dents more autonomy, since he is allowed to participate in setting house rules.

This type of arrangement is not for the elderly who are very senile or ill and need a more protective setting. It is actually sheltered housing but in small scattered units. Because we rent apartments rather than building apartments, we can easily close an apartment, move to another neighborhood or open more apartments. This program proves very suitable in small communities or large cities alike.

This program has community acceptance. We have had no difficulty in renting apartments for this purpose. It is non-threatening to the adult children since they feel less guilty about placing their parents in this kind of setting. It appeals to the elderly because their needs are met unobtrusively and they can maintain a semblance of independence. Their participation in the running of the home helps them feel useful.

The program is, as yet, only a small part of the continuum of services necessary for our elderly, but an important one since it offers a valuable, innovative way for the elderly to remain in the community and participate in it with dignity and self-direction.

Trends in Jewish Child Care*

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In effect, then, a children's service today needs to be concerned with the child's total living and must therefore provide at each stage of his life the experiences and the services that are normal to that stage, as well as the treatment services for his problems. Children do not grow up on counseling or psychiatric treatment alone. Just as parents do, the agency must take a long time, longitudinal view of the child's growth . . .

THIS article results from an assignment given the author to report on trends in Jewish child care.

In the absence of reliable published statistics and other information about needs, types and volumes of service in Jewish agencies, the writer sent a questionnaire to eight large children's and merged family and children's agencies inquiring about recent developments in children's services. The agencies in descending order of Jewish population size were Jewish Child Care Association of New York, Vista Del Mar of Los Angeles, Association for Jewish Children of Philadelphia, Jewish Children's Bureau of Chicago, Jewish Family and Children's Service of Boston, Jewish Family and Children's Service of Baltimore, Jewish Children's Bureau of Cleveland and Jewish Family and Children's Service of Detroit.

Replies to the Questionnaires

The first question was intended to obtain facts about the problems found in the families and children who come to our agencies today.

Have You Seen Any Changes in the Past Few Years in the Nature of the Family Problems That Come to Your Agency and in the Nature of the Problems That Children Present?

New York, Los Angeles, Philadelphia, Chicago and Cleveland report an increase in the unusually severe family and child problems, characterized among adults by emotional and mental illness and drug addiction, and among children by the severe character disorders exhibiting symptoms such as runaway, truancy, school failure, and bizarre behavior including drug use and sexual activity at a younger age (homosexual as well as heterosexual). These agencies observed that many more children who are referred for placement are seriously, often hopelessly disturbed. To quote Chicago, "When the request for placement comes, it is often after the children have been exposed to considerably more trauma during efforts to sustain the family in the community." Philadelphia notes that intake is flooded with poor and near poor parents who are so sick and disorganized as individuals and so utterly ineffectual in raising children from the earliest ages that the youngsters display gross deficits in physical care, emotional nurture, education and moral development. Cleveland cites an increase in the helplessness of parents in handling adolescents and an increase in serious disturbances among young children. New York and Philadelphia note an increasing number of children who display behavior symptomatic of brain damage.

New York attributes the increased child disturbance to recent changes in the delivery of mental health services, viz:

1. More out-patient clinical services are available in a community, and this

* Condensed from a presentation to the General Assembly of the Council of Jewish Federations and Welfare Funds, New Orleans, Louisiana, November 10, 1973.

may enable more parents to cope with children's disturbances in their own homes without resorting to placement. The children who are referred are the more disturbed who cannot respond to out-patient treatment.

2. Policy changes in psychiatric hospitals. The length of stay for children in hospital facilities has been reduced (often because of reduced funding). These children, when returned to their families, cannot live in the community. Thus, child welfare agencies are asked to provide services which were formerly a hospital function.

3. New child abuse legislation and greater enforcement of the laws has resulted in increased requests from family courts and protective service for placement of abused children.

