

**THE  
CHILDREN'S  
BUREAU'S  
JOB  
TODAY**

U. S. DEPARTMENT OF  
SOCIAL and  
REHABILITATION  
SERVICE  
children's  
bureau  
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The United States was the first nation in the world to establish a bureau specifically concerned with the health and welfare of its children.

When the Children's Bureau was created by the U.S. Congress in 1912, it was charged with investigating and reporting "upon all matters pertaining to the welfare of children and child life among all classes of our people, and shall especially investigate the questions of infant mortality, the birth rate, orphanages, juvenile courts, desertion, dangerous occupations, accidents and diseases of children, employment legislation affecting children in the several States and Territories."

Today, the number of children and youth in our nation almost equals the total United States population when the Children's Bureau was created.

This population increase, plus the enormous input of knowledge about health and social factors affecting the well-being of children which has occurred principally within the last two decades, has made the Children's Bureau's job today more viable than ever as both spokesman and standard bearer for the whole nation's concern for all its children.

Since it was established, the Bureau has been reporting facts about child life to the Nation for use by parents and by professional groups, both public and voluntary, which carry forward health and welfare programs.

The passage of the Social Security Act in 1935, and subsequent amendments, has given the Children's Bureau a catalytic role in the development and extension of child health and welfare services of high quality through the States through the principle of grants-in-aid.

Amendments to the Social Security Act also have given the Bureau authority to give financial support to projects which test and then put to work better ways of using available short supplies of manpower in the health and welfare fields, and which offer improved health or welfare services to mothers and children.

These are the basic tools which the Children's Bureau uses to do its job today: factfinding, testing new programs and ideas, and supporting services of high quality for the health and welfare of mothers and children.

Getting the job done has, over the years, produced a crosshatch of activities which have involved all aspects of the Bureau's programs in the achievement of a single goal.

#### INFANT MORTALITY

The reduction of infant mortality is a good example of this cross-hatching. When the Bureau was established in 1912, one out of every ten babies born alive in the United States did not live to see his first birthday. The primary target in reducing this appalling toll was better sanitation, better health practices in the home. The Bureau produced the first in what was to become a series of alltime Government bestselling parent publications: Prenatal Care, for the expectant mother, and Infant Care, to help parents guide their babies through the hazardous first year of life.

By 1935, the infant mortality rate had been reduced from 99.9 per thousand live births (in 1915) to 55.7. The number of babies born in hospitals, instead of at home, began to soar. In 1935, about 37 percent of all births were in hospitals, while a decade later, in 1945 nearly 79 percent were hospital births.

The Bureau, with the help of advisors on maternal and child health, developed standards for the hospital care of the newborn and, in World War II, launched a program of Emergency Maternity and Infant Care for the wives of servicemen in the four lowest grades to insure safe birth for their babies, largely in hospitals.

EMIC was phased out soon after the end of World War II and by 1950, the infant mortality rate was standing at 29.2. It dropped only to 26.0 by 1960.

Here is how the Public Health Service analyzed developments in infant and perinatal mortality in the United States in the intervening period (National Center for Health Statistics, Series 3, Number 4):

"The Federal Emergency Maternity and Infant Care Program, designed to meet the urgent needs of wives and infants of men in the Armed Forces during World War II, helped bring regular prenatal and infant health supervision to broad segments of the population. This program ended after World War II. A large part of the reduction in infant loss was concentrated in the control of infectious diseases whose toll was still substantial at the beginning of the 1940's. In some areas the introduction of special programs for the care of prematurely born infants also had an impact on the mortality rate.

"In the 1950's a general attitude that significant progress in reducing infant mortality required, above all, new insights to basic biological processes tended to dampen the fervor for action programs. The 1950's might also be characterized as a decade in which earlier medical and program advances continued without significant innovations. This occurred in the absence of major scientific breakthroughs that could have been expected to produce broad effects through immediate application.

"Finally, some of the very conditions which, on the surface, might be taken as harbingers of improvement had the reverse result. An outstanding example is the migration of nonwhite persons to large metropolitan areas; in these areas, then, infant mortality increased. The explanation is complex, encompassing many social, economic, and program issues. High on the list might well be a lag in community facilities in accommodating themselves to the change and a delay in the adaptation of the in-migrant group to their new medical care and social environment.

"Speculation about the possibility that an irreducible minimum in infant mortality is near generally focuses on the following conclusions: (1) most of the losses occur in early infancy, (2) many of the underlying mechanisms are poorly understood, and (3) reduction in the incidence of low birth weight is central to the problem. These are truisms; but to accept the irreducible minimum theory, one must also embrace another proposition: biological processes are involved which are not susceptible to modification through an alternation of environmental conditions. It is difficult to accept this hypothesis if environmental conditions are broadly defined to include not only general socioeconomic circumstances but also family planning, organization and availability of high quality medical care, and personal health practices of the population."

The Maternal and Child Health and Mental Retardation Planning Amendments of 1963 gave the nation the impetus it needed to make a realistic approach to these environmental conditions.

The main thrust of these Amendments was the reduction of mental retardation that is associated with complications of pregnancy. Low birth weight in an immature infant increases the hazards of mental retardation twentyfold. The correlation between low birth weight and inadequate prenatal care was obvious. And yet, literally thousands of women were going to hospitals in labor to deliver their babies with no prenatal care.

Where did these women live? Obviously, in low-income areas, but in which of the nation's lowest income areas were the risks greater? The Children's Bureau granted funds to George Washington University to pinpoint the areas where the greatest need existed and found that 56 counties (2 percent of the total) had more than one-third of all infant deaths in the U.S. in excess of the death toll reached by the counties with the lowest rate.

#### MATERNITY AND INFANT CARE PROJECTS

Maternity and Infant Care Projects, offering high quality care to women through pregnancy and delivery were established, predominantly to serve women in our crowded urban ghettos. Women who had spent hours --even days--waiting to be seen in a clinic, for the first time had regular appointments, special attention to their diets, bus fares paid to and from clinics if they could not afford these costs, hospitalization assured and special care planned for if the pregnancy was difficult and mother and baby were at high risk. By June 30, 1968, 53 of these

projects were in operation, involving not only adequate maternity care but attention to the total needs of the family.

Many of these families were so overwhelmed with their economic burdens that they had little time for anything else. In addition to health services established in neighborhoods where there were either few doctors or none at all, mothers could now get help from home economists and social workers. Nutrition services were increased, homemakers helped teach child care.

#### Rates Go Down

The Maternity and Infant Care Projects have set a new milestone in the fight to reduce infant mortality. Here is what happened to that rate in some representative cities with Maternity and Infant Care Projects:

In Chicago, there was a 9.6 percent overall reduction in the infant mortality rate in 1967 from the previous year. The decrease in the Negro rate was 16.8 percent, the largest ever achieved.

In Baltimore, the 1967 rate was 4 percent less than the previous year; the nonwhite rate, 15 percent less.

In Houston, the rate went down 16 percent from 1966 to 1967.

In Miami, in 1967 the infant mortality rate for babies born in the project area was 15. In the county as a whole, it was 23.2.

In one area of Puerto Rico where a special project was in operation, the infant mortality rate in 1967 was 23.8, as compared with a socially and economically similar area, without a project, where the rate was 27.8.

In the light of facts such as these, the Congress, in the 1967 Social Security Amendments, specifically called for services for reducing infant mortality and otherwise promoting the health of mothers and children and directed that the program of maternity and infant care project grants be continued until June 30, 1972, when it will become a special part of each State health services plan.

## FAMILY PLANNING

It is a truism that each generation of parents expects its children to accomplish more than it was able to accomplish.

The cold fact is that in the days when this nation had such a high baby death rate, many parents' greatest hope was to have enough children so that at least a few would survive past the hazards of infancy and childhood.

Early in this century, therefore, large families were the best assurance that at least some children could move upward in the scale of accomplishment.

Today, with our new abilities to reduce infant mortality, the nation has shifted from large to smaller families. This shift has been given dramatic impetus by the development, largely within the last decade, of contraceptive devices which can be produced in large quantity and dispensed at low cost. It has been accompanied by the growing recognition that:

Large families place almost impossible economic burdens on all but the most affluent.

When a woman gives birth to a baby every year, she triples the chance that her infant will be of low birth weight and subject to more health hazards.

Most importantly, parents have the right to plan for the number of children they can rear in social and economic security.

### Extending the Right

The Children's Bureau, through its maternal and child health program and maternity and infant care projects, has played a major role in making it possible for all parents to exercise their right to plan their families.

In 1964, only 20 States provided family planning services. During the year ending June 30, 1968, 333,500 women received such services and virtually all States were offering them through the maternal and child health programs.

The 1967 Social Security Amendments, for the first time, spelled out family planning services as a maternal and child health responsibility and earmarked 6 percent of the amounts appropriated for maternal and child health each year for this purpose.

The Amendments also specified that family planning services be made available, on a voluntary basis, to families receiving public assistance.

The net effect of these Amendments is to open a new door for better health and welfare care for the nation's poor.

It is significant that research studies show many of the nation's poor who are just learning of the availability of family planning services, had so little accurate sexual information that they had been completely unable to plan against unwanted pregnancies. Parents in these studies overwhelmingly said that they wanted their own children to have family planning devices available to them.

Part of the Children's Bureau's job today is to use this interest as a springboard in offering acceptable services which will protect the health of mothers and children and enrich family life for literally thousands of families which are now living outside the mainstream of our society.

#### COMPREHENSIVE CHILD WELFARE SERVICES

Aside from the inherent waste in human resources which comes when families are aimlessly adrift in our society, there has been abundant evidence that the aimless family wavers between the extremes of hopelessness and anger, not only in its internal relationships but in its relationships with society.

The hopelessness stems most usually from inability to cope with crisis after economic crisis, made more desperate by large numbers of children.

The anger is rooted in an inability to communicate in terms which our society understands and will respond to.

For too long, the only answer our society had for the aimless family was to take its hapless children, those who were dependent, neglected or abused, and put them in institutions.

The Children's Bureau pioneered in developing alternatives to this catchall way out. It helped to mobilize national support for a move away from institutional care and into specialized forms of care: foster family care for children who could not remain in their own homes and institutional care for special groups of children who could benefit from it, protective services for neglected and abused children with a goal of helping their parents work out solutions to the problems which had brought about neglect or abuse.

The Bureau fought for adequate protections--through adoptions--for many children born out of wedlock and for social services to unmarried mothers as the most constructive preventive step that society could take on their behalf.

The States were encouraged to offer the whole gamut of child welfare services with the purpose of keeping children in their own homes or, if that was not possible, of returning them to their homes after crisis situations that required their removal had been alleviated.

As our society became more complex, the river of need for such services became a vast tide. Between 1961 and 1967, for example, there was a 50 percent increase in the number of children receiving child welfare services in an average month.

Important beginnings were made in establishing communication between families in isolation and their communities with the Maternity and Infant Care Projects and with the Head Start program of the Office of Economic Opportunity, which had as its prime purpose getting children from adrift families ready for school, but, just as important, involving parents in enlarging the opportunities for their own children to grow and develop.

The Welfare Administration, predecessor of the Social and Rehabilitation Service, recognized the economic straitjacket in which these families lived by instituting a work and training program in cooperation with the Department of Labor.

## Strengthening Family Life

The 1967 Amendments to the Social Security Act fused most of these efforts into a new approach to families receiving public assistance, with this special goal: "to maintain and strengthen family life and to foster child development."

The Amendments are aimed at breaking economic barriers to strong family life as well as providing community services which can sustain and supplement family strengths.

They require welfare agencies to develop plans for helping each family, based on its special circumstances and requirements, to attain or retain capability for self-support and care. They call for the use of day care not only as a mechanism mothers may use if they choose to work, but also as a building block for strengthening family relationships.

The principle thrust in Children's Bureau programs to carry out these objectives is through the Work Incentive (WIN) Program which the Amendments authorized and to which State welfare agencies may refer AFDC family members for useful training and subsequent employment. States are required to furnish high quality day care facilities for mothers in AFDC families if they are accepted in the WIN program.

The Children's Bureau is the coordinative agency at the Federal level between the State welfare department and the Labor Department, which is responsible for the operation of the WIN program.

### DAY CARE SERVICES

The new emphasis on day care services in the Amendments carries far beyond its immediate implications for AFDC mothers who want to work as a part of the WIN program. It goes to the root of the now evident fact that the nation is undergoing a social change of such magnitude that it can and already is having a far-reaching impact upon the contemporary family and its methods of rearing children.

In raw numbers the change can be measured by the fact that about a fourth of the nation's mothers who live with their husbands and have children of preschool age are in the labor force. This is double the labor force participation rate of mothers of such children in 1948. Among widowed, divorced, and separated mothers of young children, the labor force participation rate is, and always has been, much higher.

A survey undertaken in March 1965 showed 6.3 million working mothers with an estimated 12.3 million children under 14 years, or one-fifth of all U.S. children in this age group.

And yet, in September of 1965, the capacity of all licensed or approved day care facilities in the nation was 310,400. By March 1967, it had grown to 475,000 children.

In fiscal year 1966, State and local public welfare agencies spent an estimated \$12.1 million for provision of day care, as compared with \$252.3 million for foster care of children.

The facts have been at cross purposes with the sturdy fabric of a national tradition: woman's place is in the home; the care of her children is her responsibility.

During World War II, when the nation called its women, as well as its men, for service in the war effort, industry and government alike felt a responsibility to provide some form of day care for the children of women war workers.

