



The Muttart Fellowships

Winter's Children

The Emergence of Children's Mental Health
Services in Alberta 1905-2005



Germaine M. Dechant



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Dedication

To Alberta children and their families and those who work with them in the ongoing struggle to improve children's mental health services. Progress has been achieved through your voices, generous commitment, and patient day-to-day endeavours.

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Preface

The present state of things is the consequence of the past; and it is natural to enquire as to the sources of the good we enjoy or the evils we suffer. If we act only for ourselves, to neglect the study of history is not prudent; if entrusted with the care of others, it is not just.

- Samuel Johnson¹
(1709 – 1784)
English writer

In the midst of significant challenges and major change in my organization, I was granted a leave of absence to pursue this project of immense personal interest. I felt destined to write this book. My lifelong interest in mental health began in Grade 4 when I told my family that I was going to be a psychiatric nurse—a dream realized in 1965. After several years in adult mental health and general health services, I began work as the executive director of a large Edmonton-based children's mental health agency. When I began my work in this specialized area of health care eight years ago, simple interest became a quest for personal enlightenment as my experience raised questions no one could answer. People reacted to my interest in writing a history of children's mental health services in Alberta with a chuckle and a comment on how brief such a book would be.

Although much has been written about the emotional problems of children and adolescents and the impact of these problems on their families, little has been written about the evolution of services that address these problems. Certainly, there is no historical account in the literature of developments in children's mental health services in Alberta. This gap alone is reason enough to write such a book. More importantly, the need to continually focus provincial attention on the progress in children's mental health services makes the work vital.

Alberta's centennial year seems a particularly appropriate time to question where we have been. As Alberta seeks to craft a better life for its children, it can learn from a century of experience. As understanding grows about the need to prevent problems and intervene early, the past concepts and approaches become important as they show some of the challenges and triumphs of earlier colleagues. This can help us develop new directions and unite people in common conversation for the benefit of our children and their families. Many questions emerge:

- How did children's mental health services begin in this province?
- What factors in Alberta's development as a province influenced the growth in this important but long-neglected area of health care?
- Who and what were the influential forces?
- What help was available to families of children with mental health disorders before Medicare?

¹ Samuel Johnson, *Rasselas, Prince of Abyssinia*, World Wide School, Chapter XXX, p. 1. <http://www.worldwideschool.com/library/book/phil/modernwesternphilosophy> (accessed August 31, 2006).

- What led to the development of the guidance clinics that were the precursor to today's mental health clinics where most children's mental health services are provided?
- Do today's clinics resemble their precursors in design and function?
- How have the services evolved?
- What prompted changes in mental health legislation and what was the impact of those changes?
- How are today's regions challenged by the principles embedded in the Provincial Mental Health Plan released in 2004?
- Have we evolved to a place where the quality of commitment to children's mental health will make the province a better place for children and their families?
- Is fostering social and emotional health as part of healthy child development seen as a major public health goal?
- Is it a provincial priority to ensure that the health system responds as readily to children's mental health needs as it does to their physical well-being?

These are difficult questions. It is ambitious and daunting to address these questions through an historical account. It involves the challenge of finding information in obscure archives. The story is neither simple nor linear, and some developments are shameful. The result is this book with its many stories. Fictional tales contain themes revolving around love, passion, hate, death, war, family, community, success, friendship, betrayal, loss, and grief. Many of these themes emerge in the untold personal stories within this history—the stories of pain and suffering of the children who have experienced mental health problems and of their families. The limitations of this project prevent the inclusion of these individual stories, but hopefully they will be told eventually so that the community better understands what mental disorders have done to children and their families.

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This history pulls together information available in various literature sources, including official and unofficial materials drawn from around the world in order to see what forces shaped children's mental health services and Alberta's "fit" with national and international situations. Whenever possible, I have sought accounts of children whose lives exemplified the many aspects of the issues. Many public records reveal Albertans' ongoing concerns in the late 19th and early 20th centuries and beyond. Newspapers; annual reports; and reports of commissions, surveys, boards, and institutions supplemented the published records.

My attempt was to understand and describe the evolution of children's mental health services within the context of other significant developments in Alberta as it struggled from a new province to its current situation. The events are screened

through my own perspective, therefore, and the accounts simplified for clarity. It is a history built on very delicate remains that attempt to describe what has not been described. This book retains the language of the time and the classifications and labels then applied, no matter how offensive these are today. This language reflects accurately the strongly held values, knowledge, and beliefs of the times.

This analysis poses many challenges, because services for children involve substantial overlaps between various service systems. The origins of these service systems are virtually inseparable. The children's mental health service system is rooted in juvenile justice, child welfare, and services for the developmentally delayed. Even today, it often is a matter of chance whether children receive services from child welfare, corrections, or mental health systems. Consequently, an approach linking developments within the child welfare, juvenile corrections, children's mental health, and handicapped children's services systems provides the most feasible and helpful overview. This historical overview, therefore, touches on all these areas while highlighting the evolution of support and treatment approaches, programs, and services aimed specifically at children with mental health problems and disorders. These are conceptualized according to the definitions used in Alberta's 2001 Policy Framework: Mental Health for Alberta's Children and Youth.

Mental Health Problem: A disruption in the interactions between the individual, the group and the environment. Such a disruption may result from factors within the individual, including physical or mental illness, or inadequate coping skills. It may also spring from external causes, such as the existence of harsh environmental factors, unjust social structures, or tensions within the family or community.

Mental Health Disorder: A recognized medically diagnosable illness that results in a significant impairment of an individual's cognitive, affective and relational abilities.²

In the context of this book, children's mental health services include services for the population of infants, children, and youth from birth to age 18.

My analysis has showed a progressive model of medical advances and looked for evidence of scientific progress, of the professional ethic of service and the cultural context, all of which have a profound influence on the way needs are met and services provided. For example, the way a society defines children's mental health services says a great deal about that society's understanding and economic circumstances. The story reveals leaders whose legacy is so significant that it must be more widely recognized and celebrated.

While this history does not completely disentangle the story of developments in children's mental health services in Alberta, I hope it has captured the essential

² Policy Framework: Mental Health for Alberta's children and Youth (July, 2004) Alberta Mental Health Board. p. 2

elements in a way that deepens our understanding and broadens our appreciation of its complexities and accomplishments. This book by no means exhausts research possibilities in this area. It is not intended as a definitive work but as a process upon which to build with future research.

The investigation of the truth is in one way hard, in another easy. An indication of this is found in the fact that no one is able to attain the truth adequately, while, on the other hand, no one fails entirely, but everyone says something true about the nature of things, and while individually they contribute little or nothing to the truth, by the union of all a considerable amount is amassed.³

³ Aristotle, *Metaphysics* as quoted in Charles Freeman, *The Closing of the Western Mind: the rise of faith and the fall of reason* (Toronto: Random House of Canada Limited, 2003), p. 7.

Chapter 1

The Formative Years: 1905-1920



Guttersnipes, orphans,
delinquents, neglected
and charity children

⁴ “Alberta, a Province: History in the Making in Alberta’s New Capital,” *The Evening Journal* (Vol. 2, No. 249), p. 1.

⁵ John Dafoe. *W. Clifton Sifton (1931) in Relation to his Times*. Toronto, p. 23.

⁶ The 1901 census gives Alberta’s population as 65,876. By 1906, Alberta has 185,400 people of at least 15 national and linguistic identities, and the ethnic distribution of the population had shifted from a predominance of Native peoples in 1885 to a majority (56 per cent) of non-Canadian born. Source: S. Dawson, *Census of Population and Agriculture of the Northwest Provinces 1906*. (Ottawa: Government of Canada, 1907), p. xiv. Patricia Rooke. *Studies in Canadian Childhood History: A Canadian Perspective*. Calgary: Detselig Enterprises, 1982, p. 115.

The population of major cities was:

City	1901	1916
Calgary	4,392	56,514
Edmonton	4,176	53,846
Lethbridge	2,072	9,436
Medicine Hat	1,570	9,272

As well, between 1901 and 1911, the number of farms almost quadrupled.

Paul Philips. “The Prairie Urban System, 1911-1961: Specialization and Change,” in A. Artibise, ed. *Town and City: Aspects of Western Canadian Urban Development* (Regina: University of Regina, 1981), pp. 11-15.

⁷ Donald Smiley, ed. *The Rowell-Sirois Report—The Royal Commission Report on Dominion-Provincial Relations* (Ottawa: Government of Canada, 1978), pp. 95-97.

Guttersnipes, orphans, delinquents, neglected and charity children

September 1, 1905. It was party time across the newly-established province of Alberta. The mood was high; the local pride, palpable. Fifteen thousand people attended the official inauguration celebrations in the capital city. They were inspired by Prime Minister Sir Wilfrid Laurier’s address; thrilled by the Mounted Police’s magnificent exhibition drill; entertained by concerts, parades, horse races, baseball games, lacrosse, and polo.⁴ As the day ended with an inaugural ball, Albertans agreed that they had good reason to celebrate their unique province, were optimistic about the future, and looked forward to many more celebrations.

The people’s optimism was well-founded. Indicators promised a glittering future for Alberta. This day, however, also served as respite from the stresses inherent in the explosive changes from Alberta’s frontier days with the rapid expansion of railroads and concurrent establishment of towns and emergence of cities. It was an exciting and challenging time, with the massive migration of people drawn to the Prairies by the great wheat boom, the Dominion Lands Policy building a nation by granting settlers 160 acres of land for a \$10 registration fee, and concerted provincial efforts to promote rural and urban growth. As John Dafoe noted, “The first thing to do was to settle the empty West with producing farmers; this was also the second, third, fourth and fifth thing to do.”⁵

Rapid population increases, accompanied by a new composition in the ethnic population,⁶ created new challenges for which urban centres particularly were unprepared. Rapid expansion drained the treasuries of urban centres, leaving city governments financially incapable of responding to all the demands even though they were concerned about the deplorable social conditions many residents endured. As towns grew into industrialized cities and cities into metropolitan areas, they needed transportation and communication facilities, public buildings and equipment of every kind. Priorities for all levels of government were the extension of public services to accommodate urban growth and facilitate commerce and industry, including building of streets; developing gas and electric systems, sewage systems, and water supplies; erecting public buildings (including schools); and continued promotion of growth.⁷

Building schools was a very high priority. Premier Rutherford made it his personal mission to create a system of free public education with a minimum of eight years of schooling for all children. He believed education was essential to

equip young Albertans for the future and transform the thousands of immigrants flooding the province into Albertans. He approved the construction of 140 new schools in his first budget, all with services free of charge for students.⁸ This commitment to education was reflected in legislation in 1910, when the *Truancy and Compulsory School Attendance Act* was introduced and school attendance became compulsory for children aged seven to 14. The age for leaving school was amended to 15 in 1918, with an exemption for 14-year-old children who had either attained Grade 8 or were employed.⁹ However, school attendance remained sporadic and infrequent long after this legislation was introduced. "The needs of the farm often dictated the frequency and timing of school attendance."¹⁰

The early settlers' privations and hardships were significant but were considered an aspect of frontier life rather than social problems. Although some people were wealthy, most were poor and, thus, poverty was not humiliating as it can be in an environment with prevailing class distinctions. Families did not feel degraded and served as one another's best support.¹¹ Their ethics were of thrift, hard work, and self-reliance. They wanted to lead independent lives, and governments were reluctant to introduce social policies, concerned these might be viewed as interfering with this pervasive value of self-reliance.

The crowding of people into cities was the striking social condition of the period, yet little public money was available for improving the urban poor's social and physical condition.¹² Community leaders of the time held the view that one's social and economic condition was an individual responsibility. They believed substantial public action would only encourage pauperism. Poverty was widely considered a symptom of sloth and weakness of character. As a result, municipal governments ignored the problems of neglected children, and individuals or voluntary agencies provided what help was available.¹³ "In terms of social welfare, neither Edmonton nor Strathcona had progressed further than the relief committee method of handling the most extreme financial need."¹⁴ Religious orders were automatically called to the care of those unable to look after themselves.¹⁵

In addition to addressing the agricultural interests of the province, the *Agriculture Department Act* passed in 1906 also was to oversee public health. Within a year, however, a separate *Public Health Act* (1907) was passed, mandating a Provincial Board of Health to oversee the inspection of hospitals, jails, and orphanages and supervise charity and relief.¹⁶ As reflected by this legislation, health and welfare were clearly associated in the thinking of leaders in this period.

The year 1907 also marked the passage of the *Insanity Act of Alberta*, which focused exclusively on insanity among adults and provided for committal in any asylum in the province of Manitoba or elsewhere, since Alberta had no asylums. These were provisional arrangements for severe cases in anticipation of the completion of the insane asylum, which opened in Ponoka in 1911 to treat men

⁸ Mark Lisac, "The Machine's New Ministry." *Alberta 100 Years A Home* (Calgary and Edmonton: Calgary Herald Group Inc./Edmonton Journal Group Inc., 2005), p. 34.

⁹ P. Oreopoulos, *The Compelling Effects of Compulsory Schooling In Canada* (Toronto: University of Toronto Department of Economics [preliminary draft], 2003), p. 8.

¹⁰ Ibid.

¹¹ W.E. Pollard. *Life on the Frontier: A Sketch of the Parry Sound Colonies that Settled near Edmonton* (London: A.H. Stockwell, 1944), p. 51.

¹² Artibise, ed. *Town and City: Aspects of Western Canadian Urban Development*, p. 373

¹³ Ibid.

¹⁴ Carl Betke, "The Original City of Edmonton: A Derivative Prairie Urban Community," in Artibise, ed. *Town and City: Aspects of Western Canadian Urban Development*, p. 320.

¹⁵ Patricia Rooke, *Studies in Canadian Childhood History: A Canadian Perspective* (Calgary: Detselig Enterprises, 1982), p. 123.

¹⁶ Statutes of Alberta, 1906, 1907.

and women. A person suspected of being insane and also dangerous could be jailed while awaiting placement in an asylum. It was expected that families would care for people with less severe problems. In all cases, the person, the family, or the estate was responsible for the expenses for maintaining the insane.

The Insanity Act made no reference to children; it expressed neither inclusion nor exclusion.¹⁷ It was not meant to include children, as people then did not think that children could be insane.¹⁸ Sigmund Freud's insights into mental illness had not yet reached Alberta. His ideas about the impact of childhood experiences on adult mental health triggered concern and interest in children as a legitimate area for scientific research.¹⁹ The outcomes of this research would become evident several years later in Alberta. Although the *Insanity Act* did not show evidence of concern with children, two systems that did take children into consideration—the judicial and the welfare systems—were beginning to develop, side-by-side, linked, yet independent of each other.

The Children's Aid Societies

In Calgary, the willingness of individuals to devote their energy and money to social improvement led to the founding of the Calgary Children's Aid Society in 1909. Expertise from the East was solicited in the person of J. J. Kelso, superintendent of Ontario's Department of Neglected and Dependent Children and a major Canadian child welfare advocate, who was invited to help shape the local Society. Edmonton followed Calgary's lead and soon established a Children's Aid Society, and, by 1913, societies also had been established in Lethbridge and Medicine Hat.²⁰

The Calgary Children's Aid Society was the first attempt to provide care for the city's neglected and deprived children. As in other large urban centres, many factors led to the neglect of children. These included rapid growth with soaring property values forcing a large number of working class people into overcrowded housing. The additional hardships of the business depression of 1913, the social disorganization brought about by World War I beginning in 1914, followed by the influenza epidemic of 1918-1919 profoundly affected family life—leaving many children neglected or homeless. Despite modest provincial annual grants, municipal financial responsibility for maintenance payments to shelter children and provide teachers for them, the Society eventually became unable to continue operating with the growing demands in this worsening economic and social climate. In 1920, it turned over its work to city council, which then created the Calgary Children's Aid Department. During its 11 years in operation, the Society had cared for approximately 9,000 children and exerted a major influence in turning the city in the direction of rehabilitating troubled children.²¹

¹⁷ *The Insanity Act*. Statute of Alberta (S.A.) 1907.

¹⁸ Theresa Richardson. *The Century of the Child: The Mental Hygiene Movement and Social Policy in the United States and Canada* (Albany: State University of New York Press, 1989), p. 13.

¹⁹ A.N. McTaggart, "Emotionally Disturbed Children: Description of a Treatment Program in a General Hospital," *The Canadian Nurse* 61, 4 (April 1965), pp. 294-96.

²⁰ Henry C. Klassen, "In Search of Neglected and Delinquent Children: The Calgary Children's Aid Society, 1909-1920," in Artibise, ed. *Town and City: Aspects of Western Canadian Urban Development*, p. 377.

²¹ *Ibid.*, pp. 375-91.

Troubled and Troubling Juvenile Delinquency

The many social problems facing the new province of Alberta included a growing demand for the care of juvenile delinquents.²² In 1908, a *Calgary Herald* article on the needs of deprived and delinquent children drew a sympathetic response from many citizens.²³ They worried that delinquency could threaten freedom and opportunity in their community and were concerned about the lack of legislation guiding public action in this area.²⁴ The persistence of problems was forcing municipal leaders to tackle public health and welfare issues.

This concern—including dissatisfaction with existing methods for dealing with delinquent children within the adult criminal court system—was not unique to Alberta. Juvenile delinquency was among the first social problems to be tackled nationally through the passage of the *Juvenile Delinquents Act of Canada* in 1908. The term “delinquent” was chosen to protect against the stigma associated with the label of “criminal.”

Based on the American model originally developed in Illinois, this act introduced the single most important change in children's legal policy in the 20th century—the application of the *parens patriae* principle, or the state's authority to intervene as a surrogate parent in the lives of dependent children. It also was founded on a “medical model” of delinquency—a perception that delinquent acts stem from underlying emotional, psychological, and social pathology most likely resulting from the abuses of neglect, abandonment, and an indigent environment. The function of juvenile court, therefore, was seen as a means to identify and root out this sickness.

Under the authority of the *Juvenile Delinquents Act of Canada*, juvenile courts:

- served children between six and 16 years old.
- separated the child from adult proceedings. Previously, a child over seven was considered criminally responsible, tried as an adult, subjected to the same sentences, and imprisoned in the same prisons as adult offenders.
- redefined the child offender as a delinquent rather than as a criminal.
- conducted hearings in a less rigid, more sympathetic atmosphere with less emphasis on the nature of the offence and more on the child's special needs.
- provided much wider sentencing discretion—including probation—which became a significant addition to child placement since it required more services and personnel for children. This approach was consistent with a philosophy and supportive services aimed at rehabilitation.
- concentrated services increasingly on professional guidance in the home rather than on institutionalization.²⁵

²² In Alberta, a “juvenile” under the *Juvenile Delinquent Act* was a boy under 16 years old or a girl under 18 years old. “Delinquency” referred to a violation of the law by a juvenile, which, if committed by an adult, would be a crime. Source: *Report of the Alberta Royal Commission on Juvenile Delinquency* (Edmonton: Government of Alberta, 1967), p. 11.

²³ “Need of Children's Aid Society Here,” *Calgary Herald*, August 29, 1908, p. 2.

²⁴ Klassen, “In Search of Neglected and Delinquent Children: The Calgary Children's Aid Society, 1909-1920,” pp. 366-67.

²⁵ Marjorie M. Bowker, “Juvenile Court in Retrospect,” *Alberta Law Review* 24, 2 (1986), p. 235.

²⁶ Ibid., p. 254.

²⁷ “Neglected Child” shall mean a child who is found begging, receiving alms, thieving in a public place, sleeping at night in the open air, wandering about at late hours, associating or dwelling with a thief, drunkard or vagrant, or a child who by reason of the neglect, drunkenness, or vice of its parents, is growing up without salutary parental control and education, or in circumstances exposing such child to an idle and dissolute life; or who is found in a house of ill-fame, or known to associate with or be in the company of a reputed prostitute; or who is a habitual vagrant; or an orphan and destitute; or deserted by its parents; or whose only parent is undergoing imprisonment for crime; or who by reason of ill-treatment, continual personal injury or grave misconduct or habitual intemperance of its parents or either of them is in peril of loss of life, health or morality; or in respect of whom its parents or only parent have or has been convicted of an offence against this Act, or under *The Criminal Code*; or whose home by reason of neglect, cruelty or depravity, is an unfit place for such child. Alberta Statute, an *Act for the Protection of Neglected and Dependent Children*, pp. 206-07.

²⁸ Rooke, *Studies in Canadian Childhood History: A Canadian Perspective*, p. 168.

²⁹ *Alberta Sessional Papers* 1911 7, 10, p. 8.

³⁰ Klassen, “In Search of Neglected and Delinquent Children: The Calgary Children’s Aid Society, 1909-1920,” p. 381.

Meanwhile, the Legislative Assembly passed the *Alberta Industrial Schools Act* (1908) to provide for the treatment of juvenile delinquents. “Industrial school” was a term used synonymously with “reformatory school.” Its purpose was to provide custody, education, industrial training, and moral reclamation of boys in trouble. This act empowered the attorney-general to appoint a superintendent of industrial schools. The attorney-general appointed R. B. Chadwick to the position and instructed him to investigate and make recommendations about the best way to deal with delinquent and neglected children. Concerned that the costs of building a local facility would be prohibitive, Chadwick recommended that Alberta enter into an agreement with the province of Manitoba so that delinquent boys needing industrial school training could be admitted to the school at Portage la Prairie. He also recommended a broad system of child welfare laws for Alberta. This, in addition to public pressure, led to an Act for the Protection of Neglected and Dependent Children in 1909, more commonly referred to as *The Children’s Protection Act of Alberta*. This act became Alberta’s first piece of welfare legislation, and, in effect, marked the beginning of child welfare in the province. A Department of Neglected Children was created to administer the act. Chadwick became its first superintendent, and commissioners were appointed.²⁶ Thus, Chadwick supervised the act’s implementation.

The act defined a neglected child broadly enough to meet almost any condition or contingency.²⁷ Troubled children fell into two general categories: those who received inadequate care were classified as neglected, and those who broke the law were called delinquent. As Chadwick noted, the problems of dependent and delinquent children were so interwoven they had been dealt with as one in Alberta.²⁸

The act required every city of 10,000 or more to provide a shelter for neglected children and encouraged them to form children’s aid societies. It gave these societies the power to take charge of neglected or delinquent children, bring them before a court, and become their legal guardian. This was a huge mandate for the newly-established societies, which held as essential two requirements for a fully functioning child-saving program: a shelter for temporary accommodation of neglected children and a court for juvenile offenders exclusively. Where no formally organized societies existed, committees were formed primarily to find foster homes in rural communities.²⁹

Convinced that every child should have the chance to do well in life, the Calgary Children’s Aid Society immediately established its shelter.³⁰ The shelter, staffed by nurses, a cook, janitors, and a teacher provided by the Calgary School Board, cared for the children by feeding and clothing them; teaching them to work; and offering them a public school education, religious instruction, recreation, and health care. A physician examined the children before they went to the shelter. Over a dozen city doctors with various specialties, including dentistry devoted volunteer time to this program. All served without remuneration as the society’s

work depended heavily on voluntary efforts. The society was unprepared to take on the additional responsibilities of a much more complicated juvenile court.

...delinquency was most widespread among 12 to 15 year old boys and theft was the crime they most often committed. Many resulted from adolescents trying to meet the necessities of life. Recorded thefts, for example, were of articles of clothing such as sweaters, boots and socks. Far fewer girls than boys were labelled as juvenile delinquents. Those who were in trouble were seen to be involved in some form of immoral behaviour such as prostitution or being an unwed mother. The testimony for girls charged with sexual offences shows that they had often lost their jobs, had been unable to find a job, or had felt forced into a sexual relationship in order to keep a job.³¹

The following case illustrates the complex question of whether delinquent children's problems were mental or moral in nature.³²

Jimmy's Case

Nine-year-old Jimmy tells how his father and mother beat each other; how they participated in the combat with vengeance. Jimmy is afraid of his father who hit him on the head with a stick for being late.

When he was seven, Jimmy ran away from home. He left the house by the window at one o'clock in the morning. He had seen a movie of Tarzan, and he wanted to live as Tarzan did. He took a knife with him, which he used as a dagger, and went into the woods for a week. Imitating Tarzan, he cut a hole in a tree and gathering a little straw, made his bed there. During the day, he killed crows and sparrows with his dagger and ate them raw. At the end of the week, he voluntarily went home.

Jimmy ran away again when he was eight. This time, he was picked up by the police for truancy and brought before juvenile court.

All his dreams are about good guys and bad guys. He believes that all the boys are after him. Even his brothers and sisters hate him. His actions are sometimes unaccountable. On the spur of the moment he will take a cat and cut its head off. He has fixed ideas and at this time he wants to go live on a farm where he could drive a horse and plough.

³¹ Ibid., pp. 385-86.

³² Abridgement from cases discussed by Herman L. King in *A Study of the Principles Involved in Dealing with Juvenile Delinquency and Their Application In the City of Edmonton* (Edmonton: Government of Alberta, 1934), pp. 64-65.

³³ Bowker, “Juvenile Court in Retrospect,” p. 237.

³⁴ Among those who served as court judges between 1912 and 1918 were F.D. Beveridge, a real estate agent; T.A. Frost, an alderman and Baptist clergyman; Alice Jane Jamieson; Annie Langford; A.D. McDonald, E. Bagnall, and M. Matheson, probation officers; and J.R. Joyce, a justice of the peace and former Royal Canadian Mounted Policeman. Source: Klassen, “In Search of Neglected and Delinquent Children: The Calgary Children’s Aid Society, 1909-1920,” p. 382.

³⁵ Ibid., pp. 382-83.

³⁶ The term “child savers” described people involved in protecting and caring for neglected, dependent, and delinquent children.

³⁷ Later called Our Lady of Charity School for Girls, this home looked after delinquent girls for the Child Welfare Department. Its role was to provide an integrated program of spiritual, educational, and rehabilitative services aimed at preparing the girls for a more satisfying and socially useful role in the community. Source: Jean Nelson. *Supplementary Report on Juvenile Delinquency in Alberta* (Edmonton, 1967), p. 92.

³⁸ Klassen, “In Search of Neglected and Delinquent Children: The Calgary Children’s Aid Society, 1909-1920,” p. 387.

³⁹ The federal act gave the provinces the power to appoint probation officers. Alberta, through the *Juvenile Court Act*, gave cities and towns the power to appoint probation officers who remained under the control and subject to the directions of juvenile court judges. Source: *Report of the Alberta Royal Commission on Juvenile Delinquency* (Edmonton: Government of Alberta), 1967, p. 33.

⁴⁰ Richardson, *The Century of the Child: The Mental Hygiene Movement and Social Policy in the United States and Canada*, p. 13.

In 1912, the Alberta Government established a juvenile court in Calgary, marking the beginning of a functioning system of juvenile courts. *The Juvenile Court Act* of 1913 solidified that process through provisions that commissioners, appointed under the *Children’s Protection Act*, would act as judges of the Juvenile Court. Ex-officio judges would be police magistrates, as well as District and Supreme Court judges.

Under section 44 of the Juvenile Delinquents Act of Canada, the coming into force of the Act in any province required a federal Proclamation and its publication in the Canada Gazette. The Juvenile Delinquents Act was brought into force in Alberta by Proclamation of the Governor-General-in-Council in 1913.³³

With these pieces of legislation in place, children charged with juvenile delinquency would appear before a Commissioner of the Juvenile Court. These commissioners most often had no legal training but had been appointed to the position because of their interest in “child saving.”³⁴ The judges, like the other citizens involved in the Children’s Aid Society, worked without remuneration, reflecting the reliance of the time on voluntary efforts in tackling the problems of social hardships.³⁵

Juvenile courts were held separately from the proceedings of adult courts in keeping with the “child saver’s”³⁶ views that children must be protected from contact with adult vices. Hearings were conducted informally without the benefit of counsel. It was understood that the presiding Commissioner would—in the manner of a kind, concerned adult—inquire into the events surrounding the charge and determine what should be done with the child. Three remedies were possible: the child could be placed on probation; could become a ward of the Department of Neglected Children; or be sent to the Industrial School at Portage la Prairie (if male), or (if female), to a provincial social services homes (e.g., the Good Shepherd Home established in 1912 and operated by the Sisters of Our Lady of Charity in Edmonton.)³⁷

Probation was the preferred course of action, since the court saw itself as an agent of reform dedicated to preventing children from becoming criminals.³⁸ The child would remain with the family but a probation officer³⁹ (who, in cities, was the agent of the Children’s Aid Society) would supervise him or her. Their philosophy was treatment of the juvenile delinquent not as a criminal but as a misdirected, misguided child and one needing aid, encouragement, and assistance. The old idea that punishment would make the delinquent good no longer held. Children were considered to be morally vulnerable and in need of training and protection rather than of punishment.⁴⁰

The Impact of War and Influenza

In the first dozen years of the 20th century, the Alberta economy boomed and the province progressed in its social policies. By 1913, however, a recession set in. With the onset of World War I, Alberta—with its undeveloped infrastructure—was confronted for the first time with living in wartime conditions. Child welfare services remained unchanged during the war years despite well-recognized growth in social complexities and the heightened interest in children. By 1916, the incidence of juvenile delinquency increased 25 per cent, which was attributed to the thousands of families torn apart by the war.⁴¹

The Spanish Influenza epidemic—the killer flu that first struck in the spring of 1918 and lasted into 1919, taking 4,000 Albertans in toll—further highlighted the great gaps and inadequacies of welfare services. This gave social reformers a stronger voice and added weight to their demands. Among these were the United Farmers of Alberta (formed in 1909), who, in collaboration with the United Farm Women of Alberta, strongly advocated for social and economic reform with particular emphasis on assistance for neglected and dependent children.

Public Health and Mental Hygiene

Of all the reform efforts for children that grew and flourished between the 1880s and the 1920s, the public health movement had the most immediate, the least ambiguous, and the most precisely measurable positive effects on the lives of Canadian children. They centred the attention on three aspects of child health, protecting and improving the health of school pupils; reducing mortality among infants and young children; and trying to come to grips with what they described as feeble-mindedness.⁴²

By 1914, Calgary and Edmonton had started regular “inspections” of school students by a physician or school nurse. The reasons for focusing on school children were that:

- they were highly visible and accessible. Educators agreed that working with healthy children was more productive than working with those suffering from disabilities and firmly believed a healthy body led to a healthy mind.
- the conviction was growing that the systematic medical inspection of school children was a branch of preventive medicine. Through these inspections, medical conditions could be detected and treated before permanent damage resulted. This was fed by concern that many parents did not deal early enough (if at all) with their children's health problems and the desire “to build up a nation whose men and women will be physically and mentally sound.”⁴³

⁴¹ David Lysne, “Welfare in Alberta 1905-1936.” Master's thesis. University of Alberta. 1966, pp. 65-67.

⁴² N. Sutherland, *Children in English-Canadian Society: Framing the Twentieth-Century Consensus* (Toronto: Wilfrid Laurier University Press, 2000), p. 39.

⁴³ *Ibid.*, p. 49.

- the increasingly popular theory of eugenics of the time aimed at establishing a superior race by keeping children under medical observation, and carefully guarding and directing their education to ensure they became assimilated Albertans. The goal shifted from controlling disease to a more positive one of ensuring the children were all in good health based on the belief this early attention would pay great dividends in productivity in later years.⁴⁴

Concerned with the connection between mental problems, immorality, and juvenile crime, the Canadian Medical Association appointed Helen MacMurchy, a public health activist and physician, as chair of a newly formed National Committee on Mental Hygiene in 1919. “Mental hygiene” was early 20th century terminology for describing the science of mental health. It was seen as relating to the promotion of health and prevention of disease. Public health was described as a movement of social reform and Dr. MacMurchy successfully redefined social problems as public health problems and brought public attention to many social problems to which mental hygienists would later respond. The more central ones included disease, immoral conduct, unemployment, feeble-mindedness, crime, and pauperism.⁴⁵ She also played a prominent role in convincing governments to assume greater responsibility in these areas of public health.

The formal movement to create the science of mental health originated in the United States in 1909 through the work of Clifford Beers and the publication of his book *A Mind that Found Itself*. The movement expanded to Canada in 1918, and it extended the public health movement with a pervasive concentration on education and welfare policies toward children. With the idea that society could be perfected through children’s socialization, the mental hygiene movement ushered in “the Century of the Child” as its primary focus.⁴⁶ “Happy, healthy children were argued to be society’s best assurance of a rational and productive adult population.”⁴⁷

⁴⁴ Rooke, *Studies in Canadian Childhood History: A Canadian Perspective*, p. 138.

⁴⁵ David MacLennan, “Beyond the Asylum. Professionalization and the Mental Hygiene Movement in Canada, 1914-1928,” *CBMH/BCHM* 4 (1987), pp. 7-23.

⁴⁶ Richardson, *The Century of the Child: The Mental Hygiene Movement and Social Policy in the United States and Canada*, p. 2.

⁴⁷ Ibid.

Chapter 2

The Roaring '20s: The First Phase of Organized Mental Hygiene



Idiots, imbeciles, morons,
nitwits, human derelicts,
the error of nature

Idiots, imbeciles, morons, nitwits, human derelicts, the error of nature

The mental hygiene movement is the offspring of a love for human kind, a recognition that this is perhaps the greatest medical problem that has yet been approached—the most important and far-reaching because it tears at the heart-strings of every man, woman and child.⁴⁸

“To know him is to love him.” This old adage applies especially well to Dr. Clarence Hincks, a Canadian crusader generally much better known for his work with adult mental health services even though he contributed extensively to the development of children’s mental health services across the country. Although he may be criticized for his role in the eugenics movement, his passion to promote mental hygiene changed the face of Canadian mental health services, and Alberta’s story cannot be told without significant attention to his role.

As a young doctor establishing a medical practice in Toronto, Dr. Hincks accepted a part-time position as district medical inspector for schools in West Toronto. He soon discovered that an estimated 40 per cent of his patients had emotional, behavioural, and learning difficulties—problems he felt ill equipped to address. “Nothing he had been taught in medical school could guide him in the situations he faced. No textbook could provide the solutions he sought, for they were not as yet written.”⁴⁹

In August 1913, Dr. Hincks attended the Fourth National Congress of School Hygiene in Buffalo hoping to find someone at this conference to help him. One conference speaker focused on the work of two Parisians, Binet and Simon, on the development of intelligence testing. The Binet-Simon test, or the IQ test (a series of questions of graded difficulty that measured increasing degrees of mental ability) was not used widely and not used at all in Canada. Hincks introduced himself to the speaker and immediately learned how to administer the test. Upon return to Toronto, he tested delinquents appearing before the Toronto Juvenile Court. He then tested local students identified by the teachers as having mental deficiencies. His experience led him to realize that he wanted to specialize in psychiatry, which was not a popular career choice at that time.

Knowing of his interest, Dr. Clarke, dean of the Faculty of Medicine and superintendent of the Toronto General Hospital, recruited Dr. Hincks to the Toronto General Hospital’s outpatient clinic. The clinic’s goal was to assist the

⁴⁸ Charles F. Martin, “The Mental Hygiene Movement in Canada” in *Mental Hygiene of Childhood*. Toronto: The Canadian National Committee for Mental Hygiene, 1928, p. 1.

⁴⁹ C.G. Roland, *Clarence Hincks: Mental Health Crusader* (Toronto: Dundurn Press Toronto and Oxford, 1990), p. 29.

Juvenile Court in developing a special psychiatric study of its cases. It was a great success clinically and also in educating many physicians, nurses, and social workers entering the mental hygiene field.

Hincks' experience at the Toronto clinic with children referred from the juvenile court occurred at a formative time in his professional development, strengthening his determination to expand psychiatric care in Canada. In 1917, two years after the clinic opened, he visited New York, then the centre of North American psychiatric training. There he met Clifford Beers, who introduced him to the mental hygiene movement. The National Committee for Mental Hygiene, founded in 1909 in the United States, convincingly demonstrated the value and the need for similar organizations in enlightened countries.

Hincks returned with the concept of forming a national organization and with the support of his colleagues—particularly Marjorie Hayes, a nurse at the Toronto clinic—created the Canadian National Committee for Mental Hygiene (CNCMH). The CNCMH was legally instituted on April 26, 1918, with Dr. Clarke as medical director and Dr. Hincks as associate medical director and secretary.

The Mental Hygiene Movement

The mental hygiene paradigm originated with the premise that society could be perfected through the socialization of children. Happy, healthy children were argued to be society's best assurance of a rational and productive adult population.⁵⁰

Mental hygiene was understood in the early 20th century as the branch of knowledge relating to health promotion and disease prevention. The purpose of the formal mental hygiene movement was to:

- prevent nervous and mental disorders.
- improve care and treatment for those afflicted.

Mental hygiene sought to keep children well, combining the 19th century child-saving approach with the idea that scientific promotion of well-being in childhood would prevent adult dysfunction. Mental hygienists, therefore, concentrated on educational and welfare policies directed toward children.⁵¹

⁵⁰ Richardson, *The Century of the Child: The Mental Hygiene Movement and Social Policy in the United States and Canada*, p. 2

⁵¹ Ibid.

Reform by Committee

⁵² With growing concern about feeble-mindedness, provincial governments prompted the CNCMH to conduct full mental hygiene surveys of the provinces. The four western provinces led the way, followed by the Maritime Provinces. The Manitoba survey, the first to be completed, was very thorough and served as a model for other provinces. These surveys invariably highlighted mental deficiency as society's most pressing issue.

⁵³ Clarence Hincks, *Mental Hygiene Survey of the Province of Alberta 1921* ([n. p.]: Canadian National Committee for Mental Hygiene, 1921). The University of Alberta's Professor D.G. Revell made this first survey of the province of Alberta, under the auspices of the national committee.

⁵⁴ *Ibid.*, p. 4.

⁵⁵ Note that, from the beginning, geneticists were very involved in the use of IQ testing based on their view that IQ tests measured a fixed quantity that was determined at the time of conception for each individual. Source: Alan Garland, "The Social and Economic Origins of Genetic Determinism: a Case History of the American Eugenics Movement, 1900-1940 and its Lessons for Today," *Genetica* 99, pp. 77-88.

⁵⁶ Kathleen McConnachie. "Science And Ideology: The Mental Hygiene and Eugenics Movements In the Inter-War Years, 1919-1939." Doctor's thesis. University of Toronto, 1987.

The CNCMH was the impetus for developments in mental hygiene over the next several years. The first five years were regarded as a development period. The committee's single most important activity was conducting mental hygiene surveys across provinces at the request of provincial governments.⁵² Through these surveys, they gathered statistics on juvenile courts, jails, schools, and homes for dependent children, industrial schools, and hospitals for the insane and the retarded.

The committee attempted to establish the relationship between mental abnormality, delinquency, and social inefficiency by examining facilities for the mentally abnormal. They were convinced of a causal link between mental abnormality and immorality as clearly demonstrated in the report of their 1921 Mental Hygiene Survey of the Province of Alberta.⁵³

The term Mentally Handicapped is reserved for those who suffer from mental defect or mental disorder, and who, because of their disability, cannot conduct their affairs with ordinary prudence or earn an independent living. They are rightly regarded as a social liability, and when neglected may contribute to criminality, vice and pauperism. When adequate measures are taken by a province to prevent an increase of its abnormal population (careful screening of immigrants and sterilization), and when suitable facilities are employed to control existing cases, there ensues a considerable diminution of social distress and human suffering.⁵⁴

The survey report served as an exceptionally useful historical document, revealing in painful detail mental hygienists' prevailing attitudes, knowledge, influence, and motivations. The mentally handicapped were grouped into three large classes: the insane, mentally deficient, and psychopathic.

The committee saw mental abnormalities significantly correlated with social problems of illegitimacy, prostitution, and dependency. To reach their conclusions, the committee members IQ tested⁵⁵ children who teachers identified as troublesome, mischief making, or generally disturbing. They found troublesome children more prone to a low IQ. They then interviewed children in this troublesome category, a process that reinforced their belief that these children possessed inferior moral values. They argued for auxiliary classes to provide special training for children from good homes but not for the antisocial, whose defects and social class precluded their presence in public schools. Their solution was to segregate these children from society in isolated farm colonies.⁵⁶ Their

operational links among mental hygiene, moral values, and delinquency were revealed by the following quote about a 14-year-old residing in an Edmonton Children's Aid Shelter. "This lad is a thief, and addicted to immoral habits, and has had a bad influence among his associates. He is neurotic and peculiar and in need of mental hygiene supervision."⁵⁷ The committee had equally clear views on immigration, as illustrated in the following quote:

While volume in immigration may be desirable, it is nevertheless true that quality is of paramount importance. It should be the aim of Federal authorities to so guard our ports of entry that we do not receive an undue proportion of those who will eventually become a burden to the state. It is particularly desirable to reject the insane and mentally deficient because they often prove a greater menace than any other group.⁵⁸

Judgement Calls

It is an established fact, we believe, that nitwits, both male and female, are uncannily gifted with reproductive powers and the sum total of this reproduction is more nitwits.⁵⁹

The words reflected prevailing values with exquisite accuracy while also shaping actions and determining future directions. Archival documents of the 1920s include one that reads: "Idiots. Imbeciles. Morons. Nitwits. Human derelicts. The error of nature." The power of those words enabled a zealous enforcement of the *Sexual Sterilization Act of Alberta*. This act's primary objective was to protect society but later, more enlightened social understanding and increased focus on the rights of mentally ill people made it increasingly controversial, then notorious, and finally abhorrent. This legislation dramatically and irrevocably changed the lives of hundreds of Alberta children who suffered from a mental defect or mental disorder and who had no direct voice of their own.

The process of enacting the *Sexual Sterilization Act of Alberta* was complex and protracted, with much effort made to mobilize public opinion in its favour. Sexual sterilization laws were based on eugenics philosophy (see Appendix 1). This early 20th century movement swept most of the western world and found widespread acceptance in the United States.⁶⁰ The concept, with its philosophy of race betterment, was introduced to the Alberta public in 1921 through the release of the new report of the Mental Hygiene Survey of the Province of Alberta.

Dr. Hincks provoked fear of the feeble-minded while alluding to the scientific promise of eugenic explanations.⁶¹ The CNCMH promoted these views and concentrated on four ways of improving the mental health of Canadian children.⁶²

⁵⁷ Hincks, *Mental Hygiene Survey of the Province of Alberta 1921*, p. 35.

⁵⁸ Ibid., p. 42.

⁵⁹ Timothy J. Christian, *The Mentally Ill and Human Rights in Alberta: A Study of the Alberta Sexual Sterilization Act* (Edmonton: University of Alberta Faculty of Law, 1973), p. 1.

⁶⁰ Garland, "The Social and Economic Origins of Genetic Determinism: a Case History of the American Eugenics Movement, 1900-1940 and its Lessons for Today," pp. 77-88.

⁶¹ MacLennan, "Beyond the Asylum: Professionalization and the Mental Hygiene Movement in Canada, 1914-1928," *CBMH/BCHM* 4 (1987), pp. 7-23.

⁶² Sutherland, *Children in English-Canadian Society: Framing the Twentieth-Century Consensus*, pp. 71-18.

The committee:

- asked the Canadian Government to work intensively to exclude mentally defective children and adults from the ranks of immigrants entering Canada
- advocated that feeble-minded youngsters be excluded from public schools and taught elsewhere. Since they were unable to take advantage of the instruction given, the afflicted children needed another option. The committee said that the presence of feeble-minded children impeded the academic progress of normal pupils and posed a “moral menace” to them as well.
- drew a relationship between feeble-mindedness and delinquency. They argued that abnormal juvenile delinquents were a real menace to society because they lacked the mentality to do right and had no power of inhibition.
- wanted to ensure that feeble-minded people did not reproduce.