4. More efficient diagnostic methods have resulted in identifying more of the brain damaged children.

The merged family and children's agencies do not report as much gross pathology, although Detroit reports more characterological and drug-related cases, and Baltimore cites a recent increase in children referred for residential treatment and in brain-damaged children. There is a middle-class cast and a middle-class malaise to problems noted by the merged agencies. Thus Detroit notes less striving among middle-class Jews, more immature adult behavior and more character disturbances. The children in these families are more passive and less ambitious vocationally than were Jewish children formerly. Boston finds an increasing use of the agency by middle-class families and a shift to problems of parent-child and marriage counseling. Baltimore reports more open dissatisfaction between marital partners, with the desire for self-fulfillment (doing one's own thing, women's lib, testing various life styles) superceding the sense of obligation to family. Baltimore also reports that parents are bringing children for therapy at an earlier age, exhibiting less denial of problems and observes that many more teenagers are coming on their own initiative. Detroit notes that children cannot handle the new freedom in sexual behavior and other social stimulation.

A high incidence of single parent problems is noted by Philadelphia and Boston.

Is Foster Family Care a Declining, Increasing or Constant Service in Terms of Numbers of Children Served Annually?

Declining, say New York, Chicago, Detroit, Boston and Baltimore. New York reports a decrease of 27.2 percent. Boston reports a drop from a peak of 60 children to a present population of 10, a decline of almost 90%, and Baltimore notes a decline from 46 children in January 1963 to 25 children in January 1973, a decrease of almost 50%. Detroit, at the time of the questionnaire, had two children in foster homes. It was declining, says Los Angeles and Cleveland, but it is going up again. The numbers have been constant since 1957, says Philadelphia.

The decline in the specific New York agency polled is due to changes in legislation, professional practice and community conditions. (1) With the advent of a new state law in the 1960's JCCA began to obtain court approved termination of parental rights and subsequent adoptive placement for many physically handicapped and other children who had been abandoned by their parents. Another law was passed which provides for subsidies for families that could not otherwise afford to adopt a child. Most of these children would have remained in permanent foster home care if not for the passage and implementation of these laws. (2) An ultra-orthodox group opened a new foster home program that has about 60 children.

Los Angeles experienced a decline in foster home population during the 1960's when the public agency unilaterally assumed greater responsibility for the placement of Jewish children and greatly reduced the referral of children to the Jewish agency. In late 1972, however, the Los Angeles Jewish community intervened successfully with public officials to restore the major responsibility for foster family care to the Jewish agency with the result that the caseload has been increasing.

The need for foster family care in Philadelphia actually *increased* as a service for family and child disturbance, because despite attrition from three sources during the 1960's the numbers held up, viz: (1) Since 1959 about 25 children were freed for adoptive placement as a result of the agency's utilization of the state law which permits involuntary termination of parental rights when parents have made it clear by their persistent indifference that they have no intention of resuming parenthood of their placed children; (2) placement service was completed during the mid- and late 1960's for 13 refugee children from Cuba; and (3) an average of 50 newborn infants a year disappeared from the agency caseload.

The increased need for foster family care in Philadelphia as a treatment service is all the more striking in that AJC developed two full fledged alternatives to placement in the 1960's. One alternative avoids placement by serving placement-potential children in the setting of their own homes through providing a broad range of clinical, supportive and educational services.[1] The second alternative is a family day care program for children under age three — foster home care in the day time, so to speak — which can prevent full time placement. These alternatives establish that the rising foster home population in Philadelphia cannot be attributed to a bias in favor of placement. Moreover, in the at-home treatment caseload in Philadelphia there are at least 34 children who need foster family care as the treatment of choice but whose parents will not accept it. There are no factors in these cases (outright neglect or abuse) that could *compel* placement. If all children who needed foster home care as the treatment of choice during the past years alone had been placed, the number of children in Philadelphia foster homes would be several times what it is today.

Have There Been Changes in the Components of Character of the Foster Family Care Service?

