CHANGING PERSPECTIVES IN THE CONTEMPORARY HEALTH SCENE

Proceedings of the 1969 Annual Meeting of Medical Social Consultants in Public Health and Health Care Programs

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Changing Perspectives in the Contemporary Health Scene

PROCEEDINGS OF THE 1969 ANNUAL MEETING OF MEDICAL SOCIAL CONSULTANTS IN PUBLIC HEALTH AND HEALTH CARE PROGRAMS

Sponsored By Children's Bureau
May 23, 24, 25, 1969

The New York Hilton Hotel
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Nearly four decades ago, A. Lawrence Lowell prefaced his book, Conflicts of Principle, by making the observation that man has the proclivity to simply conceptualize his kind to be divided into two camps: those who might be called idealists and those who might be looked upon as practical folk. This general sort of tendency is more prevalent today in our rapidly changing, exceedingly complex society than at any other point in history. Lowell's words regarding the "oughtness" of such a situation need to be emphasized and they respond to our present public health purposes. It is often held, he said, that "... an idealist cannot be practical or a man of affairs have a lofty purpose whereas in fact no man approaches perfection who does not combine both qualities in a high degree. Without either he is defective in spirit and unscientific in method; the idealist because he does not strive to make his theory accurate, that is consonant with the facts; the so-called practical man if he acts upon the impulse of the occasion without the guidance of an enduring principle of conduct. Hence both lack true wisdom, the idealist more culpably for he should be diligent in thought and seek all the light he can obtain. It is useful to repeat that many men have light enough to be visionary, but only he who clearly sees can behold a vision."

It is the never ending task of social workers, especially those engaged in the public health field, to define their own professional consultative, administrative, supervisory or direct service roles more clearly. They want and need to be as certain about themselves and their identity as possible at any given point in time. What is crucial is that they sense this kind of security just as the ordinarily related pieces of problem solving mosaics show that they will no longer mesh together for effective diagnosis, therapy, social action or planning. In a peak period of vast social change what could be better for social workers in public health than to be able to impressively demonstrate through practice the fruits of their faith in the generic, the greatest good of all, the multidisciplinary and the comprehensive.

Holding these thoughts foremost in mind, the Program Planning Committee directed it's efforts toward the production of a three day agenda that might afford the utmost possible allotment of skill, knowledge or "light" complimentary to both the current common and specific needs and interests of the membership of the Meeting of Medical Social Consultants in Public Health and Health Care Programs. The contents of this monograph reflect the endeavors of the Committee and the actual planned sequence of happenings at the 1969 Meeting itself.

For the commencement of the program on the evening of Friday, May 23, a topic of broad appeal and interest was sought after and none seemed more appropriate than that concerning youth and problems impeding their total well being. The core segment of the proceedings consists of the presentations and consequent, related discussion group sessions that took place on Saturday, May 24. The day's activities were given over to the theme of this year's Meeting, "Changing Perspectives in The Contemporary Health Scene", as it related to social work practice in general and in particular with respect to direct services. The concluding day's agenda consisted of four concurrent sessions that featured innovative concepts and tried means for bringing about more adaptive, effective work within programs and projects serving variously described patient-client populations. It was felt that a final presentation might involve a representative of another public health profession voicing his view of the contemporary health scene and the resulting expectations he feels incumbent upon social workers and others. Such a paper would
strategically give grounds for reflecting and refining preceding material.

The Program Planning Committee recognized the importance of creating opportunities for those attending the Meeting to meet informally with other participants sharing common interests and concerns. To some extent, scheduled coffee breaks and a business luncheon on the concluding day of the Meeting provided such opportunities. A cocktail hour provided through the courtesy of Ross Laboratories and the fine cooperation of their regional manager, Mr. James McCall, afforded an excellent chance for discussion and making acquaintances in a cordial, relaxed atmosphere.

Finally, I wish to express indebtedness to the Children's Bureau in behalf of my hard working colleagues on the Program Planning Committee and the membership of the Meeting in general for their financial assistance, counsel and advise. Appreciation is extended to planners of past Meeting programs for sharing their experiences; to this year's Meeting faculty and recorders for their untiring efforts and fine contributions; and, to all who took part by gathering with us in New York City.

David P. Kemple

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Pittsburgh, Pennsylvania
July 31, 1969
Today there is massive evidence of churning unrest, turbulence and upheaval, of deep frustration and even tactics of desperation and violence in our major institutions, our human relationships, and our value systems. Explicit and implicit in this ferment is the struggle for change. In large measure the ferment represents both a demand and a plea for a more viable partnership between our institutions, the managers of these institutions and the people who are served or affected by them.

This ferment is also reflected in exciting ideas and programs devoted to raising our standard of living, to prolonging life expectancy, and to dealing with long-standing social and health problems in new ways. Such programs are bringing a vision of new hope to the lives of many who want a better today and a better tomorrow.

This presentation will not deal primarily with statistics. Our mass media document daily with figures and facts the major health, educational, and other complex problems facing our youth in communities throughout our country. Therefore it might waste time to talk with you about percentages, ratios and numbers in such areas as illegitimacy, malnutrition, mental retardation, emotional illness, drug addiction, and school dropouts.

Rather, I propose to talk about ferment as it is reflected not only in our youth but in our broad social scene. I want to share with you some of my thoughts about the ferment. I will try to highlight some of the underlying causes, conditions and characteristics and will try to focus on our responsibility to use the ferment as an agent for meaningful and constructive change.

My frame of reference includes our program in Chicago serving school age unmarried mothers since it embodies many of the things our youth and our general society are concerned about. Our program was conceived as a model for effective planning and intervention in relation to one of our major social and health problems.

My approach is predicated on the belief that on the one hand there are some basic established facts that should guide our thinking and behavior. On the other hand, there are some unvalidated assumptions and myths which are interwoven into our psychology and our professional concepts which all too often determine and control our behavior and our plans. My general framework will be in the context of working with and engaging people on all levels, for all people are intrinsically bound together in some interchange. What happens in this interchange will have direct bearing on how we proceed and deal with our many problems.
For those of us in the helping professions, I am speaking of both professional and personal investment and commitment, a professional and personal underlying philosophy that emphasizes the dignity of man. I am speaking of the ability and the courage to recommend and make decisions that are in the best interest of the people we serve rather than being primarily vested or predicated on a bureaucratic or institutionalized shelf.

There are, of course, some natural forces (i.e., population growth and redistribution) producing today's ferment. We also see human agents largely from our young population who are often instruments and movers working toward specific results.

At this point let me attempt to clarify and define some of the social phenomena on the contemporary scene. As Sidney Harris, the eminent columnist has written, we often use language or jargon to describe superficial aspects of phenomena when what is actually occurring would be more adequately designated by using an opposite term. According to Mr. Harris we tend to identify diseases with their symptoms and delude ourselves by believing that if we suppress the symptom, we eradicate the underlying disease.

Within this context, the rebellion of youth is a symptom of adult apathy; black militancy is a symptom of white bigotry; poverty similarly is a symptom of the indifference of the affluent group which made it and which care little about those who have no choice but to remain poor, unconcerned and full of despair.

I propose that the restlessness we are seeing among some of our young, paradoxically originates partly from the fact that we may have done a better job than we think. One of the major valid purposes of education is to help people to think, to question and to learn.

Conflict seems to arise over what use should be made of the knowledge and experiences once they have been acquired. Knowledge and learning that are incompatible, alien or in conflict with the individual's experience or the political and cultural context in which he lives produces a variety of effects. This conflict is manifested in the varied and often extreme responses we are witnessing; some of which call for total and violent destruction of our society and the establishment of a new society. Some view this behavior as destructive acting out with no meaningful purpose and no meaningful goal. There are others who give recognition to the useful and important purpose of "stirring the pot," believing that progress does not come without struggle and that we must pay a price to rid ourselves and our society of oppression, wrongs and disabling conflicts.

Consistent with either view, we can perceive that many of our young people are responding to a need for familial figures that are not characterized to an excessive degree by conflictual values and practices; they seek parents and institutions that do not view themselves as omnipotent in their relationships with others, whether these be other nations or people within our own borders. These young people are seeking a society which does not hold on to conformity and tradition when these only serve to perpetuate alienation of people, to feed and nourish ambivalent and guilt ridden feelings and behavior without producing new solutions to old problems.
Our study of the dynamics of human behavior and the development of human personality have well established the fact that parents who do not provide a child by word and deed with consistent and wholesome human values, with feelings of affection and security, with strong identification models, are likely to have children with a host of problems.

Similarly, when a society and its institutions have been distant, remote and uncaring, have espoused contradictory values and engaged in contradictory practices, it is reasonable to expect that some of the people growing up in that society will suffer multiple kinds of damage. Some will react with frustration and confusion, some with bitterness and rebelliousness, and others with apathy and despair. When a society and its institutions function largely to perpetuate their own aims and activities (like do narcissistic and immature parents,) rather than having their aims and activities reflect values and behavior which are good for the whole human family, we will sooner or later see manifestations of unrest and social breakdown.

The successful and mature development and growth of a child into adolescence and adulthood will, in significant measure, be determined by conditions and factors generated within and without the child's home. Similarly, the successful and mature development and growth of a society will be greatly affected by the standards, the values and practices that operate inside and outside of that society. Our concern then should be focused not only on the individual human family but also on the larger family of society.

Young people, from the college or from the ghetto environment, although belonging to widely separated social and economic worlds, are in many instances rebelling for the same reasons. They are rebelling out of a sense of urgency about change. They have noted the increasing disparity between those who live in decent housing and those who are trapped in slums; between those who earn a decent income and those who remain unemployed, all too often existing on inadequate welfare payments; between those who are getting good health and nutritional care and those who are sick and malnourished; between those who have the opportunity for affluence and those who have little choice but to remain poor and forgotten.

I believe, it is not only the disparity between those who have an opportunity to live a good life as contrasted to those who are exposed daily to multiple and damaging onslaughts that is a cause for social unrest. The youth from the ghetto and the suburb are expressing also the feelings of emptiness and need for meaningful fulfillment.

Our young people as well as others in our society are fed up with the hypocrisy, the double standards and double messages, and the corruption and obstructionist behavior on the part of many of our institutions and their agents. They are dissatisfied with programs and services which start out with high purpose and drift on to a bureaucratic shoal. They are rebelling because of a feeling that regular channels and procedures no longer permit a resolution of our problems. They believe there has been enough probing and enough planning, but a dismal lack of action. They are seeking from their society and the makers of that society -- their parents, teachers and government officials, etc. -- preparation for the world of today, not the world of yesterday. While the tendency among some of us to view youth with suspicion, annoyance and scorn, I believe we are making a sad mistake if we overlook what they state and shape.
the principles that lead inevitably to the world of tomorrow.

In many instances they are having to carry on their backs the deficiencies of their biological parents as well as the deficiencies of their social parents symbolized by traditional American society. It is all too easy to sit back and abandon our young people to their feelings of confusion, anger, hopelessness and despair but to do so does them a vast disservice as well as ourselves.

The point I am making is that as adults we must not only listen to what is being said, but must respond in a truly understanding, non-defensive and constructive way. For just as some may view the tactics of young people as hasty, destructive and unfair, so might many of our institutions and the attitudes of their administrators be seen as outmoded, insensitive and unyielding. I am not suggesting that we act like robots, in which a button is pushed to bring about instantaneous compliance or agreement with everything that is demanded or with every word that is spoken. But we must listen and we must change.

Certainly some of what is being spoken and demanded reflects the utter feelings of frustration of the youth about the effects which chronic deficiencies are having on their lives. For those who manifest such massive feelings of desperation, I can only say that our task with them is an even harder one. We must try to bring them into the cathedral, to offer them a range of life experiences by which they can be touched, and we must offer them more than just dialogue.

An understandable but unfortunate omission on the part of youth when they interpret the events of today is their failure to fully recognize, appreciate, and understand that the paths they now tread were prepared for them by some of their immediate elders whom they want "put down." It has been aptly said, "He who knows only his own time remains forever a child." Would there have been a Martin Luther King, Jr. had there not been a Gandhi, a Thoreau or a Frederick Douglas; a Jonas Salk without a Louis Pasteur, an Albert Einstein without Galileo? What I am saying is that one must look at contemporary events within a historical perspective. Therefore, the logic of ethnic study programs. Just as Gandhi, Thoreau, Douglas, Pasteur and Galileo forced people to reexamine the situations of their day in a way which involved radical change, so do our youth, with their clear-eyed intensity, make us look again at some of the inconsistencies, the irrelevancies and the prejudices, which if we persist in holding onto them, will only keep us in an era of darkness and ignorance.

It seems to me that we can learn from today's ferment and use it constructively in our daily work, commitments and responsibilities. Man grows by frustration. Specifically, I am saying that while we must all be concerned about the total problems we are facing in our society, each of us can take a small piece upon which to concentrate our major energies.

As an example, let us take our program for adolescent unwed mothers in Chicago called the Crittenton Comprehensive Care Center. From this we can try to develop an idea of how this program reflects ferment both in our young and in the broader society and how we attempt to deal with this ferment.

Our program was launched in November, 1966 as a pioneer cooperative endeavor between the Federal, State and City agencies along with a national voluntary agency which for over 85 years has devoted all of its resources to helping solve the problems of unwed parenthood.
Growing out of a successful four year pilot demonstration project from 1963 to 1967, the center came into being when a contractual agreement was entered into by the Chicago Board of Health, the Illinois Department of Public Health and the Florence Crittenton Association of America. Seventy-five percent of program funding comes from the United States Children's Bureau, Maternity and Infant Care Project 502, the remaining twenty-five percent from State and City health agencies. The Florence Crittenton Association of America was asked to administer the program because of its long experience in developing a coordinated range of services for unmarried mothers, as well as the Association's concern to expand their services beyond the residential maternity home level. Joining in this cooperative venture is the Chicago Board of Education which has established two accredited schools for pregnant girls of elementary and high school age.

With both the girls and their families whom we serve, we see much of the alienation, the frustration, the inequities, the confusion, and the anger which are so apparent in much of our larger society. We also see evidence of a concern for meaningful personal identity, for meaningful and fulfilling aspirations, and a fervent wish to "be somebody." These young people have many strengths and many assets which are just waiting to be released and developed. We delude ourselves if we think otherwise.

Those of us who have had any role in the planning of new and innovative programs know all too well about the endless bureaucratic red tape, the conflicting guidelines, the outmoded and irrelevant policies. We are too familiar with the intra-agency jealousies in which the encrusted "old guard," in its monopoly of decision making and policy implementation, is able to obstruct and sabotage the effective delivery of services. In many instances the end product of such programs becomes a meaningless numbers game, rather than an effort to provide effective services that are therapeutically oriented to the client's environment, the client's problems, and the client's needs.

Even when there is recognition that changes in planning of services are indicated, these changes are often carried out within administrative structures in which there is fragmentation, inadequate coordination and lack of cooperation, duplication, and policies or procedures which are not in keeping with modern management techniques.

Too often do we see our goals and objectives not clearly stated and defined in keeping with an accurate conception, understanding, and acceptance of the problem. When this occurs it is quite understandable that the policies which have been formulated to achieve the objectives will be irrelevant or deficient in meeting the needs of the clients. All of us know about programs in which the establishment of policy and priority is done unilaterally. We see that sometimes individuals with a spirit of eagerness, with a body of experience and professional know-how are never consulted or brought into the decision-making process. Too often it is expected that programs adhere to guidelines that are so rigidly, irrelevantly, or conflictually conceived or interpreted that Job's patience heads the administrator's job description.

What I am trying to emphasize is a need for clearly defined and attainable goals and objectives, clearly defined and flexible policies and an operational structure to achieve the desired ends. No goal, objective or policy, including legislation, is soundly conceived which does not leave room for flexibility and change. It is just because of this need for flexibility and change that I would
stress the need to have the private sector, particularly our voluntary agencies, share the responsibility with public institutions the roles of policy making, policy planning and policy decisions.

This policy seems self-evident when a voluntary agency has a history of validated successful experience in dealing with a given problem. When not given a substantial role in decision making, the private agency becomes just window dressing, a junior partner if you will, and not a very influential junior partner at that. This inevitably happens when the private agency tries to make its voice heard as the really big decisions are made.

A caseworker or another professional may need to shift or modify some treatment techniques based on a change in the initial assessment and evaluation of the problem. Similarly those parts of a program which do not work or which are being hampered in their implementation in some serious way may need to be examined or changed. There is no single or best way to do the job. What will work in one community may fail in another. There are always variables present in relation to any problem in any community for the resources which can be tapped vary greatly.

Until the Crittenton Comprehensive Care Center and similar programs were established, the adolescent unmarried mother of minority group status was often written off as lost by society and the very institutions established to serve such girls. How often all of us have both heard and read of the cynicism of both professional and non-professionals. In words and print were found such notions as, "these girls feel no shame or anxiety for having babies out-of-wedlock"; "they are poorly motivated and untreatable and have no desire to improve their lot in life." The facts, of course, are otherwise.

While in the midst of learning and developing certain skills that will prepare them for adulthood, pregnant teenagers are confronted with disruption in one of their major sources for growth experience. That source is education. They are confronted with massive physical changes in their body that have not only psychological ramifications but implications in a more concrete way, their physical survival. They are confronted with the phenomena of being catapulted into a role of mothering and adulthood for which they are unprepared, frightened and confused. The problems that they experience are often compounded, by the problems of their elders. Their parents in many instances have been as poorly prepared as they to meet a crisis, particularly a crisis that can disrupt the whole family equilibrium.

Pregnancy out-of-wedlock is only one of the many problems and deficiencies faced by our girls and their families. In 1968 Miss Jean Bedger, our Evaluation Director conducted a survey on 300 girls who participated in our program. She found that while the entire city was represented, the greatest number of girls came from areas characterized by the lowest per capita incomes, the highest rates of illegitimacy, and the lowest levels of educational attainment.

The average size of their families was 6.1 and in some households there were three sub-groups or constellations (grandparents, parents, children.) One-fourth of our clients were themselves conceived out-of-wedlock. Only twenty-six percent of the parents of our girls were living together, the remaining were separated, divorced, deceased or never married. Thirty percent were on public assistance and social security benefits. Forty-five percent had incomes below the national
average family income level in 1966 ($7,436) and at the same time the number in
the family exceeded the national family size average. Twenty-nine percent were
below the poverty income level which had been set at $4,200 per year for a
family of six.

These and other equally distressing factors indicate that an out-of-wedlock
pregnancy has many dimensions, shadings and ramifications and must be viewed and
planned for in a multi dimensional and comprehensive way. Within this conceptual
frame of reference, we must have clearly stated and defined goals and objectives
which seek to relate realistically to these young people's needs, their aspira-
tions and their frustrations. I am speaking here of diversity in program
planning and implementation and the utilization of a variety of disciplines and
talents.

All people do not need nor can they respond to the same service, hence
planning must be flexibly and imaginatively conceived and carried out. The
diversity of our clients, the diversity of their needs and the variability of
their response to help only highlights the importance of the specific ways in
which we select to respond to them. Such responses must combine an existing or
developing ability for sensitivity to really understand; and an ability to relate
and to engage them in meaningful communication; and a willingness to look at pre-
conceived notions and biases that will interfere with and undermine the task
before us. In essence, this model requires a differential approach based on their
realistic needs and their feelings about these needs rather than on what we spec-
ulate they should be getting.

From my experiences as an administrator of a relatively new program in the
City of Chicago, one of the greatest continuing obstacles has been in the area
of the organizational structure and how this structure is responded to by the
participating parts. Ideally the plan for implementing a variety of services
might best be carried out through one organization. When this is not possible
one must then attempt to bring the various components into a viable whole so that
the greatest impact of the educational, medical, and mental health services can
be directed optimally toward the requirements of the girls and their families.
Such planning and implementation under one central administration would help to
insure that services are well-coordinated and non-duplicating. How we shape or
fail to shape a program will have direct bearing on the program's effectiveness.

The answers do not come easily, (particularly where several agencies or
organizations are involved,) but if our planning is to succeed, it must not be
carried out unilaterally or mechanistically by any one of the participating
resources. We must be willing to critically look at what we are doing, to ex-
amine our practices, to engage in some scientific testing of the methods we are
using. These practices can then bring about some desired changes which can be
built into our program of services. In essence I think this is part of the
institutional change which youth is demanding today.

We must also be willing to state positions and even criticisms based on
experiences and practices that have been less than pleasant and successful. I
am referring to some of the organizational obstacles that are put in our path;
the conflicting guidelines, the endless red tape, decisions being made by
individuals whether on the Federal, State or City level who may have neither
the knowledge, the understanding or the acceptance of the services to be
rendered, and may even care less.

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An administrator of a program that has clearly demonstrated its effectiveness and its need should not have to spend untold hours fighting for additional funds or to justify how these funds should be spent when the chronic problems being dealt with are constantly increasing. Why are not individuals who have had direct experience in such programming on all levels being called into the sacred bureaucratic sanctums when monies, policies and guidelines are being discussed and enunciated? These are areas youth is asking us to act upon. Many of our youth are only echoing things that we adults have been aware of for a long time but have not had the courage to stand up and act upon.

