

CLINICAL ORGANIZATION  
FOR CHILD GUIDANCE WITHIN  
THE SCHOOLS

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## FOREWORD

There is no community service which has shown a more phenomenal growth during the past quarter of a century than the organization of clinical facilities for the adjustment of behavior and personality problems of children. The terms "child-guidance clinic," "psychiatric clinic," "behavior clinic," "mental-health clinic," and other terms having a similar connotation are familiar to all who have any responsibility for the diagnosis and treatment of children's difficulties. In 1896 the first psychological clinic in the United States was established at the University of Pennsylvania, and the year 1909 saw the first psychiatric clinic for children organized in Chicago. Since that time the number of communities served by psychiatric child-guidance clinics has reached a mark that probably lies somewhere between 650 and 700. Among the interested agencies are, of course, the schools, the guidance function of which is outstanding. Yet the limitations of budgets, both in school and community administration, have all too often seemed to prohibit the development of a program which has been recognized as desirable.

In May 1938 the Commissioner of Education invited to Washington a group of specialists who were actively engaged in work of a clinical nature, with particular relation to child-guidance programs in school systems. The purposes and findings of that conference are presented in chapter VI of this bulletin. Among the services which the conferees requested that the Office of Education take under consideration was the preparation of material for publication describing the types of clinical organization for child guidance under way in communities and school systems of various sizes. Such a publication, it was thought, might stimulate school administrators and other civic leaders, in communities in which no definite form of clinical organization as yet exists, to seek possibilities for service in this field. Moreover, by showing trends of organization to date, one may point out the direction which future development is likely to take.

This bulletin is an attempt to meet the request of the conference. It does not purport to make a complete survey of clinical organizations in operation, but rather to present illustrative practices found in some of the States, counties, and cities in which the principles of child guidance have taken deep root. It reflects the deliberations of

the conferees as well as the data assembled by the Office of Education through the use of inquiry forms. It shows, first, certain organization plans followed on a State-wide or a county-wide basis; then proceeds to the efforts being made in small communities; next, to programs in cities of moderate size; and, finally, to a consideration of the opportunities of a large city. There has been no intent to describe in detail methods of procedure or types of diagnosis and treatment. These are the responsibility of the specialists in charge of the local program after it is organized, and it is assumed that those appointed will be capable of discharging that responsibility. Only the broad lines of organization and relationships are sketched, in order that those who are interested may see how a foundation can be laid for the development of an effective program.

To all who have supplied information through conferences, response to inquiry forms, or correspondence, the Office of Education extends grateful appreciation. The cities, counties, and States referred to in the successive chapters constitute only a small proportion of the total number of communities in which clinical service for children is under way. It is believed, however, that the programs presented are illustrative of the various types that are being operated with a direct relationship to the schools of the community.

BESS GOODYKOONTZ,  
*Assistant Commissioner of Education.*

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# CLINICAL ORGANIZATION FOR CHILD GUIDANCE WITHIN THE SCHOOLS

## CHAPTER I

### THE PLACE OF CLINICAL SERVICE IN THE SCHOOL PROGRAM

**T**HE TERMS "clinic" and "clinical" focus immediate attention upon the individual and his problem. Originally applied to medicine, they have now become identified with numerous other fields in which effective service is dependent upon a close diagnostic relationship between client and the person or persons qualified to give him expert advice. The successive steps involved in giving full clinical service to any individual are examination, diagnosis, and treatment, with the necessary follow-up to check and to insure results.

### *GROWTH OF THE CLINICAL POINT OF VIEW IN EDUCATION*

In the schools the emphasis upon clinical service has emerged as the result of a number of interlocking factors. Always present to a certain extent in a constructive relationship between teacher and pupil, it has received its greatest impetus during the past quarter of a century. The inauguration of the use of mental tests, the attendant discovery of the wide range and diversity of capacities among school children, and the intensive efforts to provide for individual differences and needs have in themselves partaken largely of the clinical approach in education. The widespread emphasis upon intelligent and sympathetic pupil guidance as a major function of the school has contributed substantially to the furtherance of clinical measures. The acceptance of the concept of the "whole child" as the object of attention, with all its inextricably interwoven implications, has necessitated a clinical study of individual cases. Classroom teachers have become more conscious of the need of making adjustments for specific pupils. Remedial teachers and special class teachers have been appointed to handle serious instructional difficulties. School counselors, visiting counselors, and visiting teachers with experience in both education and social work have found a place in the school system to study and to assist in adjusting pupil problems with particular attention to the interrelationship of community, school, and home. Health and medical specialists, psychometrists, and psychologists have been

added to the school staff. The services of all these people have been indicative of the increasing importance placed upon the clinical aspects of the educational program.

Situations arising outside the elementary and secondary schools have likewise been responsible for the growth of clinical assistance to children of school age, and these have had their part in stimulating the schools to further action. Community, State, and national projects have been undertaken which are directed toward the prevention of crime and psychosis. Widely publicized research findings have pointed to maladjustments in childhood as forerunners of serious delinquency and personality disturbances. Authorities in mental hygiene have emphasized the importance of detecting and adjusting incipient problems of behavior and of thus obviating the danger of their becoming acute. Teacher-training institutions have begun to make students recognize the importance of mental health in their own experiences and in the lives of their pupils. Private enterprise has subsidized clinical programs in demonstration centers, some on a temporary basis, others as continuing agencies.

Thus, coming from both within and without the educational ranks, significant influences have been at work to concentrate attention upon the clinical point of view and upon clinical practice in the schools. It is not surprising, therefore, that school administrators should be looking for ways and means to make better use of the possibilities for clinical service which they may already have in their midst and to add to them other services in an organized fashion.

#### *TYPES OF CLINICAL ORGANIZATION*

The desire for an organized plan of work has led to a variety of programs designed specifically to adjust behavior problems of pupils and more generally to help teachers to apply the principles of mental hygiene in the classroom. Yet, immediately one is faced with questions of definitions and relationships. What is a "behavior problem"? When does an educational problem become a behavior problem? How is a particular child's behavior related to his physical condition? To his mental capacity or school achievement? To his home situation or other environmental factors? Can a clinical program for behavior problems be divorced from the total school guidance program? Or from the total program for child study or child health? What specialists must be employed to carry on a clinical program? These and other questions have caused much concern to school administrators who are genuinely interested in developing an effective clinical service, and no one knows the final answers to them. The varying answers that have been given—as well as the financial resources at hand—are reflected in the varying types of organizations set up, ranging from

the simplest plan of cooperation among a limited personnel to a full clinical staff of specialists.

*In small school systems.*—In some cases one school psychologist or a socially minded attendance worker may offer the only hope of clinical assistance within the school system, and hence the responsibility for the program devolves upon him. In other cases it may be a school counselor or a visiting teacher; in still others a school physician who has had psychiatric training; and in others the school may have to look entirely to an outside cooperating agency for specialized service, depending upon members of its regular staff for the more general analysis of the problem. Thus, without complicated organization, one or two qualified persons may, at least in a small school system, initiate a program that will make a significant contribution to the clinical adjustment of pupil problems, including those of behavior.

*In cities of moderate size.*—When existing facilities permit a somewhat more extensive staff, problems of organization loom larger, and they become increasingly complex with the increasing size of the city. A clinical unit may be established in the division of guidance, or in the department of pupil personnel, or in the child-study department, or in the psychological division, or in the health service, or in the division of special education, or it may exist as a separate entity with its director responsible immediately to the superintendent or to an assistant superintendent in charge of a group of related functions. There is no pattern of organization which can be offered as a model for all communities.

So far as can be ascertained at the present time, however, the largest number of clinical units organized within school systems of moderate size have been made integral parts of the total guidance program of the school. In such cases guidance is interpreted, not in the narrow sense of vocational counseling but as a broad service for the personal adjustment of all types of individual problems within the scope of school consideration. Problems of behavior or social maladjustment constitute only one of these types. The director of guidance in the school system of a city of some 86,000 inhabitants points out that the guidance movement "developed out of the need to help the adjustment of the individual child within the large-scale, standardized system of education. Problems of educational adjustment, problems of attendance and behavior, and finally various social problems are the sphere of the guidance bureau or clinic activity."<sup>1</sup> Representative of this point of view, we find variously named divisions of the school system discharging allied functions of guidance and clinical

<sup>1</sup> Miller, Joseph. The function of the child guidance bureau personnel. *Educational method*, 17: 118-120, December 1937.

service. Among the titles used are division of guidance, placement, and personnel; attendance and guidance department; guidance committee; department of pupil adjustment; department of child accounting and adjustment; department of pupil personnel.

*In large school systems.*—In the largest school systems of the country one may expect to find a tendency to perform the respective guidance functions indicated here through separate bureaus, with an attempt to coordinate services through administrative relationships. One school system, for example, in a city of more than 300,000 inhabitants, carries on its individual guidance services through six coordinate divisions of the superintendent's office staff, namely, (1) the visiting teacher department; (2) the child study and special education department; (3) the department of educational and vocational guidance; (4) the attendance department; (5) the parent education and child development department; and (6) the physical education department.

In cities of this size the clinical services for behavior problems may still be considered part of a larger program of study for all children. With such an arrangement the "child study department" or the "psychological clinic" which serves the entire school population serves also through intensive study the serious cases of maladjustment. It reserves the right to determine the nature and the extent of the examination to be made and the treatment to be given in accordance with the need of the child. The reason for such an arrangement is based upon the close interaction of educational and social maladjustments and upon the imperceptible gradation in the relative seriousness of behavior problems. So many factors contribute to or are associated with so-called "behavior problems" that it is impossible to isolate them as a group until they have become rather pronounced. Through its wider application to all the children of the school system, a department of child study has the opportunity to exercise a preventive influence for many and a remedial effect for the comparatively few who need intensive measures.

In keeping with this broad conception of the clinical function of the school program, the Educational Policies Commission of the National Education Association describes the activities of the "child-guidance clinic" as follows:<sup>2</sup>

The child-guidance clinic brings together the teacher, parent, attendance worker, psychologist, and physician for consultation regarding the child with problems. The services of a psychiatrist may also be needed on occasion. The clinic studies the child from all angles seeking to discover the roots of his difficulties whether they lie in abnormality, poor health, mental maladjustment, emotional conflicts, bad home or school conditions,

<sup>2</sup> The Educational Policies Commission. *Social services and the schools*, Washington, D. C., National Education Association. P. 95.



unwholesome friendships, or unfavorable community environment. When the causes of trouble are identified the treatment is prescribed and the case followed up through the appropriate agencies of correction.

On the other hand, in a few of the largest school systems, also, the organization known as a "child-guidance clinic" limits its major services to children of at least normal or approximately normal intelligence who have displayed definite symptoms of a disturbed personality or behavior maladjustment. This is in keeping with the general conception of the functions of such a clinic as held by the National Committee for Mental Hygiene. A leading representative of this organization has defined a child-guidance clinic as a "psychiatric clinic that includes psychologists and psychiatric social workers; it is a clinic that deals primarily with behavior problems of children ranging fairly normally in distribution; it is as a rule community-wide in scope; its services are of varying degrees of intensiveness, but characteristically it is equipped to dovetail psychiatric, psychological, and social services into a single diagnostic statement and a single plan of treatment."<sup>1</sup>

There is no real conflict between the two points of view presented here. The difference appears to be largely one of terminology. Educators and psychologists, on the one hand, and medical mental hygienists on the other hand, are unanimous in advocating clinical guidance for all school children, with psychiatric assistance when needed. The former are likely to define "child guidance" in terms of various types of adjustment procedures for all types of problems found among school children. The latter tend to restrict it to psychiatric and associated techniques used for the adjustment of behavior or personality problems. In describing in this bulletin the programs in operation in specific localities, the term will be used as it is employed locally.

#### THE CLINICAL STAFF

Whatever the plan of organization used or the situation into which the clinical unit for the adjustment of behavior problems must fit, there are well-defined standards with regard to desirable personnel. These have already been implied in the foregoing discussion, and they have been determined by an analysis of the influences acting upon the child's behavior, which in general may be classified as physiological, mental and educational, emotional, and social or environmental.

*The physician and the psychologist.*—For many school systems, the point of departure in developing a clinical program in which all

<sup>1</sup>Stevenson, George S. Community clinics as training centers for psychiatrists. *Mental hygiene*, 18: 353-361, July 1934.

these influences are considered lies in the use of the time of school physicians and school psychologists. The school physician makes a physical examination; the psychologist administers a mental test, studies the child's educational progress, and, if he is qualified in the broader aspects of clinical psychology, he may go further in the analysis of the child's abilities and personality as factors in mental health and social adjustment. The findings of these two persons alone may throw significant light upon the problem and point the way to effective treatment through curriculum adjustment, medical service, or other means.

*The case worker*.—A third type of service is also important, namely, that represented by a visiting teacher, psychiatric social worker,<sup>4</sup> or person with equivalent responsibilities. Contacts may need to be made with the home, the home situation modified, community influences and resources studied, the child's environmental problems interpreted to the teacher. A psychiatric social worker or a visiting teacher, who has had training and experience both in classroom service and in social service, is well equipped for such participation in a clinical program. In the absence of such a worker, certain school systems make an effort to secure the same general type of service through special part-time assignments to regular teachers as "school counselors" or "visiting counselors" who are fitted by personality and some training to carry on work of this kind. Reports from many places indicate gratifying results under such arrangement, although one cannot, of course, expect the familiarity with social service techniques displayed by a specialist.

*The psychiatrist*.—The fourth type of service, which is essential for a complete clinical organization is that of the psychiatrist, with emphasis upon the application of psychiatry to the lives of children. The science of "child psychiatry" or "child guidance," as the term is used by psychiatrists, has evolved as an important branch of a field which originally was largely limited to the study and treatment of mental disease among adults. The psychiatrist is a physician who has specialized upon the study of the individual as a total functioning organism, with all the intricacies of relationship among physiological and emotional factors. The "child psychiatrist" is a psychiatrist who applies this specialty to children. The tremendous growth of community child guidance clinics during the past 25 years has testified to the need and, it is hoped, to the effectiveness of such service.

<sup>4</sup> A "psychiatric social worker" is a social worker who has had training in psychiatric technique but without the medical preparation of the psychiatrist. A "visiting teacher," as the term is used in this bulletin, is a person who, with teaching experience, has specialized in the social adjustment of pupil problems.

The psychiatrist, being medically trained, is equipped and sometimes prefers to make his own physical examination. In that case the school physician may be relieved of this responsibility for the multitudinous demands of his regular professional duties. Sometimes an additional member of the clinical staff, in the form of a pediatrician, assists the psychiatrist in the physiological aspects of the work or carries it on for him.

Most school systems find it impossible—and perhaps unnecessary—to employ a full-time psychiatrist. Only a few—in scarcely more than a score of cities<sup>5</sup>—provide even the part-time services of such a specialist through their own budgets. In fact, the large majority of fully staffed “child-guidance clinics” as defined by the National Committee for Mental Hygiene—and there are more than 600 communities served by them in the United States—are organized as private, community, or State agencies outside the school system.

That school children should have access to the services of such clinics regardless of their sponsorship is admitted everywhere. Ryan<sup>6</sup> says:

Psychiatric service of a high quality should be available for every modern educational program. Without the scientific basis for understanding and dealing with behavior represented by the psychiatrist and his training, no school can be considered to be meeting the all-round needs of human beings in present-day society. At present, however, the range is all the way from the full-time psychiatrist, as found in some school systems and in a number of colleges and universities, to occasional consultant service that may care for emergency cases but does not affect in any fundamental way the educational process; while the vast majority of schools and school systems have no psychiatric assistance whatever.

#### THE LARGER FUNCTIONS OF CLINICAL SERVICE

The immediate assistance to individual children who present problems of adjustment is not the only function of the clinical organization, and if it limits its program to this the clinic will fall far short of its possibilities for service. “The value of a clinic to a school system,” says one specialist,<sup>7</sup> “lies less in the benefit to the individual child studied than in helping teachers to understand and treat all problem children in a more constructive manner.” Another<sup>8</sup> considers it “important that the clinic shall be regarded not as a place to get rid of

<sup>5</sup>The National Committee for Mental Hygiene has published a *Directory of Psychiatric Clinics in the United States*, as of 1936, including those operating under the auspices of Boards of Education.

<sup>6</sup>Ryan, W. Carson. *Mental health through education*. New York, The Commonwealth fund, 1933. Pp. 205-206.

<sup>7</sup>Newell, H. W. The methods of child guidance adapted to a public-school program. *Mental hygiene*, 18: 362-372, July 1934.

<sup>8</sup>Robinson, Bruce B. The place of the child guidance clinic in mental hygiene. *Educational method*, 14: 180-183, January 1935.

a problem, but as a place where additional understanding and help may be received so that the responsible person can carry on his work more successfully."

From the report of the directing psychiatrist of a child-guidance clinic organized within a large city school system comes the statement that "the clinic operates to remove obstacles (within or without the child's personality) to education. It also has an educational function in helping parents and teachers to understand and deal with children in wiser ways. It has the function of learning from the individual cases seen what are the major sources of stress in the school system and aiding in removing or modifying these for improvement of the mental health of the average child."\*

Following out the implications of these statements, we conclude that the clinic or clinical service, to be most effective, must be intimately related to activities in the school administrative offices, in the classroom, and on the playground. School organization can be made to contribute to mental health of both pupils and teachers, but it can also contribute to their mental ill health. Classroom procedures may either help or hinder the program of mental hygiene. Principals and teachers can reinforce the clinical service or they may through lack of understanding undo all the clinic has accomplished.

It seems most essential, therefore, that these persons should be brought into the clinical program and progressively learn how to apply to school and classroom situations what the clinic is attempting to do with individual cases. They may be given the opportunity to participate in clinical conferences, to enroll in professional courses or discussion groups treating the application of mental hygiene to education, to consult the psychiatrist personally upon individual pupil problems, and to secure aid in adjusting some of their own problems. In these and other ways the influence of the clinic may be extended directly or indirectly to all the children in the school system. Principals and teachers will thus become increasingly able to handle successfully a number of the milder problems occurring, leaving the specialized service of the clinic for the more serious cases and for the ever-continuing program of parent and teacher education. When this happens, mental hygiene will really function in education, for it will constitute an intrinsic part of every teacher's equipment for service.

\* Statement contributed by the Child Study Department, Public Schools, Minneapolis, Minn.

## CHAPTER II

### SOME STATE AND COUNTY PROGRAMS

In a recent article by George S. Stevenson, at that time Director of the Division of Community Clinics of the National Committee for Mental Hygiene, it is pointed out that "approximately 80 percent of the service offered by child guidance clinics is offered to communities with more than 150,000 population, whereas the smaller community, the type that holds 75 percent of the population of the United States, has had but 20 percent of the total service. Furthermore, this 20 percent has been conducted for the most part in a rather planless way. This fact is crucial to the planning of State services because it defines the unmet need to which the State may respond."<sup>10</sup>

The significance of this statement is obvious. If the children in rural school districts and in small towns and cities are to have the benefit of expert guidance services which will recognize and treat the problems of personal maladjustment, such services will in most cases need to come from a larger unit than that represented by the school district in which the child is enrolled. There are several bases upon which this larger unit can be organized. In the first place, several neighboring districts can join forces in establishing a clinical program, thus sharing both the expense incurred and the time available. In the second place, a county program may be organized, designed to serve every school district within the county. In the third place, the State may accept the responsibility, as Stevenson suggests, for developing a State-wide system of child guidance clinics which may extend their influence into every corner of its territory. As the State is the major unit for educational provision, so it may likewise become the unit for specialized child-guidance service to those whom it would educate.

All three of these procedures have been used, with varying plans of action and with varying degrees of success. It is too early to evaluate any one of them in comparison with the others, for the whole movement is still too young. The goal of each of them must be to reach the needs of every child, whether in rural area or in crowded city. Some of the organized efforts being made to do this

<sup>10</sup> Stevenson, George S. Lines of development of child guidance clinics. *Psychiatric quarterly supplement*, 13: 31-36, January 1939.

are worthy of close examination, even though results may be as yet admittedly inadequate. In this chapter, therefore, certain programs will be described illustrative of State and county projects. Consideration of city and joint city programs will be reserved for later chapters.

