CHANGES IN CHILD CARE AND THEIR IMPLICATIONS*

by MARTHA K. SELIG

Federation of Jewish Philanthropies, New York, N. Y.

ONE of the most sensitive indices of our times is the character of our social services. During the past two decades we have experienced sweeping social and economic changes; we have witnessed expansion of government responsibility in new and broadened areas of social welfare; we have seen the development of professional philosophies and techniques that have modified social work as a profession and casework as a skill. Philanthropy has evolved from an eleemosynary program concerned with the famous "one-third of the nation"—the underprivileged upon whom government and private philanthropy were forced to focus major attention to assure their very survival—to a mental hygiene oriented program available to a broader segment of the population and utilizing the knowledge and professional skills accumulated during the years. In general, we are directing our energies toward a broader welfare state and a financial partnership with government, though we are not always aware of the implications of these developments for sectarian operations in this changing philanthropic milieu.

It is not surprising, therefore, that in reflecting these changes, private philanthropy has undergone dramatic modifications with respect to the nature and scope of programs, the clientele served and the responsibility for financing services. All functional fields—child care, family service, camps, community centers, hospitals and aged—have mirrored these changes in varying degrees, but the impact has been dramatically demonstrated in the child care field with respect to the number and nature of children seeking help, the resources required to serve them, and the cost of these services.[1]

During this period there has been a sharp reduction in the number of children in placement, reflecting both fewer applications and the refinement of professional skills. Through carefully screened intake there were fewer chil-

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[1] The varied influences of the past 15 years upon Jewish child care services in New York City have been detailed in a report "To Serve the Children Best." This study, conducted under the auspices of the Federation of Jewish Philanthropies of New York in cooperation with the non-Federation Jewish child care agencies and the New York Jewish Child Care Council, reviewed the needs of Jewish children, related the findings to existing facilities, projected these needs for the next decade, and proposed a blueprint for the function, structure and organization of the twelve participating Jewish child care agencies.

dren admitted and intensive under-care service reduced the length of time they remained in placement. The number of orphans and semi-orphans has declined and parents have become increasingly involved in the life of the child in placement. Disturbed children represent an increasing percentage of the children in placement. Our diagnostic and treatment skills, together with the addition of ancillary services of all kinds, particularly psychiatry, made it possible to deal with highly disturbed children whom in the past we could not have helped, save as we would have referred them to mental institutions or reformatories. Services were opened to a broader segment of the community. While the number of children in placement declined, applications for child guidance, day care, family counseling and homemaker service increased. Expenditures have risen sharply due to the general rise in price levels, but far more to the shift from less expensive to more costly types of care and enrichment of all services.[2]

Neither professional workers nor communities have remained indifferent to these changes and there have been many modifications in concepts, methodology and in the types of facilities. Communities have responded in a number of ways: One was to consolidate child placement agencies with a perhaps too rapid abandonment of group care facilities. Another was to merge family and children's agencies. Some communities transferred part of the child placement program to non-sectarian auspices, and others sought increased public subsidy to meet mounting costs. Many increased their emphasis on mental health and opened their social welfare resources to the wider community.

There were major changes in types of placement facilities as well. Large congregate institutions in the Jewish child care field have almost disappeared. Though there had long been question about the desirability of mass care, it was the declining population that catapulted the closing of many of these institutions. The remaining institutional services have changed in character and program from "orphanages" to "schools" and latterly to "residential treatment centers." In place of the large institutions, small group facilities are developing for children of different ages and degrees of disturbance. Foster homes have been expanded to include group foster homes and those for the emotionally disturbed child. A broader concept of adoption has given permanent homes to more children formerly regarded as unadoptable. Communities have become increasingly aware of the needs of the disturbed child and are planning special services for them. Ancillary services, particularly psychiatry, are being added in ever-increasing quantities.

Child care workers are almost at home plate in the long debate as to whether group care or foster home care is more desirable and it is now an accepted principle that a total child care service entails a variety of services. Of particular significance is the increasing awareness of the value of preventive services and the expansion of such services as child guidance, parent-child counseling, homemaker services, group day care and more recently foster family day care, to prevent family disintegration, the most frequent cause of placement. This stemmed from the recognition that the aim of child care must be directed toward the preservation of the family wherever this is possible; that at best placement should be regarded as a temporary phase in the life of the child.