With war's end, these programs all but vanished in most States. Despite the initial encouragement of a small amount of earmarked Federal money to develop day care programs during the present decade, progress has been very slow. Most of the progress has been measured in gradual public acceptance that day care facilities should be licensed and meet standards so that children will not be left in hazard of their lives by careless "caretakers" while their mothers work.

The Children's Bureau has offered consultation to the States as they have moved to solidify what gains they could. By June 30, 1967, 45 States and Territories were providing some form of day care for children through their child welfare programs.

#### Day Care Future

The future of day care, however, goes beyond the provisions of the 1967 Amendments and to the basic issue of how willing the nation is to accept the fact that the nuclear age has, in little more than two decades, changed many of our traditional concepts of family life and family responsibilities.

The nuclear family is a small family, with no relatives near enough to call on in times of crisis. Its children do not have a chance to absorb, almost by osmosis, the cultural heritage their aunts and uncles and grandparents could regularly pass on to them in previous generations.

What social influences will mold their lives? How can the parents, who are now the child's total family for all practical purposes, do a good job of parenting when their own life roles are becoming more complex?

The framers of the 1967 Amendments saw the more effective involvement of parents in day care programs as having a significant potential for increasing not only the "motivation but the ability" of parents to carry out their difficult assignment.

The Children's Bureau sees the future of day care as inextricably bound up with a more vital involvement by the total community in sustaining and enriching the family life of its members.

In principles originating in the Children's Bureau and now accepted as applying to all day care programs which receive Federal aid, the outlines of this involvement are clearly set forth:

- . Day care services should be developed and carried out as part of a comprehensive community plan designed to promote and maintain a stable family environment for children.
- . Day care can serve most effectively and appropriately as a supplement to care in the child's own family when other services support family care.
- . Day care is a service for the child, the family, and the community and is based on the demonstrated needs of children and their families.

Putting these principles to work throughout the nation is part of the Children's Bureau's job today.

## SERVICES FOR CRIPPLED CHILDREN

In 1960, the American Public Health Association singled out the crippled children's program of the Children's Bureau for one of its Albert Lasker awards, given to signify breakthroughs in medical research and advances in public health programs.

In citing the crippled children's program as one which "has vitally helped 4½ million handicapped children in the last 23 years," the Award also noted that the program was unique in that it has "stimulated the extension of the highest quality of services and developed new comprehensive services when and where needed for cardiac cripples, polio victims, amputees, epileptics, victims of cerebral palsy and congenital handicaps, speech and hearing defects, nephrosis and other chronic conditions."

Extension of the highest quality of services, which the Award cited, went hand in hand with the principle, which the program steadfastly adhered to, that there should be reasonable cost reimbursement for service. The successful application of this principle in the crippled children's program influenced the development of health insurance plans for the public at large.

### Program Extension

The crippled children's program has always had as its primary emphasis finding and treating the crippled child early, preferably during his preschool years, to minimize the damage his crippling condition can do both to his personality development and to his general physical health.

The 1967 Amendments call for an intensification of casefinding efforts under this program so that every advance in medical knowledge can be put to widest use for the greatest number of children at the time it can be of maximum benefit to each of them.

### COOPERATIVE MECHANISMS

The Children's Bureau's crippled children's program is a good example of the way the Bureau looks at its total job today. That job cannot, and should not, be done through Federal funds alone, nor by Federal directives. It must result from an aroused public interest and concern, the involvement of all segments of the community who can

contribute to progress, and the best and wisest use of available knowledge throughout program development.

The crippled children's program made use of all existing public and private agencies and involved both professional and parent groups in the program. It maximized the use of potential strength in each community and the result, which the Lasker Award citation called "an administrative triumph of no mean scope" won wide approval by physicians, hospitals, and local communities of its efforts.

In a wide variety of ways, this fusion of public and voluntary participation has been a hallmark of Bureau efforts. Most recently, the 1967 Amendments gave specific encouragement to the principle by authorizing the Bureau to use Federal funds to finance family planning activities undertaken under voluntary auspices, and to broaden the use of Federal funds by State welfare agencies by authorizing purchase of day care services from voluntary agencies for children of AFDC families.

But the examples are legion.

The Bureau collaborated with the Florence Crittenton Homes, the Salvation Army and the Family Service Association of America in a study designed to see how well the needs of unwed mothers were being met, and to plan programs which would narrow the gap between need and service.

Over the years, it has participated in many studies with the Child Welfare League of America leading to better standards of care for adoption, children in foster care, etc., and to higher standards of performance for social workers in the child welfare field.

It was the National Association for Retarded Children which raised its voice to the Congress in the early fifties and then worked with the Children's Bureau to bring the first Federally supported clinics for retarded children into operation (the number of mental retardation clinics supported in whole or in part by Children's Bureau funds grew from 4 in 1956 to 160 in 1968).

The Bureau has worked with the American Academy of Pediatrics and the American College of Obstetrics and Gynecology in regular exchanges of information and of needed program directions. Outstanding members of the medical profession have served on regular and ad hoc committees of the Bureau concerned with broad problems or specific areas in the field of health services for mothers and children, and in such child welfare programs as adoption, where the doctor has a distinct role to play.

### Training Program

Children's Bureau funds have gone to public or nonprofit private institutions of higher learning to train physicians, dentists, audiologists, nurses, physical therapists, occupational therapists, nutritionists, social workers with special emphasis on child welfare workers, psychologists and speech and hearing specialists.

In turn, the universities have been used as laboratories to refine techniques and expand knowledge in such areas of vital Bureau concern as infant mortality, family planning, the nutritional status of preschool children, the most effective ways to develop a total pattern of service that will not only meet the needs of but be acceptable to families living in urban slums.

These configurations may change as needs reflect the desirability of drawing upon one or another sector of voluntary groupings which represent an important and essential national resource, but the principle of their use remains constant. No agency serving children can remain viable unless its mission is not only understood but joined by others whose interests lie in the same direction.

### Federal Cooperation

It is equally essential that the vast network of programs of the Federal Government affecting children be responsive to intraprogram developments.

The Interdepartmental Committee on Children and Youth, for which the Children's Bureau provides the secretariat, is one mechanism for closer knowledge and understanding of developments in the area of services to children.

Through it, about 40 government units whose program interests touch children have a regular liaison and information exchange channel.

In addition, because the Chief of the Children's Bureau serves as United States representative to UNICEF, it has regular contacts with that organization and with the State Department on matters affecting children in other countries. It has had a long standing interest in day care, shared by the Women's Bureau of the Labor Department. Recently, through the WIN program administered by the Labor Department, additional emphasis has been placed on meeting the needs of working women for day care for their children. It is currently working with the Agriculture

Department to work out ways to reach more and more families with sound advice about nutrition and to bring supplementary foods to such vulnerable groups as maternity patients and preschool children.

The Children's Bureau is working with Housing and Urban Development on day care and community services as a component of public housing and is also consulting with HUD about what can be done to remove the threat that children may swallow old lead-based paint in substandard slum dwellings. When this paint is ingested, it can lead to pica, which causes severe mental retardation. It is working with the Department of Defense to be sure that, whether by mechanisms under military auspices or under regular State health and welfare programs, dependent children of military personnel living on post should not be deprived of child health and welfare services.

#### Comprehensive Health Services for Children and Youth

The Children's Bureau has also used facts developed by other arms of the Federal service as the basis for new program action. Information from Selective Service records which showed that 15 percent of all males of draft age were being rejected for military service for medical reasons alone, together with other data about health neglect of children of this age period, brought from Congress a program for the comprehensive health care of preschool and school age children, with particular emphasis on children in low-income families.

Such a program was authorized for five years by the 1965 Amendments to the Social Security Act. The 1967 Amendments extend it to 1972, after which it becomes a special part of each State health services plan.

On June 30, 1968, there were 58 projects providing health care and services to preschool and school age children, particularly in areas with low-income families. These projects serve areas in which an estimated 2,250,000 children of low-income families live. As of June 30, 1968, 220,000 children were registered for comprehensive health care. The projects are heavily involving voluntary community agencies in reaching children and families.

Based on information that about half of the children in the United States under the age of 15 have never been to a dentist, the 1967 Amendments also authorized support of up to 75 percent of cost of projects to provide comprehensive dental health services for children from low-income families. Funds to start this program have not yet been appropriated by Congress.

## TREATMENT OF JUVENILE OFFENDERS

One of the most disturbing--and least understood--statistics about youth today is that nearly half of all young persons institutionalized for juvenile crimes become repeaters. Juveniles alone comprise nearly one-third of all offenders under correctional treatment--63,000.

What it means, in essence, is that there is something seriously wrong with our efforts to rehabilitate juvenile offenders.

When the juvenile court system came into being, late in the 19th century and early in this one, it was at the urging of social pioneers who had seen what unenlightened prison practices could do to the youthful offender, and who were troubled at the possibility that his problems--many of them peculiar to his age group--could be given short shrift in an adult court.

Out of that genuine concern the juvenile court system grew, but it was staffed by inexperienced judges, some with no legal training, and manned initially by volunteers who served as probation staff. Even when paid probation officers were added to the staff the principle qualification was that they be law-abiding citizens.

Convicted juveniles went to training schools whose superintendents also were largely without training. Some of them even boasted of the security of their "solitary" confinement procedures.

Police, the first point of contact the youth had with the juvenile justice system, were all too inclined to treat the apprehended youth on the basis of where he lived and who his father was, for the police, too, had no training in work with juveniles.

It deserves notice that lacking any enforcement authority except moral suasion, the Children's Bureau has been able to do something about many of these conditions.

### Juvenile Delinquency Services

Its first efforts in this direction were in the development of standards for the operation of the juvenile court. By the midthirties, State and local governments began to ask for help in improving their own programs for juvenile control. By 1954, a new Division of Juvenile Delinquency Service was organized to give, on request, technical aid and consultation in developing programs for treatment and control of juvenile

delinquency, and assisting public and voluntary agencies in developing standards, guides and methods relating to various types of services for delinquent children.

The Bureau was increasingly uneasy about what was being meted out to juvenile offenders in the name of justice and urged that the juvenile court become a family court so that problems of juveniles would not be considered in isolation.

In 1966, the Supreme Court, in the case of Kent v. United States, expressed in its majority opinion its own disenchantment with the course of juvenile justice in this country.

"There is evidence," the opinion stated, "that there may be grounds for concern that the child receives the worst of both worlds: that he gets neither the protections accorded to adults nor the solicitous care and regenerative treatment postulated for children."

Children's Bureau standards were cited both in the Kent case and in the subsequent Gault case.

In 1967, in the Gault case the Supreme Court for the first time considered the constitutional rights of children in juvenile courts and held that children must be heard in juvenile courts with the procedural protections required in adult criminal trials by the Bill of Rights.

The juvenile court system thus stood indicted by the highest court in the land, not only by what it failed to do, but what it had done, in the name of "protection" of the child.

#### Reflects Need for Change

In the Gault case, for example, the probation officer took the child into custody, initiated proceedings, filed and verified the petition, appeared as the complaining witness to testify against the child and generally conducted himself as a prosecuting official. But he was obligated, as well to protect the interests of neglected, delinquent and dependent children in the county and to represent their interests before the court.

As nothing else could, the Gault decision has pointed to the need to establish a better judicial system for juveniles--one that is not removed from the public eye as the juvenile court has been--and has underscored the fact that while there are many more trained probation officers and police now than even a decade ago, and although training school

superintendents are more enlightened than they were when they bragged about their "solitary," much more public conviction and action is needed to make a program of treatment of juvenile offenders mean what it says. Part of the Children's Bureau's job today is to take advantage of the Juvenile Delinquency Prevention and Control Act of 1968 in encouraging States and communities to make a much-needed input of skill and training into all the programs which bear on the treatment of juvenile offenders. Society cannot afford the waste which the lack of such skill and training is creating in terms of both people and money.

In some States, where the need for adequate programs for the treatment of juvenile offenders already has been recognized and action taken, establishment of community-based services is being looked upon as the logical next step if any realistic approach is to be made to the problem of reducing juvenile repeaters and developing effective treatment efforts for juvenile offenders.

### Youth Today

In a way that is peculiar to their age group, most of today's youth in America is caught up in a tide of rising expectations which the communications media is serving only to stimulate.

While they may recognize themselves as the first full generation to emerge from the nuclear family, they do not have, as do their elders, any basis for comparing what was with what is family life.

They are more inclined than many previous generations, therefore, to be both impatient and derisive. Many are scornful of all community institutions, starting with schools.

All of these attitudes are, at the same time, symptomatic of the frustrations they feel as they try to manage their own difficulties in growing up. Many of them also are simultaneously trying to solve two major life tasks: to find meaningful employment even as they take on family responsibilities of their own through early marriages.

Obviously, helping youth with the complexities which today's society only intensifies cannot be undertaken successfully by any one element of that society.

The Children's Bureau is working with all those national agencies and organizations who are trying to do a piece of the job, whether it is in planning, standard-setting, program development services, or providing opportunities for significant involvement in community life.

There is growing recognition that successful efforts to help youth manage the diverse tasks of adolescence and the difficult job of life planning will greatly depend on the degree to which organizations, both public and voluntary, and committees throughout the nation are able to offer to youth opportunities for experience in a whole gamut of activities which convince him of his ability to contribute to his own development and to understand how his life relates to the life of others in the community in which he lives.

One of the most encouraging signs that such efforts can be launched comes from the realistic approach which an increasing number of communities are making to one problem which is now affecting two percent of the nation's teenage girls: bearing an out-of-wedlock child.

Illegitimacy is not a new phenomenon among teenage girls. But tradition made these pregnant girls automatic dropouts in most school systems. And curtailed education frequently was the trigger for a series of events which culminated in personal tragedy for the girl and her family.