I need not go into any more specific detail about the Crittenton Comprehensive Care Center, in as much as several recent publications are now available to all of you. (See references). We are a program whose strengths lie in the underlying philosophy and deep belief that the pregnant school-age girl represents a high risk group from the point of view of her health, social, psychological, educational and vocational adjustment. Irrespective of her financial circumstances, her social or class status or other factors which characterize her life situation she is entitled to services which will be geared to helping her effectively cope with the crisis. Furthermore, these services must reflect a range commensurate with her needs. Such an approach insures that the pregnancy and its multiple implications will be viewed comprehensively and the services to be planned and implemented will be carried out in a comprehensive way.

We believe that an unmarried pregnancy creates a crisis in the lives of girls involved, their families and often also for the putative father. Our staff includes social workers, nurses, psychiatric and group work consultants, arts and crafts Instructor, an evaluation director, and a supporting clerical staff. We are working with girls and their families on both an individual and group basis and it is our hope as we grow and expand, to more actively involve the fathers of our clients' babies. This is based on our recognition of the fact that an out-of-wedlock pregnancy is not only the girl's affair.

In conclusion, I would like to re-emphasize my understanding of what youth is saying. There is the need for change, a change which is constructively conceived and constructively carried out. Health, education and welfare must go hand-in-hand, and when we talk about health we are talking about all aspects of health. The individual to whom we are delivering services is not a shadowy figure or an abstract number, but a person inseparable from her human dignity.

Those of us in the fields of social work and public health must make a commitment to take the lead in opening channels for new ideas and for generating new plans in order to meet some of the crucial problems facing our communities. It seems to me that from the standpoint of commitment, vitality, drive and heart, the services of social work and public health are uniquely qualified to be in the vanguard of those to bring about changes. Of course, we do recognize that one or two professions cannot nor should not have the responsibility for doing the job alone. But neither can we afford to wait for others to assume the burden of leadership. Dedication and commitment are not enough. We must insist that any effective program needs a base and structure which is sound and solid.

Speaking to youth today, one must do much more than to just show disapproval of the wrongs of our society. It is not sufficient to just protest. We and
you must join together in being reformers and redeemers, feeling a moral out-
rage when the lives of our young and the old are being short-changed. We must
be constructive activists. We must use all the resources open to us to pressure
and challenge those forces in our society that keep people in darkness, in
ignorance and in suffering. As Frederick Douglas, the great black emancipator,
stated only a century ago, "if there is no struggle, there is no progress.
Those who profess to favor freedom, and yet deprecate agitation are men who
want crops without plowing up the ground. They want the rain without thun
der and lightning. They want the ocean without the awful roar of its many waters.
This struggle may be a physical one, or it may be both moral and physical, but
it must be a struggle. Power concedes nothing without demand. It never did
and it never will."

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"Once there were three patients who met in the hospital and decided to live together. They arrived at this decision because they had no place to go when they were discharged." Thus begins the sensitive novel "Tell Me That You Love Me Junie Moon"* written by the talented writer-social worker Marjorie Kellogg. With skill and compassion as a writer and with technical knowledge and perception as a social worker in a medical setting, she conveys the fearsome vacuum in resources for living that still faces countless rejected, chronically ill and disabled persons, especially those lacking money and family.

The "no place to go" after discharge as pointed up in Miss Kellogg's novel is a social syndrome with medical concomitants and reflects our non-system of social and medical care for the poor and chronically ill.

If the Hollywood movie to be done of this book dares to make clear to the American public the paucity of provision for home care for this discriminated group - the helpless, unwanted sick - it might arouse a lethargic and inert public to the extent and extreme of health neglect.

I have been persuaded by your Program Committee that there may be value in describing some experiences which point up the role of the social worker in the health setting in assuming responsibility and exercising initiative in efforts to achieve constructive change. I shall also suggest obligations for this type of effort as being implicit in the professional function. In the health setting, the social worker has an unparalleled opportunity to see at first hand what is needed to improve health and prevent premature death. These objectives - to make medical and health care available, to improve the health of the nation, to prevent unnecessary disablement and premature death - are the moral imperatives that underpin our efforts.

It has been my view for some decades that ignorance and hypocrisy have obscured the truth about our neglect of the sick and corrosive attitudes toward helpless people. In the late forties I wrote that "attitudes of callousness and impersonality underlie much of what we do and what we neglect to do for people who are ill, particularly those who suffer from unsightly handicaps, the aged, and those whose illness disturbs social, family and community patterns. These community attitudes have not failed to affect social work which naturally cannot disassociate itself completely from this cultural phenomenon."*

*Farrar, Straus, Giroux, 1969


Provided by the Maternal and Child Health Library, Georgetown University
The social upheaval we are experiencing in all aspects of community life in my view, grows out of a tragic history of disappointments and failures that have characterized our educational and service fields, health service among them. The continued operation of the profit motive as a mainspring in the health industry seems in this day not only naive and grotesque, but the major deterrent in positive programming. We hope that we may soon see the same moral standards of financial disinterest applied to the health field as is applied to the Supreme Court.

In view of these trends, it is fortunate that there is a new countervailing force made up of consumers, neighborhood health council representatives and some health professionals like the organization of medical students, Physicians' Forum, and others asking for greater community participation and control in the planning and operation of health services. Some consumer groups are operating neighborhood health centers, others are requesting representation on boards of voluntary hospitals, health planning bodies and insurance systems.

The Health Division of the Community Council in New York has an affiliated group representing local community councils and consumers. Believing that such a group should have its independent identity and autonomy, some members of the Division worked for nearly a year in a preparatory way to locate the groups, to pin-point with their concerns and problems in this field and to stand by until they selected their own leadership and developed their organizational structure. They are now a functioning part of the Health Division.

Direct participation by Consumers in the design control and operation of health services is at an early stage of development. It is not all new to social workers who have been involved in settlement houses or in the field of prepayment medical group practice. It calls for a different and I believe more traditional or philanthropic medical setting. In collaboration in developing new resources and services, the social work skill and expertise requires no real adaptation in role.

I drew attention to this some years ago in describing an early phase of the social work program at Health Insurance Plan. The subscribers who were then all members of participating organizations (Pre-Medicare and Pre-Medicaid) called themselves "members." They had "rights" which they felt they could and did exercise.

We have been discussing thus far some of the emerging social and political issues affecting our field of activity and I have indicated ever so briefly that there are changes and new trends as well as new opportunities, but that these may require some adaptation in role and some re-tooling of knowledge and methods.

*The Physicians' Forum of New York City has an incisive statement on "Community Control", 1969.
It has taken the revolution of today to force us to acknowledge the basic relationship between behavior that favors inequality and attitudes that reflect callousness and impersonality. As long as any in our society are considered inferior to others, we cannot possibly implement the moral imperative that all shall have appropriate and considerate health care. This then is the primary mandate for change and our discussion will be within this framework.

The present social crisis is regarded by some as a world-wide technological and political phenomenon. In the United States many of us consider it a long over-due reaction to racism, broken promises, inequality of opportunity and lack of governmental planning and concern for vulnerable people at time of stress.

Health care, universally regarded as an important element in optimal social development, is in a chaotic and paradoxial state in our country.

Many persons and professional groups including social workers in the health field who have been concerned with our national health problems view the current scene with dismay. While there have been gains in coverage through Medicare and Medicaid, we are lost in a maze of paper plans, promises and lag in implementation. It seems almost hopeless when we face the following: the enormous and uncontrolled expenditures; the fifty different jurisdictions making determinations; the unevenness in standards; the unpredictability of criteria for eligibility changing from one legislative session to another; and further compounded by funding from so many different sources.

Are we as a nation moving toward over-all medical care programs? Are we building on any of our pioneer experience in medical and rehabilitative programs? Or, are we disregarding projects so carefully designed and nurtured that handicapped children across the country were brought out of hiding into care? Have we as a nation slipped into an era where national policy on health is not only adrift, but moving toward greater disintegration and fragmentation than ever before?

The excitement engendered by enormous political ballyhoo and campaign promises encouraged consumers and health professionals to believe that medical care would become available to those needing it. Some of us worked for several years on studies seeking to define medical indigency and to gain agreement from a wide variety of influential national groups for eligibility standards for the mass programs.

The American Medical Association agreed some seven years ago with other national organizations on the principle that "medical care is a right and is available to those who need it." Leading public health authorities continue to publish statements in a textbooks* to the effect that "like education and freedom, health is deemed a right in our democratic society." The New York Academy of Medicine includes "right to health service" in its policy statement. But with the passage of Title XIX it became apparent that the American Medical Association and others have the greatest personal financial stake in the health industry are largely responsible for the spiraling cost and current difficulties.

*Charles E. Smith, MD, in Foreword of "The Individual, Society and Health Behavior," Russell Sage Foundation, University of California, Berkeley. 1967

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There is a great deal of literature available on change in the health field and I have selected for our consideration today certain concepts and findings that seem to me relevant to our contemporary experience. These include the recent Myrdal Study on Asia, the earlier UNESCO study "Cultural Patterns and Technical Change" directed by Margaret Mead and the recent book by Knutson of University of California at Berkeley.

In the early 1950's The World Federation for Mental Health and UNESCO conducted a survey to explore the introduction of technical change in relation to mental health. This study directed by Dr. Margaret Mead published some time ago* makes a telling contribution to our current scene. Since we are as urgently in need of pressing forward with new programs with introduced change as places we were wont to call undeveloped, underdeveloped, or developing, we may now be able to learn from the study.

We are assured that changing any one detail in habits and practices will have repercussions on other aspects of life. The goal of the study was on finding ways of facilitating harmonious change that will not produce too great a strain in the individuals involved and not upon the technical problem of producing the services.

I have summarized some points that may be useful. "Experience has taught that change can best be introduced not through central planning but after a study of local needs."... "Impersonality is abhorrent and ineffective in any of the societies studied. There is a far greater chance of acceptance of new ideas if introduced by people who show real concern."... "The aspects of change - the teacher, the nurse, the worker - must realize their own behavior, beliefs and attitudes are not universal and that the people with whom he works must hold to their behavior habits as a functional utility - as an expression of his personality and identity."

Since this study proved that introduction of change was disruptive in the societies studied, it suggests that awareness of this should be incorporated in projects. Dr. Mead's report suggests that methods for re-integration as well as a defense against disintegration be considered in situations where change is introduced.

And now we must come to the heart of the matter. Granted that as time moves on some of our tasks of advocacy, of interpretation and of social action will gradually be absorbed by consumers and others, often persons more competent than we have been, what in this rapidly changing context is the social worker's contribution? What can be the future role?

I believe the unique contribution remains in the expert knowledge of the individual, his psycho-social structure and sociocultural environment. The social worker more than almost anyone else is trained to sense the continual interaction between the person and his life, the individual and his potentiality.


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Sullivan* says of this: "The person and his environment form a fluid and dynamic set of processes and relationships, forever transaction."

To be fully effective in the newer role and in the newer partnerships, the social worker will need to be a sensitive explorer in known and as yet unknown relationships requiring skill, maturity and broad tolerance. Greater awareness of the process of perception as a personal dimension will aid in understanding need and in teaching and sharing knowledge. Perception acts as the personal-professional-psychological screen through which the social worker assesses need and determines priorities. This is the same process whether on a one to one basis or in a group or committee.

Deeply ingrained prejudices and long-standing cultural responses to people, their needs, life conditions and intangibles become an automatic part of the sensing apparatus. Professional judgment as to priorities on program direction therefore will be open or blocked dependent upon the life experience and tolerance of the individual, whether social worker, physician or administrator.

A penetrating personal description of ability to perceive is given by Dr. Robert Coles from his early field experience in the South.* Dr. Coles carries us through his growth in perceiving the strength and dignity of a black cook whom he originally perceived as a simple and relatively ignorant person - ultimately he becomes aware that her executive ability runs the boss' home and her delicate sensitivity makes her a sophisticated user of herbs and a gourmet cook.

I have suggested that the social worker's unique contribution to the changing field of health services comes from his knowledge of the psycho-social nature of man and his needs in relation to life circumstances and potentialities. The social worker's second special area of knowledge lies in his understanding of the totality of community services. He does not see the individual as a separate entity - a person requiring solely health services - but sick or well interacting with his milieu and his community. In other words, social work commits the practitioner to a holistic approach. In this field he must proceed on the assumption that the individual or patient has the right to the usual range of life expectations in a democracy. This means at least a minimum standard of living, housing, education, health services, equal opportunities for job training and jobs. Above all it must mean that services and resources are organized in useful ways and especially to help vulnerable people at times of stress.

Even if we were to disregard the right of the individual or patient to access to needed comprehensive community services, our clinical and rehabilitative goals as well as our national interest would dictate that maximum opportunities be made available for his rehabilitation and functioning.


Gunnar Myrdal in his remarkable three-volume report "Asian Drama" discusses planning for health services and lends strong support to the inter-relationship of all factors involved in health problems. The public health social worker as he sees the person and as he assesses his need must take into full account the relevant environmental conditions, and the other measures needed to prevent and cure illness. It is well known to practitioners that the effect of any isolated health improvement effort can be defeated unless other needed services are available. Hence the health social worker finds himself very often in the role of seeking services that either do not exist at all or to find that they do not exist in a way that is urgently needed for people.

Dr. Myrdal reminds us that "the certainty that social conditions are interdependent will lead the planner to attack the problem on the broadest possible front; specifically he will seek to combine a number of mutually supporting policy measures." "More than any other type of planning," he says, "planning for better health conditions must proceed by an intuitive process, wherein segmented information is complemented by informed estimates and made to yield the outline of a strategy."

Dr. Myrdal also advises that "even when as a practical division of responsibility, a narrower field is defined as health policies proper, the planner in this field needs to keep the wider perspective. But certain nutritional problems - for instance, providing children and pregnant and nursing women with the protective elements which their diets lack - are problems of policy for which the health authorities must take primary responsibility. Similarly, some matters pertaining to clothing and housing come within the purview of the health planners.

"It is the task of the health planners and the medical experts to develop and coordinate various policy measures so that jointly, in the concrete situation . . . these measures have the speediest and most wholesome effects in improving health conditions. To succeed in this physical planning they need much more specific knowledge about facts and causal relationships."

It is in the process of developing new measures affecting people's health and of coordinating existing services that the health social worker has a genuine opportunity to assist in moulding policies and services in relation to need. He will bring to a central source either in his agency or community specialized information, clues or facts that, pooled with other data and discussion with other colleagues may help the planning group to trace the circular causation of the problem within the health field or in the whole social system and plan services directed toward purposive change.

Maximum utilization of the role of the social worker in accelerating change requires not only motivation and concern but considerable knowledge.

*Asian Drama, Vol. III., pp. 1617-9*
of the community services and gaps, with up-to-date know-how and judgment about community process. While opportunities to see unmet needs and discuss them with others may frequently come to a director or consultant to a special program, there are ample opportunities to identify unmet needs at any organizational level. The ability to identify the psycho-social-environmental need will be related to the openness of perception of the worker and his readiness to document meaningfully these situations. Gripping about poor resources or services is a waste of time unless there is documentation, often then staff and group consideration and fuller review with others in the medical setting.

The role of the chief social worker in setting an example to staff is crucial. The chief social worker in today's world will need more than ever before to be ready to take leadership in accordance with his principled position.

Increasingly, the opportunity to participate in improving resources and services will include those who utilize the services. Actually it was the parents' groups who originally brought together locally and nationally the potential sources of service to develop services to meet their children's unmet needs. They knew services were not available and since handicapped children are in wealthy families as well as poor families, they could afford to set up the coordinating mechanism.

An example of failure to include the representatives of the community in the planning of hospital sites by the major community planning groups resulted in such strong neighborhood reaction that the mayor or a metropolitan city had to reverse the decision of the planning group to close the facility. As it eventually turned out, this became the Gouvernour Ambulatory unit and became the first concrete example in that city of health services developed in response to expressed consumer need and participation.

More than that other local neighborhood groups and other community observers learned that they were not helpless in articulating health needs. It spurred on other similar activities in the community and explains why the local coordinating council now has over thirty groups represented.

The social worker in this role and relationship must be mature, knowledgeable, and unafraid. He must have standards for community development and community participation. He will need to search his own attitudes and be certain that they are broadly tolerant to deal with people as they are. Readiness to share specific knowledge and experience is a must, especially in working with people not accustomed to our ways of work and communication.

If we are interested in change, we are primarily involved in people desiring change as well as the social institutions. In this connection I was deeply moved recently by the article with its title "A Crisis of Conscience in Health Care" by Howard Ennes in the American Journal of Public Health. He asks, among other pertinent questions: "Are we affirmatively opening up opportunities for jobs, education, housing, health? There are actions we can take, directly and indirectly."

Leadership job opportunities for minority group persons to move ahead should not be dictated by momentary shortages in the field or the pressure to conform.
It should be recognized that only when representatives of minority groups are in leadership roles is there the fullest chance to utilize their perceptions of patient-consumer need. Mr. Ennes further asks: "Are we making it possible for consumer-citizens to participate in our own immediate operations—to help break through the frustrations of powerlessness?" "Are we consciously and persistently seeking to open communication, to break through stereotypes, to avoid polarized thinking, despite apparent misunderstanding and hostility?"

To cope more adequately with rapidly moving changes in organization methods, many social workers are acquainting themselves with the newer concepts in administration and systems management. This broader knowledge of alternative methods is essential in order to think more freely and to allow greater flexibility in organization.

There is interest in this group in organizational change in relation to the issue of centralization and de-centralization. Shall we plan ambulatory health centers with back-up hospitals at a distance or shall we continue the mammoth clusters of big medical centers? I do not believe there is a single authoritative answer other than that we do not know.

Based on the studies previously mentioned there is strong reason to experiment with new approaches in delivery of any service in smaller units, close to the people being served and setting up a variety of such experiments concurrently. Staffing them with persons of the area and planning for opportunities for these neighborhood people to express needs must be part of such experiments.

But who is evaluating the quality of patterns of utilization in these experiments. Encouraging objective analysis of new sources is important and the social worker should do so. Changes in forms and types of service models are desirable, but in doing this, professional and technical measures need to be developed to assess response and utilization.

Similarly, knowledge of information and automated systems may permit planning for more efficient service. Particularly is it important to utilize methods to improve communication, and to gather and sort facts.

The opportunity to learn of new theories of organization can be helpful in a period of search for a different way of working. Political and social scientists as well as management systems authorities have much to give us. For example, Dr. Warren Bennis, formerly of MIT and now at the University of Buffalo, suggests establishing temporary colleges during these periods of uncertainty. In discussing the organizational conflict in schools in the inner cities, Professor Martin Landau recommends what he calls intermediate administrative structure, with greater opportunity for community participation and the maximum involvement of community people in the effort. Also in administrative theory he urges organization structures that produces redundancy. This is a surprising theory to the "no-duplication" of service school but is considered sound as a safeguard in large bureaucratic settings where human services are involved.

Evaluation and research or, at least, feedback must be a part of every program of change. Where these elements are omitted or dealt with superficially,
the facts can never be obtained. Where there is a community participation
this seems even more urgent. Every project should have some means whereby the
persons responsible may have factual information about effectiveness of their
in-put. We are misleading ourselves and our younger colleagues when we do
not insist upon at least elementary evaluation.

I should like to conclude by reminding you of the social syndrome I mentioned
earlier: "no place to go after hospital discharge." I have spoken of some
of the deterrents that have blocked us in modifying that dismal picture. In
my view it is the logical result of distorted values, the practice of discrimina-
tion among our citizens and the misplaced power given to dominant groups in
the health field.

Change is now coming after a long period of frustration and suffering. We
are at the beginning of what promises to be a period of intensive participation
and, I trust, increasing satisfaction.

In this phase the social worker has responsibilities that should be utilized.
There is a danger of abdication and wide swings away from his full participation.

Commitment to purposive change based on knowledge of needs and improved
techniques in making adaptations will assist him in meeting the challenge of
change.
NEW ELEMENTS OF DIRECT SERVICE IN THE PUBLIC HEALTH FIELD

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Whatever other function that has been served by student unrest on the campuses, protest demonstrations in the streets and the ubiquitous cry for relevance, it is evident that the entire social work establishment has been shaken. We share this response with all other professions in all other establishments; no social institution is safe any longer, none is protected from the demand for change. Appropriately, at meetings like this we address ourselves to "changing perspectives," "new elements," and other such concepts that reflect our need to reach into the future, which is upon us already in our present. These are not easy times for professionals, just as they are rather depressing times for Blacks, students, the poor and all struggling minority groups. Professional expertise is viewed with suspicion, precisely at the moment when people need services, and since in the past social workers tended to hold out more promise than they could deliver, today our very finest modes of practice are perceived as outworn, if only because they have old and traditional roots. It would seem that we cannot win, no matter what stance we take. The best practice is condemned because it is carried on in a faulty system of some kind, and when that practice attempts to achieve relevance in the modern world, it is accused of lowering standards. This, in my view, is the context within which we need to examine our subject today, "New Elements of Direct Service in the Public Health Field". We must try to look upon our practice from the client's viewpoint rather than from our own vested interest viewpoint, because that is the easiest way to know what it is that we must do to meet the challenges being made of us. We must try to adapt our practice to the rapidly changing social forces, because if we do not, then professionals like us will be passed by, and that would be too bad. Finally, despite the shifts in practice modes that must, inevitably, come about, we must try to achieve impeccable standards of proficiency through social work services. This is a very tall order, but it is my impression that that is why you are all here, to seek these simultaneous goals of relevance and standards.