These achievements, both from a professional and a community organization point of view (and the goal of both should be identical though we unfortunately have placed these interests on occasion at opposite ends of the spectrum), are all to the good; but I venture to say that, by and large, alterations in organization and function were made in response to the exigencies of the situation, the pressures of immediate emergencies and the particular direction the professional pendulum may have been swinging at the moment. They were to a considerable extent implemented within the established framework of structure and organization—sometimes without adequate study as to whether this framework, which may have been sound twenty years ago in the light of the then existing needs, was applicable today.

I venture to say that the tendency to maintain the existing framework, despite modifications in the fundamental character of the service, has resulted in limiting our capacity for a full breakthrough into new ground for the development of new concepts and appropriate structures to meet burgeoning needs. Perhaps all too frequently we consume our energies in rationalizing the base for continuing and expanding, albeit with some alterations, services and techniques which served well in the past, but in the light of present day experience should be retired with full honors for past services rendered.

When modifications have been made, we have seen how they often indiscriminately became patterns for others to follow. They were interpreted as "trends" which were translated into other communities and were regarded with even greater authority and validity as they were multiplied. In a field such as ours, where it is difficult to point with scientific precision to one road or another, it is easy to fall prey to particular approaches or identifications particularly in a transitional phase of a service.

It may be for such reasons that there has not yet been achieved the necessary integration or the most effective translation of our professional convictions, even as they are understood today. There remains a wide gap between our understanding of needs of children and their families, and the availability of the appropriate services and facilities to meet these needs.

It is, therefore, all the more incumbent upon the lay and professional leadership in every community, regardless of size, rigorously to explore the new developments in child care before they are permitted to crystallize into established patterns, for we are not at all certain that the current patterns and the present facilities are the only possible solutions, nor indeed the most desirable ones. At the same time we would wish to examine the implications of these changes and the obligations they impose.

While each community may have specific problems, I believe that there are three generic questions which have applicability to all, large and small, and which should challenge our concern. These are: (1) services to the disturbed child in terms of nature and variety of facilities, administrative auspices and relationship to psychiatry; (2) the need for a broadened view of child care and its relationship to family service; and (3) the increased cost of care and the obligations it imposes.

[2] The factual data gathered in the New York Federation study confirmed the above trends: the number of Jewish children in placement declined from over 4,000 to 1,677, or a two-thirds reduction, while the Jewish child population in New York City under 21 dropped by only 11 per cent; at least 85 per cent of the children showed some personality abnormality; 12 per cent were half orphans and 2 per cent were full orphans; 93 per cent of the families had some form of physical or mental illness; the vast majority of the families were in the lower economic bracket; adoption services expanded to include older and exceptional children; expenditures doubled and per capita cost increased six-fold.

In discussing these points, may I add that I am expressing my personal professional point of view and am not speaking as an official representative of the New York Federation, with which I am associated, or of the agencies in this functional field affiliated with Federation. These points of view reflect a review of the literature, meetings involving cross-country representation, discussions with a number of professionals and some personal inferences. May I say, too, that in none of these aspects is there a claim to being first. Many colleagues in our field can rightly say that they too have long been thinking along these lines. Nevertheless, I believe that there is value in focusing these problems as a base for further consideration.

Varied Services for the Disturbed Child

Let us deal first with the question of the disturbed child, a problem which appears to be uppermost in the plans of most communities.

With the development of broad social welfare programs designed to keep families intact, and with the increase in family service and child guidance facilities, many "normal" children who would formerly have been placed now remain at home. The population in placement has become, by and large, a residual and selected group representing the more disturbed children and families in the community.

In the past, there was a tendency—and perhaps there still remains a strong residue of this—to think of services to the more disturbed child, particularly the acting out and aggressive child, in terms of placement away from home and in institutional facilities only. With more acute differential diagnostic appraisal, pointing to a broad continuum in the category of disturbed children, there developed an ever-increasing awareness of the need to provide a wide variety of services for this group, geared to their special needs, both in placement and at home. Many children who formerly had been placed are now treated successfully in family service and child guidance agencies; the value of day treatment centers, which provide an all-day school and treatment milieu without complete separation, is being tested; the effectiveness of foster homes for a number of these children has already been validated. Small "residential treatment centers" are serving some of these children.

