiology and treatment in British child psychiatry leads to an underestimation of biological factors and less appreciation of neurochemical processes and their sensitivity to medication." Rutter (1975) provides case histories involving medication but stresses the importance of other treatments which are required simultaneously. In a recent issue of "Behaviour Today Newsletter", Scatterfield (1987) indicates that boys who were treated with a combination of medication and psychotherapy were found to have an institutionalized rate of almost one-third that of boys who were treated with medication only. Eisenberg (in Miller [ed.], 1968) suggests that drugs are very useful therapeutic agents within a limited field. Hersov (1986) suggests more research is needed on the efficacy of drugs compared with other treatments, including long-term evaluation.

In more recent years family therapy has become a means of treatment for disturbed children with a variety of disorders. This has been encouraged by the
dissatisfaction with conventional forms of individual therapy and increasing recognition of
the importance of family influences on the behaviour of the child. Hersov (1986) states:

"The approach transcends professional boundaries and the skills can be
learned and applied by a bewildering variety of professionals and others
in different fields. It has revitalized child and adolescent psychiatry,
perhaps at a cost in the loss of interest and skills in individual therapy,
and time will tell whether a sound empirical base for its indications and
methods is forthcoming." (p. 796)

Rutter (1975), after careful consideration of family therapy, comments that clinical
experience suggests that it is a most useful technique in properly selected cases.

Behaviour modification is a further type of treatment to which clinicians have
turned in recent years. Its techniques are based on learning-theory psychology and serious
interest in this technique as applied to children appears in the literature from the early
1960's. Rachman (1962), commenting on this technique, states that it has provided more
techniques for elimination of unadaptive behaviour than for the development of desired
behaviour, although both objectives are sometimes achieved. Ward (1971) indicates that in
using behaviour modification, each situation needs individual study and management of an
exacting kind. Rutter (1975) concludes that this technique is a growing one among the
procedures for use in child guidance, and in some circumstances is demonstrably superior
to other methods.

Sampson (1976) reports that attempts to evaluate the effects of therapy in child
guidance are scanty. She points out that generally speaking, and especially during the
pioneer years, a research approach is lacking and that there appears to be a need for more
research in this area. Another way of evaluating child guidance which presents a very
positive answer is suggested in "Health of the School Child" (1964-1965) which claims
that the most convincing evidence of the work of child guidance is in the increasing demand
for services. Sampson (1976, p. 26) comments, "Thus, the answer to the American
challenge (Rubin et al, 1972) 'how many of our therapeutic efforts would meet the simple
test of measurement', seems to depend partly on what foot rule is used." Kanner (1960),
in his article "Child psychiatry: retrospect and prospect", comments, "We still need, and
should encourage, the expansion of child guidance clinics which have proved themselves as indispensable pillars of community mental hygiene."

Orford (1987) suggests that primary prevention is attractive in the child mental health field for several reasons. First, under usual circumstances, by the time the emotionally disturbed child and his/her family is diagnosed and treatment is initiated, there has been a good deal of suffering. Second, there is consistent evidence that the existing treatment facilities service a minority of children who are disturbed and those who are seen in such facilities are not necessarily the ones most in need of treatment. Last, the success in treating these disorders after they are underway has been limited particularly in the case of conduct-disordered or anti-social children. Orford (1987) states:

"Thus, if these disorders could be prevented from occurring, the dilemmas associated with the treatment of established cases, namely, a period of suffering and reduced life quality prior to treatment of established cases, unavailability of treatment for large numbers of cases and the paucity of effective treatment interventions could be avoided."

(p. 10)

Bloom (1975) indicates that prevention has been identified at the primary, secondary and tertiary levels. Primary prevention aims to reduce the incidence (i.e. the number of new cases occurring in a population in a specific time period) of a disorder using such strategies as the population-wide approach, milestone approach or targeting of groups considered to be at high risk. Secondary prevention efforts are basically devoted to early identification and treatment of a disorder, while tertiary efforts have been characterized as rehabilitative in nature. Kanner (1960) reports that the idea of prevention had taken root in 19th-century medicine. It was suggested that preventative measures used in physical medicine might have application in mental health. Kanner points out that this hope found a vigorous advocate in Clifford Beers, whose enthusiasm and organizational talent led in 1909 to the creation of the National Committee for Mental Hygiene. The mental hygiene movement had for its slogan the prevention of insanity and delinquency. For this, there could be no better starting point than the appearance of the earliest signs of behavioural
difficulties in the formative years of childhood. It is out of this movement and philosophy that the child guidance concept was created. MacLean (1966) states:

"Before a preventative role can be undertaken by education, however, teachers require to know more about the emotional difficulties that beset children at school, to recognize the signs and danger signals and to understand pressures surrounding their pupils so they can interpret symptoms with insight. Attention must be directed to understanding the motivation and reasons underlying conduct, so that steps can be taken to resolve the problems and prevent their increasing intensity. The preventative aspect of education, in this respect, is of more importance than the curative." (p. 3)

Abrahamson (1955) stresses the fact that it is self-evident that in a school with child guidance services within its domain one finds more of an orientation toward mental hygiene concepts, more awareness of emotional problems and more opportunity for educating teaching personnel in the basic concepts of mental hygiene. He goes on to suggest that schools, in general, must be considered the most important preventative agency for mental ills and/or delinquency and all personnel, from the superintendent to the clerk should be cognizant of the mental hygiene aspect.

Watson (1953) stresses that work with children is not only important because of its service and scientific value, but also for the community orientation that it manifests and the preventative emphasis it maintains. Kessler and Albee (1977), in reviewing the literature on primary prevention, conclude that practically every effort aimed at improving child rearing, increasing effective communication, building inner control and self-esteem, reducing stress and pollution and the like, in short everything aimed at improving the human condition and making life more meaningful and fulfilling, may be considered part of primary prevention of mental or emotional disturbance.

Balch et al (1981) indicate that the high aims of the child guidance movement toward primary prevention had been modified by 1950. In actual practice, the clinics were engaged in secondary and tertiary prevention. Lindt (1950, p. 93) states, "Early clinics set as their goals the prevention of juvenile delinquency and of mental illness. Present day standards are more modest...not to be an insurance against future ill health but an aid to
currently better functioning." Clarke and Clarke (1986) state that the prevention arena has been exceedingly light on delivery up to now.