*THE STATE PROGRAM IN MASSACHUSETTS*<sup>11</sup>

Probably the most extensive clinical program on a State-wide basis has developed over a period of years in Massachusetts. In the State department of mental diseases, which has general supervision of all public and private institutions for the mentally ill, the mentally defective, and epileptics, there is a division of mental hygiene as well as a division of mental deficiency. Each of these makes a distinct contribution to the clinical program of the State, the former with reference to behavior and personality problems of intellectually normal children of preschool and early elementary age, and the latter with primary reference to mental retardation and associated factors. Each operates a series of clinics for which it draws psychiatric and other specialized assistance from the State hospitals and the State schools for the mentally deficient. Some of the clinics function as integral parts of the hospital program, others are carried on in closely coordinated relationship to the local school systems. All of them serve the school children of the community in which the clinic is held. Those operated by the division of mental hygiene are called "habit clinics," and those of the division of mental deficiency are "traveling school clinics." In addition, certain of the State hospitals operate their own child guidance clinics as outpatient departments. In all cases, working relationships are developed not only with the school system but with other community agencies concerned with the child in question.

*Habit and child guidance clinics.*—The habit clinics and the child-guidance clinics of the division of mental hygiene operate in connection with 11 institutional centers of the State. The communities in which these are located range in size from towns of less than 10,000 population to the city of Boston. The professional staff provided by the hospitals includes specialists in psychiatric, psychological, medical, and social service. More than a thousand children are served each year, most of them receiving intensive study at the hands of physician, psychologist, psychiatric social workers, and psychiatrist, with recurrent visits to the clinic occurring over a period of time. The psychiatrist is the coordinator of staff activities and takes the leadership in staff conferences at which the case is reviewed, a diag-

<sup>11</sup> Information concerning the Massachusetts program has been secured from (1) reports of the State department of mental diseases; (2) inquiry forms sent to local school systems; (3) correspondence and conference.

nostic summary presented, and plans for treatment made. Physicians, teachers, social workers, and others interested in a particular case are invited to the conference at which it is discussed. About one-third of the cases studied are referred by the schools, one-third by health agencies, and the other third by children's agencies, friends or relatives, physicians, or other sources of referral.

Supplementary conferences are held by the clinical staff with school officials and these serve a twofold purpose: (1) To give to principals and teachers a better understanding of the psychological aspects of children's problems and a broader understanding of the aims of mental hygiene; and (2) to provide the clinic staff with a clearer appreciation of the school environment in all its implications. Thus each professional group serves to enlighten the other in the interests of the best possible adjustment for every child. The clinics conceive their function in terms of the larger responsibility of influencing educational procedure, and they have proved a source of vital assistance to the schools with which they have operating relationships.

Such a clinical program obviously demands adequately trained personnel. In commenting upon this matter, the director of the division of mental hygiene says in one of his annual reports:<sup>12</sup>

It has been demonstrated beyond all doubt that we cannot expect the State hospitals to operate these clinics with the byproducts of their hospital staff. The needs of these clinics for children are not those of the institution either in the interest, training, or experience of the personnel which make up the staff. If this type of service is to be rendered by the State to the various communities in which State institutions are located, it is absolutely necessary that each institution be provided with funds with which to secure adequately trained psychiatrists, psychologists, and social workers and that the clinic personnel should not have duties connected with the institution. Only in this way can we expect to get wholehearted cooperation from the superintendents of the institutions in the development of community activities. It is too much to expect an already overburdened hospital staff to embark upon these extrainstitutional demands with any degree of enthusiasm even if they were trained and interested in this particular field of psychiatry.

The psychiatric and psychological approach to the child is quite different from that which is made to the adult. The social situations which cause us concern with reference to the school child are not those in which we would be interested were we thinking of patients from a State hospital. Both types of work require specially trained and experienced personnel.

This statement expresses the conviction of certain other child-guidance workers who hesitate to give to psychiatrists who have had training and experience only in institutional work for adults the

<sup>12</sup> The Commonwealth of Massachusetts, Annual Report of the Commissioner of Mental Diseases, 1936. P. 60. (Public Document No. 117.)

responsibility for clinical service to children. In order to obviate the difficulties encountered, steps have been taken by professional groups to designate the type of training and experience which will officially qualify not only the psychiatrist but also the psychologist and the social worker for service in a child-guidance clinic.<sup>12</sup>

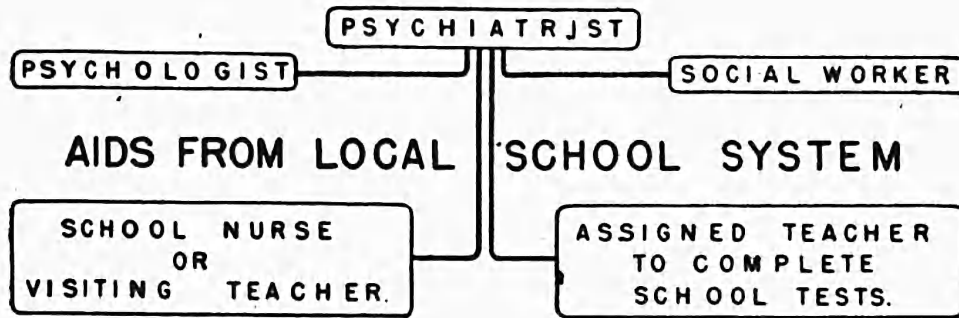
*Traveling school clinics.*—There are 15 psychiatric traveling school clinics in Massachusetts functioning under the division of mental deficiency, each of which operates from a given State hospital or school as a center and gives service directly to the schools in the surrounding territory. The responsibility of these clinics is primarily one of diagnosis and recommendation for educational placement of backward children, but other problems related to behavior or personality are increasingly demanding attention, and the scope of service rendered by the clinics is growing correspondingly broader. From 8,000 to 9,000 examinations are conducted annually in more than 200 different towns of the State, many of them of a distinctly rural character. The personnel participating in the program, on either a full-time or a part-time basis, in the year 1936-37 consisted of 20 psychiatrists, 29 psychologists or psychometrists, and 16 social workers, with the addition of the social-service staff of one of the hospitals. The total cost to the State of the operation of the clinics during that year was \$46,255.40, the average cost per examination being \$5.56.

To supplement the services provided by the State for the traveling school clinics, the local school system assigns two members of its own staff to work with the clinic. These are (1) either a school nurse or a visiting teacher, who assists in preparing the history of the child and in making contacts with the parents; and (2) a teacher who gives the educational tests requested by the clinic. Sometimes the school physician is also a member of the clinical group, and some of the larger towns furnish psychological service as well. All forms to be filled in are furnished by the State department. Through a well-organized program scheduled in advance of the clinic's coming and providing the needed preparation for its visit, an effective service is built up. The final recommendations of the psychiatrist, who is in charge of the clinic, consider educational, social, and physical adjustments that should be made, and action on the case is left with the school authorities and the parents.

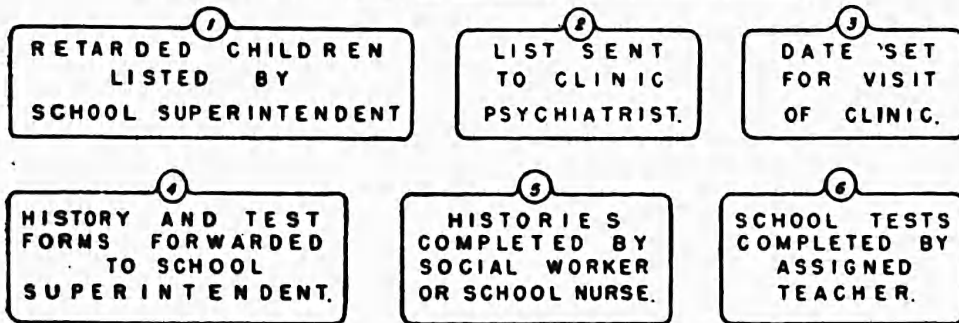
<sup>12</sup> Standards of training of professional personnel in psychiatric clinics. Recommendations of a study by the New York City Committee on Mental Hygiene of the State Charities Aid Association and the Mental Hygiene Section of the Welfare Council of New York City. 14 p.



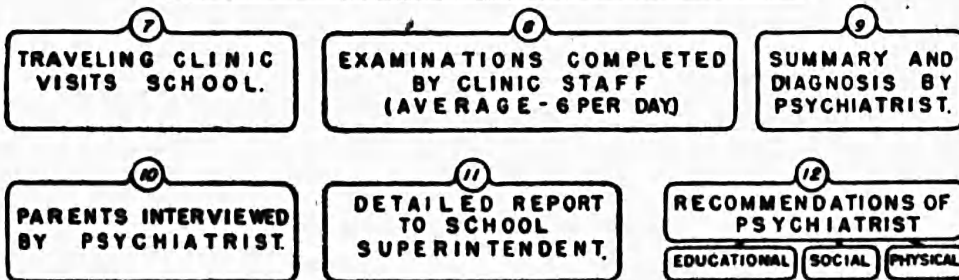
PERSONNEL OF TRAVELING SCHOOL CLINIC



PRELIMINARY PROCEDURE



FINAL PROCEDURE



CHARTS SHOWING PERSONNEL AND PROCEDURE OF TRAVELING SCHOOL CLINICS IN MASSACHUSETTS.

Reproduced by courtesy of the Massachusetts State Department of Education and the Massachusetts State Department of Mental Diseases.

These traveling school clinics are the outgrowth of a plan of cooperation, recognized by law, between the State department of education and the State department of mental diseases. They have been developed in such a way as to meet the varying needs of the school systems involved and have proved a definite stimulus to the organization of special classes for retarded pupils throughout the State. Because their contact with each child is limited in most cases to a single interview in the course of a year, their work with behavior problems must necessarily be less intensive than that carried on by the habit clinics or the child-guidance clinics of the separate hospitals. On the other hand, they are reaching a much larger territory, and for problems of mental retardation not seriously complicated with behavior difficulties a single interview with diagnosis and recommendations is usually all that is needed. There is no doubt that the service thus rendered to rural districts and small towns can be of immeasurable value in preventing the social maladjustment that so often results from school failure.

*Local attitude toward the clinics.*—The school people in Massachusetts have come to look upon the clinics—particularly the traveling school clinics—as a part of the total program provided by the State for the adjustment of the problems of school children. Most of those who have commented upon the plan believe that the cooperative arrangement is on the whole satisfactory. They point out that the clinic “brings a wealth of suggestions from other communities” which it has visited; that parents look upon it as an impartial agency coming from without the immediate community and that they are repeatedly seeking the help it can give. Certain reservations are made, however, and these refer primarily to the limitations of service available and to the inadequate understanding, on the part of some of the visiting clinical staff, of the local educational situation. “Too limited a clinical force,” “needed improvement in extent and quality of service,” “infrequent contacts,” “too little follow-up,” and “impractical recommendations of the psychiatrist” are some of the observations made. One school administrator feels that the psychiatrists in some hospitals “can do a great deal of harm.” This statement bears upon the matter already discussed with regard to desirable qualifications of psychiatrists assigned to work with children. As Stevenson points out <sup>14</sup>—

One of the most important determinations of a successful State program is its personnel. Proficiency in child psychiatry is not a byproduct of hospital psychiatry, although this is important as a foundation. More and more, as we critically evaluate our training for this field, are we finding it necessary to strengthen certain aspects—a general knowledge of child

<sup>14</sup> Stevenson, George R. Op. cit., p. 34.

development, a knowledge of community functions and how communities are organized to perform the functions particularly of education, protection, health and welfare, how they affect child behavior, and how to collaborate with them. Knowing the difference between common-sense advice and a specific psychiatric knowledge of therapeutic procedures with children, appreciating the need for joint effort on cases with psychologists and psychiatric social workers, a knowledge of standards of personnel and training in these fields is all-important to clinic staff in understanding their functions.

#### THE OREGON PLAN<sup>15</sup>

In Oregon a State child-guidance clinic has been developed, with the medical school of the University of Oregon as the nucleus of clinical activities which extend through traveling units into various sections of the State. Members of the faculty of the department of psychiatry in the medical school comprise the medical staff of the central unit, direct the organization of local units, and offer the necessary psychiatric service. In 1938 the State Legislature made an appropriation of \$12,000 per year to the medical school to be applied toward the expenses involved in carrying on the program which had hitherto been operating without any special State aid. As a result some extension of service became possible. In May of that year it was reported that "10 clinic units have been established and 5 more will probably be instituted at the beginning of the new school year."<sup>16</sup> All units have been established as a result of interest coming from within the community rather than as an imposition of service from without.

In addition to the psychiatric assistance provided by the medical school, the central unit furnishes also the social services necessary to maintain contacts with the local units. The local district is expected to make available the time of educational, social, and health workers needed to complete the clinical service for both diagnosis and treatment. It is thought, however, that the cost of operating the local units can to a large extent be met through mobilization of the facilities already available from various types of agencies within the district. The general plan of organization and functional relationships is shown by the chart on page 17.

The leaders in this program of work place great stress upon the need of cooperation and coordination of services. It is held that—

Child guidance is so closely related to the general fields of medicine, education, social work, health, law enforcement, and general community welfare that the problem of broad cooperation, both local and State, is acute. It is vital to the existence of such a plan that no single agency, representa-

<sup>15</sup> Information concerning the Oregon plan has been secured from (1) reports of the University of Oregon Medical School; (2) correspondence.

<sup>16</sup> The Oregon child-guidance program. *The commonwealth review*, 20: 475-486, May 1938.

tive of only one of these fields be responsible for its operation. The maintenance of this principle has been difficult in some instances. In some cases, community strife among those responsible in the various agencies has delayed initiation of the plan. In most cities, however, this problem has not been serious.<sup>17</sup>

It is also emphasized that—

Proper coordination of centralized State agencies is essential. Inasmuch as most local service is directed from State agencies, it is necessary that overlapping and misunderstanding be avoided by coordinated State planning. The main problem encountered in this respect was the lack of understanding on the part of the child-guidance clinic staff of the organization and operation of other State agencies.<sup>18</sup>

In at least one county of the State, the child-guidance program is conceived as an essential part of a good public-health program. It is pointed out that "the functions of a county public-health unit would be deficient if a program for the benefit of a problem child were not included. Likewise, a guidance service would seem incomplete if it did not make use of a health unit functioning in the same area."<sup>19</sup> From this county it is reported that—

The traveling child-guidance clinics are filling a very definite need in the community. This need has been recognized by the local medical society, the school superintendents, and the local health unit. Cases that previously had been neglected, because of lack of qualified assistance in the community, now are seen early enough to prevent complications which later might lead the child into the juvenile court. We are learning to recognize abnormalities in their early form, which previously had been allowed to develop into sometimes serious conditions. The relationship of the child-guidance clinic to the county health unit in Wasco County is one of mutual cooperation for the betterment of the health of the children of the community.<sup>20</sup>

#### THE CALIFORNIA PLAN<sup>21</sup>

The nucleus of the Massachusetts and the Oregon plans is the provision of psychiatric clinical service, in the form of either outpatient or traveling units, emanating from State institutions. The California plan has developed somewhat differently, although in the beginning it, too, was characterized by the organization of a full-time traveling clinical unit, the personnel of which consisted of a psychiatrist, a clinical psychologist, and one or two psychiatric social workers. Part-time units were later established (in 1931) with the cooperation of State institutions; but with a drastic curtailment of the budget 2 years later, all but one of the clinical units had to be abandoned and another medium of development sought. How-

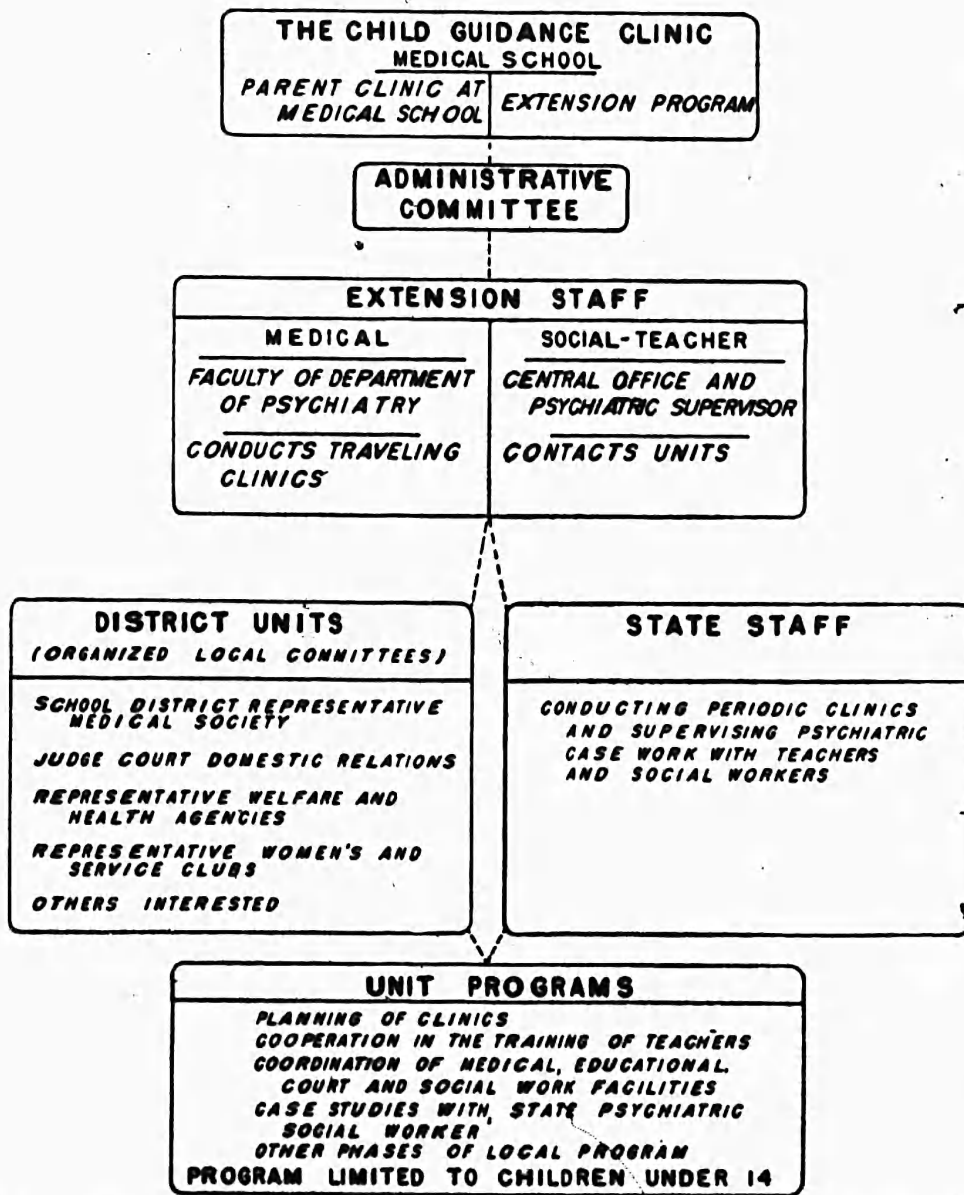
<sup>17</sup> *Ibid.*, p. 476.

<sup>18</sup> *Ibid.*, p. 482.

<sup>19</sup> *Ibid.*, p. 483.

<sup>20</sup> Information on the California plan has been secured from reports of the (1) State Bureau of Juvenile Research; (2) inquiry forms sent to local school systems; and (3) correspondence and conference.

**STATE CHILD GUIDANCE CLINIC PROGRAM**  
**UNIVERSITY OF OREGON MEDICAL SCHOOL**



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ever, the work already done in many communities served as a demonstration of child-guidance procedures which has been of significant value in further progress.