We must, however, continue to scrutinize our disturbed children carefully so that we do not view them indiscriminately and feel that we have done our duty by them simply by providing more psychiatric care. For many of these children, because of the nature of their emotional problems, require special services, different from and over and above those generally associated with the traditional child care agencies.

A community plan for services to the more disturbed child, then, must include both provision for "home care" and "foster care." The disturbed child who can remain at home could be helped through child guidance clinics, family counselling facilities, and day treatment centers. When placement is indicated, we might think of at least four broad categories: (1) special foster homes, including the group foster home; (2) the educationally oriented group care facilities with a therapeutic milieu for delinquent and/or aggressive disturbed children who do not require a closed environment; (3) the psychiatrically oriented small group facilities, utilizing education and casework as ancillary services for the more highly disturbed of the group; and (4) the hospital ward

for those requiring a closed environment.[3]

The adoption of this concept of variegated services for the disturbed child by the smaller communities, which cannot establish expensive facilities, will permit more of the disturbed children to be cared for *within the local community*. For all too frequently, with the belief that the disturbed child can benefit only from the most highly specialized services, now known as the "residential treatment centers," many communities have discounted their own resources. This has resulted in communities abrogating their obligations to this group, often turning the responsibility over to public agencies, or referring these children to "regional" specialized organizations.

Use of Regional Placement Facilities

In this connection, it would be desirable to reconsider the present use of regional placement facilities for these children.

The placement of a child in a facility hundreds and sometimes thousands of miles away from home does not facilitate adequate or integrated work with the family. Since this is a vital part of child care, separation at such distances should be undertaken only as a last resort. Obviously there will be some children in the smaller communities for whom a special service may be required and is not locally available. If regional agencies are necessary, then it would seem desirable to establish several of them throughout the country, each serving communities within a reasonable commuting distance. Thus, the special service would be more readily available and reasonable contact maintained with the family.

I would see even these regional facilities utilized only for those children for whom alternative possibilities within their own communities have been considered and excluded.[4]

Size of Units

We must also at this time give consideration to the question as to whether the disturbed child can be served most effectively in large settings of 150–200 children. This question requires serious exploration to determine whether "treatment" can go on beneficially at all "en masse." We have come to accept the concept that function and structure should be inter-related. Is it not, therefore, desirable that, with a change in function from an institution serving the "orphan child" to one serving the "highly disturbed child," the structure be modified to insure the most effective operation? I believe we will find that smaller units will be more effective in serving the disturbed group. In them children can more easily be seen as individuals and the effects of regimentation in the larger institution, despite the best of intentions, can be avoided. Furthermore, smaller units assure, to a greater degree, flexible use of program and resources to meet the changing needs of children under care.[5]

The "Residential Treatment Center"

Child care workers will also want to be more discriminating in the use of the

[3] The New York Federation study projected 3 additional services for the "less disturbed" children requiring placement—regular foster home, a facility for the less disturbed child who cannot live in a foster home, a group facility for the somewhat retarded child. These services are described in detail in the full report.

[4] The New York Federation study recommended that the agency now serving a wide geographical area limit its intake to a more restricted region.

[5] In the New York Federation study we recommended that the cottage plan units now serving these children give serious consideration to "reorganizing and relocating these facilities to bring us closer to our goal of smaller units located within the mainstream of community activity."

term "residential treatment center" which is appearing more and more in the literature of the field. On the one hand, the term applies to institutions serving very large groups of children with a wide variety of personality problems, and on the other, to small units serving 20–25 seriously disturbed children at the other end of the curve whose need is predominantly psychiatrically-oriented. The differences between these services are significant and warrant a differential nomenclature, so that the services would not be confused in the minds of the public, or for that matter, in the minds of the professionals.