In this paper, you will undoubtedly find more questions raised than answered, and I think that is as it should be. For you are the experts in your own fields, and you will know where the answers lie; it is my sole purpose to draw the outlines of the issues, and of course it will be my bias that you will notice if I should happen to hint at any courses of action. As I see it, we in social work are at another of our many crossroads, but in this year of 1969, our choice of road to take is more crucial than ever before. One road will lead to oblivion or at least to the brink of chaos, and the other road will lead us in a joint effort with the people who need our services into a productive, socially responsive era of help, health and balance found through mutual respect and technical excellence. The choice of roads would seem self-evident, but we must be forewarned that the one I would choose to discuss today is a rocky one.

Provided by the Maternal and Child Health Library, Georgetown University
It is salutary for our discussion that you happen to represent public health departments, health centers and the like, because this fact places you on the cutting edge of what seems to me to be the future mode of social service organizations. Your professional affiliation to the programs devoted to the public's health save us from having to berate ourselves for being too over-concerned with private interests and the mad pursuit of pathology. You already have a toe-hold in the future, and you have had for many years. It is a matter of logic to locate professional practitioners of social work at those points in society where people go in the natural pursuit of their lives. A health center happens to be one of the best examples of such a location; at least the individual client or patient does not have to be ridden with pathology of some kind before he gets to your services, nor does he have to "sign up" and articulate his problem, vow that he is above all else, guilty, conflicted, verbal, and grateful for the help he is about to receive. At least, I assume that these are not the criteria ordinarily devised in your programs, primarily because they are created by and for the public, and because they aim toward maintenance of health.

Perhaps it would not be reaching too far to suggest that in the public health model of practice there is room for any of us to be recipients of service; there is no need to devise "we and they" notions because we too are of the public and while we might serve as experts in carrying out our particular functions, there is no such thing as the patient being a different breed than we. In other words, "clientism" is not a functional necessity; social distance is not a requisite of good social work practice, and the only thing, we can really be assured that we know better than our clients are the knowledge and skills that must be called upon in order to provide our services properly. While this Golden Rule of social work practice may seem to be all too obvious as one of our fundamental values to which we are all committed, organizing practice approaches in accordance with this value will necessitate some very basic changes. To restate the value, the people whom we would help are our brothers and our equals, and we would do unto them just exactly as we would be done unto. Adapting our practice to this value is not a mere matter of believing, for new knowledge and skills and new organizational modes will flow from the belief, and it will not be easy to accommodate ourselves.

The value to which I am referring is not a new one in social work, but what is new is the felt pressure from the people who are the consumers of all professional services that they be heard, that they participate in the decisions affecting their lives, and that they have access to quality services that are advertised by the professions themselves. The vast re-arrangements in power relationships in this country have opened doors for the consumers of services so that they will be heard; professional experts can no longer make closet decisions that affect others, at least they cannot do so without running the risk of being taken to task. If these are indeed revolutionary days, as marked by the bull horn, the sit-in, the take-over, the march, the stride and above all, the confrontation, then it will be necessary to do more than paste on new elements of service in our direct practice; it will be our task to examine our practices in a totally new context. The times will not wait.
In my view there are three major areas of social work practice that need to be addressed in light of the changing social forces, and this paper will attempt to discuss their areas and some of the implications that derive from them. One is the way in which we perceive the client in his environment, or the person-in-situation configuration. Two is the matter of the client participation in the terms of service, or put another way, the issue of the role of the professional as expert. Three is the manpower question and how professionals and non-professional technicians will function differentially toward the same social goals.

The Client in His Environment

Traditionally, in social casework practice, the person situation configuration has in the Mary Richmond and Gordon Hamilton sense meant that each case is a psycho-social event that has inner (psychological) and outer (social) forces in interplay with each other. Hamilton gave us a good start with that formulation, and to a large extent it is still a most useful conceptualization of the social casework "case." However, in the historical development of casework theory there were intellectual and value currents that were to distort the original view of the "case", and these were, for a time, to retard the natural development of the psycho-social interactional concept toward the present day transactional notion. Said more simply, the idea that the person interacts with forces in his environment has evolved to become the idea that the person is the pivotal part of the field around him, which may include his family, the organization of the hospital or agency that he attends, and even the worker himself. As well as the political structure, his cultural affiliations, his economic class, the housing he lives in, the school his children attend, his community groups, etc. etc. In order to make the point in its most raw formulation, where the client, patient or individual consumer of professional services earlier was viewed in a one, or at the most in a two-dimensional framework, his problems and their solutions were perceived as subject to therapeutic intervention through a caseworker-client relationship. If he were poor or sick or the delinquent or conflicted, the caseworker addressed the client in trouble with a view toward changing his behaviors, strengthening his adaptations, or supporting his adjustments. To a limited extent, partly because there were limited things that could be done, the caseworker dipped into the environmental or social arena that "surrounded" the client and worked on increasing his public assistance allowance, getting the doctor to explain the patient's illness, negotiating with the judge to lighten a sentence, or even treating family members that were contributing to the client's problem.

The "case" has been defined as an individual in interaction with his specific environment, and this was conceptualization that made one-to-one interviewing a relevant practice, because the perimeters of the case were relatively finite and theoretically, the social caseworker could contain all of the elements of the case in his head and he carried with him a tool box of interventions that were primarily verbal, and usually were addressed to the individual client himself. The client's "field" was out there, and the real work of intervention occurred between the worker and the client, as they talked, felt or acted out the ideas and feelings that were interfering with the client's happiness.

As we look back over the recent decades, we can identify several elements of social casework practice that derived from this view of the "case." To the
extent that therapeutic means and goals were intrinsic to the social casework method, there had to be great reliance upon theories and tools of the professional relationship, the most significant being those that explained and facilitated the transference. Here, we must differentiate between awareness of transference manifestations that occur in all human encounters and most particularly in the therapeutic encounter, and the use of transference manifestations. Therapeutic means and goals called upon using transference phenomena, and what more did these factors call upon? They required clients who were verbal, motivated and thus aware of conflict or guilt or discomfort. To a large extent such clients were on a high order of the clinical range of problems; they were clinically identifiable and they were above all accessible to therapeutic interventive endeavors. This therapeutic definition of casework carried other determinants, besides those that demanded exactly the right kind of client with the right kind of problem to be worked. It also required the availability of sufficient therapeutic manpower to provide the essential one-to-one interviewing, and it required private offices, regular interviewing times, and an increasingly narrower scope of attention to the client apart from his field of transactions.

Perhaps this view of social casework practice might have continued indefinitely with some degree of success, but for some serious intrusions of a number of reality factors. What were some of these factors?

The definition of problem changed, so that the clinic moved outdoors, so to speak. When it became apparent through the developing use of knowledge about ego psychology and some dynamic social science concepts, that a problem had systemic characteristics, that for each emotional response there were reverberations back from the environment, and vice-versa, the boundaries of the "case" expanded noticeably. For example, the child patient in a hospital ward no longer is viewed as a medical problem alone. He is, in present day systemic terms, an absent member of his family, which will be having its own adjustments to make without the presence of that child. He is part of the organizational structure of the hospital, playing his pivotal role along with every single member of the hospital staff, from the doctor to the maintenance man who mops the floor. He is a member of the group on his ward or of the clinic he attends for his special medical problem. Although he is hospitalized, he is to be once again an active participant in the school system, and he will play in his neighborhood, use the facilities of his community and ultimately partake in the activities and provisions of all salient social institutions. In all of these transactions there are potential points of imbalance between the little patient and the immediate forces around him. Out of such a view of the "case" how relevant is the single therapeutic encounter between a caseworker and the patient? The potential diagnostic parameter of this case is wide indeed, and where there is imbalance or an upset in the equilibrium among the patient and his immediate influences, there is room for a host of early, pre-therapeutic intervention techniques. These might range from settling a jurisdictional dispute among members of the hospital staff, to family interviewing, about the tensions that have arisen due to the absence of what may possibly be the family "scapegoat," to planning with the school for tutoring, to involving a community action group in getting improved housing facilities or a day care center, or whatever. We need not rule out the therapeutic interview, for this may be an essential component in the total interventive approach, but we must keep in mind that the case problem is quite a bit broader than the
previously defined clinical view, and therefore the problem is subject to a vast array of helping techniques.

What else changed that affected the validity of the traditional one-to-one therapeutic casework approach? Society changed in many ways. It became primarily urban, and this condition brought with it increasing reliance on public social institutions to compensate for lessened family supports. The urban condition brought an increase in crowding and yet also a continuing sense of loneliness and social isolation that seem to have contributed to the popular "breakout" in behavior. We need not spell out here the results of the generation gap, uncertain parental discipline, racial discrimination, undeclared and fruitless wars, space races in the face of poverty in an abundant society. The world is upside down, authorities are not believed or trusted, people feel disaffected, and nothing seems to be going right in the bureaucracies that are intended to help. What is the clinical definition of all this? How would we identify the root causes and the symptoms of the disease? If we all are suffering from the impact of our present society, should we all have treatment? Were we to increase by the thousands upon thousands the numbers of caseworkers in our country, they could not make the world right again, for what is wrong with the world cannot be fixed by caseworkers. The one-to-one encounter simply cannot be duplicated in sufficient numbers to make a dent upon the well-being of the people who need and want our services, but also, it would not be the proper prescription for what is wrong.

Client Participation in the Terms of Service - The Role of The Professional Expert

We cannot pick up a newspaper today that does not describe some chilling situation where college students chase their deans out of windows, high school students run out of school and dare their teachers to catch them, clinic patients take over the offices of their psychiatrists, parents struggle with school boards for control of the schools their children attend, and clergymen lead their parishioners in protest against some rule of the church. Even the most conservative among us can no longer ascribe this increasingly universal protest movement to individual psychopathology. It has been said that "Thanks to the Negro, the March has become a new form of politics."

What are people asking for? To a large extent they are asking for substantive things...sufficient money to get along in a money-based society, better housing, schools, hospitals and social services. They are asking for jobs and job training, education that is relevant to their experience, religion that is brought up to date, and more and better of every component of life. But most of all, they are asking for a chance to participate in their own life decisions. The more that public social institutions provide for people, the less intimacy do people feel and the less personal control do they actually have over their destinies.

It has been said that the "source of the public's unhappiness" can be found in the alienation they feel from each other and from their lack of participation in institutional processes. If this diagnosis is even partially valid, then it must serve as a serious challenge to the practice of social work. In the first place, social work is generally practiced in the major social institutions, so when the establishment is challenged, social work
practice will be a significant object of dissonance. In the second place, since social work practice relates more than most professional practices to the individual client's style and conduct of his life, it more than most professions will feel the demand of its constituency for participation in the services being provided. Given these assumptions, that people need somehow to compensate for an increasingly bureaucratized life in our cities, and that they are demanding an effective voice in their own affairs, what will all of this mean to the special expertise of the social work practitioner? Will it be possible to remain an expert and yet allow for clients and patients to participate meaningfully? My view is that this is possible, if not inevitable, and if not a preferred mode of practice. The involvement of clients in social work services is undoubtedly a new element of direct service.

One might ask what is new about it, because traditionally social work agencies and programs have always been governed by boards of directors or lay committees who have made policies and have been in charge of the professional's work. In fact, one of the hallmarks of social work as a social institution is that it has been reflective through its boards and policy makers of the currents of the times, whenever those times were. In other words, social work practice has never been defined in terms of its professionalism, but always has been a response to the interests of the board members or the political groups answerable to the tax payers. What is new is that the demand for participation and policy making is coming, not from the community establishment but from the people themselves; the recipients of service as board members, if you will, are the new element.

As we know from the teacher's strike in New York City, when community people begin to take charge of their own educational programs, this appears as a threat to the professional educator. I have never understood why, because parents of school children do not ask to teach; they merely ask to participate and to control the educational policies that so deeply affect their children's lives. Before we consider the implication of client participation on social work programs, let us imagine the community process at work in a straight medical service. It would seem more difficult in this area, because medicine... surgery perhaps... is the prototype of professional expertise; surely a surgical patient would not expect to perform his own operation, and generally, patients hold their surgeons in high regard, and consider their expertise "untouchable" by a lay person. Yet, even here there is room for participation in the terms of service being provided. While the surgeon would exercise his skills with rather complete autonomy, it is not in fact a matter of his expertise to determine the boundaries of the community to be served, the hours that the clinic will be open, the arrangement of visiting hours, the cost of the service, the nature of the attitudes of medical and paramedical personnel, or necessarily the kind of total medical care being offered. In other words, even where professional skill is as substantial as surgical practice, there would be room for active and comprehensive community participation, without doing any damage whatsoever to the quality of professional practice.

Could one say less of social work practice? Particularly in our field, where social functioning and human relationships are the substance of our work,
lay people and recipients especially, would expect to exercise quite a bit of
control over their own lives. In my view, this is no obstacle to good practice,
but is rather an easement if we join the notion of client participation with
the idea we mentioned earlier of the client in a transactional field. The two
ideas go together. In public health social work, for example, we might view
the client systemically, not only as an individual, but also as the pivotal
element in a whole sphere of occurrences. Our patient, client or unit of atten-
tion would not remain the person as a bundle of psychic impulses alone; rather,
our case would be that individual who is a member of his community, or the
catchment area for the clinic perhaps. He would not be a passive object-to-be
worked, but an active participant with his social worker carrying out the tasks
that are essential to his well-being and state of health. Imagine the advances
that could be made from our attention to broader views of "the case" in case-
finding, in enlisting others in the community in support of a patient's needs,
in organizing the community to achieve some common goal, in setting up informa-
tion and advocacy services...using the people themselves as participants in
their own processes. My guess is that the person who is at the moment the case
would be better served, would not have to remain a patient in order to continue
to live better, and would undoubtedly feel more kindly disposed than ever
before to the social work service that was so closely in tune with the needs
of the modern community.

Participation by community people in the terms of their own service will
of course mean that social distance between client and worker will be markedly
decreased, for practice would become more or less a joint effort. This will
not call upon less professional expertise, but more. Social workers will have
to understand fully and individualize particularly each situation as before,
only the knowledge base will be expanded. It will not be sufficient to know
about personality structure or even family interaction alone; the modern
social worker will have to be competent in his knowledge of group and community
processes, social policy, organizational structures, and how all of these
impinge upon the one individual client he confronts. As far as skills are
concerned, the social worker of this mold will need to be as practiced in
advocacy, working with groups, coping with bureaucratic processes, organiza-
tional hierarchies and the like, as he has been in one to one interviewing.
This view of modern social work practice will have implications that we haven't
ever thought of yet, for it will bring social workers to the forefront of the
community as the individualizers of the urban society; it could be that
social workers will become expert in helping their clientele to negotiate the
complexities of this world. This is a function that is not taken care of
by any other profession, and is probably the most significant requisite of
life apparent today. But there will be no possibility to emerge as a significant
helping profession in today's world without coping successfully with the man-
power situation, which we will comment upon now as the third area in social
work practice that must be reevaluated in light of the changing social forces.

**Differential Use of Manpower**

It is no longer necessary even to comment upon the widening gap between
service needs and available manpower. Despite the long time and understandable
resistance in social work to face the seriousness of the manpower problem,
reality has finally forced us to reevaluate the under use of professionals and
the over use of non-professionals. It seems that the only alternative to really
applying ourselves to the appropriate and differential use of social work
manpower is to withdraw services. This, of course, is an impossible idea, in
light of the ever increasing demand for services, and the fact is that in a
transactional view of the person-in-situation, there will be need for more and
not less manpower. The thesis about manpower strategy that I would like to
suggest here is that new arrangements that would utilize wisely non-professional
staff should be more than an expedient measure that would "compensate" for
lack of professionals. Proper use of non-professionals seems indicated in
light of the practice model I have presented. When we see social work services
permeating a community, whether that community be a neighborhood, a clinic or
a health center, then we must also recognize the varied helping roles that
derive from this expanded view of practice. Some of these roles are clearly
professional in content, while others demand the presence of indigenous workers,
or college graduates, or high school graduates.

While time does not permit us to make any detailed prescriptions here
about the total manpower situation, it is important to take note of some princi-
Tles that would underly any approach to the differential use of manpower.
First among many guidelines is the need for clear definitions of various levels
of personnel in social work. For example, the use of the term non-professional
is too general and descriptive; it does not really differentiate the qualities
or functions of staff, except that it delineates the professional school graduate
from all others. The use of the term pre-professional suggests that the non-
professional person ultimately will become professional. While this may occur
in some instances, it is important to face squarely the fact that the large
numbers of non-professional staff to whom we are referring will not go on in
their schooling, and this will mean that we must apply ourselves to providing
a parallel career line for those social workers who will remain non-professional.
I prefer the term social work technician, but there are other terms that are
suitable. We must only realize that when we use terms like case-aid or social
work assistant, we are saying that the non-professional person has no function
of his own without reference to the professional. In such cases, it would be
difficult to devise a career line for the non-professional, and I am not sure
that we will have resolved our manpower problem that way.

A second caution to keep in mind is not to get caught up in romanticizing
the use of indigenous workers. The popular cry that the indigenous worker can
do better than other social work personnel simply is not born out by fact.
What the indigenous worker can do better is often case-finding and early inter-
pretation to the potential client of the available services. In other words,
the bridging service seems to be a functional one for the person who himself
comes from the particular client group. Definitionally speaking, the indigenous
person does not have to be poor; he might be middle class, educated and have
qualities that resemble the professional worker himself, but his being native
to the population being served is what defines him as indigenous. Thus, he
might be an alcoholic, a TB patient, an addict, or representative of any client
group. The point is that in the role of indigenous worker, he ought to be
viewed comparatively with a professional worker, because his tasks will be very
different.
A third guiding principle in my view, is that we must save the professional for those tasks and functions he can do best. Since professional education differentiates the professional from the non-professional worker, we need to contemplate what it is that the professional gets out of his graduate school education that is not achieved by the person who has learned through experience in life or through on-the-job-training. Certain areas of knowledge and controlled use of particular skills, as well as a framework of values and use of self would serve as a brief description of the graduate school curriculum. The professional ought to be saved to think about cases and programs, to plan, to consult, to do complex tasks in cases, and to manage manpower teams. The fact is that when we really face the professional manpower gap we confront the raw impossibility of providing sufficient professionals back a step from their traditional direct treatment roles, so as to spread the service through the efforts of non-professional staff. It would appear that professionals are not by-virtue of their training any warmer or more out-going than non-professionals. What they are is more schooled in knowledge that they can draw upon to figure out the complexities of social work cases.

The third principle that must govern any manpower arrangements we might make is that non-professionals have to be given certain degrees of freedom of action or autonomy. If we reorganize our personnel structures so that we utilize large numbers of non-professionals and then we resist giving them opportunities to find satisfaction in their work, we will not have resolved the problem at all.

There are many possible manpower models that increasingly are being written about in social work. In keeping with the above mentioned principles, one might imagine a team of professionals and non-professionals, with the professional person responsible for the entire management of the workload, be that x number of cases, or a whole clinic, or a neighborhood. On the team he might have an indigenous worker, two or three college graduates, and perhaps a high school graduate. Each level of staff would have its career line, rising to supervisor of workers or administrator of parts of programs. There is no end to the possibilities for imaginative uses of personnel. For example, in a clinic, one might use technicians to be in touch with every patient who comes in the door, or who passes by, to let them know that there is help inside. The professional might make the judgment as to the kind of help needed in a particular case, or he might follow up and have a more intensive diagnostic interview to explore the situation. One might have a unit of technicians, with a non-professional supervisor which would be in charge of actual referrals to nursing homes. The knowledge of where the vacancies are, what the programs are, and who the nursing home personnel are can be gained on the job and can become quite an area of expertise for a non-professional person. But, the decision as to who needs a nursing home, rather than another plan ought to remain with the professional worker. Another example of a different kind of use of technicians is the model where the professional worker carries the "whole case" and the technician serves as his "arms and legs" carrying out different tasks all the time. Here, the technician would not develop the expertise in a particular area, like knowledge of nursing homes, housing projects, welfare departments, etc., but he would become expert in flexible use of himself in carrying out myriad tasks that are necessary in any case. He might be an advocate one day and a supportive friend.
to a client another, but always the direction of the treatment tasks would be defined by the professional.

Each social work program will have its own characteristics, and thus one cannot draw the functions and tasks for personnel that would cover all possibilities. We can only reflect here on certain general principles and illustrations; their application in specific situations must remain with the practitioner. In any case, the choice of means and the imaginative carrying out of programs are the artful aspects of social work practice; the challenge to work out the necessary arrangements is after all at the core of professional.