The specialized children's agencies in the four largest cities — New York, Los Angeles, Philadelphia and Chicago — report the growth of specialized foster family care programs to deal with the increasingly disturbed behavior of children. The term "specialized" encompasses a host of clinical, supportive and educational services that are used singly or in combination for the individualized needs of given children. It includes nursery school and day treatment for the underdeveloped or hyperactive preschool age child, both as a growth experience for the child and to relieve the foster mother of what would otherwise be an inordinately burdensome child-care task; household help as another relief; special education for emotionally disturbed school age children, including private schools and tutoring; psychotherapy through agency psychiatrists to insure its availability; refined intake diagnostic procedures to clarify emotional, mental and neurological states; agency-employed drivers to relieve foster mothers from transport-

[1] Harriet Goldstein, Providing Services To Children In Their Own Homes," *Children Today*, Volume II, Number 4, July-August 1973, pp. 2-7.

ing young children to their caseworkers, psychiatrist, doctor, dentist, tutor; higher payments to foster parents; and year round training programs for foster parents.

New York has opened specialized foster homes for physically handicapped children, for intellectually limited children, and has increased the number of group foster homes.

Philadelphia, Cleveland and Baltimore report that their more recent foster parents are a younger, higher socioeconomic, better educated group. The previous blue collar foster parent applicants have been replaced by attorneys, corporate and business executives, engineers and skilled craftsmen. Many of these new foster parents are seeking an alternative to diminishing adoption opportunities. While Baltimore notes that these foster parents want and are capable of a more professional relationship to foster care and to the foster child, Philadelphia observes that they want "good" children, they want little connection with the agency and they want little to do with agency training programs. In regard to training, for over a decade now New York and Philadelphia have had intensive, year round training programs for foster parents, consisting of case study workshops, a foster family life education series, seminars and institutes, planned together by staff and foster parents.

None of the agencies mentioned higher or special monetary payments to attract foster parents. Experience from other sources suggests that paying more brings more applicants, but not necessarily better qualified to care for today's foster child.

Is Group Care a Declining, Increasing or Constant Service in Terms of Children Served Annually?

The specialized children's agencies in the four largest cities and Cleveland report an increase in group care within their own agency group homes. New York went from 80 to 140 children in 10 years, an increase of 75 percent. In Chicago the increase is 50 percent in 10 years. (Chicago now has 10 group homes with a total capacity for 72 children.) Philadelphia went from a capacity of 16 children in 1959 to 30 children in 1973 (47 percent) and notes that at least 20 adolescent girls and boys currently served in own homes belong in the agency's residential facilities as the treatment of choice, but their parents will not consent to it, and the family circumstances are not so deteriorated as to compel it. New York cites a preference within the general community and among professionals for group home care over foster home care for the increasingly disturbed child population and a shift in population from the large institution to group home care. Boston closed its residential facility for 16 children, and Detroit reports difficulty in finding enough Jewish children to fill group homes of seven and nine children respectively. Baltimore reports an increase in referrals for residential treatment following a decline during the past few years that resulted when the community learned the agency's funds for residential treatment were exhausted and following the closing of state institutions.

Have There Been Changes in the Components or Character of Group Care?

In the four largest cities it is apparent that the group home service has developed into forms of residential treatment, encompassing (1) the clinical and educational services that were once found exclusively in the Bellefaire and Hawthorne type centers and (2) the training and professionalization of child care staff. Chicago has developed its 12 group homes into a system which includes intensive, intermediate and transitional facilities. Children enter the system and move within it as their condition requires or permits. Cleveland opened a group home for 10 older adolescents who are close to independent living, many of them discharged from Bellefaire, based upon a peer model because the regular group homes for five children could not adjust. In its residential treatment program, Bellefaire developed a closed unit for eight children.

Now That There is Little Need for Traditional Services to Unmarried Parents and in Adoption, Have You Developed or Are You Planning Any New Services in These Areas?

Philadelphia obtained a foundation grant for a group counseling program with parents of adopted children. Los Angeles is developing a similar plan.

As noted above, JCCA of New York has addressed itself intensively to achieving adoption for physically handicapped and abandoned children in long term foster care.

New York and Chicago note the growth of subsidized adoption due to new state legislation supporting this service.