If, for the moment, the term "residential treatment center" is restricted to the highly specialized, psychiatrically-oriented small units, I would then like to urge a word of caution with respect to the too rapid duplication of such units. There appears to be no agreement at the moment as to just what a residential treatment center is. The existing ones are new and there have been insufficient experiences with them to warrant any conclusive findings. One does not yet know, for instance, the best size for such units, the extent to which mingling of different types of disturbed children is feasible, the full potentialities of special foster homes for these children, or the value of an enriched program in some of the existing facilities in solving problems for at least a part of this group. We are only now beginning to experiment with the day-treatment center for the disturbed group. Despite all of these uncertainties, many communities are planning to establish "residential treatment centers" as a panacea for their problem.

Coordination among services even now available for the highly disturbed child has been insufficient to provide differential criteria for intake, program and structure. Further experimentation and cooperative evaluation should be undertaken before large capital investments are made for services which may be swiftly superseded.[6] The field urgently needs a continuing and intimate exchange of experience of the different types of services for this group in order to find guideposts for further developments.

Need for Coordination of Services

The nature of children's difficulties is such as to make it desirable to seek a structure that would facilitate the selection of the most appropriate service for the child and the flexible utilization of the various facilities as they may be required in a smooth and unhampered matrix of services. As child care services are becoming increasingly diversified or differentiated to correlate more closely with a highly developed diagnostic differentiation of needs of children, it becomes all the more important to strive for a central intake facility.

Awareness by each agency of the facilities of the other does not necessarily guarantee the most effective utilization of these facilities. One of our executives made a very interesting observation along these lines. She said, "I am not so certain that we are free of prejudice in favor of our own agency and whether this prejudice does not blind us to the consideration of perhaps a different placement facility. I wonder whether we do not interpret the term 'intake' as 'eligibility for *our* services.' This applies to that group of children who qualify for care from the agency to which the application is being made but could be more appropriately served in another agency."

[6] In our study we deliberately did not recommend expansion of the residential treatment centers to the extent that numerical need indicated. Rather, we proposed several possible services, such as a day treatment unit, special foster homes, more child guidance, etc.

Implied in all of this is the necessity for every community to evaluate critically existing facilities and programs, to experiment with modifications of existing services, and create new approaches. And above all to coordinate all services for the disturbed child in order to serve his needs best.

In the concern for the highly disturbed child and the lure of the "treatment" centers, I hope we shall avoid the pitfall of building in this field, as we have done in the past in other fields, a hierarchy of values with resultant insufficient attention to our obligation to provide basic casework services which are the *sine qua non* of a good child care agency.

Roles for Psychiatry and Casework

The increasing number of highly disturbed children has brought in its train two additional problems which require clarification: The use of psychiatrists in a child care agency, and the auspices of psychiatrically-oriented services.

The experience of child care agencies has demonstrated that a substantial portion of children and their families can utilize successfully the services which casework can offer. In some of these instances, the agencies sought help in the form of consultation with the psychiatrist, with the objective of gaining from him the clarification necessary in carrying out the casework goal.[7] Casework, however, remained the primary service, and psychiatry the ancillary skill with no direct treatment of the client involved.

The sharpening of our diagnostic skills, however, helped to identify a group of children whose difficulties were of such a nature as to require direct psychiatric treatment to supplement the casework milieu. Agencies have been assuming this responsibility in an effort to provide a total service to the client. Treatment is arranged through panel, staff, or private psychiatrists. Psychiatry is described as "closely related" or an "integral part" of the child care agency, although there is, as yet, no clarification as to whether this responsibility is financial, supervisory, and/or administrative.

An examination of this trend raises serious question as to whether direct psychiatric treatment, which is distinct from casework, should be the function of a child care agency. When an agency assumes responsibility for providing psychiatric care under its own aegis, to that extent it is operating as a "psychiatric clinic," which is regarded as a medical responsibility. A monograph, entitled "The Relationship of the Consultant Psychiatrist to the Family Agency," describes with unusual clarity the difference between social work and psychiatry, and the obligation to keep these processes distinct. It states:

> ". . . . the fact that a family service agency has a consultant psychiatrist on its staff does not justify any expectation on the part of the community that the agency will accept added *medical responsibility*."[8] This applies equally to child care agencies.