The committee’s views presented in the 1921 report and the ensuing discussion of the report’s recommendations in numerous public forums became the driving force that shaped public beliefs and resulted in passage of the *Sexual Sterilization Act of Alberta* in 1928. Before this act was repealed in 1972, 2,832 Albertans were sterilized. Of these, a disproportionately high number were children and adolescents (39.2 per cent were under 15 years old; 25.8 per cent were 16 to 20 years old).⁶³

Christian, an Alberta researcher, offered two explanations for the higher rate of sterilization in children than in adults.⁶⁴ First, children were more likely to have been diagnosed as mentally deficient than as psychotic; hence, after the act’s amendment in 1947, they could be sterilized without consent. Second, in cases where consent was sought, the parents or guardians were likely to accept the opinion of the Eugenics Board’s panel of experts who appeared to have the child’s best interests at heart. Christian’s analysis also showed that more females were sterilized than males; most came from small towns rather than cities; and more were Protestant than Catholic. Albertans of East European and Indian or Métis ethnicity were over-represented. Today experts recognize that the tools used for intelligence testing are based on the shared cultural experience of the dominant population, and understand why vulnerable people of Indian and immigrant ancestry scored more poorly on the IQ tests used to establish a diagnosis of mental deficiency. These tests inadvertently discriminated against children, limiting their educational opportunities because they depended heavily upon reading ability and knowledge of Western concepts and values—and experience with the multiple-choice format. Many children felt the impact, as foreign-born parentage was high in Alberta. (In 1921, 41 per cent of children under age 10 came from families with two immigrant parents.)⁶⁵

Park and Radford put a human face to Alberta’s application of eugenics through their superb analysis of the Eugenics Board case files.⁶⁶ Their primary sources included clinical reports, diagnoses, test results, and patient histories with a

⁶³ Christian, *The Mentally Ill and Human Rights in Alberta: A Study of the Alberta Sexual Sterilization Act*, p. 49.

⁶⁴ *Ibid.*, p. 50.

⁶⁵ Sutherland, *Children in English-Canadian Society: Framing the Twentieth-Century Consensus*, p. 203.

⁶⁶ Deborah C. Park and John P. Radford, “From the Case Files: Reconstructing a History of Involuntary Sterilization,” *Disability & Society* 13, 3, pp. 317-42.

rationale for referrals from facilities including the Edmonton Guidance Clinic, the Provincial Training School in Red Deer, and the Provincial Mental Institutes in Edmonton and Ponoka. This analysis included heart-rending stories of people least able to defend themselves and demonstrated that, while sterilization was performed as a means of imposed birth control, it also served as a solution for social and behavioural problems including:

- abnormal sexual behaviour
- destructive and criminal tendencies
- deprivation of family support (e.g., outright child neglect, death of a parent, lack of a guardian, difficulty in securing a foster home, illegitimate offspring, and referral to social welfare agencies)
- impoverished family environment
- precondition to release from various institutions
- parental request to have a child sterilized in order to alleviate parental fears of sexual reproduction

As Christian stated, “those persons dealt with by the Eugenics Board had been branded with the most socially debilitating label of all—a psychiatric diagnosis.”⁶⁸

Eugenics Board Case 3280

Although the *Sexual Sterilization Act of Alberta* was repealed in 1972, the eugenics disgrace only came to the general attention of Albertans with Leilani Muir’s legal case in 1995.⁶⁹

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Number 3280

Leilani Muir sued the Alberta Government for wrongfully confining her, stigmatizing her as a moron and sterilizing her. The Klein government insisted on a full trial, which began in the Court of Queen’s Bench in Edmonton on June 2, 1995, the Honourable Madame Justice Joanne B. Veit presiding. After evidence provided over four weeks, Veit issued her precedent-setting decision in favour of Leilani Muir, ruling that the province had wrongfully detained her, rendering her a victim of many travesties including: loss of liberty; loss of reputation; and disgrace, pain and suffering; and loss of normal developmental experiences.⁷⁰ She determined that the province subjected Ms. Muir to irreversible wrongful sterilization, indicating that the damage inflicted was catastrophic for her.

⁶⁸ Christian, *The Mentally Ill and Human Rights in Alberta: A Study of the Alberta Sexual Sterilization Act*, p. 123.

⁶⁹ Douglas Wahlsten, “Leilani Muir versus the Philosopher King: Eugenics on Trial in Alberta,” *Genetica* 99 (1997), pp. 185-98. Muir v. Alberta, 36 Alta. L. R. (3rd) 305, (1996) 4 W.W.R. 177, 132 D. L.R. (4th) 695, 179 A.R. 321.

⁷⁰ Wahlsten, “Leilani Muir versus the Philosopher King: Eugenics on Trial in Alberta,” p. 195.

She then ordered the province to pay damages of \$740,780 plus \$230,000 for legal costs.

The court noted that the Eugenics Board knew that mental health problems could be confused with developmental disabilities. It also showed that the Eugenics Board itself recorded (especially in its early years) that some children referred to it were mentally retarded but did not fall under the board's mandate because they were not mental defectives. Finally, Dr. Hanley, a psychiatrist practicing in Alberta's Provincial Guidance Clinics in 1953 and in 1955, established conclusively that it was known in Alberta that emotional problems could cause developmental delays.

Other children with mental health disorders likely were treated similarly as intelligence—the key eugenic consideration—did not have to be documented before sterilization was performed. When documented, IQ testing was the only instrument used in the assessment. As well, the general public did not differentiate between mental illness and mental retardation at that time and institutions typically lodged individuals with both conditions together.⁷¹

Shelving the Issue

In its work across provinces, the CNCMH identified general conditions and areas for improvement and used its surveys as educational devices to influence provincial policies, organizational structures, and legislation concerning children. The extent of mental disorders was found to be greater than expected and preventive programs were nonexistent. Many of the conditions were shocking. In Edmonton, for example, a novel method of caring for low-grade, mentally defective children was observed and documented in the report. “At bedtime, the children were rolled in long strips of cotton with their arms and legs bound, and then piled on a shelf.”⁷²

Positive actions partially counterbalanced the negative, however, and the report's recommendations were taken seriously. The provincial surveys were thought to yield greater dividends in practical results than any other activity, both in spurring governments to action and in giving the CNCMH an opportunity to supervise mental hygiene developments.⁷³

Under Hincks' direction, the CNCMH continued dealing with mental deficiency in public schools, the area that had originally attracted Hincks to mental hygiene. Travelling from coast to coast, he surveyed schools in Canada's large towns and cities, examining children who were performing poorly. At a Toronto symposium

⁷¹ Benjamin Goldberg, *Developmental Disabilities in Images in Psychiatry, Canadian edition* (Toronto: Dundurn Press, 1996), p. 39.

⁷² Hincks, *Report on the Mental Hygiene Survey of the Province of Alberta*, p. 55.

⁷³ MacLennan, “Beyond the Asylum: Professionalization and the Mental Hygiene Movement in Canada, 1914-1928,” pp. 7-23.

in 1928, Dr. Charles Martin referred to Hincks' work in his report on the results of systematic inspection of Canadian schools, revealing that four per cent of school children needed mental hygiene treatment, without which they would inevitably suffer greater forms of mental disorder.⁷⁴

The Mental Defectives Act

The Mental Defectives Act introduced in 1919 reflected the legislature's recognition of the need to distinguish between mental disorders and mental retardation.⁷⁵ It defined defectives as persons incapable of managing their own affairs. Revisions to the act in 1922 left it virtually unchanged, although it expressly mentioned children in legislating dealings "with children or adults who are in a condition of arrested or incomplete development of mind."⁷⁶

Because so little was known about children's mental disorders at this time, children with mental disorders also were institutionalized under this act. Of interest, the act mentioned a home for feeble-minded children that opened in Edmonton in 1918. This home, the South Side Home for Feeble-Minded Children, was the first such centre established in Alberta. The Department of Education developed this home to accommodate as many as 50 children who could not function in the regular school system. The home was a small, temporary beginning, with the hope that a larger institution would be co-located at Oliver with the hospital for the insane.⁷⁷ This hope never materialized. What happened instead was the opening of the Provincial Training School at Michener Centre in Red Deer in 1923 on a section of land and within a three-story brick building that previously served as a women's college. The home on Edmonton's south side was closed, and the children transferred to this newly-established centre. The Provincial Training School opened with 108 children and youth under age 20 referred by family doctors, social workers, and eventually by mental hygiene (and later provincial guidance) clinics, and public schools directly. Historical accounts demonstrate that:

There was a wide range in the type of problems experienced by the various children. While retardation was the reason for admitting the child to the School, there were often other concerns, some of them relating to emotional disturbances. It was not uncommon for the occasional patient of either borderline or normal intelligence to suffer from emotional disturbances to the extent that the person could not fit into normal community life; such patients were often sent to the Training School.⁷⁸

For many years, this Provincial Training School was the only facility offering residential care and training for mentally handicapped children and youth. By 1928, the school population had reached 160 and, by 1929, it had a waiting list of 727 children, resulting in intense pressure from parents, social agencies, and legislators to increase admissions.

⁷⁴ Martin, "The Mental Hygiene Movement in Canada," p. 4.

⁷⁵ Statute of Alberta (S.A.) 1919, c. 21 *The Mental Defectives Act*.

⁷⁶ Statute of Alberta (S.A.) 1922, c. 224. *The Mental Defectives Act*.

⁷⁷ D. J. Dunn, "Mental Hygiene Activities in the Public Schools," *Public Health Journal* 15, 2 (1924), p. 57.

⁷⁸ Michener Center. *Michener Center: History 1923 to 1983* (Red Deer: Michener Centre, 1983), p. 4.

Specialized Classrooms

In 1924, Calgary and Edmonton provided special instruction for feeble-minded children. In Edmonton, Norwood School housed one of these auxiliary classes with spaces for 12 children, and King Edward School had spaces for 17. In Calgary, two special classes accommodating 30 subnormal children were established in a two-room school. These classes were hampered in many ways. There was a tendency to misunderstand and inadequately support the teachers' work, despite the fact that progress records demonstrated the value of the work. Also, the lack of psychiatrists to supervise the selection of children was a great disadvantage.⁷⁹

More Laws

In 1924, the *Insanity Act* became the *Mental Diseases Act*.⁸⁰ Once again children were neither expressly included nor excluded in this act. The act used the term "persons"; one can infer from the language of the act that children were not meant to be included among these persons.

In 1925, the *Child Welfare Act* was passed, differing little in principle from the *Children's Protection Act* of 1909. It did, however, widen the superintendent's power—including his supervision of the intake of immigrant children and broadening the grounds on which a child could be apprehended for neglect. According to this act, children could be apprehended for being found with vicious associates; found begging; found with obscene pictures; or found habitually using obscene, profane, and indecent language.⁸¹

Training and Research

On one of his many trips to Edmonton, Hincks met a teacher who had a year's training in mental hygiene at the University of Michigan. This teacher believed that his training enabled him to see how his profession could help children develop emotionally as well as intellectually into responsible citizens. Hincks believed that the CNCMH could play a more active role in this area and, subsequently, the CNCMH collaborated with the University of Toronto to prepare a one-year mental hygiene course for teachers. School boards across Canada sent selected teachers to take this training.⁸²

In 1929, the CNCMH made a modest grant to the University of Alberta to fund mental hygiene research. Professor J. M. MacEachran of the Department of Philosophy was the key person directing research in this field at the University of Alberta. His influence on education students and teachers was tremendous. He engendered great enthusiasm and interest in the topic of mental hygiene in

⁷⁹ Dunn, "Mental Hygiene Activities in the Public Schools," p. 62.

⁸⁰ Statute of Alberta (S.A.) 1924, c. 223. *The Mental Diseases Act*.

⁸¹ Statute of Alberta (S.A.) 1925, c.#4 the *Child Welfare Act*.

⁸² J.D. Griffin, *In Search of Sanity—A Chronicle of the Canadian Mental Health Association, 1918-1988* (London, ON: Third Eye Publications Inc., 1989), p. 82.

student teachers. As a result, the research sponsored by the CNCMH contributed directly to the development of mental hygiene services in the school system.

By this time, the University of Alberta also taught special psychology courses embodying mental hygiene's general outlook and main principles in all faculties—in addition to regular courses in the faculty of arts and sciences. Those special psychology courses became compulsory for medicine, dentistry, nursing, and education students. All teachers in training were required to attend a certain number of mental hygiene courses. In 1924, Dr. Dunn reported on the results of these courses:

During the last two years much interest has been shown by many of the teachers on the public school staff, who have been taking a course in psychology at the University of Alberta. This in time should have very gratifying results in the better grading of all pupils and in the assistance to place the sub-normal and mentally defective in their proper spheres.⁸³

Training people was the main objective of the University of Alberta's mental hygiene work funded by the CNCMH. Students whose interests and ability pointed to careers in psychiatry, psychology, social work, and education were targeted. Of these, the most promising received fellowships and summer employment in government clinics and public institutions.⁸⁴ This approach was prompted by the extreme shortage of professionals with mental hygiene knowledge and skills applicable to children.

Mental Hygiene Clinics

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Services provided through Mental Hygiene Clinics was the next major social service introduced after the juvenile court. After World War I, the Commonwealth Fund in the United States launched Mental Hygiene Clinics to prevent juvenile delinquency. Demonstration Mental Hygiene Clinics were opened in a number of American cities as originally conceptualized in the Commonwealth Fund program. The impetus behind and models for the Alberta Provincial Guidance Clinics therefore originated in the United States. (See "*Appendix B*" for the evolution of Provincial Guidance Clinics and the original prototype.)

⁸³ Dunn, "Mental Hygiene Activities in the Public Schools," p. 57.

⁸⁴ *Ibid.*, p. 52.

⁸⁵ Richardson, *The Century of the Child: The Mental Hygiene Movement and Social Policy in the United States and Canada*, p. 116.

⁸⁶ *Ibid.*, p. 117.

Determined to further enhance Canada's mental hygiene services, Hincks obtained a Rockefeller Foundation grant in 1924 to establish studies in the application of mental hygiene to children.⁸⁵ Within a year, the Department of Mental Hygiene Research in Toronto was established at the University of Toronto and in Montreal at McGill University. The grant provided financial support to achieve three areas of study: the intensive study of preschool children, demonstrations in parent training, and development of standards for child directed services in public agencies.⁸⁶

In Alberta, a process unfolded that significantly influenced the development of mental hygiene services. Seven years after the initial survey of the province, the Alberta Provincial Cabinet appointed Dr. Hincks and his colleague, Dr. C. B. Farrar, as commissioners to conduct another survey. This study was limited to three specific institutions: the Provincial Training School in Red Deer, the Oliver Mental Institute in Edmonton, and the Ponoka Mental Institute. The committee's task was to compare these against the standards of similar institutions. Hincks was well-prepared for the task, using a list of standards developed through his work across the country. The report, tabled in the legislature in February 1929, acknowledged progress made since the 1921 survey and repeated many of the recommendations.

Three striking new recommendations were made, however. The first focused on Mental Hygiene Clinics asking Edmonton to focus on children suffering from early mental disorders, behaviour problems, and psychopathic disorders. "If the clinic proves its worth, arrangements should be made to conduct a similar clinic in Calgary and a travelling clinic for the rest of the province."⁸⁷

The second focused on research, proposing collaborative projects between the University of Alberta and mental hygiene staff in research initiatives and for instruction in the university and the community. This followed the report's discussion on how psychiatry had been side-tracked by government from the general progress of medical science: "well coordinated research has been conducted in connection with physical disabilities but, because of lack of government assistance, there has been little research in the psychiatric field. This short-coming is now becoming evident."⁸⁸ The report recommended that the training school be relocated from Red Deer to Edmonton, arguing that an organization of this type should be located near a teaching centre where it could be supported by education and a large body of interested citizens (both of which would help attract suitable personnel).⁸⁹ This was a critical recommendation given that the average length of employment for staff at the training school was one year.

The recommendations also included the development of a nursing school and emphasized the benefits of sexual sterilization. Finally, Hincks encouraged the province to discard obsolete traditions and avoid the mistakes of older countries. In this spirit, he strongly advocated that psychiatric units be opened in general hospitals in the large cities for the treatment of mild and early cases and for the immediate placing of urgent cases under suitable medical care.

Shortly after the release of this report in 1929, the Alberta Public Health Department funded the establishment of Mental Hygiene Clinics in Calgary and Edmonton. These were set up as community agencies for the study and treatment of the whole child: "the children to whom it ministers come to its care because of disordered habits, troublesome personality traits, or unacceptable behaviour—intangible difficulties in the psychological rather than the physical realm."⁹⁰

⁸⁷ Clarence Hincks and C.B. Farrar, *Report of Commissioners Appointed to Investigate the Provincial Training School at Red Deer, Provincial Mental Institute at Oliver, Provincial Mental Institute at Ponoka* (Edmonton: Government of Alberta, 1929), p. 5.

⁸⁸ Ibid.

⁸⁹ Ibid, p. 12.

⁹⁰ Sydney Kinnear Smith, "Child Guidance Clinics," *Journal of the American Medical Association* 94, 10 (March 8, 1930), pp. 710-14.

Behavioural difficulties were seen as symptoms of serious underlying disturbances in the mental, physical, or social spheres, which were destroying “the harmonious adjustment of the child to the environment.” Helen’s story is a case in point. From agencies with a mission to provide preventive services through various mental hygiene initiatives, the clinics were becoming treatment agencies. Their chief aims were correct diagnosis and manipulation of the environment for children’s benefit.

Helen’s Story

Shortly after her older brother died, six-year-old Helen was brought to the Mental Hygiene Clinic by her aunt. Helen was so uncooperative that a formal examination was dispensed with.

Her appearance was striking—with her peculiar hopping gait and vacant, puzzled, questioning, constant laughter, and a distinctly odd stare with her mouth wide open. She admitted to auditory and visual hallucinations—and to her fear of them—during lengthy discussions with clinic staff.

“She feels that she can move people around at will, that she can shoot them out of the door and can keep them away for a considerable period. She does not get along with other children. They tease her. She speaks frankly of her brother and his death with no particular emotion.”

Up to age five, Helen had lived with her parents, moving from city to country. Her mother got tuberculosis and was sent to a sanatorium. Her father tried to keep house for her and her brother. A year later this brother died. The home was broken and Helen went to live with her aunt. Her queer behaviours dated to her brother’s death. She would awaken early, laugh and talk to herself; she would look in mirrors, make faces, and talk to the radiator. At times she appeared frightened and moved as if she were brushing something away. She began to wet and soil herself. A doctor advised sending her to school. The aunt warned the teacher that she feared the child was crazy. A month later, the teacher confirmed this diagnosis and refused to keep Helen in school.

Professionals consulted and agreed that Helen suffered from a mental disease and needed hospital observation and treatment. Five weeks after admission, she was discharged to a children’s group home. She lived there without arousing complaint or criticism and started attending public school where she did well.⁹¹

⁹¹ Smith, “Child Guidance Clinics,” pp. 710-14.

A Tireless Trailblazer's Legacy

Hincks' enthusiasm and hard work advanced mental hygiene for the benefit of all provinces. His diligence in pursuing enhancements in children's services was remarkable. Through his work from 1918 until his retirement in 1971, the CNCMH:

- improved public attitudes toward mental hygiene
- introduced the Binet-Simon intelligence test into Canada, which provided new insights into child behaviour
- introduced the first Mental Hygiene Clinic in a Canadian hospital
- conducted psychiatric screening of immigrants under federal government auspices
- developed the first university institute for child research
- initiated parent education on child development in Canada
- created nursery schools
- detected mentally deficient children in Canadian schools and persuaded school boards to provide special classes and special schools for these children
- provided the first one-year training program in special education (including children's mental health) for school teachers from across the country
- developed Canada's first vocational guidance centre.

Chapter 3

The Dirty '30s: From Mental Deficiency to Mental Illness



The dumb, the crazy,
the mad, the bad, the
problem children

The dumb, the crazy, the mad, the bad, the problem children

By autumn 1929, the Great Depression had begun. Of the Prairie provinces, Alberta was the most severely affected. By the end of 1931, 24 per cent of Alberta wage earners were unemployed and 40,000 Albertans were on relief. Unbearable hardships, such as lost jobs, homes, farms, and self-respect came with the economic depression and, in many cases, generated clinical depression that led to suicide. In 1930 alone, 71 Albertans committed suicide.⁹²

Alberta's welfare structure was too undeveloped to meet the demands for support. The crisis forced a reassessment of the fundamental values underlying Alberta's welfare programs to date. For example, traditional beliefs that poverty arose from laziness and general incapacity could not account for the masses needing public assistance. The prevailing idea that volunteer organizations and private charity provided enough support for sick and disabled people proved faulty as these organizations also lacked the resources to meet the extensive demands and could not provide services when they were needed most.

The public pressured governments to deal with the issues through social legislation.⁹³ The Alberta Government, hampered by limited revenues from various forms of taxation, was widely criticized for not doing more to alleviate the misery of the depression. The difficulties seemed insurmountable, with mass poverty becoming an overwhelming welfare problem among Albertans. Direct relief—called “the dole”⁹⁴ and the counterpart of today's public assistance—cost far more than municipalities could afford and was made possible only by federal government intervention.⁹⁵

In 1935, the *Alberta Health Insurance Act* was passed, empowering the province to create and administer health insurance districts if the municipal residents voted for such action. It enabled every person within the district to receive hospitalization in a public ward with medical and dental treatment. The province paid the medical practitioner or dentist according to the terms of the act.⁹⁶

Mental illness, rather than mental deficiency, began receiving more attention in the clinical literature of the mid-1930s. Through public education, childhood studies, and parent education, researchers now argued it was possible to alter behaviour, cure illness, and remedy problems that biological determinism once considered beyond repair.⁹⁷ American research continued to influence Canadian thinking greatly and—in Alberta as in the United States—the battle against

⁹² Ted Byfield, “1930, The Year When Everything Went to Pieces Throughout Alberta,” *Alberta in the 20th Century, Volume Six* (Edmonton: United Western Communications Ltd., 2000), p. 25.

This was a significant increase compared with the 16 recorded suicides in 1908. B. E. Krewski, *The Alberta Department of Social Services and Community Health: A History* (Edmonton: Government of Alberta, 1979), p. 8.

⁹³ Edgar McInnis, *Canada: A Political and Social History* (Toronto: Holt, Rinehart & Winston, 1959), p. 441.

⁹⁴ Byfield, “1930, The Year When Everything Went to Pieces Throughout Alberta,” p. 26. (The “dole” was a source of great shame in the 1930s, and most Albertans tried to provide for themselves with whatever other resources they could find.)

⁹⁵ Lysne, “Welfare in Alberta, 1905-1936,” p. 134.

⁹⁶ Statutes of Alberta, 1935. cap. 49.

⁹⁷ K.J.A. McConnachie, “Science and Ideology: The Mental Hygiene and Eugenics Movements in the Inter-War Years, 1919-1939.” Master's thesis. University of Alberta, 1987, p. 165.

mental defectiveness was supplanted by concern for mental hygiene. Lectures by visiting American scientists and fellowships awarded to Canadian graduate students for study in the United States ensured a cross-border flow of research findings. Mental hygiene was conceptualized in terms of acquired reaction patterns and the prevention of mental problems: "Mental disease represents a failure occurring between the individual and his environment and the problem of prevention involves a more complete understanding of the individual capacities, of the environmental factors and of the dynamic interrelations between the individual and the environment."⁹⁸

Leading scholars did not negate the role of heredity totally, but rather relegated it to a secondary role in shaping human behaviour, intelligence patterns, and social adjustment problems. In her 1930 text, *Child Psychology*, Margaret Curti cited the importance of both heredity and environment in shaping development. She emphasized opportunity, experience, training, and motivation as environmental factors shaping abilities.⁹⁹ The intelligence test, therefore, had to be seen as a measure of acquired knowledge and the ability to handle language. She dismissed the idea that the intelligence test directly and accurately measured inherited intelligence. Faith in science remained but was now tempered by an awareness of the scope and complexity of environmental factors shaping development and the scientific research yet to be done.¹⁰⁰

Efforts to forestall functional disorders by creating a positive, nurturing environment and attention to childhood grew with the new psychology. It was possible, psychologists argued, to shape and direct the child's behaviour. Delinquency, once linked to mental deficiency, was increasingly redefined as misconduct, which should be dealt with by follow-up social service agencies rather than by isolation and segregation. "The mental hygiene point of view, with its emphasis on understanding the motives which underlie conduct and its attempt to effect adjustment to the factors in the situation, is rapidly displacing older ideas of discipline."¹⁰¹ The targets of prevention programs were now all children, not just those seen as abnormal, and the political responsibility for children's welfare was thus extended to all children.¹⁰²

Symonds, a leading American psychologist, wrote a primer on the importance of mental hygiene in schools, arguing that mental hygienists largely neglected the social point of view of education. He focused on school structure and on practical approaches to dealing with a wide range of student behaviours (e.g., bullying, teasing, and daydreaming). He emphasized the importance of teachers' attitudes and understanding and the necessity of ongoing professional development. Symonds also advocated that mental hygiene principles permeate classroom work, curriculum organization, pupil placement, and extracurricular activities, as well as making the study of the problem pupil part of the school's guidance service under the direction of a specially and adequately trained psychological counsellor.¹⁰³ Albertans expressed great concern that teachers did not seem to

⁹⁸ W.T.B. Mitchell, "Mental Hygiene," *Ontario Journal of Neuropsychiatry* 37 (1932), p. 191.

⁹⁹ M.W. Curti, *Child Psychology* (New York: Longmans, Green and Co, 1938), p. 56.

¹⁰⁰ *Ibid.*, p. 200.

¹⁰¹ P.M. Symonds, *Mental Hygiene of the School Child* (New York: The MacMillan Company, 1934), p. x.

¹⁰² MacLennan, "Beyond the Asylum: Professionalization and the Mental Hygiene Movement in Canada, 1914-1928," pp. 7-23.

¹⁰³ Symonds, *Mental Hygiene of the School Child*, p. 260.

achieve full appreciation of children's classroom problems in their normal school courses:

...it is true that the classroom teacher is quite unprepared to pick out cases where symptoms of incipient mental disorder are present. In many cases no differentiation is made between mental retardation and mental disease, the "dumb" individual being called "crazy", and the "crazy" individual "dumb". Too, despite their training, teachers will openly and persistently tell Johnnie he is dumb and rag him unmercifully before the class—which leads to much more misery for Johnnie at the hands of his fellow students.¹⁰⁴

Of course, this was not the general behaviour of teachers who, on the whole, were sincere in doing their best for children. Their challenges were well-recognized, including overcrowded classrooms, lack of resources, and often-inadequate salaries. One of the most serious effects of the economic crisis between 1928 and 1933 was school closures, the reduction in the numbers of teachers employed, and as much as a 33 per cent decline in teachers' salaries. Many rural schools closed for months during the winter because school districts could not afford coal and children had too few warm clothes to wear.¹⁰⁵ Thus, school, with its natural environment for support of children's mental hygiene, was seriously jeopardized during this period.

Serious concern about the educational preparation of staff (called attendants) working in mental institutions became evident and training programs for these workers were nonexistent. The 1930s brought significant and lasting benefits to the mental hygiene field through the introduction of the first formal nursing training program for mental hospital attendants at the Ponoka Mental Institute. This program marked the beginning of what became a well-recognized credentialing process for registered psychiatric nurses, although these nurses did not care for children.

Mental Hygiene Clinics

A shifting focus in mental hygiene was evident by 1930. Clinics initially established to prevent juvenile delinquency attended to many problems that had no affiliation with delinquency or mental diseases. Apparently, minor difficulties commanded attention because they were frequent and because they might become serious if unattended. The passion to identify the abnormal had given way to preventing problems in the normal.

The Mental Hygiene Clinics established in 1929 in Calgary and Edmonton and funded by the Provincial Health Department were soon followed by clinics in

¹⁰⁴Edward Kibblewhite, "Provincial Guidance Clinics in Alberta, With a Study of Selected Clinic Cases of School Age Children." Master's thesis. University of Alberta, 1937, p. 23.

¹⁰⁵League for Social Reconstruction, *Report Produced by the League for Social Reconstruction* (Alberta: League for Social Reconstruction, 1931), pp. 20-22.

Lethbridge (1930), in Drumheller and Medicine Hat (1933), and in Coleman, High River, and Ponoka (1937). The opening of these clinics indicated the perception of their value and high priority, given the extensive demands on government to finance social programs. In fall 1934, services were expanded through travelling clinics, which began with a series of clinics in Grande Prairie and Peace River. In the 1930s, these efforts were very modest:

- The Edmonton clinic was held Monday afternoons in the Civic Block in the rooms otherwise used by the baby clinic. (The Civic Block, Edmonton's first City Hall, opened in 1913 and brought all of the city's administrative functions under one roof until the new one opened in 1957.)
- The Calgary clinic was an all-day clinic held every other Wednesday in City Hall's preschool and baby clinics space.
- The Lethbridge clinic operated every fourth Friday as an all-day clinic in the Nursing Mission.
- The Medicine Hat clinic operated two full days about every three months. The first day was devoted to adults; the second to school age cases.
- The Drumheller clinic was held a full day every two or three months.
- The clinics held in the Grande Prairie and Peace River Regions were annual events conducted over a two-week period. They were held in whatever space was available. While these were intended to be annual events, the trip could not be made in 1935 because of personnel shortages.¹⁰⁶

Clinic personnel typically included a psychiatrist and a social worker. From 1929 to 1931, Dr. Charles P. Fitzpatrick directed the clinics and S. K. Jaffary was the first social worker, who also completed the psychological assessments since no psychologist was on staff. He was replaced by Edward Kibblewhite in 1931.

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Dr. C. A. Baragar, commissioner for mental institutions and director of mental hygiene services for Alberta, took over the clinics in 1931. Dr. Baragar sought a publicly acceptable name for the Mental Hygiene Clinics and renamed them Guidance Clinics, which was consistent with the American terminology. Although they were formally called Alberta Guidance Clinics, the literature (survey reports, for example) continued to refer to them as Mental Hygiene Clinics for several more years.¹⁰⁷

Dr. W. J. McAllister, superintendent of the Provincial Mental Institute in Edmonton, was in charge of the work in the Edmonton clinic, while Dr. G. Davidson, the superintendent of the Provincial Mental Institute in Ponoka, worked with the clinics in southern Alberta. In 1936, the clinic directors included Dr. R. MacLean in southern Alberta, assisted by Dr. Michie and Dr. Valens who was in charge of the Provincial Auxiliary Hospital in Claresholm. Together with Dr. Clarence Hincks, these men were among the true Alberta pioneers in children's mental hygiene services, and they had demanding workloads:

¹⁰⁶Kibblewhite, *Provincial Guidance Clinics in Alberta, With a Study of Selected Clinic Cases of School Age Children*, pp. 5-7.

¹⁰⁷W.R.N. Blair, *Mental Health In Alberta, Vol. 11* (Edmonton: Government of Alberta, 1973), p. 9.

The psychiatrist in every case interviews the patient and relatives and guardians where this is possible, and does what examining seems indicated in the physical, neurological and psychiatric fields. The social worker assists in the interviews and does any psychological and mental testing work required, and in a certain number of cases, outside investigation work.¹⁰⁸

In 1935, 2,133 new cases were seen in 90 clinics around Alberta. The clinic assessments were extensive despite the teams' lack of psychologists and nurses. Assessments included the individual's personal history, family history, school and developmental achievements, and medical examination.¹⁰⁹ From 1931 to 1937, Kibblewhite attended all clinics held in the province as the only staff social worker. In many cases, efforts were made to schedule follow-up visits for continued treatment; however, the minimal staffing made maintaining contact difficult. Clinic staff collaborated with public health nurses throughout the province. Their support was especially evident in Calgary, Drumheller, and Medicine Hat where nurses arranged the clinic appointments and assisted in the clinics whenever possible.

Referrals came from schools, child welfare workers, juvenile courts, family doctors, as well as parents, relatives, and friends. The percentage of referrals from these sources varied across the province, reflecting local circumstances. A large percentage of Calgary referrals came from schools; in Edmonton, most were referred by Child Welfare. This was attributed to the differences in school administrations and also to the fact that Edmonton was then the "headquarters and clearing centre for child welfare work."¹¹⁰

Henry's Story

Henry was brought to the clinic after an attempted suicide by shooting himself with a 22 rifle, the bullet going through the left lung just under his heart. Henry was 12 at the time and in Grade 5. He had trouble with spelling. The day before the shooting, he failed his spelling test with a score of 45 per cent. His teacher called him "Little 45" and made him stand up and tell the class his score. Going home from school that day, he remarked that he felt like shooting himself. The following morning he got up as usual and did his chores. When he did not return for breakfast his mother called him. He was pale and crying and had shot himself out back in the coulee.

Henry recovered well physically. With the clinic's help, his parents and teacher developed a better understanding of his needs and stopped the ridicule, which led to successful social adjustment.

¹⁰⁸Kibblewhite, *Provincial Guidance Clinics in Alberta, With a Study of Selected Clinic Cases of School Age Children*, p. 2.

¹⁰⁹*Ibid.*, pp. 26-81. The assessment approach was well-demonstrated through the documented review of several clinical cases.

¹¹⁰*Ibid.*, p. 7.

The clinics' work saved lives, as the preceding story demonstrates.¹¹¹ Intervention with one child and family also benefitted other children in the classroom and in the community.

School-aged children seen at the clinics were diagnosed with a range of disorders, including mental deficiency with behaviour issues, speech defects, behaviour problems without deficiency, delinquency, epilepsy, enuresis, psychoses, and various other clinical conditions. Mentally deficient children represented the largest group examined, at 41 per cent of the total number of children seen in 1934 and 46 per cent of those seen in 1935. In 1935, 20 preschool children were examined. Of these, 11 were diagnosed as mentally deficient. Others were seen for epilepsy, hearing and speech problems, temper tantrums, and one for hydrocephalus. Analysis of school-aged children seen in 1935 showed a similar caseload with 46 per cent of children given a diagnosis of mental deficiency. The purpose in seeing them was to ascertain the extent of mental retardation and outline a suitable method of carrying on so that the child could benefit as much as possible from the training period, according to Mr. Kibblewhite.¹¹²

Another feature of the Provincial Guidance Clinics' work was preparing cases for presentation to the Eugenics Board, which reviewed cases every two or three months. The clinics offered a service for the early recognition of these children. For example, the clinic records described a family of 10 children, two of whom were brought to the clinic in 1933 for immoral conduct. They were subsequently sterilized. After a detailed family study, the clinic's recommendation was that all family members be sterilized: "With at least six of the ten siblings of the family definitely defective, and one of the others epileptic, there would seem little chance of their offspring being mentally normal, especially as they are likely to mate with those of about their own mental level."¹¹³ By 1937, the Eugenics Board had passed 950 cases and 480 of them were sterilized.

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The Provincial Guidance Clinics dealt with more boys than girls both in 1934 and 1935, at 60 per cent boys and 40 per cent girls and served adults as well. In 1934, of the 428 cases seen, 20 (4.7 per cent) were preschool children; 279 (65.2 per cent) were from seven to 18 years old and 129 (30 per cent) were over 18. The following year, 42.1 per cent of the 363 new people seen were adults. The clinics provided an important, but still insufficient service to meet the needs of Alberta children in 1935. Services were severely limited by the few available personnel. Kibblewhite strongly advocated for additional social workers and for more psychiatrists at the mental institutions so more of them could also work in the Provincial Guidance Clinics. Unfortunately, the necessary funding was not made available.

¹¹¹Ibid., pp. 67-72. Abridgement from case presentation.

¹¹²Ibid., p. 21.

¹¹³Ibid., p. 37.

By the late 1930s, urban children received health education through four different approaches: during medical inspections and routine physical examinations, through lectures given by school medical officers at parent-teacher meetings,

through health care agencies, and through the press and radio.¹¹⁴ Children's physical health was receiving increasing attention. In larger centres, children often received a complete physical examination upon entering school. Kibblewhite advocated that mental examinations be included in this process, arguing that such an approach could prevent pain and save time for the student, family, and teacher. He lamented the large amounts of funding going to improve Alberta herds, grains, roads and cars, while a mere pittance was spent on children. He was also progressive in promoting the wisdom of having accurate running records of each child with results of physical and mental examinations, school achievements, social adjustment, and special problems—a database that could be shared across service providers to guide each child into a suitable life course.¹¹⁵

¹¹⁴P. Charlotte Rooke, "Charlotte Whitton Meets 'The Last Best West': The Politics of Child Welfare in Alberta, 1929-1949," *Prairie Forum* 6, 2 (1981), p. 158.

¹¹⁵Kibblewhite, *Provincial Guidance Clinics in Alberta, With a Study of Selected Clinic Cases of School Age Children*, pp. 23-24.

Chapter 4

The Unforgettable '40s: Children's Mental Hygiene during War



The educationally subnormal,
the psychotic, the
emotionally disturbed child

The educationally subnormal, the psychotic, the emotionally disturbed child

It was an exhilarating time and also a time of great hardship. Across the province, people pursued the common cause of winning the war. Ancestry did not matter as Albertans strove for the same goal.¹¹⁶ Alberta's role in the military effort rekindled a spirit of optimism, pride, and energy. Among the war's biggest burdens for most Albertans, beyond the loss of family members serving overseas, was the shortages of basic foods and supplies and the hardships of rationing. As well, housing shortages reached crisis levels, with the influx of military personnel and farmers leaving farms for city jobs. People lived in poor conditions, including chicken coops and squalid rooms, tents, or worse.¹¹⁷

The war effort drained the provincial treasury, with government needing cash most of all.¹¹⁸ At the war's end in 1945, Albertans mourned the loss of loved ones, welcomed home the survivors, and sought better living conditions. The government, still struggling with the debt burden of the depression, was further taxed with such post-war reconstruction projects as roads, public buildings, schools, power, oil, coal, and forestry, as well as attending to the continuing serious housing shortages and extensive public welfare programs. These social programs had grown so complex it became necessary to establish the Alberta Department of Public Welfare in 1944.¹¹⁹

Visible psychiatric services in the military and more sophisticated psychological understanding (largely resulting from the dissemination of psychoanalytic principles) helped Albertans view psychiatry as important and valuable to the war effort. When peace came, this energy became directed toward treating mental illness in the general population.¹²⁰ Little time and few resources, however, were devoted to children's mental hygiene issues, perhaps because, until the middle years of the war, no major concerns had been raised about child welfare programs.¹²¹

Provincial Guidance Clinics

Work by the Provincial Guidance Clinics established in the 1930s was seriously curtailed during the war. No clinics were held in Grande Prairie and Peace River from 1938 to 1949, in Medicine Hat and High River from 1942 to 1946, nor in Drumheller and Lethbridge from 1943 to 1946 due primarily to staff shortages.¹²² Only the largest cities had regular clinic services and even there

¹¹⁶Ted Byfield, "The War that United the Province," *Alberta in the 20th Century, Volume Eight* (Edmonton: United Western Communications Ltd., 2000), p. 42.

¹¹⁷R. Collins, "As the War Became Real, Albertans Hurdled Themselves into the Cause," *Ibid.*, p. 134.

¹¹⁸*Ibid.*, p. 123.

¹¹⁹This new department consolidated responsibility for all forms of relief, child welfare, the *Juvenile Court Act*, the *Domestic Relations Act*, *Old Age Pension Act*, *Mother's Allowance Act*, and the *Act Respecting the Métis Population of Alberta* (passed in 1939 followed Ewing Commission recommendations in 1936 identifying the Métis people in Alberta as a group requiring assistance). Source: B.E. Krewski, *The Alberta Department Of Social Services and Community Health: A History* (Edmonton: Government of Alberta, 1979), p. 8.

¹²⁰Rae-Grant Quentin, *Images in Psychiatry* (Washington: American Psychiatric Press Inc., 1996), p. 21.

¹²¹Krewski, *The Alberta Department Of Social Services and Community Health: A History*, p. 18.

¹²²Griffin, *In Search of Sanity—A Chronicle of the Canadian Mental Health Association 1918-1988*, p. 117.

periodic closures occurred. The Edmonton clinic was closed from April to September and the Calgary clinic during November and December in 1945, because no staff were available. Two key members of the clinic staff, Kibblewhite and Munroe, were on leaves-of-absence doing war work in England.¹²³ Most of the clinics closed during the war years were reopened in 1947.¹²⁴ An outbreak of poliomyelitis cancelled the planned reopening of the Peace River service in 1948.¹²⁵

As originally conceived, the Provincial Guidance Clinics were to deliver services in consultation with schools, courts, and social welfare agencies. Consultation, however, soon declined sharply in favour of treating the children and their parents at the clinic almost exclusively. When fully operational, the Provincial Guidance Clinics followed this protocol:

- Collect information on the child in an effort to understand the child's difficulties.
- Conduct a physical examination.
- Complete a psychological examination to determine the child's mental status, educational achievement, abilities, and handicaps.
- Perform a psychiatric examination for diagnostic purposes.
- Plan a treatment approach best suited to each child's needs.¹²⁶

Between 1942 and 1946, 405 new cases, (a total of 1,367 children) were seen in the clinics.¹²⁷ These continued to be held at intervals ranging from weekly to monthly, with travelling clinics in 1947 providing services to: Brooks, Claresholm, Didsbury, High River, Lamont, Pincher Creek, Ponoka, Stettler, and Three Hills.¹²⁸ Dr. D. L. McCullough, medical superintendent of the Provincial Training School, conducted the Guidance Clinics held in the Red Deer Health Unit and also saw cases at the request of the Royal Canadian Mounted Police, who played an instrumental role in children's welfare. As well, the school saw many "outpatients" and advised and instructed their parents.¹²⁹ In addition to their clinical work, the clinic staff members provided public education through lectures, workshops, round table discussions, and institutes. They also cooperated with the CNCMH in its radio broadcast programs, "In Search of Ourselves," and the discussion groups following these radio shows.¹³⁰

Mental Diseases and Mental Defectives Acts

The *Mental Diseases Act* and the *Mental Defectives Act* were updated again in 1942, with essentially no changes in relation to children. Major advance in chief guidance philosophy, however, expressed in Dr. Moodie's work published in British clinical literature: "The mental defective is no longer placed in the old rigid categories of idiot, imbecile and feeble-minded. These names are considered to carry a stigma and now it is customary to talk of the "educationally subnormal."¹³¹

¹²³Alberta Department of Public Health, *Annual Report* (Edmonton: Alberta Department of Public Health, 1948), p. 144.

¹²⁴Blair, *Mental Health In Alberta, Vol. II*, pp. 22-25. Alberta Department of Public Health, *Annual Report* (Edmonton: Alberta Department of Public Health, 1949), p. 23.

¹²⁵Alberta Department of Public Health, *Annual Report* (Edmonton: Alberta Department of Public Health, 1948), p.157.

¹²⁶Francis Van Hesteran, "Foundations of the Guidance Movement in Canada." Doctor's thesis. University of Alberta, 1971, p. 145.

¹²⁷*Ibid.*, p. 24.

¹²⁸The National Committee for Mental Hygiene. *Report of the Survey of Mental Institutions and of Provincial Guidance Clinics In The Province Of Alberta 1947* (Toronto: The National Committee for Mental Hygiene, 1947), pp. 39-46.

¹²⁹Alberta Department of Public Health, *Annual Report* (Edmonton: Alberta Department of Public Health, 1945), p. 108.

¹³⁰Alberta Department of Public Health, *Annual Report* (Edmonton: Alberta Department of Public Health, 1948), p. 147. Alberta Department of Public Health, *Annual Report* (Edmonton: Alberta Department of Public Health, 1949), p. 125.

¹³¹W. Moodie, "The Future of Child Guidance," in N.G. Harris and J.H. Price, ed., *Modern Trends in Psychological Medicine* (Oxford: Hoeber, 1948), p. 189.

Moodie advocated for IQ tests being discarded in favour of intelligence profiles which would separate the various functions of intelligence from one another and express them separately. Thus, instead of seeing only the sum total, the integral parts of intelligence could be individually studied. He referred in his text to broad groups of “problem children”—the anxious, hysterical, obsessional, and delinquent—and highlighted the dawning recognition of psychosis in the young: “Previously, psychotic children were usually classed as defectives and were placed with them.”¹³² Improvements in treatment methods required accurate diagnosis. Placement decisions were difficult because of a new recognition that acute mental disease delayed normal growth and development.