The State agency sponsoring the clinical service in California is the bureau of juvenile research, a division of the State department of institutions. It is the conviction of the director of the bureau that "any community can improve its facilities for child guidance," regardless of restrictions of budget. The bureau has devoted its resources to the demonstration of practical ways in which this can be accomplished. It holds that "although child guidance has come to signify, in the narrow sense, professional interest in the mental health of childhood and youth, it should, in the larger sense, designate the interests of all workers in the personality development of children and adolescents."<sup>21</sup> Two features in the program have accordingly been given special emphasis. The first is the education of the teacher in capitalizing, in the interests of the mental health of her pupils, her day-by-day contacts with them. The second is the need of active cooperation on the part of all in the school and community who are concerned with the individual pupil and his problem.

As a result of the continuing emphasis placed upon these two features, there has evolved in California what is known as "the child-guidance conference plan." This is "essentially the gathering together of a group of school officials for the systematic and thoughtful study of a maladjusted child. It follows the general form of the child-guidance clinic, but it is adapted to the facilities of each particular school or institution."<sup>22</sup>

This means in short: Use what is at hand in the most effective way possible. If a psychiatrist is not available in a particular school situation, someone else may lead in the analysis of cases that come up for consideration at the conferences held from week to week or from month to month. It may be the school principal, a visiting teacher or psychiatric social worker, a clinical psychologist, an attendance supervisor, or a school counselor, depending upon the training and aptitude of the respective persons. If available, a private practitioner may be called in on specific cases to give psychiatric advice. Often representatives of community agencies have a contribution to make. The teacher or teachers of a given child are always present when his case is being discussed. The constant factor of the child-guidance conference is the sympathetic and intelligent participation of everybody concerned with the child and his adjustment.

After the curtailment of funds made it impossible to maintain the traveling clinical services of the State bureau of juvenile research,

<sup>21</sup> Fenton, Norman. *State child guidance service in California communities*. Sacramento, Calif., the supervisor of documents, 1933. P. XII.

<sup>22</sup> *Ibid.*, p. 83.

and when practical necessity forced the development of a less expensive technique, the child-guidance conference plan became the heart of clinical activity in the local school systems of the State. Encouragement and assistance in the organization of child guidance conferences have thus been accepted as one of the major functions of the bureau of juvenile research. Now "the ultimate objective of the Bureau program is the development of local facilities for child guidance rather than the establishment of a State-wide network of clinic units."<sup>21</sup>

Concerning the effectiveness of the plan, the director of the bureau writes:

Sufficient trial has been given to the child guidance conference in a variety of school and community conditions to indicate that under adequate leadership it is a valuable method and an efficient administrative device. Timely, also, is the recognition of the fact that it costs very little to introduce the child guidance conference, making unnecessary the disturbing alternative of waiting for years because school boards continue to consider the child guidance clinic, visiting teachers, or psychologists too expensive to add to the budget.<sup>22</sup>

In over 200 communities in California the initial demonstration of the child-guidance conference has been directed by clinical psychologists of the California Bureau of Juvenile Research. After this demonstration many of the schools with adequate leadership and interest have been able to continue the plan under the direction of some person in their own group. In other States, where no such bureau exists, the procedure could be demonstrated initially by clinical psychologists who might be members of university faculties, personnel of the State department of education, or other persons trained in child psychiatry, clinical psychology, or psychiatric social work.<sup>23</sup>

How the plan functions on a county-wide basis is described in the case of Ventura County, on page 22. The plan of organization in a small city (Santa Barbara) is discussed on page 26. In both of these cases it is evident that the school system itself is the center of clinical activity and that, lacking the more highly specialized facilities deemed necessary for a medically recognized child-guidance clinic, it can still make effective use of the limited resources at its disposal.

#### **THE MARYLAND STATE PROGRAM ORGANIZED ON A COUNTY BASIS<sup>24</sup>**

In the State of Maryland there are 23 counties, which, with the exception of Baltimore County, are largely rural in character. Extensive child-guidance service is available in Baltimore in connection

<sup>21</sup> Ibid., p. 9.

<sup>22</sup> Ibid., p. 83.

<sup>23</sup> Ibid., p. 87.

<sup>24</sup> Information on the Maryland program was secured from the bureau of child hygiene of the State department of health and from school officials participating in it.

with Johns Hopkins University Hospital and the city-school system, but in the rest of the State there are few clinical resources upon which the schools can draw. Recognizing this fact, a group of psychiatrists representing both State and private agencies have developed a plan for meeting the need on the basis of county organization. The bureau of child hygiene in the State department of health is the official State agency sponsoring the program, and psychiatrists from various public and private institutions of the State donate their services in conducting mental hygiene clinics.

The State is divided into districts, each district consisting of one or more counties. The number of clinics per year scheduled for each district varies according to circumstances. In 1936, 63 clinics were held in 19 counties and were conducted by 13 psychiatrists and their assistants. The average number of patients seen per county was 25, and the total for the year was 469, of whom 321 were between the ages of 6 and 15, a large majority of them being referred by school teachers.

County superintendents of schools and county health officers welcomed the coming of the clinics as the realization of a long-felt need. Since all service given is on a voluntary basis or is furnished by the institution with which the psychiatrist is immediately connected, no expense is incurred by the school system. One county superintendent writes of the program as it relates to the schools in his county, which is strictly rural:<sup>27</sup>

When a "problem" develops, it is time for someone to get busy and start studying not the problem but the situation that caused the problem. Of course, the "problem" will need to be readjusted and helped. I hold to the thesis that an "ounce of prevention is worth a pound of cure," and, as school administrators, it is our job to see that our schools are so organized that "problems" are reduced to a minimum.

These problems are "picked up" or reported to our supervisors and attendance worker. Then one of several things may follow:

1. In some cases the child's school program is changed—home economics or industrial arts is added—content subjects dropped. Here one must have complete understanding among the teachers as to the pupils' difficulties. This is especially effective for over-age pupils.

2. The child may be placed in a special group for temporary remedial work or for a continued program adjusted to his individual needs.

3. A child may be examined at one of our regular monthly clinics.

The parents are always interviewed and, whenever possible, attend the clinic. A trained psychiatrist is present and the Binet test is given. A conference is held at the end of the day by the classroom teacher, principal, and supervisor with the psychiatrist, and recommendations given are carefully considered. Treatment follows according to the psychiatrist's recommendation.

<sup>27</sup> Statement reproduced by courtesy of Raymond S. Hyson, county superintendent, Carroll County, Md., from paper given at meeting of department of rural education, of the National Education Association, held in Cleveland in February 1939.



The growth of the program since 1936 is evident from the fact that in 1938 the number of patients seen was 901, of whom 760 represented new cases of children under 21 years of age. The referring agencies during that year, in the order of the number of cases referred, were: The schools, social agencies, health officer or nurse, parents or relatives, courts, and private physicians. Both failure in school and conduct or personality difficulties are major reasons for referral, and a school adjustment program has a prominent place among the types of treatment recommended.

#### *A TAX-SUPPORTED COUNTY GUIDANCE CLINIC*<sup>26</sup>

The Milwaukee (Wis.) County Guidance Clinic was established by the county board of supervisors in 1926 as a tax-supported organization reporting directly to the manager of county institutions. The staff of the clinic consists of two psychiatrists, one of whom acts as director, two psychologists, three psychiatric social workers, and three office assistants. All of these persons hold their positions under civil service and are chosen by competitive examination.

Although the clinic was founded as a general mental hygiene agency designed to serve both children and adults, it is reported that from 75 to 80 percent of the cases seen are children. Referrals come from a variety of sources, including the juvenile court, social agencies, medical agencies, and the schools. The problems referred by the schools relate to disciplinary difficulties, retardation, over-activity, extreme shyness, and withdrawn personalities. The comprehensiveness of the examination and of the treatment given depends to a large extent upon the type of problem involved.

In order that adequate study may be made of each patient in accordance with his needs, the number of new cases is strictly limited to about 20 per week. "Most patients are seen on what is primarily a consultative basis, with recommendations for treatment being made by the clinic and reported to the referring agency. Only a small proportion are carried for treatment by staff members." Consultation with school officials from time to time regarding the progress of a child sent to the clinic helps the clinical staff to evaluate its recommendations and to suggest possible new directions of treatment.

From a city-school system utilizing the services of this clinic comes the statement that "all types of maladjustments requiring psychological or psychiatric treatment may be considered for clinical attention. A regular application blank is filled in and an appointment is made. At least one parent attends the clinical conference with the child. A staff conference on the case is held on the same day and a

<sup>26</sup> Information concerning the Milwaukee County Guidance Clinic was furnished by its director and by school officials using the services of the clinic.

report of the case is received by the school a day or two later." This school system considers the assistance rendered by the clinic as most valuable in guiding and carrying out remedial measures for individual cases. The limited time available to each school system, however, and the consequent necessary delay in securing appointments are considered a hindrance to the realization of the most effective service to the schools.

#### *A COUNTY PROGRAM IN CALIFORNIA\**

On a different basis, but with the same ultimate objective, have been developed several county programs in California. These follow the general principles of the child-guidance conference plan in that State, as already described. The program in one county is cited as illustrative of what can be done without a highly developed clinical organization and its attendant cost.

The county seat of Ventura County, Calif., is Ventura, a city of about 12,000 inhabitants. This is the largest city in the county and there are only two others with a population of 5,000 or more. The educational system of the county includes rural schools of varying sizes, city elementary and secondary schools, and a junior college. On the staff of the county superintendent of schools is a supervisor of child welfare, guidance, and attendance, who has had psychological training and whose responsibilities are indicated by his title. They include (1) child accounting, (2) supervision of child welfare problems, (3) formulation and evaluation of guidance plans, (4) supervision of testing and adjustment of individual problem cases.

With the assistance of the State bureau of juvenile research, steps have been taken in Ventura County to develop to the utmost the service of the child guidance conference, as described on pages 16 to 19 of this bulletin. The county superintendent took the first step by announcing the availability of the service through his bulletins and by inviting schools wishing to make use of it to send in requests. The schools which responded to this initial invitation were used as the first clinical centers. For the county as a whole a steering committee of teachers and administrators was named, representing all levels of education in the county, and it in turn appointed a subcommittee to study the problems at hand and to advise with the supervisor of guidance.

The office of the principal of each school serves as a clearing house for all cases referred to the child-guidance conference, which is usually attended by the principal, classroom teacher, psychologist or guidance supervisor, and nurse. A State hospital located in the county sup-

\* Information on the Ventura County program was secured from the county supervisor of child welfare, guidance, and attendance, and from a description of the program published in the *California Journal of Elementary Education*, 7: 60-64, August 1933.

plies psychiatric service as needed. Community agencies cooperate by furnishing information, referring cases, and giving assistance in adjustment. A follow-up program is outlined for each case, and a time is set for evaluating the results of the measures tried. The supervisor of guidance is charged with the administration and arrangements of both the child-guidance conference and the follow-up.

Problems that have been considered at the periodic sessions of child-guidance conferences held in various school districts of the county fall into one of three general classes or some combination of these. The classifications are:

1. Failure to come up to expected standards of school work.
2. Antisocial or abnormal behavior which marks the child as "different."
3. Problems in which health appears impaired or hygiene questions are involved.

Since the organization and supervision of child-guidance conferences is only one of the responsibilities of the county supervisor of child welfare, guidance, and attendance, it is impossible to arrive at any figures of cost with respect to this particular phase of his work. The program serves as a clear example of how intimately the adjustment of behavior problems may be related to the total guidance activities of a school system.

#### *OTHER STATE AND COUNTY PLANS*

A number of other States and of counties within States have a central agency charged with certain types of clinical functions. In Connecticut there is the bureau of mental hygiene of the State department of health; in Illinois, the institute of juvenile research of the State department of social welfare; in Michigan, the State welfare department and the Michigan child guidance institute; in New Jersey, the State department of institutions and agencies; in New York, the division of prevention of the State department of mental hygiene; in Ohio, the bureau of juvenile research of the State department of public welfare; in Pennsylvania, the bureau of mental health of the State department of welfare; in Virginia, the bureau of mental hygiene of the State department of public welfare; and in Wisconsin, the division of prevention of the State department of mental hygiene.

In universities, too, one finds increasing evidence of the acceptance of responsibility for service to the communities about them. Reference is made in succeeding chapters to some of the plans under way in relation to city school systems, and others are being developed, as, for example, in the newly organized department of child guidance of the University of Minnesota Medical School.

County agencies furnishing the nucleus for a clinical program include welfare societies, health boards, juvenile courts, hospitals located within the county, and mental hygiene societies. Any one or any combination of these may operate with or without the assistance of the community chest. The tax-supported Milwaukee County Mental Hygiene Clinic has already been described. Essex County, N. J., has a juvenile clinic organized as a county community project which gives extension service to school districts within the county. In Rockland County, N. Y., is located the Rockland State Hospital, which functions under the State department of mental hygiene and cooperates with the Rockland County schools in caring for the mental health needs of the children. Clinics are held in schools which range in size from two to many rooms. Concerning their relationship with the schools, the director of the clinics writes:<sup>20</sup>

One cannot have intelligent working contact with educators without making an effort to acquire the current philosophies of education. Indeed it is futile to work in a school without becoming familiar with the educational procedures and problems. Failure to do this results in a general lack of sympathy and understanding. One cannot interpret a child's personality difficulty to a teacher unless the teacher's point of view is understood and to a certain extent shared. \* \* \* Certainly education is ready and willing for psychiatry and the need must be met with a plan of action which is not only scientific but practical.

Most of the programs under way are unfortunately suffering from a lack of adequate funds to make the specialized clinical service really State-wide or even county-wide in extent. What future developments will bring no one can foretell, but it is safe to say that every intelligent plan of attack upon the problem that is being made today will contribute something to the pattern of clinical service that will ultimately evolve. The most significant trend that has appeared to date is perhaps the fact that the adjustment of behavior problems is not considered the job of one or even of a few specialists but rather the joint responsibility of all persons and agencies having anything to do with the child in question. Closely coordinated effort capitalizing the knowledge and the abilities of each of these has demonstrated its worth as by far the most effective method of procedure. The important objective to be achieved is the utilization and the integration of all available forces—local, county, and State—for a clinical organization that will show results in the lives of children.

<sup>20</sup> Tallman, Frank F. Child guidance in schools. *Psychiatric quarterly*, 9: 436-457, July 1935.

## CHAPTER III

### THE RESOURCES OF SMALL CITIES <sup>31</sup>

What the State and county have to offer in clinical service is likely to have a significant influence upon the programs of small cities, most of which through their own budgets are unable to provide even a small amount of specialized assistance for the adjustment of behavior problems among the children of their schools. Some, however, have found a way to attack the problem at least in an elementary way, and others have forged ahead with a constructive clinical program, supplementing their own resources with those of State, county, or private foundation. Certain organization plans functioning in cities with a population of less than 50,000 <sup>32</sup> are described here as illustrative of present practices and trends in the smaller urban communities.

#### A CITY SERVICE

*Winnetka, Ill.*.—So far as is known, the only city in this population group employing for its school system a full-time psychiatrist is Winnetka, Ill. The approximately 13,000 inhabitants of this city show a range of economic status as wide as that of almost any other city of its size, but the distribution is somewhat skewed toward the upper end, with a larger proportion of people in comfortable circumstances than one would find in a typical community. The city provides both psychological and psychiatric services for the children enrolled in its schools. A psychiatrist is at the head of a department of educational counsel of the school system. He takes the leadership in case conferences and is responsible for following up the treatment as recommended. Problems may be referred to him by teacher, principal, or parent, and he is likewise open for conference with children who may wish to come to him. Of the nature of the clinical activities, he writes as follows:

The teacher always participates in case conferences. The psychiatrist confers with the teacher to advise in the handling of specific problems and to keep her informed of the progress he is making when working directly

<sup>31</sup> Except where otherwise indicated, all data reported in this chapter, including quoted statements, are taken from reports contributed in 1938 by local school officials to the Office of Education.

<sup>32</sup> All population figures used are as of estimates made by the Bureau of the Census in 1933.

with a case. In some instances the teacher may do all the work with the child and with his parents under the direction of the psychiatrist.

In addition, the psychiatrist works directly with parents and children for diagnostic purposes, both in order to gain a better understanding of the case himself and to give parents and children a better understanding of their own emotional problems bearing on the case. More time is spent with parents of preadolescent children than with the children themselves, because this is felt to be more effective in most instances. Types of problems handled are: Aggressive, troublesome behavior; shy, fearful, or a-social characteristics; special educational or subject-matter difficulties; and cases of mental retardation not accepted by parents.

Discussion periods in school are led by the psychiatrist on such subjects as mental hygiene, dreams, or insanity, when the teacher desires him to supplement discussion she has already had with her class. Parent groups likewise call upon the psychiatrist for consideration of problems in child development, and seminars are held with teachers on similar problems.

It is apparent that the heart of the clinical program in this city of 13,000 inhabitants is the education of parents and teachers in the application of the principles of mental hygiene to their relationships with children. Psychiatric service is recognized as of such importance that it is given a major place among needed school facilities, and the resources available are distributed accordingly. In the words of the Superintendent, "It is not so much a question of having resources as it is a recognition of the need of using the resources available for the most important services." With a qualified child-guidance specialist at the helm, there is no doubt that the results achieved from a program developed on this basis can be of untold value to everyone concerned.

*Santa Barbara, Calif.*—Applying the principles of the California plan to a local situation, we may cite as an example the city of Santa Barbara, which, with its 36,000 inhabitants, has organized in its school system a department of child guidance. The director of this department has had training in psychological and other aspects of child-guidance service apart from its psychiatric phases. Working in or in close cooperation with the guidance organization are: One full-time visiting counselor, who has special home-visiting duties; one school counselor for each of the 12 schools in the system, who has also part-time teaching responsibilities; one full-time and one part-time school physician. Several psychiatrists practicing in the community have volunteered help in difficult cases or furnish assistance through the courtesy of the county child welfare department. The child-guidance department of the school system works with all cases of maladjustment in the schools, including those relating to educational progress, personality, and behavior.

Child-guidance conferences are scheduled regularly (at least once a month) in each of the 12 elementary and secondary schools of the

city, at which the problems of individual children are considered. The principal of the school acts as chairman of the conference. Present also are the child's teacher or teachers, the school physician, the school counselor, the director of child guidance, and occasionally a family case worker, if the child is known to a social agency. In the high school the dean of girls and the boys' adviser are added to the group. The responsibility for following up the case is assigned at the conference to the individual who seems best suited to carry out the recommendations made.

Because of its suggestive value the following account of the specific procedure used in the Santa Barbara plan is given verbatim:<sup>23</sup>

The study of the individual child presents the most efficient means of discovering the mental health needs of children. An analysis of the problems of children is a sure indicator of the adequacy of the educational practices in use. It shows whether or not the school, the home, and the community are meeting the needs and interests of the child. While no one will deny that this method of study is the slowest, everyone must admit that it is the most certain to obtain the desired results in the long run.

A request for such a study may come from teacher, parent, some outside social agency, or from the child himself. Such a request is made as the result of maladjustment somewhere in the child's relations with others. As soon as a case is referred for study, it becomes the duty of the counselor to collect the social, physical, and school history, all of which necessitates some contacts with persons outside the school who are interested in the individual child. There must be a physical examination by the school physician, without cost, and only with the consent of the parent. The social history is obtained through home visits, through checking with any religious agencies with which the child or family is identified and with the social service exchange for information concerning the family background, as well as the record of the child. In addition to this, the interview with the child himself is most important. This is done by both the director and the counselor. This involves much time, as it usually requires a carefully planned technique to gain full confidence of the child and thus establish good rapport. A Binet test is always given, and such other tests as may be deemed necessary for the case under study. When all the data are gathered, the director conducts a conference which is attended by the counselor and all the teachers of the child. When all data are presented, suggestions are made by various members of the group. Out of this come physical, social, and educational recommendations. These recommendations are passed on to those who are to put them into operation. There is seldom a study made that the help of some outside organization is not enlisted.

