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Draft of Talk by Herschel Alt at the Southwest Regional Conference of the Child Welfare League of America, St. Louis, Missouri, March 29, 1955.

NEW FRONTIERS OF CHILD WELFARE

Introduction

As I thought of this meeting and my very warm feeling for so many of you, my first impulse was to give an account of myself since I left St. Louis fourteen years ago; tell what I have done and what I have learned. If I were to do this, I would say that I have worked exclusively for the protection and guidance of children whom we call emotionally disturbed. With others I have devoted myself to a search for understanding of the causes back of childhood difficulties; the expansion of the limits of treatability--forging methods for helping more and more children who have been considered beyond help--and looking for a foothold in prevention. Out of this experience I have come to the conclusion that although we still lack an absolute science of human behaviour and we continue to rely on a mixture of faith, common sense and fragments of knowledge, yet this amalgam can be made to work. I know that many children can be helped if we do what we can.

The more I thought about this personal approach the more I felt that to dwell on this experience this evening might be inappropriate for many reasons. For one, all of you in the child welfare field have, in differing ways, pursued the same objectives. But what is more important is that this is a time to look forward, to assess the present so that we may move toward the future with greater clarity and sense of direction. We live in a time of great ferment; social changes are taking place so quickly and in so many phases of our common life that it is imperative that whatever useful experience we have of the things that heal and protect children be made to count.

We must at the same time recognize the difficulties that today stand in the way of responsible planning and action. Though we do not fully use what we know, yet in fact the tested knowledge at our command is limited. Thus we are unable to follow clearly the process of social interaction beyond the immediate impact of one single human being on another. The indirect influence of other individuals or groups upon the one-to-one relationship is difficult to comprehend.

Although we are excited by the promise it holds, we are well-nigh overwhelmed by the spread of interest in social and mental health problems which has taken place and the extent to which the welfare of children has become everybody's concern and responsibility.

We as child welfare workers must accept the challenge of the present situation. We must assume greater leadership and authority. We must do what we can to make sure that our planning and action proceed from the facts at our command rather than from the appeal of purveyors of panaceas. We must accelerate the rate at which newer knowledge is assimilated into our practice. We must work with other professions and all interested groups to establish the lines of action which our accumulated experience can validate and implement.

The Changing Social Scene

As we approach the problems of children we quickly realize that they are part and parcel of our general social scene and mirror the crucial issues of our day. If it were possible we should try to establish the interconnection of all the broad as well as more individual factors that impinge upon the life of the child before we decide how to help him. If we understood these we would also know what should be

done to prevent the difficulty. Unfortunately, at this stage of our knowledge we cannot complete the cycle of causation between world events and individual unhappiness.

This does not mean, however, that we should not, as far as we can, take account of the world we live in and what it does to us. We know that it is a troubled world, one of great contrasts and extremes. While on the one hand sections of its population seem far apart psychologically, on the other it is fast becoming one in space and time and in much of its striving. Beginning with the last world war and continuing up to the present, these contrasts and extremes seem to have been sharpened. Technological change has maintained its pace. Bigger and more destructive weapons of war are being designed; at the same time the peaceful uses of atomic energy challenge our imagination. While manifestations of deep-seated destructive attitudes increasingly appear in violent behaviour, at the same time professional associations, international agencies and individuals are engaged in manifold activities directed toward improvement of social conditions and the humanization of social relationships. It seems as though we are witnessing a race between the forces of death and destruction and those of life and affirmation. The obvious question is: which will win?

Some Major Problems

It seems hardly necessary to detail for this audience how these broad social forces express themselves in the problems with which we grapple day by day: manifestation of emotional disturbance among children to alarming proportions, a mounting tide of delinquency and growing family conflict and disintegration.

Since the third year of the last world war, the waiting rooms of clinics which deal with psychological problems of both children and adults have become more and more crowded. The pressure for more and different kinds of facilities comes from all directions. Emotional problems are not confined to any one social or economic group. Even though the children seem to be more and more severely disturbed, they have to wait for treatment in some places for as long as two years.

No one knows how to account for this phenomenon; no one knows whether our child population is fundamentally more disturbed than it was and if so, why. We do not really know whether the children are more sick or our diagnostic skills more accurate. We know that many of them whom a parent or teacher now sees as disturbed would have, a decade or two ago, been unnoticed or considered beyond treatment and sent to custodial institutions for the untreatable.