Summary and implications for social work education

This presentation was based upon the assumption that you as public health social workers are interested in exploring early intervention practice approaches. We have commented, therefore, upon the nature of our social situation today which includes community pressure for participation in social work programs. In light of the fact that early intervention means preventive services, we have noted the necessity for social workers to be available at those locations where people go in the natural course of their lives, so as to find cases before they become cases. We have observed that in the crowded urban world where people and social institutions are so intimately related, the unit of social work attention has become broader, to include in the case perimeter, all social factors that impinge upon the person. This fact indicates that the social worker's repertoire will have to include techniques that address the person, the group and the community, as well as organizational structures. Finally, the spreading of services and the enlarging of case boundaries will necessitate the use of many, many kinds of social work manpower, all of whom will have to be assigned differential and meaningful tasks so that the practice will be effective and the personnel will remain integral to that practice.

Since form ought to follow function, the implications for social work education are fairly obvious. We need to educate our social work students for responsibility. Even though they may be young when they graduate, they will be thrust into positions of team leadership, program and caseload management, consultation and organization activity. We need to educate our students to use a broad repertoire of skills in working with interpersonal, group and community processes. The cry will appear that this will mean a jack of all trades and a master of none, but the fact is that the world will not wait; people actually live out all of those processes simultaneously, and they do not in life divide themselves up into casework, group work and community organization boxes. We need to educate our students to be flexible, for they will be soon confronted with demands to treat, to advocate, to negotiate bureaucracies, to give appropriate advice, to devise tasks for technical staff, and always, to reflect the rapidly changing forces in society.

The heart of social work practice is individualizing. As we sort out from the mass, a person, a family, a group or a community, we are making each unique. This individualizing process calls upon vast areas of knowledge, and its effect upon people in our urban society will be that of humanizing the social institutions, and counter-acting terrible impersonality that has become part of the scene. Social work practitioners cannot do less than serve as the humanizers of the environment.
The group concerned itself with the historical factors that have built up to the current turmoil and demand for change in current institutional functioning. It was pointed out that social work with respect to health services has involvement with both the community and with the institutions that deliver health services and probably should play a forceful part in drawing the two together. The profession might well assume a similar role in relation to radical and conservative groups in the community hopefully reducing the gap that now exists between the two. The broad responsibility to humanize the total service process is a professional obligation.

A great deal of discussion ensued around the question of possible allies in this endeavor and how social workers join others or work collaboratively to achieve the goals of high quality health services. There was consensus that new curricula and new educational patterns in professional training must emerge. Whatever the new elements and details are, it was agreed that there should be joint educational experiences with related disciplines at an early graduate level. The team concept would become an integral part of training and therefore a learned method for delivery of services in later practice. This would supplant the present parallel training programs.

Social work has a responsibility to keep attuned to community needs as expressed by total community and to support the continued involvement of consumer groups. To do this in a balanced way training in social work should also include a basic or generic orientation to health concepts and services from which would emerge a flexible and comprehensive approach to meeting community health needs. There should be participation in a continued evaluation process always supporting the elements of change necessary to meet constantly emerging needs.

Discussion continued around the question what social work needs to do, both academically and in practice, to gear itself for the roles to be played in the health field. Schools of social work are interested in getting broadly based considerations of health back in curricula. Concepts of public health - prevention, epidemiology, a problem-solving approach could have much applicability to the field of social work.

Social work has made beginnings but needs to do a great deal more to become more relevant and effective in society and in the health delivery system. Some social workers are, and more need to, reach out to young people. Even at the high school level, they are questioning, wanting to know, wanting to be involved. Social workers should welcome opportunities to speak to groups.
of them, find ways to involve them meaningfully in agency programs. There will be increasing numbers of social work assistants on the scene, and social workers must be prepared to work with them. This will call for a high degree of willingness, flexibility and at times tenacity in overcoming obstacles of agency or bureaucratic policy. (Most social workers have a piece of power they haven't used).

Social workers, particularly case workers, are accustomed to responding to pathology. We need to focus more on "the normal", on preventive and broadly based services, and on a generic social work approach. As an example, community health centers have as a key to their success the involvement of the consumer group. Unless this concept really operates, the programs may not realize their potential. Social workers by effectively playing an advocacy role could help a community attain what it wants (and not what someone else wants or thinks it should have).

Social work has more than any other profession a unique skill in individualization. That skill in individualization can and should be expanded to a group, an agency, a whole situation, a community.

Group B

Leader: Shirley A. Nelson

Recorders: Ruth McCall
           Jean Jones

The focus of the group discussion was directed to change in the health field.

The question was raised as to the relevance of social work practice in a rapidly changing society. The social worker in the health profession is anxious as to his role and the need to retool skills. The practicabilities of the merit system, legislature and funding mechanisms along with the ferment of youth pressing us to do, contribute to this anxiety. The social worker feels irrelevant but is hesitant to say anything as not really sure of role.

The issue of consumer participation was raised with questions of how much consumer participation is enough, when is consumer participation appropriate, and does the consumer really want to participate. It was brought out that there is no reality without consumer participation, the consumer does want to be involved, Federal legislation does require their participation in many health programs, but communication is difficult.

The point was made that "consumer participation" is an overused generalization, and why should consumers be interested in all facts of a program? We, social workers, rush out to get consumer participation and leave out a vital step, that is, we must come to terms with ourselves as to (1) the role of the consumer, (2) is the social worker abdicating responsibility and expertise, (3)
the power that accrues to the consumer. As regards point (4) the "takeover" of some health facilities recently was by the non-professional staff, not the community. It is too recent an occurrence to judge whether this action was "good or bad," but the axiom of history tells us that to the victor belongs the power.

Discussion centered around the question of "how much is social work threatened by consumer participation?" The chief qualification for consumer participation is to be poor. Should not there be education or training requirements with social workers sharing knowledge to increase their capacity to participate; also, to help the consumer participant to understand and see the social worker's side of the situation, to develop a real partnership rather than a spurious relationship? It was stated that social workers really do not know where to draw the line—the permissive approach versus the guidelines. Further that social workers have not shown the moral stamina to say "this is not your expertise," to say "no". Which further points out the need to know who we are, what we do, and where we are at this point in time.

The involving of consumers in participation and planning should not be an absolute "yes" or "no" proposition, but a process of the whys, where, and what's—a thinking through and working through. It is not a sometime thing but a process that needs the keenest skills, techniques and sophistication of the social worker. It was stated that consumers need and want the social worker's expertise if the approach is genuine. They are really looking for help with this concept of participation and giving this help cannot be a 9 to 5 job for the social worker.

The present time is a period of adjustment and the excessive or over response of the consumer must not be met in kind by the social worker. Social Workers need to be a leveling influence and encourage a positive genuine look at the situation.

Another area of major discussion, the statement that social workers in public health do not have the sanction of the medical profession or the community at this point. The majority of hospital administrators are physicians. Many of the key positions in the hierarchy are political appointees. Schools do not train enough health care administrators. Public health social workers must find not only their role but the authority to implement needed community health care services.

One position was that the social workers had to sell their role to the medical profession, not in a subordinate but collaborative approach. This was countered by the question of why sell, why not win? The physicians know less about community needs, clinic needs, etc. than the social worker. The social worker must initiate action to gain recognition and authority to utilize knowledge. Why should medical care not be part of the social rather than vice versa.

The physicians have the sanction and use authoritatively without the knowledge base; the social worker has the knowledge base but not the sanction.

As follow-up to the point that social workers have to sell their role, in historical perspective, assuming that social work had its beginning in medical care in 1905, 64 years later the social worker is still "slugging" it out in a system that seems to perpetuate the social workers role as handmaiden to the physicians.

There was a real questioning of the "selling" approach and its relevance to bringing about needed change.
Some of the new legislation with the inclusion of social services as a condition of funding has effected some change. Also, it was stated that social work influence on medical education is an area that needed more input.

The question was raised as to why the expressed negativism about the profession. There are social workers in every kind of setting and an integral part of the system. Social workers undermine their own profession. It was stated that social work is there, but the bother is limited use of the social worker by the medical profession, and the growing disenchantedment of the new social work graduates. The counterpoint was made that the concept of "how is the doctor going to use the social worker" is a misdirection; why not develop services in terms of persons' needs?

The next major area of discussion, centered around how to set priorities in a particular setting, such as a general hospital. The social worker is faced with overwhelming needs and limited resources. There are increasing referrals of child abuse, attempted suicides, multi-problems families, etc., and increasing frustration of the social worker. It is difficult to make a decision of social work priorities, if not impossible, when the administrative policy of the hospital is to see all persons who seek care.

The social worker needs to broaden approach beyond the confines of the hospital or the health department. To seek a way of breaking into the cycle before problems get out of hand. But the question is "how to identify potential problems early, to intervene early, to prevent the occurrence." The social worker needs data to document problems, or if having the data needs to find an effective means to use to the fullest. The social worker needs to know what "population" is coming to the facility, and what "population" is not coming.

But then the social worker gets back to the crucial dilemma--the urgency of helping people in pain versus the broad view of documentation to bring about social action and change influencing many, and involving the community and legislative body.

On the other hand, if the social work staff assumes more responsibility than they can deliver services, or do not define priorities and establish limits, overtime, they block recognition of need and action by the community, and needed change in the system. A positive note was voiced that if we could get other things functioning well, such as family planning services, day care, etc., maybe the social work staff would be sufficient to meet the urgency of helping people in pain.
The meeting opened with Dr. Russell inviting comments on how to deal with the broad topics introduced and how to move from theory to application.

Discussion started around problems of personnel, the kind of staffing indicated, accreditation standards needed, and the variety of functions and jobs suggested by the position papers. The questions centered about whether needs should first be determined with programs planned according to needs or whether manpower considerations should govern program design. Consensus was expressed as focusing on needs and programs before jobs and of interrelating the job-manpower problem with the program design.

Manpower needs were discussed in some detail with focus on current experiences in broadening the professional competence of the graduate social worker and in identifying the elements of practice which could be performed by the social work technician. One of the ingredients identified as important in affecting the team practice between professionals as well as the team of professional-non-professional was that of personality. It was thought this could not be considered effectively in setting up programs but could be considered in allowing successful deployment of personnel as individuals develop within the program.

The group was brought back to Dr. Meyer's reference to "negotiating the complexities of life." Some specific programs were described which utilize both Masters degree social workers and social work technicians on varying levels. A problem centered approach was suggested. It was thought functional for the professional to use his skill to identify the problems, to identify and analyze a variety of needs and then organize the job assignments. Competencies should be isolated rather than the people.

In utilizing technicians, the necessity of advance preparation of existing staff was stressed. It was also pointed out that there is a need for a period of demonstration when one of the extra functions of the professional is to encourage and support the technician. It was suggested that basic training be given before employment by training centers outside the agency (such as New Careers) and that ongoing and more specific in-service training be planned within the employing agency. Suggestions for this training should be planned around the service given, i.e., (1) agency structure and function; (2) types of services given; (3) specific assignments with which technicians can achieve success.

Technicians in varied professional fields were seen as able to perform successfully in a different not necessarily lesser roles, and that a process of professional identification of job elements was necessary. Technicians
must be given time to learn dynamics of training and structure within which service is given. They are then capable of looking at their own problems in job performance and in utilizing peer supervision constructively.

It was pointed out that discussion had focused largely on levels of background rather than on levels of need. Questions were then raised. What needs are being identified and not being met? What kinds of services are being tried to fill needs? Do health workers help identify needs in liaison with the consumers? How are needs identified? How can consumers be used most effectively in planning services?

These questions brought out the tremendous complexity of modern health problems and in the delivery of services. Flexibility to allow changes was thought essential in program planning. Multidisciplinary staffs in multidisciplinary settings is required.

Implications for social work education were discussed. Social work graduates must emphasize to schools the changes demanded in practice. Learning/teaching settings should be broadened and more emphasis placed on consultation as an example of the additional skills needed in the health fields. The breath of public health was pointed out with some need for choice in expertness as social work methodology is equally broad. Short continuing education seminars were seen as one possible solution to the need to broaden and perfect a variety of social work methods. The hope was expressed that, in the push for extended social work practice methods, direct treatment should not be thrown out, particularly in initial training where this was seen as core knowledge. This was related back to Dr. Meyer's comment that the role of patient advocate and of community developer will eventually be returned to the consumer. These are roles which are currently being stressed by many schools in response to current need and current student interest.

"The Insecurity of the Profession" gets in the way (of partializing work). We neglect to partialize tasks which we took over because there was no one else around to do them at one point in history. We do not address ourselves to partializing or to say we will or will not take on certain kinds of tasks, although social workers are beginning to say "no". In this kind of approach, we have to think ultimately about the consumer of the service.

We do have some legitimate qualms: social workers are not built into the upper decision making levels of organizations. Directors already have difficulty in getting budgets for MSWs. The fear is that if they also ask for non-MSWs who are subsequently seen to be doing what appears to be the same type of work, administrators will challenge the need for so many expensive MSWs.

The question was raised as to why social workers have to justify themselves in this way. For example: the dental aid is not presumed to be a replacement for the dentist, yet social workers are the last to be added, the first to go. One answer was that this is our in-group feeling. Other groups have the same insecurities.

Any role we can play in major organizational change does not carry the implication that we need to give up direct practice completely. If we did, we
would not be as close to the changing need of the consumer as we need to be.

Dr. Russell suggested that we focus on the kinds of problems and issues raised by this morning's papers.

The comment was made that we are not sure what it is that the social workers fear to give up, as in this period the patient sets the pace, sets the need, and each level (of social work practice) will give to the patient what it is able to give. If this is so, the patient depends on us not so much for solution to his own problems, but rather he expects us to change the Establishment which interferes with his functioning or achieving of his goals. In order to meet this expectation we need to consider to what extent we are involved in a significant way with developing and modifying structure, the problems of centralized versus decentralized structure for example, and how we are trying to effect changes in our structure and service giving. The inquiry was made to what degree do you participate in discussion within your own structure? One reported that her unit participates all the way from the administrative committee through committees on money, how records are set up, and in turn funnels back to these committees what the Health Aids find in the community.

From the Federal level there is strong support for incorporating social workers in the planning boards, but we do not yet have one at the state planning level. Children's Bureau keeps lists of the number of social workers. There are none in the state health departments but we do have them in the special projects. This partly due to civil service problems where pay scales are not up to the level where they can recruit. Money comes in boxes and people land in boxes and not at the right administrative levels. Children's Bureau is currently reviewing family project plans. They find that social workers are expected to do financial eligibility, get appliances, etc. This indicates the conception the community has of our function. In these plans, social workers were never involved in the planning. The questions was raised as to whether the federal agencies could get together to link these issues.

We need to think in terms of tasks and what we can do to further the task. (re: partialization). We also need to consider how do you prepare workers and determine the qualifications for these levels of tasks.

Social workers are not in these policy making groups and we should be there. Preparation for this role is a responsibility of the schools and they are not preparing workers for this. When a worker is first out of school 90 per cent of his time goes into practice and 10 per cent to administration. As they go up the ladder, this proportion reverses. Schools of Social Work do not teach management, this can be obtained better from a School of Business and a course in business management was strongly recommended. The group was quite defensive about this comment, but this recorder regards it as a sound idea.

We have to decide what do we want to be there for and proceed accordingly. We also need some political power when social workers become involved with community people they, in turn, give a great deal of help in getting what is needed to achieve their goals. We should be taking advantage of the current upheaval and change.
In the model cities plans, people do not give the highest priority to health, but rather give it to employment and housing. They look on a project as an opportunity for employment of the people in the area.

Strength, courage and clarity in addition to knowledge are needed. We still let other people do our interpretation for us.

Group D
Leader: Kurt Reichert, Ph.D. Recorder: J. Allen Young

The persons assigned to Group "D" numbered from about 28 to 30 people all of whom expressed great interest and enthusiasm in the discussion. They represented a wide range of types of Health programs as well as a good variety of agency sponsors in terms of public, private, national, state, and local agencies. A good number of the group members were directly involved in the problems of community participation, the main subject under consideration, in their practice. Others anticipated these problems and expressed a desire to be prepared with technical knowledge and the benefit of experiences of others in this area of professional involvement. Our discussion leader, Dr. Reichert, quickly established rapport and pulled the group together by introducing himself and identifying the members and the programs with which they were working. We spent the first ten minutes to indicate how the discussion time should be used. Several topics were proposed for the discussion. Most of them were in the form of questions. Among these topics were: What are the Techniques Used to Develop Leadership Participation? How do you Involve the People of the Community when the Guidelines of the Program are already Set? How do you maintain Good Standards when Using Indigenous Workers in a Program of Community Development? How do you Finance a Program of Medical Social Service in the Face of the Rising Cost? What are the Ways in which Social Workers Can Influence State Legislators and the American Medical Association? What are the Methods for involving Legislators in the Problems affecting Social Work as these Problems are Identified? What is the Best Media to Use when You're Working Alone as a Social Worker and Must Relate to a Number of Community Organizations? How do you Deal with a Community where there are Different Language Problems? What is the Nature of (Client) Advocacy and Exactly how can the Social Worker Help in this Role? What Aides Can be Given the Professional in Accepting the New Tasks Confronted by Social Workers? How Can the Professional Social Worker Sharpen his own Skills and Change his Own Attitudes towards the Client, and the Client's Needs? (This includes the attitudes of agency board members.) What are some of the Problems of staff Professionals in their Remote Relationship to the Policy Making Group? (This refers to the old board structure and staff relationship to those boards.)

The topics suggested were inter-related and seemed to form clusters that could be handled together in the discussion.

The first part of the discussion seemed to center around how community people (consumers of service are being involved in the various public Health
Care programs around the country, and the techniques being used to accomplish this. What appeared to be the Confrontation technique, was one that seemed to create the most concern, and even anxiety for some members of the group. Reference was made to "shock" aspect of this technique - such as loud talk, inappropriate words, "telling it like it is," on the part of community residents, in the efforts to bring about change in agency policy or program direction. I don't believe that there was a conclusive resolution of this problem. However, there was general acceptance of this as a technique, and one to be expected; one that social workers must be prepared to deal with. Another technique mentioned and described as a "phony" techniques was that of the tendency to bring members of the community onto agency boards, primarily because of their verbal talent, their susceptibility to "brainwashing," and their amenability to being directed as to what the power forces on the issues and question. There was something of a debate over the ethics of this technique. The group was not so sure that the coaching technique was all bad. This was described as one useful method communicating ideas, if done properly. If it is a one-way street where the communication only goes out from the "establishment," it may be bad. If the community residents are coached on communicating their ideas and understand how to draw feelings from the community, it can be very good. A number of examples of how communication is established between the community residents and the decision makers in programming were given. It was indicated from the discussion that communication is extremely important.

On the subject of community participation through representation, several models were proposed which made this possible. One model called the Paralled structure, suggested that a second agency board be established, consisting of neighborhood residents. The traditional board and the neighborhood board would have paralleled functions and power, and would infuse into the decision making process, ideas coming directly from the community in terms of programming. This model would provide further consideration of two different sets of priorities and two different agendas, each agenda representing the interests of the paralleled boards. It would make possible a forum for different points of view. The second model offered was the One-to-one representative. For every professional employed in the program -- doctor, nurse, social worker, etc. -- there would be a community representative in the decision making and planning body. Their deliberations would provide an opportunity for exchange in attitudes and would be an educational process for both sides. This could work to enhance the program.

There seemed to be general consensus in the comments that social work in community Health programs still has a long way to go in catching up in the area of consumer participation. In some of the comments could be detected some pressure, both internally and externally, to push ahead in planning for this kind of involvement. There were feelings expressed that we were at a point where we could not stop this pursuit. The community will not let us stop, because the need for citizen participation was identified and initiated by community members in the first place. The concern at this point seemed to be, "How do you proceed in the most effective way? No real guarantees of success were offered in the suggestions of the group members. The group became involved in the question of Power. Who possesses it? Whose had it in the past? How is it used and what are the motivations for power? Throughout the discussion there were feelings expressed that the Establishment, of which social concern and even confusion as to whom social workers should listen, and with whom social workers should identify.
In further discussing who makes up the community, about which we should be concerned, some group members felt that in Health programs, we should only be concerned with consumers of service — those persons who are receiving the services offered, rather than those who represent a geographic community or a community of representative agencies. Examples given of how the former model has worked effectively were in programs for Retardation, after care, and that of pregnant girls. It was felt that there is a stronger common bond among consumers of service, than in the general community. The services have a more personal meaning to the participant. The question was raised, "What in fact can people, who are not consumers, contribute to the planning process? Can they really have a bona fide interest? How can this be done without the risk of outside political, non-service connected, irrelevant influences?

The group's attention was turned toward themselves as professional social workers inside the Establishment. How can we use our professional skills and influence creatively? Comments from the group suggested that the social workers' awareness of human behavior, group inter-action, and general knowledge of the community, can be very useful in interpreting to agency administration a community's need; feelings and desires. Social workers should use their influence with agency administration to make changes that would assist in meeting the needs of the community. Can social workers afford the risks involved, or must we take the risk and be prepared to accept the consequences? Group members debated briefly on personal commitment versus professional responsibility.