The director of guidance reports that "the most significant value of our program is that it began with school personnel and is essentially part of an in-service program through which teachers may develop. We are feeling most optimistic at present, since a large percentage of cases show most unexpected improvement. Our chief

<sup>23</sup> Johnston, Olive S. Guidance as a factor in social interpretation. *Education*, 58: 603-607. June 1938.

lack is the usual lack of personnel. We could use several full-time visiting teachers to good advantage and hope to have some time a regular consulting psychiatrist."

#### CITY AND UNIVERSITY COOPERATION

*Eugene, Oreg.*—The plan of the University of Oregon Medical School has been described on pages 15 to 17. From Eugene, Oreg., a city of 20,000 inhabitants, comes a report of how the clinic functions in that community. The fact that the State University is located there makes the arrangement a very convenient one, but it is somewhat typical of what takes place in other small cities of the State.

Through the university medical school the State provides a psychiatrist for a period of 2 days every 2 months. Psychological service is given by the State University through its psychology department. The local board of education furnishes a full-time visiting teacher, part time of a social worker and nurse, while the superintendent of schools acts as director of the clinic. The psychiatrist's scheduled days for service to the local school system are set apart for clinical conferences, attended by the superintendent of schools, the university psychologist, the visiting teacher, social worker, nurse, and any local physician concerned with the particular case at hand. Sometimes the teacher, too, is brought into the case conference.

Concerning the general procedure used, the superintendent writes:

Applications for study of cases are referred from the schools to the superintendent's office and are then referred to the medical school of the University, where they are considered for acceptance or rejection. If accepted, they are returned with directions for any or all of the following: Psychometric examination, complete physical examination, complete social case history. The information requested may be secured by the visiting teacher, the school nurse, a part-time social worker, or the worker of the welfare agency. The doctors see the child with the parent, make recommendations, and the person who prepared the case record does the necessary follow-up work. \* \* \* Although the psychiatrists are sent from the medical school, and are supported by State funds, the clinic is entirely controlled by the local school district.

*Ann Arbor, Mich.*—Similar plans of organization are in operation in other university centers in which the university is equipped to provide the necessary specialized service. In Ann Arbor, for example, with a population of 28,000, the board of education has closely coordinated the work of its full-time school physician, a case worker known as the children's consultant, two nurses, a dental hygienist, a psychologist, and an attendance officer. The University of Michigan furnishes psychiatric service and psychological assistance. The Children's Center, a privately endowed clinical agency in Detroit, supplies additional psychiatric consultant service. The name given to



the entire organization is Perry Center, and it is an integral part of the public-school organization, with offices located in one of the public-school buildings.

In commenting upon the program, the children's consultant writes:

Perry Center is a program for a plan of cooperation of all the special service agents in the school; a plan for a growing concurrence of the school with the community agencies; a belief that the emphasis be placed on the mental hygiene of the group, that material be usable to the teacher and that he or she be educated through handling the adjustment of the individual to the group; and, lastly, a plan for the treatment, through interview and conference, of the individual problem which would interfere with a constructive parent-child or teacher-child relationship.

#### CITY AND COUNTY OR STATE COOPERATION

*Muskegon, Mich.*—Muskegon is a city of approximately 48,000 inhabitants. In it the Traverse City State Hospital has for some time held an out-patient clinic 2 days each month, using the facilities of a local hospital as its headquarters. In 1937, through provision made by the county board of supervisors, another day of clinic work was added in Muskegon, this third session being held in a local junior high school and being primarily reserved for school cases. The service rendered is for all schools in the county.

The clinical staff from the State hospital includes a psychiatrist, a psychologist, and a social worker. The assistant principal of the junior high school in which the clinic is held, a supervisor of school nurses, and two counselors of the school give service to the clinic as part of their regular work, particularly in connection with the referral and follow-up of cases. Teachers report maladjusted cases, and may be called upon to assist in making case records and in carrying out recommendations. Difficult home situations discovered in connection with clinic cases are referred to the local family service bureau, which was established in 1938 and is financed from community-chest funds.

It is reported from Muskegon that "there has been a very encouraging improvement in the attitude of teachers toward maladjusted cases. A mental-hygiene point of view is developing toward all pupils. We have received considerable help in dealing with individual cases." Again, however, comes the complaint that the time allotted for clinical service is inadequate to the need.

*Waltham, Mass.*—As an example of a local organization functioning in cooperation with the State program in Massachusetts, the plan of operation in Waltham, a city of 40,000 inhabitants, is presented. In this city is located the Metropolitan State Hospital, which in 1936, at the request of the Waltham public-school authorities, instituted a child-guidance clinic to serve not only Waltham but also the sur-

rounding districts. A local city hospital, which is the health center of the community, was chosen as the most desirable headquarters, offering both consultation and treatment facilities. The Metropolitan State Hospital provides psychological, psychiatric, and social service for a scheduled number of hours each week. The schools constitute only one of the referring agencies and cooperate in carrying out the recommendations of the clinic when they involve school procedures. The problems considered are primarily those related to behavior, the number of mentally deficient children seen being reduced to a minimum, since these are ordinarily handled by the traveling school clinics of the State.

The location of the source of clinic assistance (namely, the Metropolitan State Hospital) within the community which it serves makes it possible to maintain a certain flexibility of arrangement and to keep an open door for contacts between the clinical staff and the school people. Misunderstandings can thus be eliminated and a maximum amount of service given in the light of the time available. In his first annual report of the work of the clinic, the director of the Waltham Child Guidance Clinic says: <sup>24</sup>

It is the policy of the clinic to act both as a consultant and treatment agency, strengthening the capacity of other agencies, such as parents, parent-substitutes, schools, physicians, juvenile court, and social-welfare organizations, in carrying out guidance of children. The clinic has three main objectives. The first and primary objective is the study and treatment of problem children; the second objective is the training of personnel; and the third is the securing of data, which will give those interested in this problem better understanding of human problems, including the normal, the delinquent, and the abnormal.

#### A PLAN OF JOINT CITY SERVICE WITH COUNTY OR STATE COOPERATION

*Rock Island, Ill., and Moline, Ill.*—These are neighboring cities situated in the same county, with populations of approximately 38,000 and 32,000, respectively. An organization called a child-guidance conference,<sup>25</sup> supported by the community chest, serves the two cities and operates under a board of directors, membership on which is divided between them. Members from Rock Island are appointed by the central council of social agencies; those from Moline are appointed by the Red Cross. The professional staff furnished through local funds is supplemented by the East Moline State Hospital. A full-time psychiatric social worker takes a large responsibility for

<sup>24</sup> The Commonwealth of Massachusetts, Department of Mental Diseases. Annual report of the trustees of the Metropolitan State Hospital for the year ending November 30, 1936. P. 9.

<sup>25</sup> The difference should be noted between this organization and the child guidance conference plan adopted in California.

organizing the program of the conference, securing case histories, and following up the treatment given. Part-time psychological, psychiatric, and other medical services are furnished as needed. The school principals and the school nurses are the chief coordinating officials of the school system, while teachers assist in compiling case histories and in making recommended treatment effective so far as their own relationship to the case is concerned. Parents, too, are advised in the course of the clinical procedure.

Since the conference is a community rather than a school agency, its service is not limited to the school systems of the two cities, but it applies also to juvenile court and to welfare agencies. However, more than 40 percent of the cases considered are referred by the schools. School problems studied include those of antisocial behavior, subnormality, and educational maladjustment. The superintendent of schools in one of the cities writes:

Our clinic started without funds for maintenance but it is well established now with competent workers. It is too early to evaluate its success, but we feel that our present procedure will get valuable results. \* \* \* One city alone could not support this work, and even the two cities could not carry it on without the people at the State hospital.

He points out further that there are more cases to be considered than the conference can handle, but that, so far as facilities are available, the cooperative arrangement is very satisfactory.

*Champaign, Ill., and Urbana, Ill.*—In the same State one finds a somewhat different plan of cooperative service built up in two neighboring cities of 21,000 and 13,000 inhabitants, respectively. A joint program has been in operation in Champaign and Urbana since 1923, when the child guidance service of the family welfare society was organized, designed to serve the children of both communities as well as of the surrounding territory.

The clinical service is made possible largely through the State institute for juvenile research, which furnishes the psychiatric assistance. Through an arrangement made between the institute and the University of Illinois, situated at Urbana, the psychology department of that institution makes available the services of several of its graduate students. Case workers of the family welfare society carry on the necessary preliminary study and the follow-up of the cases presented.

Clinics are held on 2 days of each month from October to June. Agencies referring cases include not only the schools, but also the family welfare society, other social agencies, the court, physicians, and parents. Many of the children referred are seen repeatedly, others come only once or twice. It is reported that about 40 different children are seen in the course of the year.

This project is typical of the kind of program encouraged by the State institute for juvenile research, which operates a fully staffed parent clinic in Chicago and has been responsible for the establishment of 12 local community clinics in various sections of the State. The institute gives professional service to the local clinics as long as it seems necessary to do so, but its aim is to withdraw as soon as and to the extent to which the local community can provide specialized services.

#### *GENERAL COMMENTS ON SMALL CITY PROGRAMS*

The foregoing descriptions will perhaps suffice to give an idea of the varied possibilities of clinical organization for small cities. They should, of course, be considered in connection with the State and county plans already described in chapter II, from which it is difficult to divorce them if they involve extensive State or county cooperation. One distinguishing feature, however, should be noted. In a highly organized and unified State plan, as in Massachusetts, the whole program emanates from an official State agency and its activities in local communities are to a large degree directed by that agency. In most of the programs described in this chapter, on the other hand, the local district plays a much more prominent part in the organization and direction of the clinical service, looking only to the county or to the State for the supplementary aid which it cannot furnish from its own resources.

Any number of variations may be cited, but the general patterns followed are about the same as those here described. The dearth of adequate specialized assistance is common to most of them. The clinic that makes only infrequent visits to a given community can give diagnostic service but it cannot become intimately acquainted with the resources and limitations of the local school system, and because of this it is felt that the recommendations made often lack practical suggestiveness. One school official reports that "it is better than having no service at all but far less satisfactory than having a consulting psychiatrist on the school staff or a local clinic handling cases cooperatively." Another calls attention to the fact that the psychiatrist "seemed to feel that the application of scientific terms to cases was the same as solving the problems." Another says that "due to crowded conditions of appointment calendar, service is slow." Still another makes the comment: "In view of the fact that we cannot have our own staff, this clinic is of incalculable value in giving us expert advice on our most problematical cases. We could hardly do without it."

Admitting all the weaknesses and inadequacies of present arrangements, one is encouraged by the efforts being made to bring clinical

services to bear upon the guidance of children in the schools of small urban centers. The variability of organization plans and of agencies sponsoring them provides in itself a wholesome experience. The attack upon the problem of maladjustment among children is being made from all sides. Health specialists look upon it as a problem in the furtherance of mental health, welfare agencies look upon it as an opportunity for social service, educational specialists consider it a challenge to their programs of guidance. All of these groups are involved in an effective coordination of available resources.

Whatever the immediate affiliation or sponsorship of the clinical organization, its major purpose is recognized as service *for children*—and the one public agency which is concerned with all the children is the American school system. If child-guidance procedures are to influence school policies in a way that will redound to the mental health of all children and not merely serve as a device aimed to “cure” troublesome cases, it seems obvious that there must be between the clinic and the schools an unbroken line of the closest possible interrelationship. At one end a clinical staff understanding child guidance and the schools, at the other end an educational staff interested in mental hygiene and in applying its implications to school procedures, and the pathway between them kept always open for helpful intercourse—this would seem to promise much for clinical work of enduring value.

The organization of specialized clinical service as an intrinsic part of the school administrative plan would, of course, facilitate such a relationship, but it need not be considered the only prerequisite of success. The small city can use to the utmost all its own resources of health, education, and welfare, perhaps join with neighboring cities in order to multiply them effectively, and then supplement them further with those which the county or the State can contribute. It can thus confidently look forward to the possibility of developing a well-coordinated service which can still be centered in the educational program of the community, but which in any case will require a mutual understanding and cooperation on the part of all the agencies concerned with the development and security of children.

## CHAPTER IV

### PROGRAMS IN CITIES OF MODERATE SIZE <sup>36</sup>

In this chapter consideration is given to clinical programs organized in cities ranging in population from 50,000 to 200,000.<sup>37</sup> As one might expect, school systems in cities of this size have more resources within themselves and are less dependent upon State, county, or community agencies than those in the smaller urban centers discussed in chapter III. Particularly is this true of the psychological, physical, and social aspects of the program. For psychiatric services most of them still look outside of their own immediate ranks, although one finds in this respect, too, provision made increasingly by the school system itself.

The illustrative programs described here are arranged in three groups, on the basis of the source of psychiatric assistance, namely: (1) Those in which, as in many of the smaller cities already discussed, psychiatric service comes from the State; (2) those in which it is supplied by a community agency or private foundation; (3) those in which it is an inherent part of the schools' facilities. The common factor of all the programs described is an emphasis upon the guidance and adjustment function of the school through the clinical approach to the study and treatment of pupil problems.

#### PSYCHIATRIC SERVICE FROM THE STATE

*Erie, Pa.*—In this city, with a population of 118,000, there is in the school system a child study department, which is directed by a psychologist and in which is included a child guidance clinic for the study and adjustment of all types of pupil problems. It is reported that about 50 percent of these may be characterized as "behavior problems." The child study department is responsible also for the supervision of special schools and classes for handicapped children and for the administration of psychological examinations in the school system as a whole. Its staff consists of the psychologist-director; the supervisor of special education; two visiting teachers, one of whom

<sup>36</sup> Except where otherwise indicated, all data reported in this section, including quoted statements, are taken from reports contributed in 1933 by local school officials to the Office of Education.

<sup>37</sup> All population figures used are as of estimates made by the Bureau of the Census in 1933.

is assigned especially to the work of the Child Guidance Clinic; a secretary-assistant; and a stenographer.

From Warren State Hospital comes a psychiatrist for 2 days each month during the school year for the consideration of cases requiring his attention. This service is without cost to the school district. Cases of pupil maladjustment are referred by school principals or teachers, medical inspectors, school nurses, attendance workers, parents, family physicians, members of parent-teacher organizations, court probation officers, visiting nurses, county nurses, relatives, and by various social agencies.

The general procedure followed in bringing a school case to the attention of the psychiatrist is described in a report of the child study department in 1933:<sup>28</sup>

In the majority of cases the psychologist initiates the study of the problem. If the facts furnished by teachers, school records, and psychological examination warrant neuropsychiatric examination, the child is referred to the visiting teacher for the clinic, who sets about procuring a case history, compiled according to psychiatric standards. This means finding out everything about the child from all available sources. She secures from the parents a history of heredity, development from prenatal time to the present, physical illnesses, social adaptability, practical abilities outside of school, habits, and delinquencies. School agencies furnish records of scholarship, deportment, physical examinations, and general observations of teachers. The family physicians cooperate by furnishing records of their findings during various illnesses. The child is then given a place on the clinic schedule, usually to be brought in by one or both parents. Before seeing the child the clinic doctor reads the history prepared by the visiting teacher and the report of the psychologist. Then the neuropsychiatric examination is made, followed by an interview with the parent. After this an estimate of the child's difficulties is attempted from a medical and psychiatric viewpoint. The psychiatrist, visiting teacher, psychologist, parent, and sometimes others immediately interested discuss the problem, and an agreement is reached as to the best practical method of procedure. The clinic offers no medical treatment. Many of the children have serious physical troubles, and in all such cases the relatives are urged to seek the aid of the family physician. A copy of the psychiatrist's report is sent to the school principal, and if medical treatment is advised a copy is sent to the family physician. After the clinic examination the visiting teacher keeps in touch with the child, making note and keeping a record of his progress at school and at home and endeavoring to secure the fulfillment of the clinic recommendations.

Reporting for the year 1938-39, the visiting teacher for the child guidance clinic calls attention to one of the interesting elements of progress in its work, as follows:

The most outstanding feature in the progress of the child guidance clinic of the Erie public schools during the current year was the introduction of a

<sup>28</sup> School district of the city of Erie, Pa. Report of the child study department, 1933. P. 17.

special children's clinic room. This room was decorated by two students of the art classes at Tech High School. The walls are a soft light blue, with a frieze of brightly colored nursery rhyme pictures at the level of a small child's eye. The lower walls and woodwork are painted a pale yellow-cream color, giving an impression of brightness and expansiveness. The ceiling is a pale orange, reflecting a spirit of sunshine in the room. The entire coloring of the room gives one a feeling of restfulness and intimacy. Dr. Rosenzweig, clinic director, reports that both children and parents have been more responsive and more cooperative during the interviews since the clinic room has been in use. The children are eager to talk to the doctor and at times reluctant to leave the room, and the parents too have seemed more relaxed and free in their conversations with the psychiatrist. It is interesting to note that one of the boy artists who worked on the clinic room project was at one time a behavior problem in the schools. However, through the efforts of the child study department his talents were discovered and are being developed.

*Wilmington, Del.*—The director of special education and mental hygiene in this city of 107,000 inhabitants serves also in the same capacity the State of Delaware as a whole. The division of which he is in charge is responsible for the supervision and administration of all the special classes in the city and in the State, and also for assistance in the adjustment of pupil problems of various other kinds. Within the division is the psycho-educational clinic. The staff of the clinic includes, in addition to the director, one psychologist for the city of Wilmington, and it utilizes the medical inspectors, home visitors, and school nurses of the city.

The primary functions of the psycho-educational clinic are, as its name indicates, the study and adjustment of instructional problems and the promotion of the mental hygiene point of view in relation to classroom situations. Behavior cases sometimes find their way to the clinic, but serious difficulties of this kind are usually re-referred to the mental hygiene clinic of the Delaware State Hospital, which provides psychiatric, psychological, and social services in connection with the cases which it studies. Thus the two types of clinical programs supplement each other.

In pointing out the significant elements of the service given, the director of the department of special education and mental hygiene calls attention to the following items:

1. An attempt is made to adjust the work of the schools to the children's needs. This removes one cause of malbehavior.
2. An attempt is made in many cases to adjust the family and environmental situation.
3. Necessary physical treatment is provided in many cases, the results of which are reflected in the later psycho-physical adjustment.
4. Greater understanding of the child's condition on the part of the teacher brings an improved attitude toward the child.



## PSYCHIATRIC SERVICE FROM A COMMUNITY AGENCY

*Des Moines, Iowa.*—The department of pupil adjustment in the school system of this city of 145,000 inhabitants combines the services usually ascribed to a psychological clinic, an attendance department, and a department of special education. There are also five visiting teachers in the school system, three of whom are assigned to full-time work with behavior and attendance problems, while the other two give about half of their time to psychometric examinations. School medical service is likewise available.

The clinical examinations of the department of pupil adjustment are psychological rather than psychiatric in nature, the person in charge of the clinical work being a psychologist by training. Problems studied include, in addition to those of a purely educational type, school disciplinary cases, attendance irregularities, and a much smaller number of serious cases of delinquency. Clinical conferences are held as the need dictates and are attended by all concerned with the case, including principal, school counselor, teacher, and representatives of social agencies or court. Assignment for follow-up work is made by the psychologist in charge.

If cases are of such a type that they demand psychiatric treatment, they are referred for consultation or for permanent assignment to the mental health clinic, which is an agency supported by the community chest of Des Moines and which has the services of a part-time psychiatrist and a full-time psychologist. In such instances, a copy of all the information collected by the department of pupil adjustment is sent to the mental health clinic and a consultation of the members of the two agencies helps to determine further responsibilities in handling cases.