The Children's Bureau has been a prime mover in a new trend which, starting with a demonstration program in Washington, D. C., has now spread to most major cities. It is aimed at helping girls solve the personal problems that may have lead to their pregnancy or resulted from it and directing them toward a satisfying future.

The communities which have moved with this trend have stopped arguing about whether public funds should be spent to help pregnant teenagers and which agency should foot the bill and are now planning how to provide the best overall services to the low-income, pregnant, school age girl.

This has led to cooperative efforts between such community organizations as the school system, the city and county health departments, and community action groups.

Now, some special program efforts are being launched to reach the young men who are the other half of the problem. Boys are being tutored for high school equivalency diplomas and helped to find job training and placement; counselors are helping boys with personal problems which led to their dropping out of school.

Through the impetus of the President's Committee on Youth Opportunity, in one year the number of camping experiences for youth grew from 150,000 to well over a million.

Youth have been involved in a dialogue with the Department of Health, Education, and Welfare to explore ways in which society and youth can serve each other in a troubled time.

These are action straws in the wind of the nation's recognition that today's youth, because they are in a nuclear world, need a new mix of experiences to help them to intellectual and social maturity.

If the availability of increased knowledge puts a greater stress on today's youth for intensive, prolonged intervals of instruction (and it does) then new ways must be found for the kinds of corollary involvement which today's youth wants.

If we are to be effective in helping youth find themselves and a place for constructive action in today's world, we must provide them with significant experiences in managing self, work, volunteer activity and associations which will stimulate them to setting their own high standards for responsible citizenship in a democracy.

**CHILDREN'S BUREAU PROGRAMS**

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## MATERNAL AND CHILD HEALTH SERVICES

Title V of the Social Security Act authorizes annual grants to the States to help them extend and improve, especially in rural areas and in areas suffering from severe economic distress, services for reducing infant mortality and otherwise promoting the health of mothers and children.

The program also provides grants for special projects of regional or national significance which may contribute to the advancement of services for maternal and child health. A proportion of the annual appropriation is earmarked for special programs for mentally retarded children.

Each year, maternal and child health services provided by State and local health departments reach hundreds of thousands of mothers and millions of children. In many instances, the only health care received is through these programs. During fiscal year 1967, 366,400 mothers received prenatal and postpartum care in maternity clinics. About 73,300 mothers and 7,000 premature infants received inpatient hospital care. About 89,900 expectant mothers received dental care.

About 1,631,900 children (of whom, 603,700 were under 1 year of age) were seen in well-child conferences. Over 1,711,700 school children were examined by physicians in school health programs, and, where necessary, referred for further treatment. Over 8,986,600 school children were screened for visual defects; 5,457,500 for hearing defects; and 2,549,100 for dental defects. Some 2,321,000 children received immunization for smallpox; 2,364,100 for whooping cough; 4,350,400 for diphtheria; and 4,550,600 for tetanus.

Public health nurses, working in the homes and elsewhere in the community, served 480,500 mothers. In addition to the nursing services offered in individual conferences and at schools, nursing care was provided to almost 3,000,000 children.

In 1968, the Children's Bureau supported 160 diagnostic clinics for mental retardation. These clinics served 47,000 children. The services provided include diagnosis, evaluation of a child's capacity for growth, the development of a treatment and management plan, interpretation of findings to parents, and followup care and supervision.

Federal Funds Appropriated for Fiscal Year 1969: \$50,000,000

## CRIPPLED CHILDREN'S SERVICES

Title V of the Social Security Act authorizes annual grants to the States for extension and improvement (especially in rural areas and areas of severe economic distress) of services to crippled children and children suffering from conditions that lead to crippling. These services include locating crippled children and providing medical, surgical, corrective, and other services for diagnosis, hospitalization, and aftercare for such children. The 1967 Amendments to Title V of the Act require the States to make more vigorous efforts to screen and treat children with disabling conditions through intensified case-finding and periodic screening of children in schools.

The program also provides grants for special projects of regional or national significance which may contribute to the advancement of services for crippled children. A proportion of the annual appropriation is earmarked for special projects to support programs for mentally retarded children.

Official health agencies reported physician's services for 448,700 children with crippling conditions in fiscal year 1967. The crippled children's program reached about 6 children per 1,000 in the population. Less than half of the children served have orthopedic handicaps; the rest include epilepsy, hearing impairment, cerebral palsy, cystic fibrosis, and many congenital defects. The youngest group (infants and children under 5 years of age) accounted for 30 percent of all children served in 1967; those 5 through 9 years, 30 percent; those 10 through 14, 23 percent; and those 15 through 20, 17 percent.

Federal Funds Appropriated for Fiscal Year 1969: \$57,000,000

## MATERNITY AND INFANT CARE PROJECTS

Title V of the Social Security Act authorizes grants to help reduce the incidence of mental retardation and other handicapping conditions caused by complications associated with childbearing and to help reduce infant and maternal mortality.

Three types of programs are authorized: (1) projects to provide necessary health care to prospective mothers (including, after childbirth, health care to mothers and their infants) who have or are likely to have conditions associated with childbearing or are in circumstances which increase the hazards to the health of the mothers or their infants (including those which may cause physical or mental defects in the infants); (2) projects to provide necessary health care to infants during their first year of life who have any condition or are in circumstances which increase the hazards to their health; and (3) projects to provide family planning services.

Fifty-three projects were providing comprehensive care to mothers and infants on June 30, 1968. Since this program began in April 1964, the projects have admitted 361,000 women for maternity care, 73,000 infants for clinical services, and 141,000 women for family planning services. Sixteen of these projects were in cities with a population of 500,000 or more; 16 were serving cities of 100,000-300,000 population; and 21 were located in smaller cities and rural areas.

These projects are reaching women in low-income areas many of whom previously have had little or no prenatal care. By setting a standard of high quality medical care and following the principle of individual attention to each patient's needs, the projects are reaching increasing numbers of women who previously had gone without medical care rather than endure long waits in impersonal clinics for frequently cursory medical examinations.

Federal Funds Appropriated for Fiscal Year 1969: \$48,000,000

## PROJECTS FOR HEALTH OF SCHOOL AND PRESCHOOL CHILDREN

Title V of the Social Security Act authorizes grants to provide health care and services to children of school and preschool age, particularly in areas with concentration of low-income families. The projects include screening, diagnosis, and preventive services, both medical and dental. Treatment, correction of defects, and aftercare services are provided to children who would not otherwise receive them because they are from low-income families or for other reasons beyond their control.

Fifty-eight projects have begun operation and were in varying stages of development on June 30, 1968. These projects serve low-income areas in which an estimated 2,250,000 children live. Since the beginning of the program in 1966, approximately 220,000 children have been registered for comprehensive health care.

These projects are making it possible for community health organizations to develop new and imaginative methods of reaching out to children in slum areas, decentralizing services into neighborhoods, and establishing well-organized systems of providing comprehensive health programs of casefinding, prevention, health supervision, and treatment.

Federal Funds Appropriated for Fiscal Year 1969: \$39,000,000

PROJECTS FOR DENTAL HEALTH OF CHILDREN

The 1967 Amendments to Title V of the Social Security Act authorizes grants to promote the dental health of children and youth of school or preschool age, particularly in areas with concentrations of low-income families. The program includes preventive services, treatment, correction of defects, and aftercare.

Federal Funds Appropriated for Fiscal Year 1969: None

TRAINING OF PERSONNEL FOR HEALTH CARE  
AND RELATED SERVICES FOR MOTHERS AND CHILDREN

Title V of the Social Security Act authorizes grants for training personnel for health care and related services for mothers and children, particularly mentally retarded children and children with multiple handicaps. Special attention is given to programs providing training at the undergraduate level.

The training programs in the university-affiliated centers offer a complete range of services for mentally retarded children and are demonstrating the specialized services for the diagnosis, treatment, education, training, and care of these children, including the retarded with physical handicaps. They provide clinical training of physicians and other specialized personnel engaged in research and diagnosis, training, and care of the retarded. Funds awarded provide support for services, clinical facilities, faculty, traineeships, and costs of short-term workshops and institutes.

During fiscal year 1968, 78 fellowships and 39 short-term traineeships were supported in such health fields as pediatrics, pedodontics, genetics, psychology, nursing, medical social work, and speech pathology and audiology.

Federal Funds Appropriated for Fiscal Year 1969: \$9,000,000

RESEARCH PROJECTS RELATING TO MATERNAL AND CHILD  
HEALTH AND CRIPPLED CHILDREN'S SERVICES

Title V, Section 512, of the Social Security Act authorizes Federal support of research projects in the field of maternal and child health services and crippled children's services. The broad objectives of the program are to improve the operation, functioning, general usefulness, and effectiveness of maternal and child health and crippled children's services. Special emphasis is given to projects to study the need for and the feasibility, costs, and effectiveness of comprehensive health care programs in which maximum use is made of health personnel with varying levels of training and in studying methods of training for such programs. Grants may also include funds for the training of health personnel for work in such projects.

While a major focal point of recent grants awards has been in various aspects of family planning, fertility and sterility, research is also going forward in nutrition, prosthetics and orthodontics, hearing, mental retardation, crippled children, health care and manpower at varying levels of training.

The amount awarded for maternal and child health and crippled children's research grants for fiscal year 1968 funds was \$5,579,578 for 68 projects.

Federal Funds Appropriated for Fiscal Year 1969: \$6,200,000

## CHILD WELFARE SERVICES

Title IV, Part B, of the Social Security Act authorizes grants to State public welfare agencies for establishing, extending, and strengthening child welfare services for the purpose of (1) preventing or remedying, or assisting in the solution of problems which may result in, the neglect, abuse, exploitation, or delinquency of children; (2) protecting and caring for homeless, dependent, or neglected children; (3) protecting and promoting the welfare of children of working mothers; and (4) otherwise protecting and promoting the welfare of children, including the strengthening of their own homes where possible, or, where needed, the provision of adequate care of children away from their homes in foster family homes or day care or other child care facilities.

The foundation of child welfare services is the recognition that every child and every adult faces difficulties in the process of living which most children, with the help of their parents and other people, can surmount. Child welfare services are available to others, regardless of income, who cannot live satisfying lives without special help. They assist both children and their families to advance the best interests of the child in ways designed both for prevention of situations which can be disruptive to the life of the child and the best form of protection of the child when such disruption occurs.

About 607,900 children were receiving child welfare services from State and local public welfare agencies on March 31, 1967. The rate was 74 children served per 10,000 in the population. Forty-eight percent of the children receiving child welfare services were in their own homes or the homes of relatives; 34 percent were in foster family homes; 10 percent in institutions; 7 percent in adoptive homes; and 1 percent elsewhere.

Federal Funds Appropriated for Fiscal Year 1969: \$46,000,000

## CHILD WELFARE TRAINING

Title IV, Part B, Section 426, of the Social Security Act authorizes training grants to accredited institutions of higher learning to strengthen their resources for training students for work in the field of child welfare; traineeships for students interested in this field; and support of short-term training courses. The purpose of the program is to provide a pool of trained personnel for work in the field of child welfare and to help institutions of higher learning train a greater number of persons for work in the field of child welfare by expanding and strengthening their educational resources.

A total of \$5.7 million was awarded in 1968 for 165 grants to strengthen teaching programs in the field of child welfare, 762 traineeships for master's degrees, 40 traineeships at the post-master's level, and 10 short-term training projects. In addition, schools granted 12 traineeships for master's degrees and 10 traineeships at the post-master's level, which were carried over from the previous year.

Federal Funds Appropriated for Fiscal Year 1969: \$5,800,000

## SERVICES TO FAMILIES AND CHILDREN RECEIVING AFDC

Title IV, Part A, of the Social Security Act authorizes Federal financial participation in State costs for social services to families and children receiving AFDC at the rate of 75 percent (85 percent until July 1, 1969). Based on each such family's special circumstances and requirements, these services assist the family to attain or retain capability for self-support and care, to maintain and strengthen family life, and to foster child development.

Effective July 1, 1968, States are required to furnish child care services as needed for each individual receiving AFDC who is referred by the welfare agency to the Department of Labor for training and employment in the work incentive (WIN) program. In addition, Federal funds may be used by States to provide day care, for other children who may be in need of it.

According to State reports for the quarter ending September 30, 1967, social services were provided to 844,000 families in which there were 2,621,000 children.

The total cost for social services to families and children receiving AFDC during the fiscal year ending June 30, 1968, was approximately \$229.5 million.

## WORK INCENTIVE PROGRAM

Title IV, Part C, of the Social Security Act authorizes "a program utilizing all available manpower services . . . under which individuals receiving aid to families with dependent children will be furnished incentives, opportunities, and necessary services in order for (1) the employment of such individuals in the regular economy, (2) the training of such individuals for work in the regular economy, and (3) the participation of such individuals in special work projects, thus restoring the families of such individuals to independence and useful roles in their communities."

The work incentive program is administered by the Department of Labor with cooperation of the Department of Health, Education, and Welfare. The Department of Health, Education, and Welfare has responsibility for the portion of the program concerned with screening of individuals by public welfare agencies for appropriate referrals to manpower agencies; provision of prereferral services; the referrals; and provision of essential services, including child care, where needed, and physician services, where needed, in support of the manpower activities.

The Children's Bureau was assigned responsibility for the Department of Health, Education, and Welfare portion of the program in December 1968.

All appropriate members of the AFDC household who are unemployed, 16 years or older, and not in school are eligible for WIN.

Child care out of the home, in day care centers and family homes, and in the home with homemakers must be available to mothers who enter the WIN program. These child care services must meet State child care licensing standards and Federal day care requirements.