A number of state and regional people had difficulty in identifying their community. How do you relate to the residents of a whole state? A suggestion was offered on the use of a questionnaire directed to consumers of service, asking them what their complaints are and what they would like to see in the way of service improvements. In an example where this method has been used we were told that response from consumers of service confirmed what professionals in the agency had anticipated program needs to be. It was further stated that this method provides good documentation for other purposes, such as funding, and etc. Another example cited: After all efforts at community organization and techniques on the part of professionals had failed to get a rat control program, a public relations firm was hired to develop a program to get the support of the legislature. This was especially difficult since the control and decision was to be made at the state governmental level. In another experience, a professional saw the need to bring about change in the conditions at a prison hospital. When her efforts failed as a staff worker, she gave the newspaper a tip and the publicity resulted in changing the situation. In the same connection, one member of the group offered the use of oneself creatively as a citizen (rather than a professional social worker) at informal social gatherings, such as a clam bake. One can meet his representative on an informal basis — engage him in discussions of problems of the agency or community, calling attention to things that he might do as an official of the state. There was some reaction from the group to this suggestion from the point of view of ethics, which lead the group into the discussion of the professional's rights as a citizen — his inclination to subjugate his citizen role to his professional role. Members of the group cautioned against ill-planned and inappropriate strategies or techniques and the harm that this can do to the client or th community. This suggested that
we should ask ourselves, "What if the strategy doesn't work out? Will the client be better off? Does the change we are making toward represent real improvement or will the situation for the client be worse.

The group became somewhat concerned with the nature of the contract of the professional social worker. What is his responsibility to his employer in connection with citizen participation? How far should he go with his loyalty to the agency? At what point does a professional reputation and other job possibilities? What are the ethical questions involved?

Time did not permit full coverage of all questions originally raised. However, a number of points were covered in the discussion that were not included in the original agenda. Some attention was given to areas in which social workers need to reinforce their knowledge and understanding. It was pointed out that social workers could no longer afford to limit their knowledge and skill to direct practice of social work, but needed to have understanding of administrative and organizational behavior -- how to negotiate in a bureaucratic organization. Social work knowledge needs to be broadened to include business methods. Some thought should be given to the place of social work in the hierarchy of the organizational structure. Additional skills are needed to offer the influence that we, as a professional group, are capable of, if we are to effect social change.

In response to this new need for knowledge, a number of references and readings were suggested, the complete list of which I was unable to note.
Dr. Cooper, I am happy to be with you this morning. You are a very key group in terms of delivery of health service because your discipline allows you to have such flexibility, it allows you to cross categories and traditional boundaries and to range widely throughout the community. It is no secret that our communities need some sort of organized way to find out what services are needed so that systems can be organized for delivering this service. From my experience, I think your discipline has a unique opportunity to help lead the way in this endeavor.

My own field of special interest is control of infectious diseases. This is how I got involved in this problem of rubella. It has been an eye opening experience to me because, quite frankly with the current techniques, it is fairly easy to take care of most infectious disease in a hospital and for the practicing physician to take care of most of the rest of the infectious disease right in his office or over the telephone. The rubella epidemic 1964 and its consequences have shown me that there is a much more fundamental and important dimension to the delivery of health service.

We wish to expose our experiences and some of our ignorance to you today because I think the lessons we have learned are applicable not just to a particular group of children -- not to just children with congenital rubella or to children with other congenital impairments, but to all children.

Barbara Fedun is the Public Health Nurse Coordinator in the Rubella Birth Defect Evaluation Project. She does literally understand the Project activities "inside and out" and bears heavy responsibility for delivery of comprehensive health service. Her description of patient oriented Project functions will be carried forward by Joanne Margolin, Project Social Worker who will describe our efforts after we realized that traditional medical care alone was not enough.

Mrs. Fedun, Miss Margolin and I are going to tell you about our personal involvement with the problem of rubella. I will center around the Rubella Project itself while Miss Margolin will tell more about our involvement with the community.

It is well known to all that normal children have certain needs, but when we consider the needs of a handicapped child, these needs become more complex. Furthermore when an epidemic causes a sudden and enormous increase in the number of handicapped children, the problems are compounded many-fold. In the spring of 1964, a rubella (German Measles) epidemic swept across the United States affecting thousands of women in early pregnancy. In the New York metropolitan area alone, over one thousand infants were born from this epidemic with some form of congenital malformation caused by rubella in pregnancy. The handicaps range from hearing loss only, to multiple involvement with hearing loss, cataracts or glaucoma, cardiac lesions and neuro-motor retardation or any combination thereof.
Bellevue Hospital in the New York University Medical Center complex has long been interested in the problem of rubella. In 1961, a rubella laboratory was established in the hospital to study the disease and to work toward development of a vaccine. This was still the only rubella lab in the New York Area when the 1964 epidemic struck. It was natural that doctors throughout the community would request clinical and laboratory consultation here for many pregnant women and their infants. After more than two hundred infants had been seen in the spring of 1965, it became obvious that some kind of program should be set up. With an emergency grant from The National Foundation (March of Dimes), the Rubella Birth Defect Evaluation Project was established in May, 1965.

The Rubella Project combined the skills of the pediatrician, cardiologist, neurologist, ophthalmologist, otologist, audiologist, public health nurse, social worker and lab technician who provide complete medical evaluation of children whose mothers had rubella during pregnancy. The purpose of our multidisciplinary project is to characterize the natural history of rubella and to establish guidelines concerning diagnosis and management. My role, as Dr. Cooper mentioned, is Coordinator of the Project. This means that I am responsible for coordinating all the medical services for the children in the Project and supervising the office activities so that the services are carried out.

At the present time, we have studied more than six hundred children with rubella syndrome. Approximately four hundred children remain in active follow-up. Sixty-five children have died and approximately forty children have been lost to the study. Twenty-five of our children have been institutionalized and twenty-five or more are on waiting lists for institutional care. Most of our patients are four and one-half year olds from the 1964 epidemic. But, at the present time we also service thirty-five infants under the age of fourteen months reflecting the continued presence of rubella in the child bearing population.

The usual weekly schedule in the Rubella Project is as follows: Three days are reserved for pediatrics examinations. One child is scheduled for approximately an hour and a half visit and four children are scheduled per day. This is the most important visit of the year. It is at this time that all the loose ends are tied together. The family has a chance to discuss with the doctor what has gone on, what is planned and what they may expect for their child during the coming year. Problems with schooling, management in the family and the community are discussed and recommendations are made. One day is set aside for specialty visits (i.e., sessions with the cardiologist, the ophthalmologist or the neurologist). Naturally, these doctors can see more patients in a shorter time period. We utilize the services of the Hearing and Speech Clinic of the Department of Otolaryngology at New York University Medical Center four days during the week. Approximately fourteen children are scheduled for audiology testing per week.

We have found it most beneficial to start each day with a morning meeting. This is where the coordination of the patient's care is accomplished. We review all the patients seen the previous day. The Project staff is brought up to date on the current status of the child, and placement problems or need for further evaluation is brought to the attention of the proper persons who will continue to work with the child. A typical child who we feel has received coordinated service is one who came to us with hearing loss, bilateral cataracts, heart disease and some neuromotor retardation. In early infancy, his cardiac lesion was

Provided by the Maternal and Child Health Library, Georgetown University
repaired without complication. Later, he had cataract surgery bilaterally and then he was fitted for proper glasses. He began home training with the Industrial Home for the Blind until he was ready for more intensive training. He was started in the Experimental Preschool Program at Bellevue in 1967 and, after a year's time, was functioning well enough to be given a trial at St. Francis School for the Deaf. We are still working with this school in order to determine whether a child with such limited vision can fit into their program.

We also have had numerous disappointments. We are still finding children who have been misdiagnosed and not given proper training. For example, one new referral is a four year old boy who had been followed in a mental health clinic where he had been diagnosed as schizophrenic. The family was made to feel totally responsible for his problem. When someone finally looked back further into his history, it was found that the mother had a rash illness during her pregnancy. Then the question was raised as to whether some of his acting out might be on the basis of deafness. On audiologic testing he showed no response in one ear and severe loss in the other. He is now being fitted for a hearing aid and being managed in the Bellevue Experimental Preschool Program. (Miss Margolin will say more concerning this program).

It is important to remember that despite all our efforts, we fail regularly to meet our goal of coordinated, comprehensive service. Another recent example is fresh in my memory. A young Puerto Rican mother and her baby were referred to us from the Bellevue Cardiac Clinic. We saw this family in seventeen visits during early infancy. The child had heart disease, bilateral cataracts, and psychomotor retardation. The child received what we considered to be complete care, including immunizations, formula changes etc. Then 10 days ago we were called by the mother who said that she was about to leave the child in another hospital for a complete work up. We contacted the hospital and found out that they were going to admit the child for cataract surgery but that this had to be delayed because the child had a cold. We explained to the other hospital about our program for this child, and why cataract surgery was inappropriate at this age, for this child. We learned that the mother had not told the other hospital of her involvement with our unit. She really wanted to get her baby's cataracts taken off before a new baby arrived! She did this despite all the explanations we had given her concerning the best time for the eye surgery. Nevertheless we are back in business with this family. While awaiting her eye surgery and receiving other care, the child has been sent to St. Joseph's School for the Deaf for a special educational program. We know that a language barrier and cultural gap helped create this problem. Despite the presence on our staff of a nurses aide who is a member of the Puerto Rican community this still remains as a serious problem.

It is difficult to capsule briefly what we do in the Rubella Project. We operate on the premise that early recognition and correct identification of handicaps and problems within the family is the first step toward better management and patient salvage. Long term study is important to the scientific aspects of our program and there will always be problems of maintaining such follow-up. With much effort and personal attention, we do believe we can keep our patients together. Since congenital rubella creates handicaps that are not unique, we feel that our experience with the rubella problem should serve as a useful model which will permit us to examine the methodology of managing any child.
with a congenital malformation and to us this makes the effort doubly worthwhile. Thank you.

Miss Margolin. The Rubella Epidemic in 1964-65 not only demonstrated the need for coordinated medical service but also the need for coordinated community service. In 1964 and 1965 our community resources were strained to a severe degree and were unprepared to deal with the large number of handicapped children that the epidemic produced. In New York alone the figure was estimated to be over one thousand children from this epidemic while in the country it was roughly thirty thousand. In our early stages, the Project was not oriented toward working with the community nor defining the network of services that the congenital rubella child needed. It took us two or three years to realize the magnitude of the difficulties they had in managing the children and needs became apparent, our placement of these children. Of the four hundred children that we are presently following in the Project, there are roughly seventy-five percent who are in need of special education in a skilled facility because of learning problems created by their congenital defects -- a facility geared to help develop language, make good use of their vision, focus on sounds and enhance socialization. In the past year, we have seen not only an increase in the number of children needing special education, but also an increase in the number of multi-handicapped children. This increase, I think, reflects better medical techniques which allow seriously impaired infants to survive and increased ability of the medical personnel to detect subtle congenital defects in these children as they grow older.

After we had surveyed existing community resources for the pre-school multi-handicapped child, we learned that there were not sufficient facilities to meet the needs of these children. A host of difficulties had to be overcome in order for the community to begin to deal effectively with this problem. For one thing, agencies were not accustomed to sharing their philosophies and methodologies. Other agencies had rigid admission policies for the severely involved child. Duplication of services often occurred when there was no central coordinating agency. In addition, there were also a shortage of trained staff to work with the multi-handicapped child. Our parents, too, became frustrated by these gaps in service because they were often left on their own to search for further help without any guidance.

Because of the dramatic unfolding of these problems and the community's lack of anticipation of the needs of these children, irretrievable ground has already been lost. Our children have already suffered the consequences, and as they are now approaching the traditional school age of five, the public schools special classes are being flooded. With the coming of the 1969-70 school year, it is hoped that the progress will continue rapidly and that the educators will plan adequately to develop these special programs so that their education will no longer be delayed.

The rubella epidemic clearly demonstrates how new health needs had to be met; how medical priorities had to be established and new rehabilitative techniques had to be devised in order to cope with the problem that the epidemic created. Community coordination must be effected successfully so as to provide early recognition and identification of handicaps, to facilitate the management of the patient,
to establish better community planning and to provide for early stimulation and training for this group of children. A center that assumes responsibility for this coordination must first survey the existing community facilities before it can identify services lacking and make recommendations for supplementation of new ones. Visits to the facilities in the community should be made so as to establish relationships with the agency personnel, in addition to evaluating its suitability for a particular child. The coordinator must also share information with both agencies and help them to understand the existing problem. In a sense the coordinator of the coordinating agency assumes the role of a stimulus for change, thus helping the facilities to expand and plan for new programs. Many times diplomacy is required because the coordinating center serves as a mediator between all the existing facilities in the community. It assists the agencies in realizing their limits and function since many times agencies become over-protective and are reluctant to give up their client. The center must be available to provide information both to parents and to other professional agencies and serve as a resource facility, using the expertise and knowledge of its staff.

The center should serve as a liaison between patient needs and community service and must therefore assume prime responsibility for referral of the children to training facilities. In making a referral, contact must be first made with the agencies to determine whether its services are appropriate for the child. The psychosocial dynamics of the family must be taken into consideration for many times these can cause obstacles in taking advantage of service. After the evaluation of both the agency and the family, immediate plans must be formulated and then shared with the family. At the same time, long-range planning for the education of the children must take place. Medical reports must be then abstracted and sent to the agency. Communication must be maintained with the facilities after the initial referral is made. If this does not happen, the children often get lost in the shuffle.

One mechanism that we have used to keep track of the placements of our children is to telephone the families. Every three or four months we call to discuss the child's present placement with the family, thus enabling us to identify the gaps in service.

In our own attempt to provide coordinated community service, the Rubella Project in collaboration with the New York City Board of Education established a pilot training program at Bellevue Hospital in October, 1967. The purpose of this program was to serve as a model for the development of services for the preschool, multi-handicapped child. We presently have three teachers assigned from the different fields of special education in addition to staff from the Departments of Hospitals and Health. New methods of instruction are explored. Auditory stimulation is emphasized as well as the development of visual-motor skills, self-care and socialization. Presently there are twenty-one children in school from the New York City Boroughs, attending either two or three times a week in a group depending on their level of functioning. All of these children manifest some degree of brain damage while half of them are also affected visually. In the school itself, coordination of services is essential in providing comprehensive care since the children often need hearing aids, physical therapy and other corrective appliances. It is difficult for us to determine how much progress these children will make but at least we are giving them the opportunity to learn. We do hope that this experience in establishing a preschool program for the multi-handicapped will serve as an impetus for the community to develop more services of this nature. One indication of progress that has been made is the passage of two amendments to Title VI of the Elementary and Secondary
Education Act, entitled The Deaf-Blind Centers Act and the Handicapped Children's Early Education Assistance Act which are providing for establishment of new regional centers for children.

We still have a need for more effective community coordination and adequate services if better facilities are to be provided for the handicapped child. The creation of a central agency to handle the problems of the handicapped would establish a single unit as a primary resource center among the vast network of community services. It would also provide surveillance in the planning and provision of service for such children. A current file of all agencies that service the handicapped, their criteria for admission and a system for grading the adequacy of service must be kept. A national birth defects registry with a reliable method of reporting would lead to the early identification of handicaps and therefore help the community to anticipate its needs. With the devastating effects that a major epidemic can produce, the community must be as adequately prepared as soon as possible to face a crisis. The community must be educated so that it can utilize and support such programs. Health planning must take place, and new models for delivery and organization of services must be established if the community is to make use of knowledge gained from previous experience.

Dr. Cooper. As Mrs. Fedun and Miss Margolin have illustrated, our unit has attempted to provide organized service for children with congenital rubella. Unfortunately, too few facilities have attempted to provide such care. When we look at the country as a whole, the picture is a frightening one. Community expectations have been raised to a level by our Presidents and by our Legislators such that the community now believes (because they have been told it is so) that health care is a right and there should not be different classes or qualities of such care. In the meantime the costs of health care continue to rise and if the spiral continues, may reach ten percent of our gross national product. Furthermore, more than three million people currently are engaged in delivery of this care. Of itself, this should not be surprising or frightening. Unfortunately, we still are spending most of this money with the methodology of the "mom and pop grocery store." Even if we spent fifteen percent of our gross national product on health care using existing techniques we might still have third rate service.

It is clear to anyone who looks at the problem here in America that perhaps the best health care in the country is not given to the rich, or to the poor, but is probably that which is delivered to our Armed Forces. Although this care lacks some frills, it is fairly uniform. It makes heavy use of organization and paraprofessionals, and has heavy emphasis on preventive medicine. It would be hard to find any segment of our community now receiving better care than our Armed Forces and their families. To me at least, the lesson is clear. We do need a logical system for delivery of health service.

These remarks about the health needs of millions of Americans are not a digression. They are central to the questions of why we are so concerned and interested in congenitally impaired children and why there should be a lesson from the rubella epidemic of 1964? Rubella is dramatic, discrete and easy to define. One should be able to generalize from the rubella experience because the handicaps which this condition produces involve virtually every organ system: the brain, with mental retardation, typical cerebral palsy, behavioral disturbances and learning disabilities; sensory deprivation, as you know from eye lesions and hearing loss; congenital heart disease and transient or permanent defects in many other organs. The problems
these children face are typical of those faced by handicapped children in general.

What is so attractive to me about learning lessons from congenitally impaired children and why do I think these lessons might be applicable to those of us who are concerned with delivery of health care and health systems? The first and most obvious reason is that these children's needs are enormously complex and can only be met by a truly multidisciplinary team. Second is the fact that numerically, they are not so large a group as to be overwhelming, but are not so small that one can dismiss progress with them as not relevant to the general public. Third, and not to be ignored is the fact that no established group really wants responsibility for the congenitally impaired child. The services required are so complex that there is no single discipline that can do the job adequately. Progress tends to be slow and on the short haul economically unrewarding. Therefore in establishing coordinated care for the congenitally impaired one would not have to do battle with established vested interests who would resent new approaches. An example of the advantage this provides is known to many of you. People concerned with mental health services have "a leg up on us" in terms of their attempts over the past ten or more years to create organized, comprehensive systems. The reason that they have had a head start is the same as that which exists for the congenitally impaired child. No individual or single discipline really has had the facilities, manpower or knowledge to provide comprehensive community mental health services. Therefore, when people began to organize approaches to such service, to their good fortune, they were not competing with any existing group. In terms of providing comprehensive services to the congenitally impaired we also have no one to compete with. Physicians alone can't do the job; neither can educators, social agencies or parent groups. What an excellent place to start on comprehensive "health" service.

Miss Margolin and Mrs. Fedun have talked about specific requirements for comprehensive, coordinated care. Fortunately, the concepts expressed of early identification, on going diagnosis, early and age appropriate, family oriented intervention and input from many disciplines are not original with us. Far from it. As I travel across this country and talk with people concerned with children, these concepts are being expressed over and over again. Although the words vary depending upon the discipline involved (e.g., school teachers, doctors, or social workers), the "tune" is the same. All that remains are such fundamental questions as who should take responsibility for such programs, how will they be staffed and funded. In our heterogeneous country, there must be many different approaches to meet our varying needs. Montana is not Manhattan. Contributions from the private sector and the public sector must vary from Puerto Rico to Pennsylvania. Nevertheless, attempts must be made to implement these concepts and each of us must accept responsibility for contributing that which we have to offer. As social workers sophisticated in public health, I know of no group whose contribution can be greater than your own. Thank you for your attention.
COMMUNITY BASED PROJECTS FOR THE AGING

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I am most grateful for the opportunity to participate in this annual meeting of the medical social consultants. Let me use this time to share with you some experiences of the National Council on the Aging in its work on the local scene. I shall deal mainly with two Demonstration and Research programs which NCOA has conducted during the last two years. One of these is Project FIND; the second is the Senior Community Service Corps. These projects have been implemented by NCOA in 22 different communities. Based on our guidelines they have also been conducted by other agencies in many additional areas.

Both of these projects were developed around the notion that more of the elderly, including the very poor, have skills that can be utilized to deliver needed community services. Let me underscore that this does not imply that all of the elderly can nor wish to work or volunteer for such service; but rather that there are a great many jobs in voluntary and public agencies that need doing, and that many of the elderly would welcome the opportunity to do them, particularly if they could thereby earn some income.

Project FIND, conducted in a dozen areas of the nation, employed older poor persons to locate and study the elderly poor, to document their greatest needs and to make recommendations for change in public policy. The Senior Community Service Corps projects were implemented in 11 communities to employ the elderly to provide a great variety of services. Some 850 older persons, most of them from the lower economic sectors, were employed by local subcontractors who conducted these projects under NCOA's supervision and guidance. Project FIND was funded by the Office of Economic Opportunity, the Senior Community Service Corps by the Department of Labor.

Project FIND derives its name from the acronym formed of the words: Friendless, Isolated, Needy, and Disabled. The words however do not provide the real clue to the impact of the program. The significance of the title lies in the word itself. Over 50,000 individuals were contacted and interviewed. It was necessary to FIND those elderly poor persons who both served the program and were served by it. Some were truly lost. They lived on mountains or prairie roads which led nowhere; they were in cabins up a hollow alongside a creek where no auto could go. Others were lost even to the census taker though they lived in the heart of our great cities, for persons who reside in hotels are presumed transient and are therefore not included in the nation's count of its citizens. Some were not lost, but invisible, because nobody wanted to look. The former mayor of one community discovered the condition of some of his older residents only after leaving office and taking a photography course which used Project FIND as the subject for its study. The photographer saw what the mayor had refused to see.