Moodie emphasized environmental adjustment whenever possible as the modern treatment approach and argued that a child be removed from his or her home only when conditions were seriously disturbing and unalterable. He also advocated the use of non-medical specialists working under psychiatric supervision, highlighting the example of play therapists’ expertise at enabling children to express feelings in words, pictures, or play, depending upon age and choice.¹³³

Around the same time, Dr. Baldwin, a University of Iowa psychologist, was conducting research in preschool mental health. His work centred on preschool children because he saw most adolescent problems—especially delinquency and social maladjustments—developing between the ages of one-and-a-half to six years which he called the most important years of childhood.¹³⁴

Amending the *Child Welfare Act*

In 1943, criticism of the administration of child welfare programs led to a public inquiry and amendments to the *Child Welfare Act* the next year. These amendments provided for the establishment of a Child Welfare Commission responsible for investigating charges, allegations, and reports relating to the Department of Public Welfare’s Child Welfare Branch.¹³⁵ Before this Commission (established in 1947) had completed its first inquiry, the Imperial Order of the Daughters of the Empire (IODE) published the results of its own study—A Canadian Welfare Council Survey—completed by Charlotte Whitton in 1949.¹³⁶ This report levelled remarkably disturbing criticisms of Alberta for falling below all other English-speaking provinces except for New Brunswick in caring for dependent children.¹³⁷ The survey itself was troubling enough to compel government to appoint a commission to inquire into its findings. The commission’s report, tabled in the Legislative Assembly on February 18, 1949, affirmed a number of the IODE report’s recommendations. It also led to the *Public Welfare Act* of 1949, which mandated provincial payment for 60 per cent of the costs incurred by municipalities for child welfare and social assistance. This was great progress from years of major reliance on municipalities and

¹³²Ibid., p. 190.

¹³³Ibid., p. 194.

¹³⁴B.T. Baldwin, “Child Development,” *Mental Hygiene of Childhood* (Toronto: The Canadian National Committee for Mental Hygiene, 1948), p. 2.

¹³⁵Statue of Alberta. *An Act to Amend the Child Welfare Act*. 1944.

¹³⁶Rooke, “Charlotte Whitton Meets ‘The Last Best West’: The Politics of Child Welfare in Alberta, 1929-1949,” pp. 143-63.

¹³⁷Rooke, *Studies in Canadian Childhood History: A Canadian Perspective*, p. 86.

philanthropy for the support of children's social services. The commissioners expressed great concern about the scarcity and poor quality of care available for juvenile delinquents.¹³⁸ Concerns expressed in the body of the report were reflected in its recommendations for:

- modernized facilities
- institutional training for boys to be immediately instituted under provincial auspices
- girls not to be committed to a correctional institution unless and until found by a court to be delinquent
- juvenile court judges to be carefully selected, appointed, and paid by the Attorney General.¹³⁹

Two years later, the Department of Public Welfare went even further in transferring responsibility for juvenile delinquents to the Attorney General's Department.

A Third CNCMH Survey

Towards mid-decade, concern was growing among mental health professionals about the conditions in mental hygiene programs, particularly in the provincial asylums. These programs had been seriously affected by staffing shortages and impoverished budgets characteristic of the depression and war years. Through an Order-in-Council dated September 19, 1947, government commissioned Dr. Hincks and the CNCMH to complete a third survey of mental institutions and the Provincial Guidance Clinics. The four-week survey succinctly identified very poor conditions in institutions but acknowledged the government's interest in improving them as the beginning of positive changes.

The Provincial Training School in Red Deer was included in this review as one of the mental institutions in the province. The report recommended that this facility improve its physical plant, noting that overcrowding patients posed one of the greatest threats to scientific treatment and humanitarian care, while acknowledging a \$50,000 government grant in 1947 for facility improvements. The review was positive overall: "In regard to mentally deficient children, Alberta has made separate provisions for this group at the Provincial Training School with suitable arrangements for segregation according to sex, chronological age and mental age. These provisions for children are in line with accepted standard practice."¹⁴⁰

The report noted that the Provincial Training School had two physicians and drew upon the Ponoka hospital's medical and laboratory resources. It applauded the organized training courses available for nurses, teachers, and attendants, saying that these contributed to high staff morale: "...as evident during the war when markedly reduced staff assumed double duties, without complaint, as their contribution to the war effort."¹⁴¹

¹³⁸Alberta had more than 5,000 delinquents under the provisions of the *Public Welfare Act* by 1940. Of these, only 238 were girls. The province had no reform schools, and delinquents were placed in foster homes, usually on farms where they helped with the farm work. Source: Malcom Bow, "Public Health and Welfare in Alberta," *Canadian Welfare Summary* 15, 5 (1940), pp. 38-45.

¹³⁹Kathleen Jackson, "Alberta's Children: A Review of the Royal Commission on the Child Welfare Branch," *Canadian Welfare* 24, 8 (1949), p. 41.

¹⁴⁰National Committee for Mental Hygiene. *Report of Survey of Mental Institutions and of Provincial Guidance Clinics in the Province of Alberta*, p. 14.

¹⁴¹*Ibid.*, p. 33.

In another publication,¹⁴² Hincks cited the need for 1.25 to 2 beds per thousand people and the fact that less than one bed per thousand was available. Hincks also commented enthusiastically on Provincial Guidance Clinics' progressive efforts and an Edmonton pilot project begun in 1946. This experiment was a partnership between the Provincial Guidance Clinic and the Sturgeon Rural Health Unit, actively supported by local Medical Officer of Health H. Siemens and the district school boards. In this pilot, Mr. MacDougall, an experienced teacher, received a bursary to train in clinical psychology. The school boards paid his salary, and he consulted with teachers in the district about children with mental health problems. He provided students with individual counselling as needed, conducted classroom discussions about behaviour and human relations, and worked with parents individually and in mental hygiene study-group meetings about the wholesome upbringing of children. He also referred children who needed more intensive services to Edmonton's Provincial Guidance Clinic and served as a clinical liaison between the clinic and the schools.¹⁴³ It is clear from Dr. Siemens' description in *The Canadian Medical Association Journal*¹⁴⁴ that this approach was introduced to address needs not met through the Provincial Guidance Clinic's periodic visits and because a local clinic was not affordable through municipal funding.

This approach was seen as leading edge work by the CNCMH. Hincks saw it as a prototype for a new profession whose focus would be not only on prevention of mental illness but on the active development of mental health in school children, as well as on serving as a connecting link between the mental hygiene system and the child in school. He noted Provincial Guidance Clinics were providing an essential service in the treatment of children. He also praised this new approach as necessary for prevention and used his influence to introduce this unique Canadian model across the country: "As a direct result of this pioneering work in Alberta, plans are now being developed for the training of guidance officers to be attached to clinics throughout Canada who will work in school systems in partnership with teachers, parents and health personnel."¹⁴⁵

The standards against which Hincks measured the clinics included:

- staffing of each clinic must have trained personnel including a psychiatrist, psychologist, social worker, and secretary
- establishment of an intimate partnership with physicians, teachers, public health, and community social workers
- furnishing of diagnostic, treatment, and preventive services
- provision of one full-time clinic team to serve the needs of 100,000 to 200,000 of the population.¹⁴⁶

Hinck's recommended that in order to meet these requirements, Alberta add one full-time clinic a year for several years.

¹⁴²C. Hincks, "Twenty-Five Years of Mental Hygiene," *Canadian Welfare* 24, 7 (1949). pp. 48-52.

¹⁴³H. Siemens, "Mental Hygiene in a Health Unit," *The Canadian Medical Association Journal* 68, 3 (March 1953), pp. 205-09.

¹⁴⁴*Ibid.*

¹⁴⁵*Ibid.*

¹⁴⁶*Ibid.*, p. 42.

The report commented positively on three other new developments:

- The introduction of a full-time permanent clinic headquartered in Calgary, which provided services in a number of rural locations south of Red Deer, in 1947. This clinic was headed by Dr. A. R. Schrag, a psychiatrist with specialized experience in working with children and the first full-time psychiatrist in Provincial Guidance Clinics. The Calgary clinic also was staffed by three social workers.
- An Edmonton clinic opened in 1948 funded by federal health grants and staffed by a psychiatrist who had trained in child psychiatry in Detroit.¹⁴⁷ Until then, Edmonton had operated with only a part-time psychiatrist from the Edmonton Mental Institute and a full-time social worker.
- These clinics were seen as very progressive because they were community-rather than hospital-based. Dr. Jean Pettifor, a psychologist at the Calgary Guidance Clinic in 1948, described the values of these pioneering clinics, emphasizing the importance of the child: “The greatest contribution to the mental health of society is in helping children to develop normally by either helping parents or by public education.”¹⁴⁸
- Counselling services in schools blossomed. Calgary had 30 part-time counsellors under the supervision of a director of guidance, and Edmonton had nine part-time counsellors. By 1949, Lethbridge, Medicine Hat, and Red Deer had appointed school counsellors, and Calgary and Edmonton had appointed supervisors of guidance in their schools.¹⁴⁹

School Counselling Services

Headway in school counselling came with the establishment of the Department of Education's Guidance Branch and the appointment of Mr. Aldridge as its first director. He emphasized the importance of the counsellor's role in “making every effort to achieve the fullest possible personal growth of the student.”¹⁵⁰ Emphasis shifted from vocational guidance—offered to some extent in select schools since the 1930s—to a concern for all of children's personal, social, and emotional problems. This development fitted with the belief that existed from the beginning of the mental hygiene movement that schools and their teachers would, of necessity, have to play a vital role in successfully implementing the mental hygiene philosophy. The two movements complemented each other and, at times, blended as demonstrated in the Sturgeon Health Unit project so highly praised by Dr. Hincks.

The report concluded that Alberta had attained a credible standard of humanitarian care—the cautionary note being that a still higher level of care could be achieved through a number of recommendations (phrased as “desirable lines of progress”),¹⁵¹ including an increase in the ratio of staff to patients.¹⁵² The report,

¹⁴⁷Alberta Department of Public Health, *Annual Report* (Edmonton: Alberta Department of Public Health, 1948), p. 158.

¹⁴⁸Jane Matheson, “Children's Mental Health in Alberta: We Are Where We've Been.” Public Presentation, Woods Homes, Calgary, 2001.

¹⁴⁹Alberta Education Planning & Research, *Report of the Task Force on School Counselling and Guidance in Alberta* (Edmonton: Alberta Education Planning & Research, 1981), p. 192.

¹⁵⁰Van Hesteran, *Foundations of the Guidance Movement in Canada*, p. 162.

¹⁵¹*Ibid.*, p. 46.

¹⁵²*Ibid.*, p. 37.

completed in a very short time, was perhaps too positive. Its impact was likely to minimize the problems of the day in the public's perspective and, in doing so, proved a disservice to Albertans in not serving as a stronger prompt for greatly needed government action in this area.

Following on the heels of this survey was an unrelated but powerful national development. In 1948, the Canadian government implemented the National Health Grants Program—a precursor to national health insurance—to help the provinces update and strengthen health programs. The largest of these grants (\$4 million) was earmarked specifically for new work in mental hygiene. A mental hygiene advisory committee urged research and a coordinated program for postgraduate education in the mental health disciplines, as well as initiatives to further public education and prevention.¹⁵³ The federal government encouraged every province to conduct a survey of its needs for services and personnel. Having just completed the CNCMH report, Alberta was prepared.

Simultaneously, Leduc #1 struck oil, profoundly changing Alberta's history and economic security. Many oil derricks soon peppered the fields, and Albertans—whose depression and war years' experience had created a mentality of “hope for the best, expect the worse, and take what comes,”¹⁵⁴ closed the decade with cautious optimism. Hincks, meanwhile, concluded that much had been achieved but professionals had only scratched the surface of what must be done: “The chief tasks lie ahead and if significant progress is to be made, it is not enough that the general public understand the importance of mental health. They must also cooperate wholeheartedly in the tremendous task of solving this problem, upon whose solution rests the whole future of civilization.”¹⁵⁵

¹⁵³Quentin, *Images in Psychiatry*, p. 17. Hincks, “Twenty-Five Years of Mental Hygiene,” p. 52.

¹⁵⁴R. Collins, “After A Fruitless Ten-Year Search, Imperial Strikes the Big Bonanza,” *Alberta in the 20th Century: Leduc, Manning & the Age of Prosperity, 1946-1963* (Edmonton: United Western Communications Ltd., 2000), p. 14.

¹⁵⁵Hincks, “Twenty-Five Years of Mental Hygiene,” p. 52.

Chapter 5

The Flying '50s: From Handicapped Child to Exceptional Child



The patient, the victim
of conditions, the
intellectually inadequate,
the exceptional child

The patient, the victim of conditions, the intellectually inadequate, the exceptional child

As oil mania swept the province in the decade after the Leduc oil strike, Alberta experienced growing pains as it changed from a primarily agricultural to an industrial province.¹⁵⁶ Alberta oil became plentiful, which gave Albertans new hope.¹⁵⁷ Oil and gas royalties gave the government the enviable position of relying on two industries, oil and agriculture: “In the 1955-56 fiscal year for instance, the Alberta Government pulled in \$225 per capita in revenues, compared with the \$125 per capita average of other provincial governments. Forty percent of the money came from oil and gas.”¹⁵⁸ In 1951, the government spent \$25 million on municipalities, school boards, and health boards and \$13 million on major highways. This spending responded to the needs (and provided some satisfaction) for Albertans supporting their growing post-war families.

Some things had changed little since Alberta’s birth as a province. The politicians in office and their supporters remained true to the belief that most people could and should look after themselves. Although government recognized a responsibility to help those in need through misfortune, it still saw the financing of welfare programs as socialism that would only encourage idleness and sap individual enterprise. As MacGregor noted: “The oil riches actually became an embarrassment to a government with a noisy minority who derided social programming as socialist handouts—especially with unemployment at five percent.”¹⁵⁹ This staunch approach became increasingly difficult to maintain, however, in the face of Alberta’s new-found wealth and demands from growing cities for grants to maintain the infrastructure for essential services and support social programs.

Alongside the “good life,” jails also were built, including the opening of the Bowden Institution for juvenile delinquents between the ages of 16 and 25 in 1961.¹⁶⁰ Youth crime was growing along with fears about youth using street drugs and joining gangs that would terrorize communities.¹⁶¹ Edmonton Mayor Harry Ainly claimed that 60 per cent of policing in Alberta dealt with juvenile crime: “...they are youth from 14 to 25 years whose crimes have not been those of hardened criminals, but intolerable acts against society—acts for which punishment must be given.”¹⁶² Disturbing youth behaviour led to structural changes. Prior to January 1, 1952, the Department of Welfare administered the *Juvenile Delinquents Act of Alberta*. This administrative structure fitted with the act’s intent of care, treatment, and guardianship. An investigation into the

¹⁵⁶Collins, “After A Fruitless Ten-Year Search, Imperial Strikes the Big Bonanza,” *Alberta in the 20th Century: Leduc, Manning & the Age of Prosperity, 1946-1963*, pp. 4-23.

¹⁵⁷Alberta ended 1956 with 7,390 wells gushing oil, compared with 418 wells 10 years earlier. Albertans lived in a dream world in which the earth seemed to yield a second harvest with oil under every wheat stook. Source: J. G. MacGregor, *Edmonton, a History* (Edmonton: M.G. Hurtig, 1967), pp. 274-80.

¹⁵⁸*Ibid.*, p. 64.

¹⁵⁹*Ibid.*, p. 63.

¹⁶⁰Regarded as a progressive institution for its times, Bowden had the capacity for 240 young offenders.
<http://www.justice.gov.ab.ca/JustIN/fall05/page4.htm> (October 2005).

¹⁶¹MacGregor, *Edmonton, a History*, p. 190.

¹⁶²*Ibid.*, p. 193.

increasing crime rate, however, clearly indicated that the Department of Welfare was unable to properly fulfil the act's judicial function; juveniles involved in criminal activity quickly discovered that no real legal roadblocks thwarted them.¹⁶³ Regardless of the act's humanitarian intent, it existed to deal with those who violated the law and so became seen as a matter for government's law enforcement and judicial arm, the Attorney General's Department.

Provincial Guidance Clinics

The Provincial Guidance Clinics, with their expertise in ambiguous areas, met popular needs and continued to grow, though less quickly than the CNCMH had proposed. In 1950, a new plan for the administrative overview of the clinics divided the province into three zones, each of which had three to nine clinic locations. Edmonton was the Northern Zone headquarters; Calgary the Southern Zone headquarters; and the Provincial Mental Hospital in Ponoka and the Provincial Training School in Red Deer were Central Zone Headquarters.¹⁶⁴ National Health Grants provided support for the clinics (particularly in Calgary and Edmonton), with funds for staffing, books, and equipment. In 1954, a full-time clinic opened in Lethbridge with a social worker as the regular staff member, followed by the appointment of a psychiatrist two years later. Staffing remained a major issue, with professionals travelling from one clinic to another through the end of the decade (e.g., Calgary clinic's psychologist also working in Lethbridge). Travelling teams visited rural communities for one week at each location.

The clinics collaborated closely with the Children's Aid Departments, Child Welfare Department, health units, public health and district nurses, school authorities (including superintendents and teachers), as well as physicians in private practice whose offices often hosted the clinics (which usually lacked permanent sites). Clinic staff also continued public education, including television appearances later in the decade.¹⁶⁵ The CNCMH became the Canadian Mental Health Association (CMHA) in 1950 and stressed the potential of radio and television for promoting mental health. CMHA conducted a study on how to educate parents in order to promote infants' and children's mental health. Its national office promoted children's mental health needs on the Canadian Broadcasting Corporation (CBC) and produced brochures, pamphlets, and study guides which it distributed directly to the public or through its newly-established Provincial Divisional Offices. The Alberta Division was opened in 1954, with its head office in Edmonton. Shortly afterwards, it introduced its first community services, group homes, and drop-in centres.¹⁶⁶

Clinic caseloads increased annually around Alberta, but the travelling clinics were continually vulnerable to cancellations due to inclement weather, impassable road conditions, communicable disease outbreaks, and (most often) loss of hard-to-

¹⁶³*Report of the Alberta Royal Commission on Juvenile Delinquency* (Edmonton: Government of Alberta, February 15, 1967), p. 30.

¹⁶⁴Alberta Department of Public Health, *Annual Report* (Edmonton: Alberta Department of Public Health, 1950), p. 179.

¹⁶⁵Television broadcasting arrived in Alberta in 1954. Reception via a roof antenna was mostly snowy and the sound tinny. Most programming, including commercials, was broadcast live—resulting in many glitches and interruptions. Even so, Albertans seemed to prefer it to radio, a more sophisticated medium with a worldwide network of connections. Source: Ric Dolphin, "The One-Eye Monster Arrives—Notwithstanding Some Heavy Odds," *Alberta in the 20th Century, Volume Nine: Leduc, Manning & the Age of Prosperity, 1946-1963* (Edmonton: United Western Communications Ltd., 2000), p. 140.

¹⁶⁶Griffin, *In Search of Sanity—A Chronicle of the CMHA, 1918-1988*, pp. 160-75.

replace professional staff. From 1952 to 1956, Alberta recorded 6,003 new cases, compared with 1,367 seen between 1942 and 1946.¹⁶⁷ A significant number of children were seen because of “intellectual inadequacy.” In 1953, for example, 37 per cent of children under five, 23 per cent of children aged six to 18, and 12 per cent of young adults over 19, fit into that classification.¹⁶⁸ The clinics also saw young adults over age 19 (between 10 and 20 per cent of the total clients, according to the annual reports of the 1940s and 1950s). Services to the jails continued. For example, 50 prisoners were assessed in 1957 at the request of the jail authorities.¹⁶⁹

In addition to people requesting assessment and diagnosis, the clinics saw an increasing number of returning cases, demonstrating an increased treatment focus. Often these regular clients were severely disturbed young children:¹⁷⁰ “There was little opportunity for any sustained program of psychotherapy in the early years of the clinics. Now, with increases in staff and better physical accommodation, psychotherapy is a regular part of the program and many cases are continued in therapy for varying periods of time, usually with encouraging results.”¹⁷¹ By the 1950s, children now seen as normal children with difficulties were examined and tested in order to help them with their emotional problems rather than to gain information about them. Children were viewed as victims of conditions rather than as participants in them—a change that profoundly influenced clinical methods, with the child becoming an active participant in the process designed to result in better adjustment: “...no longer are children regarded as automatons, reflecting unhealthy attitudes of others and incapable of change except as conditions in which they live are changed.”¹⁷²

The field also recognized that work should involve both child and parent: “... basic to clinic practice is the recognition that both child and parent have had a part in the creation of the difficulty for which help is sought and that both will have a part in the solution.”¹⁷³ This did not imply that the clinics provided no help when a child had no parent available, but that most clinics undertaking treatment sought to work with the individual responsible for the child as well. This approach called for individualized treatment plans. The involved parent played an active role and discovered that this had a powerful impact on the child’s own use of treatment.¹⁷⁴ By this time, the belief that childhood problems were the precursors of adult difficulties and maladjustments became entrenched and was reflected in the beginning of the clinics’ parent support approaches.

The General Practitioner and Emotional Disturbances

The literature of the 1950s clearly documented family physicians’ frustrations in dealing with children’s emotional disorders in their practices. Family

¹⁶⁷The CMHA, Alberta Division, *Mental Hospital Care: Revisiting the 1920s* (Alberta: The CMHA, Alberta Division, 1990), p. 1.

¹⁶⁸Blair, *Mental Health in Alberta*, Vol. II, p. 24.

¹⁶⁹Alberta Department of Public Health, *Annual Report* (Edmonton: Alberta Department of Public Health, 1953), p. 158.

¹⁷⁰Alberta Department of Public Health, *Annual Report* (Edmonton: Alberta Department of Public Health, 1957), p. 85.

¹⁷¹*Ibid.*, p. 82.

¹⁷²Blair, *Mental Health in Alberta*, Vol. II, p. 21.

¹⁷³J. Franklin Robinson, “Current Trends in Child Guidance Clinics,” *Mental Hygiene* 34, 1 (January 1950), p. 109.

¹⁷⁴*Ibid.*

Physician Dr. M. Lattey described these disorders as the least well-handled in spite of the fact that they represented an estimated 30 per cent of a general practitioner's work: "Although the treatment of these patients is time consuming, I do not think that this is the reason for this neglect, because a conscientious and interested doctor will always find time to help his patients if he knows how. Much of our irritation and difficulty stems from the fact that we do not know how."¹⁷⁵ In a different article highlighting the specialized skills needed with children, another general practitioner, Dr. M.G. Martin, suggested ways of proceeding with the extremely difficult process of psychiatric diagnosis with children, noting that a physician who was skilful in interviewing children was typically quite expert in interviewing adults.¹⁷⁶ These appeals for help seem to have gone largely unheard despite the widespread agreement that family physicians were a strong and essential resource in providing mental health services.¹⁷⁷

Services for Retarded Children

Pressure to increase treatment spaces for children with intellectual inadequacies continued throughout this decade. In 1950, the Provincial Training School in Red Deer admitted 101 new children, most of them labelled as bed-ridden imbeciles requiring permanent institutionalization.¹⁷⁸ Admission applications were accompanied by the guidance clinics' assessment memorandum to help the school prioritize admissions.

The need for professional care was great and trained staff nearly unavailable. The ongoing struggle for adequate staff was a serious handicap, although the numerous applicants in 1950 allowed the school to be selective. Thus, the school chose staff members with a Grade 11 or 12 education and trained them through specifically designed courses that led to a diploma in Mental Deficiency Nursing in three years.¹⁷⁹ This program included many of the same basic courses offered by other nursing schools, and it became well-recognized for its excellence locally and by other provinces.

In 1950, the school added social work services after recruiting a professionally trained social worker. This role facilitated patient placements after discharge and the follow-up needed for success in the community. A qualified dietician and a certified occupational therapist were secured in 1951.¹⁸⁰ National Health Grants funded the development of new units. Annual admissions exceeded 200 for most of the 1950s, and the bed count rose to nearly 800 by the end of the decade—a great change from the 108 beds in 1923.

In 1954, the Alberta Association for Retarded Children was established as a new voluntary organization. One of nine provincial associations affiliated with the Canadian Association for Retarded Children, its primary goal was to

¹⁷⁵M. Lattey, "The General Practitioner and Emotional Disturbances," *Canadian Medical Association Journal* 68, 3 (1953), p. 209.

¹⁷⁶M.G. Martin, "Examination of the Disturbed Child in General Practice," *Canadian Medical Association Journal* 79 (1958), p. 499.

¹⁷⁷W.R.N. Blair, *Mental Health in Alberta* (Edmonton: Government of Alberta, 1969), p. 75.

¹⁷⁸Alberta Department of Public Health, *Annual Report* (Edmonton: Alberta Department of Public Health, 1950), p. 172.

¹⁷⁹*Ibid.*

¹⁸⁰Alberta Department of Public Health, *Annual Report* (Edmonton: Alberta Department of Public Health 1951), p. 150.

establish new programs and services to meet the backlogged needs of mentally retarded children. The Canadian literature (although not the Alberta reports) began using the terminology “exceptional child” to describe all children who were handicapped physically, intellectually, emotionally, or in their social adjustment, and to describe those who were mentally gifted. The term “exceptional” was thought to have a more positive connotation than the commonly used “handicapped” and also could include extreme characteristics not usually considered handicaps.¹⁸¹ Proponents of the term argued that it would perhaps decrease stigmatization.

They also cooperated with the CNCMH in its radio broadcast programs, “In Search of Ourselves,” and the discussion groups following these radio shows.

The Golden Jubilee and Legislative Change

The celebration of 50 years as a province could not have come at a better time. Energized by the buoyant economy, Albertans celebrated with fireworks, parades, sports days, dances, pageants, formal proceedings, and festivals of pioneering history and ethnic heritage. Life was easier overall, thanks to substantial progress having been made in many areas. This included progress in services for the mentally ill—new buildings, new clinics, improved and increased staffing, and the development of research programs for mentally ill people, all of which helped to establish mental health and mental illness as a new professional interest. At last it seemed that the province was moving forward in this area.

Despite progress in the mental health field, the federal *Hospital Insurance and Diagnostic Services Act* of 1957 specifically excluded mental hospital patients from the benefits offered patients in general hospitals. As Tyhurst observed: “Once again, mental illness was stigmatized officially as a disorder apart, segregated and excluded from benefits and services offered in treatment of physical illness.”¹⁸² In 1956, as the Canadian government prepared the legislation for national hospital insurance, it announced that it would not contribute financially to services already being provided by the provinces. Consequently, all mental health services were excluded from this proposed legislation. The justification for this exclusion was the reasoning that the provinces would see federal participation in mental hospital programs as fiscal aid.¹⁸³ Advocacy by the Department of National Health and Welfare, the CMHA, the Canadian Psychiatric Association, and universities successfully altered this policy direction so that only mental hospitals were excluded when the new legislation was introduced. In 1957, the government enacted the *Hospital Insurance and Diagnostic Services Act*. When it was proclaimed, six of the 10 provinces endorsed it immediately and the remaining provinces joined the plan within four years. Under this act, the federal government paid the provinces 50 per cent of all costs of hospital care and inpatient services. Canadians thus had access to hospital care at no personal cost.

¹⁸¹J. Asseltine, “Child Guidance, the Exceptional Child and the School System,” *Canadian Psychiatric Association Journal* 4, 3 (1959), pp. 198-99.

¹⁸²J.S. Tyhurst, et al., *More for the Mind: A Study of Psychiatric Services in Canada* (Toronto: The Canadian Mental Health Association, 1963), p. 3.

¹⁸³C. Roberts, “Major Changes in the Administration of Psychiatric Services in Canada,” *Canadian Psychiatric Association Journal* 2, 3 (1966), pp. 228-41.

This change encouraged the development of psychiatric units in general hospitals, as well as substantially increasing private practice, community clinics, and outpatient departments of general hospitals—all programs in which psychiatric services were fully covered.¹⁸⁴ Before this change, the Calgary General Hospital had opened a 20-bed psychiatric unit in 1954 and the University of Alberta Hospital followed suit. (Actually, a “psychopathic” ward had accommodated 16 patients at the University of Alberta Hospital in 1931 but closed two years later because of economic reasons.¹⁸⁵) These two new units were functioning at full capacity in 1955, with 424 first admissions in the Calgary unit (which admitted both men and women) and 461 first admissions at the University of Alberta Hospital (which admitted women only).¹⁸⁶ Although these developments did not contribute to children's services immediately, they set the stage for positive developments to follow.

Another important legislative change was introduced specifically for children's mental health services. This 1959 amendment to the *Mental Diseases Act* contained a new section referring specifically to a child's admission to “Emotionally Disturbed Children's Wards.”¹⁸⁷ This new section added: “The Lieutenant Governor in Council may declare to be an emotionally disturbed children's ward any part of an approved hospital within the meaning of The Hospitals Act.”¹⁸⁸ Although the province had no such wards at that time, the legislation now provided for children (defined as under the age of 14) to be admitted if they were suffering from an emotional disturbance and upon the request of a medical practitioner or a psychologist from a Provincial Guidance Clinic and with a written application by the parent or guardian.

¹⁸⁴C. Roberts and J. Griffin, “History of Psychiatry in Canada,” in Quentin, *Images In Psychiatry*, p. 16.

¹⁸⁵Blair, *Mental Health in Alberta*, Vol. II, p. 84.

¹⁸⁶Alberta Department of Public Health, *Annual Report* (Edmonton: Alberta Department of Public Health, 1955), p. 76. Over the next few years, all major hospital opened similar units, with Red Deer being last in 1982. Source: Canadian Mental Health Association, *Mental Hospital Care: Revisiting the 1920s* (Alberta Division: Canadian Mental Health Association, 1990), p. 1.

¹⁸⁷*The Mental Diseases Act*, Amendment Provision, 1959, C.51, s.2.

¹⁸⁸*Ibid.*, C.51, s.4.

Chapter 6

The Revolutionary '60s: Psychiatric Treatment in General Hospitals



The socially deviant,
the mentally ill child,
Indian children

The socially deviant, the mentally ill child, Indian children

The social movements of the 1960s introduced unique and fundamental changes to a decade that, on the surface, looked similar to the 1950s. It was a difficult decade in many ways, with a lasting impact on the very foundations of Alberta. Whether the cause was the Vietnam War, feminism, sexual freedom, civil rights, the environment, or the struggle for world peace, the message was clear. Traditional values needed to make room for youth culture. The hippie phenomenon, rock and roll, pop bands, and folk music all focused on exposing the issues of the time and expressed the ever-present social consciousness. Unprecedented levels of personal disposable income came with the thriving economy and supported the explosion in popular and classical arts. The generation gap became part of common consciousness, as did a tendency to resist authority.¹⁸⁹ Barbaric and bizarre crimes shocked the province. Newspaper reports claimed that crime had risen by 29 per cent in the last year of the decade.¹⁹⁰ As the 1960s progressed, so did the use of street drugs—especially marijuana and LSD.

Albertans living in impoverished conditions in the midst of a prosperous province, and their problems, became more visible. Native Albertans living in deplorable conditions and farmers (half of whom were estimated to live below the poverty line) received particular attention. Urbanization taxed the infrastructure of growing cities and plagued city planners.¹⁹¹

Fundamental changes became evident in mental health service delivery. Adult psychiatry units in general hospitals were becoming much more common, as Dr. Hincks had recommended in 1929.¹⁹² Centred in the large metropolitan teaching hospitals associated with academic health centres and medical schools, these units were controlled by the individual hospital boards and were not part of the services provided through the Division of Mental Health.¹⁹³ As foreshadowed by the 1959 amendment to the *Mental Diseases Act*, these improvements in adult mental health services influenced mental health services for children.

A Children's Unit in Edmonton

In keeping with the trend in adult services and influenced by CMHA advocacy, the Alberta Government agreed to expand treatment opportunities for children by creating a child psychiatry unit at the University of Alberta Hospital. An eight-

¹⁸⁹Mike Maunder, "Tune in, turn on and take over: 'youth culture' feel its power," *Alberta in the 20th Century, Volume 10: The Sixties Revolution and the Fall of Social Credit, 1962-1971*, p. 42.

¹⁹⁰David Staples, "The Gallows and the Lash: Barbaric Relics, or Crucial Tools of Justice," *Ibid.*, p. 197.

¹⁹¹Farmers, who accounted for almost half the provincial population in 1941, fell to 19.2 per cent by 1966. Estimates indicated of half of Alberta's farm families lived below the poverty line. By 1967, more than 100 farmers a month were abandoning their land, unable to cope with rising farm operating costs. Source: Carme Wittmeir, "The Great Alberta Shake-Out," *Alberta in the 20th Century, Volume 10: The Sixties Revolution & the Fall of Social Credit* (Edmonton: United Western Communications Ltd., 2000), pp. 239-51.

¹⁹²Hincks and Farrar, *Report of Commissioners Appointed to Investigate the Provincial Training School at Red Deer, Provincial Mental Institute at Oliver and the Provincial Mental Hospital at Ponoka*, p. 54.

¹⁹³Blair, *Mental Health in Alberta*, Vol. I, p. 10.

bed unit opened in January 1960.¹⁹⁴ It was established as a short-stay unit intended to diagnose disturbed children and provide a therapeutic and treatment experience that involved the child's family. From there, children might go on to intermediate or long-term care. As the first such unit in western Canada, this was a very innovative step for Alberta.¹⁹⁵

The unit operated in close liaison with the university departments of pediatrics and psychiatry. Staffing included a clinical team and a teacher provided by the Edmonton Public School Board to teach the children during their hospital stay. Dr. McTaggart, an assistant professor in the department of psychiatry, headed this unit for its first four years of operation.

The most frequent referrals were children with such problems as: unruliness at school and home; angry, aggressive behaviours; running away; temper tantrums; and resistance to eating and sleeping. Children typically had suffered from these problems for months or even years and had become the focus of concern for their family, community, and school. As seen in Samuel's case, some responded well to therapeutic intervention involving both the child and family.¹⁹⁶

The unit's close working relationship with pediatrics resulted in many consultation requests for children with medical conditions such as asthma, anorexia nervosa, and ulcerative colitis. Over the first few years, doctors referred an increasing number of psychotic children diagnosed with adolescent phase schizophrenia. Many of these were sent on to institutions for long-term care.

Samuel's Story

As an eight-year-old, Samuel already had been setting fires for several years, to the great concern of his neighbourhood. He was well-known in the community, as his fire-setting activities had received page one coverage in the local newspaper.

After admission to the unit, Samuel established a reputation by sketching a picture of the University Hospital going up in flames on the blackboard in the playroom. The picture remained for many days until a roommate could no longer tolerate it and erased it. When Samuel's father was told about the incident, he laughed and remarked on his son's ability to establish notoriety in a new setting so rapidly.

His father also gave Samuel cigarettes even though the rules forbade it. Simultaneously, the parents attacked their son for his behaviour and set

¹⁹⁴A.N. McTaggart, "Emotionally Disturbed Children: Description of a Treatment Program in a General Hospital," *The Canadian Nurse* 6, 4 (1965), pp. 294-96.

¹⁹⁵The first unit of this type opened in Saint Justine's Hospital in Montreal in 1957 followed a year later by another at Montreal's Children's Hospital. Source: *Ibid.*, p. 294.

¹⁹⁶Abridgement from McTaggart, "Emotionally Disturbed Children: Description of a Treatment Program in a General Hospital," p. 295.

up a series of events that gradually destroyed Samuel's feelings of self-esteem. His rebellious behaviour was rooted in intense anxiety.

Samuel responded well to his hospital treatment involving his family in the treatment process, and was discharged without further misdemeanours.

Referrals of children with subnormal intelligence were also common, and the psychological and neurological services available enabled a rapid and effective assessment and helped ensure appropriate placement. Other hospital diagnostic services used frequently included ophthalmology, dental, and x-ray facilities. Multidisciplinary treatment was seen as one of the marked advantages of locating the unit in a hospital. The unit was also advantageous when outpatient treatment was unsuccessful. In such cases, short hospitalization might help the child better adjust. At times, for example with Samuel's family, such a hospitalization also gave the child's parents an opportunity to see the impact of their relationship on their child more clearly—something impossible without this intensive treatment approach. Great effort went into creating a therapeutic milieu with a core program. The therapeutic core program was one in which children's behaviour was observed, assessed, and adjusted in the following context:

Children were on the unit 24-hours a day, with two children to a room. An attempt was made to create a family setting in which each child was accepted unconditionally and received a sincere display of affection and approval at all times. The rhythm of the day involved:

- occupational therapy first thing in the morning, followed by school
- meals were eaten sitting around the table among other children and nursing staff
- after lunch, children freely discussed problems arising on the unit for one hour
- school for two hours, followed by an hour of free time
- individual therapeutic sessions scheduled throughout the day
- the evening meal, followed by time for study and physical activity
- a program of organized recreation using the hospital department of rehabilitation facilities

- children going home on weekends whenever possible. Information gained from the parents about their weekend experience was used to plan therapy.¹⁹⁷

The unit's social worker played an invaluable role from preadmission to discharge with families, as well as with community organizations involved with discharge planning. Major difficulties occurred when the community was unable to provide adequate placement programs following hospital discharge; unfortunately this occurred regularly.

Linden House

Except for the new unit at the University of Alberta Hospital, no psychiatric treatment facilities for children were available in the province at the time. In its many years of operation, the Provincial Training School (PTS) in Red Deer had accommodated some children of normal intelligence who had emotional disorders even though it served primarily retarded children and young adults: "...wards at the PTS had a mix of patients of different levels and type of handicap in spite of the efforts to separate the mentally ill from the mentally retarded."¹⁹⁸ For many years care-providers had been concerned that many school trainees (and, indeed, children across the province) had emotional rather than mental handicaps or were emotionally disturbed and only mildly retarded. Finally, public acknowledgment of and government support for emotionally disturbed children being treated in a facility distinct from that for mentally retarded children resulted in a new treatment program in 1960. Called Linden House, it started as a pilot project in a renovated building at the Provincial Training School under Dr. L. J. leVann's direction and supervision.

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Linden House was designed to treat emotionally disturbed children aged five to 15 who had normal or better intelligence, with emphasis placed on the medical aspect of their care. Most of the children came from families living in extreme poverty "including homes where parents were severely psychoneurotic, insane, alcoholics, as well as on public assistance."¹⁹⁹ Children stayed for several months and, in some cases, years in this facility and typically attended school in Red Deer during the day.

The pilot project was designed to accommodate 30 children and admitted 25 in its first year.²⁰⁰ Linden House's innovative program was successful from early on and attracted many visitors. In 1965, its status as a pilot project was terminated and the program extended.²⁰¹

¹⁹⁷Ibid., p. 296.

¹⁹⁸*Michener Centre: History 1923-1983*, p. 6.

¹⁹⁹Blair, *Mental Health in Alberta*, Vol. I, p. 33.

²⁰⁰Ibid., p. 14.

²⁰¹Ibid.

Calgary's Children's Hospital

A program for inpatient care of emotionally disturbed children opened at the Children's Hospital in Calgary in 1969,²⁰² an appropriate setting considering the Children's Hospital's major focus on children with complex illnesses throughout its history. Similar to the University of Alberta Hospital unit opened in 1961, it included both scheduled treatment and schooling activities in a therapeutic environment involving the family.

The Mental Health Act

The Mental Health Act introduced in 1964 repealed the *Mental Defectives Act* and the *Mental Diseases Act* and combined “mentally defective persons” and “persons suffering from mental diseases” under the same legislation. The new act did not include the section in the 1955 *Mental Diseases Act* that addressed “Emotionally Disturbed Children's Wards,” but such children were mentioned in its regulations.²⁰³ These were the first substantial Mental Health Regulations and the first and only time a specific section dealt with children. An “emotionally disturbed child” was defined as “a person suffering from mental disorder without mental retardation under the age of 16.”²⁰⁴ Emotionally disturbed children, as specified by these regulations, could be treated at Linden House at the Provincial Training School in Red Deer. They could be admitted pursuant to Section 5 of the act with consent of one parent or legal guardian and a physician's recommendation.

The regulations also determined that persons suffering from mental retardation between the ages of four and 16, as well as grossly deformed mentally retarded children under the age of four who required specialized care, could be admitted to the Provincial Training School (now called the Alberta School Hospital) in Red Deer.²⁰⁵ This represented a significant change as the PTS previously had admitted children over five years old only.

The new regulations designated Linden House, its parent organization (the Alberta School Hospital), and the University of Alberta Hospital Unit as hospitals under *The Mental Health Act* Regulations. This new legislation also renamed the Provincial Guidance Clinics as “Alberta Guidance Clinics” and designated them as hospitals, although they could examine and treat outpatients only.²⁰⁶

In affiliation with the Alberta School Hospital, Calgary's Baker Memorial Sanatorium opened a Pediatric Unit in 1962, followed by the opening of an additional 41-bed unit two years later. This unit treated mentally defective infants who also had some gross physical abnormalities or who also needed medical or surgical attention. It was described as a short-term measure only, in anticipation of the development of purpose-designed programs and facilities for this special population.²⁰⁷

²⁰²A. Coppes-Zantinga and I. Mitchell, *The Child in the Centre: 75 Years at the Alberta Children's Hospital* (Calgary: University of Calgary Press, 1997) p. 154.

²⁰³*The Mental Health Act*. Statutes of Alberta. Alberta Regulations 675/1964.

²⁰⁴*Ibid.*, s.7(1).

²⁰⁵*Ibid.*, s.5(1) and s.5(3).

²⁰⁶*Ibid.*, s.8.

²⁰⁷Blair, *Mental Health in Alberta: A Report on the Alberta Mental Health Study*, p. 6.

Glenrose School Hospital

A major change benefitting children was the opening of Edmonton's Glenrose School Hospital in September 1966. This new provincial hospital developed to provide a multidisciplinary team approach to treatment, education, and rehabilitation of physically handicapped and emotionally disturbed children from age five to 18.²⁰⁸ One program stream could handle up to 40 emotionally disturbed children and a second, 180 physically handicapped children. The Alberta Guidance Clinic in Edmonton administered the unit for emotionally disturbed children—a structure that created practical problems for the unit because it operated in isolation from the rest of the provincial hospital.²⁰⁹

Despite this problem, the unit provided a high level of patient care.²¹⁰ Its treatment approach was sophisticated, facilitated by a rich mix of expertise from physiotherapy, occupational therapy, speech therapy, psychology, social services, nursing, medical specialists, and two resident psychiatrists. As in other hospital-based psychiatric treatment programs, the local public school system (in this case the Edmonton Public School Board) provided teaching, with six students being the maximum class size on the unit for emotionally disturbed children. To qualify for the program, children had to need psychiatric treatment and have an IQ of 75 or higher. Although the program was initially conceptualized as a short-term diagnostic centre,²¹¹ the projected length of stay was one year, and the program sought to prepare each child to return to his or her own community and school.²¹² Monique's story²¹³ tells something important about the impact of this program on the lives of Alberta children.

The Glenrose School Hospital, Linden House, and the University of Alberta Hospital Unit were tremendous additions to treatment services available for children, but they could not meet the needs. No hospitals or facility-based services for disturbed children and adolescents existed south of Red Deer. As well, many of those with less severe problems that could and should have been managed in non-hospital programs (e.g., guidance clinics) could not access these very limited services. Kennedy Hall and the Apollo Unit—two important new programs—opened in the mid-1960s.

²⁰⁸J.W. Briggs, *The Glenrose School Hospital, Edmonton, Alberta: History* (Edmonton: The Glenrose Hospital, 1969), p. 2.

²⁰⁹Blair, *Mental Health in Alberta: A Report on the Alberta Mental Health Study*, p. 36.

²¹⁰*Ibid.*, p. 35.

²¹¹*Ibid.*, p. 187.

²¹²*Ibid.*, p. 14.

²¹³“Monique” told her story to the author, believing that she has survived a difficult time and perhaps can help others by sharing her story. Her name has been changed.