As of the first week in December 1968, the U.S. Department of Labor had allotted a total of 78,610 training slots in the WIN program in 38 States.

Federal Funds Appropriated for Fiscal Year 1969: \$117.5 million for the work incentive program, of which the Department of Health, Education, and Welfare allocated \$94.9 million to the Department of Labor and \$22.6 million for day care.

## CHILD WELFARE RESEARCH AND DEMONSTRATION PROJECTS

Title IV, Part B, Section 426, of the Social Security Act authorizes grants for (1) special research and demonstration projects in the field of child welfare which are of regional or national significance; (2) special projects for the demonstration of new methods or facilities which show promise of substantial contribution to the advancement of child welfare; and (3) projects for the demonstration of the utilization of research in the field of child welfare in order to encourage experimental and special types of welfare services.

In the area of protective services, a number of projects are underway on how to deal with the extremely serious problem of children abused by their parents--the battered child syndrome first identified by Dr. C. Henry Kempe. Demonstration projects are also being funded both in day care for children of various age groups and in the foster care of children. Special projects to study the current needs of children in both urban and rural areas, and to meet the social and emotional needs of children who are mentally retarded are also included in this program.

Grants totaling \$3,996,021 for 39 child welfare research and demonstration projects were awarded in fiscal year 1968.

Federal Funds Appropriated for Fiscal Year 1969: \$4,400,000

WORK EXPERIENCE PROGRAM

Title V of the Economic Opportunity Act authorizes grants to enable States to expand opportunities for constructive work experience and training for low-income families. For certain projects effective as of July 1, 1967 (new projects and renewals), the Department of Labor is involved in both approval of the projects and the commitment of funds. The program expires June 30, 1969, and no new projects are being funded at this time.

Federal Funds Appropriated for Fiscal Year 1969: \$10,000,000

## JUVENILE DELINQUENCY SERVICES

The staff of the Division of Juvenile Delinquency Service provides technical assistance to public and voluntary agencies and develops standards, guides, and methods for services for delinquent children. The areas covered include police work with juveniles, court and probation services, legal aspects of delinquency, detention services, institutional care for delinquent children, community organization, and training programs for personnel, professional and nonprofessional, working with delinquent youth.

**CHARTS DEPICTING CHILDREN'S BUREAU PROGRAMS**

MATERNAL AND CHILD HEALTH SERVICES

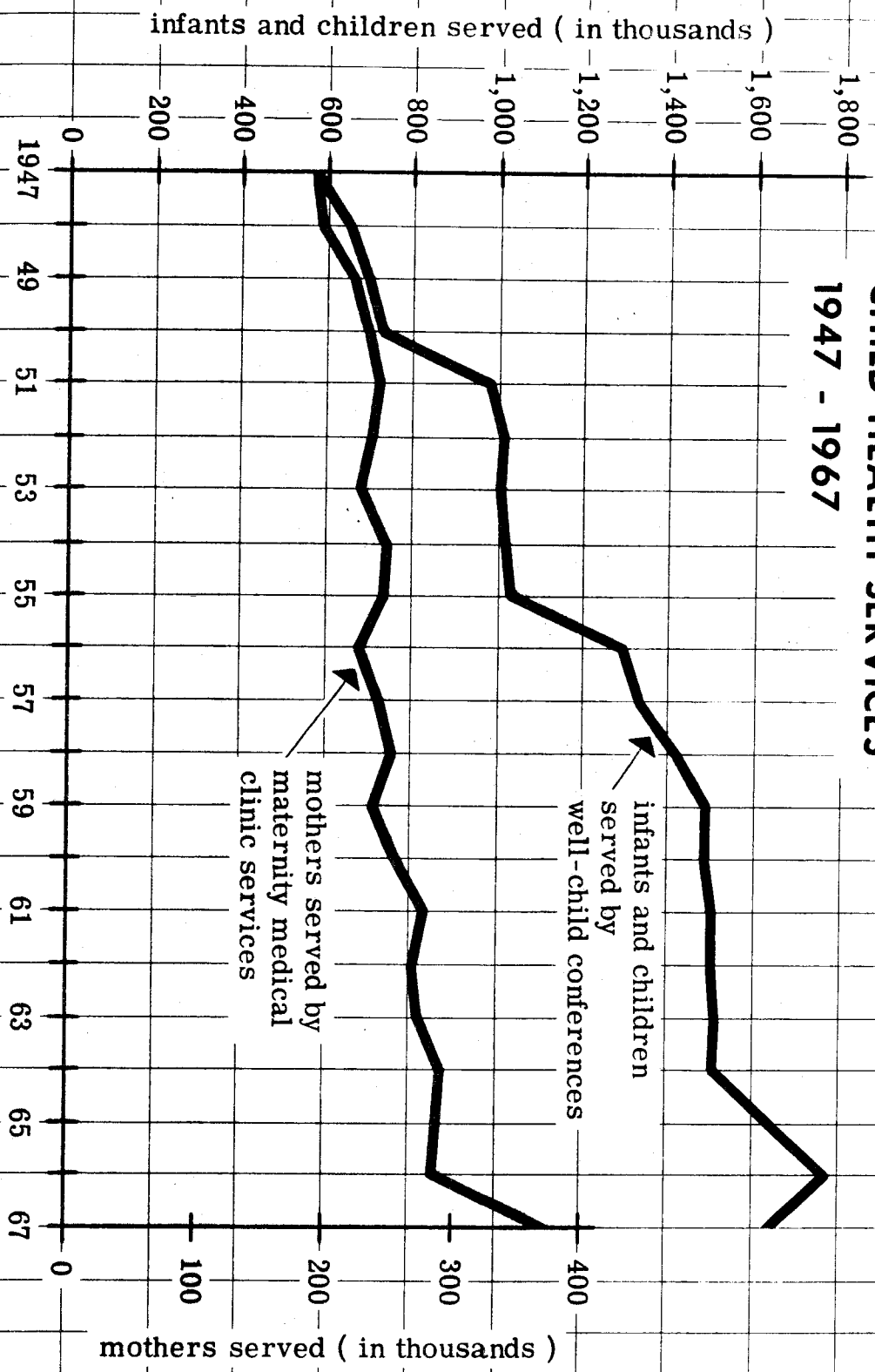
1947-1967

During fiscal year 1967, State and local maternal and child health programs provided maternity clinic services for 366,400 expectant mothers. About 73,300 mothers and 7,000 premature infants received inpatient hospital care. About 89,900 expectant mothers received dental care.

About 1,631,900 children (of whom, 603,700 were under 1 year of age) were seen in well-child conferences. Over 1,711,700 school children were examined by physicians in school health programs, and, where necessary, referred for further treatment. Over 8,986,600 school children were screened for visual defects; 5,457,500 for hearing defects; and 2,549,100 for dental defects. Some 2,321,000 children received immunization (including boosters or revaccinations for smallpox; 2,364,100 for whooping cough; 4,350,400 for diphtheria; and 4,550,600 for tetanus.

Public health nurses, working in the homes and elsewhere in the community, served 480,500 mothers. In addition to the nursing services offered in individual conferences and at schools, nursing care was provided to almost 3,000,000 children.

# MATERNAL AND CHILD HEALTH SERVICES 1947 - 1967



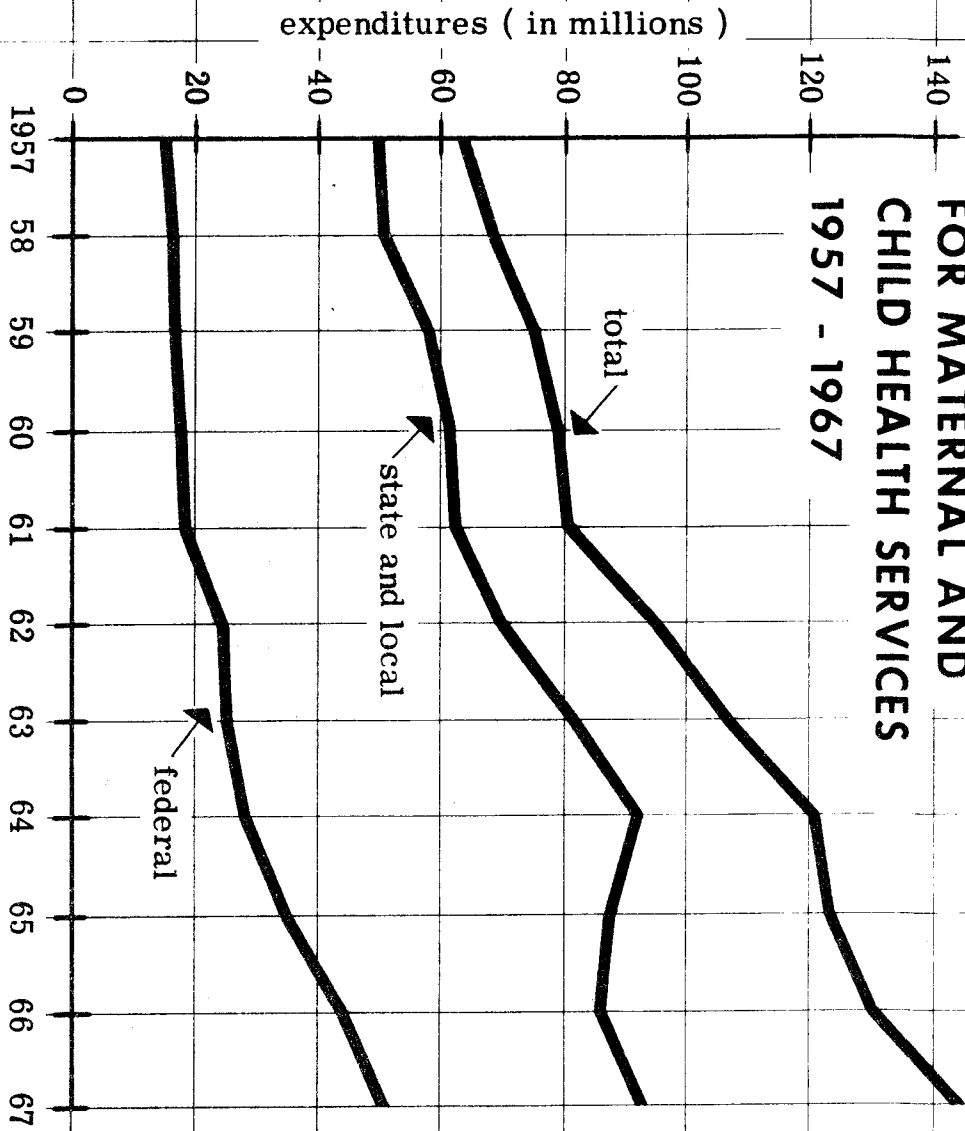
GROWTH IN EXPENDITURES FOR MATERNAL AND CHILD HEALTH SERVICES

1957-1967

Expenditures for maternal and child health services more than doubled in the decade 1957-1967.

State and local public health agencies spent an estimated \$143.6 million in 1967 for maternal and child health services. This included expenditures of \$93.1 million from State and local funds (65 percent of the total) and \$50.5 million from Federal funds (35 percent).

# GROWTH IN EXPENDITURES FOR MATERNAL AND CHILD HEALTH SERVICES 1957 - 1967



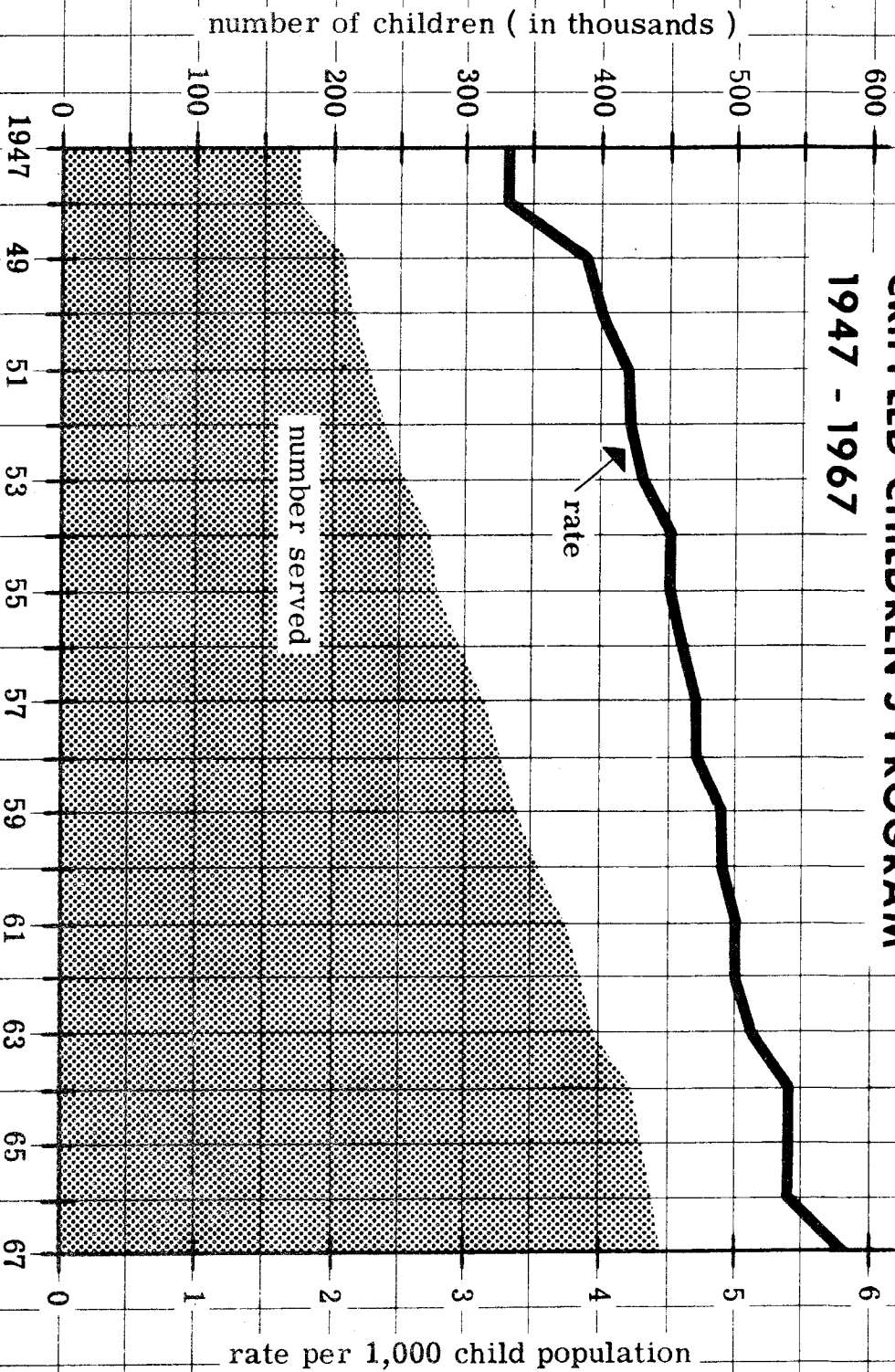
CHILDREN SERVED IN THE CRIPPLED CHILDREN'S PROGRAM

1947-1967

Official health agencies reported services for 448,700 children with crippling conditions in fiscal year 1967, as compared to 175,000 in 1947. The crippled children's program reached about 6 children per 1,000 in the population.