SUMMARY

The major countries of origin of child guidance clinics are the United States of America and England. In the United States of America, clinics developed out of the study of juvenile delinquency and related difficulties while in England the first child guidance efforts began with the study of problems of school children. Definitions of the term "child guidance clinic" come from a variety of settings. While some clinics are community sponsored, others are affiliated with hospitals or universities, while others are part of a school system. Clinics have adjusted their services to local needs and attitudes of the communities which they serve. However, basic themes which run throughout the literature indicate that child guidance clinics provide both mental health and educational services through multi-disciplinary teams of professionals to the school-aged child or adolescent, their families and school personnel.
CHAPTER IV
DISCUSSION

INTRODUCTION

Due to the limited literature regarding the Child Guidance Clinic of Greater Winnipeg, additional information was obtained first-hand from C.G.C. staff members as well as archival materials.

PROCEDURE

Information was gathered through the use of interviews with individual participants by the principal investigator. Interview time averaged forty-five minutes. The interviews were recorded on tape and later transcribed. Permission was obtained from the participants prior to recording. Participants agreed to be interviewed after being approached by the principal investigator. The interview included the following three open-ended questions which allowed the participants considerable freedom to present their perceptions of the growth and development of the Child Guidance Clinic:

1. What major changes have taken place in the administration and funding of C.G.C. since its inception and with what results?

2. What major changes have taken place in the role and function of your discipline and with what results?

3. What major changes have taken place in the delivery of services of C.G.C. since its inception and with what results?

PARTICIPANTS

One representative from each of the five professional disciplines including Psychology, Psychiatry, Reading, Social Work and Speech and Hearing were selected as participants. Each participant had 20 or more years of involvement with the Child Guidance Clinic and all had experiences as field workers, supervisors and administrators with the Child Guidance Clinic. In addition interview data provided by the participants was reviewed with a member of the C.G.C. Directorate who was asked to provide further comments on the historical validity of the interpretations.
INTERVIEW DATA

The following information regarding the Child Guidance Clinic of Greater Winnipeg was gathered from interviews conducted for this study. Each interview will be presented individually and a general analysis will follow.

Psychology

This participant pointed out that the Psychology Discipline had undergone major changes in its role over the past 20 years. Until 1967, Psychologists were basically involved in psychometric assessments and some consultation. No treatment was carried out. Psychologists are currently involved with assessment, consultation, treatment and some preventative work. Treatment includes individual psychotherapy, behaviour therapy, family therapy and group therapy. Recently, several psychologists have become involved in neuro-psychological assessments. The type of treatment is partly dependent on the training and expertise of the individual Psychologist. The participant felt that prior to 1967 there was too much emphasis on assessment in the Psychology Discipline and it was pointed out that Psychologists were not involved with parents; after completion of assessment only school personnel were contacted and the Social Worker interpreted results to parents.

The reason presented for the major shift in the role of the Psychologist was due to the hiring of better trained and more qualified personnel. Many of the original Psychologists were trained as teachers. Currently the preponderance of Psychologists hold M.A. and Ph. D. degrees. With the advent of required School Clinician certification in the late 1970's, qualifications for Psychologists hired by C.G.C. have become standardized. As a result of availability and hiring of more qualified staff there has been a decrease in emphasis on professional development in the Psychology Discipline as well as less time spent on supervision. This has led to more emphasis on delivery of service rather than training of staff in recent years.
It was felt by this participant that the introduction of the Unit system in 1972 has increased communication among unit members from various disciplines at the expense of communication among Discipline members. The unit has become the focus of service delivery. Psychologists have, therefore, received increasing support and supervision through communication with Unit members. With the advent of geographical units, clinicians are able to focus their service delivery onto fewer schools. This has increased communication and visibility of clinicians in the schools and led to greater acceptance of the clinician in the schools.

As a former Department Head under the pre-1972 clinic structure and currently an Area Service Director (A.S.D.), this participant pointed out several resulting administrative changes. The Area Service Director has much more direct contact with a smaller number of clinicians. Clinicians on the Area Service Director's team are directly accountable to him/her which allows for better supervision of service delivery and increased administrative contact with the schools. Under the pre-1972 "medical model", the Director took responsibility for most administrative decisions. With the advent of the A.S.D. position, responsibility for administrative decisions has been delegated to the A.S.D. for the areas his/her Units service and the Discipline members he/she supervises. This has given greater authority to the supervisory role which is now an administrative position as opposed to a line position in the pre-1972 Clinic structure. The new structure has also allowed for a larger support group for the A.S.D. position.

Psychiatry

This participant pointed out that the role of the Psychiatrist has changed significantly since the reorganization of the Clinic structure in 1972 to the Unit system with a non-medical Director. Originally structured along the medical model, where the Director was a Psychiatrist, the Psychiatric position was placed at the top of the hierarchy of the professional positions at C.G.C. Case conferences based on the medical model were held on a regular basis. These were always chaired by a Psychiatrist and the other professionals
would give their input and were basically told what to do. Control of most situations was in the hands of the Psychiatrist.

The change in structure of the Clinic after 1972 to the Unit system with a non-medical Director as it exists now had many positive effects. The geographic Units increased communication among its members. With the removal of the medical model, all professionals were seen as taking on an equal role in the operation of the Unit. With this change the Psychiatrist no longer had total responsibility for the treatment of cases. This sharing of responsibility was welcomed by the Psychiatrist. The participant pointed out that a difficulty arising out of this situation was that some people were not willing to take on the mantle of equality and added responsibilities. On the other hand it was pointed out that this situation led to tremendous growth in many C.G.C. clinicians in the area of problem solving.

There is little question that today's Clinicians are better trained and qualified to provide treatment. When the Clinic first began many of the Clinicians were teachers who were interested in working with problem children. Now people are specifically trained in their areas and are much better able to deal with problems. People had little training in solving psychological problems in the early 1960's.