Monique's Story

Monique was the baby in a family of 13 children—a bright and happy child who could read and write at the age of five. She was protected, pampered, and given much loving attention. When she had just turned 12, her world fell apart. It began with the debilitating illness of her father, who had been a healthy, robust farmer full of energy and *joie de vivre*. She had idolized him; he was her pal, her hero. Her prayers for his recovery became an obsession that kept her awake at night. Perhaps if she was a really good girl, he would get better, she thought. His death at the age of 55 was a terrible shock.

Less than two months later, her 49-year-old mother (who had suffered for years with severe asthma and more recently with heart disease) died in her sleep. Monique had slept in her mother's room since her father's death and was the last one to see her mother alive.

She did not understand that they had left for good and waited in vain for their return, becoming sadder with each passing day. She was sure that she was being punished. If only she could understand why. The pain was too great. She began keeping to herself at home and at school. Her friends could not talk to her. It became simply too hard so they left her alone. Her schoolwork no longer interested her, and achieving good marks lost all importance. In fact, she no longer wanted to go to school at all. She went to bed early at night only to be plagued by recurrent terrifying nightmares. Insomnia became the norm, and she had trouble getting up in the morning. Her brother, who at the age of 21 was now her legal guardian, spent many sleepless nights in the rocking chair in her room trying to ease her fears. He coaxed her out of bed in the morning, made her breakfast, and encouraged her to eat. He helped her get ready in time for the bus to school where she accomplished less each day. He helped with her homework, tried to interest her in making a meal, gave her pep talks every day. Nothing seemed to work.

Because this was such a dramatic change from her previous behaviour and high academic achievements, the school principal referred her for an assessment by the travelling Alberta Guidance Clinic on one of its twice-yearly visits to their rural community. This assessment resulted in a referral to the newly-opened unit for children with emotional disorders at Glenrose School Hospital in Edmonton. Now 13, she was the first adolescent to be admitted to the new program. She was devastated when her brother left her there in the winter of 1966. This pained her, and she worried and wondered: "Was he ever going to come back? Was

he dying, too? Why was he abandoning me? I must be a really bad girl. I begged him not to leave, and it took me a long time to understand why he left me there by myself with all these strangers. I found out several years later that he cried as much as I did that day.”

She recalls her experience: “At first, I was terrified by the new environment: the noises, the strange and seriously disabled kids all around me. As the only teenager on the unit, I went to school with the physically disabled kids. I was the only one who was not in a wheelchair, so the kids picked on me viciously until they had me running out of the classroom to the refuge of my room on the unit. The teacher was an angel who quickly found ways to stop this cycle, and my classmates and I eventually became friends.

“The Glenrose became like home. Its routines were predictable and comforting. I was well-behaved, and the staff really liked me, as did the younger kids on the unit. I didn’t want to leave but, at the end of the academic year, they thought I was ready for discharge. The summer months at home were okay but, as soon as school started again, I was back to square one, unable to motivate myself to face school and its everyday demands. So, I was sent back to the Glenrose for a second term. I had failed again, this time not only my family but the Glenrose staff as well. They had been so proud of me. Finally, towards the end of that school year—I don’t know if it was because of support from the staff or simply because I was getting older, or maybe a combination of both—I was finally able to say my parents have died. It was not because of me or anything I did. They were very sick. They will not be coming back. This marked the beginning of my healing. This time when I went home from the Glenrose, I was ready.”

Today, Monique is a successful adult who has accomplished much and has children and grandchildren who bring her much joy. She is deeply grateful for her family’s support and recognizes that they simply did not have the tools to help her after her parents died. She shudders to think what her life would have been like without the Glenrose’s clinical intervention during this crisis period in her life. Monique wishes the same support for each child in need.

Kennedy Hall and the Apollo Unit

Kennedy Hall at Alberta Hospital Edmonton and the Apollo Unit at Alberta Hospital Ponoka, treated severely disturbed mentally disordered adolescents with a history of aggression and assaults.²¹⁴ The Alberta Hospital Edmonton's school annual report documented the problems these teens caused for the school, their hostile attitude towards teachers, their histories of negative school experiences, and lack of success in the regular school environments. Turning this around presented a major challenge for this specialized school program.²¹⁵

Westfield Diagnostic and Treatment Centre

In addition to Department of Public Health programs, the Department of Social Services and Community Health was developing institutions to meet the needs of children with severe emotional and behavioural disorders. One of these—the Westfield Diagnostic and Treatment Centre established in Edmonton in 1967—served three types of children aged six to 16:

- wards of the Director of Child Welfare. This included children who had been neglected, physically or sexually abused by their caregivers, had parents who were addicted to drugs or alcohol or parents who were incarcerated.
- children who had serious psychiatric problems. This service increased significantly after Kennedy Hall and the Apollo Unit closed in the 1970s. These children were admitted through compulsory orders or certificates under the *Child Welfare Act*.
- juvenile delinquents.

Government officials now considered neglected children, those with emotional and behavioural disorders, and juvenile delinquents to have similar rehabilitative needs and thought the same program could serve them all.²¹⁶ The ratio of staff to children was low, with few trained health professionals as staff members. These structural problems were compounded by ongoing staff recruitment and retention challenges. Many parents who wanted their child treated for an emotional disorder were troubled by having to surrender their child to the care of the Director of Child Welfare. They believed they should be able to access the health care their child needed without being forced to take this extreme measure.

More for the Mind

These problems existed not only in Alberta but across Canada, and Canadians made impassioned and effective pleas for better services for children. In

²¹⁴Richard Drewry, *Report of the Task Force to Review the Mental Health Act* (Edmonton: Government of Alberta, 1983), p. 169.

²¹⁵Alberta Hospital Edmonton School, *Annual Report* (Edmonton: Alberta Hospital Edmonton School, 1976).

²¹⁶Provincial Ombudsman, *Report on the Westfield Diagnostic and Treatment Centre* (Edmonton: Provincial Ombudsman, November 27, 1979), p. 22.

response, the Canadian Government ordered a number of commissions and studies, the most significant of which was *More for the Mind*, published in 1964.²¹⁷ This landmark report emphasized patient rights and community-based services, with a particular focus on expanding psychiatric services in general hospitals. The report claimed that psychiatric units of general hospitals could successfully treat 93 to 97 per cent of mentally ill people. Its recommendations rested on five guiding principles:

- integration of mental health services within the framework of general health services
- regionalization of community mental health services for planning and delivery
- continuity of care for each individual through all phases of illness
- decentralization of the management and administration to local control within regions
- coordination of services for maximum effectiveness.

Many studies and reports have endorsed these principles, which served as a template for long overdue improvements of community services in an effort to meet unaddressed needs across the country.

More for the Mind focused specifically on services for children, emphasizing that these should follow the guiding principles enunciated for adult services and highlighting the need for more hospital units, outpatient departments, and community clinics.²¹⁸ It emphasized family involvement from the earliest identification of an emotional disorder and throughout treatment. It also emphasized the need for well- trained personnel, including volunteer services, as integral to the therapeutic team.²¹⁹ It strongly supported the psychiatrists' role in diagnosis, teaching, and consultation.

The report's many recommendations advocated for:

- special classrooms in schools for children with emotional disorders. The school's critical role in children's lives was clearly highlighted: "Mental health transcends medical concern with sickness and health. It relates to the whole spectrum of organized social living. It has to do not only with spotting and treating children with mental health problems in the school but with the whole fabric of the school itself...involving careful planning with many other professional disciplines, including among others, psychology, education, social work, theology and the law."²²⁰
- provision of child and adult care in community clinics and outpatient departments that involved families
- special assessment centres under psychiatric direction to assess and prescribe care for mentally retarded people.

²¹⁷A parallel process in the United States resulted in a report called *Action for Mental Health*. This report's major emphasis was the Community Mental Health Centre as the focal point of a network of services. The process culminated in 1963 with President John F. Kennedy's address to Congress on the plight of mentally ill people. Kennedy was the first chief of state to address a country's government in the name of the mentally ill, and it resulted in legislation and financial support for program development. Source: Federico Alloli and Henry Kedward, "The Evolution of the Mental Hospital in Canada," *Canadian Journal of Public Health* 68 (May/June 1977), pp. 219-24.

²¹⁸Tyhurst, et al., *More for the Mind: A Study of Psychiatric Services in Canada*, p. 136.

²¹⁹*Ibid.*, p. 138.

²²⁰*Ibid.*, p. 205.

The report also drew attention to the fact that most juvenile delinquents have psychiatric problems needing diagnosis and treatment. It saw the working relationship between the courts and community psychiatric services as generally positive, as were the developing mental health services in training schools and other specialized programs. Examples included the Bowden Institute for boys under the age of 16 and the William Roper Hull Home in Calgary. The latter, created through the will of the late William Roper Hull, provided a residential treatment centre for teenaged boys, who were housed in four cottages accommodating 12 boys each. The cottages were staffed by counsellors from various professional disciplines and supervised by a consulting psychiatrist.

Royal Commission on Juvenile Delinquency

Alberta remained concerned about juvenile delinquency, and an Order in Council established a Royal Commission to inquire into this problem in September 1966. The commission sampled a group of Alberta delinquents and found such risk factors as: youth from broken homes, excessive use of alcohol in the home, conflict between parents, little involvement in youth groups or church activities, poor academic achievement, and a history of running away from home.

The commission's report emphasized the need for school teachers and social workers to recognize these youth, and a need for increased resources and clear channels of communication with other agencies so early distress signals could be investigated:²²¹ "There appears to be little doubt that the younger a child is when he becomes delinquent, the more severe is the problem and the more likely he is to become a repeater. By implication the more urgent is the need to spot signals and institute preventive measures."²²² The commission referred to an earlier study completed by a royal commission studying child welfare in 1948 that emphasized the need for greater and earlier use of psychiatric services in cases of juvenile delinquency. This need remained unmet, complicated by the differences in responsiveness of psychiatric assessment and treatment services in Calgary and Edmonton.

In Calgary, the Guidance Clinic and Bosco Homes worked cooperatively with the juvenile courts. Both emphasized that children needing assessment and therapeutic services must receive these services as quickly as possible. The different situation in Edmonton was creating problems. Children referred to the Guidance Clinic from the city's Social Services Department, juvenile courts, or detention homes did not always receive services in keeping with the urgency of the case. Edmonton professionals believed that an evaluation service attached to the court should be set up for this purpose—a proposal based on the conviction that evaluation and treatment functions should be separate and should be

²²¹Alberta Royal Commission, *Report of the Alberta Royal Commission on Juvenile Delinquency* (Edmonton: Alberta Royal Commission on Juvenile Delinquency, 1967), p. 12.

²²²*Ibid.*, p. 21

provided by different teams. The reasoning was that treatment would be jeopardized by the youngster's hostility if the same therapist who completed the assessment provided the treatment. Edmonton professionals also believed the Guidance Clinic should provide treatment.

Dr. Van Stolk, Director of the Edmonton Guidance Clinic, was particularly vocal on this issue: "I believe that this kind of service should not be provided by the Guidance Clinic because the Guidance Clinic must not become the extended arm of court or probation, but remain a community agency providing assessment and particularly, treatment for everyone."²²³ This view was perhaps not surprising given the paucity of clinic services available at the time. Dr. Van Stolk also emphasized that this clinic should receive sufficient government funds to initiate and promote research into juvenile delinquency.

The commission concluded that the Calgary approach was more desirable because it provided continuity of care. It also argued that, with this approach, the Guidance Clinic staff would become highly skilled in assessing juvenile delinquents and would gain knowledge about their treatment. They believed that this approach would maximize the use of staff skills and that—at a time when there was a great shortage of staff in mental health—it seemed more reasonable to build on existing services than to establish new ones. As noted in the report: "Consultation must be held between the Division of Mental Health and the Juvenile Offenders Branch, Child Welfare Department and City Social Services in Edmonton to find a solution to the provision of consultative psychiatric assessment and treatment services to the courts, child welfare and juvenile delinquents."²²⁴

The commission recommended that services for young offenders be expanded, with concerted efforts made to recruit qualified mental health staff. It asked that clinics in outlying areas be held more frequently and be better integrated with local health units. In addition, it recommended that clinic staff provide follow-up after the consultant team departed and suggested universities and colleges re-examine the child-study courses offered to prospective elementary school teachers. It said that these courses should enable teachers to gain better understanding of child development and become more aware of the special needs of exceptional students.

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Alberta Guidance Clinics

By this time, child psychiatry was considered a subspecialty within general psychiatry. It was well understood that professionals needed distinct knowledge and specialized skills to work with the clinical syndromes seen in childhood. Child psychiatrists developed their expertise through extensive clinical experience in the Guidance Clinics and in hospital-based child psychiatry units, which typically

²²³Ibid., p. 24.

²²⁴Ibid., p. 107.

were linked with academic programs. The Alberta Guidance Clinics began to provide clinical placements for professionals in the field, including psychiatrists, psychologists, and social workers.²²⁵

The travelling clinics continued to provide services from their bases in the major centres. Many rural areas still depended on these clinics that operated sporadically (one day a year, one week twice a year, or a few times a year). Teachers or public health officials generally made referrals, and only the most troublesome cases were seen.²²⁶ Some progress, however, was seen in the development of regular local services. In 1963, the Edmonton Clinic opened a Grande Prairie branch with an Edmonton psychiatrist visiting Grande Prairie regularly. Red Deer also opened a regular clinic. Clinical staff increased at the various clinics to a total of 86 professionals across the province in 1968.²²⁷ Given that an estimated 10 per cent of children in a province with a population of 1.5 million needed mental health services, children were seriously underserved. Increases in clinical staff and clerical support, however, meant that more psychotherapy became available to meet individual and family needs in these busy clinics. Between 1962 and 1966, 16,824 new cases were seen across Alberta—up significantly from the 9,882 seen in the previous five years. Of these, nearly 1,200 involved assessment of mental deficiency.

²²⁵Griffin, *In Search of Sanity—A Chronicle of the Canadian Mental Health Association, 1918-1988*, p. 167.

²²⁶Vera Corfield, *The Utilization of Guidance Clinic Facilities in Alberta*. Academic paper. University of Calgary. 1968, p. 32.

²²⁷Calgary had five child psychiatrists, 11 psychologists, 11 social workers, and one recreational therapist.

Edmonton had nine child psychiatrists, 13 psychologists, 15 social workers, and one recreational therapist.

Grande Prairie had three psychologists and two social workers.

Medicine Hat had two psychologists and one social worker.

Red Deer had one child psychiatrist, two psychologists, and two social workers.

Source: Blair, *Mental Health in Alberta*, Vol. II, p. 23.

²²⁸Blair, *Mental Health in Alberta: A Report on the Alberta Mental Health Study*, p. 22.

The Blair Report

In November 1967, the Premier and the Minister of Health announced that Dr. W. R. N. Blair, head of the University of Alberta's psychology department, would direct an Alberta mental health study designed to:

- assess province-wide resources and evaluate the needs for maintaining mental health and treating mental illness
- make recommendations for the development of an improved, comprehensive, and integrated program for diagnosing, treating, caring for and rehabilitating mentally ill people, and preventing mental illness in Alberta.²²⁸

The result of this study—*Mental Health in Alberta* (now widely known as the Blair Report)—was released in 1969 and is a voluminous document. The result of over a year's worth of study and discussion around the province, the report revealed serious problems in all areas of mental health service, culminating in 189 recommendations and 13 areas of priority. The report, its recommendations, and many of its principles follow closely those of the Tyhurst Report, *More for the Mind*.

With regard to children, Blair emphasized expansion of services in all areas: inpatient and outpatient, emergency services, consultation to community agencies, diagnosis and assessment services, follow-up support following treatment, family

involvement at the earliest possible point in treatment, regionalization of services, improvements in coordination across government and community programs, and a formal approach to community education. He especially emphasized:

- **research.** Blair called for a commitment to research in order to “fill the mammoth gaps in current knowledge regarding the incidence, nature and treatment or management implications for mental illness and maladaptive behaviour...”²²⁹ He quoted a paper published by the World Federation for Mental Health which read:

It would seem to be no more than prudent conduct, whenever social legislation is contemplated, to make provision in the legislation for evaluation and scientific control from the outset, and for a continuous program of research into ways of improving techniques and methods. It is important to ensure not only that public effort and money are being well spent, but also that research and evaluation become an integral part of social action; that the latter should no longer be regarded as an outside or luxury activity dependent on charitable foundations or the part-time services of a few interested scientists, with all the arbitrariness and lack of coordination that are likely to arise when it is so regarded.²³⁰

- **staffing.** Personnel issues had reached a crisis level, with too few people available and positions too often filled with poorly trained staff. Blair urged government to undertake energetic and sustained recruitment and retention of adequate staff.
- **mental deficiency.** The report suggested a comprehensive legislative framework and comprehensive program (including a separate division) to attend to mental retardation. Canada had no specialty in mental deficiency and had difficulty recruiting physicians and other professionals with a background in this area. Blair recommended the establishment of a specialty, with accreditation, in recognition that mental deficiency affected as many people as most other major illnesses of the day. (By the time of the Blair Report, the Red Deer Provincial Training School population had reached 2,200. The report strongly recommended that small regional training and treatment centres be added. In fact, the Training School was not expanded nor duplicated in other centres of the province.)²³¹
- **school counselling.** Blair urged school boards to increase the numbers of qualified front-line school counsellors providing primary prevention services. He emphasized that guidance required specialized skills, and services should be withheld until suitable people were found. He also said that all principals should be required to take a course in guidance and counselling. Blair suggested that emphasis shift from cure to early discovery, diagnosis, and prevention.

²²⁹Ibid., p. 25.

²³⁰Ibid.

²³¹Ibid., p. 331.

- **addictions.** Blair recommended the development of a care delivery system to address addictions and drug dependence among emotionally disturbed youth and within the mental health services structure.
- **university-based treatment programs.** Blair proposed psychiatric clinics for universities to provide students with interrelated health and counselling services, including ready access to psychiatric consultation.
- **family physicians.** Psychiatrists were urged to work in consultation with family physicians in order to reach more Albertans. Blair clearly thought that psychiatrists could not meet the urgent need alone. The timing was right to take action, as family physicians had declared their readiness to assume more responsibility.²³²
- **stigma.** The segregation of mentally ill patients, locked doors, and the number of long-term hospitalisations among those who could function in the community with proper support demonstrated the prevailing attitude of Albertans towards mental illness. The lack of facilities reflected, as Blair saw it, the generally uninformed public's reluctance to accept patients back into the community. He said the stigma extended beyond patients to the professionals involved in treatment and service delivery. Blair maintained that difficulties in recruiting staff and the lack of recognition of psychiatric nurses outside the hospital further reflected the community's negative attitude.

The Blair Report recommended that regional mental health clinics be established in each region, enabling communities to care properly for local citizens and supporting local hospitals and physicians. It noted: "There is perhaps more reason to create regional services for emotionally disturbed children than there is for adults."²³³ The report also strongly supported the family involvement in treatment, which mandated a treatment service close to home. "Reasonable proximity" was defined as a distance involving a trip by car of no more than an hour and a half. The province met that standard only in the largest urban centres.

While the needs for expanded programs were obvious, they required many resources. A proposed solution was to establish so called "all-purpose clinics" to serve both children and adults. Such clinics were a trend in the United States in the late 1940s and 1950s and were thought suitable for rural or smaller urban areas where full-time child guidance clinics might be impractical or where adult services could not be established independently.

Blair and other professionals expressed significant support for this model, but also great trepidation. Therapeutic work with both children and adults would require professionals to have more advanced training and extensive experience. Others using this model had experienced problems, with some communities pressing professionals into service who could not do the work effectively. Some feared that the high level of child guidance clinical practice, which in the past had accounted for the success of the clinics, would not be universally maintained.²³⁴

²³²Ibid.

²³³Ibid., p. 255.

The Blair Report highlighted a crisis in care for mentally ill patients, showing the persistent disparities in services to the mentally as opposed to the physically ill. The report's comprehensive overview and its strong recommendations served as real impetus for government to improve services across the province. The Blair Report summarized the lack of progress in mental health in Alberta—something Dr. Hincks, that early pioneer, bemoaned just prior to his death in 1964: “Future generations will weep for us,” he said. “They’ll call this the dark ages.”²³⁴

Research

More positively, interest in research was developing. The director of the Division of Mental Health received \$10,000 over two years (1966 and 1967) to initiate research projects in Alberta Guidance Clinics and Alberta Hospitals Edmonton and Ponoka in collaboration with the universities of Alberta and Calgary's departments of psychology. Research areas included schizophrenia, alcoholism, and geriatrics needs, but not children's mental health.²³⁵

More laws and structural changes that had long-term impact on mental health included:

- **The Medical Care Act.** The legislative foundation of Canada's Medicare system was enacted by government in 1966 and took effect the following year. This act initially provided federal sharing of 50 per cent of provincial medical care insurance programs with the remaining 50 per cent coming from the provinces. The act also established basic operating principles, including four of the five principles of Medicare: comprehensive medical coverage, a universally available plan, portable benefit coverage, and public authority administration.²³⁷
- **The Child Welfare Act.** Amended in 1963 to include the definition of a neglected child to mean a “child in need of protection,” this act was further amended in 1966 to better define children in need of protection.²³⁸
- **Evolution of the Department of Public Health into the Department of Health.** In 1967, the Department of Health divided into two sections: Hospital Services and Health Services, with a deputy minister responsible for each section. The Alberta Health Care Plan that followed introduced universal coverage for basic health services for all Albertans.²³⁹
- **The Preventive Social Services Act.** In 1966, this act mandated provincial funds for up to 80 per cent of preventive programs in municipalities. This represented a change in philosophy from maintenance and custody to the support and social development of individuals.²⁴⁰ This legislation enabled nonprofit daycare centres to apply for and receive funding from the municipalities. The municipalities controlled the development of this service and set standards, while the province provided funding for up to 80 per cent.²⁴¹

²³⁴J.F. Robinson, “Current Trends in Child Guidance Clinics,” *Mental Hygiene* 34 (1950), pp. 106-16.

²³⁵Ronald A. LaJeunesse, *Political Asylums* (Edmonton: The Muttart Foundation, 2002), p. 74.

²³⁶Blair, *Mental Health in Alberta: A Report on the Alberta Mental Health Study*, p. 55.

²³⁷The fifth principle, accessibility, was added in the *Canada Health Act* of 1984. Source: Dr. Janet Storch and Dr. Carl Meilicke, “Political, Social and Economic Forces Shaping the Health Care System,” in Judith M. Hibberd and Donna Lynn Smith, ed., *Nursing Leadership and Management in Canada* (Toronto: Elsevier Canada, 2005), p. 12.

²³⁸Statute of Alberta. *An Act to amend the Child Welfare Act*, 1963 and 1966.

²³⁹Statute of Alberta (1967), Chapter 27.

²⁴⁰B. Krewski, *The Alberta Department of Social Services and Community Health: A History* (Edmonton: unpublished document, 1979), p. 41.

²⁴¹The Cavanagh Commission, *Board of Review: The Child Welfare System* (Edmonton: Government of Alberta, 1963), p. 68.

- ***The Welfare Homes Act.*** This 1963 legislation provided a framework for licensing institutions for children.
- ***The Psychiatric Nurses Training Act and The Psychiatric Nurses Association Act.*** Two acts introduced in 1960 provided for the establishment and control of the Psychiatric Nurses Association and for training of psychiatric nurses. This also provided recognition of nurses' greater role in providing mental health services.

Chapter 7

The Sizzling '70s: Mental Health Staff—the Forgotten Civil Servants



Welfare brats, Native children,
the battered child, children:
our greatest resource

Welfare brats, Native children, the battered child, children: our greatest resource

The 1970s began with the release of *One Million Children*, published under the aegis of the CMHA and several other Canadian voluntary agencies.²⁴² One Million Children promoted the development of services for special needs children, adding weight to the attention given to children's mental health services in the Blair Report. This release was followed in 1973 by the publication of another influential Canadian report, *Law and Mental Disorder*.²⁴³ Together with *More for the Mind*, these reports greatly influenced Canada's changing mental health legislation through their consensus that the mental health system needed major reforms.

In 1970, the Calgary Task Force Report on Mental Health Services for children from age three to puberty was released. The primary purpose of this task force was to examine the needs and plan for comprehensive children's services based on a model of normal development rather than on one limited by any single professional approach or political or economic restrictions. Its secondary purpose was to deal with the structure for delivering these services—including facilities, staffing, training, and research.

The plan emphasized children's basic needs—a healthy environment, healthy family and social relationships, and a healthy body—as factors understood to contribute to personal development and good mental health. The plan emphasized qualities of the emotionally healthy child and the importance of the parent-child relationship as fundamental to efforts aimed at prevention of emotional and behavioural problems.²⁴⁴

From this base, the task force report focused on problems and issues, clearly emphasizing the fact that existing programs were unable to cope with the problems of Calgary's children. The unmet needs of emotionally disturbed children were demonstrated dramatically. Some services were understaffed, both in staff numbers and in their lack of adequate clinical preparation. Service delivery suffered because services were typically divided among health, education, welfare, and corrections, and further subdivided at government level (as well as in private agencies) instead of being coordinated.²⁴⁵

Few day hospital treatment programs for children existed. Calgary had only one such facility—the Psychiatric and Educational Centre—with 15 spaces for young severely emotionally disturbed children, operating under the combined auspices of the Public School Board, the Children's Hospital, and the Alberta Guidance

²⁴²The Commission on Emotional and Learning Disorders in Children, *One Million Children. A National Study of Canadian Children with Emotional and Learning Disorders* (Toronto: The Commission on Emotional and Learning Disorders in Children, 1970).

²⁴³F.C.R. Chalke, *The Law and Mental Disorder: A Report on Legislation and Psychiatric Disorder in Canada* (Toronto: Canadian Mental Health Association, 1973).

²⁴⁴*Report of the Calgary and Region Mental Health Planning Council Task Force #2 for Mental Health of Children Age 3 to Puberty* (Calgary: Calgary and Region Mental Health Planning Council, 1970), p. 2.

²⁴⁵*Ibid.*, p. 37.

Clinic. Hospital treatment was difficult to obtain except for physical illness. No hospital facilities were available for emotionally disturbed children, with or without some other chronic medical problems. Although Calgary had some non-hospital group homes providing treatment at this time, too few spaces were available. Shortages meant that children with emotional disorders needing residential treatment often were apprehended by Child Welfare, because it was so difficult to find other supportive placements.

At the time, the Calgary-based Alberta Guidance Clinic used a multidisciplinary approach to assess and treat emotional problems in children and families, yet the team was understaffed and needed more professionals to serve the large and ever-growing population: "Referrals from schools for outside clinical help involved travelling clinics in rural areas, community clinics in the city, private physicians and psychiatrists and special university clinical services such as the recently established psycho-educational clinic."²⁴⁶

The clinic registered 1,785 persons in 1970. Of the children assessed, nearly 70 per cent needed continuing treatment, increasing the clinic's total workload while decreasing its capacity to respond to new cases. In addition to its clinical workload, the clinic pursued its teaching role vigorously. It provided inservice training and clinical placements for undergraduate and graduate students in psychology, educational psychology, social work, and nursing. The clinic also shared a psychology teaching position on a joint appointment basis with the University of Calgary's department of psychology.²⁴⁷

The task force report said that early identification of problems in preschool children was extremely urgent. Services to address the hardships in rural communities were another priority: "The paucity in the spectrum of services offered in the areas of health, welfare and education is even more appalling in the rural areas of Alberta."²⁴⁸

The report clearly noted that much of the burden of diagnosis and treatment fell to family doctors, who had few supports available to them. Travelling psychiatrists, travelling guidance clinics, travelling speech therapists, and public health nurses were available as consultants in some areas of the province, but these services were fragmented and inconsistent, and ineffective where ongoing treatment was required. Adding to this problem was the rural reality that social services considered basic in urban settings were almost completely lacking: "Social help is viewed almost entirely in terms of financial assistance and the Puritan Ethic which relies on self-reliance, hard work and mutual self-help is still a predominant value."²⁴⁹ Confidentiality in small centres also was a great concern, where the stigma of being a "welfare brat" or a family "on the dole" affected the developing rural child even more profoundly than it did a city child. Rural communities also needed treatment resources and facilities.

²⁴⁶Ibid., p. 40.

²⁴⁷Alberta Department of Public Health, Mental Health Division, *Annual Report* (Edmonton, Alberta: Department of Public Health, Mental Health Division, 1971), p. 39.

²⁴⁸Report of the Calgary and Region Mental Health Planning Council Task Force, Appendix 2, p. 2.

²⁴⁹Ibid., p. 3.

The task force's recommendations included establishing a central, highly specialized, Calgary-based multidisciplinary assessment and treatment centre to provide services for more difficult cases throughout southern Alberta. This centre was to provide such services as: outpatient assessment and treatment, inpatient assessment, day hospital treatment, inpatient residential treatment, parent counselling, integrated professional training, information and public education, and research. Effectively, the centre would provide continuity of care and treatment of whatever degree and intensity was required.²⁵⁰

The Board of Visitors

Another process—in the form of a Board of Visitors—existed in Alberta to provide government with mental health information for informed decision-making. The Board of Visitors investigated the care, treatment, rehabilitation, and general attitudes of patients and staff in all institutions administered by the Department of Health. The board submitted its findings in an annual report to the Minister of Health, which was tabled in the legislature. It also investigated and reported on programs for disease prevention and made recommendations for improvements to the minister. Ellen Armstrong was the Chair of the Board and the members were Monsignor J. E. LeFort, Reverend E. J. Thompson and Chief Judge Nelles V. Buchanan.

The *1971 Annual Report of the Board* read like a bad news story:

The year 1971, like 1969, was marked by extensive staff shortages in all programs administered by the Division of Mental Health Services. As in the year 1969, so in the year 1971, in newspapers, at conventions, both professional and hospital, on the public platform, the care of the mentally ill and physically handicapped were common subjects of debate and criticism, most citizens deem themselves entitled to express their opinions, generally critical.²⁵¹

The report highlighted the treatment of autistic children provided in Calgary's Sick Children's Hospital program on the modest scale permitted by facility limitations and noted that Calgary could become a leader in this area given increased staffing and greater financial support. It reported that the Edmonton Clinic was happy with its new downtown location. Over the previous two years, Grande Prairie and Peace River had become independent of the Edmonton Clinic. The staff in the new Peace River Clinic, opened in 1970, consisted of a psychologist and a part-time social worker. The report noted that staff in the isolated Peace River Region needed more opportunities to associate with colleagues through seminars, conferences, and other professional gatherings.

²⁵⁰Ibid., p. 51.

²⁵¹Board of Visitors, *Annual Report to the Minister of Health tabled in the Legislature*, September 8, 1971 pursuant to Order-in-Council 2114/66, p. 44.

The report noted every guidance clinic in the province had assumed greater responsibility for services to rural areas, as determined by the availability of staff in each clinic. Edmonton was now sending teams by air to Fort Chipewan and Fort McMurray and by car to Camrose, Edson, Jasper, St. Paul, and Wetaskiwin. In Red Deer, staff jointly provided services to Alberta School Hospital, Deerhome,²⁵² the General Hospital, and the separate schools. The Medicine Hat Clinic had enough space, but no psychiatrist other than a visiting one from Calgary. In Lethbridge, the psychiatrist also made regular trips to Brooks and Medicine Hat, Lethbridge was advocating an appointment of a psychiatrist to Medicine Hat to simplify service provision.

The report discussed increasing patient loads around the province and proposed a study addressing the degree or extent of mental health guidance that would be optimal. It insisted that the clinic directors receive guidance on three important questions:

- Does the Department intend to leave no mentally disturbed child unhelpt?
- Does the Department deem itself responsible to cover the province either by the establishment of clinics or by the dispatch of guidance teams, to adequately meet the needs dictated by Albertans' mental health condition?
- Is the Department satisfied with the status quo or will it persist in its attempts to bring guidance services to the rural areas in spite of inadequate staffing?²⁵³

These questions remain unanswered to this day.

The Board of Visitors also investigated Linden House, where it saw 10 girls and nine boys under the care of one junior psychologist and one junior social worker: "Obviously such a diminished staff could not hope for success in the treatment of these special patients. Appointees to complete the establishment of professional persons should be aggressively sought. The original purpose of Linden House, namely, the cure of emotionally disturbed children, is not now met and will not be met until adequate staff is provided."²⁵⁴ Rather than arranging for adequate staffing, those in charge closed Linden House in 1972, with the rationale that other community facilities opening across the province would provide the same treatment. The remaining children were transferred to other facilities. The logic behind the closure is puzzling, however, given how few treatment facilities the province had.

The Board of Visitors also included the Glenrose Hospital in its review and proposed a similar facility for the Calgary region: "Now that the Glenrose School Hospital, in Edmonton, is safely and generously launched—the envy, undoubtedly of Canada's other nine provinces, attention should be turned to the needs of the southern part of the province."²⁵⁵

The report praised Dr. Sig Koegler, executive director of the Alberta School Hospital since 1974 and a pediatrician by training, for his leadership in

²⁵²Deerhome opened in 1958 as an extension of the Alberta School Hospital in Red Deer and served "mentally retarded" adults initially transferred from mental institutions. Source: Ronald A. LaJeunesse, *Political Asylums* (Edmonton: The Muttart Foundation, 2002), p. 307.

²⁵³Board of Visitors, *Annual Report to the Minister of Health tabled in the Legislature*, September 8, 1971 pursuant to Order-in-Council 2114/66, p. 54.

²⁵⁴*Ibid.*, p. 23.

²⁵⁵*Ibid.*, p. 24.

establishing Canada's first children's psychiatric research institute. In its report, the board expressed deep gratitude for the mental health system staff members who—in spite of poor staffing levels, public criticism, inadequate salaries, and lack of recognition—stayed with their tasks and rendered loyal and generous service. In view of the circumstances, board members questioned how much could fairly be demanded of the staff: “Are they now being imposed upon? Are they largely the forgotten among the public servants?”²⁵⁶ As a measure to improve morale, they recommended that staff opinions be sought in the planning process for program changes.

Again, the lack of treatment programs for providing even basic mental health services for Alberta children was documented clearly—this time in the midst of a very prosperous province. By now, Alberta had reached a greater stage of maturity in its infrastructure. It was no longer struggling for survival, even though its population was continuing to grow by leaps and bounds.²⁵⁷ Government surpluses were applied to new programs for libraries, municipalities, business and farm support, and research. The millions of dollars allocated for top priorities were evident in construction and new developments everywhere. These priorities included oil sands research, agriculture (in an effort to stem the course of rural economic decline), rural electrification, highways, cities, schools, post-secondary education, support for handicapped people and for seniors, recreation and cultural programs, provincial parks, and new rural hospitals across Alberta.²⁵⁸ As Koch noted: “...spending increases accelerated in defiance of wildly fluctuating resource revenues, creating a jumble of deficits, surpluses and balanced budgets.”²⁵⁹ Money flowed like the crude oil under Alberta fields, shaping the province's future, transforming Albertans' everyday lives, building the success of businesses and companies, and changing the look of urban and rural communities. The power behind these circumstances was purely economic and this sizzling economy showed little concern and invested little financially in the mental health of its people.

Compulsory School Attendance Act

In 1970, an amendment to the *Compulsory School Attendance Act* lowered the maximum school entry age from age seven to age six. This was a very positive change for the benefit of Alberta children, especially those with mental health disorders as those were most likely to be identified in the school setting.

School Counselling

Although the Minister's report paid little attention to it, school counselling continued to grow during the 1970s. In 1972, for example, Alberta schools

²⁵⁶Ibid., p. 46.

²⁵⁷Alberta's population grew by 700,000—or 44 per cent—between 1971 and 1979. In total, this was a change from 1.6 million to 2.3 million. Source: George Koch, “Getty Returns as Quarterback and Fumbles Nearly Every Ball,” *Alberta in the 20th Century, Volume 10: The Sixties Revolution and the Fall of Social Credit, 1964 to 1970*, p. 53.

²⁵⁸Ibid., p. 55.

²⁵⁹Ibid., p. 66.

employed 526 counsellors, which grew to 639 counsellors six years later. Of these, 227 were full-time employees and approximately 400 were half time or more.²⁶⁰ As a relatively new profession, school counselling was experiencing some growing pains, including plentiful questioning of its value. School boards were asked to clarify whether school counselling services were educationally necessary or an expensive frill.²⁶¹ Without a doubt, children had problems; the question was whether the schools had a role in addressing these problems. Counsellors traditionally had emphasized educational and vocational guidance, but also a number of "home visiting teachers" also supported classroom teachers in helping children grow toward mental, emotional and social maturity. These teachers' role was essentially as a child development specialist working with the child, the family, the teacher and other professionals to meet the child's special needs. In 1969-1970, the home visiting teachers in the Calgary region had made 218 referrals to the Alberta Guidance Clinic,²⁶² worked closely with Woods Home, and referred 161 students to the schools' consulting psychiatrists.²⁶³ This role seemed to contribute greatly to early intervention.

Qualifications for school counsellors were unclear. Should counsellors have a teaching background? With a ratio of one counsellor to 450 students in urban schools,²⁶⁴ costs were high and critics claimed that students received a woeful lack of guidance in the schools. Many argued that it would be better to establish regional counselling services outside the school system to provide these services. While most urban school systems employed school psychologists, few rural systems did. Some recommended revisions to the Department of Education's grant policy that would extend counselling services to all schools in the province.²⁶⁵ The decade ended with more questions than answers, and Alberta Education commissioned a study of the quality and adequacy of guidance counselling in Alberta schools as a guide to decision making for the 1980s.²⁶⁶

²⁶⁰Alberta Education, *Report of the Task Force on School Counselling and Guidance* (Edmonton: Alberta Education, 1981), p. 197.

²⁶¹Ibid., p. 199.

²⁶²C. Safran, *Implications of the Blair Report as it Pertains to Education* (Calgary: Calgary Public School Board, 1970), p. 15.

²⁶³Three psychiatrists (Drs. M. Carnat, J. Fair, and D. Rapier) worked the equivalent of two full days per week in consultation with Calgary Schools.

²⁶⁴Safran, *Implications of the Blair Report as it Pertains to Education* p. 15.

²⁶⁵Ibid, p. 32.

²⁶⁶Ibid.

²⁶⁷Blair, *Mental Health in Alberta*, Vol. 2, p. 296.

Response to the Blair Report

Thankfully, Alberta did respond somewhat to the Blair Report recommendations. The minister of health presented notable changes in mental health services in an address delivered to delegates attending the Alberta Medical Association Annual Meeting in Edmonton September 22, 1972.²⁶⁷

This progress report included:

- **Allocation of \$1.2 million as a special fund for the development of mental health services.** Thirty-three staff positions were transferred from the mental hospitals budget for redeployment to Guidance Clinics and community care units. The role of Guidance Clinics, now called Alberta Mental Health Clinics, expanded to provide comprehensive services for all age groups rather than restricting their services to children's assessment and treatment. The clinics

had always done some follow-up and liaison work for the mental institutions, but this was never their major task. In earlier years, the psychiatrist in charge of each clinic usually belonged to the staff of a mental institution, thus linking the institutions and their patient population. This change was introduced with good intentions, primarily to facilitate the transition of hospitalized psychiatric patients back into the community, thus preventing hospital readmission. The decision, however, became very damaging for children's mental health as adult needs took precedence in service delivery, leaving children and their families with few services.

- **An additional clinic was established in St. Paul**, bringing services to northeastern Alberta for the first time. This was in addition to the opening of a new clinic in Peace River.
- **A total of \$256,000 was allocated for training programs, research, and analysis** to be governed by newly-established regional mental health councils.
- **The Division of Mental Health transferred responsibility for the care of mentally retarded people to a newly created separate service.**
- **An active recruitment program was announced**, with \$48,000 assigned for bursaries for specialist training in the mental health field. Dr. Blair later called this a fraction of the money required annually if progress was to be made in developing the specialized workforce required for mental health.²⁶⁸
- **A committee was formed to review mental health services for children.**
- **The Sexual Sterilization Act in force since 1928 was repealed.** Although the Blair Report had not recommended that this act be repealed, it did recommend that more safeguards be introduced (e.g., the appointment of a human geneticist to the Eugenics Board as well as complete professional documentation in presentations to the board.)²⁶⁹ Sadly, 78 people were considered by the Eugenics Board just prior to the repeal of the Act, and, of these, 77 were passed for surgery. Sixty-one of the 77 had been assessed by an Alberta Guidance Clinic prior to consideration by the Alberta Eugenics Board and surgery was performed on 55 of these individuals in 1971, 22 males and 33 females.²⁷⁰
- Blair considered it unfortunate the minister's progress report gave no account of pupil personnel services in Alberta schools.²⁷¹ He actively promoted counselling in schools and the use of child development specialists as an alternative to the mental illness model in hospitals and clinics. He saw schools as an entirely appropriate setting for mental health services for children. Other changes also followed, which had been advocated by the Blair Report:
- **The Mental Health Act, 1972.** As *The Edmonton Journal* reported: "sweeping changes in the treatment of mental illness"²⁷² were introduced to the legislature on May 12, 1972, in the form of the new Mental Health Act. Health and Social Development Minister Neil Crawford called the act "the first giant

²⁶⁸Ibid., p. 303.

²⁶⁹Blair, *Mental Health In Alberta, A Report on the Alberta Mental Health Study*, p. 267.

²⁷⁰Alberta Department of Public Health, Mental Health Division, *Annual Report*, Edmonton: Alberta Department of Public Health, Mental Health Division, 1971), p. 40.

²⁷¹Blair, *Mental Health In Alberta, A Report on the Alberta Mental Health Study*, p. 300.

²⁷²"Sweeping Mental Health Changes," *The Edmonton Journal*, May 13, 1972, p. 1.

legislative step” in adopting the recommendations of the Blair Report, which in the *Journal's* words, “called for massive reform and new techniques in treating mental illness.”²⁷³ The new act, with its revolutionary provisions, was described as the pacesetter for North America.²⁷⁴

The act carefully protected patients' rights and recognized that prompt treatment could occur only at the community level. In accordance with the decentralization of services and the delegation of operational control to communities, as recommended by the Blair report, the act provided for the establishment of regional mental health zones and regional mental health councils.²⁷⁵ It also set the stage for other necessary reforms such as the coordination of services through regional councils and facilitated wider employment of psychologists, social workers, and nurses. Through its protection of “formal patient,” it helped to remove mentally ill people from second-class citizenship.²⁷⁶

The act and its regulations, however, did not specifically mention children, the emotionally disturbed child, or the hospitals designated to serve them, as in the 1964 regulations.²⁷⁷ Advocates, once again, questioned what had happened to the efforts (clearly evident in 1964) to address children's mental health needs through well thought out legislation.

- **The Age of Majority Act.** With the introduction of the *Age of Majority Act* in 1974, youth became of full legal age at 18 rather than at 21.²⁷⁸ This change likely had no impact on the mental health clinics since their mandate had changed to serve all age groups. It did, however, define the age range in hospital units and specialized community-based treatment programs providing services for children and youth as from birth to the age of 18.
- **Alberta Alcohol and Drug Abuse Commission.** In 1970, the Alberta Alcohol and Drug Abuse Commission (AADAC) was established as a direct result of the Blair Report recommendations. It was structured as a public health agency to contribute to the health of Albertans through a province-wide system of addiction information, prevention, and treatment services.²⁷⁹ This would become a tremendous service for youth with combined addiction and mental illness.
- **Departmental Shift.** In 1975, the Department of Health and Social Development split into two departments: the Department of Hospitals and Medical Care and the Department of Social Services and Community Care. The Department of Hospitals and Medical Hospital Care funded hospital psychiatric treatment programs. All other mental health programs fell under the Department of Social Services and Community Care's administration. This splitting of responsibilities for mental health services between two ministries led to serious problems, including inconsistent policy direction, poorly coordinated services, communication problems, fragmented care, and poor continuity across programs. As a result, the already existing gaps in the service delivery, planning, and funding increased.²⁸⁰

²⁷³Ibid.