The youngest group (infants and children under 5 years of age) accounted for 30 percent of all children served in 1967; those 5 through 9 years, 30 percent; those 10 through 14, 23 percent; and those 15 through 20, 17 percent.

# CHILDREN SERVED IN THE CRIPPLED CHILDREN'S PROGRAM 1947 - 1967



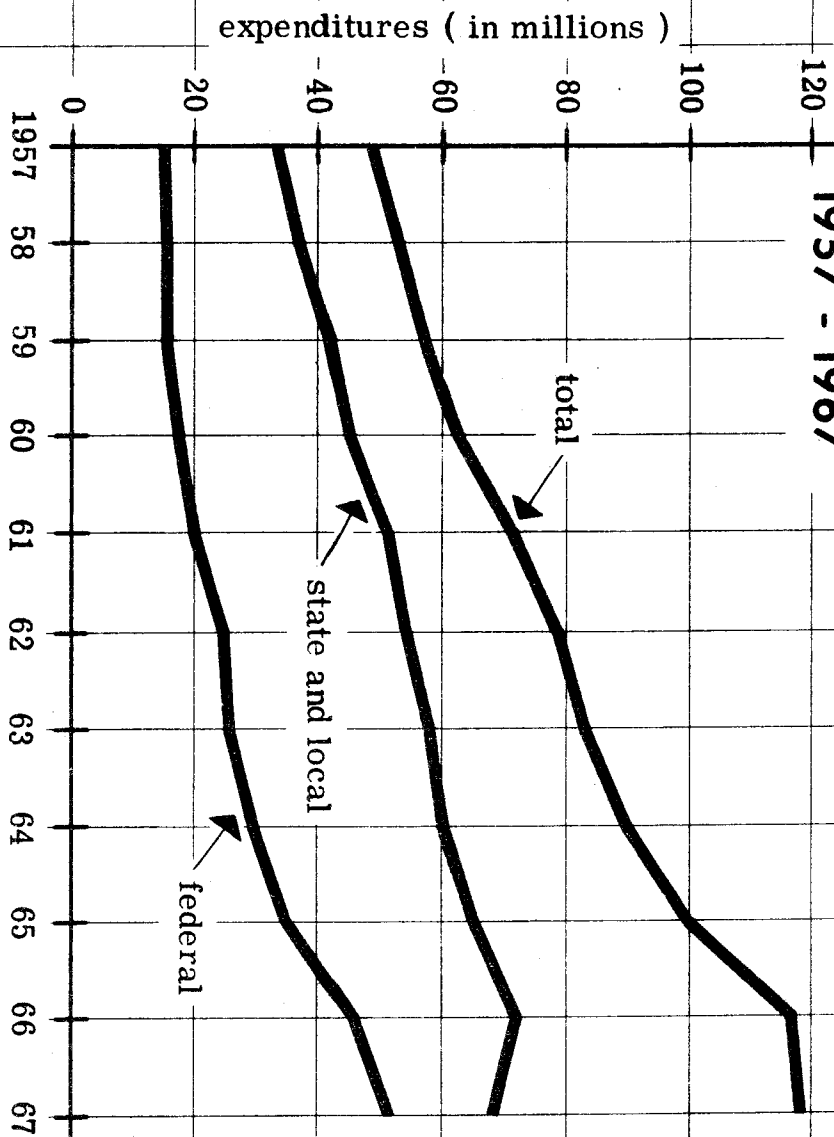
GROWTH IN EXPENDITURES FOR CRIPPLED CHILDREN'S SERVICES

1957-1967

Expenditures for crippled children's services increased from \$48.6 million in 1957 to \$117.8 million in 1967. This included expenditures in 1967 of \$67.5 million from State and local funds (57 percent of the total) and \$50.3 million from Federal funds (43 percent).

# GROWTH IN EXPENDITURES FOR CRIPPLED CHILDREN'S SERVICES

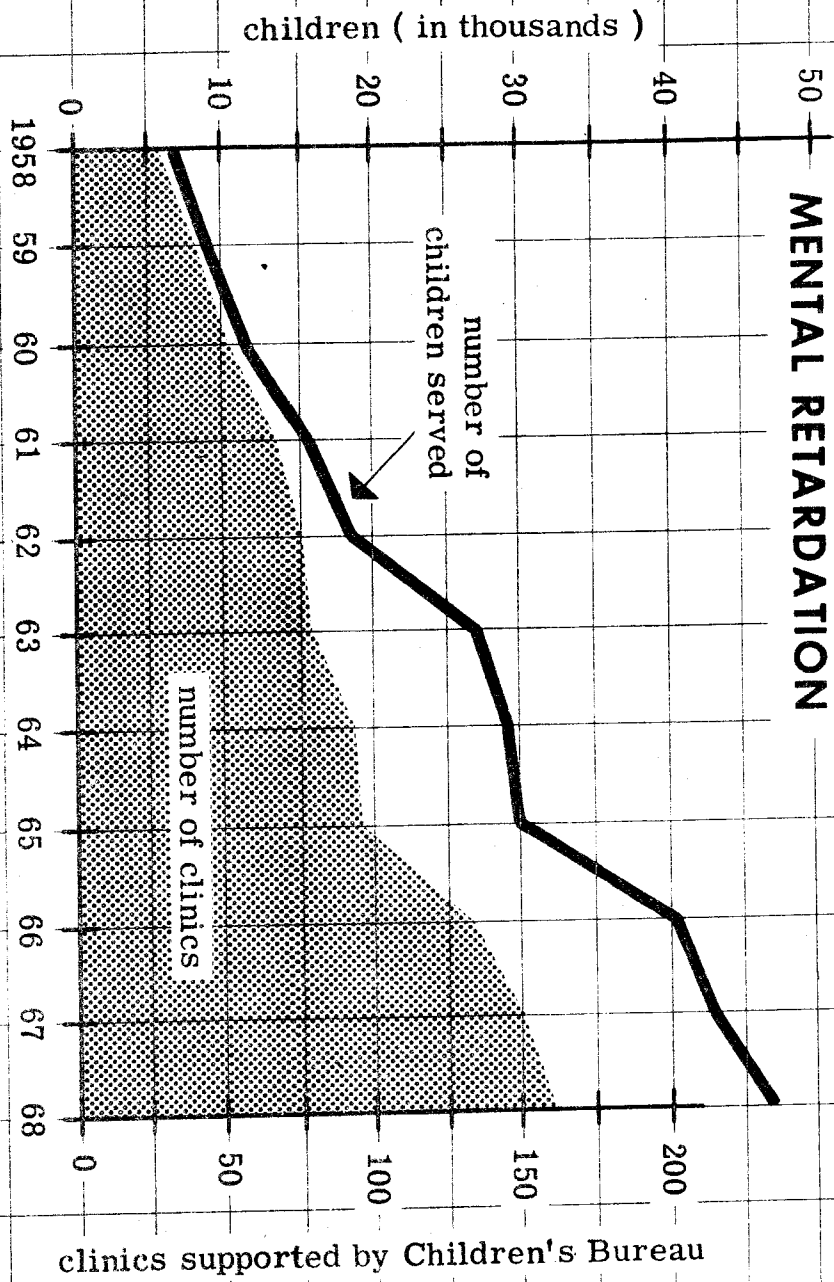
1957 - 1967



#### DIAGNOSTIC CLINICS FOR MENTAL RETARDATION

Clinical services for mentally retarded children have increased substantially as the number of clinics supported in whole or in part by Children's Bureau funds has increased from 30 in 1958 to 160 in 1968. Services provided include diagnosis, evaluation of a child's capacity for growth, the development of a treatment and management plan, interpretation of findings to the parents, and followup care and supervision. In 1958, about 6,800 children were served. In 1968, the number of children served had increased to 47,000.

# DIAGNOSTIC CLINICS FOR MENTAL RETARDATION

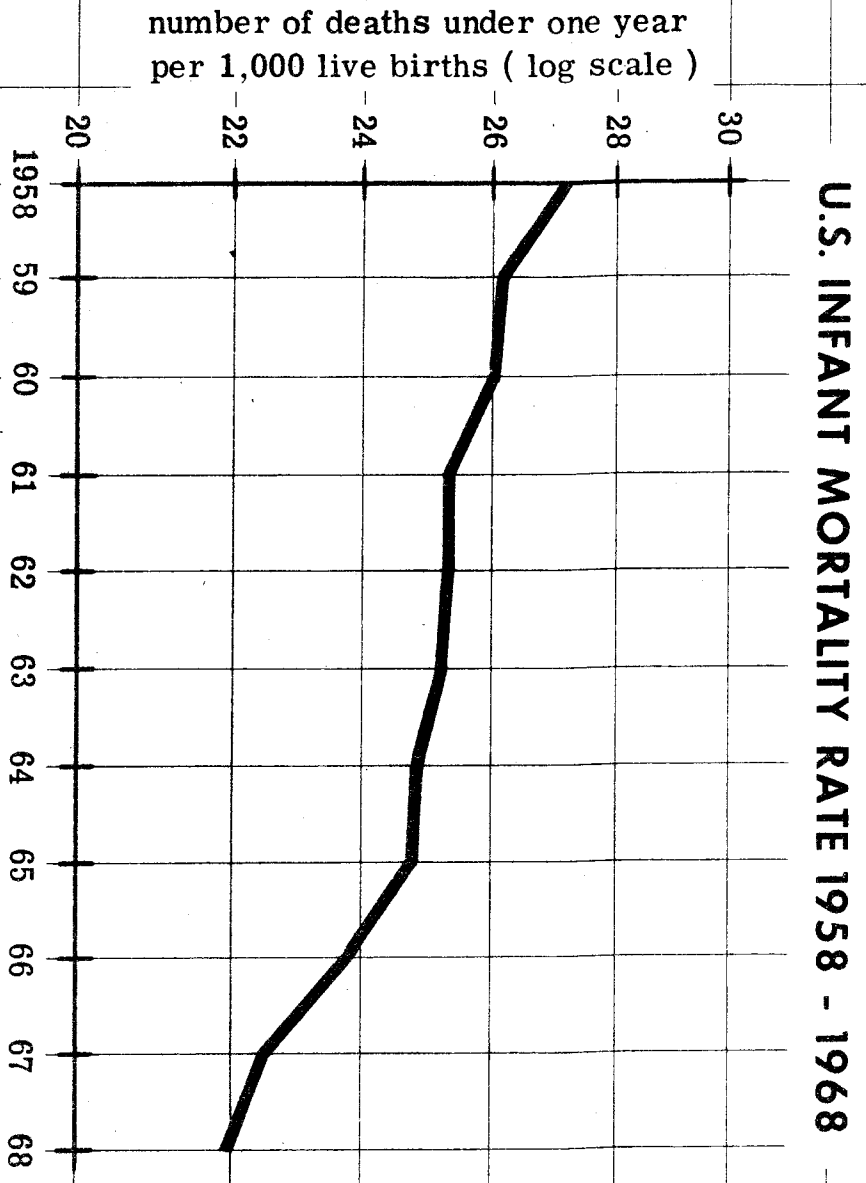


U.S. INFANT MORTALITY RATE

1958-1968

In 1968, the provisional infant mortality rate reached an alltime low of 21.9 deaths under 1 year of age per 1,000 live births.