*Pasadena, Calif.*—Pasadena has a population of about 81,000. Its school clinical service is definitely centered in the guidance department, with cooperative relationships extending to numerous other agencies both within and without the school system. The director of guidance, assisted by one full-time psychologist, leads in the clinical study, while health specialists, attendance workers, school counselors, principals, and teachers all contribute to the consideration of the problem at hand. Parents, too, may participate in the clinical conferences.

The chart reproduced on page 39 shows rather comprehensively what special services Pasadena offers to unadjusted school children and what relationships obtain with agencies outside the school system. It is significant that school methods of adjustment, as listed on the chart, begin with a positive health and mental hygiene program

through classroom organization and pupil-teacher relationships, and that only when the school resources are exhausted is the case to be referred to the special service agencies of the guidance department and the child welfare department.

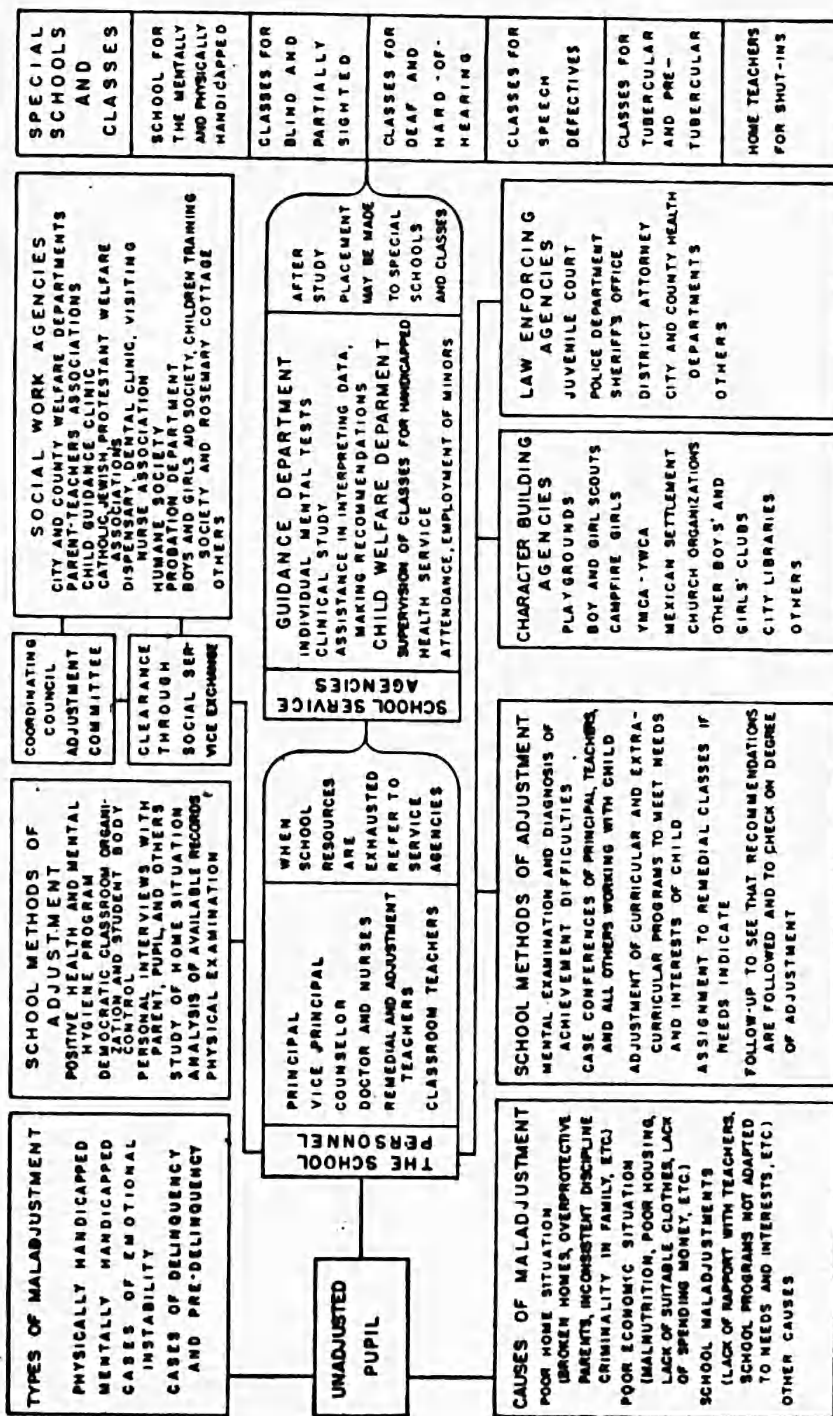
Important, too, is the position which the coordinating council-adjustment committee has in the scheme of work. This is a community group representing various social agencies which attempt to mobilize their resources for the interests of the individual child. Each case brought to the attention of the committee is cleared by way of the social service exchange, so that the maximum coordination of effort may be obtained.

Among the agencies listed on the chart is the child guidance clinic. This is an organization sponsored by the Southern California Society for Mental Hygiene and supported by the Los Angeles and Pasadena Community Chest. It serves both of these cities as a unit and does not limit its cases to school problems, but it accepts from the schools cases which appear to demand the psychiatric assistance which it is prepared to give. Thus again we find a community psychiatric clinic supplementing the psychoeducational clinical service which is an intrinsic part of the school program and which is intimately related to every other phase of the school activities affecting the lives of children.

*Niagara Falls, N. Y.*—Some cities have located in their midst a clinical service which is supported by a private foundation. Niagara Falls, with a population of 79,000, is one of these, looking to the child guidance clinic of the Martha H. Berman Foundation for the specialized services which are not available through the school system. The board of education employs one full-time psychologist, a full-time school physician, and a full-time visiting teacher. These in themselves constitute to a certain extent an effective clinical unit which meets once each week, together with representatives of any social agencies involved, to discuss problem cases. Teachers are likewise frequently invited to participate in staff conferences. The result has been a significant progress in the understanding and adjustment of pupil difficulties.

The Berman Foundation, through the child-guidance clinic, furnishes psychiatric help, as well as additional psychological and social services. The schools are only one of the referring agencies. Others contributing to the case load of the clinic are the welfare organizations of the city, the courts, parents, relatives, friends, and private physicians. In the year 1936-37, 155 new cases were studied, of which 55, or 36 percent, were referred by the schools. The cooperative arrangements between schools and clinic are reported to be very satisfactory.

# SPECIAL SERVICES AFFORDED THE UNADJUSTED SCHOOL CHILD OF THE PASADENA CITY SCHOOLS



Reproduced by courtesy of the Pasadena, Calif., Public Schools.

*PSYCHIATRIC SERVICE WITHIN THE SCHOOL SYSTEM*

*Gary, Ind.*—This city, with a population of 108,000, has within its school system an organized child-guidance clinic, the supervision of which is in the hands of the director of child welfare of the schools. A school psychologist gives about half of her time to clinical responsibilities; a school physician and school nurses serve the clinical cases when needed; and 11 school visitors cooperate in the social case work. A psychiatrist is employed by the board of education for 24 half days during the year, or the equivalent of 2 half-day clinical sessions each month.

Cases to be considered by the clinic are referred to the school psychologist by the schools, parents, court, family physician, or other interested persons. The psychologist, in turn, arranges for their presentation at clinical conferences, which are attended not only by the clinical specialists but also by principal, teacher, school visitor, school nurse, and social worker from an interested social agency. Follow-up work is assigned at the conference, and in this responsibility principals and teachers always play an important role through the adjustment of the school program to meet the child's needs. Environmental adjustments in the home or community are followed up by the school visitors and representatives of community social agencies.

*Long Beach, Calif.*—With a population of approximately 157,000, the city of Long Beach has organized within its school system a child-guidance clinic. This is under the direction of the "coordinator of curriculum and child welfare," whose responsibilities lie in the field of adjustment both with reference to pupil problems and to curricular adaptations in relation to the needs of pupils. In addition to the coordinator, the clinical staff includes one school psychologist who gives part time to clinical cases, the supervisor of health services, who is also a psychiatrist, and one full-time visiting teacher.

Clinical conferences are held once each week. Besides the regular clinical staff, the school supervisor of attendance, principal, teacher, and school counselor are present. Cases to be considered are referred through the visiting teacher by the schools or by community social workers with whom a cooperative relationship is maintained. The visiting teacher and the school counselor are responsible for following up the case after diagnosis and recommendations have been made. The teacher of the child in question assists in compiling school history and in making follow-up reports.

The service of the child-guidance clinic is reserved primarily for the study of cases presenting problems of behavior as distinct from those of an instructional nature, although it is realized that the two

types are closely interrelated. Approximately 100 cases are studied each year, but many of them do not receive full clinical attention. It is found that a large number of problems can be adjusted by the visiting teacher, either alone or with the assistance of one or more staff members.

In commenting upon the values and the difficulties of the clinical program, the coordinator points out the importance to the clinic of the information concerning the patient possessed by persons coming in contact with him (such as principals and teachers) who are not members of the clinical staff; also the importance to these persons, as they sit in with the clinic, of learning the techniques used in approaching problems of this character. It is likewise pointed out that there is danger of isolating the clinic in the school system, so that its effect upon school practice is not as great as it might be. The question is raised as to whether the major function of the clinic should be defined in terms of the number of cases to which it gives full clinic study or in terms of its educational influence upon practices in individual guidance. In Long Beach the attempt is made to realize both these functions in the clinical program.

*Berkeley, Calif.*—Since 1928, the city of Berkeley, with its population of 86,000, has supported within its school system a behavior research clinic, operating as part of its bureau of guidance, placement, and personnel. It is sponsored by the Berkeley Coordinating Council, which was the forerunner of a large number of similar councils organized throughout the State of California and in other parts of the country.<sup>20</sup>

Psychometric service for the clinic is provided by selected teachers who have been carefully trained in the technique of giving mental and educational tests. One full-time visiting teacher and the school counselors in all schools do the needed follow-up and case work. School health service is utilized for clinic cases when desirable. A pediatrician is employed by the board of education for 2 half days each week and a psychiatrist for 3 half days each week.

Clinic conferences are held on three mornings each week, either at a school or at the central administrative offices. The cases to be considered at a given conference are designated by the supervisor of guidance, placement, and personnel, to whom they have been previously referred by the school principals. A principal, a school counselor, or the visiting teacher acts as chairman of the conference; the psychiatrist and the pediatrician (when available) take a leading part; and the parent or guardian and the child's teacher are likewise

<sup>20</sup> For history and description of the work of coordinating councils, see Beam, Kenneth S. *Coordinating Councils in California*. Sacramento, Calif. State Printing Office, 1938. 54 p. (State of California, Department of Education Bulletin, 1938, No. 11.)

present whenever feasible. In any case the teacher is notified of the results of the conference and of the recommendations of the psychiatrist regarding the problem of a child in whom she is interested.

The behavior research clinic in Berkeley is primarily (but not exclusively) designed for the study and adjustment of serious behavior problems. A "serious behavior problem" is defined as "one which varies sufficiently from normal behavior to cause the teacher to feel that the child does not adjust satisfactorily to the group." Emphasis is placed upon the fact that such cases should include not only aggressive types of misdemeanor which disturb the discipline of the classroom but also emotional instability of any kind, exaggerated reticence or timidity, shut-in or depressed personality. If medical attention is needed, parents are advised to consult their own physicians for treatment. If family finances do not permit this, the pupil is referred to city agencies for free medical care. The case worker is also in touch with various other community agencies which give assistance in providing special diets, medicine, lunches, and other needed items.

The importance of clinical service in relation to the entire school program, with special reference to provisions for handicapped children, is indicated by the statement of the superintendent of schools in Berkeley:

There is no doubt that the public school should develop extensive use of the child-guidance clinic, where the psychiatrist, the pediatrician, and the psychologist may assist the teachers and the parents in understanding some of the more hidden and more subtle causes of maladjustment. The mentally retarded child or the child who has some physical or mental handicap is always more likely to be misunderstood; is always more likely to develop some complex or fear because of his inability to have an even break with other children of his own class and age. It is the business of the school to study the abilities and the limitations of each child. When these abilities and limitations are properly understood and properly met there will be less of the struggle that results in failure. The sense of failure and of inferiority in the child is one of the basic elements in causing social maladjustment which eventually, unless corrected, leads to delinquency and crime. If we are to reduce delinquency and crime, the public school must give important consideration to child-guidance clinics, using the best scientific training and scientific skill in helping parents and teachers to make early adjustments in the lives of children.

#### GENERAL COMMENTS

The general pattern of the local child-guidance clinic is evident from the foregoing descriptions of programs in city-school systems. In each of the school systems considered one finds health services, visiting-teacher or similar functions of a case-work type, and psychological, or at least psychometric, assignments. Psychiatric service is available at best only on part time within the school system,

and in most cases comes from a community agency outside the schools.

*Relation of the clinical staff to the rest of the school system.*—The clinical staff, exclusive of the psychiatrist, is rarely in cities of this size reserved for clinical cases only, but its members carry on their clinical duties as a part of their total responsibilities in the school system. Such an arrangement, necessitated in most cases by budgetary limitations, has both its advantages and its disadvantages. Because of the many other demands made upon them, the members of the clinical staff cannot isolate themselves from general school activities but must perforce become intimately acquainted with the educational program of the school system and its numerous possibilities for and hindrances to adjustment of pupil problems. This is conducive to more effective adjustment procedures. On the other hand, manifold demands for general service may become so pressing as to weaken the effectiveness of the clinical program. Unless sufficient time is definitely and regularly set aside for attention to clinical cases, both in conference and in follow-up service, the results are likely to be quite unsatisfactory. A weekly clinical conference would seem to be the minimum in cities of this size, with well-organized procedures of referral, clinical consideration, and follow-up. The intervals between conferences are obviously of great significance for the actual treatment of the cases in question, and, if the clinical recommendations are to be more than mere statements filed away on a case history, someone must be actively at work to see that they are followed out. The assignment of such responsibility must be definite and must allow for the time-consuming nature of the duties involved. No standards have been worked out to date designating the amount of time required by the various types of specialists participating in the clinical program, but the descriptions given in this chapter will give some indication of how much time is allowed. Almost unanimously comes the expressed desire for more time or for a larger staff.

*Functions of the clinic.*—Reference has been made to the question of the priority of functions of the clinic as they relate, on the one hand, to the adjustment of individual pupil problems and, on the other hand, to bringing about desirable changes in the educational program. It seems impossible to separate these in the concept of a completely functioning child-guidance clinic in the school system. The first is one of immediate responsibility; the second is one of ultimate value, the realization of which will in turn minimize—or at least greatly lessen—the need of the first.

The situation finds a close parallel in the provision of medical and health services for the body. The cure of physical ill health is impor-

tant, and its need will always be present; but the prevention of illness through health education is just as important. The modern physician aims to keep his patients well, and public-health agencies have the same objective for the community at large. So, too, the child-guidance clinic must affect educational practice in the interests of mental health for every child if it is to make its greatest contribution in adjustment measure for those whose mental health is endangered. The very fact that in most of the cities considered in this chapter the clinical activities are not limited to "behavior problems" as such, but include other difficulties related to the educational program indicates the closeness of the relationship. Moreover, the clinical staff, in being concerned with all phases of the educational program, has an advantage in carrying out the larger function of the clinic. Through the application of clinical ideals to all their contacts and activities, they can constitute a leaven through which the character of the entire school program is improved. Most essential, of course, are the soundness of their own point of view on educational matters, their own ability to understand people, and their own willingness to make reasonable adjustments in the light of the situation at hand.

*Coordination of services.*—Of growing significance in city programs such as those which have been described is the conscious effort made to coordinate all the services which the community has to offer either within or without the school system. The Berkeley Coordinating Council and the Pasadena Coordinating Council Adjustment Committee are typical of the form of organization which has been instrumental in many communities throughout the country in promoting the maximum use and the minimum duplication of existing facilities for the welfare of children. Even without the formal organization of such a body, there is apparent a marked effort to make all the forces of the community count for a well-integrated program of service, each agency contributing of its own resources to the total structure. Of the vital contributions which the schools can make to the entire program, not the least important is a well-organized clinical service for the adjustment of pupil problems.



## CHAPTER V

### THE OPPORTUNITY OF THE LARGE CITY <sup>40</sup>

There are 41 cities in the United States with a population of more than 200,000.<sup>41</sup> All but 4 of these report the availability of some clinical service, with psychiatric attendance, either within the school system or through a community agency not immediately connected with the schools. Twelve of these cities report psychiatric service as a definite part of the clinical program sponsored by the board of education. These are: Los Angeles, Calif.; Chicago, Ill.; Baltimore, Md.; Detroit, Mich.; Minneapolis, Minn.; Jersey City and Newark, N. J.; New York City, Rochester, and Syracuse, N. Y.; Portland, Oreg.; and Providence, R. I. Certain other cities have extensive psychological or child-guidance clinics of a nonpsychiatric type in the school system (as, for example, Cincinnati and Cleveland, Ohio; Philadelphia and Pittsburgh, Pa.; and Seattle, Wash.), but utilize for the most part extra-school psychiatric facilities; while practically all the cities in this population group provide through their school systems some psychological or social service in the interests of pupil adjustment.

Since the majority of the programs described in the previous chapters have been characterized by the utilization of community psychiatric services for the children in the schools, those discussed in this chapter, with one exception, will be limited to situations in which a child-guidance clinic with psychiatric service (or division with similar function) is set up and financed as a definite part of the school provisions. An account of the program in Portland, Oreg., is included because the public schools in this city constitute one of the official sponsoring agencies of the clinic, although not directly employing the psychiatric services.

#### *PROVIDENCE, R. I.*

(Population: 255,600)

In the department of research and guidance of the city school system of Providence there is a school clinic for children's problems,

<sup>40</sup> Except where otherwise indicated, all data reported in this section, including quoted statements, are taken from reports contributed in 1938 by local school officials to the Office of Education.

<sup>41</sup> All population figures used are as of estimates made by the Bureau of the Census in 1933.

under the immediate direction of an assistant in the department who is in charge of psychological examinations for the school system as a whole. Serving the clinic are three additional school psychologists, each devoting about one-third time to clinic cases; two full-time social case workers; and a psychiatrist for 8 hours each week. The school medical inspection and referrals to hospital clinics in the city are utilized as needed.

Clinic conferences are held twice each week, with the director, the psychiatrist, psychologist, and case worker attending. Sometimes the representative of an interested social agency also participates. The director of the clinic is responsible for receiving applications for clinical service and for bringing the cases to the attention of the clinic. A social worker or school counselor is usually charged with following up the case. A psychologist discusses the findings with the teacher of the child, and, if the case warrants, the case conference is held at the school where both teacher and principal can participate.

General comment on the work of the clinic is made by the director, as follows:

Types of cases considered may be divided into personality difficulties and conduct disorders. The former are of the neurotic type, while the latter involve overt behavior. In treating the latter, we work closely with the disciplinary department, as it is difficult at times to determine which department can deal with the child to best advantage at the time referred. In studying a case psychometric testing takes place first, school history is compiled, and personal traits analyzed. The interview with the parent comes next, with appointment for the psychiatrist. The visit to the psychiatrist is followed by a conference of all concerned. Each year close about one-third of our cases as making satisfactory progress, keep one-third on a semiactive list as in need of possible help, and carry over one-third as active for the next year. Of those whose names were on the semiactive list last year, only about 10 percent returned for further help. A few cases (five or six special ones each year) are referred to the Providence Child Guidance Clinic, sponsored by the Rhode Island Society of Mental Hygiene and the Community Chest, or to the clinic of the Rhode Island State Hospital.