The point, ladies and gentlemen, is that programs aimed at the elderly need to find them, and cannot take for granted that they will emerge from isolation to make use of the service being offered.
As the aides talked to the elderly, they recorded needs, and then with the help of advisory committees and sometimes professional supervision, sought and organized sources of help within the community, helping with the referral and serving when necessary as client advocates. When no organized help was available, the FIND aides gave such direct service as they could and mobilized volunteer help and stimulated self-help services.

The experiences of these 12 projects show that with the variations that reflect local differences (and these were considerable) there was, on the whole, a considerable amount of service available. However, the elderly were in large measure unaware of these services. Even Social Security and Medicare were outside the knowledge of considerable numbers of the people located by this project. In many instances, however, there were few resources available. Where the need was immediate and urgent, for transportation to a doctor or a hospital, for food or warm clothing, a bed or a stove, for firewood, a telephone call, for cleaning up a house, giving a bath, preparing a meal, or providing a social contact, the aides or volunteers they located provided the only answer.

Let me underscore this point. In many areas services, including such services as may be purchased under Medicare -- home health services as an example -- simply did not exist. On the other hand, in those places where they did exist, those who needed to use them were often unaware of their existence. "Outreach" may have become an overused word but it is an underused program component.

The statistical data reflecting the findings of our interviews, and I must remind you that this was not a scientific sampling but rather a door-to-door search, have been sent to the Duke University Computer Center and are just now being collated and analyzed. Any figures I use are therefore preliminary and subject to later revision. Let me cite just a bit of the data coming through, particularly as it relates to subjects of special interest to health related workers, and to people concerned with social policy.

The target areas in the communities studied were in the main poverty areas, the target areas of the Community Action Agency funded by the Office of Economic Opportunity. It was intended that we talk to the poor in the poor areas. Some, whose incomes were over the poverty levels, were found in many of the target areas, and in one community where an attempt was made at careful sampling, pockets of poor older people were found in middle income areas.

Taking into account all the questionnaires completed, and some 45,000 actually are being studied, these figures on income show up: Fourteen percent of the couples have incomes of less than $1,000 per year, or $500 per person. Nearly one third of the couples had incomes of less than $1,500; two-thirds were below the Social Security Administration low income index and eighty-two percent below the modest but adequate budget for an elderly couple ($3,869) established by the Bureau of Labor Statistics.

The individuals living alone had similar proportions with incomes below the poverty and low income levels. Considering all those questioned, about seventy percent had incomes below the Social Security Low Income Index.

An important aspect of the status of the aged in our society is their silence, their apparent acceptance of their lot and their needs. President Eisenhower has
been frequently quoted as saying that as a child he was poor but not aware of it because most of the town people were likewise poor. But two-thirds of those questioned said their incomes were inadequate and over one-third said that there were things they needed "badly" -- with money, clothing and medical care being the most frequent serious needs cited directly. Other needs show up indirectly through the analysis of the data. In other words, these people know they are poor and respond when asked about their needs but don't talk up or fight for their resolution.

While twice as many of the elderly interviewed in poverty areas were receiving public assistance than is true of the aged as a whole, thirteen percent less of the couples were receiving Social Security, less than half as many had earnings, and substantially less had veterans benefits. It seems pertinent that such a considerable percentage were not receiving Social Security.

One community reported---
"Many senior citizens do not know that they are eligible for Medicare at 65. For some reason they were missed during the Medicare Drive. The same may be said for Social Security. Elderly people are misinformed about the aged when Social Security eligibility begins."

A surprising number of people seemed to be totally unaware that small Social Security incomes could be supplemented by old age assistance. One man needed to keep a doctor's appointment and get drugs for a heart condition but had no money. He had been receiving Medi-Cal cards monthly but had been destroying them regularly, not knowing what they were.

The projects referred over 28,000 people to 412 services and agencies; seventy-five percent of these referrals resulted in provision of the needed service. These included 1,286 Social Security referrals and 2,309 public assistance referrals.

Illness and medical care are particularly acute problems for the older poor, in spite of the advent of Medicare. Thirty percent of those questioned said their health was poor or very poor; twenty-five percent said they thought their health was worse than that of other people their age. Fifteen percent said they had to stay in bed one or more days during the last month because of a health condition; twenty percent stated that they had been hospitalized during the last year for an average stay of about eleven days.

Aside from these types of answers, those that related to needed services because of a health condition need to be stressed for this group. One-fourth of the women said they couldn't do their housework and needed help; one-fourth couldn't do laundry without help; one-fourth couldn't shop for food. Over half the men said they could not maintain or repair their living quarters without help; forty percent said they couldn't do the outside chores and one-third couldn't shop for clothing.

Without physicians' examinations, it is hard to assess or measure health care needs accurately. The figures used here reflect self-evaluations and estimates of need. But the statistics, with all their flaws, indicate that there are considerable amounts of care needed but not received by this group. For example, twenty percent indicate they never go to a doctor or go less often than once a year; two-thirds of the total group say they would like to go to a doctor more often than they do. Many said they needed various corrective devices. There were an average of 40 physical aids needed but did not own dentures; eleven percent needed but did now own eye glasses; eight percent needed hearing aids; two percent needed canes. Only one-fifth of these aged had been to a dentist during the past year.
Some fourteen percent said they were not signed up for Medicare, about twice the proportion for all the aged, indicating that they either do not know about it or cannot afford the payments involved.

Negroes interviewed by the aides reported poorer health, more days in bed, more symptoms and more doctor visits than whites in the same income groups. The rate of physical aids needed is almost twice as high for older Negroes as for older whites.

A surprisingly large proportion of Negroes, about one-fourth of those questioned, reported that they had not signed up for the voluntary portion of Medicare. This figure is being studied further, but if confirmed would indicate a rate three times the national average of the aged not using this part of the Medicare program.

One of the most disturbing findings relate to the adequacy of diet according to the estimates of those questioned. The disturbing thing is that the answers reflect a lack of awareness of minimal nutrition standards and are refuted by the incomes and fixed costs reported for rent, etc., by the number of referrals for surplus commodities and food stamps, and by the volume of case histories regarding food needs.

In one community where almost everyone said they were pretty well satisfied with their food most of the time, answers to other questions showed that the self-evaluation of good diet was faulty. For example, nineteen percent reported that they ate only twice a day and seven percent only once a day. In contrast to the supposed high rate of meal satisfaction, sixty-one percent reported that their food was tasteless.

In a poem written during World War II, Karl Shapiro said:
"Cite me no statistics of the dead;
The dead die one by one."

In that vein let me read to you just a few of the individual case histories as reported by the older aides. Perhaps better than the broad statistics, these one by one human vignettes will tell what FIND found:

1. Female, 71 when first seen by the surveying FIND aide was almost passed by: she was so aristocratic looking and stood in front of a solid brick house. The aide, remembering this as the home of a former friend, which was now a rooming house, broached her. In a timid voice, she graciously invited the aide into her living quarters. There was one dark room too hot and cluttered by dolls and oddities. They were her "companions" obtained free from the Salvation Army the year before, after the Christmas rush for toys for children was over. From the recipient of $89.00 Old Age Assistance, she had once been a sort of combination practical nurse-companion for some of the city's wealthy citizens. Now, though the mother of two sons, long since grown, whose whereabouts she did not know, she was sick, having poor eyesight and a recurring kidney ailment (having had one kidney removed when she was twenty) and exceedingly lovely.

2. Males 58 and 56, two brothers, unemployed since last November, lived together in a frame house on a paved street. From the outside, just at a glance, the
house seemed quite nice. On closer inspection, the FIND aide found some decaying planks in the front porch — the status symbol. The inside, even to a FIND aide, was a shock: dark, stenchy, almost bare rooms with closed windows. The "furniture" consisted of two double bedsteads with lumpy mattresses, one ragged quilt each, a broken down wood heater, also used to heat a can of soup, and a refrigerator not connected and obviously a discard, since its doors were unhinged as a protection for children. In the room designated as a kitchen was the house’s only faucet, from which water had been coming only the last two days, the water having been turned off because the bill was not paid. The older brother, a World War II veteran, not long released from the V.A. Hospital where he was treated for six months, during which time all his teeth were extracted, looked like a cadaver. Though given a follow-up appointment to be fitted for dentures, he was too sick to go on foot and had no money to go by city bus, much less a taxi, so he had failed to go. Having no telephone he made no cancellation — just hadn’t gone.

3. A steelworker’s widow, 80 years old, sat lonely and desolate, locked in arthritic agony. Until a FIND aide paid her a visit. She speaks no English, but happily her FIND visitor can communicate with her in her native Spanish.

When we got here, there was absolutely no heat, the weather was below freezing. The water pipes were frozen. The broken windows were covered with cardboard. The building is condemned. They weren’t charging rent and soon it will be razed. We managed to get some window glass at a discount store and repaired the windows. We located a gas heater for her.

4. There is a needy lady who lives along with no-one to look after her and in very poor health. She can hardly get around in her house and hasn’t been out for over two years. One of our FIND aides called on this poor lady and found her suffering with a toothache. She said she had been in pain for about a month. The aide reported this to the Neighborhood Center and they got busy and called a dentist and asked if he would be willing to go if someone went along to help him. We went with him. While we were there, another old lady saw and recognized the dentist’s car and she came over. She had been having a toothache too, and had no way of going to the dentist. He pulled five teeth for the first lady and two teeth for the visiting one. They were so grateful and happy, they cried.

5. Nearby was an old man living all alone. There was no-one to look after him. He was very ill. The aide contacted the Welfare Office and they asked her to get in touch with the County doctor. He said, "bring him in". She then contacted the funeral home and they donated their ambulance and brought him to the hospital. He had pneumonia.....He is getting along fine now.

6. I went to Mr. B.’s house and found him very sick and trying to build a fire. He was so short of breath he could hardly talk. He told me he hadn’t had any dinner, but didn’t want me to fix any, as he would breathe so hard he couldn’t eat. I went for someone to help him. We got a taxi to take him to the hospital where his condition was considered a heart attack. I have visited him twice in the hospital.....He is getting along very well.

7. The old man was 92. He had poor vision and was partially deaf. His wife was 85. Because of their handicaps, especially the man, they were thought to be
senile. But I found them spirited and lively of mind....We will work on getting devices for hearing and glasses and proper food; which because they had so little income, they couldn't afford to get.

8. In these hills and hollows there is a dilapidated shanty. The grandmother is 92 years old. Her granddaughter is crippled and blind so she stayed in bed with her. It was her only way to keep the girl warm and give her a sense of personal contact. The grandmother had once had a guitar and had taught the granddaughter to sing a little. The walls were not plastered, but colored pages of a newspaper had been pasted on the boards to make the room "more cheerful".

9. I found a 74 year old migrant worker, living with his wife, their daughter and her three small children in a tiny three room shack. The old man only earned $600 last year, picking vegetables in the field. He never collected any Social Security. I helped him file for Social Security and from now on they'll get a monthly payment. To think he could have collected Social Security for the past nine years, if he had known, but this is lost to him now.

10. I found Mr. C. living in a broken down little house....His bath and toilet are no good. He has a few days work now and then, and he says it comes to an income of about $1,000 for the past year. Out of this he pays about $960 for his rent and food. He looks bewildered. He has gone along this way so long, he thinks there is no help. The hand-to-mouth existence is the only life he knows as an itinerant field worker. Bill collectors are routine at his door so, therefore, all strangers are suspect. He is handicapped with defective sight in one eye, the result of cotton picking in the south. He expects little, but we are going to see he gets proper care and help.

11. I came in to see an older couple. They are living in a converted chicken house. There is a big crack where the wall and floor meet on one side of the house. The sill is rotted and the floor is separating from the wide wall. He is a World War I veteran and has many health problems. She needs an operation. I have encouraged them to apply for food stamps and have found an agency that may help them with their drugs. They were happy to know about these things...

12. This woman lives not very far from the best part of town...She lives alone and while we were there the chickens ran in and out of the house. The mattress was eaten up by the rats; however, she is still sleeping on it. She has no bath - just a cold water hydrant and a lavatory. The sad part of this story is this woman thinks her way of living is perfectly normal. She does not know there is a better way....

13. One day we got a telephone call: "I'm at the end of my rope" a man said. "I need some help and I need it bad"....We went to find him. He heard about us on the radio. He and his wife both sick. "I'm 79," he said. "My wife has leukemia. We used up all our savings. I don't know which way to turn."

14. An elderly Filipino gentleman told me that many of his people work in the sprout fields until they fall dead and are found by their fellow workers.
After a work span of forty or fifty years or more, of harvesting the crops at such low wages, all they possess is some fishing gear or an old car. They have very little money - not enough to pay for the most modest funeral.

Yet only one has had to be buried by the county in the past five years. Friends manage to raise money for funeral expenses. It is not unusual for the coroner to keep the body a month while the money is raised. I met the men in the fields through a 73 year old retired Filipino. We've helped twenty of these men, the youngest was sixty, the oldest 76 years old. Not one knew about Old Age Security benefits.....

We sensed their fear of being sick, of disturbing the boss, of insecurity, under their courteous and cheerful attitude.

At the top of those stairs in two small rooms I found Frances Saltow. She is completely alone in the world; she is crippled and her eyesight is so bad she can no longer read her Bible. She CAN see TV to a degree. And only that TV set and a couple of helpful neighbors stand between Mrs. Saltow and despair.

"We lived in Buffalo, New York," she said. "My husband died there in 1963 and my daughter brought me out here. She died last April. I don't have nobody -- I'm like Topsy."

In spite of her aloneness, crippling from a broken hip and glaucoma that is dimming her vision, Frances Saltow is not sitting there feeling sorry for herself.

"God has been good to me but I do miss not getting out," she said. "I used to be able to walk downtown and go into Woolworth's and get a cup of coffee and a piece of pie, once in a while." She looked wistful. "That was a big day for me -- something I could look forward to."

Now the doctors have told her she will probably be unsteady on her feet for the rest of her life. She doesn't dare to go out alone, or without using her "walker".

"Sometimes I get the blues," she said. "When I had pneumonia last year I asked the doctor why he didn't just forget to give me the medicine and let me die."

In most of the areas where the projects were invited there had been either no prior coordination of efforts on behalf of the elderly or only minimal efforts. The projects brought together workers from various disciplines and agencies to serve on advisory boards, to train the aides, to facilitate referrals and to coordinate efforts. In most communities these projects provided the bases for some long range coordination and planning for the future.

A second by-product of the project was that in each community several out-stations were established to serve as neighborhood information and referral centers. Over 6,600 persons, in addition to those interviewed in their homes, visited these offices for assistance. Manned by other older poor, located where they were accessible, heralded by appropriate community announcements, there neighborhood based centers attracted clients, served as satellite offices for interviewing by other agencies, as stops for transportation programs set up by the projects, and increased the
visibility of the whole operation in the community.

In several of the projects the elderly organized significant self-help programs. These ranged from a community clean up drive to clubs and modern senior centers. They produced listings of resources available to help, published newsletters, conducted meetings, set up craft manufacturing programs, clothing exchanges, friendly visiting services, etc. When the demonstration phase of the project ended, most of these programs remained behind as ongoing operations. In addition, in each community one or more funded programs were established to remain behind after the demonstration phase had ended. These programs were all based on studies of the priority needs found in the project as well as what funds were available. But built into the initial demonstration design was the requirement that the phasing out of the initial program would include the phasing in of a permanent program. This has happened in each community.

Permanent changes have also come about through the involvement of the project staffs, the clients and such coalitions as could be formed in social action. Social action took different forms in different places, and did not always emerge in the traditional sense of mass involvement or participation. Sometimes it involved the implied threat of potential pressure. Sometimes it included picket line, leaflet distribution and large public meetings. The projects left behind new surplus commodity programs, decentralized food stamp distribution offices, liberalized welfare department regulations, protection for single room occupancy tenants, new health and dental facilities, several councils on aging, meals on wheels programs and almost everywhere greater awareness of the needs of the elderly.

The elderly served as staff, on boards, on advisory committees, as group captains and in a vast multitude of other roles including project directors. Few had even been involved in such a program before, all needed the income, most felt useful and related to the community again. The elderly were not just clients, they were colleagues. They often worked longer than they should have and went out in the cold of winter and the heat of summer, committed to the job and even more to their neighbors whom they were serving. In several instances opportunities for promotion and upgrading were available and filled by the aides. The new careers, or para-professional concepts, proved equally applicable to those 55 to 70+ as to the young.

These experiences are not unlike the ones we are having in our 10 community demonstrations of the Senior Community Service Corps. In this project, 457 persons 55 and older are working part-time in a vast variety of public and voluntary agencies. About half are providing direct services to people of all ages, others are in administrative and organizational jobs. In all cases the jobs were previously not being done, though the need had been there.

For example, 20 aides are employed in the State of Maine helping get surplus foods into hunger counties. In the last few months these 20 aides have combed the counties, informing people about surplus foods, certifying those eligible, arranging for the delivery of the foods and have, in this short period, brought 32,000 people into the program.

In San Francisco, 30 aides working out of senior centers and other voluntary agencies are offering personal assistance and establishing protective service networks in the community. These services range from minimal help to more sophisticated financial assistance, referral and support to enable the frail to stay in their own homes, knowing there is someone on whom they can call in a time of need.
In West Virginia the aides are used to help improve the operations of a sheltered workshop, several serve as aides in a school for trainable mentally retarded children, others in a juvenile delinquency facility.

In New Jersey a large State hospital has assigned the aides as geriatric assistants. One of these aides is age 75. The Director of Nursing Service reported: "These aides are frequently more effective with the patients than our own nursing personnel. The patients appear to respond better to those with whom they can share past experiences." The same favorable impression is reported from the San Francisco General Hospital and the University of Oregon Medical Hospital. Interestingly, in each of these instances, there was initial reluctance on the part of the institution to participate in the program.

In one southern border community, an 82-year-old Negro man who had worked recently as a porter, in spite of an early college education, was placed on the County Health Department staff and has become a sanitary aide and is now at work on a sophisticated pollution study.

Almost all of these people were poor, and in spite of their part-time earnings remain pretty much so. As this program grows (it is now about a year old) wage increases and promotions will help bring some of these individuals out of their impoverished circumstances.

It is our hope that the exciting results of these projects will help prove the necessity for implementing a permanent national senior community service program through the U.S. Department of Labor to create jobs for those older persons who can and wish to work in broadening the range of services provided to their fellow citizens.

Of course, the results of Project FIND and many other studies show that as the elderly increase in number, other means must be found to stop poverty and to provide answers to its related problems. The poor need money, and more than money, for they also suffer from poor housing, poor health, poor nutrition, poor transportation, poor social and recreational programs and poor access to community influence and power.

While much of this is true of the elderly in better economic circumstances, the priority must remain on ending the cycle of poverty first.

We hear much about ending the cycle of poverty for the young so that their tomorrow is better than that of their fathers and grandfathers. But what of their fathers and grandfathers? Their needs have been shown by our studies to require urgent attention and their tomorrow is now.

Our task as concerned citizens, as molders of systems of service, as workers helping people, is to remember that all of the numbers and the statistics we hear are of people; and to use our work and our knowledge to make the changes in our work and in our institutions so that change takes place, so that those who need service are reached and secure it, so that those who can lend a hand have an opportunity to do so, so that we work with as much as for our clients, and so that we bend the system to the shape of the people rather than try to train the people to fit into our system or program.

Unless we do this, particularly in regard to the present aging, we will find that the pattern of poverty and isolation will be our main inheritance from this generation of older people when we stand in their place.
CONTEMPORARY DEVELOPMENTS IN DAY CARE

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I am pleased to have an opportunity to talk with you because you are among those who stand in very important positions at this time in regard to improving many aspects of the health of children. I will speak about current trends and questions regarding day care of the very young child. It is my intent to try to include in the last part of what I shall say this morning some of the questions we should be asking about this important area.

It is my custom to start with the developmental or historical approach to things so I shall begin by reminding you that there have been many changes in our conception of day care for children in recent years. Day care was designed originally to provide a service for parents and it focused on the health, safety and care of bodily needs of children. We felt reasonably good if we could protect the child during the day, feed him well, look after him when he was ill and return him safely to his parents at the end of the day. Most of the regulations developed for day care had to do with these things until very recent years. During World War II, as you know, there was a rapid and widespread, but short-lived development of day care services necessitated by a need for women for the labor market and the need of those women to have a safe place for their children to be during their working hours. I believe I am correct in saying that all of the states but two, California and New York, largely dropped their public day care operations at the close of the war. But these two states continued them with varying degrees of success and with further development of their programs.

One of the exciting and very important things that has happened recently is the way in which knowledge about child development has influenced the thinking of people in the field about what ought to be provided for children who have to be away from their families during the day. The early childhood educators have long been influential in California and New York, for example, in some of the standard setting and in the discussions of content of day care programs. Quite recently, people especially interested in the child's cognitive development have talked more and more about early learning and what experiences might be provided for the very young child that would promote and facilitate learning.