For many years I felt that delinquency statistics did not truly measure the extent of the problem because they tended to reflect many accidental factors such as the zeal of the police in making arrests and the differences in the meaning assigned to the term delinquency in different communities. Reluctantly I now find myself conceding that there has been a substantial rise in delinquency and it isn't sufficient to dispose of or minimize the problem by pointing out that the figures always include children whose delinquency is incidental. Today one out of every twenty-five children will appear in court once or more often between the time he is 8 and 18. For some groups in our population, one out of ten or an even greater ratio will appear in court. As we know, there is no single explanation for the phenomenon of delinquency.

We can only see it as a barometer of the social and mental health of our nation.

We are more and more concerned about the conservation of the family as the most important medium for child rearing. This concern is fully justified by some well-known facts about family life.

1. One out of every eight children, or a total of six million, in the United States, in 1948, were not living with two parents.

2. Two million were not living with either parent. Four million were living with only one parent. Of these, approximately one and a half million were living with a widowed father or mother, and nine hundred thousand with a divorced parent. In the case of one and a half million, one parent was absent from the home.

3. Among the thirty-nine million children living with both parents (including stepparents and adopted parents, as well as natural parents), at least six million had one parent who was remarried.

In summary twelve million out of forty-five million children did not live with their own two natural parents. Therefore, approximately two-sevenths of the total number of children faced problems of adjustment to one or more parent persons other than their own.

One Troubled Child

I have decided to tell you about the problems of one boy as a way of illustrating more concretely some of the issues we need to consider.

Just one year ago we were asked by the child welfare department of a large southern city to accept into one of our residential treatment centers a twelve-year old boy called Jerry. We were told that the Jones School in Texas, where Jerry had been sent for treatment two years earlier, had asked that he be removed as quickly as possible.

We were struck by two unusual aspects of the situation. First, all the psychiatrists who had worked with this child in his home community felt that he was untreatable and should be committed to a state hospital. Secondly, they were going along with the application to our center because Mrs. Roberts, a prominent citizen active in mental health, was interested in the boy and eager that he be given one more opportunity for recovery. Mrs. Roberts had been paying for his care in the Jones School and was willing to foot the bill at our treatment center.

Mrs. Roberts, we learned, while visiting one of the state hospitals on the outskirts of the city found Jerry, who was then ten years old, the only child in an adult ward. He had been committed there after a period of observation in the psychopathic division of the local general hospital.

We can only allow ourselves a few glimpses of Jerry's story. Jerry first became known to the Juvenile Court at the age of five when he was picked up by policemen wandering the streets and parks after dark. One year later, at the age of six, he was made a ward of the court.

Jerry was an illegitimate child. At the time he was first known to the court his mother and stepfather had been married for a number of years and Jerry's three younger brothers and sisters were all the offspring of this marriage. His mother and stepfather were both of southern mountain stock and did not seem to be able to meet the demands of urban life. There were violent quarrels and frequent separations. The mother became mentally ill and died in the state hospital before she was thirty.

From the age of six on for a period of three and a half years Jerry and his younger sister shuttled back and forth between the home of the parents, the homes of relatives, the children's shelter and foster homes. Within a period of three years Jerry was in thirty-one foster homes and had nine different social workers.

It is difficult to get a clear picture of the development of Jerry's difficulties from the agency's record. We know that his home was one of extreme disorganization. The mother was ill a good deal of the time, there was drinking, carousing and cursing.

Jerry's conduct in the foster homes gradually grew worse. He stole and ran away. His disturbance seemed to reach a peak after the death of his mother. When the foster mother told Jerry of his mother's death he was greatly upset, screamed and beat his head against the wall. On the way to the funeral he sat huddled in the car with tears streaming down his face.

After this the shuttling back and forth between foster homes and children's shelters became more rapid. Often Jerry remained in a home for only a few days. His behavior became more violent. He frequently announced that he wished he was dead, that he was going to kill himself as well as everyone in the foster home and shelter. The instinct to kill is as near the surface in this child as any we have ever had.

The Jones School approached Jerry's problems with thoughtfulness and understanding. A psychologist with knowledge of the usual methods of psychological treatment worked consistently with the boy. On his side, Jerry resisted and rejected all efforts to help him. He made many demands for the attention of adults but violently spurned all

relationships as soon as they came near to being close and intimate. In fact, when animals and pets became affectionate, Jerry resisted them too, sometimes letting them die through neglect or even killing them.