Chicago has moved into abortion counseling.

Boston is working with unmarried mothers, usually teenagers, who keep their babies and sees a need to expand this program, and Baltimore is beginning to see these mothers.

Philadelphia, Boston and Cleveland note the need for counseling programs to help childless couples seeking adoption face the realities of the present situation.

Although Chicago and Philadelphia were the only agencies to mention the Illinois and Wisconsin State Supreme Court decisions that give increased rights to putative fathers, it is obvious that these decisions will require all agencies to involve fathers as never before in order to protect the validity of adoptive placements.

What New Services Has Your Agency Developed in the Past Few Years?

In addition to the new services already mentioned the large city specialized children's agencies have initiated programs to keep children at home and thereby avoid placement. In addition to the Philadelphia program mentioned earlier, Chicago developed an out-patient alternative to placement which includes crisis intervention, individual and group counseling for parents and children, psychotherapy, special education in the agency's own classes, day treatment and an after school program, tutoring and Big Brother and Big Sister relationships. Cleveland began an extended intake service to help children in doubtful placement cases remain at home.

Day care and day treatment programs were developed in New York, Philadelphia and Cleveland. One of the New York services was created for educable children who might otherwise require or have to remain in mental hospitals and treatment centers and includes clinical, educational, supportive and recreational services. Another New York day treatment service is for 30 preschool age children, offering educational enrichment and preventive services. Cleveland has a day treatment program for 30 children at Bellefaire, a special group of disturbed children in its day nursery program, and has increased its family day care service.

In addition to its family day care program, Philadelphia opened a school age treatment oriented day care service for 25 children and their parents that operates daily after school and every day in the summer months.

Baltimore and Detroit intensified child therapy for seriously disturbed youngsters with special staff training

and special psychiatric consultation and group counseling for adolescents.

The new services reported in the merged agencies deal with therapy, rap sessions, group therapy and outreach to drug involved and school failing youth who have resisted coming to establishment agencies.

What New Services Would You Like to Develop in the Next Five Years?

Plans for opening or expanding outpatient treatment services and day treatment services dominate. Several of the largest cities want to develop group homes for younger children, such as the age 6-10 group, and another wishes to open a graduate house for 19 year-olds who come from the residential center. Chicago anticipates a type of group home in which parents will be required to attend at least one afternoon and one evening a week at the group home with the children and in which a trained child welfare worker will visit in the home on weekends for several hours to give the parents relief and to demonstrate child management techniques. An emergency shelter for children, probably in cooperation with the family agency is noted, as is an increase in group homes for adolescent girls. Cleveland is concerned with developing child care and teacher training programs not only for its own staff but for outside persons who seek certification in child care.

Discussion

The foregoing facts and figures lead to certain impressions and conclusions.

1. The specialized children's agencies which began many years ago with a placement function are now becoming agencies to prevent placement.

2. The merged agencies have intensified their direct child treatment services and are rendering child guidance clinic type services.

3. Most of the parents and children who appear in the caseloads of the specialized children's services had prior extensive treatment experiences elsewhere. These earlier treatment experiences seem, in retrospect, to have provided temporary relief or to have ameliorated serious problems that really required placement as the treatment of choice and that later erupted uncontrollably during the adolescent years.

4. Several factors seem to account for the inappropriate use of out-patient services for this clientele. One is a bias against placement in the helping professions that reinforces a natural parental resistance to separating from children. Another may be a failure in diagnosis. Diagnosis of parental capacity is a dimension of family evaluation that seems to elude many practitioners. It is no longer taught in the schools of social work, few articles are written about it, and the subject rarely appears on the agenda of staff training programs. Third, social workers tend to be overly optimistic in their evaluation of family and child pathology, the course it will take, the consequences it will have for the child and the capabilities of outpatient treatment. These factors often obscure a correct view of the conditions for family and child. Placement is misused and abused when it becomes the final solution for earlier diagnostic errors or misguided sentimentality for devastating parent-child ties. There are no doubt factors, as enumerated by Detroit and Baltimore, that have acted to reduce the number of children who need treatment through separation — increased direct treatment services, greater parental tolerance and less shame about deviant child behavior, medication that quiets otherwise uncontrollable behavior — but the questionnaire replies suggest that differences in diagnosis of parental capacity and the attitude of professionals about placement are nevertheless critical determinants of the foster care population.