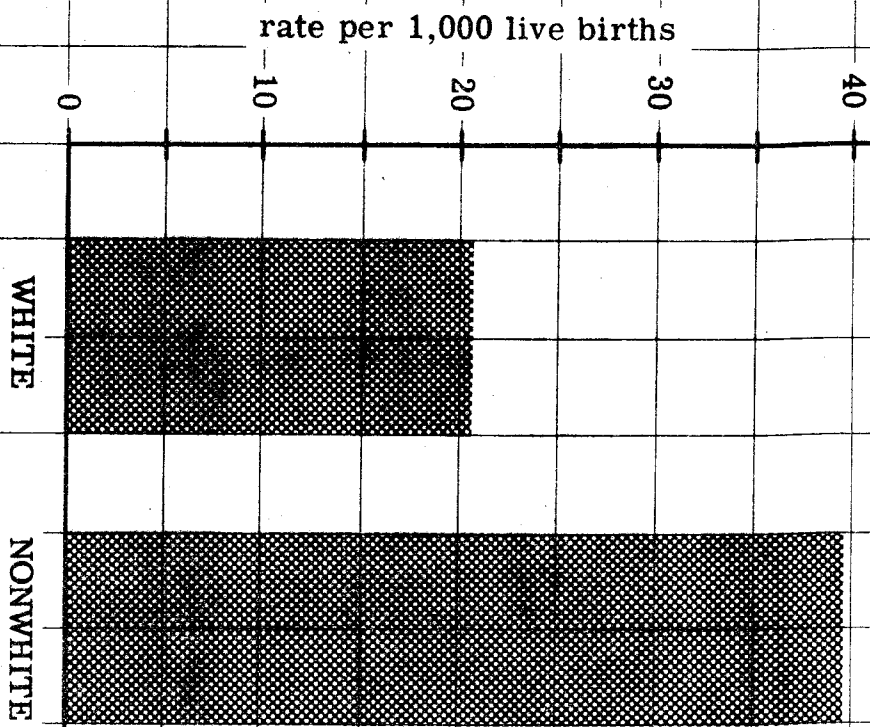
The infant mortality rate decreased by 19 percent from 1958, with the greatest decreases occurring in 1966 and 1967.



INFANT MORTALITY IS ALMOST TWICE  
AS HIGH FOR NONWHITE

The infant mortality rate for nonwhites in 1966 (the latest year for which such figures are available) was almost twice as high as the infant mortality rate for whites: 38.7 deaths under 1 year of age per 1,000 live births for nonwhites, as compared with 20.6 for whites.

**INFANT MORTALITY IS ALMOST  
TWICE AS HIGH FOR NONWHITE**



WOMEN RECEIVING COMPREHENSIVE MATERNITY CARE

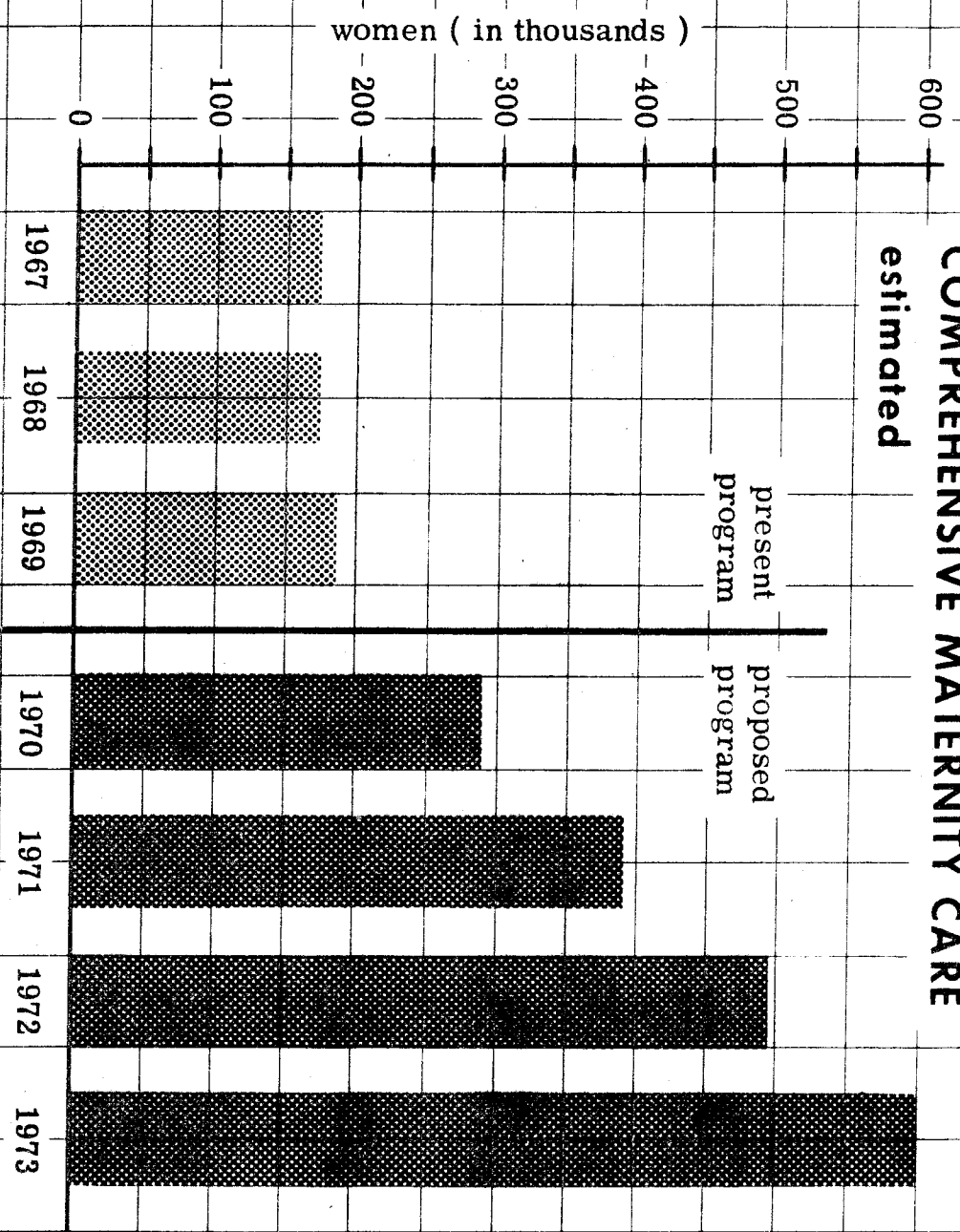
In 1968, 175,000 women received comprehensive maternity care.

Under the new child health proposals, 600,000 women would receive comprehensive maternity care in 1973.

# WOMEN RECEIVING COMPREHENSIVE MATERNITY CARE

estimated

present program  
proposed program



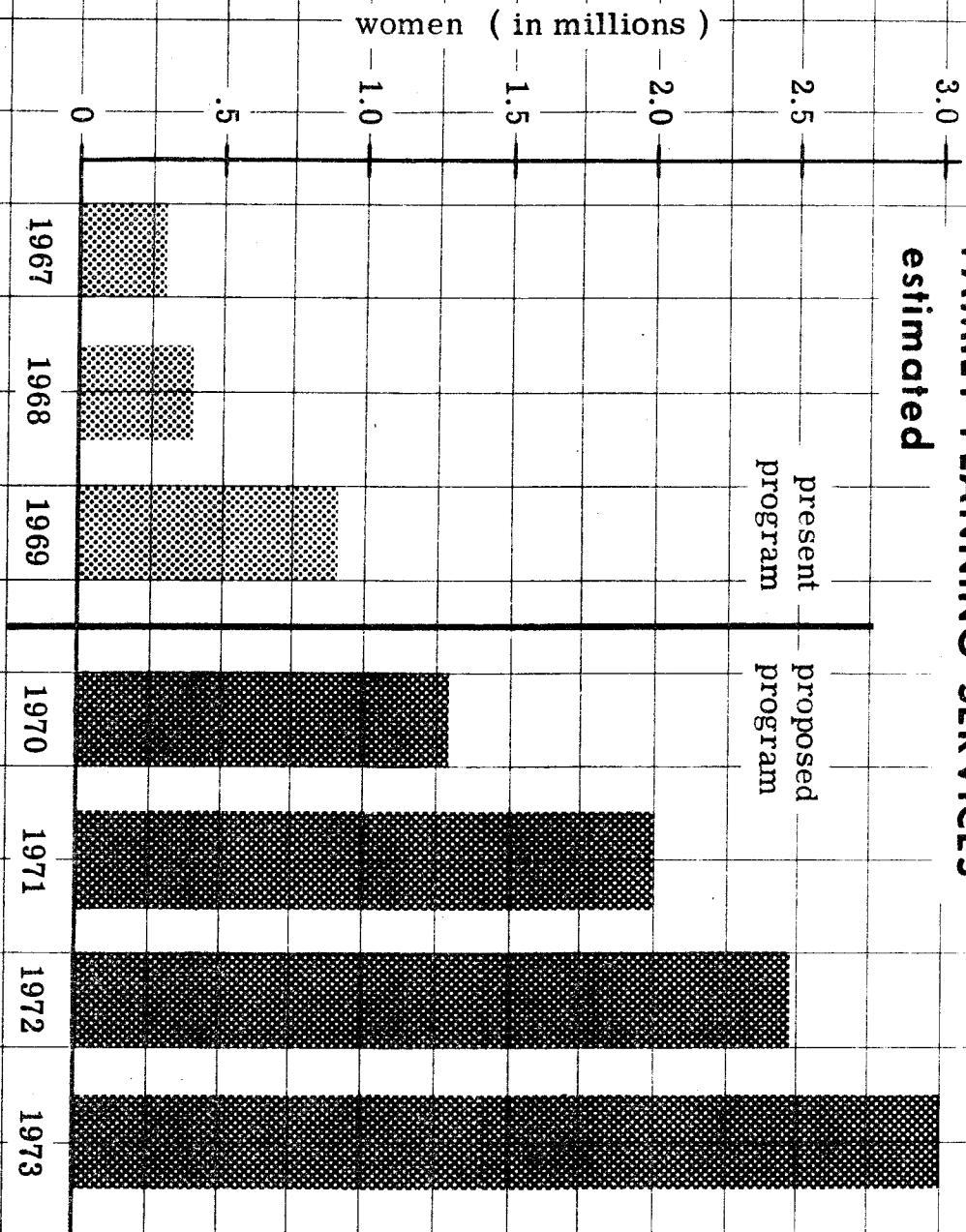
WOMEN RECEIVING FAMILY PLANNING SERVICES

Approximately 400,000 women received family planning services through the maternal and child health programs and the maternity and infant care projects in 1968.

Under the new child health proposals, 3,000,000 women would receive family planning services in 1973.

# WOMEN RECEIVING FAMILY PLANNING SERVICES

estimated



CHILDREN RECEIVING CHILD WELFARE SERVICES  
FROM PUBLIC WELFARE AGENCIES

March 31, 1957-1967

About 607,900 children were receiving child welfare services from State and local public welfare agencies on March 31, 1967, or 91 percent more than were being served on March 31, 1957.

The rate was 74 children served per 10,000 in the population, as compared with 48 per 10,000 in 1957.

children receiving child welfare services ( in thousands )

0 100 200 300 400 500 600

1957

58

59

60

61

62

63

64

65

66

67

rate per 10,000 children under 21 years

0 20 40 60 80

# CHILDREN RECEIVING CHILD WELFARE SERVICES FROM PUBLIC WELFARE AGENCIES March 31, 1957 - 1967

number of children served

rate per 10,000 children

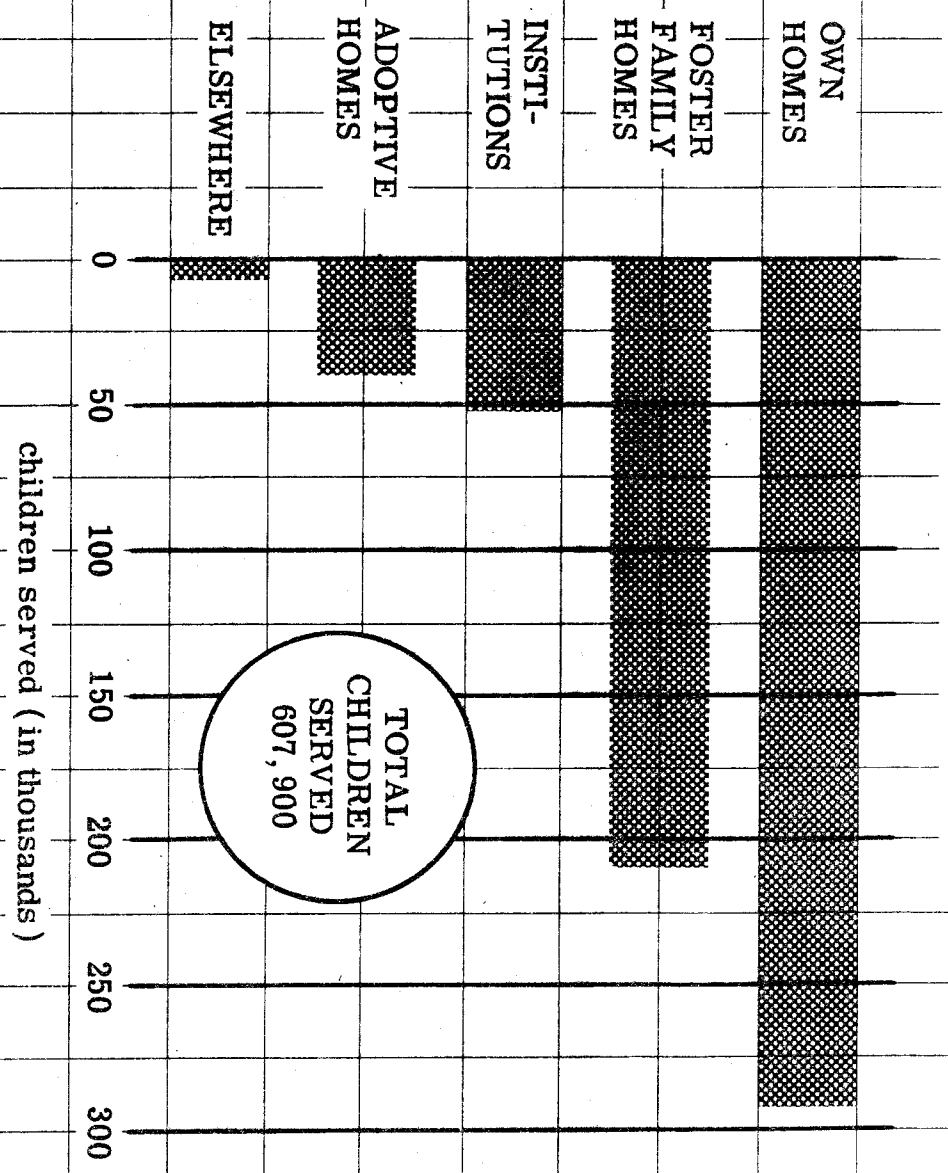
CHILDREN RECEIVING CHILD WELFARE SERVICES  
FROM PUBLIC WELFARE AGENCIES

by living arrangements--March 31, 1967

Of the 607,900 children receiving child welfare services from State and local public welfare agencies on March 31, 1967, 48 percent were living in their own homes or the homes of relatives, 34 percent were in foster family homes, 10 percent in institutions, 7 percent in adoptive homes, and 1 percent elsewhere.