It would therefore appear to me desirable that a psychiatric service of any nature be affiliated with a medical setting having an appropriate psychiatric service. Association of a psychiatric program with a hospital is particularly important because of the manner in which psychiatry has developed and the grow-

[7] Agencies use the consultant psychiatrist in a number of ways. If time permitted, one could raise many questions regarding the direction of this trend, particularly when the psychiatrist is asked for a diagnosis without seeing the client, or where the consultant psychiatrist directed the casework plan, or what often became a psychiatric plan carried out by the caseworker.

[8] Prepared by the Committee on Psychiatry and Social Work of the Group for the Advancement of Psychiatry, 1956. Italics in quotation are mine.

ing importance of the medical and chemotherapeutic aspects of the profession. An adequate psychiatric service of any nature should have at its disposal a total range of services from intensive individual psychotherapy to medical intervention, to be drawn upon as needed. Identification of psychiatric services with medical facilities provides this opportunity in a properly structured setting, where members of the staff can be alert to the new trends in the discipline.

In the past, casework agencies may have been compelled to offer direct psychiatric treatment because of lack of other appropriate facilities in the community. There were few out-patient departments in psychiatric hospitals and those that were operating were not prepared for a joint relationship. Unfortunately, the medical profession and hospital management had, until recently, neglected this important aspect of the medical discipline and responsibility. When relationships were sought with hospitals where this discipline belonged, experiences were disappointing because the psychiatric ties were artificial graftings and not indigenous to the hospital function. Indeed, many of the casework agencies may not have been ready for an association with hospitals. However, as many of the hospitals are making rapid strides in developing psychiatric programs and in demonstrating broad social-minded attitudes, and as casework has developed its own inner security so that it is prepared to say, "This is for you, and this is for me," it may now be the appropriate time to move toward a closer relationship between the casework agency requiring the psychiatric service and the hospital.

While this relationship is being explored and so long as direct psychiatric treatment remains within the orbit of the casework agency, it would seem to me that the agency would wish to be as scrupulous with respect to this service, vis-a-vis supervision and control, as it is with its casework service. It should, therefore, not be content with just "handing over a case to a psychiatrist," regardless of the psychiatrist's qualifications, but would wish to establish a structure which would identify the psychiatric program as apart from the casework program, with provision for proper orientation and adequate supervision at its own level of competency.

What may be necessary to differentiate these distinct services and provide the necessary supervision is the establishment of a psychiatric department of the agency, which, while remaining related for the time being to the casework agency, would be supervised and directed by a psychiatrist and identified with a psychiatric hospital or university medical school for the reasons given earlier. Thus, each of the disciplines would operate in an appropriate milieu while adequate means of communication would insure integration in the best interests of the client.

Auspices of Psychiatric Services

There is an additional aspect of this problem—namely the auspices of those child care services that are primarily psychiatrically oriented.

Out of the success or failure of programs for children under care, caseworkers are beginning to recognize that for a segment of children in placement the casework milieu may no longer be adequate and special psychiatrically-oriented units have developed, often known as residential treatment centers, particularly for the highly disturbed child. For historic reasons some of these psychiatrically-oriented units have evolved from casework agencies and have remained under casework auspices as one of several facilities—as indeed have child guidance clinics—without changing

basically their identification. I believe that this only helps to confuse the picture, since auspices, direction, and supervision should reflect the nature of the program.

For when the clientele of the casework agency—whether it is a placement or an extra-mural service—changes in character to the degree that the basic service required is a psychiatric one, as distinguished from casework, with psychiatry as primary and casework as the ancillary service, then we are dealing with a *psychiatric agency* and we would expect the total administration, direction, and supervision to change in relation to the new function and responsibility, and organic ties sought within the appropriate discipline—in this instance, psychiatry.[9]

If the service of a psychiatric agency were administered and supervised by psychiatric leadership, two values would obtain: it is reasonable to assume that internal operations would be clearer, and, on a communal basis, a more clearly defined difference would be established between casework agencies under casework leadership and psychiatric services under psychiatric leadership. By not identifying the services properly, the casework function frequently becomes synonymous with the psychiatric function. Casework runs the risk of losing its distinguishing characteristics, and it is this that we should try to avoid.