²⁷⁴Blair, *Mental Health In Alberta, A Report on the Alberta Mental Health Study*, p. 295.

²⁷⁵Ibid., p. 296.

²⁷⁶Ibid., p. 298.

²⁷⁷Alberta Regulations 119/73 “*The Mental Health Act, 1972: Mental Health Regulations*”

²⁷⁸Statute of Alberta. *Age of Majority Act* (1974) Chapter A. s.8.

²⁷⁹<http://www.aadac.com/>.

²⁸⁰The Clarke Institute of Psychiatry. *Southern Alberta Study of Psychiatric Needs and Provisions: A Report Commissioned by the Southern Alberta Psychiatric Services Committee* (Calgary: The Clarke Institute of Psychiatry, 1983), pp. 1-22.

- **Mental Health Planning Council.** In follow-up to the Blair Report, an Order in Council established a Calgary and Region Mental Health Planning Committee in 1970. This committee actively studied the problem of the exceptional child in Calgary and prepared recommendations for government.²⁸¹ *The Calgary Herald* reported on the committee's long string of costly proposals to help problem students in public schools. Among the more pressing problems identified were a shortage of qualified counselling staff and an increasing number of depressed children. As *The Calgary Herald* reported, "There are more depressed children than ever before."²⁸²

There was good reason to worry. Not only were more children depressed, the suicide rate in children and youth also had grown since the early 1960s.²⁸³ In 1950, the rate of suicide among adolescents was 2.7 per 100,000. By 1978, the suicide rates for youth between the ages of 15 and 24 more than tripled. Alberta showed the highest rate of completed suicides among the Canadian provinces. In 1978, 55 teenagers killed themselves and an estimated 60,000 others attempted suicide.²⁸⁴ Mental illness was recognized to play a significant role in suicidal behaviour. Following the recommendation of a provincial steering committee formed to suggest a course of action in the area of suicide intervention, a provincial sociologist was appointed in January 1978. This person was to: conduct suicide research, evaluate suicide prevention services, and disseminate information on suicide. The provincial program included a \$35,000 grant for Edmonton to provide follow-up for people known to have attempted suicide.²⁸⁵

Other positive developments followed the release of the Blair Report. Some changes did not result directly from his recommendations but honoured the spirit of the report. These included:

- **Information System.** In February 1976, a computer system was introduced to standardize clinical records, including the information recorded and the terminology used. The system was accessible from any provincial mental health office in the province, and this cutting-edge system for mental health services was the first of its kind in Canada.²⁸⁶ It was such an important advance in mental health services because some patients might receive treatment at intervals over considerable periods of time. For children, treatment might continue throughout the years of their growth and development.
- **Woods Christian Home.** In recognition of the need for facilities to treat emotionally disturbed children south of Red Deer, funds were provided for Woods Christian Home in Calgary (which had served as an orphanage since 1914, funded primarily by Alberta Social Services). The Department of Health designated the new funds to develop the site as a treatment centre. In 1972, a multidisciplinary team involving psychiatrists, social workers, and psychologists was created and severely disturbed adolescents were accepted on transfer from general hospitals for longer-term treatment.²⁸⁷ Woods also

²⁸¹Safran, *Implications of the Blair Report as it Pertains to Education*, p. 32.

²⁸²Gordon Legge, "Depressed children a pressing problem," *The Calgary Herald*, December 9, 1970, p. 16.

²⁸³F. Trovato, "A Durkheimian Analysis of Youth Suicide: Canada, 1971 and 1983," *Suicide and Life-Threatening Behavior* 22, 4 (1992), pp. 413-27.

²⁸⁴Pettifor, et al, "Risk Factors Predicting Childhood and Adolescent Suicides," *Journal of Child Care* 1, 3 (1983), pp. 17-48.

²⁸⁵Alberta Social Services and Community Health, Community and Institutional Services, *1977-78 Annual Report* (Edmonton: Alberta Social Services and Community Health, Community and Institutional Services, 1978), p. 21.

²⁸⁶Alberta Social Services and Community Health, *1974-75 Annual Report* (Edmonton: Alberta Social Services and Community Health, 1975), p. 41

²⁸⁷Blair, *Mental Health In Alberta, A Report on the Alberta Mental Health Study*, p. 293.

trained psychiatrists, psychologists, special education teachers, and social workers. The Calgary Public School Board provided the schoolteachers.

- **Battered Children.** In early 1970, a subcommittee of the Calgary and Region Mental Health Planning Committee focused its attention on the causes and treatment of emotional disorders of very young children. Inspired by the recently published work of Dr. Henry Kempe and his colleagues²⁸⁸ (who were the first to recognize and bring widespread North American attention to child abuse²⁸⁹ as a clinical problem—which they called the Battered Baby Syndrome), the subcommittee concentrated its deliberations on child neglect and abuse. It made several recommendations that had tremendous impact on program development, as well as in changes to the *Child Welfare Act* (revised in 1973) that made reporting of child abuse and neglect mandatory and established a central Child Protection Registry (implemented January 1, 1974) of cases reported to social service agencies or to police.

During the first 12 months, 502 cases of suspected child abuse were reported throughout the province. Of these, 373 were well-founded cases of physical battering. By comparison, in 1971, 133 complaints of physical abuse in need of investigation were reported; in 1972, the number totalled 199 and in 1973, 295.²⁹⁰

Mandatory reporting requirements clearly made a difference, and the registry proved useful for service provision as well as for research into the factors associated with child neglect and abuse.²⁹¹ A 1973 Ontario report identified the common elements of child neglect and abuse as poverty and severe environmental stress, combined in some cases with personality disorder and alcoholism.²⁹² In addition, abusive parents came from all socio-economic circumstances, ages, and racial groups. Most had been abused themselves in early childhood, thereby revealing a cycle repeating from generation to generation. Early recognition and prevention of child abuse in high-risk infants was emphasized, therefore, as essential to break this cycle.²⁹³

Prompted by this committee's recommendations, the CMHA sponsored a symposium on child abuse in fall 1971. At its conclusion, a number of Calgarians formed a group called the Calgary Child Abuse Advisory Committee, which proved to be amazingly productive. Convinced that preventing child abuse was of primary importance, it produced educational materials and provided seminars on the issue of child abuse and the importance of good parenting in high schools. It proposed the development of a multidisciplinary treatment program for prevention, crisis intervention, treatment, and rehabilitation of abusive families to be located at Alberta Children's Hospital in Calgary. The provincial government funded a three-year pilot program in 1974. The Children's Hospital was a logical choice as it already had a children's mental health program that had expanded from the inpatient unit to include a developmental clinic for children with emotional disorders, as well as those with mental retardation and learning disabilities.²⁹⁴

²⁸⁸R.E. Helfer and C.H. Kempe, *The Battered Child* (Chicago: University of Chicago Press, 1968).

²⁸⁹Kempe defined the battered or abused child as one who received non-accidental physical injury as a result of the parent's or guardian's acts or omissions. Physical abuse or battering is the most severe form of parental disorder. Emotional deprivation and neglect often resulting in failure to thrive are more common although less dramatic evidence of difficulty in the parenting role. Source: G. Bell, "Parents Who Abuse Their Children," *Canadian Psychiatric Association Journal* 18, 3 (1973), p. 223.

²⁹⁰Statistics drawn from Government of Alberta, Department of Health and Social Development in C. Johnson, "Child Abuse," *Canadian Welfare* 11, 8 (1975), p. 16.

²⁹¹V. MacMurray, "The Effect and Nature of Alcohol Abuse in Cases of Child Neglect," *Victimology: An International Journal* 4, 1 (1979), pp. 29-45.

²⁹²C. Greenland, *Child Abuse in Ontario* (Toronto: Ontario Ministry of Community and Social Services, Research and Planning Branch, 1973), p. 19.

²⁹³Bell, "Parents Who Abuse Their Children," pp. 223-27.

²⁹⁴A. Coppes-Zantinga and I. Mitchell, *The Child in the Centre: 75 Years at the Alberta Children's Hospital* (Calgary: University of Calgary Press, 1997), pp. 223-27.

As a specialized centre for children's complex medical conditions, it was also well-equipped to deal with battered children's physical problems (e.g., head injuries and broken limbs).

The committee also created a resource library on child abuse and neglect for researchers, students, and workers in the field. It conducted public education campaigns and advocated for parenting skill development classes to be offered in junior and senior high schools, prenatal classes, and adult education programs. While many called for punishment of the abuser, the committee highlighted the research evidence that showed that—in 80 per cent of cases—rehabilitation programs successfully rebuilt a safe family environment. Much work remained to be done in this area provincially, and the Calgary work served as a good example.

- **Norwood Head Start.** Developments in the United States eventually influenced Alberta's approach to service provision significantly. The United States introduced Head Start Programs in the mid-1960s in an attempt to combat the effects of poverty. This action was driven by knowledge of the impact of poverty on children's physical and mental health; awareness that infants and young children in poverty were the most vulnerable and suffered the most; and that, for most children, mental health promotion programs were unavailable until they reached school age. Fundamental to Head Start programs is the belief that the child's first years of life are critical in learning skills essential to future development.

The first Head Start programs (which began as a national endeavour in the United States) ran for six to eight weeks during the summer of 1965. More than \$100 million was spent that first summer on enrichment, medical care, and food for more than half a million low-income children. The approach was popular with the public who found it acceptable for schools to address social problems. In the early 1970s, the programs expanded from summer only to year-round. Head Start established performance standards and developed staff training programs.

These programs were structured so that three-year-old children from low-income families attended half-day, school-like sessions located in a school setting until they reached school age. They and their parent received transportation to the school. There, they received medical, dental, and nutritional attention, as well as speech and language, developmental, emotional, behavioural, and learning assessments and opportunities. The programs also helped the families by linking them to services available in the community.²⁹⁵ Extensive evaluation of Head Start programs in the United States demonstrated their effectiveness in improving children's health to a level comparable to more advantaged children. The children also showed gains in school readiness, learning, self-esteem, and social behaviour. Some studies found Head Start children more likely to advance to the next grade and less likely to be assigned to special education classes. Other children in the family

²⁹⁵E. Ziegler, *Head Start: The Inside Story of America's Most Successful Educational Experiment* (New York: Basic Books, 1992), p. 42.

also benefitted. Studies also showed, however, that the impact was short term; the gains were no longer evident by the end of the third year after graduating from Head Start. In short, this powerful early intervention approach was valuable, but not enough to combat the disadvantages faced by children living in poverty over the long-term. Continuing interventions were necessary.²⁹⁶ In Alberta, the first Head Start Program was established in 1970 in Norwood, a community in north central Edmonton with a high concentration of low-income families.

The 1960s had unleashed irreversible changes that had impact on the 1970s. The influence of organized religion was fading, and, as populations grew larger and more mobile, the bonds of family and community weakened. The large number of families with young children in which both parents had full-time employment created demands for childcare that escalated beyond what society could meet. Finding good quality childcare became a major challenge. The low wages paid child care workers and the consequent high staff turnover rates contributed to the problem.

Such social problems as adolescent pregnancy, alcohol and substance abuse, mental illness, poverty, child neglect and abuse, and family violence led to more out-of-home placements for young children who then faced a loss of stability with multiple caregivers, all strangers.

As child welfare needs increased, the Department of Social Services and Community Health responded with a range of programs including foster homes, group homes, residential treatment units, and compulsory care institutions. The only facilities for children and adolescents suffering from mental disorders were the compulsory care placements available for wards of the crown and for juvenile delinquents subject to compulsory care under the *Child Welfare Act*. These facilities included the Westfield Diagnostic and Treatment Centre in Edmonton; the William Roper Hull Home in Calgary; and the Youth Development Centres in Edmonton and in other locations around the province. Many children in these facilities needed psychiatric treatment. In fact, the admissions of adolescents with serious psychiatric problems increased significantly at Westfield and Hull Home after the Apollo Unit at Alberta Hospital Ponoka closed in 1977 and the 26-bed facility Kennedy Hall at Alberta Hospital Edmonton closed in 1979.²⁹⁷ Psychiatrically disturbed teenagers now were admitted to a closed unit through compulsory orders or certificates under the *Child Welfare Act* to largely custodial care facilities without psychiatric units where medical care was limited to consultant physicians.²⁹⁸

In 1970, Westfield constructed a unit to serve as a closed setting for juvenile delinquents. Until 1969, the responsibility for juvenile corrections lay with the Department of the Attorney General, at which time it was transferred to the Department of Health and Social Development—a questionable decision considering the rationale for the transfer in 1952 from the Department of Welfare

²⁹⁶U.S. Department of Health and Human Services, *The Impact of Head Start on Children, Families and Communities: Final Report of the Head Start Evaluation, Synthesis and Utilization Project* (Washington: Office of Human Development Services, 1985), p. 14.

²⁹⁷Alberta Department of Public Health, *1979-80 Annual Report* (Edmonton: Alberta Department of Public Health, 1980), p. 37.

²⁹⁸Richard Drewry, *Report of the Task Force to Review the Mental Health Act* ["The Drewry Report"] (Edmonton: Government of Alberta, December 2, 1983), p. 72.

to the Attorney General's Department. Government officials operated on the philosophy that neglected children, those with emotional and behavioural disorders, and juvenile delinquents had similar rehabilitative needs. This belief allowed for common accommodation strategies.

- **The Northern Regional Treatment Residence.** Another example of treatment programs established under the Child Welfare Branch of Alberta Social Services and Community Health was the Northern Regional Treatment Centre in Peace River. This treatment facility had provided six spaces for seriously disturbed six- to 12-year-old children with emotional and behavioural problems since 1977. The children were all wards of the provincial government under the Child Welfare Act²⁹⁹ and referred by the Regional Child Welfare Committee in Grand Prairie. The treatment goal was to return these children to their communities able to function. The treatment used behaviour modification techniques, which required highly skilled therapists but both staffing ratios and staff training were poor—leading to child abuse and eventual closing of the facility.³⁰⁰
- **Calgary General Hospital.** Meanwhile, the need for psychiatric services for juvenile delinquents was great. Eight psychiatric beds were established in the Calgary Remand Centre, administered by the Calgary General Hospital in 1976. Two years later, these services were transferred to a new 21-bed unit at the General Hospital that served both adult and adolescent offenders from Southern Alberta and the Northwest Territories.³⁰¹

²⁹⁹The Cavanagh, *Board of Review: The Child Welfare System*, (Edmonton: Government of Alberta, 1983), p. 24.

³⁰⁰A.H. Thompson, *A Report on the Northern Regional Treatment Residence, Peace River, Alberta to the Child Welfare Branch of Alberta Social Services and Community Health*, (Grande Prairie: Alberta Social Services and Community Health, 1980).

³⁰¹The Clarke Institute of Psychiatry, *Southern Alberta Study of Psychiatric Needs and Provisions: A Report Commissioned by the Southern Alberta Psychiatric Services Committee*, pp. v-60.

³⁰²McKinsey Report, *The Challenge For Psychiatric Care in Edmonton and Northern Alberta*, (Edmonton: Edmonton Hospitals Psychiatric Study Committee, 1980).

³⁰³*Ibid.*, p. 3.

The McKinsey Report

Although Alberta's strong economy far outstripped those of all other Canadian provinces, things were looking bleak for children's mental health. This was revealed by the McKinsey Report released at the end of the decade with an action plan for the 1980s.³⁰² The McKinsey Report examined children's mental health services in Edmonton and northern Alberta and reported that the 315,000 children and adolescents in this area were the single most underserved group in all areas of mental health.

There are serious gaps in psychiatric services for children and adolescents in all areas of service, ranging from detection and assessment through treatment and follow-up care, with the most serious shortages being in well organized outpatient treatment programs and medium and long-stay inpatient facilities.³⁰³

Although the prevalence rate was estimated at 10 per cent of the population of children and adolescents (which translated into 31,500 individuals), only 2.6 per cent were receiving help. All programs were stretched beyond their limit. The opportunity to see a psychiatrist was extremely limited, with only four full-time

and three part-time child psychiatrists serving Edmonton and Northern Alberta. The regional clinics saw 1,600 to 1,800 children and adolescents annually.³⁰⁴ The fact that the Edmonton Clinic had 1,559 registered cases in 1959—mostly children and youth—demonstrated the lack of progress.³⁰⁵ Provision for children and adolescents who needed more intensive care was available only in the Adolescent Evening Program for 25 patients operating out of the Edmonton Mental Health Clinic and a Day Program for 10 adolescents operated by the University of Alberta's External Services Division. In acute care hospitals for short-stay intensive treatment, the University Hospital had 10 beds and the Royal Alexandra Hospital had six. The Glenrose Hospital provided the only medium-stay treatment program, defined as up to six months, with a total of 28 beds with separate wards for children and adolescents. Highly disturbed adolescents—particularly those who were aggressive or violent and who required a secure unit—had no access to long-stay treatment beds. Kennedy Hall at Alberta Hospital Edmonton had been the only such facility but had closed in 1979 because it could not attract adequate staff. Comparisons with national standards and with programs in other provinces further exposed the paucity of services in Alberta. Service providers reported: “We’re in a terrible mess. The service has deteriorated recently. Children are being lost in the system.”³⁰⁶

Aiming at “bringing Alberta’s service infrastructure for treatment of children approximately up to Canadian standards,”³⁰⁷ McKinsey recommended making services for this age group the highest priority for program improvements, with radical upgrades in outpatient clinics, day hospital programs, and medium and long-stay beds, as well as enhanced community supports. The recommendations also included the establishment of a Chair of Child Psychiatry at the University of Alberta and a centre for psychiatric care for children located in Edmonton with funding for teaching and research. Finally, the recommendations called for enhanced psychiatric consultations to schools and increased front line staff in the Mental Health Division of the Edmonton Board of Health and within Child Welfare. In short, in children’s mental health, the decade ended exactly where it began—with Alberta’s children left behind, their needs set aside despite the new rhetoric describing them as the province’s greatest resource.

³⁰⁴Ibid., p. 5.

³⁰⁵Alberta Department of Public Health, *Annual Report* (Edmonton: Alberta Department of Public Health, 1959), p. 114.

³⁰⁶Ibid., p. 8.

³⁰⁷Ibid., p. 12.

Chapter 8

The Grey '80s: Children's Rights,
Outpatient Services, and a
Flagship Program



Infants, young offenders,
runaway youth,
Native Indian children

Infants, young offenders, runaway youth, Native Indian children

Child and Adolescent Services, Edmonton (CASE), an innovative community-based program, was launched in 1980, with funding provided by a number of government departments and through the leadership of Dr. Maurice Blackman, Kit Gillies, and a number of devoted staff.³⁰⁸ CASE appeared just as the McKinsey Report circulated with its extensive recommendations for service improvements. CASE's initial mission—to provide comprehensive assessment and treatment services for adolescents—expanded in 1983 to serve younger children as well. Its target patient population included high-risk children and adolescents from local areas, as well as from central and northern Alberta. Among these were provincial wards, children from low-income families, children subjected to neglect and abuse, Native Indian³⁰⁹ children, and children from isolated rural communities for whom there were no local mental health services. A team of professionals including nurses, a psychologist, social worker, psychiatrists, and a pediatrician provided services within a clinical and administrative model directed by Dr. Maurice Blackman, a senior child psychiatrist.

These consolidated services were located at St. Joan's School and structured on a continuum from less intensive to very intensive programming, including assessment and treatment in a clinic setting, an evening program for adolescents, a day program for adolescents with a schooling component and teachers funded by the Edmonton Public School Board, and two clinically supported group homes. In 1985, CASE House was added to this continuum. It provided a 10-bed intensive residential treatment program for adolescents with severe psychiatric problems and was located at the Yellowhead Youth Centre.³¹⁰ Tanya's story reflects the intensity of the needs of adolescents referred to CASE House.

Tanya's Story

Seventeen-year-old Tanya first came to the attention of Child Welfare authorities as a neglected infant, and she spent most of her childhood in care. She had been pregnant twice by the time she was 14 and was referred to CASE House after a number of suicide attempts. Her referral came from a locked Child Welfare facility where she was under 24-hour guard because of her aggressive behaviour directed at herself and at others.³¹¹

³⁰⁸C.A.S.E. Parents' Support Group, *Preliminary Proposal For the Establishment of a Board Administered Integrated Community and Residential Mental Health Service for Children and Adolescents in the Edmonton Region* (Edmonton: C.A.S.E. Parents' Support Group, 1988), pp. 1-39.

³⁰⁹In the 1980s, it became politically incorrect, as reflected in the literature, to call children "Native" children. The name was changed to "Native Indian" and then to "Aboriginal" children in the 1990s and more recently to "First Nations" children.

³¹⁰M. Blackman, J. Eustace, and T. Chowdhury, "Adolescent Residential Treatment: A One to Three Year Follow-up," *Canadian Journal of Psychiatry* 36 (September 1991), pp. 472-49.

³¹¹Abridgement from case history in Blackman, et al., "Adolescent Residential Treatment: A One to Three Year Follow-up," p. 473..

An evaluation of this program was conducted over 28 months between 1985 and 1987. Results showed the treatment model to be successful, with most of the adolescents continuing to make lasting changes after discharge when supported with active follow-up.³¹²

An innovative partnership between the Department of Social Services and Alberta Mental Health Services supported the operating costs of CASE House. Drs. Gary Hnatko and Maurice Blackman facilitated continuity of care by sharing their time as the unit psychiatrists at CASE and at the Walter C. MacKenzie Centre, where hospital back-up services were provided for CASE through 10 beds available for child psychiatry.³¹³

CASE was distinguished by a number of factors including its staff complement which included 28 clinical and six support staff, five child psychiatrists (of the eight practicing in Edmonton), one psychiatric resident, one pediatrician, and a senior pediatric fellow for a medical staff of 4.5 full-time equivalents. This staffing constituted 33 per cent of the children's mental health human resources in the Edmonton Region,³¹⁴ yet the demands for CASE services were so great there was a continued push for expansion as the pressure for services was mounting in all areas.³¹⁵

Royal Alexandra Hospital Edmonton

By the 1980s, the Royal Alexandra Hospital reached a crisis point in its ability to meet service demands. Since the mid-1960s, it had provided adolescent psychiatric treatment by admitting adolescents needing these services to regular medical beds.³¹⁶ Patients received the school component of their hospital stay through an agreement with the Edmonton Public School Board and the Glenrose School Hospital.

The lack of dedicated space for pediatric psychiatry imposed many limitations on treatment and placed patient care in jeopardy. By 1982, the six beds allocated for adolescent psychiatry simply could not meet the needs. The McKinsey Report had recommended three times that number. The hospital had denied multiple requests for a dedicated unit because of insufficient funds. Subsequent requests to Alberta Hospitals and Medical Care were also denied because of uncertain provincial budgets. Child psychiatrists became increasingly concerned. They worried that patient care was at risk and threatened to withhold services if their appeals for improvements continued to be denied. Approval for a 12-bed unit for adolescents up to age 16 was finally received, and the newly designed Unit 36 marked the first admission on May 22, 1984.³¹⁷

These new programs were highlights for children's mental health in Alberta in what many Albertans came to think of as the lost decade when the 1981-1982 recession hit:

³¹²Ibid., p. 478.

³¹³C.A.S.E., *Status Report on Child/Adolescent Services* (Edmonton: C.A.S.E., 1987), p. 2

³¹⁴Ibid., pp. 1-6.

³¹⁵Ibid., p. 6.

³¹⁶Adolescent admissions in 1965, 83; in 1966, 87; in 1967, 84, in 1968, 93. Source: Murray Armstrong, *History of Unit 36*. Excerpts from Royal Alexandra Hospital files. August, 2005.

³¹⁷Ibid., p. 5.

³¹⁸Jenish D'Arcy, "Crash, Layoff, Exodus, Repeat; Welcome to the 'Lost Decade,'" *Alberta in the 20th Century, Volume 12: Alberta Takes the Lead* (Edmonton: United Western Communication Ltd., 2000), p. 5.

³¹⁹*Ibid.*, p. 8.

³²⁰Koch, "Getty Returns as Quarterback and Fumbles Nearly Every Ball," p. 41.

³²¹*Ibid.*, p. 48.

³²²The Clarke Institute of Psychiatry Consulting Group, *Southern Alberta Study of Psychiatric Needs and Provisions: A Report Commissioned by the Southern Alberta Psychiatric Services Committee* (Calgary: The Clarke Institute of Psychiatry, 1983), pp. V-60.

³²³Dr. Timothy Yates, *Need for Child Psychiatrists in Calgary and Southern Alberta, 1981-90*, (Calgary: Calgary Regional Psychiatric Services Committee), 1981.

³²⁴*Ibid.*, p. 10.

³²⁵*Ibid.*, p. 8.

³²⁶M. Blackman, S. Pitcher, and F. Rauch, "A Preliminary Outcome Study of a Community Group Treatment Programme for Emotionally Disturbed Adolescents," *Canadian Journal of Psychiatry* 31 (March 1986), pp. 112-18.

³²⁷Gerry Fewster, *Expanding the Circle. A Community Approach to Children's Mental Health. A report prepared for the Alberta Children's Mental Health Project* (Edmonton: Alberta Department of Social Services and Community Health, 1986).

³²⁸Murray Armstrong, *Exploring the Circle: A Journey into Native Children's Mental Health. A report for the Alberta Children's Mental Health Project* (Edmonton: Alberta Department of Social Services and Community Health, 1986).

Those born after the depression, and they were the majority, had never seen such a deep downturn in the fortunes of their province. Unemployment hit double digits, businesses large and small collapsed in almost every sector of the economy and the crash in real estate values wiped out an astonishing \$5 billion in homeowner equity. After a disaster of that magnitude, Albertans assumed they had experienced enough hardship to last a lifetime.³¹⁸

Falling oil and real estate prices and soaring interest rates soon devastated the Alberta economy. By the fall of 1986, 62,000 Albertans were dependent on welfare, 10,000 more than a year earlier and a record number in the history of the province. By January 1987, as the world oil prices started to rebound and the economy was showing signs of climbing out of the recession, 310,000 individuals, or 13 per cent of the province's 2.4 million people, were "on the dole."³¹⁹ The provincial deficit for 1986-87 fiscal year was announced at \$3.4 billion. The government hiked taxes of all kinds in an effort to cope, the end result being a tax load increase of 19 per cent for the average Albertan.³²⁰ Between 1980 and 1988, welfare costs quadrupled and, by the end of the decade, government was in the worst financial shape in its history.³²¹

Different branches of government commissioned numerous studies to find solutions to the continuing shortages of services for children with mental health disorders during this climate of austerity. In 1983, following on the heels of the McKinsey Report, the *Southern Alberta Study of Psychiatric Needs and Provisions* (now well-known as the Clarke Institute or Clarke Report) was released.³²² This report eloquently outlined the ubiquitous problems with rural psychiatric services; the lack of access to mental health services for children and adolescents; and the plight of children in Native Indian communities. It recommended program enhancements and highlighted the unlikelihood of improvements because of the unavailability of well-trained staff for new or expanded programs.

Many studies revealed the same problems and agreed unanimously on the major priorities—expanding and improving services for children and adolescents. The Yates Report³²³ stated: "Many adolescents and children needing help go unrecognized; most (50 – 99%) go untreated."³²⁴ Yates further observed that, in Alberta, "... in the most richly endowed part of Canada, services for an adult with a major illness are seen as four times more available than services for psychiatrically disturbed children and adolescents."³²⁵

Blackman et al.³²⁶ compared the Ottawa region with a catchment area similar in size to Edmonton and found Ottawa had child psychiatric units in all the major hospitals and 55 child psychiatrists, while Edmonton had six child psychiatrists. The themes which emerged from other briefs and reports—notably, *Expanding the Circle* (1986),³²⁷ *Exploring the Circle* (1986),³²⁸ *Caring and Responsibility*

(1988),³²⁹ *Reducka Report on Juvenile Delinquents* (1980),³³⁰ *Drewry Report on the Mental Health Act* (1983),³³¹ *Thompson on Children in the Care of Child Welfare* (1988),³³² and *Brief to the Premier's Commission* (1989)³³³—all pointed to severely inadequate services and made an impassioned plea for improvements in this specialized area of health care. Themes focused on:

- lack of access to treatment because of the few available programs in every area of service delivery
- intensified access problems for children in rural and Native Indian communities
- the need for mental health services to be offered in Native languages and through Native culture
- dire shortages of trained professionals with expertise in children's mental health
- great emphasis on the serious shortages of child psychiatrists across the province
- lack of service coordination
- the contribution of social problems to children's mental health disorders and the lack of commitment to prevention programs
- little focus on research in this area of medical specialization
- the pain and anguish of families whose children needed treatment for which they typically waited months
- the lack of impact the many studies and reports had in bringing about change.

The situation remained tragically unimproved throughout the 1980s with extreme hardships on many families. Their stories made the headlines of local newspapers. For example, Journalist Mark Lisac documented in *The Edmonton Journal* the problem of a woman who had to give up legal custody of her teenaged child to ensure that her child received treatment.³³⁴

³²⁹Caring and Responsibility: A Statement of Social Policy for Alberta presented by the Hon. Neil Crawford, Minister of Special Projects. March 28, 1999.

³³⁰Kathryn Reducka, *Psychiatric Services for Juvenile Delinquents in Northern Alberta. A report submitted to Dr. Robbie Cambell and the Edmonton Group for Child and Adolescent Psychiatry* (Edmonton: Government of Alberta, 1980).

³³¹Drewry, *Report of the Task Force to Review the Mental Health Act*.

³³²A.H. Thompson, *Young Offender, Child Welfare, and Mental Health Caseload Communalities*. Unpublished paper, 1988.

³³³Margaret Shone, *Brief to Mr. Lou Hyndman, Chief Commissioner, Premier's Commission on Future Health Care for Albertans* (Edmonton: Institute of Law Research and Reform, January 6, 1989).

³³⁴Mark Lisac, "Giving up daughter harsh way to get help," *The Edmonton Journal*, July 16, 1988, p. 14.

Mom's Story

...The child had gradually been sliding into difficult behaviour because of what turned out to be a genetically based illness. A hospital admitted the child last spring. Some weeks later, the annual summer shutdown of psychiatric beds rolled around. That left the parents with a choice. The mother's voice still goes hollow with disbelief when she repeats it: "You either take the child home and hope for the best or you put the child into secure treatment." Secure treatment means placement in an institution run by the Social Services Department. Children have to be wards of the province to go into these institutions. So this mother found herself in family court, applying for a guardianship order that would cost her custody of her child.... The centre seemed to be doing a fine job with

runaways and kids who had fallen into drugs or prostitution, but it was not equipped to deal with children from psychiatric units. “They didn’t have a psychiatric nurse there at the time.”... The episode left her with big questions about the way government handled mental health services. “We’re not shaking our finger and saying ‘hey, you’re a bunch of jerks.’ We’re saying, ‘we know what’s going on. Do you?’ When am I going to be able to access mental health services without losing custody of my child?”

Mark Lisac presented the question to Jim Dinning, then Minister of Community and Occupational Health, who said: “There’s no reason on this God’s green earth that a child should be given up by his parents to social services in order to receive quality mental health services.”³³⁵ This issue was a big one, its impact one of such heartbreak for families. Not surprisingly, it came to the attention of the task force appointed by a ministerial order to review *the Mental Health Act*. The task force report emphasized the inappropriateness of this practice:

Wardship is usually reserved for children without parents, or whose parents have “neglected” them. The children of loving and conscientious parents may also suffer from mental disorder. It should not be necessary for the Director of Child Welfare to take over the parental role for these children to receive needed treatment.³³⁶

The reason for the practice, as the report explained, was that with the closure of Kennedy Hall and the Apollo Unit, no facility existed for involuntary hospitalization of children or adolescents under the *Mental Health Act* for those:

- suffering from a mental disorder and
- in a condition presenting a danger to himself or others.³³⁷

The report stated: “A child, or more likely an adolescent, cannot be committed as an involuntary patient if there is no designated facility to admit him...”

Nevertheless, it is inappropriate to require a child to be placed in government custody or wardship to gain admission to the only facilities available for the extended supervision of mentally disturbed young persons whose main requirement is psychiatric care.”³³⁸

The task force recommended that the Minister of Social Services and Community Health have a legislative obligation to establish and maintain a satisfactory system of community-based mental health services as outlined in the McKinsey and Clarke Institute Reports.³³⁹ The task force report also recommended the designation of psychiatric units with adequate physical accommodation and appropriately trained staff in general hospitals for the treatment of involuntary patients. At the time, Alberta Hospitals, Edmonton and Ponoka, were the only

³³⁵Ibid.

³³⁶Drewry, *Report of the Task Force to Review the Mental Health Act*, p. 170.

³³⁷Ibid., p. 67. The task force recommended at third criterion: incompetent to give a valid consent to treatment or, if competent, refuses hospitalization as a voluntary patient. The revised *Mental Health Act* introduced this amendment.

³³⁸Ibid., pp. 169, 172.

³³⁹Ibid., p. 3.

facilities in the province that functioned as facilities for all purposes under the *Mental Health Act*. This measure was intended to address the needs of adults with severe mental health disorders. Over time, however, its benefit also accrued to children and adolescents, as psychiatric units for their treatment opened in general hospitals in the province's large urban centres. The task force report then urged government "to embark on a course of expeditious implementation."³⁴⁰ The work of this task force led to the new *Mental Health Act* (Bill 29), which received Royal Assent on July 8, 1988, and was proclaimed on January 1, 1990.

The Child Welfare Act

The *Child Welfare Act* had more impact on children's mental health services than the *Mental Health Act*. An almost total absence of health facilities for children with severe disorders meant they had to be admitted to child welfare facilities under a secure treatment certificate. The 1966 child welfare legislation no longer met community standards, requiring new legislation.³⁴¹ Changes to the *Child Welfare Act* were introduced in the Legislature on November 16, 1983 (as Bill 105), with proposed amendments to the section on required disclosure to protect the child. The new act also introduced criteria for compulsory care:

- a) The child suffers from a mental or behavioural disorder.
- b) The child presents a danger to himself/herself or others.
- c) The child must be confined in order to protect his/her survival, security, or development.³⁴²

This language was further adjusted in the 1985 amendment to *The Child Welfare Act* to be more consistent with a treatment focus. Part C now said: "It is necessary to confine the child in order to remedy or alleviate the disorder."³⁴³

The new act also introduced several new concepts for the care of Alberta children, including the introduction of a children's guardian who assumed some responsibilities held by the Director of Child Welfare under the former act. The new act also had new provisions for mental health assessment and treatment services for children and adolescents, shorter timelines for court appearances, special considerations for Native Indian children, and provisions for an appeal process.

In 1980-1981, 1,167 children were confined in provincial compulsory care facilities. The Alberta Committee on Children and Youth reported: "Eighty-four percent of the children assigned to compulsory care are 13-15 years old and slightly more than a third of them are girls. Fifteen percent receive more than one period in compulsory care. While the length of the stay in the locked wards is usually between 60 and 150 days, 19 children were locked up for six months or longer in 1981."³⁴⁴ Thompson³⁴⁵ studied the population of children in care³⁴⁶ and

³⁴⁰Ibid., p. 43.

³⁴¹The Cavanagh Commission in 1983 made many recommendations for improving child welfare legislation as well as for system changes, addressing of organizational issues, staff training, and improvements in staff morale. The Cavanagh Commission, *Board of Review: The Child Welfare System* (Edmonton: Government of Alberta, 1963).

³⁴²Ibid., p. 167.

³⁴³Statute of Alberta. Amendment to the *Child Welfare Act*. 1985. Application for secure treatment order.

³⁴⁴The Alberta Committee on Children and Youth, *What You Should Know About Alberta Children and their Families...The Darker Side* (Edmonton: The Alberta Committee on Children and Youth, 1982), p. 54.

³⁴⁵A.H. Thompson, *Mental Health Needs of Children in the Care of Child Welfare*. Report for Alberta Mental Health and the University of Alberta. 1986, p. 6.

³⁴⁶The term "in care" generally referred to circumstances in which a child can no longer be cared for by his/her natural parents and, therefore, lives somewhere other than the natural parent's home. Being in care implies that the child has a legal status in which the province assumes the natural parents' guardianship rights. Source: Ray Thomlinson and Catherine Foote, "Child Welfare in Canada," *Child and Adolescent Social Work* 4, 2 (Summer 1987), p. 131.

³⁴⁷A.H. Thompson and D. Fuhr, *Psychopathology of Children In the Care of Child Welfare*. Unpublished paper. 1986, p. 20.

³⁴⁸Research conducted by Dr. Roger C. Bland, et al. as discussed by A. H. Thompson and C.A. Roberts, *Mental Health in Alberta 1: Philosophical Issues*. A Submission to the Premier's Commission on Future Health Care for Albertans. 1989, p. 67.

³⁴⁹The Clarke Institute of Psychiatry. Southern Alberta Study of Psychiatric Needs and Provisions: A Report Commissioned by the Southern Alberta Psychiatric Services Committee, pp. 1-8.

³⁵⁰Alberta's population reached 2.2 million in 1981, over half (5.3 per cent) of the total population of the Prairie west—compared with 1.3 million 20 years earlier. With this growth, the influence of Calgary and Edmonton grew enormously. Both now were larger than Winnipeg, which had been the single metropolis of the Prairies in 1941. In 1981, Alberta's rural population declined from 66.6 per cent in 1941 to 22.8 per cent in 1981. The number of farms was cut in half during this period. Petroleum drove these changes and fueled a booming economy and diversified wealth. Source: Gerald Friesen, *The Canadian Prairies: A History* (Toronto: University of Toronto Press, 1990), pp. 427-29.

³⁵¹*Ibid.*, p. 1-9.

³⁵²*Ibid.*, p. 1-9a.

³⁵³*Report of the Suicide Prevention Provincial Advisory Committee to the Minister of Alberta Department of Social Services and Community Health, the Hon. Bob Bogle. The First Year*. September, 1982. Menno Bolt chaired the committee and members were Jack Butler, Thelma Chalifoux, Dick Ramsay, and Alice Romaniuk. Members were chosen as representative of a cross-section of Albertans for one-year terms.

³⁵⁴*Ibid.*, p. 4.

found the results were startling. Between 35 and 40 per cent of children in care were of Native Indian ancestry—a large over-representation. Children in care also were found to be at extremely high risk for severe and hard to treat mental health disorders: 44 per cent of children in care needed mental health intervention but—like other children in high-risk groups—had little access to treatment programs.³⁴⁷

The Darker Side of Social Stress

Reports produced since the 1960s identified social stress as the root cause of the growing numbers of children needing mental health services. This was further supported by research in the 1980s that showed a clear correlation between social problems and mental disorders. For example, youth involved in criminal activity and children in the care of Child Welfare as a result of abuse or neglect represented the highest risk groups for mental disorders.³⁴⁸ The Clarke Report's³⁴⁹ overview of the problem discussed how Alberta was straining under the effects of rapid growth and increased social complexity.³⁵⁰ The social fabric of Alberta included such factors as:

- the hospitalization rate for stress-related illnesses (ranging from heart disease to anorexia nervosa) 29 per cent higher than the national average, according to a 1975 study
- per capita alcohol consumption higher than the Canadian average since 1967. An Alcoholics Anonymous survey in 1980 reported increasing numbers of women and young people under 30 among alcoholics.
- the highest suicide rates for both men and women among the Canadian provinces (although the rates differed by region within the province: “Northern Alberta suicide rates are higher than Southern Alberta and Edmonton rates are higher than Calgary rates. Teenage suicides are on the increase and suicide rates among young Native people are alarming.”³⁵¹ In 1982, teenage suicides in Calgary were 13 per 100,000 and in Edmonton, 18 per 100,000. While the Alberta average was 20 per 100,000, the rate for registered Indian teenagers was 113 per 100,000).³⁵²
- the highest divorce rate in the country.

In 1981, Bob Bogle, Minister of Social Services and Community Health, established the Suicide Prevention Provincial Advisory Committee in an effort to reduce the suicide rate.³⁵³ With a government-mandated framework and funds set aside specifically for suicide prevention and crisis intervention, it worked closely with the provincial suicidologist. In its first year, it established outreach services for people who were suicidal or who were bereaved by suicide; trained and educated “gatekeepers” in every community; and researched suicide specifically related to Alberta.³⁵⁴ The suicide bereavement programs established in Calgary and Edmonton were two of only four suicide bereavement programs operating in

all of Canada. A Research Centre opened at the University of Calgary as well as an Edmonton Resource Centre for education and training. A province-wide suicide prevention and intervention training project began, with outreach services through community networks in Calgary, Edmonton, Fort McMurray, Lethbridge, Medicine Hat, and Red Deer. The committee placed a high priority on the development of Native suicide prevention programs, recognizing that the Native suicide rate was five times that of non-Native youth. In 1982, the Native Counselling Services of Alberta was provided a grant to develop and field test a suicide prevention education and training program specific to the needs of Alberta's Native Indian people.

The Young Offenders' Act

The continuing growth in violent crime and youth criminal activity was another significant social stressor. As the Alberta Committee on Children and Youth noted:

Crime in all forms is increasing in Alberta youth. The number of juveniles (children under 16) found delinquent in 1978 was four times the number found in 1971. Delinquency rates are lower in Calgary than in Edmonton, and rural areas have higher rates than urban areas. Girls especially are increasingly involved in crime. There is also a trend towards more violent crime among the province's children.³⁵⁵

There was great debate in the province and across Canada about how to deal with this problem:

One school of thought saw criminals as victims of childhood abuse and poverty who could become law-abiding citizens if properly treated. The opposing view was expressed by...those who railed against the coddling of young offenders and lenient new laws such as early parole for murderers. Some advocated for the tough love approach to training and discipline rather than counselling and psychology, and believed in the therapeutic value of hard work. Permissiveness has been the root of a lot of the problems for these young kids.³⁵⁶

In 1982, the *Young Offenders Act* replaced the *Juvenile Delinquents Act* after years of review and heated debate. This act focused more on rehabilitation than on retribution, with provisions structured to ensure that young offenders would receive every benefit of the doubt and dealt with as youth requiring help, guidance, encouragement, supervision, and treatment.

³⁵⁵The Alberta Committee on Children and Youth, *What You Should Know About Alberta Children and their Families... The Darker Side*, p. 96.

³⁵⁶David Staples, "The Boom and the Boomers Lift Crime to New Heights," *Alberta in the 20th Century, Volume 2: Lougheed & the War With Ottawa* (Edmonton: Western Communication Ltd., 2000), p. 173.

³⁵⁷“Forensic Unit Opens for Young Offenders,” *The Edmonton Journal*, November 11, 1986, p. 12.

³⁵⁸The Clarke Institute of Psychiatry. *Southern Alberta Study of Psychiatric Needs and Provisions: A Report Commissioned by the Southern Alberta Psychiatric Services Committee*, pp. V-62.

³⁵⁹1977 to 1982 Annual Reports, Alberta Social Services and Community Health, Mental Health Division.

³⁶⁰The Alberta Committee on Children and Youth, *What You Should Know About Alberta Children and their Families... The Darker Side*, p. 98.

³⁶¹K. Kufeldt and M. Nimmo, “Youth on the Street: Abuse and Neglect in the Eighties,” *Child Abuse and Neglect*, Vol. 11 (USA: Pergamon Journals Ltd., 1987), pp. 531-43.

³⁶²J. Lipsitz, *Growing Up Forgotten* (Lexington: D.C. Health, 1976).

³⁶³W. Nesbit and L. Karagianis, “Child Abuse: Exceptionality as a Risk Fact,” *The Alberta Journal of Educational Research* XXXVIII, 1 (March 1982), pp. 69-76.

³⁶⁴C. Bagley, “Child Abuse and Neglect: Basic Dilemmas of Theory, Research and Practice.” Unpublished paper, University of Calgary Faculty of Social Welfare, p. 2. as quoted in R. Thomlinson and C. Foote, “Child Welfare in Canada,” *Child and Adolescent Social Work* 4, 2 (Summer 1985), p. 132.