# CHILDREN RECEIVING CHILD WELFARE SERVICES FROM PUBLIC WELFARE AGENCIES

by living arrangements      March 31, 1967

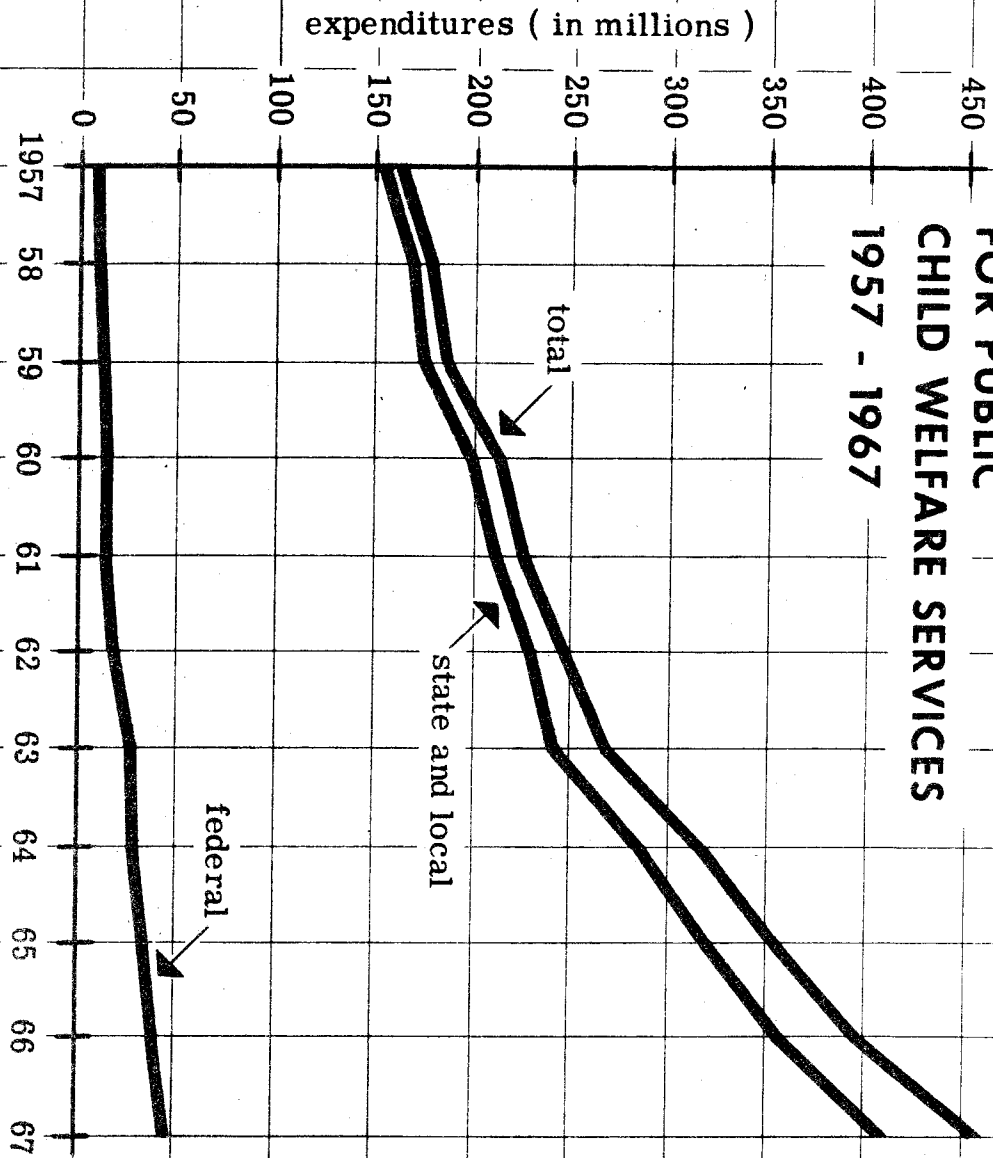


GROWTH IN EXPENDITURES FOR PUBLIC CHILD WELFARE SERVICES

1957-1967

Public child welfare expenditures rose from \$159.5 million in 1957 to \$452.7 million in 1967. This included expenditures in 1967 of \$407 million from State and local funds (90 percent of the total) and \$45.7 million from Federal funds (10 percent). It is estimated that \$283.3 million was used to pay for foster care of children in 1967, \$14.3 million for provision of day care, \$128.3 million for personnel, \$4.3 million for educational leave to provide professional education for promising workers, and \$22.5 million for other purposes.

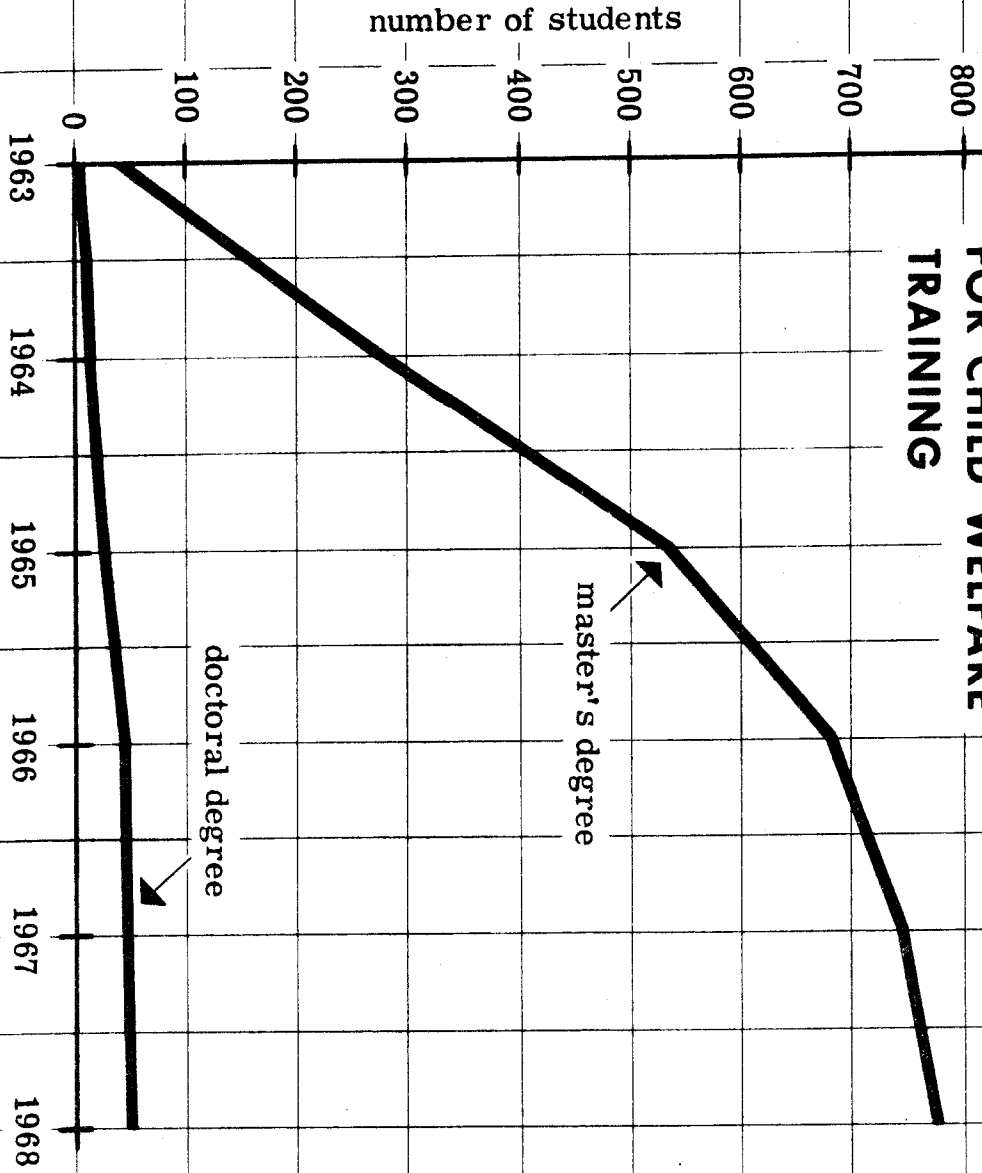
# GROWTH IN EXPENDITURES FOR PUBLIC CHILD WELFARE SERVICES 1957 - 1967



#### TRAINEESHIP AWARDS FOR CHILD WELFARE TRAINING

A total of \$5.7 million was awarded in 1968 for 165 grants to strengthen teaching programs in the field of child welfare, 762 traineeships for master's degrees, 40 traineeships at the post-master's level, and 10 short-term training projects. In addition, schools granted 12 traineeships for master's degrees and 10 traineeships at the post-master's level, which were carried over from the previous year.

# TRAINEESHIP AWARDS FOR CHILD WELFARE TRAINING



CHILDREN ADOPTED IN THE UNITED STATES

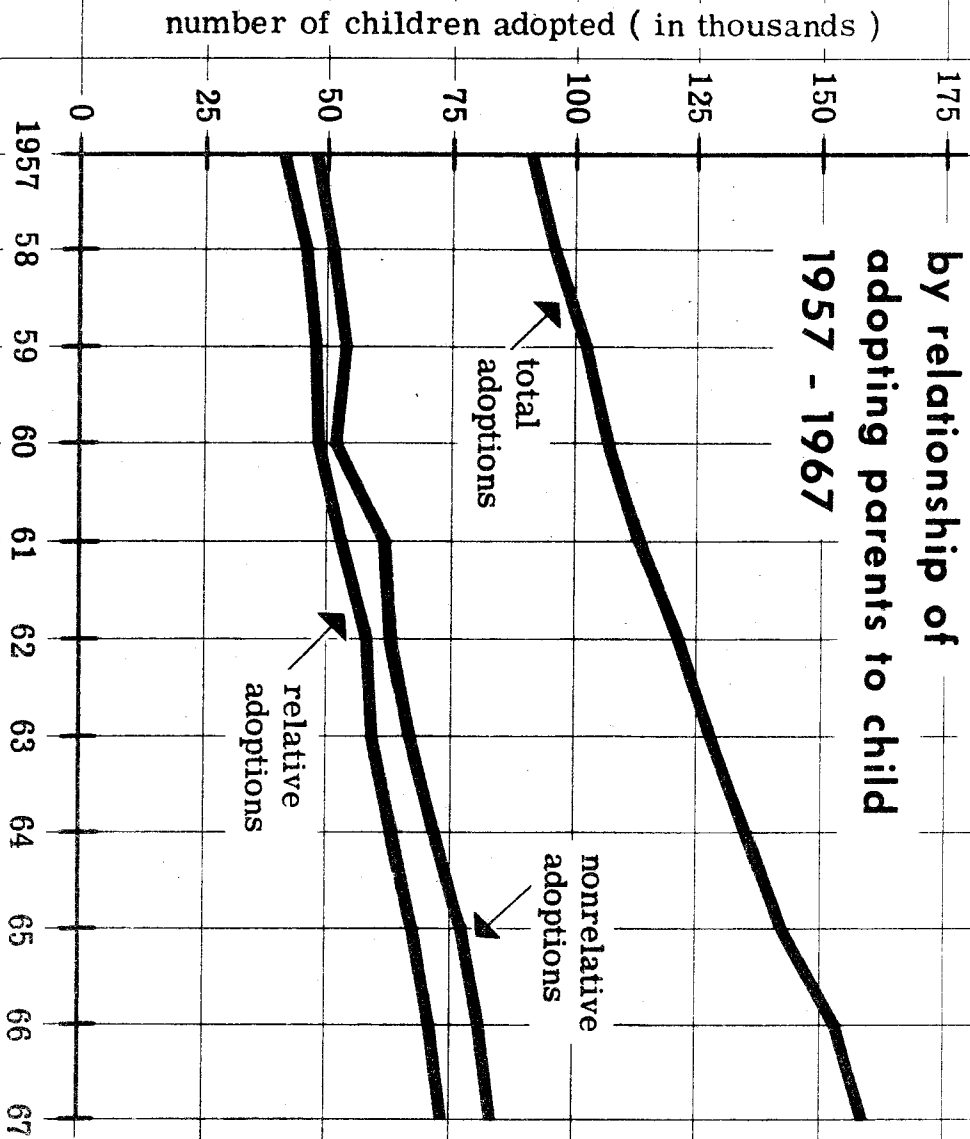
by relationship of adopting parents to child

1957-1967

The number of children adopted by nonrelatives rose from 48,200 in 1957 to 83,700 in 1967, a 74-percent increase. The number of children adopted by nonrelatives through social agency placement increased by 143 percent.