5. The questionnaires reveal clear differences between the specialized children's agencies and the merged agencies. First, the specialized agencies report vastly more gross family and child pathology and total parental incapacity than do the smaller Jewish communities in which we find the merged family and children's agencies. A comparison of cases, for example, reveals that the Detroit JFCS does not get the level of pathology which is common in the AJC of Philadelphia. Second, the newer, innovative children's programs are found more often in the big city specialized agencies, e.g., day care, day treatment and after school programs, special education and tutoring, specialized foster homes, sophisticated group homes and elaborate preventive programs. These services even suggest a different conception of the treatment task as being multi-dimensional and oriented to developmental growth, coping skills and social competence, in contrast to the merged agencies' primary orientation to therapy and intra-psychic change, marriage counseling, parent-child counseling and expanded family life education. Again, Cleveland is the exception among the smaller cities, for in the area of treatment services as well as in case types, Cleveland is more like the big cities than its population counterparts, even to an increasing foster home population.

Does big city life in itself produce so much more family and child pathology? True, Detroit is virtually devoid of Jews for they have moved to the suburbs. But the same shift occurred in Cleveland. Or are the most disorganized families and the most severely disturbed children not coming to the attention of the smaller city agencies? Does the specialized children's agency have a different native conception of the child care problem than do the merged agencies? Or does the very volume of cases in the big cities compel a different perception and response? Does the need to apportion the always insufficient funds among many services in a merged agency dilute the inputs for the expensive children's services? Does the singleminded mission of the specialized agency motivate staff and board to greater effort and achievement on behalf of unfortunate children? Is it necessary first to have the services for the most severe types of family and child pathology before the cases come?

6. Perhaps the experience of Philadelphia, the only agency that experienced a growth in foster family care as a service for family and child pathology from 1957-1973, contributes some answers. The Philadelphia agency seems to have had the greatest success in recruiting enough foster homes during the 15 year period — all of them Jewish. In a meeting of child care agencies and family and children's agencies at the 1971 General Assembly it was clear that Philadelphia had made an unparalleled investment in time, money and effort to maintain a supply of foster homes, and it seemed that many agencies had somewhat given up on the effort. That meeting also left the impression that Philadelphia had done a good deal starting in the late 1950's to enrich all of its foster homes with the services and supports for children, natural parents and foster parents that make it possible to accept, contain and treat highly disturbed children. Was the availability and systematic enrichment of foster homes only a coincidence or was there a causal relationship?

7. There are signs that the popularity of the large residential and institutional center is waning. One executive is unhappy because his agency is locked into an existing physical plant and beds whose very presence is a major deter-

minant of service options. Another executive would like to decentralize his residential treatment center to community based group homes for a variety of reasons, among them that factors indigenous to the culture of large scale institutions make the treatment task more difficult.

8. Despite the success of an occasional community in recruiting enough foster homes, foster home finding everywhere is extremely difficult and the conditions that make it so — more women going to work, the depersonalization and anonymity of modern life, the quest for personal pleasure and the increasingly disturbed behavior of young children — can only be expected to get worse. A Children's Bureau funded research project conducted by Philadelphia in 1966-1967 which compared the Jewish and non-Jewish communities revealed that Jewish people are much more resistant to becoming foster parents.[2] Although the Philadelphia agency has thus far managed to recruit enough homes, it acknowledges that many of them are of less than desired quality and are usable only because of an enormous investment of casework time and supportive services. Even these marginal homes are becoming harder to find. It is therefore questionable that foster homes can continue to be the major resource for placement of children up to adolescence, and if placement as the treatment of choice ever became fashionable, it would be clearly impossible to find enough foster homes! The alternative is group care (for younger children) preferably in the form of small group homes. Some agencies are already thinking in that direction.