The participant went on to indicate that over the past several years the role of the Psychiatrist at the Clinic has changed considerably. Very little is being done in terms of direct therapy or intervention with families as was done earlier. Psychiatrists are only at the Clinic on a part-time basis and they have basically assumed a consultant role. They are involved in the assessment process and provide direction for treatment by the other Clinicians involved. Psychiatrists are more involved in the supervision of use of medication particularly in the area of attention deficit disorders. At the present time this is the treatment of choice in dealing with this disorder. Medication is used less in treating other disorders. For example, in earlier times because Psychiatrists were not as knowledgeable in dealing with children with behaviour difficulties, medication was often
used as a means of treatment for these children. This decreased their acting out and satisfied teachers and parents. However, it was not the best treatment for the child who was tranquilized and not learning in the classroom. Very rarely is medication prescribed in these situations today. Medication is also used in dealing with psychotic children to prevent hallucinations and improve thinking processes along with other treatment. The number of psychotic children being treated has increased over the years. The participant pointed out that although the population of psychotic children has not increased, people are more open to dealing with psychological problems and are more willing to ask for help. It was indicated that the Psychiatrist would like to be involved in a greater variety of treatment interventions at the Clinic, however, the best use of their limited time is in assessment and consultation to Units.

An aspect of the Psychiatry Discipline which was discontinued in the late 1970's was the field placement for third-year medical students at the Clinic. This participant had gone through this process, spending six months at the Clinic as part of his training. It was felt that this training experience was valuable to the resident in terms of learning the resources available in the community and in turn the Clinic benefited from the residents' involvement with Clinic cases. Over the years, the number of residents choosing the Clinic as a placement decreased to the point where the programme was discontinued.

It is felt by this participant that over the past twenty years Clinic services have improved due to better qualified Clinicians and better organized delivery of service through the Unit system. There is also greater awareness of the Clinic services in the community. The comprehensive services offered by the Clinic is a unique situation for Canada.

Reading

The participant representing Reading pointed out that prior to the change in administrative structure of the Clinic in 1972 the medical Director was the key person in administration and took major responsibility for decision making. With the advent of the Area Service Director administrative position under the Unit system, the A.S.D.'s assumed
a significant role in the total management of the Clinic which the former Department Head position did not have under the old system. The combination of administrative and supervisory roles in the A.S.D. position provided considerable liaison between the two responsibilities.

The change in structure from Departments to Disciplines allowed the Reading Discipline to maintain its discipline identification. The role of the Reading Clinician has changed considerably over the past thirty years. In the 1960's the role was mainly that of a diagnostician. Reading Clinicians were involved in vision testing, extensive parent interviews and other diagnostic procedures, often carried out at the Clinic. Reading Clinicians supervised field workers in the schools who carried out tutoring of students. These field workers were teachers selected by the Department Head in the Winnipeg School Division No.1 through an arrangement with the Superintendent's Department. The Reading Clinicians identified the needs of students and did the total supervision of the field workers in their tutoring of these students. The Reading Department provided regular professional development activities for their field workers as well. In the late 1960's these field workers became the core group for the Resource Teachers in the schools. This began to change the Reading Clinician's role in the direction of taking on more tutoring cases.

Once the Resource Teacher role came into place the Reading Clinician took on a combined diagnostic/tutoring role. Energies transferred from supervising the field workers to tutoring students.

In the late 1960's and early 1970's a major thrust for the Reading Clinician was to do more school-based work. The diagnostic process moved from the Clinic to the schools and was carried out over a period of time rather than in one sitting. In 1972, when the Clinic structure changed to the Unit system, the Reading Clinician, for a short period of time, dropped the diagnostic role and became consultants to the team. Within a year, the position reverted to more systematic diagnosis.
At the present time, Reading Clinicians are involved with a combination of diagnostic tutoring over a period of time as well as consultation to school personnel and parents. The participant felt that by moving into the diagnostic/tutoring role, the Reading Clinician is gaining a great deal more general information about the child at the expense of losing some of the formal diagnostic data.

It was felt by the participant that the legitimacy of the Reading Clinician role was established with the advent of School Clinician's certification in the late 1970's. Qualified Reading Clinicians were difficult to find and prior to certification the Reading Discipline was forced to take people and train them on the job. After certification was initiated, the Discipline could not hire people without appropriate training and course work as required for certification. This situation forced the Discipline to go farther afield in hiring certifiable clinicians, and as a result people were found with excellent backgrounds with training from a variety of universities. As a result of bringing in more qualified Reading Clinicians, the professional development and training aspect of the Reading Discipline is no longer as necessary as in previous times and more time is going into service delivery.

The participant felt that the collaborative model of the Unit system is effective from a systems point of view. When you have all the resources in a school system, teachers become more aware of the student's needs. However, it was pointed out that the collaborative model is only as good as the people in it. As the Unit system has been strengthened, this has tended to water-down the Discipline system. It was felt by the participant that the Unit system has forced the broadening of the Reading Clinician's role. A Clinician has to have both good diagnostic and remedial skills as well as good consultative skills. The consultative role has taken time from the diagnostic and remedial role of the Reading Clinician. The participant felt that there is much greater acceptance of the C.G.C. clinician in the schools today. Clinicians are much more a part of what is going on in the schools and school personnel are much more knowledgeable in the use of Clinic services.
Social Work

The Social Work participant pointed out that in its initial existence, the Social Work position was basically involved with attendance problems. Social Workers were called Visiting Teachers at that time. In 1963, with a change in Department Head, the social work component came more to the forefront. It was recognized that attendance difficulties were symptoms of more serious social problems. At that time a Central Registry existed in Winnipeg which Clinic Social Workers could contact to determine other agencies involved with their referred cases. This Registry was discontinued in 1965. Social Workers were involved in interpretation of Psychological reports to parents, preparation of social histories prior to Psychiatric involvement and pre-court reports.

There has been a continued movement toward inclusion of the family in the treatment of the child. The participant indicated that at one time Social Workers could treat a child without knowing the family. In the late 1960's, parental permission became a requirement of referral to the Clinic. This initiated family contact through the referral and strongly facilitated the Clinician's involvement with the family. In the early 1970's, family therapy was strongly promoted at the Clinic and continues to be the treatment of choice for many Clinicians including Social Workers, Psychologists and Psychiatrists.

In 1969, two students from the Brandon Welfare Worker's course became involved with the Clinic's attendance problems. This allowed the Social Workers to concentrate their efforts on other Social problems. The Assistant Department Head of Social Work, was at that time the Chief Attendance Officer for the Winnipeg School Division. This position is currently the responsibility of one of the Social Work A.S.D.'s. In 1972, Attendance Officers were hired by the Winnipeg School Division No. 1. They were housed and supervised at the C.G.C. This is the current situation at the Clinic; the individual school divisions which the Clinic services have taken on the responsibility for attendance with support from and close liaison with the Clinicians.
A further aspect of the Social Work Discipline, is the involvement with Social Work student placements since the early 1960's. Initially this involved students at the Master's level from the University of Manitoba, but more recently it has included students at the first and second year of the Bachelor's level. With the major change in the Clinic to the Unit system in 1972, more regionalization of services resulted. With Clinicians assigned to specific areas, they became much more familiar with the schools to which they were assigned. The referral form changed so that specific Disciplines could no longer be requested by the referrant (see Appendix C). Area Service Directors screened all referrals and cases were assigned to appropriate Unit members, usually after some discussion during the regularly scheduled Unit meetings.