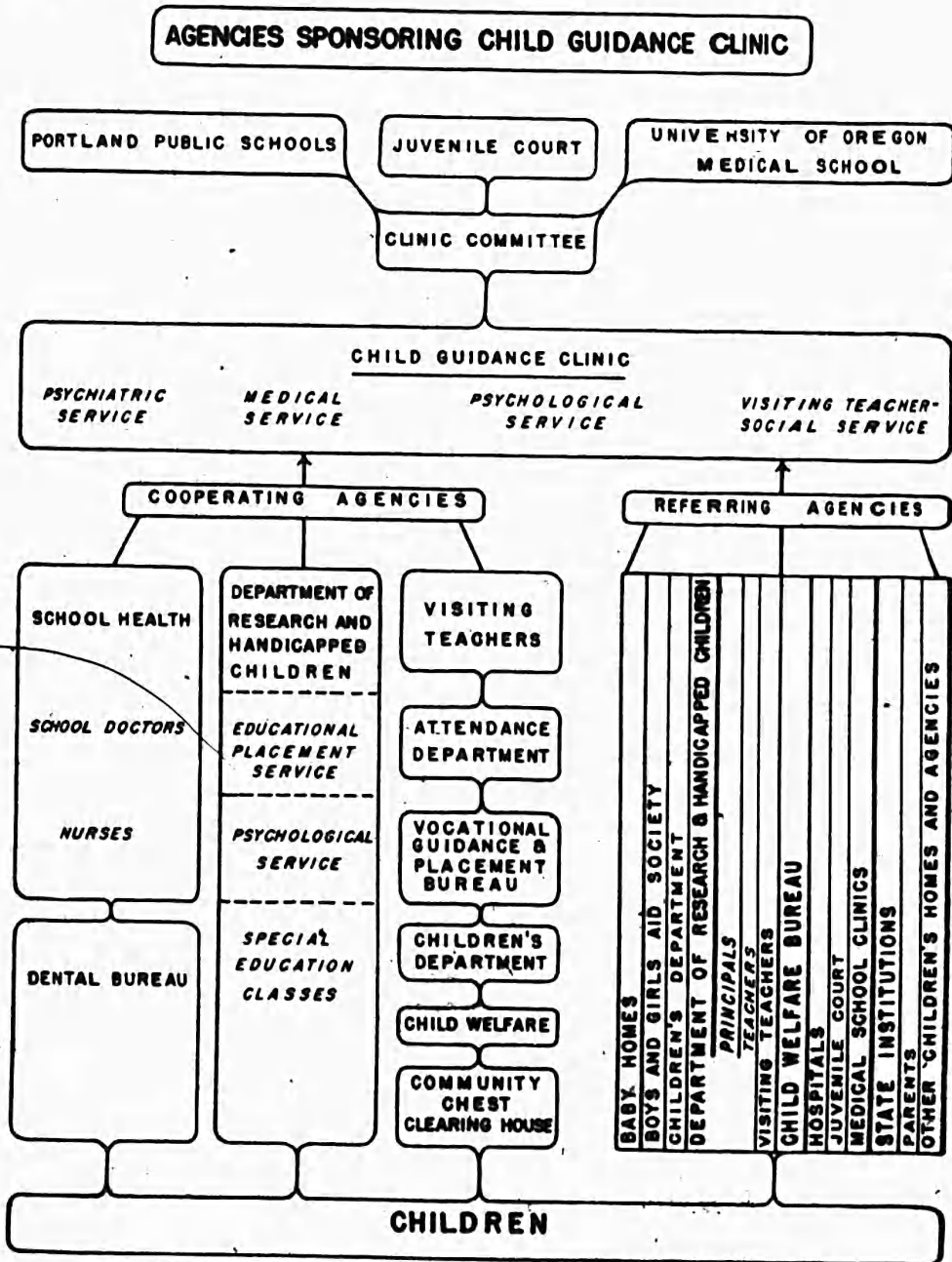
#### PORTLAND, OREG.

(Population: 309,100)

It has been pointed out how the Oregon plan functions in relation to a small city such as Eugene. It might be expected that a more highly organized program would exist in a city of the size of Portland, and this is evident from the chart of page 47. An interesting feature of the plan is the official joint sponsorship of the clinic by the Portland public schools, the juvenile court, and the University of Oregon medical school. The chart shows, in addition to these, the cooperating agencies and the referring agencies. The clinic is thus a

# CHILD GUIDANCE CLINIC ORGANIZATION

## PORTLAND, OREGON



Reproduced by courtesy of the Portland, Oreg., public schools.

real community project, in which the schools participate as one of the community agencies involved.

During a 4-year period of the clinic's work for which data are available, the schools referred about 50 percent of the cases studied, and two-thirds of these involved problems other than those produced by educational retardation. Significant is the fact that of the total number of cases referred during this period, 165, or 25 percent, were diagnosed as "recessive." This represents the highest frequency of any one diagnosis made, and it is indicative of the increasing recognition being given to the dangers to mental health of excessive timidity as well as of excessive aggressiveness.

Despite the successful operation of the clinic as a community project, its limitations are pointed out by the director of child study and special education for the Portland schools. He ascribes these limitations to the lack of adequate clinical time for the schools and to the lack of opportunity on the part of school people to work with the clinic on their own cases. To remedy this situation, he suggests the desirability of establishing within the school system a clinical service through which teachers and administrators may help in solving a problem through consultation with clinical specialists. He writes:<sup>12</sup>

Bringing the clinic into the school will bring it closer to the community through the teacher, principals, school nurses, parent-teacher organizations, as well as through the parents of the children served. This would develop a better understanding of the work being done and thus make possible the more adequate financial support needed for sufficient expansion of clinical facilities to provide for the needs of the community.

#### JERSEY CITY, N. J.

(Population: 319,900)

The general organization of the bureau of special service in the school system of Jersey City is depicted on page 49. The purpose of this bureau is "to handle all cases of juvenile maladjustment or delinquency within the school system." Its program is of particular interest because it not only coordinates the usual child-guidance services of a school system but brings into immediate relationship to them the services of one police inspector and five plain-clothes officers.

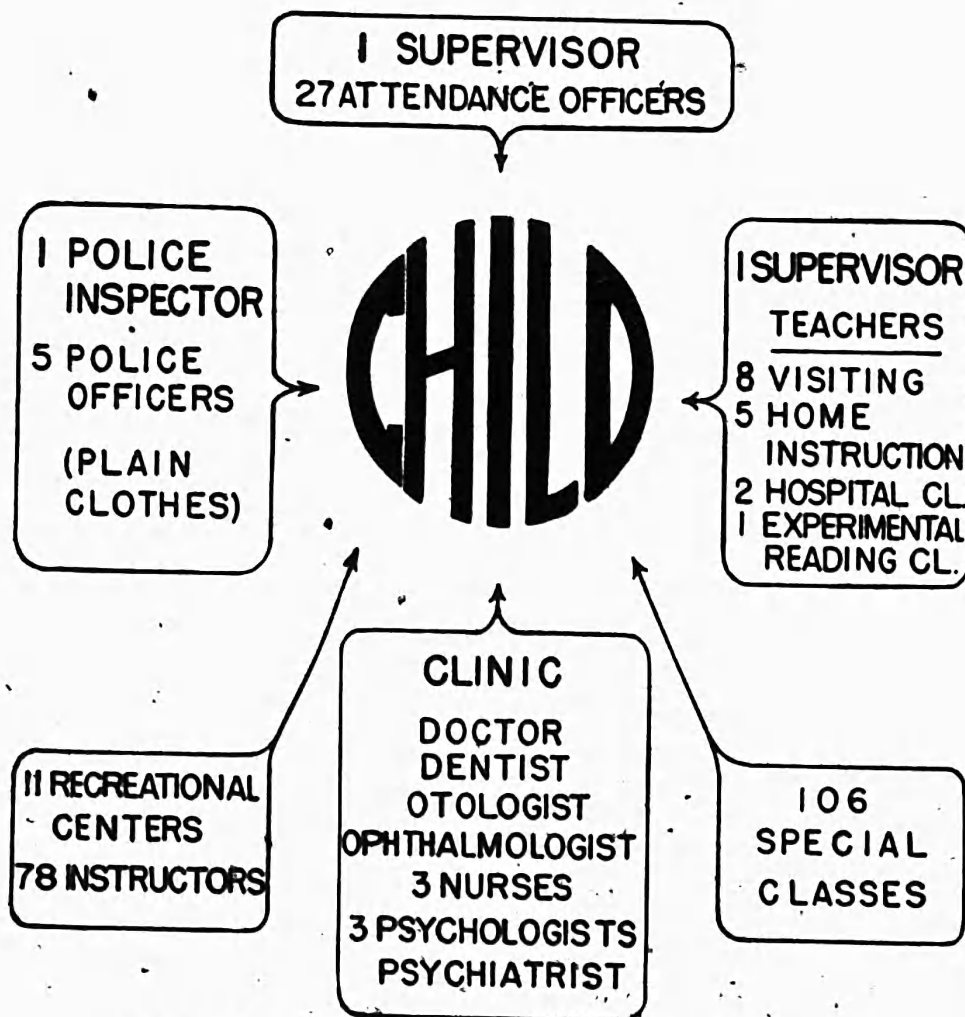
The following statement appears in a mimeographed report describing the work of the organization:

The thesis of this entire program is that every case of maladjustment has definite causal factors of a physical, mental, or environment nature which should be recognized and carefully considered before the child is insti-

<sup>12</sup> Martin, Lewis C. Organization of the child guidance clinic. *Journal of exceptional children*, 5: 212-216, May 1939.

# ORGANIZATION OF BUREAU OF SPECIAL SERVICE

BOARD OF EDUCATION, JERSEY CITY, N. J.  
UNDER THE SUPERVISION OF ASST. SUPT.



Reproduced by courtesy of the Jersey City, N. J., public schools.

tutionalized or held responsible in any other manner. The many sociological studies of recent years have served to point out the importance of environmental influences, of maladjusted home conditions, maladjustment within the school, as well as physical and mental maladjustment. Until the school has thoroughly investigated all of these potential influences and has attempted to understand the individual in the light of them, it has failed in its duty to the child and to society and must accept full responsibility for the failure rather than attempt to place it upon the child.

The procedure used in handling school problem cases is characterized as follows:

1. Children showing definite signs of abnormal physical or mental conditions are reported to the bureau of special service on special forms prepared for such reports. Accompanying this report is a complete statement of the school history on the permanent record card of the school system, as well as the analytical statement of personality traits, recreational habits and interests, and any special indications of maladjustment.

2. These cases are then referred to the visiting teachers for complete investigation of both home and school conditions. This record becomes a cumulative one by means of weekly follow-up visits by the visiting teachers.

3. All children are scheduled for complete clinical examination in the light of the information gained from school and home. Special attention is given to sensory defects due to the alarming number which have been found to escape detection by the classroom teachers.

4. Weekly conferences are held for the discussion of these cases in an attempt to formulate a well-rounded judgment of the proper way of handling each individual.

5. Recommendations are made to the superintendent of schools regarding the necessity for transferring children to the various special classes and schools. Further than this, recommendations are also made for the establishment of additional classes of a given type or additional types of classes.

For handling serious cases that demand police attention, the procedure is outlined as follows:

To replace the old system of allowing individual police officers to take boys to police stations or place them in correctional institutions pending action of the court, the following procedure in the handling of police cases has been established:

1. Whenever a child is detected committing some juvenile offense of sufficient importance to demand police attention, he is escorted to his home by the officer who secures the name, age, address, and school attended. The following day a complete report is made to the inspector of the police detail assigned to this bureau giving the above information together with the offense committed by the child.

2. Parents are notified to present themselves at the office of the bureau of special service accompanied by the child for a conference regarding the reported offense.

3. Complete statements are taken from parents and children regarding the family conditions, home life, and recreational habits of the child. They are given to understand that continuance of such offenses

will lead to serious difficulty and are advised in regard to the regulation of the children's habits along constructive lines.

4. All of these cases are given clinical examinations as those described for children reported by the school authorities, when they seem advisable, and the parents are advised in regard to necessary treatment.

5. Follow-up visits are made to the home and the school by plain-clothes officers who secure information regarding the child's activities until such time as there is sufficient evidence that there is no further need for this follow-up work.

6. In those cases where parents show the proper cooperation, and still the children continue to be delinquent, the child is taken before the juvenile court with a complete statement of the case and the desirability of a correctional institution is decided by the judge. This has been necessary in less than 10 percent of the cases which were formerly automatically referred to such a court.

It is pointed out in the report of the bureau of special service that one of the most important features of the entire program in Jersey City is the coordination of all public agencies in the interests of childhood. The school was chosen as the central agency "since it already had a large group of trained workers who were bound to be in close contact with the child for about one-third of his waking hours during the formative years of his life. In addition to this, the school system included in its personnel many of the experts needed to carry out the objectives of the program and could offer not only the guidance needed but the physical facilities for both educational and recreational activities. The added expense to the taxpayer has been negligible due to the existence of such facilities."

ROCHESTER, N. Y.

(Population: 333,500)

The functions of child study and special education in the school system of Rochester are combined in one department, with a director in charge. Besides the director, the central staff of the department consists of 1 assistant director for special education, 2 supervisors, 15 psychologists, 1 part-time psychiatrist, and 1 part-time otologist. An ophthalmologist's services are available upon request. Eighty-six teachers of special classes for handicapped children scattered throughout the city come under the supervision of this child study and special education department. The board of education also has a working relationship with the psychiatric division of the Strong Memorial Hospital, located in Rochester, to which cases needing such attention are referred for treatment after examination by the child-study department.

The functions of the department of child study and special education, as listed by the Rochester public schools, indicate how closely

the adjustment of behavior and personality problems is related to the diagnosis and adjustment of other types of pupil difficulties. These functions are as follows:

1. To diagnose learning difficulties of individual children and to suggest remedial treatment and grade placement.
2. To investigate causes of personality and social maladjustments; to plan for treatment in cooperation with other personnel workers; and to arrange for psychiatric interviews at child-study office, at health bureau, or in hospital clinics.
3. To help discover, through special tests, pupils with unusual ability in art, music, mechanics, and other special fields.
4. To examine all pupils by group intelligence tests at kindergarten, fourth-grade, seventh- or eighth-grade, and ninth-grade levels.
5. To advise in the organization of special groups for remedial or enrichment work and in the organization of ungraded and nonregents classes.
6. To organize and supervise special classes and schools for mentally handicapped children; to provide adapted instruction for children having defects of hearing, speech, and vision; to conduct audiometer surveys for hearing acuity at three grade levels; to conduct hospital and convalescent classes.
7. To arrange home tutoring as provided by the State for pupils exempt from school attendance.
8. To make contacts with agencies and State departments caring for physically and mentally handicapped children.
9. To maintain a file of case records.

There is a separate visiting teacher department in Rochester, with a director and 16 visiting teachers. These cooperate with the child-study department in furnishing case reports, but they also carry on their own social-case work with certain problems referred directly to them. Visiting teachers are assigned to serve specific schools, and accordingly many difficulties can be handled in the school without referral to the central office. The health and physical education department likewise cooperates through medical examinations and special health services for children referred for clinical treatment.

At the central office, a council of personnel services acts to coordinate activities in relation to any problems involving two or more departments, looking toward the realization of well-balanced and consistent treatment. This council also serves as a means of keeping each department informed of what other departments are doing. A complete diagram showing all agencies within the school system concerned with adjustment services is inserted.

*NEWARK, N. J.*

(Population: 447,000)

The director of the department of child guidance in the Newark public schools is a psychiatrist, and with him are associated three full-time psychologists, three full-time visiting teachers, and two



### VISITING TEACHER DEPARTMENT

#### STAFF

Director  
16 Visiting teachers  
1 Psychiatrist (part time)

#### FUNCTIONS

1. To plan and effect short or continued psychiatric social case work treatment in the interest of individual children who show deviations from the average in matters of personality and behavior.
2. To maintain home contacts for the school in cases where home conditions or parental attitudes do not favor satisfactory child development.
3. To co-operate with all accredited family, child welfare, and recreational agencies in the community.
4. To co-operate specifically with social agencies concerned with the prevention of delinquency and to plan with the Court and social agencies for the welfare of children who have become delinquent.
5. To secure in co-operation with the school nurse and the Health Education Department clinical assistance for individual children needing physical treatment, and to arrange for psychiatric treatment.
6. To supervise city, state, or federal relief as such relief applies to children of school age.
7. To give the counseling service of one staff member to children receiving scholarships from the Children's Memorial Scholarship Fund.
8. To maintain a file of case records of individuals studied.

### CHILD STUDY AND SPECIAL EDUCATION DEPARTMENT STAFF

Director  
Assistant director (Special Education)  
2 Supervisors  
15 Psychologists  
86 Special education teachers  
1 Psychiatrist (part time)  
1 Otologist (part time)

#### FUNCTIONS

1. To diagnose learning difficulties of individual children and to suggest remedial treatment and grade placement.
2. To investigate causes of personality and social maladjustments; to plan for treatment in co-operation with other personnel workers; and to arrange for psychiatric interviews at Child Study office, at Health Bureau, or in hospital clinics.
3. To discover through special tests pupils with unusual ability in art, music, and mechanics.
4. To examine all pupils by group intelligence tests at kindergarten, 4th grade, 7th or 8th grade, and 9th grade levels.
5. To advise in the organization of ungraded, opportunity, and non-regular classes.
6. To organize and supervise special classes and schools for mentally handicapped children; to provide adapted instruction for children having defects of hearing, speech, and vision; to conduct audiometer surveys for hearing acuity at three grade levels; to conduct hospital and convalescent classes.
7. To arrange home tutoring as provided by the state for pupils exempt from school attendance.
8. To make contacts with agencies and state departments caring for physically and mentally handicapped children.
9. To maintain a file of case records.

# CHILD SERVICES - ROCHESTER PUBLIC SCHOOLS

SUPERINTENDENT OF SCHOOLS

ASSISTANT SUPERINTENDENT OF SCHOOLS

CO-ORDINATOR OF CHILD SERVICES

## DEPARTMENT OF CO-ORDINATION AND RESEARCH

Director

### STAFF

**FUNCTIONS**  
CO-ORDINATION

1. To act as a conference center for the consideration of policies and cases in which all the child services should work as a unit.
2. To secure integrated action in projects involving two or more of the child services.

### RESEARCH

1. To prepare and distribute results of elementary school tests related to each center of interest in the curriculum.
2. To prepare with committees and to distribute tests for the eighth, ninth, and tenth grades of secondary schools in subjects where uniform city tests are desired.
3. To compile statistics of all city-wide tests and to send to each principal statistical studies of his own school.
4. To send to each elementary school principal for permanent record studies of the work of individual children.
5. To participate in curriculum building.
6. To conduct research studies related to the curriculum and to the child services.

## HEALTH AND PHYSICAL EDUCATION DEPARTMENT

As Its Functions in Relation to Individual Pupils

This column does not include the program of the Health and Physical Education Department as a whole, the report of which is made through the assistant superintendent of schools.

### STAFF

Director  
1 Associate director  
1 Assistant director  
100 Health teachers

### FUNCTIONS

1. To plan and direct corrective programs in physical education for children having remedial physical defects.
2. To discover children who are below par in vigor and to keep the school staff aware of the health needs of such children.
3. To aid the Attendance Department in securing school health supervision and modified activities for pupils returning to school after illness exemptions, in accordance with the advice of physicians.
4. To co-operate with the Child Study and Visiting Teacher Departments in securing home and school adjustments necessary to improve the vigor of pupils having health difficulties.
5. To work with community agencies in the health interests of individual cases.
6. To co-operate in retail activities relating to undernourished children or children needing glasses or school equipment related to the health of the individual.

## PARENT EDUCATION AND CHILD DEVELOPMENT DEPARTMENT

### STAFF

Specialist  
Teacher of parent education classes and supervisor of nursery schools  
Nursery school teacher and assistant

### FUNCTIONS

1. To stimulate individual parents to study the interests and needs of children of all ages and to work toward meeting these through the family, school, and community.
2. To conduct parent education groups under professional leadership for the study of childhood and family life.
3. To train discussion leaders for local parent education groups, church groups, or neighborhood organizations.
4. To conduct nursery schools as laboratories for parent education.
5. To offer counsel and educational information to parents of pre-school children.
6. To familiarize parents with the progress of present-day education and the ways in which they may co-operate with the school.
7. To make available to parents, teachers, and group leaders literature in the fields of child development and parent education.
8. To counsel students interested in working in nursery schools.