[2] Joseph L. Taylor, Jerome L. Singer, Dorothy Kipnis, John S. Antrobus, "Attitudes on Foster Family Care in Contrasting Neighborhoods," *Child Welfare*, Volume XLVIII, Number 5, pp. 252-258.

Some Implications For Treatment Services

1. The differences that exist in the general conception between what constitutes out-patient treatment on one hand and treatment in foster care on the other hand, need to be obliterated. Today the richest and the most varied services go to the child in residence. He is diagnosed through different techniques, and he receives a broader range of treatment services. Yet often there is not that much difference between the disturbed child who lives at home and is treated in a family counseling, child guidance or protective agency and the child who goes into placement. Many children in these different settings are virtually interchangeable, especially if one alters slightly the timing of placement. In effect, then, a children's service today needs to be concerned with the child's total living and must therefore provide at each stage of his life the experiences and the services that are normal to that stage, as well as the treatment services for his problems. Children do not grow up on counseling or psychiatric treatment alone. Just as parents do, the agency must take a long time, longitudinal view of the child's growth and provide such services as pre-school socialization, educational and remedial help, recreational experiences, religious education, medical services, vocational counseling, post-high school scholarship help and volunteers to provide enriching services and relationships.

2. This point of view about treatment invokes a redefinition of goals and techniques. Social work goals generally have tended to be ambitious and global, oriented to achieving significant personality and behavioral change and improved inter-personal relationships. The major objectives have been for self-exploration, self-discovery, self-

understanding. Greenberg and Mayer[3] speaking of criteria for discharge from residential care and treatment, state:

> It is important that the causes and manifestations of the child's psychopathology that brought him to the (residential) center have been sufficiently affected by the center's total treatment resources to the point where they have either been abolished or do not interfere grossly with his social adjustment. . . . To terminate residential treatment, the child must have moved significantly in the direction of cure.

There is, however, a growing body of research which suggests that social work treatment of socially disorganized families and severely disturbed children is at its most effective with more modest goals in helping people deal with fairly specific, concrete and defined tasks, e.g., helping mothers learn child-rearing and training practices and how to manage household activities more effectively, helping children get an education, manage daily living routines successfully, acquire work skills, [4,5] and that a combination of services (education, counseling, day care, etc.) is more effective than a single service (counseling). Research shows less or negligible change in such areas as marital relationships, personality change and interpersonal relationships. The areas which showed the greatest improvement for both adults and children involved functioning that can be approached as tasks to be taught and learned, as contrasted with sophisticated, in-depth techniques that attempt personality change. Another finding from the same research study showed that the most helpful treatment techniques were reassurance, understanding and encouragement. In fact, supportive techniques were the only treatment techniques that showed a statistically significant relationship to outcome in the CWLA study.

3. Given the extreme degree of parental incapacity, given the highly disturbed nature of the children and the unproductiveness of the many previous short term contacts these families had, one could question whether the brief forms of treatment are adequate for this clientele, again whether the child is in placement or is at home. A recent CWLA research report confirms this point with respect to foster home care.[6] The study revealed that when an agency does a thoughtful, careful, planned casework job with natural parents, surprisingly large numbers of children remain in long term care. It is in cases that are neglected or receive haphazard attention that idiosyncratic parental decisions withdraw the child from placement prematurely. In other words, intrinsically many if not most foster care situations today require long time service. This finding is a decided departure from the prevailing notion that placement is and ought to be temporary. The often quoted Reid, Shyne study on brief treatment found it ineffective with families who have chronic multi-problems.

4. It is heartening that many agencies have been able to obtain the support and the funds required to professionalize the traditional child-care services and to develop the many new and expensive ones noted above. Group-home care averages $10,000-$12,000 or more in cost a year. The cost of a foster

[3] Arthur Greenberg and Morris F. Mayer, "Group Home Care As An Adjunct to Residential Treatment," *Child Welfare*, Volume LI, Number 7, pp. 423-435.