As a former Department Head under the pre-1972 administrative structure, the Social Work participant pointed out that the dual role of administrator and Discipline supervisor of the A.S.D. allowed one to take on an administrative role and maintain contact with the professional skills of the Discipline. However, due to the administrative demands of the A.S.D. position, the supervisory role has decreased. It was felt by this participant that although Social Workers are now better qualified in every sense, they still require considerable supervision when new to the agency. In some ways the Unit provides this kind of support to its members.

With the change in the administrative structure from the medical model to a more educationally oriented structure and the change in major funding from Health to Education, the Clinic was brought more in line with the Educational system. The certification of Clinicians by the Department of Education gave the non-teaching staff of the Clinic the same privileges as teachers. Non-teaching Clinicians became members of the Manitoba Teachers' Society and Winnipeg Teachers' Association. This has led to greater acceptance of the Clinicians in the schools.

It was felt by this participant that the current structure of the Clinic has the advantages of a centralized administration with decentralized delivery of service. This
allows the A.S.D.'s to have a team or support group, provides a broader base for supervision and professional development activities for Clinicians and Administrators and facilitates the transfer of cases from area to area along with a central filing system for the Clinic. The decentralized service delivery provided by the Units allows for greater contact and familiarity of the schools and surrounding community in which the Clinicians work.

**Speech and Hearing**

The Speech and Hearing Discipline currently includes Speech and Language Pathologists and Audiologists; the preponderance of positions are in Speech and Language Pathology. The Speech and Language Pathologists are responsible for the assessment and treatment of articulation and language difficulties while the Audiologists deal with hearing and related difficulties and act as consultants to the schools regarding audiological difficulties. The Winnipeg School Division No.1 is currently the only school division in Manitoba which employs its own Audiologists. Audiological services for the suburban divisions serviced by the Clinic have become the responsibility of The Department of Health, Hearing Conservation Programme. This shift was begun in 1982 and completed in 1986.

The participant pointed out that in the past Clinicians were licensed as Speech and Hearing Clinicians. Currently, there is separate licensing for Speech and Language Pathologists and Audiologists and universities provide separate graduate programmes for each position. The treatment of language difficulties became a major aspect of the profession in the mid to late 1970's and the professional association initiated the change in titles and licensing. Prior to this shift in role, the "Speech and Hearing Clinician" was mainly involved in dealing with articulation problems.

The participant pointed out that prior to the structural change to the Unit system, the Speech and Hearing Discipline worked in isolation from other Disciplines. The shift to the Unit system changed the Clinician's perspective in that he/she was now forced to look at the total child and at the same time it facilitated the involvement of other Disciplines. The
participant felt that the Unit structure expanded the knowledge base of the Speech and Language Pathologists as they began to look at the roles of the other Discipline members. Prior to the Unit system, the Speech Clinician would often work with the referred child without ever contacting the parents. They often worked in total isolation. With the shift from the former medical-model administrative structure, the Speech and Hearing Discipline has greater input into the total treatment of the child. When children were reviewed under the old model, Psychiatry directed the meetings and Speech and Hearing had little input. Under the present Clinic structure the Speech and Hearing Discipline is more a part of the school system and there has been a shift to looking at the child as part of the school system, i.e., how speech and language and hearing difficulties are related to academic functioning.

Volunteer programmes were begun in the late 1970's to involve auxiliary personnel in articulation treatment. Some children respond well to volunteer help, but this is dependent on the needs of the child. The volunteer, under the supervision of the Clinician, can extend the practice time in speech difficulties and move the child through the system more quickly. Programmes are being developed to put more of an onus on parents, teachers and the child to become more involved in treatment. In this way the school and family system can be better utilized in the treatment process.

The participant indicated that the Speech and Hearing Discipline is involved in many new approaches in dealing with the child. They are now running groups and family programmes. Another major shift in the role of the Discipline is the provision of in the classroom. In an early-childhood programme in the inner-city, a Speech and Language Pathologist works as a team teacher. The teacher, Speech and Language Pathologist and Psychologist work as a team and all treatment is carried out in the classroom. The Speech and Hearing Discipline is also now involved in second language assessments and in the early identification of speech, language and hearing difficulties.

The participant pointed out that members of the Speech and Hearing Discipline are much better qualified than in the past. A Master's degree is now a prerequisite for a
School Clinician's Certificate. All members of the discipline are assigned to peer groups which meet on a monthly basis for support and sharing of ideas and experiences. Professional development is provided by the Discipline through presentations by clinicians and visiting speakers.

As an A.S.D. and formerly a supervisor under the pre-1972 Clinic administration, the participant indicated that that the dual role of administrator and Discipline supervisor encompassed in the A.S.D. position has legitimized the supervisory role. By giving administrative authority to supervision, The A.S.D. position has allowed input into changes in this area. The participant stated that as a line supervisor, if you saw a need for change in service delivery or interpersonal relationships among clinicians you simply were not in a position of authority to effect these changes. The A.S.D. position allows the administrator to become involved in problem situations both in the areas of supervision and delivery of services.

Directorate

The interview data gathered in this study was reviewed with a member of the C. G. C. Directorate and comments were requested. He concurred with the information presented and provided additional information. It was pointed out that the role of the Social Worker and to some extent that of the Psychologist have changed considerably in the past few years as a result of the reorganization of the Children's Aid Society into regional Child and Family Services agencies. The increase in service demands resulting from regionalization has created a greater demand on C. G. C. personnel to deal with child abuse and related issues. In addition, there has been increased Clinic involvement in the areas of personal safety and adolescent suicide prevention. Current indications suggest a future role in dealing with acquired immuno-deficiency syndrome (AIDS). Clinicians have also become more involved in multi-cultural and community issues.

It was stressed by the member of the Directorate that with the certification of Clinicians by the Department of Education, the Child Guidance Clinic has gained a closer
tie with the educational system. As a result of certification, C.G.C. Clinicians became full members of the Manitoba Teachers' Society. It was pointed out that school personnel now view the Clinic as a support service to the schools rather than as an external agency.