Day care for the very young child, that is for those under three years of age, has become more relevant at this time for a number of reasons. One is that there is renewed interest, or at least more widespread interest than ever before, in the early years during which infants learn a great deal. Those of us who have been preoccupied with infants for more years than we care to admit, feel it is about time the importance of the early years is acknowledged in practice.
Much of the impetus for day care comes from the parents. Some of it, but by no means all, comes from parents who are economically and socially disadvantaged—who, through word of mouth or from direct experiences with programs such as Headstart, have come to believe that opportunities ought to be provided for their children for early educational experiences that have long been possible for middle class children. Whether or not Headstart realizes the high hopes set for it in promoting the learning of the child in school, I am convinced that Headstart or something like it is here to stay, and certainly ought to be here to stay, if it is done well.

Another reason for parents' requesting day care is that more and more mothers in all social classes are needing or wishing to go to work. Economic pressures are primary reasons for many. Others need work outside the home as a part of self-fulfillment. Whatever their reasons more and more parents need to have a good place for their children while they are at work. It is important that we keep in mind the thousands of children we know of whose mothers have always had to work and who have not been well cared for in the absence of their mothers. Some of these poorly cared for infants have been poorly cared for in group arrangements for the very young child; some of these have been well cared for in such arrangements; some others have been poorly or well cared for in private day care arrangements. By far the largest number of very young children are being taken care of by women with whom private arrangements are made. It is not at all unusual for a situation to exist such as the one involving a little girl of seventeen months who entered our day care center more than a year ago, whose conscientious, hard-working mother had tried to provide good care for her through making private arrangements. But she had been taken care of by six women in her first thirteen months. None of these women was grossly inadequate as a mother substitute, as far as we knew. All of them, though, were trying to take care of too many small children of the same age; they were trying to do something that really could not be done well by one person. Such private arrangements, though they can sometimes work well, are often risky and subject to change. This is of special importance since we know that discontinuity and inconsistency of care interfere with the development of the very young child.

In many states there are attempts to develop family day care facilities on a broader scale than ever before under the supervision or sponsorship of public and private agencies. This kind of facility needs further support and development. Hopefully, there will be financial support and professional support that are adequate to help maintain some kind of stability. But let us not deceive ourselves: we all know that in very few situations is there enough assistance to the family day care mother either in helping her to improve her care of the children or through providing adequate financial support.

One of the relatively recent ideas that is being implemented is the concept of the Center which is developed to provide a spectrum of services for parents and child. This movement toward centers for parents and children has come from several different sources, developing in parallel ways with slightly different emphases. Still, many of the objectives of these centers are congenial if not identical.

Without trying to be comprehensive, I shall mention three of the currently prominent types. One is the parent and child centers being developed by the Office of
Economic Opportunity through its community action programs. They are characterized by an effort to provide services of various kinds such as health services, social services, legal services, support for jobs and including, often times, day care. These centers are also characterized by the insistence that the people to be served be involved in their development, planning and administration. There is another type that has developed primarily as the neighborhood health center. The concept of health services has grown increasingly broad in an effort to meet the needs of the people the centers will serve. One such example of the neighborhood health center approach includes special projects such as those supported by the Children's Bureau, one of which is directed by this session's chairman, Dr. Green, for children and youth here in New York. Starting from a focus on physical health, such projects have great opportunity for expanding the concept of what they can provide, to include a variety of facilities within the center itself and an increasing opportunity for reaching out into the neighborhood and community. They can provide important social, educational and other services in addition to those concerned with physical health.

From quite another source similar recommendations are currently being made. I have recently been a member of Task Force I of the Joint Commission on Mental Health of Children. We were assigned the task of producing a document that would recommend ways of promoting the mental health of the child under five. We found it impossible to talk about promoting the child's mental health without talking about prenatal care, out-of-wedlock pregnancies, contraceptive information, post partum care of mothers, child health conferences and child development services, including day care. If one compares documents describing these three kinds of centers one finds great overlapping in what they recommend and a central theme of the importance of providing services that have to do with the prevention and cure of illness. If we want for example to improve mental health and physical health we need to consider services that address themselves to the education and nurturing of the young child. We will also need to plan for parental involvement and assistance to parents if we seriously wish to influence the development of the child.

There is a great need for resources in which children will be safe and well cared for but good child care services must be much more than safe. We are in a difficult spot now because we are lagging badly in the development of comprehensive services which support the development of children. There are enormous health problems and developmental problems among our children which could be prevented. While many of these are among the poor, many privileged families also urgently need assistance with child care. I believe that one essential approach to alleviating these problems is to provide better and more comprehensive services, including good day care services. At present we do not have the facilities nor do we have the manpower. However, we can and must begin. Some of the resources to be developed can from the beginning, be excellent places that provide for good physical care, but whose opportunities for further development are promising. I think we must combine an awareness of current realities with a consistent and hard headed insistence on improvement of care within a particular program or facility.

One of the ways to begin to provide a place where children can be safe and where their developmental needs can begin to be met is to have something one might call a development period for a new center. The development period would be not just a few months or a year or two of grace in which one does not have to comply with regulations but a period during which regulations can be flexible if progress is being show toward the development of standards of good care. Progress toward excellence would be expected.
Some of the questions that you as interested professionals might ask in regard to the development of day care facilities in your area are as follows:

(1) What are the provisions for licensure in your state or community?

(2) What are the guidelines and when do they become regulations?

(3) What are the requirements for staff especially in regard to education and to personal qualities?

(4) What kind of daily experience is to be planned for children? Is it planned in accordance with knowledge about developmental characteristics and needs?

(5) What are the provisions for staff training for growth in knowledge and effectiveness in work with children?

(6) What are the plans for improving the status of those who care for children?

It is a sad commentary on our contemporary values that the people who care for children, whether they are pediatricians like Dr. Green and myself or teachers, nurses, social workers or parents, have less and less status the younger the child is, and usually earn less money than those who care for adults. It is very common, moreover, for a mother to say, "I'm only a mother." It is regrettable that so many women have to feel that being "only" a mother or "only" a person who takes care of children is being the low man on the totem pole. Those of us who are in a position to influence attitudes need to realize that, in our country at least, one of the ways to influence attitudes is to influence what people get paid for their work. We must try to bring our influence to bear to improve the status of the people who care for the very young.

One should ask what plans there are in a particular facility in its developmental period and later for providing a nurturing environment that meets the needs of the very young child. There are aspects of the nurturing environment that can be defined. But before I speak of these I wish to emphasize that assistance to parents in their growth as parents and in meeting the realities of their daily lives is enormously important in providing good day care for children whether it be in a group situation or publicly supported family day care or in private arrangements. I believe, especially in regard to group day care, that even when the provision for children is excellent, we will not have the kind of constructive and long-lasting influence we wish to have if we leave the parents out of such situations. Thus I urge upon you that you ask the question: what is the parent's part in the day care program? I am not talking about who runs the center or of policy making. Rather, I speak of some way of involving parents in ongoing communication with those people who take care of the child and support them in their "parenting" (an ugly but useful word). If we make real and consistent efforts to include parents we can be of real help to them. A genuine commitment for communication and involvement with parents is required.
Of course in meeting the needs of children we must have a physical environment that promotes the physical health of the child. Here we speak of space, food, sanitation and the like and of attention to illness when it occurs. I shall not dwell on these since I am sure they are better understood than are some of the other needs and are generally the first things that are provided when a facility opens its door.

I want more than anything else to emphasize the need for adequate staff. For the young child, there is no substitute for interested adults who have the time to take care of him during his long hours away from home. The inter-personal relationship is the basic experience through which the child's intellectual and emotional development comes about and many aspects of his physical development as well. Environmental influences for the very young child are mediated primarily through his caretakers. If one talks only about the learning process for the moment, it is important to note that the quantity and quality of the interaction with people determine whether certain stimuli or experiences provided in the environment have the desired influence on the child's learning. I do not wish to be misunderstood. I do not say that someone has to be with the child every moment; I do say that a great deal of individual attention, of one-to-one contact, is essential for the provision of adequate learning experiences, for experiences that support emotional and personality development and provide safety for the very young. I especially emphasize this point since one can put ten or twelve infants in a room with one person. In so doing one creates a bad institutional setting during the day with all of its known disadvantages. We can keep children from getting injured by keeping them in their cribs and playpens but we do them an enormous disservice with that kind of staffing. I think it is awfully important to remember this, because if you are running a center within which you have infants, toddlers, and three, four and five year olds are normally mobile and demanding. If something has to "give", it is often the infant in his crib. Therefore, I urge that we not support day care programs for infants if there cannot be adequate adults available for their care and stimulation.

Starting with interested staff, more or less experienced with infants, how does one spell out for them how they will spend time with the very young child? In a booklet published two years ago called Guide for the Care of Infants in Groups,\(^1\) I made an effort to describe what adults should provide in order to promote good development in group care. More recently (1968), a similar effort has been made by several authors in a publication called Early Child Care.\(^2\) Other suggestions will be forthcoming as workers in the field gain increasing experience in infant day care. The point I wish to underscore is that it is possible and necessary to plan specific kinds of experiences for the infant which are designed to meet his developmental needs. Group baby sitting is not enough. The planful approach geared to developmental and individual needs is absolutely essential to providing adequate day care services.

Because of the demand, the need and the dreams for day care and what it can do for our children, there is a great danger that in our haste we will develop bad programs and that people will become disillusioned. It will follow that within a few years people will be ready to throw out the entire day care idea. This is the way we seem to do things. We are prone to demand that one approach provide all the answers and we become disillusioned when it does not. In providing good day care services we have part of an answer to only a small part of society's needs, but it is a relevant and can be a constructive answer.

I think that we can if we work hard and insist upon excellence, we can develop many good centers for children which have services for the very young that do not endanger development but enhance it. It requires staff and money; it requires great energy; it requires eternal vigilance.
REFERENCES


Since most of you are employed in federal, state, and local public health departments and in public or private medical care programs, I have decided to focus on the areas which might be of special interest to you and in which many of you may already be engaged, rather than to try to cover in an even more superficial way, all aspects of the social work role in family planning.

When asked to present this paper, I was told that the major theme of this meeting would be "Changing Perspectives in the Contemporary Health Scene," and I understand that earlier sessions have been devoted to a general consideration of change mandates for social workers in the health field with regard to notions of priorities for social action, the delivery of comprehensive care, and consumer/community participation - as well as new elements in the delivery of direct service practice in the health field. It occurred to me that it might also be helpful to discuss the possibilities for social work involvement in family planning in relation to some of these newer trends in the health field.

Perhaps the most important and dramatic change currently taking place in the health field is the growing demand by the community (including consumers from every socio-economic level in the community) to become more actively involved in every aspect of health care activities. This means involvement in every step of health care - from planning programs (where consumers demand a voice in setting priorities in relation to their needs for health care) to implementing these programs (where consumers are demanding an active role in carrying them out) and finally, to evaluating them (as members of community health councils, advisory committees, etc.)

So let us look at how social workers can bring their special expertise to bear, in meaningful ways, on this particular trend toward greater consumer/community involvement in family planning. But first, a few words about the attitude of the professional social worker. Before we can make a meaningful contribution in this area, we (and this means each of us) need to look at the way we really feel and think about this trend. Do we see this trend as a renewal and re-invigoration of the democratic process, which is the keystone of our nation and the basis of social work practice as well? If we do, we are ready to be helpful in a meaningful way. Or - do we see this trend simply as interference on the part of incompetent, ignorant and uneducable people who are presuming to tell the experts how to do things, when the experts, after all, are the only ones who really know how to do these things in the first place? If we feel this way, we cannot be truly helpful regardless of the motions we go through or the lip service we give this new trend.

But, assuming that all of us have the former attitude, how can we make a meaningful contribution to the growing consumer/community participation in the health field - in this instance, specifically in family planning?
The Role of Social Work in Consumer/Community Participation

In the area of program planning, perhaps we should assume more responsibility for educating consumers in ways of working with formal planning bodies. This may mean that a social worker would volunteer, as part of her regular job, or on her own, to act as a consultant to a local citizens' group which may be working toward developing a new health service in their community, such as a model city program, a neighborhood health center, a mental health or mental retardation program, a comprehensive regional or local health program, or a health program for teen-agers.

As a resource person to these lay groups, the social worker has a great deal to contribute to their education and sometimes through them to the education of the professional planners with whom they are working as well. First, about the need to include, and the value of including family planning services in each of the above-mentioned health services. Once we have ensured that family planning has been included in the scope of health services being offered, we must help the people in the community articulate their demands regarding the family planning program in such a way that these demands will be taken into consideration by the officials and professionals who are responsible for setting up and implementing the services. Some planning considerations are particularly crucial to the success or failure of a family planning program, and therefore consumer-planners should be encouraged to fully explore and consider the following basic elements:

1. **The geographical location of the program**

   Here we need to involve the consumer-planners in a consideration of the total effort and goals of the program, such as the purpose of the services and who in the community will be needing and using these services, as well as how these factors relate to where the program should be located. Once consumer-planners are helped to think about and discuss these factors, I believe that, because they are more familiar with their cultural milieu, they would enable the formal planners to arrive at a more appropriate decision about where the services should be located than would occur if the officials (who are usually from outside the community) make their decisions on the basis of a survey or for the convenience of those who are operating the program.

2. **The time the services are available to the consumers**

   Here, consumer-planners can make a contribution to a decision about when the services should be made available since they will be more knowledgeable about other demands being made on their cohorts' time, because they tend to follow similar life patterns.

3. **The atmosphere of the family planning program**

   Consumer-planners may ensure that a positive supportive atmosphere prevails if they are encouraged to make suggestions and share their ideas about the physical aspects of the service, the pattern of flow of patients through the service, and the actual handling of patients by personnel in the service, all of which are factors which will
help determine the use made of the services as well as the degree of satisfaction derived from using the services.

The above material clearly suggests that the consumer-planner should be encouraged to engage in and be accepted as a partner in policy determination by officials and professionals in family planning programs. Consumer-planners can be helpful in teaching professionals and officials about the mores and value system of the community served by the program, such as whether or not unwed teenagers who have never been pregnant should be serviced. They can also be helpful in determining the content and emphasis of the program in addition to the basic service of providing contraceptive devices. For example, a community group in East Harlem demanded that family life education be the main emphasis of the family planning program and that family planning services be just one facet of this total approach. Another reason for involving consumers in policy determination is that people who are actively involved in setting rules and making decisions are more apt to follow the rules and make use of the services. Also, it enables them to "sell" the program to others in the community, because they understand why things are being done in a certain way and have greater acceptance of the program.

In the area of implementing family planning programs many social workers have already recognized that there is an active role for the consumer, and generally accept the value of training community service workers with potential for providing services to other consumers as a means of raising the utilization rate of the services. These consumer-community service workers can be helpful to the doctors, nurses and professional social workers in family planning programs by engaging in case-finding, referrals and follow-up of patients. They can be particularly helpful with hard-to-reach patients who are fearful of the services, too discouraged to attend on their own, too ashamed to attend, or unconcerned about their family responsibilities. Many times the consumer-worker from the community has an entree to places where professionals cannot go. She may hold discussions in her own or a neighbor's home, a church, or a local social club, thus reaching many potential patients who might not be reached otherwise. The male consumer-worker can be especially helpful in reaching males in families who may need family planning services, but are not obtaining them because of male resistance. These male consumer-workers also can be especially helpful in getting at and dissipating superstitions which prevent the intelligent use of family planning services. Also, the male consumer-worker can meet with potential patients in bars and social clubs, where the professional social worker may not be accepted.

Because consumer-community service workers have proven to be a valuable adjunct to family planning services, it means that we have a responsibility to provide them with in-service training related to their work in family planning which will build on their natural ability and skill. This is very important role for which social workers in family planning services can assume responsibility, or at least to which we can contribute as members of teaching teams since our area of expertise includes the dynamics of social interaction; the effecting of improved interpersonal relationships; and the enhancement of personal and interpersonal competence. And thus we can make the contribution of transferring our knowledge of social factors and psycho-dynamics to these consumer community workers.
In the area of evaluating family planning programs, it is my belief that consumer-evaluators have an important dimension to contribute which should not be overlooked. This does not mean that they need to be taught complicated research techniques; however, it does mean explaining the purpose and aim of evaluation in understandable terms, and encouraging them to make a contribution in this area. As community service workers or as members of community advisory committees to the family planning programs, they may have received complaints, suggestions and questions from other consumers which may not otherwise reach professionals, and we need to encourage them to share this information with us for the purpose of evaluating family planning programs.

A second broad area to be considered is Social Work and Social Action in Family Planning.

Because of the relatively short period of time that has elapsed since family planning has become a popular, open issue, much remains to be done to close the gap between expressed public policy and prevailing practices in family planning.

I believe that social workers have a particularly important contribution to make in the area of social action whether they are employed directly in family planning services, in peripheral social services, or in totally unrelated social services.

Recent federal legislation has encouraged broader involvement in family planning activities, first under public health auspices, then under public welfare auspices. However, many states have outmoded statutes on their books which still prohibit public involvement in family planning or which may confuse the issue for state policy makers in health and welfare, so that statutes may have to be repealed or amended before the federal mandates can be openly and clearly implemented. This clearly requires political involvement in relation to family planning.

Through our professional organization we can organize committees to study the situation at the state or local level in relation to family planning, and then work to influence legislators at the state level, not only to up-date these statutes, but to ensure that all restrictive and punitive provisions are removed from these statutes. The social work goal should be the removal of all social barriers to family planning services such as financial eligibility, legal residence, age, sex, marital status and prior pregnancies from our statutes, where appropriate, and from state or from local policies and directives where these occur in contradiction to state law.

The following examples indicate how social work can make an imaginative and creative contribution:

1. The first is an example of social action taken by a social worker in an information and referral service of a private agency providing social services for families and communities in the South Bronx. Late in 1965 the New York State Department of Public Welfare Directive No. 45, dated 6/23/65, came to her attention. It specifically limited physicians to discussions on birth control only upon the request of patients who were receiving public assistance - who must be a married
woman or head of a household - and only authorized physicians to provide information and devices "required for a clearly defined medical condition in which the life or health of a woman client may be jeopardized by pregnancy" .... (and such) "articles and instruments required shall be for the cure and prevention of disease." At that time the Thompson-Metcalf Bill had been passed, eliminating all restrictions on the dissemination of information and authorizing the sale of contraceptives in drug stores to all but minors under 16 years of age. The social worker was concerned because the directive clearly discriminated against welfare recipients and thus violated their civil liberties, including the freedom to plan their families. In order to change the directive, she developed social action strategy on two levels - informing persons in power positions with leverage to change the directive - and enlisting the support of mass communication media for social action. With regard to the former strategy, Governor Rockefeller and Mayor Lindsay's Task Force on Poverty were informed of the directive and welfare recipients were mobilized. They sent petitions and letters to legislative representatives on all levels; presented their own case to the Welfare Commissioner and to other city and state officials; also they interested other groups in their cause. The second strategy was to approach the newspapers by phone, followed by a letter with a copy of the directive. The New York Post gave the issue newspaper coverage and delivery on a T.V. program. The American Civil Liberties Union, as well as relevant committees of the Community Council and other community agencies, became involved in the issue. Thus, through a variety of sources, attention remained focused on the issue, activities snowballed, precipitating action which resulted in changing the State Board of Welfare Rules in December 1966, one year after the issue was opened up.

2. In the second example, a social worker with primary responsibility for organizing and chairing a state-wide Institute on Family Planning, under the auspices of that state's Graduate School of Social Work and the Children's Bureau, learned of a state legislator who had been pressing for repeal of an ancient, antiquated statute prohibiting the public giving of advice on family planning or the use of contraceptives. She invited the legislator to speak at the Institute on the law in that state as it related to family planning. He was unable to attend but sent a young attorney with whom he had worked closely in the family planning area. The attorney discussed the outmoded statute and its deleterious effect on family planning efforts in the state quite frankly. In the introduction of the publication based on the Institute, the chairman made a reference to the negative attitude in the executive branch of the state government which also had a stifling effect on the development of family planning programs in the state. Copies of the publication of the Institute were sent to the legislator and the attorney who used them to publicize their efforts and to obtain support for the changes they were attempting to legislate. Less than a year later, although the legislation has not been amended to lessen the severity of the statute, policy directives have been issued at the state level which completely ignore the antiquated statute. It can be assumed that the added impetus of the state-wide exposure of the legal situation by social work played a role in the change in policy in the state.
Delivery of Comprehensive Care

If social work is committed to the delivery of comprehensive health care, social workers will need to move more aggressively into the organization and implementation of family planning programs and services. Where possible, family planning services should be part of maternal and child health or family health programs, and social work should press for the inclusion of family planning services in these health care programs.

Also, family planning services should be a part of the array of services offered under Medicaid. When they are not included, social work has a responsibility for ascertaining why they are not included and finding the means for including them under Medicaid.

Another social work responsibility in the area of providing comprehensive care is to work for the inclusion of social work services as an integral part of family planning programs. Social workers, out of their long involvement in preserving and enhancing family life have a special contribution to make to the family planning field. As Professor Lydia Rapaport pointed out so succinctly in her paper, "The Social Work Role in Family Planning: A Summation," in Family Planning, the Adelphi University School of Social Work Publication.

"In fact, it is most striking to a novice like myself in the family planning field who first encounters the literature and finds that virtually no attention is paid to complex areas of sexual feeling and behavior, and that contraception behavior is treated as if divorced from sexuality."