While acknowledging the validity of a total psychiatric unit under the direction of psychiatrists, many agency executives are fearful that supervision and direction of the psychiatric program of a child care agency by a psychiatrist as part of a hospital setting would result in "psychiatric and hospital domination" of the entire agency. May I suggest that this is an unnecessary fear, for a clear differentiation of the appropriate function of the two disciplines can only enhance both and we should be eager to make available to our clients the best possible services. I believe that the suggested relationship is desirable and possible and I would hope that this could be rapidly accomplished; for only as hospitals assume their full responsibility for the psychiatric problems in children as well as in adults, will the casework profession be assured of the most effective utilization of all techniques available and will casework be freed for the further development of its own services and skills.

Some have expressed the point of view that it is well to talk of associating a psychiatric program with a hospital in the larger communities where such facilities are available, but that this is unrealistic for the smaller communities. While many of the hospitals throughout the country do not now have psychiatric services, more of them are beginning to develop such services as the need to tie medicine to psychiatry and psychiatry to medicine becomes more universally recognized. It may well be the obligation of the casework agencies to encourage the medical field in this responsibility by a willingness to explore such relationship.

If our current design faces clearly that there is a difference between psychiatry and casework, then there is some need for a new approach for the implementation of our services. The addition of psychiatric time within a framework that clearly defines the role of psychiatry within such an operation would in the long run be more effective and economical than the purchase of time on an *ad hoc* basis, related to the increasing inci-

[9] In the interest of exploring this possibility, the New York Federation study recommended that new psychiatrically-oriented facilities be organically tied to a hospital. One such unit will be in operation shortly.

dence of personality problems. The recognition of the clear difference between psychiatry and casework and the delegation of appropriate responsibilities to each will inevitably strengthen the role of the caseworker, define that of the psychiatrist and lead to the structural relationship that combines the best of both for the ultimate value of the client.

I believe that we have reached the stage of development where we can now differentiate these roles with sufficient clarity to put this difference into practice and make the appropriate modification. This will reduce the danger of obscuring the differences and creating an unsound hierarchy which would defeat the ultimate concept of the "team." The two disciplines have recently begun to work together. The clarification which is required is not alone within the casework field but must be achieved by psychiatry and the hospital as well, so that each will be prepared for the professional acceptance of the other.

Child Care and Family Service

I should like now to deal briefly with the need for a broadened view of child care and the implications for relationships between the child care and the family service agencies.

While we accept the fact that placement may be a positive step, and often a very necessary one in the eventual rehabilitation of children and families, we have also come to recognize that separation should occur only as a last resort and when we are certain that the problems cannot be dealt with without this drastic step. This involves a thorough understanding of the family and its potentialities. Child care workers must, therefore, inevitably become involved with families and family service workers involved with children.

The whole problem of placement has become more complicated not alone because of the nature of the families and children coming under care, but because our new knowledge and skills have increased the responsibilities of agencies for the social and psychological rehabilitation of children and their families.

The more we examine the children and families who come to the placement agencies, the more we recognize that child care can no longer be considered in isolation, but must be viewed as a "family care" problem. The entire concept of child care should be broadened from the narrow view of placement with which it has historically been associated and should take into account preventive services—homemaker, child guidance, parent-child counseling services, etc.—designed to prevent family disintegration. As this will further occur, the lines of demarcation between the responsibilities of a child care and family service agency will grow more and more indistinguishable. For even now it is becoming more difficult to distinguish between parent-child counseling and marital counseling where there are children involved, and between such counseling and child guidance, except in the orthodox use of the term as a "clinic service."

The separation of function necessitating a referral to another agency adds to an already complicated problem in the client and sets up artificial differentiations because of structure which have no counterpart in the life of the client. With the recognition that a total service is necessary to achieve greater comfort for the client as well as the goal of family rehabilitation, some of the placement agencies are even now thinking of setting up as part of their structure such ancillary services as counseling prior to placement, "child-centered homemaker service," and after-care counseling. I would have serious question about this development since the proliferation of

duplicating services would inevitably lead to fragmentation of the total community services rather than to their integration.