The member of the Directorate made reference to an external evaluation of the Child Guidance Clinic conducted by Currie, Coopers and Lybrand entitled Child Guidance Clinic of Winnipeg. The recommendations of this report are still under consideration and this report was not available during the process of this study.

ANALYSIS

All participants interviewed indicated major changes in both Discipline and Administrative functioning throughout the Clinic's history. The major shift occurred after 1972 when the main funding of the Clinic went from the Department of Health to the Department of Education and service delivery was regionalized into multi-disciplinary Units under the administration of Area Service Directors. The Director of the Clinic had an educational rather than a medical background as in the previous administrative structure.

The shift from the medical to an educational model had many repercussions. The Psychiatrists no longer took a dominant role in the psycho-social treatment of referred children; Social Workers and Psychologists increased their treatment responsibilities. The shift to the educational model also brought the Clinicians closer in line to the school system and fostered greater acceptance and communication with school personnel and a greater understanding and more appropriate use of clinic services on the part of school personnel. Parental involvement became an integral part of all Discipline functioning and this was initiated with the requirement for parental permission for all referrals to the Clinic. The Unit system fostered greater communication among inter-disciplinary team members and provided additional support and direction to members in the delivery of services. The A.S.D. position gave greater administrative autonomy to the A.S.D. in his/her responsibilities for delivery of services to the geographic areas his/her Units served. The Discipline supervisory role of the A.S.D. position, gave administrative authority to the
process of supervision. The certification of Clinicians by the Department of Education, initiated more stringent requirements in the hiring of Clinicians. (see Appendix B) This has led to more professionally qualified Clinicians and reduced the former training and supervisory role of the Clinic resulting in more emphasis and time spent in the delivery of service.

Over the years, there has been an increase in the consultative role of Clinicians as a result of greater contact and involvement with parents and school personnel. Although there has been an increasing demand for direct service to the schools and clinicians are mainly involved in this aspect of service delivery, there has been an increasing effort in the direction of primary prevention through clinicians' involvement with early identification programmes, parent and teacher consultation and involvement in the community and schools in the presentation of parenting programmes and inservices in clinicians' areas of expertise.
CHAPTER V

SUMMARY AND CONCLUSIONS

The purpose of this study was to trace the factors which influenced the development and growth of the Child Guidance Clinic of Greater Winnipeg and to examine its function as a support service to the school Divisions served in Greater Winnipeg. The general history of the Child Guidance Clinic of Greater Winnipeg, including significant historical developments in the Winnipeg School District which led to its development in 1951, to the present time was presented. Since no specific, comprehensive work on the Child Guidance Clinic had been written, information was obtained from relevant documentary materials, committee reports and archival files. In addition, perceived effects of major changes and developments in the areas of administrative structure and funding, role and function of disciplines and delivery of services were obtained through interviews with members of the Clinic staff representing each of the five professional Disciplines as well as the Directorate.

It is felt by the author that a comprehensive overview of the Clinic will provide a valuable educational document to present and future educators, parents and community agencies involved with the Clinic and lead to a better understanding and more effective use of Clinic services. There has been a great deal of growth and change evident in the Clinic's 36-year history. The major shift in funding from Health to Education as well as the shift from a medical to an educationally-oriented model has brought the Clinic more in line with the educational system and encouraged greater acceptance of the Clinic personnel in the schools. Over the years, Clinicians have become better trained and qualified to carry out their professional roles. The advent of the Unit system has increased communication among Discipline members and provided greater contact of Clinicians with school personnel. In addition, there has been increased contact and involvement with parents, the community and community agencies.
The Child Guidance Clinic provides both mental health and educational services to the schools in Greater Winnipeg through multi-disciplinary teams. The comprehensive nature of the services provided in many ways makes the Clinic unique in North America. In spite of budget cutbacks and declining enrolments in the school system the growing demand for Clinic services has been evident in continuing increases in staffing and cases handled (see Figures 3 and 4). Future directions for the Clinic lie in the areas of increasing emphasis on primary prevention, research and community involvement. It is suggested that further areas of study might include the current status of Child Guidance Clinics in Canada, the United States of America and England.
FIG. 3. C.G.C. staff by year

FULL-TIME STAFF ESTABLISHMENT

YEARS
- 78-79 79-80 80-81 81-82 82-83 83-84 84-85 85-86 86-87 87-88

STAFF
- 159.4 156.6 154.4 144.7 142.7 138.8 133.2 129.7 126.5
REFERENCES


Asselstine, J. L. (1959). Development of the Child Guidance Clinic of Greater Winnipeg. (Mimeographed.)


APPENDIX A
APPENDIX A

The Winnipeg School Division No. 1
C.G.C. 1987 Budget as adopted by Board of Trustees - March 13, 1987

Details of the amounts included for the 1987 Budget for Child Guidance Clinic are as follows:

Division Staff:

Salaries...........................................$4,348,900
Employee Benefits and Allowances..............228,200
Services.............................................129,000
Supplies, Materials and Minor Equipment........48,500
Professional Development............................9,000
Capital Equipment................................12,200

$4,775,800

Suburban Staff:

Salaries...........................................$3,026,900
Employee Benefits and Allowances..............140,800
Services.............................................95,000
Supplies, Materials and Minor Equipment........22,800

Private Schools (Winnipeg)......................136,500

$3,422,000

Total Clinic budget..............................$8,197,800
Recovery from Suburban and Private Schools...$3,422,000
Total 1987 Budget Estimate......................$4,775,800

(note: Psychiatrists are paid directly by the Department of Health)
APPENDIX B
DEPARTMENT POLICIES RELATIVE TO THE CERTIFICATION OF SCHOOL PSYCHOLOGISTS

1. **Minimum Qualifications for Provisional Certification**

   A Master's Degree in School Psychology or equivalent.