³⁶⁵The Alberta Committee on Children and Youth, *What You Should Know About Alberta Children and their Families... The Darker Side*, p. 82.

Forensic Services

In August 1986, Alberta Hospital Edmonton opened a Forensic Unit for assessing and treating young offenders aged 12 to 17. Called the Turningpoint Program, this 19-bed unit was staffed by a team of nurses, a psychiatrist, social worker, psychologist, neuropsychologist, occupational therapist, recreation therapist, and teachers. On average a young offender was assessed in two weeks, but those who received treatment might stay four to nine months.³⁵⁷

Outpatient services were also provided through a Forensic Assessment and Community Services Unit (FACS), established in the late 1970s in Edmonton and Calgary. In 1978, the Calgary Forensic Assessment and Outpatient Services (FAOS) unit was disbanded and its responsibilities taken over by the Calgary General Hospital Forensic Unit.³⁵⁸ In the early 1980s, the Edmonton FACS was seeing, on average, 140 youth under 17 years of age each year.³⁵⁹

Growing Up Forgotten

Over 10,000 Alberta children ran away from home in 1979.³⁶⁰ In 1984, research conducted in Calgary showed that runaway and homeless youth living on the streets of large Alberta cities were at great risk of being drawn into illegal activities.³⁶¹ Their mean age was 16, equally divided between males and females. Among the disturbing findings was the fact that a high percentage of the runners had experienced physical or sexual abuse. They were two years behind in school on average and their individual private problems were compounded by systemic failures. Fifty-three per cent of runaways were from Child Welfare facilities. Little had been added to the body of knowledge on this population since Lipsitz's study, *Growing Up Forgotten*, published in 1976.³⁶² This local research, however, led to an international conference held in Calgary in 1985 and the opening of a safe house for runaway and homeless youth two years later.

Child Abuse and Neglect

Child abuse continued to be a significant health issue of the 1980s and a focus of public and professional concern. As Nesbit and Karagianis showed through their research: “Abusive Acts cause the death of children each year.”³⁶³ Across Canada, child abuse was the leading cause of death in infants aged six months to one year.³⁶⁴ In the fiscal year 1980-81, the Alberta Child Protection Registry received reports on 14,781 children suspected of being victims of child abuse or neglect. Half of these cases required intervention. Knowing that only 50 per cent of actual cases of child abuse were ever reported created great concern.³⁶⁵

In 1980-81, the child abuse program at the Calgary Children's Hospital served a total of 525 families, a 60.5 per cent increase over the previous year.³⁶⁶ Research showed that children who suffered abuse experienced profound, long-lasting, and devastating consequences, with symptom clusters including suicidal behaviour, aggressive behaviour, school problems, anxiety, physical health problems, and difficulty sleeping.³⁶⁷ Chris Bagley, a University of Calgary professor, advocated strongly for better mental health treatment, both for those currently being abused and for those suffering impaired mental health because of earlier abuse.³⁶⁸ The province had few programs with this specialized focus in the 1980s, although things had improved. A publication called *Tracking the Trends*, with a special focus on Edmonton youth, said: "... increased reporting of family violence and disclosure of child sexual abuse will require a significant increase in specialized treatment services."³⁶⁹

Many abused children, of course, still ended up in government care—5,221 children were in the province's care in 1980-1981.

School Guidance and Counselling Services

Thompson and Roberts emphasized that children and youth with mental health problems were at extremely high risk for disorders as adults.³⁷⁰ They recommended such enhanced services and basic preventive strategies as teaching young children problem-solving and social skills, while recognizing that delivering such programs would involve working with families, day cares, and the school system. Alberta Education's policies and guidelines showed that it shared this philosophy. It emphasized guidance and counselling services as an integral component in the total education of students: "Alberta Education supports the position that all students in all schools should have access to guidance and counselling services as an integral component of their regular school services and programs."³⁷¹ Alberta Education acknowledged that not all schools had counsellors, yet their role was important and all schools should provide them. As a partial solution, they proposed: "In the absence of a qualified counsellor, the principal should ensure that these responsibilities are fulfilled."³⁷²

A 1983 provincial survey exposed the limited support available for children with emotional and behavioural disorders in schools: "Residential/educational placement options in the province are practically nonexistent for this population at the high school and junior high school level. Existing settings operated by Alberta Social Services and Community Health generally are not available for these pupils. Indeed, such settings do not accept referrals from school jurisdictions or parents."³⁷³ Westfield, the Youth Development Centres, William Roper Hull Homes, and Stampede Boys Ranch—which provided treatment programs funded by Child Welfare—were notable exceptions. Bosco Homes

³⁶⁶K. Kovitz, "Multidisciplinary Team Functioning," *Child Abuse and Neglect*, Vol. 8 (1984), pp. 355.

³⁶⁷M. Clarke and J. Hornick, "The Child Sexual Abuse Victim: Assessment and Treatment Issues and Solutions," *Contemporary Family Therapy* 10, 4 (1988), pp. 235-43.

³⁶⁸Bagley, "Child Abuse and Neglect: Basic Dilemmas of Theory, Research and Practice," pp. 17-23.

³⁶⁹Community Trends Working Group, *Tracking the Trends: Future Direction for Human Services in Edmonton*, Edmonton: Community Trends Working Group, 1989, p. 25.

³⁷⁰A.H. Thompson and C.A. Roberts, *Mental Health in Alberta I: Philosophical Issues, A Submission to the Premier's Commission on Future Health care for Albertans*, 1989, p. 5.

³⁷¹Alberta Special Education Services Branch, *Guidance and Counseling Services in Alberta Schools*, Edmonton: Alberta Special Education Services Branch, 1984, p. 51.

³⁷²*Ibid.*, p. 24.

³⁷³Alberta Education Special Education Services, *Review of Programs and Services for the Learning Disabled and Behaviorally Handicapped* (Edmonton: Alberta Education Special Education Services, 1983), p. 20.

³⁷⁴Bosco Homes: A Society for Children and Adolescents, Bosco Homes, opened in Strathcona as a 14-bed residential treatment program, with Dr. Gus Rozycki as founding executive director. It has grown into a multi-tier organization providing group care for very disturbed children and youth, including psychological assessments, foster care, services for aboriginal children, special education with remedial services, and child and youth support services.

³⁷⁵Alberta Special Education Services Branch, *Guidance and Counseling Services in Alberta Schools*, p. 35.

³⁷⁶R.C. Bland, S. Newman, and H. Orn, "Schizophrenia: Lifetime Co-morbidity in a Community Sample," *Acta Psychiatrica Scandinavica* 75 (1987), pp. 383-91

³⁷⁷A.H. Thompson and C. Roberts, *Mental Health in Alberta 111: Mental Health Promotion and Innovative Strategies. A Submission to the Premier's Commission on Future Health Care for Albertans*, 1989.

³⁷⁸Roberts and Griffin, "History of Psychiatry in Canada," in *Images in Psychiatry*, p. 32.

³⁷⁹Bowlby proposed in the mid-1960s that an infant's attachment or tie to his/her mother or primary caregiver is formed out of a number of behavioural systems or responses that develop during the first year of life and ensure survival by attracting the caregiver's attention. These behaviours become increasingly focused on a particular caregiver by the time the infant becomes six months old. Attachments can change from secure to insecure when negative life experiences affect the parent or caregiver's sense of security and, consequently, interactions with the infant. Source: Sarah Landy, *Pathways to Competence: Encouraging Healthy Social & Emotional Development in Young Children* (Baltimore: Paul H. Brooks Pub., 2002), p. 162.

³⁸⁰Klaus Minde, *Child Psychiatry* (Beverly Hills: Sage Publications, 1987).

added its specialized programs to this group of services for very disturbed children and adolescents when it opened in Edmonton in 1997.³⁷⁴ In most cases, however, parents had to send their children to out-of-province programs. Alberta Education had a list of 16 approved out-of-province programs in British Columbia, Colorado, New York, Ontario, and Texas, and reimbursed parents up to 85 per cent of the costs of placing their children in these programs. The fact that this approach to service provision continued was seen as less than ideal. It was also viewed in various reports as a serious lack of leadership in program development to meet the needs of Alberta children.³⁷⁵

The Alberta School Act of 1988 was the first major overhaul of provincial education policy since 1970. This new legislation focused primarily on parental rights and private schools and provided more choices for parents, greater autonomy for independent schools, and more provincial funding for people who chose to educate their children outside the public system. It did not, however, address the lack of services for the support of emotionally disordered children.

Prevalence and Long-Term Implications

Dr. Roger C. Bland, a prominent psychiatrist noted for studying the prevalence of mental disorders in Alberta, found a prevalence rate of 17.1 per cent among adults in an Edmonton-based study.³⁷⁶ Thompson and Roberts placed the overall prevalence rate of childhood mental disorders in the same range in a submission to the Premier's Commission on Future Health Care for Albertans.³⁷⁷ The now famous Ontario Child Health Study, completed by Dr. Dan Offord in 1987, found a prevalence of psychiatric disorders in 18.1 per cent of children. Offord also found that only 16.1 per cent of children with these disorders had received any form of mental health or related services within the six months preceding the study.³⁷⁸ Psychiatric experts considered these findings applicable to all of Canada and to be stable not only across age groups, but also across time. One of the implications was that mental disorders would be present in Alberta's infant population.

Infant Psychiatry

Bowlby, a psychiatrist and psychoanalyst well-known for his seminal work on infant attachment published in the mid-1960s, promoted interest in empirical study of infant mental health.³⁷⁹ Klaus Minde's book, *Infant Psychiatry*,³⁸⁰ published in 1986, was the first book devoted to infant psychiatry. It set in motion a resurgence of interest in the effects of the child's earliest years on later development:

Until that time most Canadian child psychiatrists had not considered working with families who were concerned about their infant's behaviour. Yet some of these child psychiatrists had trained in pediatrics and wanted to maintain their ties with their previous colleagues by acting as consultants to pediatricians.³⁸¹

Infancy was now recognized as a distinct stage in life, like childhood, adolescence, adulthood, and old age. In the fall of 1984, the first Canadian psychiatric clinic for infants and their families opened in Toronto and by the end of the 1980s, trainees from across Canada came there to learn about infants. Dr. Frieda Martin from Toronto's Hincks Institute gathered a group of individuals interested in helping infants and their families.³⁸² Among these was Dr. Carole Anne Hapchyn, an Edmontonian who specialized in infant mental health in Toronto and returned to Alberta in 1990 to practice at the Glenrose and at the Child and Adolescent Services Association (CASA). She was instrumental in implementing CASA's specialized early intervention program in infant and preschool mental health, with pilot project funding provided by the Edmonton Community Foundation.³⁸³

Child and Adolescent Services Association

CASA was brand-new in 1991, but its program structure (which had grown out of the CASE program) had been in place since 1980. Parents of children receiving services through CASE were frustrated and disturbed by the lack of progress in children's mental health services and strongly motivated to make a difference. They assembled as the CASE Parents' Support Group under the leadership of Mary Hyndman, Murray Sheckter, Margaret Shone, together with Dr. Maurice Blackman. Together, they submitted a proposal to the Minister of Health, the Honourable Nancy Betkowski, for the administrative integration of CASE under a Community Board. This proposal was in response to government's public statements that the Alberta community needed to accept more responsibility for the care of its youth.³⁸⁴ The proposed CASA, modelled on Toronto's Hincks Clinic, was inspired, to some extent, by the McKinsey Report's suggestion that a flagship program³⁸⁵ be established in the Edmonton region: "Consider establishing a centre for psychiatric care of children. Collect expertise and leadership in one organization to provide program leadership, expertise in patient care and a centre for research and training."³⁸⁶

The minister approved the transfer of community-based child and adolescent mental health services under a community board, as proposed by the "Parents' Group," and CASA was incorporated in 1989. The CASA Board of Directors assumed responsibility for service delivery, opening CASA's doors in 1991 with 450 children and adolescents transferred from Mental Health Services and admitting another 500 during its first year. CASA's continuing role as the Alberta

³⁸¹Roberts and Griffin, "History of Psychiatry in Canada," in *Images in Psychiatry*, pp. 33-36.

³⁸²*Ibid.*, p. 37.

³⁸³Child and Adolescent Services Association, *1989-1999 Annual Report* (Edmonton: Child and Adolescent Services Association, 1999), p. 10.

³⁸⁴CASE Parents' Support Group. *Preliminary Proposal for the Establishment of a Board Administered Integrated Community and Residential Mental Health Service for Children and Adolescents in the Edmonton Region*, 1988, p. 1.

³⁸⁵McKinsey Report, *The Challenge For Psychiatric Care in Edmonton and Northern Alberta* (Edmonton: Edmonton Hospitals Psychiatric Study Committee, 1980).

³⁸⁶*Ibid.*, p. 1.

³⁸⁷Child and Adolescent Services Association, *1997-1998 Annual Report*, "A History of CASA" (Edmonton: Child and Adolescent Services Association, 1998), pp. 8-9.

³⁸⁸Alberta Social Services and Community Health, Mental Health Division, *Annual Report* (Edmonton: Alberta Social Services and Community Health, Mental Health Division, 1982), p. 42.

³⁸⁹The Clarke Institute of Psychiatry. *Southern Alberta Study of Psychiatric Needs and Provisions: A Report Commissioned by the Southern Alberta Psychiatric Services Committee* (Calgary: The Clarke Institute of Psychiatry, 1983), pp. 111-15.

³⁹⁰*Ibid.*, pp. IV-54.

³⁹¹*Ibid.*, pp. IV-63.

³⁹²Alberta Social Services and Community Health, Mental Health Division, *Annual Report* (Edmonton: Alberta Social Services and Community Health, Mental Health Division, 1982), p. 41.

³⁹³Alberta Health, *Mental Health Services in Alberta: Sharing a Vision for Better Health* (Edmonton: Alberta Health, 1988), p. 5.

³⁹⁴Alberta, British Columbia, Nova Scotia, Ontario, Prince Edward Island, and Saskatchewan all provided services in clinics serving both adults and children. Source: Robert Doherty, *Provision of Services to Children with Behavioral or Emotional Disorders* [Doherty Report] (Edmonton: Alberta Social Services and Community Health, 1985).

³⁹⁵*Ibid.*, p. 113.

³⁹⁶Alberta Social Services and Community Health, Mental Health Division, *Annual Report* (Edmonton: Alberta Social Services and Community Health, Mental Health Division, 1977-1982). 1977 to 1982 Activity Reports.

Mental Health Clinic for children and adolescents in the Edmonton region was sealed by a Tripartite Affiliation Agreement with the University of Alberta and the University of Alberta Hospital. This agreement provided a coordinated approach to the delivery of clinical services, facilitated the education of undergraduate and graduate students, and supported research in infant, child, and adolescent mental health.³⁸⁷

Alberta Mental Health Clinics

In 1981, Mental Health Services changed from a division to a program within the Health Services Division. In this new structure, six regional directors were responsible for clinics that were reorganized in six regions along the regional boundaries mapped out by the Department of Social Services and Community Health: Calgary, Central, Edmonton, Northeast, Northwest, and South.³⁸⁸ This regionalized structure was intended to provide a service system that could respond to people of all ages. Patients were intended to be able to access services more readily in their communities. Regions were to make decisions more relevant by involving local citizens and professionals in the decision-making.³⁸⁹ The impact was widespread concern that mental health services would be lost in the ever-increasing demands of Child Welfare services and the persisting climate of fiscal restraint: "Compared to community health services which come under local boards, mental health services are less protected, in terms of policy, funding and the allocation of human resources."³⁹⁰ The Clarke Report reflected these concerns and recommended that mental health clinics be accountable to the Regional Mental Health Boards rather than the regional social services administration.³⁹¹

By 1982, the Mental Health Clinics had 330 staff members,³⁹² up significantly since the 1960s, despite continuing hardships in recruiting staff. The number of mental health clinics increased from 46 in 1985 to 58 in 1988, with another 44 travelling clinics serving rural Alberta.³⁹³ The combined adult/child mental health clinic approach made sense in theory, but the tendency was to hire professionals skilled in working with adults, raising concerns in Alberta and elsewhere.³⁹⁴ Perhaps this was a moot point, with so few professionals having specific children's mental health expertise. Adults' needs tended to be seen as more serious, especially if they involved a breadwinner's or the mother of small children's ability to function. (Another factor that served as a detriment in this approach was the potential loss of focus on children in the context of their family, school, and community. This comprehensive approach with children was a less common practice in adult mental health settings.)³⁹⁵ The disproportionate amount of services to adults was very evident across regions, as shown by the following statistics.³⁹⁶

	1979-80	1980-81	1981-82	1982-83	1983-84	1984-85
Total Cases	9,248	9,413	17,787	21,028	22,842	20,803
17 Years and Under	3,111	2,873	4,623	5,589	5,584	5,092
Percentage of Total	33.6	30.5	25.9	26.5	24.4	24.4

The casual observer of these statistics might conclude that the clinics were doing well. The 1980s showed a lot of activity but mostly for adults. Real substance to the province-wide complaints of lack of services for children was evident. Prior to the creation of the adult/child clinic structure, the percentages seen above were reversed. Children and adolescents under the age of 17 had received 80 to 85 per cent of services, and the remaining 15 to 20 per cent had been supplied to young adults (generally to age 25). While the 1980s showed substantial improvements in the number of clinics and in total numbers of children served, these did not accommodate for the significant increase in Alberta's population of children.

Service Delivery System

"Every attempt will be made to ensure universality of access to Children's Mental Health Services," said Alberta Social Services and Community Health in 1985 as it set about developing a comprehensive Children's Mental Health Services Delivery System.³⁹⁷ Alberta was far from providing universality despite offering considerable services through numerous government departments that struggled valiantly to meet the needs of those most in distress. In *Expanding the Circle*, Fewster concluded that the province lacked a coherent approach and the absence of a clear legal mandate made it impossible for any jurisdiction to assume a position of leadership.³⁹⁸ One of his recommendations was the creation of legislation specifically addressing mental health services for children, adolescents, and their families.³⁹⁹

Families in Alberta with mentally ill children fought an uphill battle as they searched for treatment for their sometimes-dangerous young children. DIALOG Writer Cathy Reininger revealed just such a desperate picture in January 1989 through Shawn's story and his mother's painful experience in obtaining treatment and appropriate placement.⁴⁰⁰

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³⁹⁷Alberta Social Services and Community Health, *Children's Mental Health Project: Service Philosophy, Principles, and Guidelines* (Edmonton: Alberta Social Services and Community Health, 1985), p. 8.

³⁹⁸Fewster, *Expanding the Circle. A Community Approach to Children's Mental Health. A report prepared for the Alberta Children's Mental Health Project*, p. 61.

³⁹⁹*Ibid.*, p. 66.

⁴⁰⁰Excerpt from Cathy Reininger, "Nowhere to Go," *DIALOG*, A Division of Disabled Persons Society of Alberta, 1989, pp. 28-34.

Shawn's Story

Shawn, an 11-year-old Edmonton child with schizophrenia and epilepsy, had been suspended from two schools because of his unpredictable bouts of anger. He was considered a danger to both children and teachers. After a year at the Glenrose, he had stabilized somewhat through behaviour modification and special schooling and he returned to the regular school system. He did well for a few months, but then his symptoms progressively worsened and became out of control. The school suspended him for his violent behaviour.

At home, his behaviour did not improve. He was very aggressive, made animal noises, and grunted. If someone broke something on television, Shawn started smashing and overturning things in the room. His sudden

mood changes frightened everyone. His violent episodes increased until one day he stabbed his mother with a pair of scissors. She contacted 25 to 30 places that provided services for children with mental health disorders, but no one would take him. All facilities were full and had long wait-lists, and no foster home—as she was told—would tolerate him for more than three hours.

Finally, the Royal Alexandra Hospital admitted him. After three weeks of intensive treatment, he was discharged to a group home under the care of Social Services. To access this placement, his mother had to sign over permanent wardship to the province. Shawn was assigned to a group home, staffed by people not trained to work with mentally ill children. Shawn ran away. After much advocacy, his mother finally found an appropriate service with a program designed to meet Shawn's intensive and long-term treatment needs.

The *Canadian Charter of Rights and Freedoms, Constitution Act* came into effect in 1982. Its Section 7 on protection of life and liberty and Section 15 on protection of equality came into effect three years later. The Charter provisions appeared to implicitly prohibit discrimination against mentally ill individuals. Certainly, the act carried implications for government policies and practices relating to the provision of services for children with mental disorders. No literature was found to indicate that these implications were explored in Alberta.

In late 1989, Canada co-presented *The United Nations Convention on the Rights of the Child*. In its co-sponsorship of the Convention, the Canadian Government in fact affirmed that every Canadian child had a right to access mental health services. In doing so, it accepted the challenge to enable every family and every child to receive necessary mental health services when they were needed and in the context of a coordinated, comprehensive system of services. The convention was an international document. Each country or state or province, upon signing the document, was bound by it and signified its intention to comply with the convention's provisions and obligations. The convention recognizes the right of the child to the: "Enjoyment of the highest obtainable standard of health and to facilities for the treatment of illness and rehabilitation of health ... (and) that no child is deprived of his or her right of access to such health care services."⁴⁰¹ A decade later, Alberta was the last Canadian province to sign the charter.

Although there were, of course, many good stories in children's mental health, the lack of access or extensive delays in intervention were prevalent and extremely painful for families. Alberta was clearly in breach of the requirements of the *Canadian Charter of Rights and Freedoms*, as well as the provisions and obligations of the Convention for those who fell through the cracks of the non-system of services.

⁴⁰¹*The United Nations Convention on the Rights of the Child (1989)*, Article 24.

Chapter 9

The High-Tech '90s and Alberta's
Promise: Partnerships, Networks,
and Primary Care



Aboriginal and First Nations
children, the resilient child,
the forgotten, and the damned

⁴⁰²Kathleen Guy, "Our Promise to Children," in *Start Young-Start Now. Report of the Task Force on Children at Risk* (Edmonton: Government of Alberta, February 2000), p. 3.

⁴⁰³The Alberta Children's Initiative, *An Agenda for Joint Action* (Edmonton: Government of Alberta, 1998), p. 1.

⁴⁰⁴Success By Six, *Helping all Children Succeed for Life*. Promotional brochure. Edmonton: Success By Six.

⁴⁰⁵Alberta's Official Opposition, *Vulnerable Children in Alberta; Advantaged or Abandoned? A Report to Albertans* (Edmonton: Alberta's Official Opposition, 1998), p. 12.

⁴⁰⁶Alberta Education, *93rd Annual Report* (Edmonton: Alberta Education, 1997/98), p. 1.

⁴⁰⁷Canadian Mental Health Association, *Getting the Word Out...Children's Mental Health*. Fact Sheet (Edmonton: Canadian Mental Health Association, 1998).

⁴⁰⁸Alberta Children's Services, Program Advertisement for new Parent Information Line, *The Edmonton Journal*, October 20, 2005, p. B6.

⁴⁰⁹Federal/Provincial/Territorial Working Group on Mental Health of Children and Youth, *Building for the Future: A Framework for Mental Health Services for Children and Youth in Canada* (Ottawa: Federal/Provincial/Territorial Working Group on Mental Health of Children and Youth, March 1993), p. 1.

⁴¹⁰Child and Adolescent Services Association, *1999/2000 CASA Annual Report*, Values Statement (Edmonton: Child and Adolescent Services Association, 2000), p. 7.

⁴¹¹Accountability Report Committee, *Accountability for Children's Mental Health: Let's Get On With It!* (Edmonton: Accountability Report Committee, February, 1991), p. 1.

Aboriginal and First Nations children, the resilient child, the forgotten, and the damned

Children are the key to our future ⁴⁰²

The future of Alberta is our children ⁴⁰³

Children are today and tomorrow ⁴⁰⁴

Our children are society's most valuable asset ⁴⁰⁵

First Things First...Our Children ⁴⁰⁶

Children are our first priority ⁴⁰⁷

Our Children*Our Future ⁴⁰⁸

Children Matter ⁴⁰⁹

Kids Come First ⁴¹⁰

By 1990, understanding of children's mental health needs and issues of service delivery had improved tremendously; however, corresponding improvements in service provision were still not realized. Bridging the gap between knowledge and action was a daunting challenge. Professionals in the field, as well as parents of children without access to services, were tired of waiting. The messages to government were clear: "Let's Get On With It!" (the title of a CMHA accountability workshop held in Edmonton in 1990). The outcome of this workshop was a call to government to lead and to professionals and families to work together for change:

...it is time to take action on children's mental health. There is no further need to debate or document the existence of children's mental health issues. Studies and recommendations for strategies to address the issues have accumulated during the past decade. There is community support for implementation....The leadership required of government is accountability for children's mental health demonstrated by legislated mandate and designated funding. We need a children's mental health system created by design, not by default. ⁴¹¹

The workshop's appeal to government focused on major themes: the critical need for treatment of seriously ill children, intervention for those at high risk and mental health promotion for all children. The development of specific legislation to enable appropriate responses to children's mental health and illness issues and the creation of a Children's Ombudsman to address inequities in children's mental health services were among the many suggested strategies that emerged from the workshop.⁴¹² Perhaps the appeals were not heard beyond the Edmonton Region Health Facilities Planning Council, which reviewed the adequacy of Edmonton's children's mental health services in 1991.⁴¹³ No action was taken to address the workshop's proposed strategies.

Margaret Shone, a prominent voice in Alberta mental health law, approached the issues from an ethical perspective in the University of Alberta *Bioethics Bulletin*. This discussion was noteworthy because it framed the issues in children's mental health—including lack of services—as ethical issues. Given that appropriate support and treatment services were known to be powerful in relieving the emotional pain and anguish endured by families, it was surprising that more discussions did not adopt this perspective. It was also surprising because it is well-demonstrated that, for many children with emotional disturbances, support and treatment make a great difference in their ability to get an education, get a job, develop healthy relationships, and lead productive lives. Shone concluded:

...ethical considerations require that a fair share of healthcare resources be dedicated to meeting the needs of children with mental disorder. The time has come to cast off old attitudes and old ways in light of the new knowledge about mental disorder in children. The time is ripe for healthcare policy makers and providers to assume responsibility, provide leadership and work with others to respond appropriately in meeting healthcare needs of children with mental disorder.⁴¹⁴

Literature from the United States discussed the issues in financial terms, encouraging decision-makers to consider children's mental health as a pay now or pay later problem. High quality services were recognized as expensive, but lack of adequate care was equally costly, through individual and family suffering, increased welfare costs, higher crime, and lost productivity.⁴¹⁵ Available Canadian data also demonstrated the cost-effectiveness of early intervention. An Ontario demonstration project showed the cost of keeping one young offender in custody as \$100,000 per year, while the cost of having a child cared for by the Children's Aid Society (the equivalent of Child Welfare in Alberta) was only \$26,000 per year. The lifetime income loss for each youth who dropped out of school was estimated at \$350,000, with the associated government revenue loss and increased use of income supports estimated at \$167,000. "Every dollar spent on prevention today saves at least \$7 tomorrow in health treatment, policing and criminal justice, welfare, and other social costs."⁴¹⁶

⁴¹²Ibid., p. 4.

⁴¹³B. Skinner, *Edmonton Region Health Facilities Planning Council: Task Force on Child and Adolescent Mental Health, Literature Review Summary* (Edmonton: Edmonton Region Health Facilities Planning Council, November 13, 1991).

⁴¹⁴Margaret Shone, "Children with Mental Disorder: Unmet Needs," *The Bioethics Bulletin*, a publication of the University of Alberta Division of Bioethics, (December 1991), pp. 1-4.

⁴¹⁵National Conference of State Legislatures, *What Legislators Need to Know About Children's Mental Health*, Toronto: National Conference of State Legislatures, 1990, p. 37.

⁴¹⁶Paul Steinhauer, *What is Needed to Support Early Child Development Adequately*, unpublished document, 1997.

⁴¹⁷The National Longitudinal Survey of Children and Youth (NLSCY) is designed to follow a representative sample of Canadian children and youth from birth to age 25, with data collection occurring at two-year intervals beginning in 1994. The data enable the identification of vulnerable children by actual outcomes rather than by risks. Outcomes measure the children's progress in health, behaviour, and social, emotional, and cognitive development. <http://www.hrdc-drhc.gc.ca/nlscy-elnej/home.shtml> (accessed November 2, 2005).

⁴¹⁸*Ibid.*, p. 2.

⁴¹⁹Health Canada, Federal/Provincial/Territorial Advisory Committee on Mental Health, *Foundations for the Future: A Report of the Working Group on Child and Youth Mental Health Services* (Ottawa: Health Canada, March 1990).

⁴²⁰*Ibid.*, p. 37.

⁴²¹*Ibid.*

⁴²²The General Hospital (Grey Nuns) of Edmonton, Department of Psychiatry. New Program Request for the Establishment of an Inpatient Adolescent Program, 1991. Dr. D. Perry, Misericordia Hospital Medical Vice-President, letter to Don Phillipon, Alberta Health Assistant Deputy Minister, RE: Adolescents at Risk Program.

⁴²³Northern Alberta Children's Hospital. Program Proposal for Establishment of a School Site Psychiatric Program in Edmonton, An Evaluation Project Developed in Cooperation with the Edmonton Public School Board, the Edmonton Catholic School District and the Edmonton Board of Health, October, 1991.

Analyses of Statistics Canada's National Longitudinal Survey of Children and Youth launched in 1994,⁴¹⁷ further supported the importance of early intervention. This survey provided a wealth of information on Canadian children and demonstrated that the welfare of children and youth over time is strongly influenced by their early experiences. "There is substantial evidence to link educational performance, the incidence of delinquency and many other aspects of young people's development to what happens in early childhood."⁴¹⁸ These links were emphasized in support of early intervention such as preschool initiatives and the need to fully understand their nature to develop well-designed and appropriately targeted programs. Clearly, investing in children paid off with children growing up to be healthy productive youth, accomplished workers, effective parents, and engaged citizens.

Foundations for the Future,⁴¹⁹ a national report on children's mental health services, discussed the serious inadequacies in financial, human, and program resources and identified enhancement of resources as a top priority in all provinces. It identified four building blocks for change: mental health promotion and prevention, innovation and excellence, partnerships, and access to services. The report also emphasized the need for research, noting that children's mental health was under-represented in the allocation of research funds across the nation. "The Medical Research Council and Health and Welfare Canada dedicate approximately 4.3% of their research grants towards mental health in general, of which only 16.8% are geared towards children's issues."⁴²⁰ The report noted many compelling reasons to increase research into children's mental health:

...mental illness is the most prevalent form of illness, and children have as high a prevalence and incidence of emotional and behavioural disorders as does the general population. Furthermore, children's disorders may, and often do, develop into adult mental health problems later in life. Thus, research on children could reasonably be expected to be over-represented in the mental health area.⁴²¹

Edmonton professionals and organizations motivated to fill the gaps also were making appeals. The Grey Nuns and the Misericordia Hospitals in Edmonton proposed programs for adolescents at risk.⁴²² At the time, the Edmonton Public School Board had 24 schools designated as district-learning sites for students with severe behaviour disorders and the Edmonton Catholic School Board had five. Both asked for resources to develop school-based psychiatric programs to manage these students in a school setting, arguing that school districts should not have to divert instructional resources for treatment services.⁴²³ None of these proposals, however, were implemented.

Studies and reports proliferated, consuming professional time and resources in efforts to create a better system of mental health services for children. In 1992, the Alberta government approved *Future Directions for Mental Health Services in*

Alberta as the province's mental health policy.⁴²⁴ *Future Directions* described a client-focused, balanced, and integrated mental health system that would provide a spectrum of services ranging from promotion and prevention to intensive hospital interventions. Services for children were the top priority. A Mental Health Strategic Planning Advisory Committee was established to oversee the implementation of *Future Directions*. Its recommendations were documented in the report called *Working in Partnership: Building a Better Future for Mental Health* released in August 1993.⁴²⁵ Its many recommendations included: more emphasis on determinants of health and well-being, multi-dimensional interventions, teams and networks of support, continuity of care, participatory planning, and regional mental health boards.

⁴²⁴Alberta Government, *Future Directions for Mental Health Services in Alberta*, April 1992.

⁴²⁵Mental Health Strategic Planning Advisory Committee, *Working in Partnership: Building a Better Future for Mental Health* (Edmonton: Mental Health Strategic Planning Advisory Committee, August 1993).

⁴²⁶McDermott & Associates Consulting Inc., *Framework Action Plan Project: The Restructured System, Presentation to the Edmonton Regional Mental Health Planning Committee* (Edmonton: McDermott & Associates Consulting Inc., September 13, 1994).

⁴²⁷Mike Jones, *A Proposed Model For Child and Adolescent Mental Health Services to Children and Adolescents Within the Capital Region, Report prepared for the Child and Adolescent Mental Health Network* (Edmonton: Raptor Research, June 9, 1995).

⁴²⁸Kenneth Boessenkool, "A Rumpled Rogue From Calgary Becomes a Fiscal Revolutionary," p. 261.

⁴²⁹J. Storch and C. Meilicke, *Political, Social, and Economic Forces Shaping the Health Care System in Nursing Leadership and Management in Canada, Third Edition* (Toronto: Elsevier Canada, 2005), p. 17.

⁴³⁰Boessenkool, "A Rumpled Rogue From Calgary Becomes a Fiscal Revolutionary," p. 269.

The McDermott Report, prepared for the Edmonton Regional Mental Health Planning Council, presented the parameters for a restructured mental health system for the Edmonton Region based on the *Future Directions* principles.⁴²⁶ Mental health professionals expressed concerns about the proposals in the McDermott Report. As a result, the Edmonton Region Child and Adolescent Mental Health Network commissioned another extensive study, resulting in The Raptor Report—which proposed yet another model of service delivery.⁴²⁷

Meanwhile, dramatic changes in health service planning and financing were taking place federally. The federal government restricted its role to maintenance of the five principles of health care, leaving the main responsibility for funding to the provinces. This shift in responsibility, combined with the recession of the 1980s and eight consecutive years of budget deficits, added to the immense financial pressure on the Alberta government. For the newly elected Premier Klein, the government's financial mess was the biggest challenge in 1992. Among his campaign commitments, Klein had promised to eliminate the deficit and to pass legislation making balanced budgets mandatory.⁴²⁸ Change was inevitable and far-reaching, with a tremendous impact on health services.

Health Care Reform

"By 1993, there were clear signals that health care restructuring with a view to health care reform was more than rhetoric and that virtually all policies and services were vulnerable to change."⁴²⁹ The Klein Revolution was underway by 1994, with Albertans urged to embrace deep spending cuts in health care, education, and social services. Schools were the first target, with a massive centralization reducing the number of school boards from 142 to 60. Klein next cut health, social services, and advanced education, announcing that all other departments combined would be reduced an average of 30 per cent.⁴³⁰

Albertans at the front lines in service delivery were expected to "do more with less." The then Health Minister, the Honourable Shirley McClellan, announced a

wave of staff layoffs and bed closures; wide ranging cuts to hospitals, long-term care facilities, and drug programs; and caps on selected health services.⁴³¹ Mergers, amalgamations, and regional planning were to define roles, refine operational missions, and minimize costs. Alberta led provinces in devolving authority for health and social services to regional levels. Seventeen regional health authorities replaced individual hospital boards. This massive restructuring was intended to reduce costs, increase responsiveness and flexibility, integrate services, and improve health outcomes.⁴³²

The Provincial Mental Health Board (PMHB) was created September 21, 1994 under the *Health Authority Act* as one component of the restructuring. A ministerial announcement on plans to reform the mental health system stated:

We are taking the first steps to developing a strong and unified system of service delivery which puts the mental health service consumer at its centre.... Although the Advisory Committee had recommended the creation of separate regional mental health boards, we feel that the creation of one board is more consistent with our efforts to streamline the health system. Eventually, the Provincial Mental Health Board's responsibilities will be fully integrated within the regional health authorities.⁴³³

The new board's mandate was to consolidate existing programs, plan and implement new community-based initiatives, and divest mental health programs and services to the 17 regional health authorities through an orderly transfer.⁴³⁴ The report *Building a Better Future: A Community Approach to Mental Health* described the steps in divesting services that were to be completed before the board's term ended in the summer of 1996. The new vision for mental health set out in the report was encouraging:

In the health system of the future, mental health will be considered an integral part of health. Programs and services will enhance individual functioning and the use of natural environments for support. The needs of consumers will be central in the new system and physical, emotional, social, intellectual and spiritual needs will be recognized as essential components of one's health and well-being.⁴³⁵

The board began its work from a disadvantaged position, however. Mental health funding, historically a low priority, had decreased from 4.9 per cent of total health funding in 1983/84 to 3.7 percent in 1994/95.⁴³⁶ Before the PMHB could accomplish much, its role was changed to an advisory capacity on August 14, 1996, and it was renamed the Provincial Mental Health Advisory Board (PMHAB). Its new mandate was to advise the Minister of Health on the continued divestment of services, while retaining operational responsibility for

⁴³¹Ibid., p. 266.

⁴³²Storch and Meilicke, *Political, Social, and Economic Forces Shaping the Health Care System in Nursing Leadership and Management in Canada, Third Edition*, p. 18.

⁴³³Alberta Health. News release: Minister Announces Plan to Reform Mental Health System, Edmonton: May 24, 1994, p. 1.

⁴³⁴Provincial Mental Health Board, *Building a Better Future: A Community Approach to Mental Health*, March 1995, p. 1.

⁴³⁵Ibid., p. 2.

⁴³⁶Provincial Mental Health Board, *The Road to a Better Future*, Alberta: Provincial Mental Health Board, Summer 2005, p. 12. In 1995, total health funding was \$67 million less than in the previous year. Source: "Working Together Towards a healthier future," *Capital Health Quarterly* (Summer 1995), p. 4.

the provincial mental institutions, the 67 existing provincial mental health clinics, and program funding for community agencies.⁴³⁷

Regional Planning

Regional planning for divestment of services began in earnest in 1996 with the development of a detailed three-year service delivery plan in each of the 17 health regions. These strategic plans, developed by each health region in partnership with the PMHAB, were intended to reflect a move towards an integrated, accessible, comprehensive continuum of care across all regions. This intensive work involved professionals in the field, planners, consultants, boards, administrators, families, and representatives of the public receiving services. The Regional Mental Health Service Delivery Plans (completed in 1997) reflected current services, as well as the issues, gaps, and needs in each region, with proposals for restructuring services and enhancing programs. All regions emphasized the need to improve the number and type of children's mental health services as a priority. To a large extent, the needs and plans in this area reflected the same findings as major Alberta studies completed in the 1980s and 1990s. The complexity of existing service systems in the two large urban centres, compared to rural regions, was very evident in the plans. It is notable that only the Calgary and Edmonton plans discussed mental health research, and even these mentioned research as a continued priority only briefly. Other themes, however, were consistent across regions, reflecting a pervasive, province-wide, chronically neglected area of health care. Critical issues included system fragmentation, significant service gaps, service system imbalance between urban and rural communities, lack of access, limited early intervention, lack of crisis services, too little community-based programming, inadequate system information because data collection was not standardized, staff shortages, lack of psychiatrists, need for staff training, and lack of public education. One region highlighted the fact that religious ministers—who had no specific mental health training—often were the only resource people would access; this had not appeared in previous reports.

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The plans were compelling and revealed disturbing issues in children's mental health services across the province. Some sparsely populated regions most lacking in services were exactly those that rated high in the determinants known to contribute to or reflect children's mental health problems. These included: high unemployment and generalized low-income, high incidence of single-parent families, teenage pregnancy, suicide, assault, abduction, suspected and confirmed child neglect and abuse, sexual abuse, drug and alcohol abuse, and parent or guardian problems. Some regions with especially high numbers of First Nations people emphasized community development and transformation through support groups and holistic treatment approaches in their plans. Although the regions invested a lot of resources, time, effort, enthusiasm, and hope for change in their

⁴³⁷Alberta Provincial Mental Health Advisory Board, *1996/97 Annual Report* (Edmonton: Alberta Provincial Mental Health Advisory Board, 1997), p. 2.

plans, divestment of services from the PMHAB to the regions was postponed, and the service plans were shelved.

The PMHAB's life proved to be almost as short as the board's previous incarnations. On April 1, 1999, the Alberta Mental Health Board (AMHB) replaced the PMHAB and received an expanded mandate, including the continuing preparations for divestment of services. A firm date for divestment remained to be set.

In January 1996, Klein effectively ended his fiscal revolution. He reversed an earlier decision to cut funding for kindergarten and put more money into health care to clear a backlog on waiting lists. The economy was on a roll once again, with swelling provincial revenues and the start of a nine-year cycle of impressive budget surpluses.

Mental Health Promotion and Population Health

"Resilience" was the focus of a think tank organized by the Regional Centre for Health Promotion in Lethbridge, Alberta in 1996.⁴³⁸ Resilience was defined as "the basic and essential sense of being in control with regard to oneself and to the outside world,"⁴³⁹ and recognized as a central component of mental health promotion. The focus of the discussions at this think tank flowed from the national direction for health promotion activities in Canada set by the 1986 Ottawa Charter: *Achieving Health for All, a Framework for Health Promotion*. Because of this charter, Canada became recognized as the birthplace of health promotion. The charter promoted six principles for guiding the development of health promotion policy: equity, participation, collective responsibility, ecological vision, increasing options, and strengthening communities.⁴⁴⁰ The charter embodied a community action approach that represented a shift in thinking towards a more comprehensive approach to health. It also promoted the integration of individual and social determinants of health—including early childhood development as a powerful determinant of health in its own right—with a demonstrated impact on adolescent and adult health, well-being, and competence.⁴⁴¹ The 1990s brought an expanded health promotion movement emphasizing attention to four areas:

- broadening the definition of health and its determinants to include the social and economic context within which health—or more precisely, non-health—is produced
- moving beyond the earlier emphasis on individual lifestyle strategies for achieving health, to broader social and political strategies

⁴³⁸J. Kulig and L. Hanson, *Discussion and Expansion of the Concept of Resilience: Summary of a Think Tank* (Lethbridge: University of Lethbridge, 1996).

⁴³⁹L. Driscoll, *Mental Health Promotion: A Policy Framework*. Report Submitted to the Mental Health Promotion Unit, Ottawa, October 1, 1998, p. 16.

⁴⁴⁰*Ibid.*, p. 11.

⁴⁴¹Federal/Provincial/Territorial Advisory Committee on Population Health, Working Group on Child Development, *Investing in Early Child Development: The Health Section Contribution* (Ottawa: Federal/Provincial/Territorial Advisory Committee on Population Health, September 1999), p. 32.

- embracing the concept of individual and collective advocacy as a key health promotion strategy
- advocating community participation in identifying health problems and strategies for addressing those problems.⁴⁴²

Canada's approach to population health as a means of keeping people healthy by preventing illness and injury and promoting good health also had been evolving since the release of the Lalonde Report in 1974.⁴⁴³ Principles of the new approach to population health included a focus on evidence-based decisions, multi-level and multi-sector responsibility, partnerships, shared accountability, "upstream focus" (preventing the causes of a problem), equity, and a holistic view of health.⁴⁴⁴ Together, the key components of health promotion and population health offered a clear framework and a comprehensive range of actions to improve health. Since all provinces were to use this framework and follow these principles, they should be evident in Alberta's mental health reform initiatives.

Alberta Children's Initiative

The Alberta Children's Initiative, later renamed the Alberta Child and Youth Initiative (ACYI), included several priorities, strategies, and action steps for enhancing the health of Alberta's children. The Honourable Halvar Jonson, then minister of health, confirmed that this commitment extended to mental health in a news release issued December 15, 1998 announcing the new Children's Mental Health Initiative: "Improving mental health services for children is a priority area within the Alberta Government's recently released Alberta Children's Initiative, and will be a key part of the overall effort to enhance services to children in the province."⁴⁴⁵

ACYI responded to the priority on children identified through the Alberta Growth Summit and to community calls for integrated services. Signed by the ministers of health, community development, justice, children's services, education, and family and social services, this document was developed to serve as Alberta's Business Plan for children and youth. It reflected the government's commitment to collaborative systems for planning and delivering services and demonstrated joint accountability for successfully achieving the business plan's vision, expected outcomes, and goals—all designed to support the healthy development of Alberta's children. Success was to ensure that: "Alberta's Children are well cared-for, safe, successful at learning, and healthy."⁴⁴⁶

The ACYI business plan also included a set of performance measures, with a commitment to develop more measures and meaningful targets for monitoring progress. The measures were preliminary and needed refinement. (For example, the plan had no target for reducing youth suicide—a surprising omission, especially because of the historical concern about the disturbingly high suicide

⁴⁴²Ibid., p. 13.