[4] Ludwig Geismar, "Implications of a Family Life Improvement Project," *Social Casework*, Volume LII, Number 7, pp. 455-465.

[5] Edmund Sherman, Michael Phillips, Barbara Haring, Ann Shyne, "Service To Children In Their Own Homes, Its Nature and Outcome," Child Welfare League of America, New York, 1973.

[6] Edmund Sherman, Renee Neumann, Ann Shyne, "Children Adrift in Foster Care, A Study of Alternative Approaches, Child Welfare League of America, New York, 1973.

home with the proper supports runs close to $5,000 annually. At some point, however, the expensiveness of these services, which serve relatively small numbers of children, may collide with the mood of "ephemeralization" that is sweeping the social work profession. This mood is described by Bernard Gelfand who wrote:

> One might predict that the preferred mode of future treatment will be delivered in large groups which have relatively few contacts and in which the principle of peer helping is emphasized. . . . Social treatment made rapid strides in its ability to ephemeralize, that is to provide more and better service to clients through the expenditure of less time, energy and personnel.

As one consequence of this ephemeralization, the multi-problem, poor Jewish family tends to slip through today's network of community services that is composed so heavily of crisis-oriented programs, group treatment modalities and brief treatment services that demand a high degree of client motivation and self-responsibility.

5. To reduce costs, agencies may have to develop forms of practice that systematically include paraprofessional workers, volunteer or paid, and that space out long time service. Otherwise one caseworker can be tied up for years with a caseload of 15-20 children and their parents and there obviously is not enough money, let alone conviction, for such intensive service. Several current experiments in preventive services that utilize paraprofessional volunteers working under the direction of M.S.W. social workers should be watched carefully.

[7] Bernard Gelfand, "Emerging Trends in Social Treatment," *Social Casework,* Volume LIII, Number 3, pp. 156-162.

Emerging Trends in Services to Children*

ALAN S. GRATCH

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Two contradictory trends seem to be developing . . . At the political level there is a constriction of interest in and allocation of funds to child welfare services. At the professional level and at the level of private welfare agencies the effort and interest are in expanding services by encompassing greater numbers of children and enlarging the types of available modes of service.

MY point of view is that of a layman, a director of a child welfare agency, a member of the Chicago Jewish Community, and the spouse of a social worker and family therapist.**

As background, I want to give a general overview of services to children.

Two contradictory trends seem to be developing in Chicago and throughout the State of Illinois. At the political level there is a constriction of interest in and allocation of funds to child welfare services. At the professional level and at the level of private welfare agencies the effort and interest are in expanding services by encompassing greater numbers of children and enlarging the types of available modes of service.

A recent statistical study discloses the disappearance of child welfare services in their own right — either by mergers or by the elimination of separate child welfare departments in public and private welfare agencies. Historically, this presages a shift away from services which give first priority to their child component.

It is increasingly self-evident that children need advocates. And it is apparent from the reality around us that children are the underdogs on the playing-field of advocacy and vested interests. Children have no vote. Adults do not seem to identify with needs of children. Adults seem to forget where they have been. Adults focus on where they are now: the problems of adulthood; and where they are going: the problems of aging.

Commitment to children is a myth. My guess is that we do not put our money where our mouth is. I would guess that proportionate to population representation, less money is allocated to services to children than other population categories, as for example, the elderly. Look at the agendas of local Jewish Federations. How often are children the focus of concern? Even the 1974 meeting agenda of this very conference glossed over the unique needs and problems of children.

A major reason for the constriction of child welfare services is the high cost involved, particularly for institutional care. Children require more care than adults. They cannot fulfill their own needs as well as adults. The range of problems and the corresponding range of services which must be kept available for children in need seem to be greater than with adults. Moreover, the problems of high unit costs are accentuated by the current leveling or in some cases reduction in community contributions to support private welfare services.

* Presented at Meeting of the Association of Jewish Family and Children's Agencies on November 20, 1975.

** My remarks and thoughts incorporate in large measure the ideas and expertise of Morris Davids, Executive Director of JCB.