2. **Areas of Study Required (minimum of 39 hours of graduate training not including credit for dissertation).**

   a) **Professional Areas** (MINIMUM: 24 hours)

      1. Psychological testing (MANDATORY)

         At least ONE course from FOUR of the following areas:

         2. Psychological and/or Education Research Methods
         3. Developmental Psychology (Normal)
         4. Psychopathology
         5. Principles of Learning
         6. Practicum (program of applied psychological methods, preferably in a school setting).

   b) **Related Areas** (MINIMUM: 12 hours)

      1. Interview Techniques
      2. Psychotherapeutic Methods
      3. Application of Behavioural Principles
      4. Learning Disabilities
      5. Psychology of Exceptional Children
      6. Professional Issues and current developments in School Psychology
      7. Statistical methods
      8. Community Psychology
      9. Social Psychology
     10. Perception
     11. Education Programming
     12. Communications and/or Human Relations

If you wish to have your credentials reviewed by the Psychologist Advisory Committee, in addition to official transcripts, please submit the following information:

1. A chronological summary of schools attended and courses taken.

2. A summary of course descriptions for those courses which are submitted or will be submitted for certification as a School Psychologist.

3. A clear statement concerning past supervised clinical experience (if any) outlining content, frequency, duration, etc.

4. A chronological statement of classroom teaching experience, if applicable.
DEPARTMENT POLICIES RELATIVE TO THE CERTIFICATION OF
SCHOOL SPEECH AND HEARING CLINICIANS AND AUDIOLOGISTS

Minimum Qualifications for Provisional Certification

Academic qualifications to meet the licensing requirements of the Manitoba Speech and Hearing Association for the practice of speech and hearing therapy or audiology in the Province of Manitoba. Proof of certification with the Manitoba Speech and Hearing Association must be submitted.

Requirements for Permanent Certification

Successful experience (for the provisional period) as a School Speech and Hearing Clinician or Audiologist with recommendation for permanent certification.

If you wish to have your credentials reviewed by the Speech and Hearing Advisory Committee, in addition to official transcripts, please submit the following information:

1. A chronological summary of schools attended and courses taken.

2. A summary of course descriptions for those courses which are submitted for certification as a Speech and Hearing Clinician or Audiologist.

3. A brief statement from the prospective candidate indicating why, from the candidate's point of view, certification should be granted and how this will affect the candidate's job function.

4. A clear statement concerning past supervised clinical experience (if any) outlining content, frequency, duration, etc.

5. A chronological statement of classroom teaching experience, if applicable.
1. **Minimum Qualifications for Provisional Certification:**

1.1 Master of Education degree, or equivalent, from an accredited institution to include appropriate work in Clinical Reading and Related areas.

1.2 Two years of successful classroom teaching experience in which reading instruction has been an important responsibility and/or equivalent clinical or remediation experience.

2. **Areas of Graduate Studies required:**

2.1 **Compulsory Area - total 21 credit hours**

- A. Theoretical Basis of Reading and Reading Instruction (6)
- B. Diagnosis and Remediation in Reading (6)
- C. Clinical Practice in Reading (6)
- D. Measurement and Evaluation (3)

2.2 **Research requirement in Reading/Related Areas - total 6 credit hours**

- either
  - A. Design of Applied Research (3) and Analysis of Research (3)
  - or
  - B. Thesis (6)

2.3 **One 3-credit hour course from each of the following areas - total 12 credit hours**

- A. Exceptional Children (3)
- B. Interviewing Counseling (3)
- C. Children's Literature/Adolescent Literature (3)
- D. Linguistics (3)

**Minimum required: 39 credit hours**

3. **Minimum requirements for Permanent Certification:**

3.1 Hold a Provisional School Clinician (Reading) certificate;

3.2 Successful completion of the equivalent of two full school years of supervised internship after Provisional certification;

3.3 Verification from the appointed supervisor of at least 20 hours of clinical supervision within the two-year internship program.
DEPARTMENT POLICIES RELATIVE TO THE CERTIFICATION OF  
SCHOOL SOCIAL WORKERS

1. Minimum Qualifications for Provisional Certification
   A Bachelor of Social Work degree or its equivalent, as established by the School of Social  
Work, University of Manitoba.

2. Areas of Study Required
   a) Basic requirements: Undergraduate courses in normal human development,  
sociology, economics, anthropology, etc.

   b) Professional course content to include:

      1. the values, purposes and practice of social work
      2. the study of human behaviour and social environment
      3. theoretical knowledge and practical training in the  
management of psychological and social problems
      4. knowledge of the social welfare system and related social  
systems
      5. general knowledge of programs important for healthy  
emotional and social functioning
      6. theory and practice pertaining to the treatment and  
education of children with emotional and learning difficulties

   c) Supplementary study in appropriate areas of education, clinical  
psychology, guidance and counselling, medicine, psychiatry, law, etc.

   d) Field work practice.

3. Minimum Qualifications for Permanent Certification
   a) A Master of Social Work degree or equivalent, as established by  
the School of Social Work, University of Manitoba.

   b) Successful experience (for the provisional period) as a School Social  
Worker with recommendation for permanent certification.

If you wish to have your credentials reviewed by the Social Worker Advisory  
Committee, in addition to official transcripts, please submit the following  
information:

   1. A chronological summary of schools attended and courses taken.

   2. A summary of course descriptions for those courses which are  
submitted for certification as a School Social Worker.

   3. A brief statement from the prospective candidate indicating why,  
from the candidate's point of view, certification should be granted  
and how this will affect the candidate's job function.

   4. A clear statement concerning past supervised clinical experience  
(if any) outlining content, frequency, duration, etc.

   5. A chronological statement of classroom teaching experience, if  
applicable.
APPENDIX C
# Current

## Child Guidance Clinic of Greater Winnipeg Referral Forms

### Referral Form

Please complete in duplicate and return original to The Referral Clerk, 700 Eglinton Ave., Winnipeg, R3E 1E2; 786-7841

<table>
<thead>
<tr>
<th>Please complete ALL Blanks</th>
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</thead>
<tbody>
<tr>
<td><strong>School</strong></td>
</tr>
<tr>
<td><strong>Name</strong></td>
</tr>
<tr>
<td><strong>Address</strong></td>
</tr>
<tr>
<td><strong>Reason for referral (be as descriptive as possible — use reverse side if necessary)</strong></td>
</tr>
</tbody>
</table>

Remedial action taken by school personnel (principal, teacher, resource teacher, guidance counselor): Indicate nature of action, frequency of contacts, results, etc. — use reverse side if necessary; please attach guidance and resource reports and E.I.P. Information.

What are the results of your contacts with parents/guardians regarding this problem?

Parental/Guardian permission must be obtained before the Child Guidance Clinic becomes involved with a child under the age of 18 years. Parental/Guardian(s) understand the reason for referral and approve of Child Guidance Clinic involvement. Parental/Guardian(s) have been contacted by name, and provided consent on date.