⁴⁴³M. Lalonde, *A New Perspective on the Health of Canadians* (Ottawa: Minister of Supply and Services Canada, 1974).

⁴⁴⁴P. Lightfoot, J. Edwards, N. Fraser-Lee, A. Kaida, and G. Predy, *A Population Health Approach to Planning in Nursing Leadership and Management in Canada, Third Edition* (Toronto: Elsevier Canada, 2005), p. 49.

⁴⁴⁵Alberta Health, News Release: New Children's Mental Health Initiative, Edmonton, December 15, 1998.

⁴⁴⁶Alberta Children's Initiative, *The Alberta Children's Initiative: An Agenda for Joint Action* (Edmonton: Alberta Government, 1995), p. 5.

rates among Aboriginal youth.) These performance measures, targets, and those that have been set since would provide Albertans an important annual “report card.” The Alberta Children’s Initiative demonstrated its commitment to hold an annual provincial forum on children and to release its first report card on children and families in 2000.

The Children’s Forum

More than 1000 Albertans gathered in Edmonton October 5-6, 1999 for the first provincial public forums, “First Circle—Uniting for Children.” Chaired by Colleen Klein, this forum was designed as an open dialogue intended to give stakeholders an equal voice in sharing their ideas and identifying solutions to the challenges facing children.⁴⁴⁷ Drs. Margaret Clarke and Lionel Dibden, leading Alberta pediatricians, opened with keynote addresses, followed by a series of seminars dealing on various children’s issues. Dr. Dibden urged the use of a “children’s filter” in policy and planning decisions. The filter would involve asking: “How does this decision affect children?” and “Is this decision in the best interests of children?”⁴⁴⁸ Dr. Clarke noted that real change would come through the use of the “children’s filter” and urged mobilization of all possible resources to support children’s well-being.⁴⁴⁹ Forum participants presented a comprehensive report of their recommendations to the ministers who are partners in the Alberta Children’s Initiatives and share responsibility to improve the lives of Alberta children and families.

Alberta Children’s Initiative

In August 1998, \$5 million was allocated to the Alberta Mental Health Board as part of the new Children’s Mental Health Initiative to help establish a comprehensive system of children’s mental health services. The AMHB was responsible at this time for the development of province-wide children’s mental health services. To fulfil this role, AMHB established the position of provincial coordinator, children’s mental health, in the spring of 1999.⁴⁵⁰ This person reported progress on staff training, developing student health initiative partnerships, and establishing a provincial framework for eating disorders services. The AMHB also contracted with Calgary’s Mount Royal College to develop a children’s mental health certificate program, with the University of Calgary to develop children’s mental health graduate and undergraduate courses, and with Child and Adolescent Services Association (CASA) to develop a provincial comprehensive staff orientation and preceptor program.⁴⁵¹ The AMHB, in partnership with AADAC, also sponsored a multi-media campaign—the “Take Time Campaign”—on resilience and inclusion issues in 2001. “Take Time” was

⁴⁴⁷The Children’s Forum, *The Children’s Forum Report: First Circle—Uniting for Children. Record of Proceedings from a Public Forum held October 5-6, 1999 at the Shaw Conference Centre in Edmonton, Alberta.*

⁴⁴⁸*Ibid.*, p. 10.

⁴⁴⁹*Ibid.*

⁴⁵⁰Alberta Mental Health Board, *1999/2000 Annual Report* (Edmonton: Alberta Mental Health Board, 2000), p. 14.

⁴⁵¹Alberta Mental Health Board, *2000/2001 Annual Report* (Edmonton: Alberta Mental Health Board, 2001), p. 22.

designed to encourage environments that increase the ability of children, families, and communities to adapt to and cope with life's difficulties.⁴⁵²

Seeking ways to meet Aboriginal children's mental health needs, the AMHB appointed an Aboriginal children's mental health coordinator in July 2000, who developed initiatives in consultation with the AMHB Wisdom Committee and in partnership with community Elders, Aboriginal service providers, organizations, and provincial/federal jurisdictions. New promotion, prevention, and treatment services focused on the well-being of Aboriginal people's mind, body, spirit, and emotions and sought to integrate traditional holistic and western healing approaches to wellness. In 2002, the ACYI Aboriginal Youth Suicide Prevention Initiative was launched to develop a province-wide approach to preventing Aboriginal youth suicide. This initiative included a provincial conference, mental health promotion workshops for Aboriginal youth, community training in suicide prevention, resource materials, and cultural awareness and training workshops for educators and service providers.⁴⁵³

Steinhauer Report

Despite the many recent studies, decision-makers obviously remained uncertain about needs and direction. The Alberta Mental Health Board, the Capital Health Authority, and the Calgary Regional Health Authority commissioned Dr. Paul Steinhauer, an Ontario senior child psychiatrist, to conduct a review of children's mental health services in Calgary and Edmonton in May 1999. The goals of the review were to seek opportunities for improvement, identify the best use of currently available resources and identify priorities.

Dr. Steinhauer found a shortage of mental health resources throughout the system. He also found many professionals frustrated and discouraged, still experiencing the effects of the cuts of the mid-1990s. With budget cuts in all sectors serving children, the sector defined the services it could offer more narrowly. As a result, existing gaps became chasms, and children fell between the cracks, ending up without needed services. Dr. Steinhauer emphasized collaborative work across systems and emphasized the need for early intervention, reflecting his belief that the basis for a quality mental health system is adequate and universal support for child development. He illustrated his point with the following story.⁴⁵⁴

Going Upstream

Two children's mental health professionals stood by a mighty river, watching thousands of children drowning, their bodies rushing down-stream as they were dragged by the current. Frantically, they dragged as many

⁴⁵²Alberta Mental Health Board, *Take Time Campaign Brochure. You can make a difference to a child's mental health*, 2001.

⁴⁵³Alberta Mental Health Board, *Aboriginal Initiatives: Children's Mental Health* (Edmonton: Alberta Mental Health Board, December 5, 2002).

⁴⁵⁴Paul Steinhauer, *Review of the Organization and Delivery of Children's Mental Health Services in Edmonton and Calgary*. Report Prepared for the Alberta Mental Health Board, the Capital Health Authority and the Calgary Regional Health Authority, 1999, p. 7.

children as they could out of the river, giving them mouth-to-mouth resuscitation in the hope that it was not too late, while thousands more than they could deal with continued to be carried downstream. Eventually one of them, aware of the gap between the few that they could save and the many who were drowning, went upstream to try to do something about the conditions that were pushing so many children into the river in the first place.

Dr. Steinhauer focused on the magnitude of needs in this area and the need to go upstream, to use resources creatively and make use of the “multiplier effect.”⁴⁵⁵ With this approach, highly trained and experienced mental health professionals would spend a significant proportion of their time consulting with less trained professionals working with children (for example, child psychiatrists consulting with family physicians). He recognized the difficulty in this, given Alberta’s shortage of child psychiatrists. For this, and other reasons (such as the need to further develop research in children’s mental health), he recommended a Division of Child Psychiatry be established at the University of Alberta, noting one already existed at the University of Calgary. This recommendation has since been implemented, with Dr. Gary Hnatko as its first head. Many of his other recommendations also have been implemented, primarily with funding made available through the Children’s Mental Health Initiative since 2000. These include such new services as: early intervention, dedicated positions for children’s mental health services in provincial mental health clinics, crisis services, services for youth with eating disorders, training opportunities, clinical internships to promote professional specialization, and intensive treatment programs. These new and enhanced services have contributed significantly to the existing service continuum, although extensive program needs and service gaps remain in all regions.

School Mental Health

Dr. Steinhauer’s influence also was important in school mental health. In a 1995 publication, he spoke about the Canadian school situation:

...Our schools are staggering under the burden of trying to contain—let alone educate—a student population of whom up to a third lacks the cognitive, emotional and social skills necessary for success. School violence is rising, and teachers’ confidence and morale are sorely threatened.⁴⁵⁶

⁴⁵⁵Ibid., p. 32.

⁴⁵⁶Paul Steinhauer, “The Whys and Hows of Mental Health Promotion for Children.” Panel. Child Health 2000 Conference. Toronto, June 3, 1995, p. 98.

He recommended increased resources for mental health services in schools, as well as efforts to bridge the gap between the community and schools in areas where these have long been alienated from each other.

In the United States at the time, a significant national program was under way to expand school mental health programs far beyond what schools traditionally had provided.⁴⁵⁷ Since the mid-1990s, schools in many large American cities had replicated mental health programs for children and adolescents usually offered by community mental health clinics. This approach provided concentrated mental health services for students whose emotional difficulties impaired their school performance and who otherwise had limited access to such services. Clinical services included comprehensive assessment; psychological and psychiatric consultation; individual, family, and group therapy; student referrals for more intensive therapy (e.g., medication and inpatient treatment). These programs also provided a range of preventive services for students who had not been formally identified as having emotional or behavioural difficulties (e.g., classroom presentations on mental health issues and support groups for students in transition such as from elementary to junior high). Although evaluations of these programs were scant, they showed positive outcomes.

Alberta schools showed a similar commitment to school health promotion. The need for health supports in schools, however, had increased since the introduction of the policy in 1993 that placed disabled students and behaviourally challenged students in school programs and activities with non-challenged peers.⁴⁵⁸ A year after the introduction of this policy, the numbers of school counsellors were decimated by provincial funding cuts:

When the funding cuts came, difficult decisions had to be made about which staff would be retained and counsellors were let go. As we focused on teachers and class size, counsellors became the unadvertised casualties of under funding in education.⁴⁵⁹

By the late 1990s, a number of inter-agency collaborative projects were in place throughout the province. For example, Calgary reported a Comprehensive School Health Project⁴⁶⁰ involving 80 schools for which the Calgary Health Region provided resources, staff, information, and linkages to varied community services.

Across the province, services were insufficient to meet students' mental health needs in the natural school environment. The number of students identified as having special needs had increased dramatically, including students needing psychological assessments, personal counselling, physical restraint and removal, psychiatric and psychological intervention, family counselling, provision of information, and administration of medications. Providing such services was known to directly affect children's lives and failing to provide them negatively influenced their ability to learn. In extreme cases, services also were required to protect those interacting with the children during the school day. The complex needs in this area were seen to far exceed the expertise available in schools, and school personnel, as always, needed opportunities to improve their skills in child psychology and behaviour management.⁴⁶¹ As well, Alberta Learning had set guidelines for pupil-counsellor ratios at one counsellor for every 500 students, but

⁴⁵⁷L. Flaherty, M. Weist, and B. Warner, "School-Based Mental Health Services in the United States: History, Current Models and Needs," *Community Mental Health Journal* 32, 4 (1996), pp. 341-52.

⁴⁵⁸Alberta Education, *1993/1994 Annual Report* (Edmonton: Alberta Education, 1994), p. 15.

⁴⁵⁹Dave Colburn, "Counsellors Crucial to Student's Well-being and Academic Success," Letter to the Editor, *The Edmonton Journal*, August 29, 2005, p. A15.

⁴⁶⁰Laura Ghali, "Comprehensive School Health: Learning through Health Initiative. Evaluation Report" in *Current Capacities in School Mental Health Promotion. A background paper prepared for "Creating Connections and Capacity: International Symposium on Whole School Mental Health Promotion"* (Calgary: University of Calgary Centre for Health and Policy Studies, 1997), p. 5.

⁴⁶¹Alberta Education Response Centre, *Special Education Review: A Discussion Paper* (Edmonton: Alberta Education Response Centre, May 1990), p. 12.

this goal remained unmet throughout the province. In 2005, school counsellors were still seen as optional, as evidenced by the St. Albert Catholic Schools' decision to cut back on those positions to balance their budget while meeting Alberta Learning's class size standards.⁴⁶² Recognizing the critical importance of the emotional children's well-being, Dave Colburn, an Edmonton Public School Board trustee, recommended the partnering of the Ministries of Health and Education for jointly funded mandatory replacement of counsellors in all Alberta schools.⁴⁶³ Perhaps such approaches will be seen in the future, given recent indications that Alberta Education and Alberta Health and Wellness would be jointly funding a school health and wellness manager position. This manager's main task would be to develop a school health and wellness plan and align efforts of both ministries to develop effective and sustainable long-term school health strategies.⁴⁶³

Student Health Initiative

The Alberta Student Health Initiative (SHI)⁴⁶⁵ was announced by government March 17, 1999 under the umbrella of the Alberta Children's Initiative. Through this initiative, government provided \$25.6 million annually for Student Health Partnerships designed to support students' health and educational needs. The partners in service provision were required to provide joint service plans reflecting an integrated approach to community-based services for children and their families. These services typically included emotional and behavioural supports, speech and language services, occupational therapy, physiotherapy, and nursing services. The recognition that these were part of a continuum of services with several partners involved in service delivery was fundamental to this initiative. All health regions in the province submitted proposals reflecting their goals for special needs students and outlining the intended local approach; the different approaches across regions reflected local needs and philosophies. Commonalities, however, included the recognition that the needs and demands for student services would significantly outstrip the resources available. The greatest need for services was for students with emotional and behavioural disorders. In the Edmonton region, children at that time were waiting for up to five months for mental health assessments.⁴⁶⁶

⁴⁶²Mark Wells, "Counselling Cuts Panned; Students will Suffer, says Consulting Psychologist," *The St. Albert Gazette*, July 23, 2005, p. 1.

⁴⁶³Colburn, "Counselors Crucial to Student's Well-being and Academic Success."

⁴⁶⁴Career advertisement, *The Edmonton Journal*, September 10, 2005, p. 12.

⁴⁶⁵Alberta Children's Initiative, *Student Health Initiative Report* (Edmonton: Government of Alberta, October 2000).

⁴⁶⁶Edmonton Student Health Initiative, *Partnership: Joint Service Plan* (Edmonton: Edmonton Student Health Initiative, June 30, 1999), p. 8.

Establishing Best Practice

All new initiatives introduced since the mid-1990s were funded with the requirement of a grounding in evidence-based or best practice (given the current state of knowledge) and for a commitment to ongoing program evaluation. It was understood that a highly functional mental health system required ongoing comprehensive monitoring and evaluation. The new expectation was that

activities and outcomes be monitored routinely, and results cycled back to funders and stakeholders for continual improvements. Of course, the system had some catching up to do in providing adequate resources to fund evaluation and in developing a database to support such analysis.

Wired for Health

By the late 1990s, rapid technological advancement was celebrated as part of the “Alberta Advantage,” a slogan the government coined to describe the province’s competitive position in the global economy. Industries provided numerous examples of what could be done with the innovative and widely available technology. Web links provided the capacity for patient information to be shared across hospitals, community organizations, and family doctors’ offices. This technology opened the way for a seamless information continuum that care-providers could access across departments and community services. The system continues to struggle, however, with inadequate technology, lack of funding for enhanced equipment, confidentiality issues, and territorial protection. As a consequence, obtaining required information on direct transfer from one facility to another and to and from schools continues to be an ongoing challenge.

Two areas, however, were beginning to have an impact on children’s services—the Internet and mental-mental health clinical consultation using computer and videoconferencing technology. This approach began exclusively with adults and expanded to children in 2002, under the leadership of Dr. Robert Drebit, with Edmonton psychiatrists providing tele-psychiatry consultations to remote regions and CASA therapists using tele-learning approaches for workshops on, for example, childhood depression.⁴⁶⁷ This technology was seen as very promising, both in providing clinical services in areas lacking highly trained professional staff, and also for ongoing staff development and support in isolated communities.

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Computers in schools began to make a huge difference on program options for students with emotional and behaviour problems at high risk of school dropout or expulsion. Access to information on the Internet, with its explosion of health-related sites, also provided families with a plethora of information on health conditions. It soon became common for families to arrive at clinical appointments equipped with printouts, reports, and fact sheets about their child’s condition. Ample research pointed to the importance of being a well-informed patient:

Individuals with a clear understanding of their diagnosis, treatment and recovery are much better equipped to cope with illness, make informed decisions and adhere to treatment recommendations. They also use health care services more effectively.⁴⁶⁸

⁴⁶⁷Child and Adolescent Services Association, *2002/2003 Annual Report* (Edmonton: Child and Adolescent Services Association, 2003), pp. 26-27

⁴⁶⁸C. Loiselle and S. Dubois, “Getting Wired for Interactive Health Communication,” *Canadian Nurse* 99, 4 (2003), p. 22.

Creatively combining innovative tools with traditional information support, for example, interventions that foster self-directed, interactive learning and support have been shown to be cost effective in some health conditions such as in people with HIV infection, coronary heart disease, and breast cancer.⁴⁶⁹ Similar approaches for optimal care in children's mental health services were not evident in the research or in the Alberta children's mental health literature.

Provincial Report Card

Frustrations with lack of services continued. In September 1998, the Alberta Official Opposition issued a report to Albertans highlighting the growing number of children with special needs and the continuing large gaps in service provision. The report highlighted the lack of adequate community mental health services for children and youth as a particularly significant problem. It also discussed the continuing effects of the 1994 cutbacks on support services in schools. The Alberta School Boards Association estimated in 1997 that the needs of 20,000 to 40,000 special needs students were not being met. Also, because of policy changes, 50,000 students with mild to moderate disabilities no longer qualified for funding support. A six months' wait for assessment was common.⁴⁷⁰ The Official Opposition demanded action to address the urgent needs of children. It called for integration of children's developmental needs into economic policy and planning at all levels of government; for establishment of mechanisms to track and monitor the status of vulnerable children and their families; and for a provincial report card compiled annually by an independent children's advocate, tabled in the Legislature, and released to Albertans. This report card, it said, should focus on identified indicators of vulnerability including:

- low birth weight infants
- children in poverty
- children on welfare
- undernourished children
- children of single parents
- children with disabilities
- pregnant teenagers
- Aboriginal children (overrepresented in all vulnerable categories)
- youth aged 15 to 19 who fell between the cracks for access to social programs
- incidence of child abuse
- incidence of missing children
- Child Welfare caseloads
- neglect and death of children

⁴⁶⁹Ibid., p. 24.

⁴⁷⁰Alberta's Official Opposition, *Vulnerable Children in Alberta: Advantaged or Abandoned?*, p. 24.

- social assistance rates for single and two-parent families
- children involved in substance abuse.

This proposed report card appeared to be consistent with government's commitment to reporting on performance measures in the business plan for children, Alberta Children's Initiative: an Agenda for Joint Action. It could be used as a springboard for change, with public support for funding of services targeted very specifically to achieve outcomes in priority areas.

Legislating for Children

In July 1993, Children's Advocate Bernd Walter submitted his report to the minister of family and social services. In his review of provincial children's mental health services, he concluded that initiatives to resolve fundamental mandate and funding responsibility were moribund:

The lack of political resolve, decisiveness, or management effectiveness in this area are devastating for children and their families who are affected by mental, emotional, behavioural disorders, substance abuse, suicide and other mental health problems.⁴⁷¹

Walter decried the fact that families were still forced to obtain child protection status for no other reason than to access needed mental health treatment. He recommended changes to legislation to ensure that legislative barriers, which required that a child be found in need of protection in order to access treatment, be abolished. The secure treatment provisions of the *Child Welfare Act*, in his view, should be transferred to children's mental health legislation.⁴⁷²

In 1997, the Federal/Provincial/Territorial Advisory Network on Mental Health commissioned a review of the legislation for community-based mental health services. Two prominent Alberta lawyers, Mary Marshall and Margaret Shone, completed the review. Their report discussed change, pointing out that significant changes in legislation follow significant changes in mental health care and that legislation should follow and reflect policy decisions, thereby serving as a tool that can be used along with other measures to support an effective system of mental health care.⁴⁷³ As they noted,

It is characteristic for legislation to move with societal changes. In Canada, as elsewhere, developments in mental health legislation over the years have reflected advances in knowledge about mental health disorder, shifts in professional and public attitudes, the availability of resources, prevailing political views and contemporary trends in service delivery.⁴⁷⁴

⁴⁷¹Bernd Walter, "In Need of Protection: Children and Youth in Alberta," *Child Welfare Review* (1993), p. 191.

⁴⁷²*Ibid.*, pp. 194-96.

⁴⁷³Mary Marshall and Margaret Shone, *Review of Legislation for Community-Based Mental Health Services and Programs* (Ottawa: Federal/Provincial/Territorial Advisory Network on Mental Health, March 27, 1997).

⁴⁷⁴*Ibid.*, p. 5.

Their review was to provide a conceptual framework around which further study could be organized. Although the review focused on comprehensive mental health legislation for treatment of adults in community settings, its findings and principles might be equally applicable to services in children's mental health. No legislation specifically covered children's mental health in Alberta, as the *Alberta Mental Health Act* has never addressed children specifically (and this still is the case). The act says very little about the mental health system itself and focuses primarily on protocols to meet the needs of adults requiring compulsory hospital treatment. It does not address community care and support, in which most children are treated. As Savage and McKague said:

Mental health legislation in Canada is improperly named. It could more appropriately be called "legislation on the procedures for dealing with persons who are institutionalized. It takes a strictly medical-model approach to mental disorder, and focuses on pathology rather than on ways of assisting people to live in non-institutional settings.⁴⁷⁵

Marshall and Shone proposed a different way to conceptualize mental health legislation. This alternative approach would contain clear value statements and deal with the provision of preventive services in community settings rather than exclusively on treatment services. It would set out the vision, values, and principles to govern mental health care as well as to protect individual rights. Its structure also would recognize that several professional disciplines in addition to physicians have a role in providing services, including self-help organizations, families, and friends. This approach also would include an expanded role for the mental health advocate's office currently restricted to services for involuntary patients.

The task of designing such legislation would be a creative one, reflecting children's needs and the province's uniqueness. Extrapolating from Marshall and Shone's report with application to children rather than adults, the benefits of such legislation would signal the importance of children's mental health services and give them more legitimacy; provide public accessibility to information about children's mental health services based on a clear vision and guiding values and principles; and clarify patients' rights to these services and other community rights and entitlements. Such legislation also could give powers to service providers and impose duties on persons who otherwise would not have them, and create clear accountability frameworks. For mental health legislation to be effective, the report claimed it must reflect accurately the current status of the mental health programs and projected developments. In the end, "Legislation will only be as good as the policy decisions on which it is based."⁴⁷⁶ Well-developed, it could consolidate current achievements and guide future developments. It also could secure what might otherwise be seen as a fragile commitment to the restructuring of mental health services in an integrated and comprehensive system.⁴⁷⁷

⁴⁷⁵Harvey Savage and Carla McKague as quoted in *Ibid.*, p. 38.

⁴⁷⁶*Ibid.*, p. 107.

⁴⁷⁷John E. Gray, Margaret A. Shone, and Peter F. Liddle, "Community Mental Health Legislation," in *Canadian Mental Health Law and Policy* (Markham, ON: Butterworths, 2000), p. 15.

Alberta in the New Millennium

At the beginning of the new millenium, the message to the Alberta Government became even stronger: "Enough is enough!" said the report of the Task Force on Children at Risk.⁴⁷⁸ "Don't wait until there is a problem. Start Young—Start Now."⁴⁷⁹ Premier Ralph Klein established this task force in 1999 shortly after the tragic shooting death of a student by a fellow student at the W. R. Myers High School in Taber. Many people were asking what could be done to ensure this did not happen again. The task force was told to search for answers and solutions. Its findings showed that, while most of Alberta's children and youth were doing well, serious problems existed:

- The number of Alberta youth involved in criminal and violent offences continued to be higher than the Canadian average.
- A total of 134 young people involved in prostitution were apprehended between February 1 and November 30, 1999.
- The incidence of teen suicide was higher than the Canadian average and the rate among Aboriginal youth was five times higher than among other Alberta youth.
- Aboriginal children were more likely than children in the general population to live in care.
- Gang-related behaviour was increasing.
- Verified cases of child abuse totalled 13,693.
- An estimated 1,200 children in the care of Child Welfare suffered from Fetal Alcohol Syndrome or Fetal Alcohol Effect.
- Bullying at school was identified as a very big problem causing children to feel unsafe at school.
- The number of children affected by marital break-up had tripled in the previous 20 years.
- A single parent headed 42 per cent of all Aboriginal families and 90 per cent of these were women.
- Lack of access to service was identified as a significant problem for children with a mental health disorder.⁴⁸⁰

The task force made several recommendations, starting with early intervention and focusing extensively on parent support, access to multidisciplinary support and counselling in schools, expanded mental health services with improved access for children and youth, and removal of barriers to services for Aboriginal children and their families both on and off reserves. It also emphasized research, with the goal of establishing an Alberta endowment fund to support applied research on effective strategies for promoting healthy development in children and youth and addressing the problems of children at risk.⁴⁸¹ These

⁴⁷⁸Task Force on Children at Risk, *Start Young Start Now*, Edmonton: Task Force on Children at Risk, February 2000. Task force members were: Iris Evans, Alberta Children's Services Minister; Heather Forsyth, MLA, Calgary Fish Creek; Rob Lougheed, MLA, Clover Bar-Fort Saskatchewan; Gary Severtson, MLA, Innisfail-Sylvan Lake; Shiraz Shariff, MLA, Calgary-McCall; and Ivan Strang, MLA, West Yellowhead.

⁴⁷⁹*Ibid.*, p. 1.

⁴⁸⁰*Ibid.*, pp. 39-52.

⁴⁸¹*Ibid.*, p. 38.

recommendations came with the task force's commitment to provide Albertans with annual progress reports.⁴⁸² A protocol for a crisis response plan developed by the Taber Response Team as a model for other communities and schools also was included in the report.⁴⁸³ The task force report also noted that the AMHB's highest priority areas for the three years following 2000 included services for children and youth and Aboriginal people,⁴⁸⁴ with increased funding for children's mental health, suicide prevention, and programs for eating disorders.

Nationally, 21 per cent of children aged six to 11 were classified as having special needs. The Canadian Council on Social Development demonstrated this in 2000 through an analysis of data collected through the National Longitudinal Survey of Children and Youth. These children faced a number of challenges, including the risk of being excluded from opportunities that most children took for granted. This was compounded by the fact that these children were inadequately served and faced many barriers to accessing services:

While article 23 of the UN Convention on the Rights of the Child recognizes that children with disabilities have the right to enjoy full and decent lives—this research indicates that this opportunity is not fully enjoyed by all children with special needs.⁴⁸⁵

In Alberta, researchers used a novel approach to determine prevalence of mental disorders in Alberta children. Provincial administrative data from 1996 were analyzed using the diagnoses provided by physicians when submitting their billing data for reimbursement. The findings of this analysis, published in 2001,⁴⁸⁶ indicated that distinct patterns of disorder were evident and that people often had more than one condition—including psychiatric and physical conditions—at the same time. For example, the analysis found that 10 per cent of children who had asthma also had a mental disorder. Mental disorders were found to be more common in young boys and adolescent girls and among children whose families were receiving welfare—for whom the rates of mental disorder were twice that of the rest of the population. This very important finding supported the relationship between socioeconomic status and mental disorders in children that had been demonstrated in previous Canadian research:

The undermining effect of poverty is cumulative. Children growing up in poverty show almost three and one-half times the conduct disorders, almost twice the chronic illness, and more than twice the rate of school problems, hyperactivity and emotional disorders than those who are not poor.⁴⁸⁷

Another striking finding of this research was the actual Alberta information on medical service providers, confirming the important role of primary care in diagnosing and treating mental disorders:

⁴⁸²Ibid., p. 2.

⁴⁸³Ibid., pp. 39-52.

⁴⁸⁴Ibid., p. 30.

⁴⁸⁵Canadian Council on Social Development, *Children and Youth with Special Needs* (Ottawa: Canadian Council on Social Development, 2003), executive summary, p. 2. <http://www.ccsd.ca/pubs/2001/specialneeds/snexecsum.htm> (accessed November 10, 2005).

⁴⁸⁶D. Spady, D. Schopflocher, L. Svenson, and A. Thompson, "Prevalence of Mental Disorders in Children Living in Alberta, Canada, as Determined from Physician Billing Data," *Archives of Pediatric Adolescent Medicine* 155 (October 2001), pp. 1154-59.

⁴⁸⁷Paul Steinhauer, *Methods for Develop Resiliency in Children from Disadvantaged Populations*. Prepared for the National Forum on Health, 1996, p. 5.

General practitioners provided services to 59% of children; pediatricians to 35% and psychiatrists to 22%. Other specialists such as emergency department physicians or internal medicine physicians saw about 4% of children.⁴⁸⁸

This research report, full of valuable information for policy-makers, planners, and service-providers, was exciting because it provided an analysis of the entire population of Alberta children receiving mental health services and used readily available data, likely at a much lower cost than the standard approach of using surveys to determine prevalence. Government's use of this knowledge in policy development and repeated application of this approach is unknown.

Primary and Shared Mental Health

Canada has recognized for some time the critical and extensive role that family physicians play in children's mental health. A joint statement by the College of Family Physicians of Canada and the Canadian Psychiatric Association in 1997 said "in theory, the family physician and the psychiatrist are natural partners in the mental health care system."⁴⁸⁹ The unfortunate reality, however, is that these two groups often have not worked together to improve quality of care for their patients. Significant recent changes across the country focusing on primary care—including shared care models—have created new hope for improvements in service provision.

A Calgary model described a collaborative approach to mental health care in which psychiatric consultation could be obtained quickly by the family doctor who could then learn by taking part in the psychiatrist's assessment process.⁴⁹⁰ This, and the subsequent discussion were found to help the family doctor provide ongoing care. A primary care focus, of course, involves not only the psychiatrist and family physician, but also various professionals from other disciplines. Such scenarios of great promise in children's mental health have been in the planning phase for a variety of primary care centres across Alberta. The first was launched in south Edmonton in May 2005. Dr. Ken Gardener, Capital Health's medical affairs vice-president, expressed commonly shared excitement about these new initiatives: "These initiatives represent a new level of collaboration between family physicians and health regions. They mark another step toward improving access to medical care, managing chronic disease and improving co-ordination of services."⁴⁹¹

⁴⁸⁸Spady et al, "Prevalence of Mental Disorders in Children Living in Alberta, Canada, as Determined from Physician Billing Data," p. 1155.

⁴⁸⁹Nick Kates et al., "Shared Mental Health Care in Canada," *The Canadian Journal of Psychiatry* 42, 8 (1997), p. 87.

⁴⁹⁰W. Weston, "Shared Mental Health Care: The Calgary Model—A Commentary," *Families, Systems & Health* 22, 4 (2004), pp. 439-44.

⁴⁹¹"Capital Health Launches Alberta's First Primary Care Network," *Capital Health Quarterly* (Summer 2005), p. 18.

Early Childhood Development

In September 2000, the Canadian government reached an agreement with the provincial and territorial governments to improve and expand services and programs for children under six years of age. This Early Childhood Development Agreement was structured as a long-term commitment to help young children achieve their potential and to help families support their children.⁴⁹² In this agreement, governments committed to report regularly on 11 indicators that provide valuable information on young children's early development and physical health. Of these, indicators of emotional health, social knowledge and competence, cognitive learning, and language communication included:

- emotional problem—anxiety
- hyperactivity—inattention
- physical aggression—conduct problem
- personal—social behaviour
- language.⁴⁹³

The first national report was published in 2003 but, as a national report, provides no provincial data.

Policy Framework

Under AMHB direction, a provincial policy framework for children's mental health developed within the context of the ACYI was released in 2000/2001.⁴⁹⁴

This framework broadened accountability for children's mental health and called on government and stakeholders to focus their efforts in three strategic areas: building capacity, reducing risk, and providing support and treatment. It also provided a base for future strategic planning.

The AMHB documented an urgent need to address mental health problems of children and youth:

It is estimated that about one quarter of those currently facing mental health challenges in Alberta are under the age of 18, and this proportion is expected to increase over the next ten years. As just one example, thousands of young people in Alberta, predominantly women, suffer from eating disorders. This is a serious illness that causes death in approximately 10% of cases.⁴⁹⁵

It also reported on Aboriginal people's pressing mental health needs, emphasizing the continuing high rate of suicide in Aboriginal youth at 126 per 100,000.⁴⁹⁶

⁴⁹²Federal/Provincial/Territorial Early Childhood Development Agreement, *The Well-Being of Canada's Young Children: Government of Canada Report, 2003*, p. 5.

⁴⁹³Ibid.

⁴⁹⁴Alberta Mental Health Board, *Policy Framework: Mental Health for Alberta's Children and Youth* (Edmonton: Alberta Mental Health Board, 2001).

⁴⁹⁵2000/2001 Annual Report, Alberta Mental Health Board, p. 13.

⁴⁹⁶This contrast with 14 suicide deaths per 100,00 in Alberta's general population. Alberta's suicide rate continued to be one of the highest in the country, second only to Quebec. Ibid.

Continuing to Wait

In April 2002, a children's mental health regional central intake system was introduced in Calgary and Edmonton to facilitate access to services. This exceptional collaborative effort was intended to help children and adolescents who needed mental health services to find the right service. This approach provided some benefits for families and made information on access clearly available to decision-makers for use in regional planning. For example, Edmonton in 2004/2005 had a backlog of 148 children waiting to be screened, and after screening they usually waited four to five months for assessment and treatment.⁴⁹⁷ Reasonable access to mental health services for children continued to be unavailable, despite the recent system enhancements across the province.

Since waiting for care was seen as unavoidable across all provinces, efforts were undertaken to improve the fairness of the system. The Western Canada Waiting List Project (WCWLP), for example, began in 1998 as a collaborative initiative involving Alberta, Saskatchewan, British Columbia, and Manitoba.⁴⁹⁸ It set out to develop priority-setting tools meant to be valid, reliable, practical, and clinically transparent to help manage waiting lists in children's mental health among other clinical areas. The project results have so far been applied only in very limited ways in Alberta.

Other forms of service unavailability across the province in areas where wait-lists have not been used to guide access have been made evident particularly through

⁴⁹⁷Child and Adolescent Service Association 2004/2005, *Enhancing Children's Mental Health in the Capital Region: Children's Mental Health Initiative Evaluation Annual Report*, p. 55.

⁴⁹⁸Canadian Medical Association, *The Taming of the Queue: Toward a Cure for Health Care Wait Times. A Discussion Paper* (Ottawa: Canadian Medical Association, 2004).

⁴⁹⁹Karen Kleiss, "Troubled youths looking for a home," *The Edmonton Journal*, June 9, 2005, p. B1.

⁵⁰⁰Ibid.

⁵⁰¹Jody Sinnema, "Street kids lose drop-in refuge," *The Edmonton Journal*, October 6, 2005, p. B3.

The iHuman Story

iHuman is an Edmonton program for troubled, homeless youth between the ages of 12 and 24, marked by drug addiction, violence, suicidal behaviour, prostitution, and criminal convictions.

"... we are the collection agency of the damned, the forgotten and the misfits."⁵⁰⁰

These youth have been kicked out of school and other programs and have been unable to live in group homes. For the last seven years, they have found solace and the help they need to turn their lives around at iHuman, a program funded primarily through private philanthropy.

One who has come to the place and been animated by big dreams is Kenny Ramsey, a 22-year-old whose street name is Guardian. "This place kept me alive," said Ramsey. "It helped me get off meth and stay off meth and go back to school. It's like a support system."⁵⁰¹

The reason for the article in the *Journal* was the planned demolition of the facility used for the iHuman program. Without accommodation, the program would close and these kids would be back on the street. They appealed to the city for help. Mayor Stephen Mandel was eager to help them, but noted “we have limited capacity and there are hundreds of groups looking for it”⁵⁰² No space was found. Staff today work from the street, driving to meet youth at coffee houses for counselling, taking telephone calls from girls working as prostitutes, and responding to crisis situations.

media reports. This is particularly true for youth with dual diagnoses such as crystal methamphetamine addiction and a mental health disorder. For example, *The Edmonton Journal* featured a story in June 2005 on the iHuman program:⁴⁹⁹

A Framework for Reform

A Framework for Reform, the report of the Premier’s Advisory Council on Health informally known as the Mazankowski Report, was released in 2002. This report emphasized the integration of mental health services with the regional health authorities and set a deadline for integration of March 31, 2003. AMHB’s role changed once again, this time to focus its efforts on integrating mental health services in all regions by the new deadline. The transfers were, in fact, completed by that date, an important milestone reflecting a vision of children’s mental health on the continuum of child health and setting the course for the next steps in the evolution of children’s mental health services in the province.

Alberta’s Promise

The program Alberta’s Promise was launched in 2003, asking everyone in the province to do more to support children. It encouraged community partners to work together to develop a healthy environment for children and mobilized businesses, communities, and all Albertans to focus on one goal: a brighter future for Alberta’s children. This promise was announced in the 2003 Throne Speech and subsequently introduced into the legislature as Bill One, the *Premier’s Council on Alberta’s Promise Act*.⁵⁰³

⁵⁰²Ibid.

⁵⁰³Advertising feature, “Alberta’s Promise: A Partnership with Children and Youth,” *The Edmonton Journal*, January 9, 2005, p. F1.

Child Welfare Legislation

On March 4, 2003, the *Child Welfare Amendment Act* was introduced in the Legislative Assembly where it received Royal Assent on May 16, 2003 and was later renamed the *Child, Youth and Family Enhancement Act*. A community consultation process guided the changes to this legislation. In this process, families requested separate legislation to address the unique needs of children with disabilities. This resulted in new legislation, the *Family Support for Children with Disabilities Act*, proclaimed in the summer of 2004.

The *Child, Youth and Family Enhancement Act* proclaimed on November 1, 2004 reflected substantial changes from the previous legislation, with the intent of further enhancing the development and well-being of children, youth, and families, while keeping them safe and protected.⁵⁰⁴ A very significant change was that the act removed references to treatment; for example, “secure treatment” now was referred to as “secure services.” These changes underscored the ministry’s new philosophy that treatment was no longer part of Children’s Services’ role. This, of course, would have a serious impact on children’s mental health services. Those implications and strategies to address them were not developed before the new legislation was implemented, and health regions were left to find ways to address these as part of their regional plans.⁵⁰⁵

Provincial Mental Health Plan

In April 2004, *Advancing the Mental Health Agenda*, A Provincial Mental Health Plan for Alberta was released. This provincial mental health plan said Health and Wellness had overall responsibility to:

- maintain the provincial policy framework for mental health
- enter into performance agreements with health authorities
- monitor results in achieving the expectations of the provincial policy
- meet its legislative, policy, and funding requirements.

The plan made health regions responsible for delivering the vast majority of mental health services. As an agency of the Government of Alberta, AADAC was responsible to operate and fund information, prevention, and treatment services to address alcohol, and other drug and gambling problems (including related research). The Alberta Mental Health Board was to advise and provide provincial leadership, collaboration, coordination, and support activities in such areas as Aboriginal mental health; forensic services; mental health research, planning, and co-ordination; performance standards and measures; province-wide prevention and promotion initiatives; and mechanisms for decision-making and treatment provision for extremely hard-to-serve clients. Other provincial ministries were to

⁵⁰⁴Alberta Children’s Services, *Overview of Changes to the Child, Youth and Family Enhancement Act* (Edmonton: Alberta Children’s Services, August, 2004).

⁵⁰⁵Capital Health Region, *Capital Health Plan for Mental Health Program Service Delivery* (Edmonton: Capital Health Region, January, 2005), pp. 4-15.

be held responsible for services and supports provided through cross-ministerial initiatives.

The comprehensive plan reflected thoughtful attention to needs and issues specific to children and adolescents. As in 1996, health regions were asked to develop (or perhaps dust off and update) mental health service delivery plans. The expectation this time was that the service plans would comply with the directions set in the Provincial Mental Health Plan and be completed for submission to the AMHB by the end of March 2005. Completion of the plans was delayed, and most plans were unavailable for review by September 2005.

As “Happy Birthday, Alberta” echoed across the province and Albertans gathered for “the party of the century” with great entertainers, good food, spectacular fireworks and festivals, one thing was certain: Alberta could not, despite the significant enhancements since the late 1990s, continue to function as it had with children on long wait-lists for desperately needed services. New approaches would be needed for Albertans to live up to all Alberta has to offer, to rise to the challenge of the Alberta promise expressed in Colleen Klein’s words: “Together we will make Alberta the best place in the world to raise our children.”⁵⁰⁶

⁵⁰⁶Colleen Klein, Honourary Chair, *Alberta’s Promise: A Partnership with Children and Youth*, Advertising feature, *The Edmonton Journal*, January 9, 2005, p. F1.

Conclusion

Alberta's Heritage and Future

The developments, struggles, triumphs, and continuing issues within Alberta's 100-year history of children's mental health services shows that these services evolved intermingled with other systems of care in the developing province. Systems of care integral to children's mental health included public health, juvenile justice, education, services for children with developmental delays, and child welfare services. Progress came excruciatingly slowly, influenced by the interplay of economic and political forces, social factors, cultural attitudes, and societal values—including racial and ethnic biases hidden deep in the province's history. Despite better understanding of the factors that influence children's healthy growth and the availability of scientific knowledge to inform decision-making, a resistance to providing needed services persisted. As a result, this area of health care was drastically underserved for many years, with significant service gaps that continue today. Alberta children needing mental health services were left behind, "out in the cold," compared with those needing physical medical interventions—hence, they became "Winter's Children."

Organized services for children are a relatively recent phenomenon. In the newly-established province, welfare was a local government responsibility, and welfare services lagged far behind those of other parts of Canada because of Alberta's new status as a province. The ability of local governments to intervene in local issues was limited, not only by financial realities, but by early settlers' independence and self-reliance. Problems were solved as they arose, with local government intervention provided case-by-case, when an individual need grew beyond the family's ability to cope. In those early years, no system of care or uniform approach or policies existed. Commitment to volunteerism, the work of individuals with compassion, and reliance on religious organizations was very evident and often led the way to organized services. Services focused on providing basic care for children who were neglected, abandoned, orphaned, or "different" from their peers because of physical or developmental characteristics. In all cases, they were considered charity children and cared for in institutional settings, most often mixed together without consideration for special needs or circumstances. Placement in these settings was typically long-term and focused on reform and training aimed at preparing young people to fit into society. While these services in retrospect were intrusive and controlling, they were set up with the best of intentions in an attempt to deal with social problems; in the context of their times, they were viewed as caring expressions of a concerned society.

The needs for support and welfare programs grew beyond the resources of local governments as towns grew into industrialized cities. This was evident, particularly in the growing problems of neglected and dependent children and juvenile delinquency, which forced municipal leaders to tackle public welfare issues and pass needed legislation. New approaches were based on a medical model with problems viewed as stemming from psychological and social pathology and intervention efforts focused on protection, segregation and child-saving as the contemporary values underlying service development.

Changes were greatly influenced by developments in the United States and other Canadian provinces, particularly Ontario. The flourishing public health movement centred its attention on schools as a natural centre for health protection and promotion. It defined social problems as public health problems, bringing public attention to immoral conduct, feeble-mindedness, crime, and pauperism. This attention led to the introduction of mental hygiene, a concept rooted in the determination to prevent juvenile delinquency. An Ontario psychiatrist, Dr. Hincks, was the chief early advocate of mental hygiene in Alberta (as in other Canadian provinces), and the Alberta Government invited him to Alberta on three separate occasions for surveys of mental hygiene services. These surveys had a major influence on developments in clinical services, research, and training, yet it would be years until key recommendations of his survey reports were implemented. Although the reasons are unclear and certainly complex, they are inexorably linked to the devastating impact of two world wars, the Great Depression, the Spanish Flu epidemic, phenomenal growth, the lack of infrastructure to support new initiatives, the legislative framework and program funding structures, the stigma attached to mental illness, the belief that mental illness affected only adults, and a general lack of societal value placed on this little understood area of health care. Also, no local advocate effectively championed the cause of children's mental health.