## ATTENDANCE DEPARTMENT

### STAFF

Director  
14 Attendance officers

### FUNCTIONS

1. To investigate cases of irregular attendance reported by the schools.
2. To aid in securing home conditions leading to regularity of attendance.
3. To hold hearings in persistent cases of irregularity of attendance.
4. To prepare and present in City Court cases where there is no parental co-operation in securing school attendance.
5. To issue work certificates.
6. To issue newboys' badges.
7. To take the school census by street census yearly and to maintain the correctness of census statistics by monthly reports from the schools.
8. To maintain a file of attendance cases.

## DEPARTMENT OF EDUCATIONAL AND VOCATIONAL GUIDANCE

### STAFF

Director  
Guidance counselors  
Co-operating with the counseling services of the secondary schools:  
Girl and boys' advisers  
Registration officers  
Department heads

### FUNCTIONS

1. To organize and direct a guidance counseling service in each school to assist pupils in formulating long-term educational and occupational plans.
2. To determine with heads of departments the possibilities of integrating guidance material with the courses of study in their respective fields and to develop this material.
3. To develop a close co-ordination with all other functional services of the school system which deal with pupil personnel.
4. To maintain cumulative records embodying psychological, physiological, and sociological information and personality factors essential to guiding individuals in educational and occupational plans.
5. To co-operate with existing agencies in securing employment and in maintaining a follow-up service for all drop-outs and all graduates of secondary schools.
6. To catalog material containing authentic information for use in guidance.
7. To develop basic courses of study for group guidance instruction and to publish professional and occupational guidance bulletins.
8. To maintain files of occupational and educational information in each school guidance department.
9. To sponsor and direct a program for the improvement of counseling methods.
10. To study local educational and occupational opportunities in co-operation with existing public and private agencies.

1937

BOARD OF EDUCATION

ROCHESTER NEW YORK

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J. 168794\* (Page p. 52)

clerical helpers. The department was organized in 1926 as a separate division responsible directly to the superintendent of schools. For several years previous to the organization of the department, the public schools of Newark had received child guidance service from the Essex County Juvenile Clinic, but, when the demand from the Newark schools became so heavy as to require almost one-half of the time of the Essex County Clinic, steps were taken by the local board of education to organize its own service and thus to free the county clinic for more assistance to other parts of the county.

The department carries the three major responsibilities of psychiatric service, clinical psychology, and visiting-teacher work. Cases referred include both those needing intensive analysis and treatment and those needing only consultative service or brief study for a particular purpose. The psychologists, for example, administer psychological tests to children recommended for placement in one of the special classes of the public schools, to children for whom evaluation of ability is requested as a basis for determining school adjustment, and to children who wish post-elementary school or post-high-school advice as it applies to further education or vocational choice. The visiting teachers are helpful in adjusting many problems not requiring full clinical study, only about 25 percent of the cases seen by them being referred for intensive analysis and treatment. These come to the attention of the psychiatrist through the visiting teacher assigned to the school in which the problem has originated or, if there is no visiting teacher at hand, through the principal.

The psychiatrist-director reports that, in all the activities of his department, special emphasis is placed upon teacher participation in case study and upon treatment through the use of the school as an important part of the child's environment which must be modified to meet his needs. With this objective in view, a consultative service to classroom teachers has been established, whereby the teacher gathers all data needed and discusses with the visiting teacher the facts of the case and possible lines of treatment. Such cases do not reach the clinic unless developments indicate the need of psychiatric help.

*MINNEAPOLIS, MINN.*

(Population: 477,700)

To Minneapolis belongs the distinction of having organized the first psychiatric child-guidance clinic in the country, which functions as an integral part of the city school system. In 1924 such a clinic was established as an outgrowth of an experimental project financed during the preceding year by the Commonwealth Fund. With a full-time psychiatrist in charge, the staff included also psychological, pediatric, and social-service specialists. For 9 years the clinic functioned as a

separate school department, directly responsible to the superintendent of schools.

In 1933 a reorganization took place through which the child-guidance clinic took on new duties and assumed the name of child study department, with the clinic as one element of the program. The psychiatrist-director remained in charge of the expanded department and was given the opportunity of utilizing the services of psychologists, visiting teachers, and attendance social workers who were already employed in the school system. In 1938 the clinical staff included, besides the psychiatrist, 3 psychologists and 25 visiting teachers who gave about one-fifth of their time to the work of the clinic.

In accordance with the enlarged functions implied in the name of the child study department, this unit now includes among its activities the following: Diagnosis, advice, and treatment of emotionally and mentally disturbed children; neurological and physical examinations and advice; examination and decision as to placement in special classes for the retarded; examinations and advice in special problems of grade placement, promotion, demotion, curricular changes, application and effort of pupils, and other largely educational matters. It is reported that about 50 percent of the cases studied by the clinic present well-defined behavior difficulties.

Thus in Minneapolis one has an example of how a clinical organization, originally established for the consideration of behavior and personality problems only, has evolved over a period of years into a department with a much larger range of responsibilities, in order that its contribution to the life of the school system might be more effective and widespread. In a recent annual report of the department, its director says:

The greatest service the child study department can render to the schools and the children of Minneapolis will be through the *prevention* of maladjustment and not through aiding a small percentage of those who are becoming warped to a satisfactory state of mental health. This preventive service is called mental hygiene, and in its aims it is closely allied to if not identical with education itself.

Following out this philosophy, members of the department give series of lectures to groups of parents and teachers, lead in group discussions on mental health problems, and participate in various types of school projects directed toward more effective guidance and curriculum adjustment for all pupils.

DETROIT, MICH.

(Population: 1,666,100)

For administrative purposes, the Detroit public-school system combines its research and adjustment services in one large division and

places them in charge of a supervising director, who in turn is responsible to the deputy superintendent of schools. The responsibilities thus combined include research, attendance, special education, guidance and placement, parental advisory service, and the psychological clinic. Each of these constitutes a separate section of the division of research and adjustment, and each has its own director. The psychological clinic is the unit in which are centered the clinical activities of the school system and to which other sections, departments, and divisions look for case work.

The responsibilities of the psychological clinic are broad in scope and relate to the entire school system. They include group testing; individual testing, diagnosis, and adjustment; vocational testing; physical examinations; and social work. The staff in 1938 was composed of 1 psychologist-director; 13 other psychologists and mental examiners; 1 psychiatrist and 3 other physicians, each for half-time; 6 visiting teachers; 1 reading diagnostician; 6 group and vocational examiners.

The director reports that from 30 to 40 percent of the cases referred for clinical adjustment might be termed "behavior problems," but he calls attention to the fact that "it is difficult to make clear-cut distinctions as to those that are behavior problems only. \* \* \* Many children with some mental or physical handicap have certain behavior difficulties. This may also be true of children having a reading or other educational disability." The clinic's work thus concerns itself with pupil problems of all kinds, and it regards undesirable behavior or personality as only one of the many manifestations to which it should give attention. The effort is made to reach every school of the city in promoting mental health practices and in furthering insight on the part of supervisors, teachers, and principals into the causes and treatment of undesirable behavior.

In addition to the psychiatric service made available through the psychological clinic, there are various community clinics in the city of Detroit to which urgent cases may be referred. These supplement the program which the school system is able to provide, but members of their staffs cannot, of course, in a city as large as Detroit, have the intimate acquaintance with the school facilities and possibilities for adjustment which the members of the staff of the psychological clinic possess. As the population of a city nears or exceeds the million mark, it becomes increasingly difficult for any one adjustment agency to keep intelligently informed of what other agencies are doing. In cities of this size especially, one must expect, for successful coordination of the program, a very clear statement of interrelationships, a definite allocation of responsibilities, a well-planned provision for interchange of records and for reports of

findings, and a wholehearted willingness on the part of each agency to give as well as to ask cooperation.

Detroit is unique in having established, also, an endocrine gland clinic and an epileptic clinic, for the study and treatment of endocrine disturbances and epilepsy. These are both functioning under the general guidance of the director of special education, and each is staffed with one half-time and two full-time physicians. Educational adjustments in special schools or classes accompany the physician's treatment.

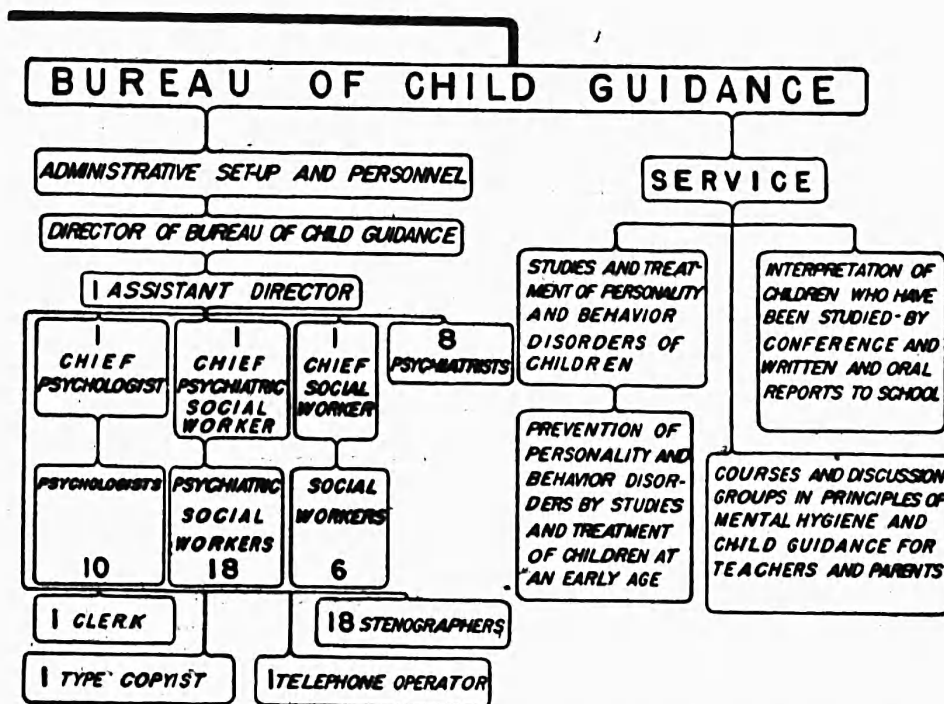
NEW YORK, N. Y.

(Population: 7,154,300)

While the population of New York City is so far beyond that of most cities in the country that its educational organization as a whole cannot be considered typical, yet its plans for certain phases of the program are highly suggestive of a type of organization that can be applied in accordance with population needs. One of these is the bureau of child guidance, which constitutes one of eight distinct divisions operating under an associate superintendent of schools, all of which are concerned with adjustments for handicapped children and others in special educational need. The other seven divisions included in this category are (1) bureau for children with retarded mental development; (2) division of the blind and sight conservation; (3) division of physically handicapped children; (4) industrial and placement work for physically handicapped children; (5) school for the deaf; (6) speech improvement; (7) visiting-teacher service.

There are many sources of psychiatric child guidance service in New York City functioning under a large variety of auspices. In 1931 the board of education took steps to organize its own bureau of child guidance for the school system, and in April 1932 clinical activities were begun. In successive years additional personnel was appointed, until in 1938 the organization was as represented in the chart on page 57. The bureau as a whole is under the direction of a psychiatrist, but its activities have been decentralized in such a way that one clinical unit is assigned to serve each respective section of the city. A unit consists of a psychiatrist-director, a psychologist, two to four psychiatric social workers, a school social worker, and the necessary stenographic assistance. Each of the boroughs of New York City is thus provided with clinical facilities as a part of the public-school system.

The program of the bureau is described by the director as including (1) clinical or child-study activities, (2) educational responsibilities, (3) community activities. The first of these pertains to the direct study and treatment of pupil problems; the second to the orientation



ORGANIZATION OF THE BUREAU OF CHILD GUIDANCE OF THE NEW YORK CITY PUBLIC SCHOOLS.

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of the school personnel in the field of mental hygiene; and the third to the maintenance of a mutually cooperative relationship with all community agencies contributing to the mental health of the people.

The case services of the bureau are designed primarily for the study and treatment of personality and behavior disorders of school children of approximately normal or above-normal intelligence. Children who are referred to the bureau, but who upon being given a psychological test show evidence of an intelligence quotient of 75 or below are automatically referred to the bureau for children with retarded mental development, to which all clinical records concerning them are then transferred. This bureau has its own psychological and visiting teacher staff, in addition to facilities for medical inspection. Its services are directed toward the educational adjustment of the child through assignment to a special school or class more nearly suited to his needs.

Cases are usually referred to the bureau of child guidance by a school principal by means of an application form made out for that purpose. It is reported that three-fourths of the cases referred require attention only from the psychologist or a psychiatric social worker, or perhaps both, working in conjunction with the school. The other fourth represent difficult problems demanding a full clinical study, which involves social case history; physical, psychological, and psychiatric examinations; clinical conference with diagnosis; and a plan of treatment. The psychiatric social worker makes needed contacts with teachers and parents and whenever feasible draws them into the treatment program. At ensuing conferences the progress on the case is noted and further steps outlined, each member of the clinical team keeping in touch with developments.

In a special report of the activities of the bureau of child guidance, the director calls attention to its educational values for teachers:<sup>43</sup>

The examination of a child discloses not only the causes of his problem but reveals also general principles of human behavior that apply to other children. Teachers, principals, and others attending the initial conference at which the examination results of a child are presented and discussed acquire not only an understanding of that child's problems but obtain also an insight into basic principles of conduct that apply to other children as well. In these conferences, concepts of child development and child training, together with their practical application, come up for discussion with the general result that those attending carry away with them a better understanding of child life in general, which includes the role played by the adult in the formation of the child's personality.

In addition to actual case work, the child-study function of the bureau includes psychological surveys of entire grades, looking

<sup>43</sup> Bureau of child guidance 5-year report, 1932-37: A special report submitted with the thirty-ninth annual report of the superintendent of schools, city of New York, New York, board of education. P. 55.



toward the prevention of educational maladjustments which are so often the forerunners of behavior problems. In this respect, it approaches the scope of service represented by the departments of child study in cities in which the adjustment program of the schools is not so highly differentiated as in New York. It is to be expected that, as a city increases in size, its services may be increasingly broken down into separate divisions or departments, each department carrying a more restricted type of responsibility for a larger school population. This is what has happened in the school system of New York City, and the bureau of child guidance because of its restricted sphere of activities probably more nearly represents the original conception of a medically recognized child-guidance clinic than any other similar organization within a school system, with the possible exception of that of Newark, N. J.

Yet in New York also the role of the clinical unit is assuming a wider significance, and it is identifying itself more and more with the problems of the entire school system. The director visualizes education as a total clinical process in which the functions of child guidance and instruction must ultimately be combined. "To this end," he says, "I am encouraging our psychiatrists, psychologists, and social workers to observe in classrooms, have discussions or conferences in the schools with principals and teacher groups for mutual learning, in order that we may bring about a closer identity than now exists."

#### GENERAL COMMENTS

From the accounts presented in this chapter, it appears that even in many of the largest cities of the country which have a well-defined organization for child guidance within the school system, the function ordinarily attributed to a child-guidance clinic may be found within the division of general educational guidance or, more often, as part of a more highly specialized bureau of individual child study and adjustment. In any case it is conceived as one phase of the total program of child study, guidance, and adjustment for all pupils and is accordingly assigned to some division of the superintendent's staff charged with this type of service.

The experience of other large cities, the programs of which have not been described in detail, seem to bear out this conclusion. In Chicago, for example, the bureau of child study is responsible for diagnosis and adjustment service for all pupils and the behavior clinic is a part of this bureau. In Los Angeles, the whole program of individual adjustment is a coordinated one to which several departments contribute. Cleveland and Philadelphia have extensive psychological clinics giving attention to a large variety of problems.

These cities, in addition to Detroit and New York City, already discussed, are all close to or exceed the million mark in population.

Similarly, in Cincinnati, the vocation bureau (which is essentially a bureau for individual guidance and adjustment) includes a psychological clinic and visiting teacher service. Seattle has its child-guidance department, which is charged with "setting up a preventive and remedial program of group and individual guidance," including the clinical study and treatment of children with problems. Oakland, Calif., has its department of individual guidance. In Baltimore, a child-guidance clinic was initiated during the year 1938-39, the chief responsibility of which at present is not so much to treat cases as to coordinate all school and community agencies already available for the study and treatment of behavior problems. These cities range in population from about 300,000 to 800,000.

The exact type of affiliation within a large school system must necessarily vary to some extent, but it is significant that so many programs of clinical service for behavior problems are identifying themselves with the total program of individual guidance. To school people who see the personality or behavior problem as one of many types of individual difficulties encountered in the school program and so frequently associated with other factors involving school adjustments, this appears to be a logical administrative relationship. The danger in such an arrangement is that proper precautions may not be taken to preserve the integrity of the clinical unit within the larger organization, with all that this implies as to qualified and adequate staff for intensive case work. If safeguards are thrown about the program so as to avoid the submergence of individual clinical study and treatment in the maze of departmental responsibilities, this type of organization might eventually prove to be the one best adapted to school systems.

The most important objective to be achieved is the provision of clinical service somewhere—either within or without the school system—for all children who need them. In their child-guidance clinics, Stevenson and Smith say:<sup>44</sup>

There are no yardsticks with which to measure the amount of clinical service a given community needs. The experience of two-score large communities which have child-guidance clinics yields only a rule-of-thumb ratio of one full-time psychiatrist, one full-time psychologist, and two or three full-time psychiatric social workers to a population of approximately 200,000. Such a staff is kept busy in a well-organized community of that size, and such clinics have been stable financially. Obviously this is by no means an ideal or a maximum quota of workers, but it is the norm about which clinics now seem to gather. Cities much larger usually develop a

<sup>44</sup> Stevenson, George, and Smith, Geddes. *Child-guidance clinics, a quarter century of development*. New York, The commonwealth fund. Pp. 134-135.

number of clinical units, sometimes as a result of a deliberate plan, sometimes at random. Cities much smaller rarely have the social equipment which justifies full-time service, even though they may have troops of children who would benefit by skilled attention.

Stevenson and Smith are considering the needs and the facilities of the entire community—not only those of the school system. Hence the figures they suggest must be applied accordingly. If the sum of the child-guidance facilities made available through the schools and through other community agencies reaches the norm he cites, it might be thought that a well-coordinated program could be developed for the city as a whole. If, on the other hand, the only source of psychiatric clinical service is a community agency outside the schools, the definite allocation of a reasonable proportion of time and service for the schools appears essential. From school systems in which such provision has not been made, statements have come indicating a serious lack in the school program from the point of view of the school people.

For example, from a school official in one city with a population of approximately a half million—a city in which there is an extensive psychological, visiting-teacher, and guidance service in the schools but which is restricted in school psychiatric service to that which is available from community agencies—comes the following:

Field workers and directors in the school bureau agree that the only advantage is that it (i. e., the utilization of community psychiatric service) is better than not having any psychiatric service at all. The chief disadvantages are that it is not possible to have early enough psychiatric diagnosis, or to have adequate follow-up interviews between psychiatrist and child, and psychiatrist and worker. Besides these difficulties, the clinic with which we have had the most frequent contacts is located in the city general hospital, and it is exceedingly difficult to get children and parents to go there, and, if they do go, they are frightened by the necessary red tape of being registered as patients of the hospital.

From another city of approximately the same size in a widely separated part of the country comes a similar statement. "It (i. e., the use of the community clinic) is much better than no clinic service at all. A clinic as part of the school set-up would insure a much better mutual understanding on the part of the clinic staff and the school people."