**What kind of assistance are you expecting from the Clinic?**

**School Record** (a description of past academic achievement, classroom behavior, attendance problems, interpersonal relations with peers, teachers, etc.; use reverse side if necessary).

**Other schools attended**

**Standardized intelligence and achievement tests (names, dates, results)**

**E.I.P. Referral** Yes No

**Relevant medical information**

<table>
<thead>
<tr>
<th>Vision</th>
<th>Hearing</th>
<th>Medication</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal</td>
<td>Loss</td>
<td></td>
</tr>
</tbody>
</table>

**Name of Family Physician**

**Other significant medical information**

**Known to:** C and F Services Child Dev. Clinic Other (Specify)

**Signature**

**For Clinic Use Only**

**Comments**

<table>
<thead>
<tr>
<th>Date</th>
<th>C.G.C. Signature</th>
</tr>
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<tbody>
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</table>

*Form 612 R 55569*
1980 Referral Form

School: ___________________________ Room: _______ Teacher: ___________________________

Name: ___________________________ Grade: _______ Birth date: ___________________________

Address: ___________________________ Phone No.: ____________

Father (guardian): ___________________________ Occupation: ___________________________

Mother (guardian): ___________________________ Occupation: ___________________________

Siblings (given names, birthnames/ages, schools, educational levels, occupations, etc.): ___________________________

Language spoken at home (other than English): ___________________________

Reason for referral (be as descriptive as possible — use reverse side if necessary): ___________________________

Remedial action taken by school personnel (principal, teacher, resource teacher, guidance counselor, indicate nature of action, frequency of contacts, results, etc.) — use reverse side if necessary: ___________________________

What kind of assistance are you expecting from the Clinic? ___________________________

Parental/Guardian permission MUST be obtained before the Child Guidance Clinic becomes involved with a child under the age of 16 years. Parents/Guardians have been contacted (date) by ___________________________

What are the results of your contacts with parents regarding this problem and this referral? ___________________________

School record (description of past academic achievement, classroom behavior, attendance problems, interpersonal relations with peers and teachers, etc.) — use reverse side if necessary: ___________________________

Other schools attended: ___________________________

Standardized intelligence and achievement tests (names, dates, results): ___________________________

Relevant medical information (vision, hearing, speech, physical defects, illnesses, medications, family physician, specialists, etc.): ___________________________

Other agencies and services (if known): ___________________________

Signature: ___________________________ Title: ___________________________

For Clinic Use Only: ___________________________

File No.: ___________________________

Comments: ___________________________
# Child Guidance Clinic of Greater Winnipeg

## Referral Form

**Date:** Nov 23, 1974

**Pupil's Education**

**Student Name:**

**School:**

**Address:**

**Father's Occupation:**

**Mother's Occupation:**

**Siblings:**

**Language spoken in home (other than English):**

**Reason for Referral:**

- He has speech problems and is enrolled in speech therapy.

**Remedial action taken by school personnel:**

Principal, teacher, resource teacher, guidance counselor, indicate nature of action.

**What kind of assistance are you expecting from the Clinic?**

**What are the results of your contacts with the parent regarding this problem and this referral?**

**School Record:**

Description of past academic achievements, classroom behavior, attendance problems, interpersonal relations with peers and teachers, etc.

**Other schools attended:**

**Standardized intelligence and achievement tests:**

Names, dates, results.

**Relevant medical information:**

Vision, hearing, speech, physical defects, illnesses, medication, physicians, etc.

**Other agencies and services:**

**Signature:**

**Comments:**

**Date:**

**C.G.C. Signature**
### Child Guidance Clinic of Greater Winnipeg

**Referral Form**

Please complete in duplicate and return original to Secretary, 700 Elgin Ave., Winnipeg.

<table>
<thead>
<tr>
<th>School</th>
<th>Grade</th>
<th>Rem.</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Family Name)</td>
<td></td>
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<td></td>
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<tr>
<td>(Given Name)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Birthdate</td>
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<tr>
<td>Day Month Year</td>
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<td>Address</td>
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<td>(House and No.)</td>
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<td>(District)</td>
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<tr>
<td>Phone No.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Father (Guardian)</td>
<td></td>
<td></td>
<td>Occupation</td>
</tr>
<tr>
<td>Mother (Guardian)</td>
<td></td>
<td></td>
<td>Occupation</td>
</tr>
<tr>
<td>Siblings (Give name, age, school and grade or occupation)</td>
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</table>

**Problem (Reason for Referral):**

... (details)

Has there been contact with the parent regarding this referral? What was the result?

Information from Medical Card (Development, hearing, speech, physical defects, illnesses, etc.):

... (details)

Name of Family Physician (if known):

Standardized Intelligence and Achievement Test (Name of test, date, results):

... (details)

**Other schools attended:**

<table>
<thead>
<tr>
<th>Attendance record</th>
<th>Attendance record</th>
<th>Services Requested</th>
<th>Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year</td>
<td>Gr.</td>
<td>Att.</td>
<td>Year</td>
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</tbody>
</table>

**FOR CLINIC USE ONLY: COMMENTS:**

Transfer: Cancel referral; Is school aware of interdepartmental referral etc.?

Date: C. G. C. Signature
### 1965 Referral Form

**CHILD GUIDANCE CLINIC OF GREATER WINNIPEG**

**REFERRAL FORM**

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
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</thead>
<tbody>
<tr>
<td>Date</td>
<td>1965</td>
</tr>
<tr>
<td>School</td>
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</tr>
<tr>
<td>Teacher</td>
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</tr>
<tr>
<td><strong>Name</strong></td>
<td></td>
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<tr>
<td>(Family Name)</td>
<td></td>
</tr>
<tr>
<td>(Given Names)</td>
<td></td>
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<tr>
<td><strong>Address</strong></td>
<td></td>
</tr>
<tr>
<td>(Street and No.)</td>
<td></td>
</tr>
<tr>
<td><strong>Father (Guardian)</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Mother (Guardian)</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Siblings</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Problem (Reason for Referral)</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Has there been a personal contact with the parents in the past year by the teacher, principal or public health nurse?</strong></td>
<td>Yes/No</td>
</tr>
<tr>
<td><strong>Information from Medical Card</strong></td>
<td>Development, hearing, speech, physical defects, mental, etc.</td>
</tr>
<tr>
<td><strong>Name of Family Physician (if known)</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Standardized Intelligence and Achievement Test (name of test, date, results)</strong></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Attendance Record</th>
<th>Year</th>
<th>Grade</th>
<th>Days</th>
<th>Year</th>
<th>Grade</th>
<th>Days</th>
<th>Year</th>
<th>Grade</th>
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</tbody>
</table>

| Other Schools attended | |
|------------------------| |

| Any additional information | |
|----------------------------| |

| Service requested from: | |
|------------------------| |
| School Social Worker   | |
| Reading                | |
| Psychology             | |
| Speech and Hearing     | |