Broad philosophies of care are discernible in the evolution of services. The transition from child rescue to child welfare began early in the century with a change from reliance on voluntary services and Christian charity to professionally staffed therapeutic services. Consistent with this new philosophy, the mental hygiene movement soon expanded its primary focus on juvenile delinquency to more general attention to promotion of children's well-being. Children were referred to mental hygiene clinics by their family doctors, parents, friends, schools, and child welfare agencies. In the 1930s, the mental hygiene clinics already reflected the changed focus from child-saving, protection, and segregation to treatment interventions, although they were very few in number and limited in professional staff. This new philosophy aimed to alleviate pain and suffering and manipulate the environment for the child's benefit. Many children seen in these clinics were classified as feeble-minded, because no distinction was made then between children with development delays and those with mental disorders. Mental hygiene services developed slowly and were available primarily to

children in large cities for many years, with limited services available through travelling clinics to rural communities.

As a new province, Alberta lacked the stability of older provinces and its young economy was repeatedly overwhelmed by catastrophes. The hardships of war, long years of drought and agricultural depression, and the flu epidemic caused intense distress and suffering throughout the province and brought to light the complete inadequacy of Alberta's welfare structure. In this context, the paucity of social services is not surprising; in fact, it is quite remarkable that there were social programs at all in this new and struggling province. Social services, however, were soon needed on a large scale and municipal governments were faced with extensive public pressure for change. This led to appeals to the provincial governments for grants and by the mid-1930s to improved funding strategies. By then, mental illness, rather than mental deficiency in children began to receive increased attention, however, the mental hygiene clinics (now called provincial guidance clinics) continued as small operations. Their work, already severely limited by lack of funding and unavailability of personnel, was further curtailed during the Second World War. The clinical approach in the clinics was impressive, even then. They conducted thorough assessments through a team approach although staffing issues seriously challenged them. Assessment was followed by the development and implementation of a treatment plan that included the child's family. This approach persists as standard practice today. What has changed since the 1940s was influenced by scientific knowledge leading to more accurate diagnoses and improved treatment methods, the involvement of the child as an active participant in the treatment process, and more comprehensive multidisciplinary teams of professionals. What was also amazing in the work of the early clinics was the value placed on training and public advocacy and their engagement in these activities—an engagement proportionally greater than offered by today's much larger and more numerous clinics.

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The mental hygiene movement greatly influenced the 1940s and 1950s. Distinctions were made between the mad and the disturbed, criminal offenders, the morally weak, the unemployed and poor, orphans, and the homeless. Intervention became more formalized as guided by the growing professions of social work and psychology, as well as by the increased movement within psychiatry towards a specialization in treatment of children. The professionalization of service organizations and their influence on program development greatly accelerated in the years immediately after the Second World War, as responsibility was transferred from lay individuals in the community and religious groups to professional staff.

Belief that people should look after their own needs was still very evident in the prevailing attitudes of ruling politicians of the 1950s, despite notable advancements in social services. This belief could not be sustained in Alberta's

thriving economy and the inability of growing cities to support the needed growth in social programs. New knowledge brought gradual change and collaborative practices (for example, the clinics worked in close association with juvenile courts, Children's Aid Departments, Child Welfare, public health units, public health nurses, schools, and family doctors. They did this, not because they were told partnerships were essential, but because it made sense and was practical in meeting the needs of children in treatment. Once again, this would be viewed as an ideal practice strategy in today's clinic environment).

The 1960s brought fundamental changes to the delivery of mental health services through the introduction of specialized intervention with psychiatric treatment programs in general hospital settings. These units grew rapidly in number for adult services, but not for children; the University of Alberta Hospital unit for children was the only such unit until the mid-1960s. Hospital units were a great advance with a therapeutic milieu and intensive treatment approach unavailable anywhere else for children with severe psychiatric disorders. They were structured as short-stay units and expected to provide outpatient follow-up services for continuity of care. Major difficulties arose, as the community was unable to provide adequate placement following hospital discharge. Typically located in academic centres, these units (together with the guidance clinics) came to serve as clinical teaching placements for child psychiatrists and professionals of all disciplines working in children's mental health. Unfortunately, location in academic centres did not generate researchers in this specialized field of clinical practice. Research in children's mental health consequently has not flourished in Alberta. This is disappointing, but not surprising, given that few professionals had the skill set to work in this field, and all were needed for clinical work.

While units in general hospitals were opening, additional specialized treatment programs for severely disturbed children and adolescents with severe mental disorders and a propensity for aggressive behaviour were also developing. Two of these—the Apollo Unit and Kennedy Hall—were intensive psychiatric treatment programs, but closed in the late 1970s because of difficulties in recruiting staff. The others were structured through child welfare rather than health services. It is, therefore, not surprising that the legislation on compulsory mental health care for youth emerged and remains to this day in the child welfare rather than in the mental health legislation, where it would be expected. The requirement for parents to surrender their child to the care of child welfare in order to access treatment services has caused great hardship for families. This unacceptable practice continues today, although to a lesser extent. It continues because of long-held societal attitudes and continued lack of understanding of these children's treatment needs. Too few voices are raised in advocacy. It would be unthinkable, for example, for parents to be obliged to surrender custody of their child for access to treatment for pneumonia, heart disease, diabetes, or any other physical condition.

While the specialization era peaked in the 1970s, consumers' rights became characteristic of the 1980s. Outpatient and follow-up programs were strengthened in recognition of the need for continuity of care between residential and community environments. Efforts to effect a cure were replaced by a trend towards shorter stay programs with a focus on strengthening the child's positive attributes rather than eliminating negative behaviours. The new approach placed more responsibility for long-term commitment within a continuum of services rather than within a single organization. Formal and informal linkages, affiliations, collaborative initiatives, and partnerships proliferated in an attempt to create integrated, extensive networks of services. None of that was easy. The challenges in promoting partnerships between patients and professionals, consumers and providers, and across organizations were enormous. Addressing issues of service fragmentation, service inaccessibility, and service ineffectiveness were and continue to be necessary.

The release of the *Canadian Charter of Rights and Freedoms*, and Alberta's decision to sign *The United Nations Convention on the Rights of the Child* imposed new obligations on children's services. The implications of these two documents as they apply to children's mental health services have not been fully examined perhaps. Alberta's children and families would likely benefit from such an exercise.

The 1990s were marked by the initial development of new programs, and then traumatized by imposed and demanding reform strategies, and finally challenged by significant funding support for new program development and expanded community services within networks of partnerships. New legislation, administrative structures, and government commitment to improve children's mental health services began to make a significant difference by the end of the decade.

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The eras were not mutually exclusive, with each phase inheriting the strengths and weaknesses of its predecessors. The proliferation of commissions, reviews, analyses, public forums, studies, briefs, and reports in which professionals and families made determined attempts to be heard and to influence needed changes was common to all eras since the 1920s. These documents contained excellent descriptions of the current status, gaps in services, needs in urban and rural communities, and the special needs of ethnic populations and First Nations People. They were instrumental in developing an understanding of what actions were needed. Still, government action in response to this well-intentioned and expensive work most often was absent, to the great and ongoing distress of service providers and service recipients alike.

The Blair Report was instrumental in setting the direction for change in Alberta, although its impact was more evident in adult services. The turning point for children came with the release of Alberta Children's Initiative: An Agenda for Joint Action, Alberta's business plan for children and youth in 1998. Program

funding flowing out of this business plan through the Children's Mental Health Initiative contributed extensively to strengthen and expand the system of services. This very real progress has not been universal, however; it has affected children unevenly, varying—not surprisingly, and primarily—with place of residence and economic status. Children in poor families, in ethnic communities, of First Nations, and in rural communities continue to have less access to mental health services and to professionals with specialized skills, as do hard-to-serve children and youth and those grouped in special school programs, because they are unable to function in regular schools.

Long wait-lists and waiting times for services persist despite major improvements since the mid-1990s. Suicide rates among youth continue to be unacceptably high when compared with the rates of other provinces. Child abuse and neglect continue. The problems of runaway and homeless youth add to the serious and growing problems of violence, drug and alcohol addictions, and continuing juvenile delinquency. Although these problems are very visible, Albertans have little ready access to information on how well or how poorly children as a whole are doing in this province. Tracking outcomes with the release of an annual provincial report card—which has been promised since the 1990s—must become a major priority, using well-defined indicators to guide decisions for targeted program development and funding allocation.

The Provincial Mental Health Plan of 2004 was a major accomplishment in providing a template for service provision. What is perhaps not immediately evident is that the release of this plan, in addition to the strengthened continuum of services, has positioned Alberta for developing mental health legislation that would address children's specific requirements. This would be the logical and most important next step in the evolution of the province's mental health legislation and perhaps even imperative, given Alberta's need to meet the requirements of *The United Nations Convention on the Rights of the Child*. Legislation specific to children's mental health should reflect and support the Provincial Mental Health Plan's provincial vision, mission, and principles. Such an undertaking could consolidate recent achievements, support future developments, and perhaps add security to what 100 years have shown to be a fragile commitment to providing children's mental health services. It would say clearly, children's mental health services in Alberta are a recognized priority, not an expendable option.

The high prevalence of mental disorders, the continued shortage of services, and the burden of suffering for children and families are clear. A serious challenge for all Albertans at the beginning of this second century is to set and reach goals of diagnosing and treating psychiatric and mental health disorders among Alberta's children, perhaps by finding viable alternatives to the traditional approaches of the last century. The work is not done and requires continued improvements in service provision with strong emphasis on prevention and early intervention. The

recent transfer of responsibility for mental health services to each region has made the role of the regions instrumental in the future of children's mental health. It will be critical to monitor how well that works within the Provincial Mental Health Plan framework. Facilitation within and across regions will be vitally important because of the tremendous challenges and complex needs and issues in ensuring children reach their developmental potential. Examples of these include:

- Promote research and disseminate research findings, so that treatment services continue to advance by using what has proven to be effective. The results of outcome studies and scientific research findings should serve as the basis for policy development. Changes that result in rewards for research and teaching are also needed.
- Develop professionals in order to address the continuing staff shortages in this field and the distribution of skilled specialists for access to remote regions and to programs that are difficult to staff.
- Make the best possible use of available technology.
- Integrate services beyond mental health and within the continuum of child health.
- Develop strategies for eliminating the stigma that prevails to the detriment of families needing services.
- Provide support for family physicians in their primary role, as opportunity is provided through the developing primary care centres across the province.
- Enhance school services, ensuring that they are not the first to be discontinued when funding is tight.
- Maintain a culture of openness so that voices advocating on behalf of children and youth are heard.
- Foster community development in order to avoid exclusive reliance on government-funded services.

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The story of children's mental health services in Alberta illustrates the degree to which economic circumstances, social values, and stresses influence needs and decisions. At a prosperous time in oil-rich Alberta, further progress in this important area of health care is reasonable, but bold steps must be taken to ensure that children's mental health continues to be a priority when economic circumstances change (as they likely will), so that past errors will not be repeated.

Alberta has come a long way in the last 100 years and has a long way to go. At this point, the province is well-positioned to leave no child behind, to ensure that children's mental health services are never regarded as second class compared with physical health services, and to provide continued leadership in this area. Alberta should be able to say—not that its programs are second to none when compared with other provinces and jurisdictions—but that they truly meet the mental health needs of infants, children, youth, and their families.

*Many things we need can wait, the child cannot.
Now is the time his bones are being formed,
his blood is being made,
his mind is being developed.
To him we cannot say tomorrow,
His name is today.*

- Gabriela Mistral
Chilean Poet⁵⁰⁷

⁵⁰⁷Gabriela Mistral, in "Society for the Protection of the Rights of the Child," *The State of Pakistan's Children* (London: Oxford University Press, 2002), p. 50.

Appendix A

Eugenics Philosophy and Sexual Sterilization

Eugenics philosophy was at the foundation of the sweeping movement to enact sexual sterilization laws in England, Germany, and North America in the early 20th century. "Eugenics" comes from the Greek word meaning "well born." It was first introduced in 1883 by Darwin's cousin, Francis Galton, who initiated England's Eugenics Movement in 1904, and was later redefined by Charles Davenport in the United States as "the science of the improvement of the human race by better breeding."⁵⁰⁸

The movement was based on a belief in the genetic inheritance of social traits and was two-pronged with "positive" and "negative" eugenics. Positive eugenics included practices to encourage procreation by those viewed as possessing characteristics needed to improve and strengthen society's overall gene pool. Negative eugenics, the primary focus and the drive behind sexual sterilization legislation and administrative practices, involved discouraging or preventing procreation by people seen as having undesirable characteristics. Common methods included sterilization, marriage prohibition, segregation, and institutionalization.

Geneticists and supporters of eugenics believed certain social traits⁵⁰⁹ were undesirable and almost exclusively hereditary. These included mental retardation, mental disorders, pauperism, criminality, prostitution, sexual perversion, and immoral behaviour. The link between mental retardation and criminal behaviour and the threat to society posed by those identified as mentally defective were prominent themes of eugenics philosophy. The pseudo-science behind eugenics was a belief that, without scientific and medical intervention, the "feeble-minded" would inevitably pass defective genes on to their offspring, breeding faster than the fit, to the detriment of society. The movement progressed steadily despite scientific evidence available as early as 1927 that eugenics blatantly ignored scientific truth.⁵¹⁰

Influential leaders also connected Canadian immigrants with the feeble-minded and labelled them as "defectives." This label was applied particularly to Eastern and Central Europe emigrants entering Alberta with high fertility rates and little education. Many thought that they threatened the social fabric and created problems that undermined the province's structure and stability. Proponents said that economic efficiency was a major argument for sterilization; they said it was inefficient to allow genetic defects to multiply and then have to deal with

⁵⁰⁸Allen Garland, "The Social and Economic Origins of Genetic Determinism: A Case History of the American Eugenics Movement, 1900-1940, and its Lessons for Today," *Genetica* 99 (1997), pp. 77-99.

⁵⁰⁹Ibid., p. 79.

⁵¹⁰Pearl Raymond, "The Biology of Superiority," *The American Mercury* 12 (1927), p. 260 in McConnachie, *Science and Ideology: The Mental Hygiene and Eugenics Movements in the Inter-War Years*, 1919-1939, p. 12.

consequences costly to the province. Certain people were seen as simply too expensive to maintain.

Early advocates of the eugenics movement included Canadian public health leaders, mental hygienists, women's rights advocates, and social activists who sought answers to social problems in science as consistent with a fundamental shift from a religious to a bio-medical rationale for social order. They provided the philosophy, language, and rationale for reform based on the science of eugenics as they sought to bring order⁵¹¹ to an increasingly complex society. Municipal leaders, organizations, and individuals concerned about social economy and efficiency joined in the fight to combat the "threat" of the feeble-minded. Their influence continued to shape public policy long after the scientific basis for hereditary determinism was rejected.

Prominent leaders included:

- Charles K. Clarke, a prominent Toronto psychiatrist, who took the lead in labelling immigrants.
- Helen MacMurchy, who became Ontario's inspector of the feeble-minded in 1915. She argued that feeble-mindedness could be largely eliminated within a generation through segregation and sterilization.
- Clarence Hincks, Canadian director of the Canadian National Committee on Mental Hygiene. The primary purpose of this committee was to survey the provinces, report, and make recommendations on matters of mental hygiene and social welfare.

Eugenics in Alberta

Alberta was a young province when the eugenics movement swept North America. It had a small population, little experience in self-determination, and was heavily influenced by the United States. Its enactment of the *Sexual Sterilization Act* was highly praised across Canada. As Dr. Baragar stated:

The need for this legislation has been fully demonstrated and the very careful and efficient manner in which the Board has discharged its responsibilities under the Act has placed this province in a position of leadership in dealing with this great problem. Many enquiries have been received from other provinces, and other parts of the Empire, as well as from foreign countries, as to the working of the Act and the progress of the work in Alberta. I feel satisfied that the Government has initiated a valuable activity which should materially lessen the problem of the propagation of the feeble-minded.⁵¹²

⁵¹¹Ibid, p. 6.

⁵¹²Sheila Abercrombie, *Alberta Hospital Edmonton 1923-1983—An Outline of History to Commemorate the 20th Anniversary* (Edmonton: Alberta Hospital Edmonton, 1983), p. 22.

Interest was great in Ontario, where legislation was never passed despite strong political backing and the lobbying efforts of its proponents as “the most progressive in the Dominion.”⁵¹³ In adjoining provinces, Saskatchewan never passed a eugenics law and British Columbia passed one five years later but never enforced it with the same vigour as Alberta. The reasons were not clear; however, the literature widely supported the theory that a handful of influential people championed and aggressively implemented Alberta’s legislation.

Emily Murphy, Canada’s first female magistrate, lectured widely on the dangers of bad genes, proclaiming that insane people were not entitled to progeny. Nellie McClung, the well-known Alberta suffragist, promoted the benefits of sterilization and was instrumental in passing Alberta’s legislation. Dr. John MacEachran, founding chair of the University of Alberta’s department of philosophy and psychology, promoted his belief that the purity of the race should be achieved by regulating marriage and reproduction. The literature presented him as the most influential leader in the sexual sterilization movement through his numerous public presentations. He chaired the Eugenics Board from its inception until his retirement in 1965.

Margaret Gunn, in her presidential address to the United Farmers Women of Alberta, concluded that “democracy was never intended for degenerates.”⁵¹⁴ The United Farm Women of Alberta organized a campaign to garner public support for sexual sterilization. Members of Camrose local, however, were vociferous in their belief that sterilization constituted a drastic and violent invasion of the most elementary human right and urged the segregation of the feeble-minded as well as the elimination of undesirable immigration which they thought was the chief source of the defective class.⁵¹⁵

The Honourable George Hoadley, Alberta’s Minister of Health, presented the bill in 1927, stressing the need for sterilization of mental deficient and re-introduced the bill in the Alberta Legislature in 1928. *The Alberta Sexual Sterilization Act* was passed March 7, 1928 amidst strong dissenting voices and heated debate among members of the Legislative Assembly, private citizens, the press, and the Catholic Church—all of whom argued that this proposed legislation was immoral and not based on good science. Their arguments opposing the bill lacked public support, and those in power placed the welfare of the state over the rights of the individual.

The act provided for the formation of an Alberta Eugenics Board composed of two medical practitioners nominated by the Alberta College of Physicians and Surgeons and two persons who were not medical practitioners appointed by the University of Alberta Senate and Lieutenant Governor in Council.⁵¹⁶ This board first met in January 1929 to develop its operational policies and begin to review referred cases. Between then and the repeal of the act in 1972, the Alberta Eugenics Board reviewed and passed 4,739 cases for sterilization (2,832 were actually sterilized).⁵¹⁷ The repeal of the act was brought about by a critique

⁵¹³McConnachie, *Science and Ideology: The Mental Hygiene and Eugenics Movements in the Inter-War Years, 1919-1939*, p. 221.

⁵¹⁴Christian, *The Mentally Ill and Human Rights in Alberta: A Study of the Alberta Sexual Sterilization Act*, p. 9.

⁵¹⁵Lysne, *Welfare in Alberta, 1905-1936*, p. 100.

⁵¹⁶*Sexual Sterilization Act, 1928*, Statutes of Alberta, s. 3(2).

⁵¹⁷Deborah C. Park and John P. Radford, “From the Case Files: Reconstructing a History of Involuntary Sterilization,” *Disability & Society* 13, 3 (1998), pp. 317-42.

completed in 1969 by two University of Alberta geneticists who concluded that the act had no scientific foundation and was a disgrace to the whole of Canada.

The Sexual Sterilization Act of Alberta

June 1928. Enacted, naming four people to the Alberta Eugenics Board and giving them authority to examine all inmates of provincial mental hospitals and to direct sterilization according to Section 5 of the act.

By 1937, the act was thought to be too restrictive and was amended to dispense with the need for consent for mental defectives and grant the Alberta Eugenics Board authority to compel the sterilization of such patients. The act still required that consent be obtained prior to the sterilization of psychotics.

In 1942, the scope of the act was expanded to broaden the category of mental patients who could be directed to undergo sterilization. The board could now direct sterilization for patients suffering from neurosyphilis, epilepsy with psychosis, mental deterioration, Huntington's chorea, and—more generally—those whose procreation would involve the risk of mental injury either to the patient or to the progeny. This amendment also exempted from civil action any person taking part in the surgical operation as well as those in charge of mental institutions who had referred the inmate for the examination of the Eugenics Board.

No further substantial amendments were made from 1942 until the act was repealed in 1972 by the newly elected Progressive Conservative Government.⁵¹⁸

⁵¹⁸*Sexual Sterilization Act, 1928*, Statutes of Alberta, chapter 37.

Sexual Sterilization Act, 1937, Revised Statutes of Alberta, chapter 6.

Sexual Sterilization Act, 1942, Revised Statutes of Alberta, chapter 194.

Appendix B

Mental Hygiene Clinics: Prototype and Evolution

The literature credited juvenile delinquency legislation with the first attempt to recognize children's special needs by providing for children's cases to be heard apart from those of adults. This legislation was also regarded as playing a prominent part in the initiation of the mental hygiene movement in the United States. This is how it began.⁵¹⁹

In 1909, Mrs. William Drummer of Chicago was horrified by juvenile court and volunteered to finance a clinic for five years to investigate young delinquents. She believed the public would take responsibility for the work if clinic results were successful. With her funds, Pediatrician W. Healy founded the Juvenile Psychopathic Institute. Its patients were referred mostly by the juvenile courts, although some were referred directly by families and social services. Efforts were made to see referred children as soon as possible, reflecting a well-accepted practice even then. Professionals believed that those most eligible to refer children to the Institute were those closest to the children who were able to observe behaviour difficulties. Parents and schools therefore were considered the two most important sources of referrals.

The emphasis of the institute's study was on social history, physical examination, and psychometric evaluation. Efforts were made to correlate this information with conduct, determine causes, and initiate corrective action. The value of the clinical psychologist in this research was demonstrated early. Dr. Healy formulated the concept that problem behaviour was not necessarily the expression of psychopathology but a potentially normal reaction to a vicious environment. He also emphasized the importance of early diagnosis, adequate treatment, involvement of social work in investigation, and the use of the therapeutic process in placing children in foster homes and institutions. He advocated for careful selection of both the foster home and the child in these placements. Publications on the work of this institute and its findings led to additional developments across the United States. By 1914, Dr. Healy had demonstrated the institute's value so successfully that the country took it over. Three years later, the government assumed responsibility for the institute and it became The Institute for Juvenile Research.

⁵¹⁹Horace B. English, "Trends in Child Psychology," *Education Research Bulletin* XV, 5 (1936), pp. 123-27.

D.N. Hardcastle, "The Child Guidance Clinic in America: Its Evolution and Future Development," *British Journal of Medical Psychology* 13 (1933), pp. 328-53.

J. Franklin Robinson, "Current Trends in Child Guidance Clinics," *Mental Hygiene* 34,1 (January 1950), pp. 106-117.

Sydney Kinnear Smith, "Child Guidance Clinics," *American Medical Association* 94, 10 (March 8, 1930), pp. 710-14.

In 1912, the Boston Psychopathic Hospital opened with a special clinic for children, marking a greater acceptance of juvenile services apart from the legal aspects. This clinic's outstanding contribution was the discovery that children's problems and early conflicts were precursors to more serious disturbances in later life. This clinic also developed the social worker's role and coined the term "psychiatric social worker" in 1915 to indicate the special work and training of these employees. By 1916, the clinic employed two full-time social workers whose role included data collection, family histories, and follow-up work.

In 1913, the Henry Phipps Psychiatric Clinic in Baltimore opened with a special department for children. Many clinics opened throughout the United States during the following years. Most started in connection with juvenile courts and followed with a gradual transition to broader community service. In 1919, five mental hygiene clinics, with major emphasis on children's individual needs operated in major cities in the United States. Ten years later, there were 67.

This movement, including the results of the surveys of the National Committee for Mental Hygiene since 1915, culminated in the launching by the Commonwealth Fund in 1922 of Child Guidance Clinics as a five-year demonstration program. By this time, the emphasis had shifted almost entirely away from juvenile courts to community and from a study of delinquency to a study of conduct. Terminology had also changed from Psychopathic Institute to Child Guidance Clinic or Institute for Juvenile Research.

In 1918, the Smith School of Social Work opened in Chicago to supply the urgent need for trained psychiatric social workers. The team composition of child guidance clinics (referred to as the clinical team and the staff as child guidance staff) was standardized by 1920 to include:

- The psychiatrist, who completed the psychiatric examination as well as the physical examination including laboratory investigation, except in cases where a pediatrician was affiliated with the clinic (for example, in clinics attached to outpatient departments of general hospitals). The psychiatrist also provided team clinical leadership and analyzed the information gathered by the clinical team members to formulate a diagnosis.
- The psychiatric social worker, who obtained the social history through home and school visits, as well as visits to any recreational facilities the child attended. The social worker also provided supervision and follow-up, initially to see that the child carried out the treatment prescribed by the psychiatrist. Social work was seen then as a role for females who undertook part-time training for 18 months to three years, attending school while working at the clinics.
- The psychologist, who evaluated the child's intelligence quotient, school knowledge, and special aptitudes. Psychologists could be either male or female, although the clinics employed primarily women. They were expected

to have skills in teaching, psychometric testing, handling of educational disabilities and of handicapped children, as well as extensive knowledge in vocational guidance because a number of adolescents were referred to the clinic for this purpose only.

A clinic without these three disciplines was seen as having an incomplete child guidance team.

An initial conference was held after clinical team members had completed their interviews, to which anyone interested in the welfare of the child was invited (including the family physician, community social workers, and teachers). All contributed their knowledge of the child, family, and school situation. A diagnosis was then completed and a treatment plan initiated and discussed with the parents and referral source. Treatment conferences were held periodically during the course of treatment and a final conference held to close the case and review treatment.

The types of disorders experienced by children seen at the clinics covered a wide range. In one group, physical factors were viewed as an important underlying cause of the problem. These included endocrine disorders, epilepsy, malnutrition, physical defects, encephalitis, a few syphilitic cases, and some resulting from accidents, injuries, and illness. There was also a group with mental deficiency.⁵²⁰ Although cases did not present themselves in tidy categories, the clinics' classifications generally included:

- asocial conduct: running away, lying, stealing, destructiveness, fire-setting, sex assaults, and cruelty
- physical conditions: sleep disturbances, appetite problems, disturbances in elimination such as bed-wetting, convulsions, headaches, speech defects, and such habits as nail biting and thumb-sucking
- personality traits: daydreaming, fears, a "turning-in" of personality, unusual likes and dislikes, premature sexual manifestations, habitual crying, obstinacy or negative behaviour, temper tantrums, and incipient dementias.

The clinics' essential aim was to treat children within the family context, but the clinics also had a much broader role. They were active in mental hygiene advocacy through public lectures, discussion groups to educate the public on the responsibilities of parenthood, student placements, consultation to community social agencies, and working closely with schools and the probation departments of the Juvenile Courts whose staff attended classes and clinical conferences. Some clinics also actively engaged in clinical research.

By 1931, the more progressive clinics had evolved a flexible approach that simplified the need for contacts with clinic staff. The full team approach now was used only when a full investigation was seen as necessary to help with therapy rather than as a clinic routine. For example, if a child presented with no school or

⁵²⁰Sanger Brown, "Preventive Work Undertaken During the Year and Future Plans," *Psychiatric Quarterly* 2 (1928), pp. 333-41.

intellectual problems, the psychologist did not complete intelligence testing and the focus was placed on the key factors in the specific case. Parents were encouraged to come to the clinic instead of the social worker visiting the home, freeing the social worker to focus on therapy. Direct work in individual therapy with the children by both the social worker and the psychologist became more common.

Smith described a clinic established in a New Jersey town of 10,000 people in 1930, with a psychiatrist, a full-time psychologist, and three psychiatric social workers.⁵²¹ After its first year of operation, it had a waiting list of 200 children. He estimated then that a population of 40,000 would keep a clinic of this structure very busy. By 1942, practically all of the large American cities had child guidance clinics modelled on Dr. Healy's template and modified to meet local conditions, including available personnel. At least half of the medium-sized cities boasted a similar service, and smaller cities were rapidly moving in this direction.

Dr. Hincks was very aware of these developments through his association with Clifford Beers and his own involvement in the mental hygiene movement in the United States. Hincks, as ever determined to enhance mental hygiene services in Canada, obtained a grant in 1924 from the Rockefeller Foundation to establish "studies in the application of mental hygiene to children."⁵²² He established clinics with these funds, first in Toronto and in Montreal, and these served as models for other provinces.

In Britain, child guidance clinics started just before 1930, long after these were well established in America.⁵²³ Modelled on the clinics in the United States, these were flooded with cases as soon as they opened—which left no time for spectacular advances or modifications in structure or service approach.

⁵²¹Sydney Kinnear Smith, "Child Guidance Clinics," p. 714.

⁵²²Richardson, *The Century of the Child: The Mental Hygiene Movement and Social Policy in the United States and Canada*, p. 116.

⁵²³William Moodie, "The Future of Child Guidance" in N.G. Harris and J. H. Price, ed., *Modern Trends in Psychological Medicine* (Oxford: Hoeber, 1948), p. 179.

Appendix C

Milestones in Alberta Children's Mental Health Services 1905-2005

1905 September 1—Alberta became a Province.

1906 The *Agriculture Department Act* was passed to attend to agricultural interests and public health.

1907 The *Public Health Act* was passed, mandating a Provincial Board of Health to oversee the inspection of hospitals, jails, and orphanages, and to supervise the areas of charity and relief.

The *Insanity Act of Alberta* was passed but did not mention children, focusing exclusively on insanity in the adult population.

1908 The *Juvenile Delinquents Act* of Canada introduced the authority of the state to intervene as a surrogate parent in the lives of dependent children and introduced juvenile courts.

The *Alberta Industrial Schools Act* was passed to make provisions for the treatment of juvenile delinquents. Industrial Schools were synonymous with Reformatory Schools.

1909 The *Children's Protection Act of Alberta* was passed, serving as the first piece of welfare legislation—in effect heralding the beginning of child welfare in Alberta.

The Department of Neglected Children was established to administer the *Children's Protection Act*.

The Calgary Children's Aid Society was founded, followed by Edmonton's and then with societies established in Lethbridge and Medicine Hat by 1913.

1909 United Farmers of Alberta was formed. Together with the United Farm Women of Alberta, it strongly advocated for social and economic reform with a particular focus on providing assistance to neglected and dependent children.

1910 The *Truancy and Compulsory School Attendance Act* was passed, compelling seven- to 14-year-old children to attend school.

Psychologists Binet and Simon developed the intelligence test.

1912 The Alberta Government established the first juvenile court in Calgary.

1913 The *Alberta Juvenile Court Act* of 1913 provided for the appointment of commissioners to serve as juvenile court judges.

1914 Regular “inspections” of Alberta school students by a physician or nurse began.

World War I. Among the effects of the war was a 25 per cent increase in the incidence of juvenile delinquency.

1918 South Edmonton Home for Mental Defectives opened under the Department of Education.

Dr. Clarence Hincks formed the Canadian National Committee for Mental Hygiene. “Mental hygiene” was the terminology applied to the science of mental health. As an extension of public health, it focused on education and welfare policies toward children. Its initial focus was on preventing juvenile delinquency.

The Spanish influenza epidemic took 4,000 Alberta lives.

1919 The *Mental Defectives Act* was passed, separating mental disorders from mental retardation.

1921 Dr. Hincks began a mental hygiene survey of Alberta at the request of the provincial government.

Intelligence testing was brought to Alberta.

1923 The Provincial Training School at Michener Centre in Red Deer was opened to offer residential care and training for mentally handicapped children and youth.

1924 The *Insanity Act* was amended to become the *Mental Diseases Act*, once again with no reference to children.

Auxiliary classes began in Calgary and Edmonton to provide special instruction for feeble-minded children.

1925 The *Child Welfare Act* replaced the *Children’s Protection Act of 1909*.

1928 The *Sexual Sterilization Act of Alberta* was enacted, allowing sexual sterilization of children and adults with mental deficiencies.

A second survey of Alberta mental hygiene institutions was conducted under the umbrella of the CNCMH.

1929 The CNCMH gave a grant to the University of Alberta for research in mental hygiene. By this time, the university offered mental hygiene courses in all faculties.

Mental Hygiene Clinics opened in Calgary and Edmonton. This was the next major social service for children and youth after the juvenile Courts.

The Great Depression began; its hardships including major impact on social programs.

The Alberta Eugenics Board was established under the *Sexual Sterilization Act* and began reviewing referrals and issuing decisions for sterilization.

1930 A mental hygiene clinic opened in Lethbridge.

1931 The mental hygiene clinics were renamed Alberta Guidance Clinics.

1933 Guidance Clinics opened in Drumheller and Medicine Hat.

1934 Travelling clinics began providing services to rural communities.

1935 The *Alberta Health Insurance Act* was passed empowering the province to create and administer health insurance districts.

1937 Guidance Clinics opened in Coleman, High River, and Ponoka.

1939 World War II brought a time of great hardship to the province, including significantly reduced mental hygiene services.

1942 The *Mental Diseases Act* and *Mental Defectives Act* were updated.

Intelligence tests were discarded in favour of intelligence profiles. Emphasis was placed on accurate diagnoses and adjustment of the environment to meet the needs of children. The preschool years were argued to be the most important years of childhood.

1944 The Alberta Department of Public Welfare was established to manage the growth and complexity of social programs.

The *Child Welfare Act* was amended providing for the establishment of a Child Welfare Commission.

1947 A Child Welfare Commission was established to investigate charges, allegations, and reports relating to the Child Welfare Branch.

The CNCMH conducted a third survey of Alberta mental institutions and Provincial Guidance Clinics.

A permanent guidance clinic with full-time staff was opened in Calgary.

A Guidance Branch within the Department of Education was begun emphasizing the importance of the role of counsellors in schools.

Imperial struck the Big Bonanza, with an oil well near Leduc, changing the course of Alberta's economic security.

1948 The National Health Grants Program was implemented to help the provinces update and strengthen their programs. The largest grant was earmarked for mental hygiene.

A permanent clinic with full-time staff was opened in Edmonton, with funding from the National Health Grants Program.

1949 The *Public Welfare Act* was passed. It provided payment by the province for 60 per cent of the costs incurred by municipalities for child welfare and social assistance.

Counsellors were appointed in high schools in Lethbridge, Medicine Hat, and Red Deer.

1950 The CNCMH changed its name to the Canadian Mental Health Association (CMHA).

Children were now viewed as victims of conditions. There was common agreement that parents should be involved in their child's treatment. These beliefs led to profound changes in treatment approaches.

The province was divided into three zones—central, northern, and southern—for the administrative overview of the guidance clinics.

The Red Deer Provincial Training School started a training program leading to a diploma in Mental Deficiency Nursing over three years.

1951 The Department of Welfare transferred responsibility for juvenile delinquents to the Attorney General's Department.

The Bowden Institution for juvenile delinquents opened.

1954 A Provincial Guidance Clinic opened full-time in Lethbridge.

CMHA Provincial Division Offices were established, with the Alberta Division opening in 1954.

The Alberta Association for Retarded Children was established as a voluntary organization to establish new programs and services for the mentally retarded.

1955 Alberta celebrated its 50th anniversary.

1957 The federal *Hospital Insurance and Diagnostic Services Act* was proclaimed. It provided payment to the provinces for 50 per cent of hospital costs. This payment structure provided incentives for the development of psychiatric units in general hospitals.

1959 The *Mental Diseases Act* was amended with a new part referring specifically to “Emotionally Disturbed Children’s Wards” although none existed at the time.

1960 The University of Alberta Hospital opened a child psychiatry unit operated in affiliation with the university.

Linden House opened at the Provincial Training School in Red Deer, for treatment of emotionally disturbed children from five to 15 years of age.

The *Psychiatric Nurses Training Act* was introduced.

1963 A branch of the Edmonton guidance clinic opened in Grande Prairie and Red Deer. Rural communities were still largely dependent on travelling clinics based in major urban centres.

The *Child Welfare Act* was amended with a definition of neglected child.

The *Welfare Homes Act* provided the framework for licensing institutions for children.

1964 The *Mental Health Act* was introduced, repealing *The Mental Defectives Act* and the *Mental Diseases Act*. For the first and only time, the mental health regulations referred to treatment services for children, specifically Linden House.

The Provincial Training School in Red Deer was renamed the Alberta School Hospital in Red Deer.

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A 41-bed unit for mentally defective infants was opened at the Baker Memorial Sanatorium in Calgary as a unit affiliated with the Alberta School Hospital in Red Deer.

A national report, *More for the Mind*, was published that emphasized patient rights and community-based services as well as outlining guiding principles for children’s mental health services.

1965 Kennedy Hall at Alberta Hospital Edmonton and the Apollo Unit at Alberta Hospital Ponoka opened to treat severely disturbed adolescents.

1966 The Glenrose School Hospital in Edmonton was established to provide treatment, education, and rehabilitation of physically handicapped and emotionally disturbed children.

A Royal Commission reviewed the increasing problems of juvenile delinquency.

The *Child Welfare Act* was further amended to define a child in need of protection.

The Division of Mental Health received \$10,000 to initiate research in Alberta Guidance Clinics.

The *Medical Care Act* established the legislative foundation for Canada's Medicare system.

The *Preventive Social Services Act* directed major funding for preventive programs in municipalities.

1967 The Department of Public Health became the Department of Health.

The Blair Report was released. This landmark report was very influential in directing the course of mental health services in Alberta.

The Westfield Diagnostic and Treatment Centre was opened in Edmonton.

1969 A unit for emotionally disturbed children opened at the Children's Hospital in Calgary.

1970 The reports, *One Million Children* and *Law and Mental Disorder*, were released, published under the aegis of the CMHA and several other voluntary agencies across Canada.

An amendment to the *Compulsory School Attendance Act* lowered the maximum school entry age from seven to six.

The Alberta Alcohol and Drug Abuse Commission was established to provide addiction information, prevention, and treatment.

A unit was opened at Westfield for the treatment of juvenile delinquents.

Alberta's first Head Start Program opened at Norwood in north central Edmonton.

A Guidance Clinic opened in Peace River.

1971 The Calgary Child Abuse Advisory Committee was formed to study the causes and treatment of emotional disorders in young children. They focused on the "battered child."

The Board of Visitors' Annual Report made significant recommendations for children's mental health services.

1972 The *Sexual Sterilization Act* of Alberta was repealed.

The guidance clinics were renamed Alberta Mental Health Clinics and their role expanded to provide services for all age groups.

The new *Mental Health Act* protected patients' rights and opened the way for major reform with emphasis on community services and employment of professionals.

A mental health clinic opened in Red Deer.

Linden House in Red Deer closed

Health funding was provided to develop Woods Christian Home in Calgary as a treatment centre.

1973 The *Child Welfare Act* was revised, making reporting of child abuse mandatory and establishing a Child Protection Registry.

The national *Law and Mental Disorders Report* was published, with recommendations consistent with those of *More for the Mind* and the Blair Report.

1974 The Child Protection Registry was implemented to keep a record of cases reported to social services or the police.

The *Age of Majority Act* was introduced making youth of legal age at 18.

1975 The Department of Health and Social Development split into two departments: the Department of Hospitals and Medical Care and the Department of Social Services and Community Care.

1976 A province-wide information system to standardize clinical records was implemented. It was the first in Canada.

1977 The Apollo Unit at Alberta Hospital Ponoka closed.

The Northern Regional Treatment Centre opened in Peace River.

1978 A provincial suicidologist was appointed as a component of suicide prevention and intervention services.

School counselling was growing, with 639 counsellors in Alberta schools.

1979 The McKinsey Report on children's mental health services in Edmonton and northern Alberta was released with an action plan for the 1980s.

Kennedy Hall at Alberta Hospital Edmonton closed.

1980 Child and Adolescent Services Edmonton (CASE) was established.

1981 A protracted recession devastated Alberta's economy, seriously taxing the province's ability to support social programs.

Treatment services for neglected and abused children were initiated in Calgary, as were services for runaway and homeless youth.

1982 The *Young Offenders Act* replaced the *Juvenile Delinquents Act*.

The *Canadian Charter of Rights and Freedoms, Constitution Act* was introduced with implications for all areas of health services.

1983 The *Child Welfare Act* was amended to include criteria for compulsory care.

The Southern Alberta Study of Psychiatric Needs and Provisions was completed as well as many other studies, briefs and letters appealing for service improvements.

1984 A 12-bed unit for adolescents was opened at the Royal Alexandra Hospital

1985 The *Child Welfare Act* was further amended to clarify the criteria for compulsory care.

CASE House opened to treat adolescents with severe psychiatric problems.

1986 A Forensic Unit for the assessment and treatment of young offenders opened at Alberta Hospital Edmonton.

Infant Psychiatry by Klaus Minde was the first book devoted to infant psychiatry issues. It created interest in the impact of children's early years.

Canada co-presented *The United Nation's Convention on the Rights of the Child*.

1990 The new *Mental Health Act* was proclaimed.

1991 CASA began service delivery under a community board.

1992 The Alberta Government approved Future Directions for Mental Health Services in Alberta as the mental health policy for the province.

1994 The National Longitudinal Survey of Children and Youth was launched providing a wealth of information on Canadian children.

Massive health care restructuring began in efforts to eliminate the provincial deficit.

1996 The Provincial Mental Health Board was established to oversee programs and to prepare for divestment of services.

Klein's fiscal revolution ended and increased funding was allocated for services for children.

1998 The Alberta Children's Initiative: An Agenda for Joint Action was released as Alberta's business plan for children and youth.

The New Children's Mental Health Initiative included mental health care as one of its priorities. This was demonstrated through the release of the Children's Mental Health Initiative whose purpose was to establish a comprehensive system of care for children.

Alberta worked with other western provinces on the Western Canada Waiting List Project, which included children's mental health.

1999 Dr. Steinhauer conducted a review of children's mental health services in Edmonton and Calgary.

Premier Ralph Klein established a Task Force on Children at Risk.

The Alberta Student Health Initiative was initiated to support the health and learning needs of school students.

2000 The Canadian government reached a historic agreement with the provinces to improve and expand services for children under age six.

2001 The AMHB released a provincial framework for children's mental health.

2002 The Mazankowski Report, A Framework for Reform was released, setting a deadline for the transfer of mental health services to the regions.

Regional central intake systems were introduced in Calgary and Edmonton to facilitate access to children's mental health services.

The ACYI Aboriginal Youth Suicide Prevention Initiative was launched.

2003 Mental Health Services were transferred from the AMHB to the health regions on March 31.

Alberta's Promise was launched as a provincial program to support children.

2004 The *Child Welfare Act*, renamed the *Child, Youth and Family Enhancement Act*, was proclaimed with extensive changes to enhance services for children, youth and their families.

2004 The *Family Support for Children with Disabilities Act* was proclaimed to address the unique needs of children with disabilities.

The Provincial Mental Health Plan for Alberta was released providing direction for all areas of mental health services. The health regions were expected to complete a regional service delivery plan within the parameters of the provincial plan by the end of the 2005 fiscal year.

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The Muttart Fellowships

Biography



Germaine M. Dechant

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Germaine M. Dechant is a registered nurse with a master's degree in health services administration from the University of Alberta. She is currently the executive director of Child and Adolescent Services Association (CASA), which provides mental health services for infants, children, adolescents, and their families.

Germaine brings to her work a rich background built on nearly 40 years of healthcare experience, including bed-side nursing, consulting, and senior administration in large hospital and community organizations.

She has previously published in the areas of resource management and healthcare ethics. She is the proud recipient of the 2004 Alberta Association of registered Nurses Award for Excellence in Administration. Germaine considers health to be a great treasure that must be protected and nurtured. She is passionate about staff and patient education and empowerment.