Our task, both professionally and from a community organization point of view, is to create a structure which would coordinate the specific functions not only to make the client's journey easier, but for professional growth and development. Too frequently in the past there was a tendency to live in a kind of isolated atmosphere where the findings in family service were by and large offered to, used and discussed by family workers, while the findings in child care similarly travelled the "functional line." Now, with the development of common goals, it becomes manifestly clear that there needs to be a greater degree of cross-fertilization without necessarily obscuring the differences. It would be turning the clock back if we were to deny and to lose the value of the specific skills that grew out of the period of specialization. But caseworkers now have reached that stage of maturity where it is not necessary to choose between the generic and the specific but they can apply both expertly to the needs of the family. In practice what this means is that the lines of communication among the several services in the field of casework must be thrown wide open so that whenever the findings in one field have bearing on another, they will be readily available and what is more important will be used.

Experience has indicated that the closer the structure the easier it is to accomplish the cross-fertilization. The experience of merged child care and family agencies has demonstrated that these services can work side by side, as a single profession and service entity, with such internal subdivisions as may be indicated. Multi-service agencies prevent the mushrooming of duplicating services and provide a unique opportunity for exchange of experiences and for mutual influence in the interest of the client.

While professional cooperation and communication can be attained by good will, and while any single structure in and of itself does not necessarily insure good service, a proper structure plus good will may alleviate a great many of the difficulties, make it possible to render a more effective child and family service and prevent further fragmentation of services. It is with this point of view in mind that the child care agencies should move toward closer integration and, if possible, eventual merger with the family service agencies.[10]

The Increased Cost of Care

Let us now deal with the third major consideration, the increased cost of child care.

Child care agencies throughout the country have experienced a sharp rise in per capita cost largely because of the nature of the services and the enriched programs. Expenditures for service to children designed to build wholesome relationships may in the end be an economic investment for the community; the emotional advantages, of course, can never be calculated in monetary terms. But we must be sure that we are spending this money wisely.

There are many facets to this problem, but I would like to restrict my comments briefly to three: 1) the obligation to examine basic processes and procedures including flexible use of available facilities to assure maximum efficiency and productivity, 2) the most effective

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[10] The New York Federation study recommended that child care agencies "purchase" the necessary services from the family service agencies pending closer integration rather than establish these services as part of their own organization.

use of professional time and skill, and 3) the effect of other sources of income.

We need to review critically such administrative procedures as scheduling interviews, length of interviews, recording, time spent in conferences and seminars, etc., to achieve more economical methods of operation.[11]

We should review critically the criteria for using ancillary resources such as psychological examinations, psychiatric consultation, etc., which may be desirable in certain instances, but not necessarily effective for others, so that these do not become routine and costly procedures. Greater flexibility in the selection of placement facilities will reserve the more expensive types of service only for those for whom there is clearly no other alternative solution. The need for more foster homes for an increasing number of children who are now referred to more costly institutional care, may require modifications in the traditional home-finding procedures, more flexible criteria for selecting foster mothers and a modified method of payment to provide reimbursement for service in addition to expenses. There is further implied the need to experiment constantly with new ways of serving the children, for such endeavors may be less costly, and may open up new vistas of professional service as well.

The critical personnel shortage which often impedes the implementation of programs has affected all the agencies throughout the country. While additional personnel is being recruited, perhaps this is a good opportunity to evaluate the function and responsibility of the highly skilled professional worker, so as to reserve for him those aspects of the total job which require professional skill and training, and delegate some of the other responsibilities to case aides and even volunteers. This has been accomplished in the medical field via medical aides, attendants, practical nurses, who assume many of the burdens formerly carried by the registered nurse now freed to administer the highly skilled aspects of patient care. Similarly, in the teaching profession today experiments are going forward quite felicitously in the use of teacher aides to alleviate the critical teacher shortage. The increased utilization of such persons for ancillary jobs which now drain the skilled workers' time would make it possible for the trained worker to assume responsibility for casework with more children and thus reduce the per unit cost.

The problem is more complicated, of course, in the casework field where so much depends on the casework skills required in the person-to-person relationship, but implementation of this suggestion would carry with it the concomitant advantage of recruiting additional personnel to the field and of eliciting more intimate interest of lay people in the operation of the casework agencies. A positive approach to this immediate crisis could result in a constructive solution to an otherwise critical situation.