The percentage of children adopted by nonrelatives through social agency placement rose from 53 percent in 1957 to 74 percent in 1967.

# CHILDREN ADOPTED IN THE UNITED STATES by relationship of adopting parents to child 1957 - 1967



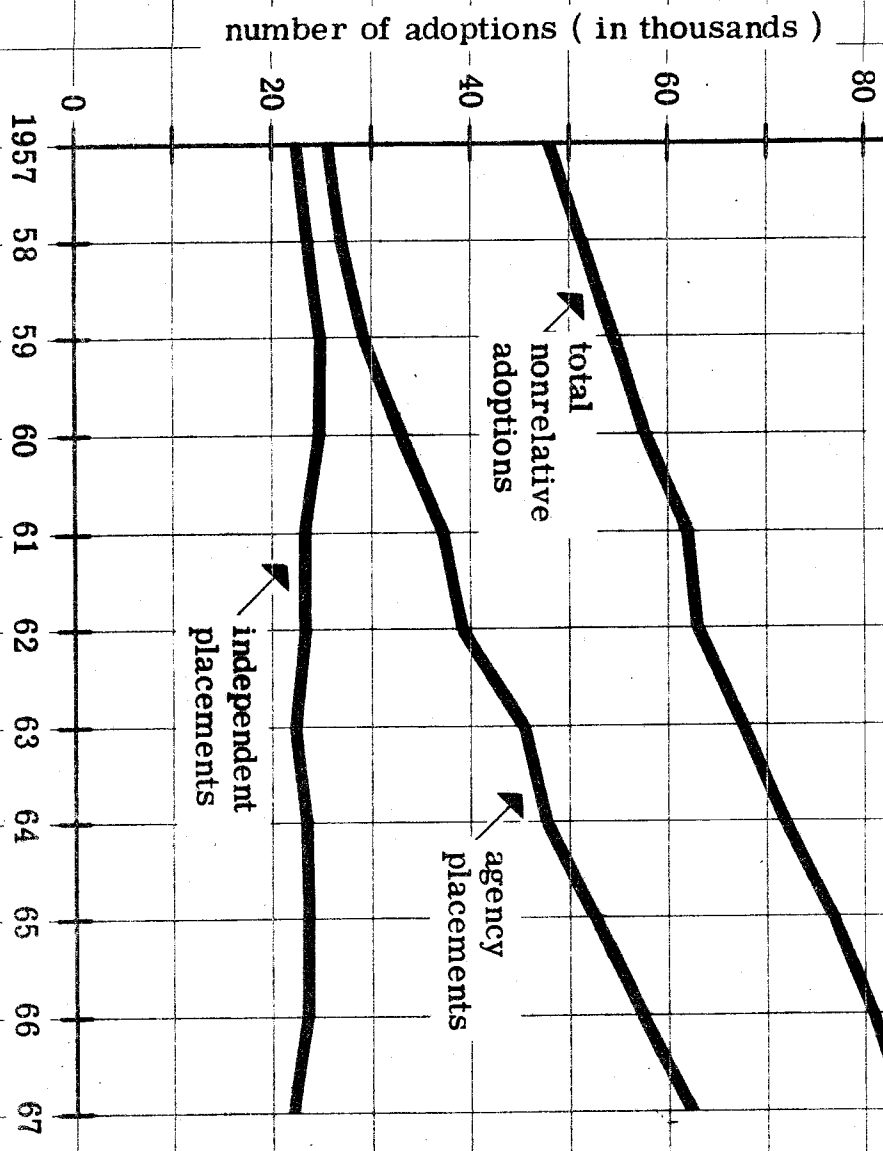
CHILDREN ADOPTED BY NONRELATIVES

by type of placement

1957-1967

Approximately 158,000 children were adopted in the United States in 1967. Of these, 83,700 were adopted by nonrelatives, and 74,300 were adopted by relatives.

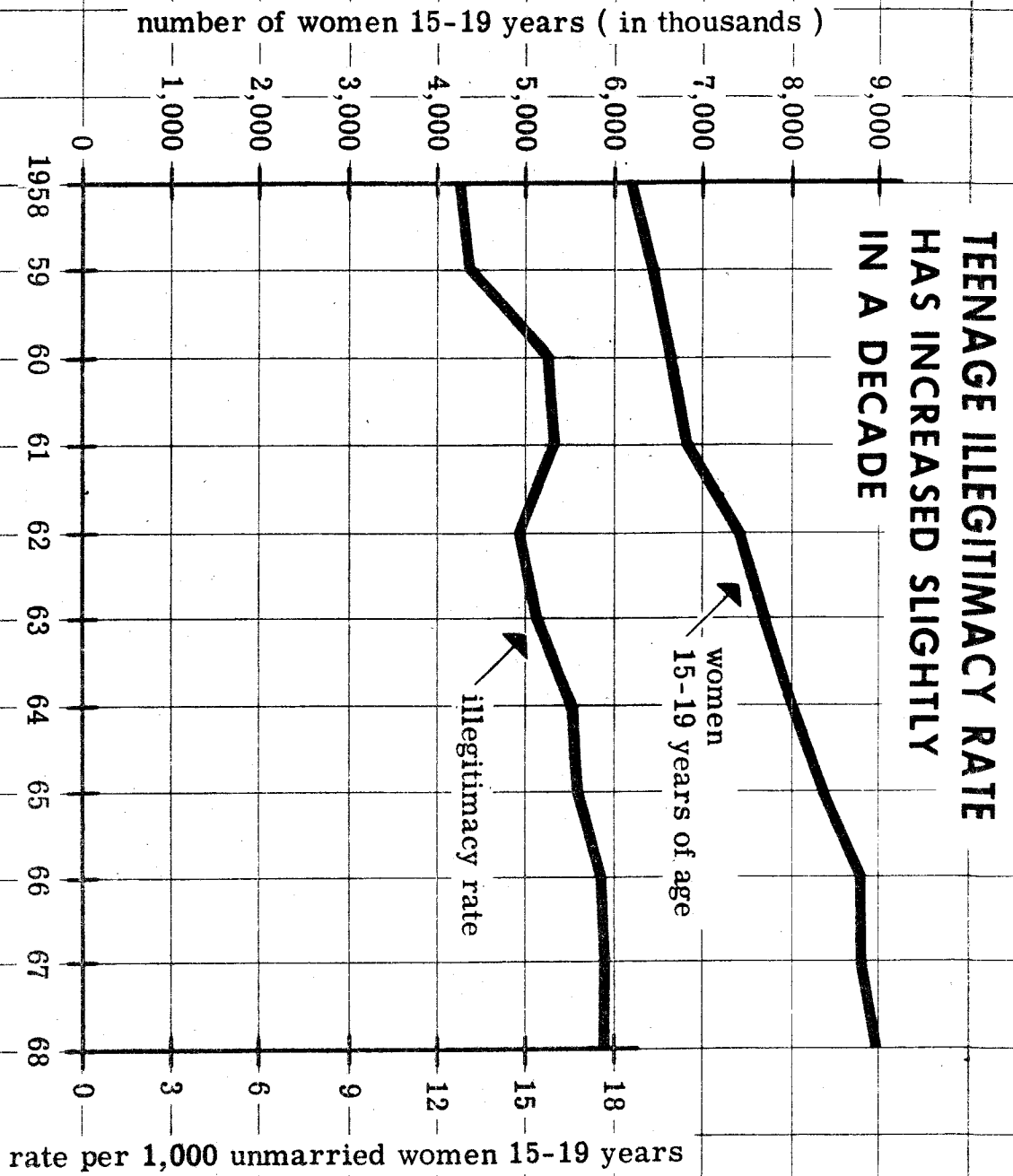
**CHILDREN ADOPTED  
BY NONRELATIVES  
by type of placement  
1957 - 1967**



TEENAGE ILLEGITIMACY RATE HAS INCREASED  
SLIGHTLY IN A DECADE

There were an estimated 140,000-145,000 births out of wedlock in 1968 to girls 15-19 years of age.

While the population for girls 15-19 increased 45 percent in the decade 1958-1968, the teenage illegitimacy rate increased by only 38 percent.

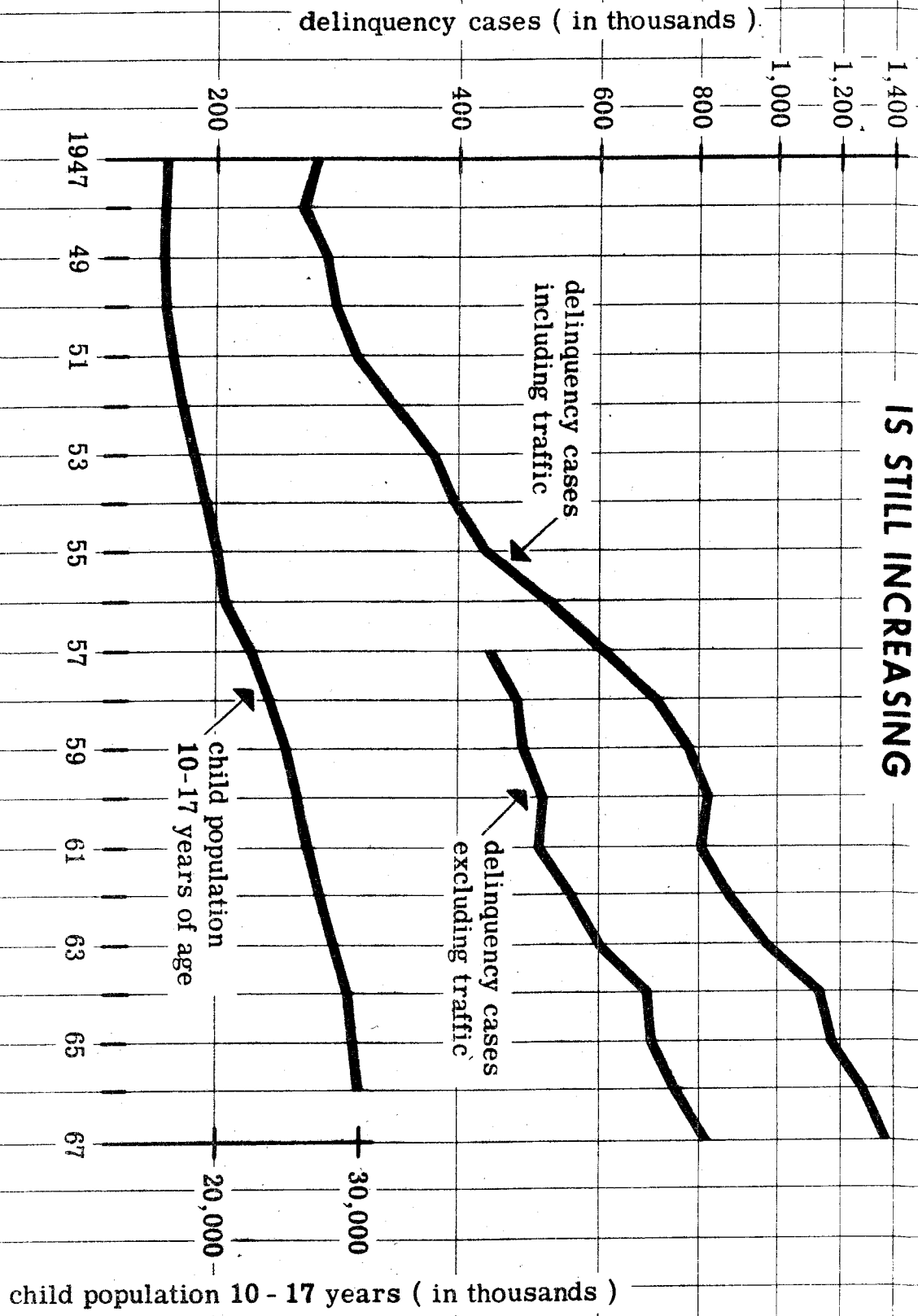


JUVENILE DELINQUENCY IS STILL INCREASING

About 811,000 juvenile delinquency cases (excluding traffic offenses) were handled by juvenile courts in the United States in 1967, as compared to 745,000 in 1966, an increase of 9 percent. These cases represented 699,000 different children, or about 2.3 of all children 10-17 years of age.

The rate of juvenile delinquency court cases in urban areas was three times higher than in rural areas.

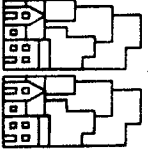
























# JUVENILE DELINQUENCY IS STILL INCREASING



GAPS IN PROGRAMS FOR DELINQUENTS ARE WIDE

On June 30, 1967, there were approximately 53,000 children living in public institutions for delinquent children, an increase of 4 percent over 1966. There were 307 public institutions serving children committed by juvenile courts. Of these, 212 were training schools; 83, forestry camps; and 12, reception and diagnostic centers. Sixty-eight percent of the institutions served boys only; 23 percent, girls only; and 9 percent, both boys and girls.

# GAPS IN PROGRAMS FOR DELINQUENTS ARE WIDE

POLICE SERVICES			<p>1 out of 2 cities between 25,000 - 50,000 have no special juvenile police officer</p>
DETENTION SERVICES	     	   	<p>100,000 children held in jail each year</p>
COURT SERVICES		   	<p>1 out of 4 counties have no juvenile probation services 3 out of 4 juvenile probation officers have no social work training</p>
STATE TRAINING SCHOOLS	     	   	<p>3 out of 10 have no staff social workers 4 out of 10 have no staff psychologists</p>