Through consultation we can help other professionals in the family planning field understand the importance of motivation, including the dynamics of willful exposure to unwanted pregnancy, institutional norms and cultural taboos, all of which affect the utilization rate of family planning services. There is need for the inclusion of all three social work methods in family planning services as well as in other agencies on the periphery of these services. Through social case work we can provide necessary counselling in family planning programs, thus enabling families to clarify their needs and plan ahead in this very important area of life which is so intimately related to how a family functions. Through social work help, family spacing and limitation, determined on the basis of each family's individual needs, can represent an effective adaptation to life's realities. Social work can help ensure that coercion is not made a part of family planning activities and that family planning programs remain related to their primary goal - the preservation and enhancement of family life.

Through social case work in agencies not directly involved in family planning services, we can engage in case finding by identifying patients at risk who are in special need of these services and enabling them to obtain the services by making effective referrals.

I'm sure that all of you will recognize the following guidelines to follow when providing information or counselling families in relation to family planning services.

Provided by the Maternal and Child Health Library, Georgetown University
1. Discussions should take place when both case worker and patient can discuss the material with some degree of comfort;

2. Privacy is important;

3. Discussions must be handled on an individual basis and related to the immediate concerns and interests of the patient;

4. Language handicaps must be taken into consideration and professional terminology avoided;

5. There should be no implication of coercion;

6. The patient's right to self-determination must be respected by the case worker; and

7. The patient's pace must be respected.

Social work should assume a role in the education of other disciplines in the family planning field regarding the importance of social and economic indications of the need for family planning services.

Some social indications may be:

1. A mother's frustration and inability to cope with several small children;

2. Marital discord or conflict;

3. The presence in the home of a child or parent with an emotional problem;

4. The presence of conflicting social roles or social goals in the family;

5. The presence of out-of-wedlock children;

6. The occurrence of a crisis in the family which might be further compounded and complicated by an additional pregnancy;

7. Family goals;

8. Adolescent acting-out sexual behavior, whether or not a previous pregnancy has occurred;


Some economic indications may be:

1. Families engaged in a struggle to maintain their economic development;
2. A desire on the part of a mother for training or for becoming a wage earner to improve the economic status of the family.

Through social group work we can meet educational and informational needs of patients, both in family planning programs and in agencies on the periphery of these services. Those of you who are familiar with group work can readily see the possibilities for peer group interaction and encouragement.

Through community organization we can make a contribution to more concerted planning in the community, enabling community planners to take into consideration the interrelatedness of environmental, social and health problems which all have a direct bearing on the need for family planning services. Social workers in all three methods may need to assume the role of advocate with patients or potential consumers of family planning services.

Because of the importance of family planning as a preventive health measure which promotes positive health and well-being of the entire family, it is imperative that social work relate itself to the social component of family planning in the ways noted above, as well as through additional innovative ways with which many of you may already be experimenting in your particular settings.

Education and Social Work in Family Planning

Those of you who are engaged in innovative efforts should write about them for publication in our Journal, thus helping to build a body of knowledge in this area for the social work profession.

Social work also has at least two other contributions to make: one, in relation to formulating, supporting and promoting sex education in elementary and secondary schools; and two, in relation to developing relevant curricula in schools of social work much more universally than is currently being done. In both graduate and undergraduate schools, family planning content should be included in courses on social policy, growth and development, research, and all of the methods courses. Field experiences in family planning should be made available for students at the graduate level in all methods.

Conclusion

In concluding this paper, I would like to make a few general comments. The community is having and will continue to have an impact on all health services, and particularly on family planning services. The impact is characterized by confrontation, collaboration, communication and change. Social work has a significant contribution to make toward avoiding frustration and confusion in the family planning area by engaging in a continuing dialogue with those from the communities in which we work. We must be prepared to shift from teacher to learner, and from controller to cooperator and collaborator, to ensure that our response to the community's involvement is action and not reaction.
If during the course of these remarks you suspect a note of frustration, bitterness, or cynicism, you may well be right. I am rapidly reaching the point of experiencing such feelings, especially as I attend meetings like this one where we seem to indulge in discussions, seminars, and institutes as a form of group therapy during which we ventilate freely, seek expiation for our sins of omission and inaction and then return to our agencies to continue business as usual.

There are many of us in public and private positions which could be considered influential who believe we know at least some of what is wrong with our health care delivery system and how to correct it, and yet I see no inclination to make the hard decisions and fight the hard battles which change will require.

During the past decade, there has been great wringing of hands and breast beating about the plight of the poor and the disadvantaged. The kind of health care they receive has been studied, analyzed, and dissected. We have compared health indices and decried the disparities between the health status of the affluent and that of the poor without seeming to recognize that such comparisons are based on assumptions at least two of which are false. These are:

1. That better health services, even preventive services, in and of themselves would correct these disparities, and,

2. That those who are not poor or otherwise disadvantaged receive better health services and are, as a result, healthier than the poor.

These simplistic assumptions are fallacious because they overlook the impact of illiteracy, limited education, unemployment and poor housing, on health. They also ignore the difficulty which even the affluent encounter in obtaining quality health care in our non-system.

In recent years, considerable effort has been invested in creating new health services for the poor. We have insisted that they should be comprehensive, family centered, readily accessible, and of high quality. The Office of Economic Opportunity as part of its war against poverty, has provided millions of dollars across the nation for the creation of 51 neighborhood health centers which meet these criteria, but they provide care only for the poor. The Children's Bureau of the Department of Health, Education, and Welfare has also spent millions on
It seems to me that there is a serious and far-reaching error in all this because it is, in fact, just another categorical approach to the development of health services and will do little, if anything, to create a rational health care system for our nation. Health care for the poor is just as categorical as health care for victims of heart disease, renal disease, cystic fibrosis, and all the other categories for which resources, both human and financial, have been allocated in recent decades.

Creating neighborhood health centers in slum neighborhoods is indeed laudable, and I would not have us discontinue this effort, but it will do nothing to promote proper planning and development of environmental health programs; it will do little to stimulate the Congress to address itself to the difficult problem of how best to finance a new health care system. In fact, it may even impede such action since those who believe the middle-income and affluent populations are well cared for will argue that with the poor accounted for in neighborhood centers, Maternal and Infant Care, and Children and Youth programs, there will no longer be the need to do anything else.

In addition to its obvious failure to provide decent preventive, curative, and rehabilitative services to any substantial proportion of the population, our health care non-system suffers from other serious maladies. Its most serious problem is insistence on trying to deliver a 20th century product with a 19th century vehicle. That vehicle is the solo practice, fee-for-service entrepreneurial model. I can tell you from 15 years of personal experience that it is archaic, anachronistic and wasteful of both human and financial resources.

The increasing sophistication of medical technology has made the practice of medicine a team effort with increasing numbers of technical personnel making a vital contribution to the care of the patient, and yet the proponents of the solo practice model persist in supporting the one-to-one model on the grounds that to do otherwise is to violate the sanctity of the patient-doctor relationship. Only recently, I read a short nostalgic article by a physician lamenting the demise of the traditional doctor-patient relationship and pointing out that it had fallen victim to three factors: (1) increasing technology which interposed technicians and even computers between the doctor and his patient, (2) third party payment programs which deluged the doctor with paperwork and shortened the time he had for his patients, and (3) the doctor shortage which forced him to see more patients in less time.

It occurred to me as I read his sad lament, that he was stating some very sound reasons for putting the solo practice model to rest so that some other model could evolve which would indeed strengthen the doctor-patient relationship by relieving the doctor of all non-doctor functions and freeing him to spend more time with the patient performing those services which only he is trained and equipped to perform. This is the goal toward which we should be striving.

Furthermore, one could reasonably expect that physicians truly concerned about the equality of care received by all patients and genuinely dedicated to
a sound and reasonable organization of human and physical resources and would
welcome the possibility that patients could receive the different elements of
their health care in the most expeditious and humane manner from persons trained
to provide these elements in a coordinated fashion. This approach would elevate
rather than diminish the role of the doctor.

The argument that proper organization and careful planning in the field
of health care violates the doctor-patient relationship is patent sophistry and
is unworthy of an ancient and honored profession.

Another serious malady of our non-system is the continuing dependence upon
voluntary health insurance as a major source of financing for health services.
Aside from its other deficiencies, the term "health insurance" is a misnomer in
the first place. It really should be called "illness insurance" because most
insurance does not provide a single penny of benefits until the insured is ill
and the provider of service can state a diagnosis for which treatment was given.

There is widespread recognition that prevention and health promotion are
the cornerstones of a meaningful health system and yet there is absolutely no
incentive to either in the present health insurance system.

Another weakness of the health insurance system has been its limited scope
of benefits even within the "treatment rather than prevention" framework. Services
such as mental health care, extended care and home care were, until recently,
excluded; and even those plans which do include them provide very limited benefits.
Rehabilitation services, a major area of need, are still generally excluded
from even the most liberal plans, and when covered are usually a part of somewhat
expensive "major medical" policies which only relatively affluent enrollees can
afford even when they represent collective bargaining fringe benefits.

It is to the credit of the Board of Governors of the Blue Cross Association
that at its meeting in December, 1966, it passed a resolution urging its member
Plans to write comprehensive health care benefits and, where necessary, to seek
enabling acts and charter authorization to make this possible, and also urging
the Board of the National Association of Blue Shield Plans to take similar action.

But if the experience of the past 30 years is a good index, progress in the
direction of broadened scope of benefits will be slow because it will be preceded
by studies, and surveys, and demonstration projects and considerable deliberation
and discussion. I am not sure we can wait that long. Even now, two years and
a half after the Blue Cross Association resolution, the Health Insurance Council
continues to report progress in the health insurance industry in terms of hospital,
surgical, and medical expense coverage and in terms of numbers of persons covered
with little attention to the scope of benefits. 2

Inappropriate utilization of manpower continues to be a major deterrent
to the effective delivery of health services. The Gorham Report on Medical Care
Prices pointed out the need to reassess our use of manpower. It said, "it is
clear....that the demand for physicians will far outrun supply unless ways are
found to use physicians more efficiently." 3 All recent projections of health

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Manpower needs have been based on our present use of manpower. They are therefore useless. For as the Gorham Report emphasizes, supply will never meet demand within the present framework of utilization.

We have furthermore allowed ourselves the luxury of a confusion of objectives by proposing to improve health services by training more health professionals. If this is to be the approach, the improvement of health care must of necessity be a long term goal, and I don't believe our restless, dissatisfied populations will be willing to wait.

I could go on describing this first "face" of health care, but I believe that with this broad outline you can fill in the remaining details yourself.

Looking at the second "face" is more painful because while the outline of what ought to be might be clear, I believe that the will to fill in the details is lacking.

For over 35 years health economists have been proposing alternatives to the fee-for-service system of health care financing and the private solo practice model of health care delivery. There have been valid studies showing the economies and other benefits to be derived from such alternatives. 4

Yet we find in 1968 the Republican Party Platform promising to be "diligent in protecting the traditional patient-doctor relationship and the integrity of the medical practitioner", 5 and the American Medical Association interpreting that declaration to mean "support......for the private practice of medicine".

We also find federal legislation designed to improve the quality and availability of health care prescribing any interference with the existing patterns of private medical practice. 7 I have never understood why we seem to consider the existing patterns of private medical practice to be sacrosanct. Everthing in our lives has changed in the last 50 years - medical knowledge, technology, hospitals, even people and diseases have changed and yet we continue to insist that obsolescent patterns of medical practice must be protected and continued.

This ostrich-like ignoring of evidence makes me despair for the implementation of the previously stated recommendations of the Gorham Report as well as those of the National Conference on Group Practice which proposed "that public funds be provided where necessary to support the growth of existing groups and the establishment of new groups", and that "the formation of group practice arrangements to provide comprehensive medical care by the faculty of medical schools should be encouraged as a replacement of the traditional outpatient department of the teaching hospital." The conference report asserted that "formation of such group practice is important to provide a role model for medical students, in order to influence them to accept this system of practice as an effective method for the delivery of health care." 8

I despair for the implementation of the various recommendations because 2-1/2 years after the release of the Report on Medical Care Prices and 18 months after the Group Practice Conference no significant steps have been taken to begin the creation of a system.
Nationally the federal financing of health services is still categorical—by disease, by age group, by economic status, by occupation. Health insurance is still private, voluntary, and lacking in comprehensiveness. We continue to address ourselves to the special needs of discrete groups apparently without recognizing that to the extent that we are successful in creating optimal systems for these special groups we militate against the eventual rationalization of the total system.

To focus the spotlight locally, I could wonder to what extent we prevent optimal pediatric care for all newborn infants by concentrating our most highly trained staff in a few "premature centers." Is it not conceivable that the impact on neonatal mortality, and therefore on infant mortality, might be greater if this staff were widely distributed throughout the system to provide better care, leadership and education, in that order, and thereby to raise standards in all nurseries? I could ask why a municipal hospital system created and supported by public funds for the express purpose of providing care for the sick, and voluntary hospitals supported largely by public funds, have been permitted to degenerate into a system where teaching and research are paramount and care of the sick is a by-product of these primary concerns. If you think that statement an unfair indictment, consider the fact that some of our municipal hospital out-patient departments and some of our best teaching hospitals boast upwards of 100 different subspecialty clinics. Certainly no one will argue that this particular organization of scarce resources is necessary to the proper care of the sick or to the promotion of health.

I could further ask why State public health agencies and Welfare agencies charged with the responsibility for the expenditure of large sums of tax funds for health care, permit those funds to be channeled into ever increasing quantities into provider mechanisms which are known to be inefficient and unnecessarily expensive without making any effort to either modify those mechanisms or create more effective alternatives. As a matter of fact, I am convinced that some of these agencies are not even aware of the import of some of the decisions they make. For example, my own State Health Department at one point in the development of our Medicaid program approved a group practice capitation plan which I had negotiated with a voluntary hospital at about the same time that they approved such a high out-patient rate for that same hospital, and that the administrator of the hospital rejected our prior agreement on the grounds that he could receive much more money by accepting the State's fee-per-visit rate. It appeared to me at the time that the bureau making those two decisions almost certainly had not taken into account the effect that one would have upon the other.

It is becoming increasingly obvious that real change will require federal initiative. The first step must be the establishment of national priorities. Shall we aspire to be the first nation to put a man on the moon or shall optimal health care for every American citizen be a higher priority? Shall we permit a substantial elite to enjoy the benefits of income tax loop holes, and an even larger group to boast two cars and two homes per family while millions go without food, adequate health care and the ordinary necessities of life? Shall we continue to commit millions of dollars for the creation of the supersonic transport so that travelers can reach the west coast in two hours, where they will circle for two more hours before being able to land and then spend two more hours getting to downtown Los Angeles, while our children languish in sub-standard schools?
Perhaps these are not mutually exclusive aspirations, but all present evidence seems to say they are. Very soon we as a nation must decide and demonstrate whether we really believe adequate health care to be the right of every citizen. Or is that statement to be just another empty slogan? Recent actions by the Congress and the New York State Legislature seem to indicate the latter.

Assuming that we have the will to grant health the proper priority, it will then be necessary for us to address ourselves to the social policy decisions which will promote the proper utilization of available funds. Federal legislation must provide funds which will encourage the implementation of well designed local comprehensive health plans in lieu of current categorical funding patterns. Public Law 89-749, the comprehensive health planning law, promises to provide such funding and has the potential for supporting planning agencies which can develop comprehensive health programs. This however will not be accomplished unless such planning agencies are given the proper authority to control the creation of health resources in their areas.

New delivery systems must be designed to produce maximum benefit to the total community, and such designs must provide for the use of auxiliary health personnel under the supervision of available professionals. We must also expand our efforts to train additional health professionals, but their training too must change since they must be taught to work in new relationships with auxiliary personnel and within new organizational frameworks. These new designs must be fully exploited even when to do so will incur the wrath of the defenders of the status quo who have vested interests in maximizing personal gain. We must also take steps to modify our professional practice laws in order that auxiliary personnel may legally perform the services for which they can be trained and to relieve professionals of the legal liability for these delegated services, and we must look dispassionately at our credentialing requirements which have systematically excluded people from service and modify them so that they be relevant to the tasks to be performed.

Health planners and other health professionals must recognize that health means not merely the absence of disease, but the maximum improvement of the quality of the totality of life, and that it is therefore incumbent upon them to become aware of and sensitive to total human need and to make a substantial contribution to total planning for the improvement of the environment.

To accomplish these goals will require political action and community action (and I am beginning to believe that these are synonymous). Community health professionals will therefore have to relinquish their traditional simon-pure aloofness from the political system and enter into the hurly-burly real world of activism where the levers can be grasped and where change can in fact be accomplished. We must begin to find ways of building a health constituency. This will be difficult because recent legislation has created demand and expectations, but had done little to satisfy these expectations or to create the resources to meet the demand. Our credibility as professionals is therefore in jeopardy since we have been unable to deliver on the promises of the new legislation. But, in spite of this, we must continue to make our communities more aware of their health needs and to mobilize their support in order that together we may accomplish some of the tasks which face us.
The challenge is here and now. The opportunity available to us to prove whether we really want to create a rational health system which will promote and protect and restore the health of all Americans so that the poor will be able to lift themselves from ignorance and poverty, and so that those who are not poor can maintain their health and continue to make their contribution to our society, or whether we will spend another decade in seminars, institutes and meetings discussing health care for the poor, for the rich, for migrant workers, for heart disease, cancer, and stroke, and for any other category which our considerable ingenuity will lead us to segregate.

I say we have discussed and ventilated long enough. Let's all go back to our agencies and get on with the job!!

REFERENCES


4. Densen, Paul M., Jones, Ellen W., Balamuth, Eve, Shapiro, Sam, "Prepaid Medical Care and Hospital Utilization in a Dual Choice Situation," American Journal of Public Health 50: 1710-1726, November, 1960:


7. Public Law 89-749.

APPENDIX I

PROGRAM

FRIDAY, MAY 23, 1969

Evening Session

David P. Kemple, Chairman

6:30 - 7:45  Registration
7:45 - 8:00  Welcome and Introductions, Chairman
8:00 - 9:30  Moderator - Mary Watts, Assistant Chief, Medical Social Consultant, Children's Bureau

"Youth In Ferment" - Mrs. Mattie K. Wright, Director, Crittenton Comprehensive Care Center, Chicago, Illinois

SATURDAY, MAY 24, 1969

Morning Session

David P. Kemple, Chairman

8:15 - 9:15  Registration
9:15 - 9:30  Welcome and Introductions, Chairman
9:30 - 10:30 "Change Mandates for Social Workers In the Health Field", Mrs. Edith S. Alt, Consultant in Community Health, New York, New York
10:30 - 11:00 Coffee
11:00 - 12:00 "New Elements of Direct Service In the Public Health Field", Carol H. Meyer, D.S.W., Professor of Social Work, Columbia University School of Social Work
12:00 - 1:30  Lunch

Afternoon Session

1:30 - 4:00  GROUP DISCUSSIONS (regarding papers presented thus far)

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GROUP A

Discussion Leader: Solomon Levy, Chief Social Worker, Rebound Health Center, Philadelphia, Pennsylvania

GROUP B

Discussion Leader: Shirley A. Nelson, Social Work Consultant, Family Health Services of Massachusetts Department of Public Health

GROUP C

Discussion Leader: Maurice V. Russell, Ed. D., Director of Social Service Department, Harlem Hospital Center

GROUP D

Discussion Leader: Kurt Reichert, Ph. D., Director, Accreditation and Standards, Council on Social Work Education

4:30 - 6:30 Cocktail Party...Courtesy of Ross Laboratories

SUNDAY, MAY 25, 1969

Morning Session

9:30 - 10:30 Concurrent Session I
Mrs. Marguerite Russo, Chairman

"Rubella - A lesson in Health Service", Louis Z. Cooper, M.D., Joanne Margolin, A.C.S.W., and Mrs. Barbara Fedun, R.N., Rubella Birth Defect Evaluation Project, New York University Medical School

9:30 - 10:30 Concurrent Session II
Benjamin I. Coleman, Chairman

"Community Based Projects for the Aging", Jack Ossofsky, Deputy Director, National Council on the Aging.

10:30 - 11:00 Coffee

11:00 - 12:00 Concurrent Session III
Frederick C. Green, M.D., Chairman

"Contemporary Developments In Day Care", Sally Provence, M.D., Director, Child Study Center of Yale University

Provided by the Maternal and Child Health Library, Georgetown University
11:00 - 12:00  Concurrent Session IV
Catherine Casey, Chairman

"Social Work in Family Planning", Mrs. Alice M. Varela, Director, Division of Community Resources, The Health Insurance Plan of Greater New York

12:15 - 2:00  Luncheon
Barbara Kohlsaat, Chairman

"The Health Administrator Looks At The Contemporary Scene", James G. Haughton, M.D., First Deputy Administrator, New York City Health Services Administration
APPENDIX II

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APPENDIX III

Geographical Distribution of Participants

Annual Meeting of Medical Social Consultants
in Public Health and Health Care Programs

New York, New York
May 23, 24, 25, 1969

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Total of 183 Participants