It is an open question whether the disadvantages of extra-school community clinics, as seen by school people, are necessarily inherent in this type of organization or whether they are due to the inadequacies of total clinical service available and of mechanical arrangements for most effective cooperation. If a community clinic were sufficiently staffed to give definitely to the schools a reasonable allotment of time and service, and if desirable adjustments were worked

out with regard to method of referral, place of clinical conferences, and exchange of findings and of counsel between clinical specialists and school people, the disadvantages might largely disappear so far as the treatment of individual cases of maladjustment are concerned. The integration of the clinic with the entire structure of the school program and its effective influence upon school policies for the mental health of all pupils would be more difficult to achieve in a large school system without making the clinic an actual part of the school organization. It is this entire problem of coordination of school and community resources which the newly initiated project in the Baltimore public schools is attempting to solve through the establishment of the child-guidance clinic as a coordinating rather than as a treatment agency. It will be interesting to watch developments in this direction in a city in which there are so many community facilities for clinical service outside the school system.

In the published report of a survey made in 1935 of the Cincinnati public schools, attention was called to the fact that "no psychiatric help is available except through the cooperation of clinics, hospitals, and private practitioners. This has been most generous in spirit but necessarily limited in time. It is reported that only two weekly appointments are given by the central clinic for school cases, with additional time for emergency cases. But the time to give attention to unadjusted children is before they become emergency cases."<sup>48</sup> The survey report continues with the following statement, which is of general significance and with which this chapter is concluded:

If the child guidance facilities of the school system are to function as a complete unit, a more nearly adequate amount of psychiatric time must be allocated for the consideration of school problems. It may not be necessary for the schools to employ a full-time psychiatrist, although this has been done in several cities of the size of Cincinnati, but certainly 2 or 3 days per week would not be too much. If this were supplemented by adequate visiting-teacher service (or something of similar type) in all the schools, and adequate psychological and medical facilities, there would be a nucleus for a child guidance or mental-hygiene program that could be extended into every classroom of the city. Such a program would involve not only the handling of behavior problems in their early stages but also an education of teachers, looking toward the development of an insight into mental hygiene problems which would supplement the work of the specialists. Classroom adjustment of behavior difficulties is the simplest and most desirable procedure; but the teacher must be trained to grasp the significance of certain symptoms and to deal wisely with the children displaying them. Only through a close relationship on her part with all the specialized agencies in child guidance can she learn to make her daily contacts with children effective in this direction.

<sup>48</sup> Survey report of the Cincinnati public schools made by the Office of Education, United States Department of the Interior. Cincinnati, Ohio, The Cincinnati Bureau of Governmental Research, July 1935. P. 150.

## CHAPTER VI

### A CONFERENCE AND A SUMMARY

One of the early steps taken by the Office of Education in carrying on the investigation reported in this bulletin was to invite to Washington for a 2-day conference a group of 14 specialists active in clinical service for school children, to explore some of the major problems involved in such a program. The objectives of the conference were stated by the Office of Education as follows:

1. To analyze the problems of organization in school systems for the diagnosis and treatment of behavior problems.
2. To assist school authorities to develop effective service in this field.
3. To determine the spheres in which the Office of Education can be of service to school systems in the development of such programs.
4. To assist in planning a study by the Office of Education of clinical organization in school systems.

It was thought that a preliminary exploration of the entire problem with a few of the people who were experienced in carrying on local programs and in meeting the exigencies of local situations might indicate the direction which further study should take, as well as the type of report which would be helpful. The discussions at the conference touched upon general problems of clinical organization, services to be rendered, participation of teachers and principals in the clinical program, relationship of the clinic to the total school program and to the community, and the importance of instituting coordinating techniques among the various agencies concerned. Since these points are also those which have been considered in the preceding chapters, a report of the proceedings of the conference becomes in large part a summary of the major items brought out in this study. The two are therefore combined in this chapter of the bulletin. Except where otherwise indicated, it may be assumed that the statements made in the following pages express the consensus of judgment on the part of the visiting conferees and the findings of subsequent investigation. They are presented in the form of answers to certain questions which are pertinent to the development of child guidance facilities.

**VISITING CONFEREES**

Conference on organization for clinical adjustment of behavior problems of school children

Office of Education, May 1938

- Margaret E. Bennett, *Director of Guidance, Public Schools, Pasadena, Calif.*  
Alan Challman, M. D., *Bureau of Child Guidance, Public Schools, New York, N. Y.*  
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Thomas W. Hopkins, *Assistant Superintendent of Schools, Jersey City, N. J.*  
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A. Leila Martin, *Director of Child Study and Special Education, Public Schools, Rochester, N. Y.*  
Alice Metzner, *Director of Special Education, Public Schools, Detroit, Mich.*  
George S. Stevenson, M. D., *Director of Division of Community Clinics, National Committee for Mental Hygiene, New York, N. Y. (More recently appointed Medical Director of the Committee.)*  
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F. E. Willard, *Assistant Superintendent of Schools, Seattle, Wash.*

**What clinical services are included in a comprehensive child-guidance program?**

As the term "child guidance" is interpreted by the National Committee for Mental Hygiene and associated agencies, its function is specifically the diagnosis and adjustment of behavior and personality problems of children. The services of a child guidance clinic are rendered "through the direct study and treatment of selected children by a team consisting of a psychiatrist, a psychologist, and psychiatric social workers, and also through focusing the attention of physicians, teachers, social workers, and parents on what is commonly called the mental hygiene approach to problems of child behavior."<sup>46</sup>

**What contribution does each member of the team make to the child-guidance program?**

The *psychiatrist* is a physician who has specialized in the study and treatment of the patient as a total organism, with all the complex interrelationships of physical, mental, and emotional experiences. A *child psychiatrist* is a psychiatrist who is qualified to analyze the experiences of children in these directions and to ferret out, on the basis of the total clinical study, the underlying causes of behavior maladjustment. Since he is medically trained, he may make his own physical examination or he may turn this responsibility over to a physician associated with him in the clinical service. Following a clinical conference at which the findings of all members of the team are discussed, he makes recommendations for treatment and follow-up, looking toward the ultimate adjustment of the child's problem. Pending such adjustment he may need to see the child again and again over a period of time.

The *psychologist* usually studies the mental equipment of the child, his educational abilities and disabilities, and may help to apply remedial measures in cooperation with principal and teacher. Psychologists vary widely in their qualifications, some restricting their activities to the administration of standard tests, while other are equipped to go deeply into a clinical analysis of the mental and emotional life of the child.

The *psychiatric social worker* is a case worker trained in the techniques of the psychiatric interview but without the medical training of the psychiatrist. She studies the influence of environmental factors in the home, school, and community upon the

<sup>46</sup> Stevenson, George S., and Smith, Geddes. *Child-guidance clinics: A quarter century of development*. New York, The commonwealth fund, 1934. P. 1.

behavior of the child and does what she can to adjust undesirable conditions. Other types of case workers frequently substituted for psychiatric social workers, particularly in clinical organizations within school systems, are the social worker without special psychiatric association; the visiting teacher, with training in both teaching and social work; and the school visiting counselor, who does part-time teaching and part-time case work.

**To what extent have such completely staffed child guidance clinics been established either within or without the school system?**

According to data compiled by the National Committee for Mental Hygiene, approximately 650 communities in 34 different States are receiving the services of one or more child-guidance clinics. In only about 20 cases, however, have such clinics been established as integral units of the school organization. Other auspices under which they are operating include State or city departments of health or welfare; State, county, or city hospitals; universities or university hospitals; societies for mental hygiene; juvenile courts; and private foundations. Wherever clinics have been established, some service is rendered to children referred by the schools.

**Should school systems attempt to build up their own full-time clinical organizations of this highly specialized type?**

Present trends seem to indicate that this type of specialized clinic, restricted in general to the consideration of behavior and personality problems, does not lend itself easily to school organization except in cities in which the population served is so large that the various functions of guidance can be assigned to different bureaus and coordinated through the central office. However, every school system has the responsibility for developing a child-guidance program which will make available to every child who needs it intensive clinical attention covering his physical, mental, emotional, and social needs. In meeting this responsibility, it should utilize every source of specialized assistance available in the city, county, or State.

**To what agencies can rural communities look for specialized assistance?**

For rural communities, as well as for many small urban districts, one of the most logical sources of highly specialized assistance is either the State or the county. Through a properly



coordinated plan the same clinical specialists can serve several school districts within the county or in some cases the entire county. Several programs have been developed on this basis outside the schools, but serving school children, as, for example, in Essex County, N. J.,<sup>46</sup> through a community project; in Milwaukee County, Wis.,<sup>47</sup> through a tax-supported mental hygiene clinic; and in Rockland County, N. Y.,<sup>48</sup> through a State hospital located in the county. Similarly, if adequate coordination obtains, an effective service can be built up through traveling clinics, with a State department as the basis of operations, as, for example, in Massachusetts,<sup>49</sup> through the State department of mental diseases; and, of more recent initiation, in Maryland,<sup>50</sup> through the State department of health.

### What are the advantages and disadvantages of such a plan?

One of the major problems encountered in any clinical organization the source of which is remote from the schools is the lack of opportunity on the part of the clinical specialists to become intimately acquainted with existing educational practices and school facilities in the local communities. Coupled with this is the difficulty encountered by a traveling clinic in following up a case or in advising with teacher or principal regarding its adjustment. In order to be able to make recommendations that are practical as well as scientifically sound, it is important that the specialist know not only his patient but also the possibilities and the limitations of the school, the home, and the community in which the patient lives—with a clear vision, too, of how the existing possibilities may be capitalized and improved.

On the other hand, through the use of a traveling clinic, a given school district has the benefit of a totally objective approach to the child's problem by one not connected with the school system, as well as the advantage of profiting from the clinic's experience with other school districts which it has visited. If the disadvantages of infrequent contacts and lack of mutual understanding and cooperation can be corrected, the development of child-guidance services emanating from a State or county department, whether in the school system or out of it, appears to have significant possibilities for small communities, particularly in rural areas.

<sup>46</sup> See p. 21.

<sup>47</sup> See p. 24.

<sup>48</sup> See p. 10.

<sup>50</sup> See p. 19.

**Lacking the availability of clinical assistance from State or county, what can a county school superintendent do to initiate a program of child guidance?**

The experience of school administrators in certain counties of California <sup>51</sup> should be helpful in answering this question. Every encouragement is given in that State by both educational and welfare authorities to develop local interest in the mental health of all children in the schools and to utilize whatever facilities are available for child guidance, even though they may not include psychiatric service. A county supervisor of guidance in the schools, a visiting teacher or other case worker, a school psychologist, or a school counselor might constitute the nucleus of a program of case conferences that will eventually draw into active participation all the principals and teachers of the county. In some cases a limited amount of psychiatric service may be available on a volunteer basis from a private practitioner. Originating with the schools and permeating them with the clinical point of view, such a program may exert a vital influence upon classroom practice for the mental health of all pupils.

**How can a city school system proceed to inaugurate a clinical program?**

Granting the existence of even a limited guidance and adjustment program for the children in the schools, the procedure used in expanding such a function may be much the same as in a county school system, discussed in the preceding paragraph. In the absence of psychiatric services, a qualified school psychologist, an attendance worker with a social vision of his responsibilities, a visiting teacher or other case worker can, with the cooperation of the school physician, carry on effective clinical service for many cases of behavior difficulties if given enough time for the work. The type of program carried on in Santa Barbara <sup>52</sup> and in other small cities in California is illustrative of constructive efforts in which the schools themselves take an important part without extensive specialized service. In both counties and cities, however, every attempt should be made to locate either within or without the school system a psychiatrist versed in child guidance whose services can be made a part of the total program.

Sometimes several adjoining cities can make arrangements for the financial support of a clinical project which no one of

<sup>51</sup> See p. 22.

<sup>52</sup> See p. 26.

them could provide alone, as, for example, in the case of Rock Island and Moline, Ill.,<sup>53</sup> or of Champaign and Urbana,<sup>54</sup> in the same State. Social-welfare agencies existing in the community may supplement the case work furnished by the schools; and the school or city health department might contribute the needed health services. In effecting a cooperative program of this type it is most important to have a clear understanding of the areas to be served by each agency, as well as a well-planned interchange of records among them.

**If a clinical unit is organized, in what division of a school system does it logically belong?**

If a city is large enough to warrant the employment of a full-time child psychiatrist who is conversant with modern educational philosophy, a full clinical unit might be set up, with the psychiatrist as director, responsible to the superintendent or associate superintendent. This procedure is favored by psychiatric authorities. However, in most city school systems a psychiatrist is likely to be employed for part time only. In that case present practice is in favor of including all provisions for the study and treatment of behavior problems as a section within the general program of child study or pupil adjustment. This arrangement is justified by educational administrative authorities on the basis of the facts (1) that there is seldom an isolation of a behavior problem as such, apart from complicating or causal factors found within the educational history of the child; and (2) that the preventive functions of a program of guidance and adjustment for all children are legitimate aspects of a child-guidance organization.

Following out such a plan, the school system may employ one or more full-time psychologists, case workers, and school physicians. A psychiatrist is employed for a stated number of hours per week. These constitute the clinical staff, but the full-time workers have, in addition to their duties of a strictly clinical nature, other responsibilities related to the entire school system. Thus one finds in Berkeley,<sup>55</sup> Calif., a behavior research clinic operating within the division of guidance, placement, and personnel. In Pasadena<sup>56</sup> the clinical service is part of the department of guidance. In Erie,<sup>57</sup> Pa., and Rochester,<sup>58</sup> N. Y.,

<sup>53</sup> See p. 30.

<sup>54</sup> See p. 31.

<sup>55</sup> See p. 41.

<sup>56</sup> See p. 37.

<sup>57</sup> See p. 34.

<sup>58</sup> See p. 51.

it is a unit within the department of child study and special education. In Providence,<sup>59</sup> R. I., it operates within the department of research and guidance. Such an allocation seems to facilitate the necessary coordination of the various pupil-adjustment services that the school system has to give.

### **How much does a child guidance clinic cost?**

It has been estimated<sup>60</sup> that, in cities of approximately 200,000 population, the budget of a full-time community clinic might be about \$20,000 per year. This would include the services of a full-time psychiatrist, a full-time psychologist, two or three full-time psychiatric social workers, and two or three clerks. However, in school systems in which the clinical service is only one phase of a larger program of pupil adjustment, and in which members of the clinical staff perform other related duties, it is difficult to arrive at any standards of cost for clinical work alone. One school system in a city of approximately 450,000 population reports total annual salaries for its department of child guidance, which is directed by a full-time psychiatrist, as amounting to \$25,820. Another school system in a city of 250,000 reports annual salaries allocated to the clinic service, including the amount paid to a part-time psychiatrist, but excluding the salaries of school physicians who give time to the clinic, of somewhat more than \$9,000. In a city with a population of 80,000 the special salary budget is reported as about \$5,000. This includes the amount paid to a part-time psychiatrist, a part-time pediatrician, a full-time visiting teacher, and a half-time clerk. Additional services are contributed to the clinic by school counselors, school nurses, and school mental examiners. In smaller cities it becomes increasingly difficult to isolate the clinical costs, these being an integral part of the costs of pupil-adjustment work as a whole.

### **What specific means will promote the active participation of principals and teachers in the clinical program?**

A child guidance clinical service has not achieved its ultimate goal until every principal, teacher, and supervisor in the school system becomes conscious of the mental health needs of the pupils and is able to cooperate with the clinic in the preventive aspects of its work. Through pre-service and in-service training they can become active participants in the clinical program,

<sup>59</sup> See p. 45.

<sup>60</sup> Stevenson, George S., and Smith, Geddes. Op. cit., p. 55.

detecting incipient cases of maladjustment and applying the general principles of mental hygiene in the classroom. The following have been found to be effective means of bringing principals and teachers into close relationship to the clinical service:

1. Appointment of an advisory council of principals to consult with the director of the child guidance unit on problems of child guidance as related to school management.
2. Professional courses for principals and teachers in the principles of child guidance.
3. Round-table conferences of groups of teachers and principals to discuss the application of child guidance to the classroom.
4. Referral of cases initiating as school problems through the teacher and the principal, or at least with their knowledge and understanding.
5. Cooperation of teacher in writing case history.
6. Holding of clinic in school building in which the child is enrolled.
7. Presence of child's teacher at case conferences, with discussion of specific difficulties which she can help to adjust.
8. Reports both to and from the teacher on progress of the case.

**What is the relationship of the clinical service to the total school program?**

The purpose of a clinical child guidance program is not limited to the adjustment of a comparatively small number of serious behavior problems. As already indicated, its influence should be preventive as well as remedial, and its service should be directly or indirectly to all the children in the school system. Moreover, psychological findings concerning the abilities and disabilities of children should help supervisors and teachers to make adequate curricular adjustments. Social work which brings information concerning home and community environment should assist in developing for all children a close cooperation between school and home. Physical findings should indicate the importance of nutrition and other provisions to meet the needs of all types of physically handicapped pupils. Psychiatric diagnoses and recommendations should point to desirable changes in the entire school administration and to

adjustment measures conducive to meeting the emotional needs of all children. Finally, an effective child guidance program will be reflected in a more careful selection of teachers, with attention to desirable personality and emotional adjustment on the part of candidates as well as to their intellectual qualifications. When the influence of an efficiently staffed and efficiently conducted child guidance clinic has thus permeated and affected school practices throughout the system, its contribution to the total guidance program is of maximal import.

The director of the bureau of child guidance of the New York City public schools points out some of the specific areas in which mental hygiene clinicians should be of service to the school system. After calling attention to the outstanding need of the the mental hygienist's contribution in the selection of candidates for teacher-training insitutions and teaching positions, he says:<sup>61</sup>

It is not possible to discuss even briefly the many opportunities that the field of education offers for the application of mental hygiene principles. The type of examinations children should receive on entering school; practical methods of giving these examinations and the frequency with which they should be repeated; homogeneous versus heterogeneous groupings; 100 percent promotions; sex education; the place of religious training in public-school education; vocational and educational guidance; the activity program; the junior high school and its influences on the general school organization; and the changes taking place in the type of student now entering high school are samples of problems to be found in school systems, the ultimate solution of which involves the knowledge, experience, and cooperative action of both educators and clinicians in mental hygiene.

#### **What means can be used to coordinate effectively the community resources for clinical service?**

Community resources established in the interests of wholesome child development frequently find themselves duplicating or infringing upon one another's services. In order to prevent such duplication, to promote a corresponding economy of time and effort, and to minimize the number of agencies or persons dealing with the same cases, a plan of coordination in which all cooperating agencies have a part is essential to the success of a child-guidance program. Whether the source of service be the city, the county, or the State—or even a combination of these—the area of each agency should be clearly defined to the satisfaction of all concerned and with a specific understanding of the activities expected of each. To be most effective, such coordination must be voluntary—not legislated into being. Its chief impetus comes

<sup>61</sup>O'Brien, Frank J. Educating for mental health. *The American Journal of orthopsychiatry*, 9: 273-286, April 1939.

from the *desire* to cooperate in serving the children of the community.

One of the most effective media devised to date through which coordination can be given tangible expression is the coordinating or community council, consisting of representatives of the various agencies in the community concerned with human needs. At regularly scheduled meetings problems of mutual interest are discussed, individual cases may be considered, responsibility for action assigned, and follow-up reports received. It is not a clinical group but it is a sponsor of the clinical program as one of the means through which it can make its united services for the children of the community effective. Child guidance is clearly not the sole responsibility of any one agency. Regardless of where it is centered, its work will be well done only when the coordinated resources of all agencies are at the disposal of a single child who needs them. Because of their strategic position in relation to all the children of all the people, the schools have at their very doors a challenging opportunity—and responsibility—for leadership in such a program.

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## A GUIDE TO STATES, COUNTIES, CITIES, AND CLINICAL AGENCIES REFERRED TO IN THIS BULLETIN

**NOTE**—This is not an exhaustive list of localities or school systems marked by clinical programs for child guidance within the schools or of clinical agencies contributing to such programs. It presents only those concerning which material has been contributed for this bulletin and which furnish examples of the types of programs carried on.

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