<table>
<thead>
<tr>
<th>(Sig)</th>
<th>Name</th>
<th>(Total)</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
</tbody>
</table>
CHILD GUIDANCE CLINIC OF GREATER WINNIPEG

REQUEST FORM

NO 44485

DATE 4 May 65

SCHOOL

NAME

ADDRESS

FATHER (Guardian)

MOTHER (Guardian)

SIBLINGS

REQUESTED BY

PREVIOUS CONTACT (Teacher, etc.)

PROBLEM

The school has referred for untrained class.

SOCIAL WORK

READING

PSYCHOLOGY

SPEECH & HEARING

PSYCHIATRY
1959 Referral Form

CHILD GUIDANCE CLINIC OF GREATER WINNIPEG

No. 4087

Date: January 20, 1959

Name: [Redacted]

PO Box [Redacted]

Address: [Redacted]

School: [Redacted]

Birthdate: [Redacted]

Grade: [Redacted]

RM. No.: [Redacted]

Father's Name: [Redacted]

Mother's Name: [Redacted]

Siblings: [Redacted]

Probation Officer: [Redacted]

Problems: [Redacted]

Problems in School: [Redacted]

Any additional information: [Redacted]

Amended Record:

<table>
<thead>
<tr>
<th>Year</th>
<th>Grade</th>
<th>Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>1959</td>
<td>[Redacted]</td>
<td>[Redacted]</td>
</tr>
</tbody>
</table>

Services requested by: [Redacted]
184 Montrose Street, 
Winnipeg, Manitoba, 
June 22, 1985

Mr. L. B. Fleisher, Director, 
Child Guidance Clinic, 
Winnipeg, Manitoba

Dear Larry,

I am currently enrolled in the Master of Education programme at the University of Manitoba. Part of the requirements for this degree is a thesis. The topic I have chosen is "The Development and Growth of the Child Guidance Clinic of Greater Winnipeg".

This study will be basically an archival search of Child Guidance Clinic materials. Perceived effects of changes and developments in the functioning of the Child Guidance Clinic will also be obtained through interviews with past and present members of the Clinic staff who are familiar with its thirty-four year history.

I hope this project meets with your favourable approval. If you have any questions, please do not hesitate to contact me.

Sincerely,

Sherman Y. Lang
School Psychologist
Child Guidance Clinic
Child Guidance Clinic of Greater Winnipeg

700 Elgin Avenue
WINNIPEG, MANITOBA
R3E 1B2

Telephone: 786-7841

27 June 1985

Mr. Sherman Lang
184 Montrose Street
Winnipeg, Manitoba
R3M 3M7

Dear Mr. Lang:


I have reviewed your letter requesting permission to carry out a study of the Clinic's development and growth, and grant you permission to do so.

I have no hesitation in saying that you may approach Clinic staff members and avail yourself of pertinent clinic materials to gain information for your study.

I wish you well in your project and look forward to reading your thesis upon completion.

Yours sincerely,

L. B. Fleisher,
Director.

/sg
August 1, 1985

Sherman N. Lang
184 Macdonald Street
WINNIPEG, Manitoba
R3H 3M7

Dear Mr. Lang:

Your research project does not appear to present any concerns for the members of the Winnipeg Teachers’ Association. We wish you well in your thesis work, and would appreciate the opportunity to read your paper upon completion.

Yours sincerely,

Carolie Basarab
President

CB/jg
Mrs. Carole Basarab, President,  
Winnipeg Teachers' Association,  
191 Marcourt Street,  
Winnipeg, Manitoba.

Dear Mrs. Basarab,

I am currently enrolled in the Master of Education programme at the University of Manitoba. Part of the requirements for this degree is a thesis. The topic I have chosen is "The Development and Growth of the Child Guidance Clinic of Greater Winnipeg".

This study will be basically an archival search of Child Guidance Clinic materials. Perceived effects of changes and developments in the functioning of the Clinic will also be obtained through interviews with present and former members of the Child Guidance Clinic staff who are familiar with its thirty-four year history.

I trust this research project meets with the approval of the Winnipeg Teachers' Association. Should you have any questions please contact me at 264-0771 (home) or 726-7841 (work).

I look forward to hearing from you at your earliest convenience. Thank you for your consideration of this letter.

Sincerely,

Sherman N. Lang  
School Psychologist  
Child Guidance Clinic

c.c. Mr. L.E. Fleischer  
Ms. F. Clark
ETHICAL APPROVAL OF RESEARCH AND EXPERIMENT DEVELOPMENT PROJECTS
INVOLVING HUMAN SUBJECTS

This form is to be completed in accordance with the Faculty of Education policy on ethical review. This policy requires that Committee members take into account the relevant standards of the discipline concerned as well as, where appropriate, the standards specified by certain external funding bodies.

Project identification
(to be filled in by investigator)

Investigator(s)  Sherman N. Lang

Title  The Development and Growth of the Child
Guidance Clinic of Greater Winnipeg

If applicant is a student, name the faculty member supervising the proposed research
D. Bruce Sealey

This is to certify that the Review Committee has examined the research and experimental development project indicated above and concludes that the research meets the appropriate standards of ethical conduct in research with human subjects.

Date: Nov 9-87  Signature of Chairperson:

[Signature]
All Metro school divisions with the exception of St. James-Assiniboia are serviced by the Child Guidance Clinic of Greater Winnipeg. Within the Winnipeg School Division No. 1 the following units exist: Aberdeen, Audiology and Aural Rehabilitation, Churchill, Daniel McIntyre, Elmwood, Gordon Bell, Grant Park, Independent Schools, Kelvin, St. John's, Sisler and Trainably Mentally Handicapped. Suburban Units include: Assiniboia-South, St. Boniface, Fort Garry, St. Vital, Norwood, River East, Seven Oaks and Transcona-Springfield.