In the light of increasing financial burdens, it is quite natural that agencies are giving a good deal of thought to income from other than from philanthropic sources. One possibility, of course, is the extension of child care services to fee paying clientele in the wider community. Here, too, there are many aspects which require careful consideration. If child care agencies are to take into account income from fees in budget-making, does this not imply

[11] The family service agencies in New York City in an effort to increase the number of in-person interviews—though the figures compared favorably with the social work community as a whole—modified administrative procedures with resultant substantial increase in the number of in-person interviews per worker without any loss in standards.

a decision concerning percentage of free, partial paying and full paying service rendered? If no quotas are set and a "first come first served" policy is established then the income becomes a very unreliable one.

The changed character of our social services plus the introduction of the fee has made for a new step forward in the evolution of the philanthropic idea but again we must consider the implications. If the trend is to extend service to the upper economic group at the expense of the poor, it is not philanthropy. If the trend is to develop a communal service, then one cannot select in favor of the paying group. Service could be extended to this group, if added facilities were available which did not reduce the level of operations to the nonpaying group, in which instance a "profit" might possibly ensue. Expanded service to the upper economic group with resultant reduction of service to the non-paying or partially paying groups is neither philanthropy nor general communal service, but perhaps a necessary device to balance the budget. While this is important and should not be underestimated, child care agencies should know the direction in which they are moving, lest in the desire to increase income they neglect their basic philanthropic responsibility.

Public contributions are representing an increasing percentage of the total cost of care.[12] I venture to say that this should be encouraged and that the partnership between public and private agencies maintained and enhanced, for only with increased public subsidy can the philanthropic organizations hope to continue to maintain the extent and level of service required to meet the need of the children and their families. This, however, need not influence the nature of the service to children, which, I believe, should continue under sectarian auspices since this only reflects the expressed wish of the Jewish community.

It is incumbent upon Jewish agencies, particularly the placement agencies acting in *loco parentis,* to provide the essential cultural and religious identifications. This is consonant with a democratic society which emphasizes the validity of a cultural pluralism.

Our Basic Responsibilities

These then are some areas of concern with which we would wish to deal as we continue to develop child care services.

The experiences of the past and the guides to the future lead us to anticipate several strong probabilities.

1. As extra-mural services expand, as a healthy economic climate continues, and as benefits of the welfare state extend even further, the census in placement agencies will continue to decline.[13]

2. In the remaining population there will be a higher proportion of children with serious emotional disturbances.

3. The population will require more of the specialized placement services and less of the traditional forms of both care and foster home facilities.

4. There would be need for a number of different services to meet a wide variety of needs.

5. The cost of service would remain substantially the same despite a decrease in the number of children, largely because of the intensification of the services.

A courageous yet cautious approach must influence our decision to eliminate, retain or expand services. Projections at best are estimates based on obtainable facts and figures, and while they are in-

[12] In New York City, despite continuous increase in public subsidy, the voluntary philanthropic contribution is about 54 per cent.

[13] In New York City we estimated a decline of about a third in the next decade.

valuable in pointing a direction they are subject to too many intangibles and unforeseen contingencies to warrant translating them rigidly. This is all the more important in social planning where human beings play a vital and unpredictable role. Only time can tell what further effects diagnostic techniques, new methods of working with clients, or development of chemo-therapy for mental illness will have upon the needs for our total child care services. An altered picture in any of these areas might substantially influence the need. Above all we should be influenced by the conviction that while we would wish to be guided by experience, future plans should not be circumscribed inflexibly by past patterns.

A pattern of services developed for any community should derive from an understanding of the child and his family. If in the light of our newer understanding of people in trouble, the way to serve them best implies changes, sometimes sweeping, it makes it none the less our responsibility to adapt our tools and services to the needs of families rather than to ask the families to adapt to our traditional tools and services.

It has become rather trite to say that the development of child care is at the crossroads, yet we are in a position which offers us a most creative opportunity. Caseworkers have made rapid strides toward attaining maturity and toward finding a place in the community in relation to the other professions. An obligation of a mature profession is constantly to examine and re-examine the nature and quality of services rendered rather than to be concerned with status and chances of survival. The crucial questions are what are the services our clients need at the moment, and how can we bring all our capacities to bear upon the development of these services.

Either we join efforts with vested interests to preserve our old face at any cost, or we take leadership in determining what is outmoded, what services are required and what is the best structure in which to offer these services. This is our challenge.