When Jerry arrived at Hawthorne we found him to be a very handsome, attractive boy with a winning smile. Although rather small for his age, he seemed to have unusually good physical co-ordination, kept himself clean and exuded a great deal of charm.

As an index of the stage of development of psychiatric knowledge it is of interest to contrast the diagnostic impression of our psychiatrist at Hawthorne and the diagnosis of the psychiatrists in his home community who sent him to the state hospital. The consensus of the psychiatrists who met in his home city to consider whether or not Jerry should be referred to our agency was that Jerry's condition was not caused by damaging emotional experience--that is, the mother's death, disturbed home, frequent transfers or other adverse environmental circumstances--but resulted from a constitutional deficiency present at birth. The group characterized Jerry's problem as "moral agenesis" and approved the medical student's diagnosis of psychopathic character disorder--psychopathic in the sense that the patient was born without the "equipment necessary for developing social relationships." The chief psychiatrist of the medical school envisaged a condition in which certain brain cells were lacking, at the same time conceding that he was unable to localize the brain deficiency because of gaps in contemporary knowledge of the subject.

In contrast, the psychiatrist at our treatment center, starting with a different professional orientation, makes this observation a few days after Jerry's arrival: "This seems to be a boy who has been badly traumatized, who is distrustful of all adults in all relationships, and to whom any close relationship is threatening. In all this there is present, apparently, a good deal of underlying depression as well as anxiety. For the present he may be considered 'borderline' with marked anxiety and depression. Treatment with this boy must necessarily be slow, prolonged and cautious."

While I do not have time to tell you all that has happened during the ten months Jerry has been with us, I can only say that for much of the time he has continued to be a problem in the same ways that he was at the other school, except that I think he has met with a different response. We recognized that a boy like Jerry would be intensely distrustful of adults, fearful of the rejection entailed in each relationship and wary of any efforts to make personal contact with him. So the traditional "office interview" type of therapy was out of the question. Jerry had to be met on his own ground, where a safety exit was near at hand. His need for emotional elbow room had to be respected and, at times, hardest of all, we had to keep from taking his symptoms personally.

A glimpse of our therapist's notes is revealing.

"In our first formal interview J. was polite but somewhat distractible: looking out of the window, answering questions briefly. He said that he had hated the Jones School—that he had not liked anybody there, that he had been to a 'lot of places' and had hated everybody. This—without much overt display of emotion. He volunteered the information

that he didn't think he would like it here, but that it was his 'aunt's' idea that he come here.

"He also said that he hates everybody here, and then proceeded to stare out of the window without further conversation. After a lengthy pause I said that I had heard a little about him through the Jones School and that I am not surprised that he is angry and distrustful. He nodded without replying, and I passed him back to his assignment.

"He visited me again later the same day, without a pass, and demanded a cigarette in a hostile, antagonistic way. I offered him one, but he refused it, saying that he had changed his mind. He then sat down, but said nothing. After a few moments I asked him if he had found out what he wanted to know, and he smiled. He then left, slamming the door behind him.

"As he returned to his cottage after four o'clock lineup, he stopped outside my window and shouted a few obscene curses at me, then ran away in the direction of his cottage.

"Next morning he burst into my office and stood smiling in the doorway. I sat looking at him, and said 'Hya.' He just stood there, and finally I said, 'Well, either come in or get out.' He came in and sat down. I asked if he wanted that cigarette, but he said nothing. I tossed him one. He caught it and put it behind his ear. Again, he sat for a while, saying nothing. Then he demanded a light. I tossed him the matches, and he lit the cigarette, but I noted that he took very few puffs on the cigarette--letting it burn down in his hand. He seemed to sense that my tossing the cigarette and matches was a sign of respect for his need for distance. I said, 'Tomorrow.' He replied

that if I sent him a pass he would tear it up. I said that if he didn't like the idea of being 'sent for' he could just tell the O.D., and then come over. He said he was damned if he was going to tell any damn O.D. what he was going to do. I said, 'OK'—and he left, slamming the door.

"This continued, in contacts of five to ten minutes, through the next few weeks. He began to tell me that he hated me, and I would reply with a friendly smile that I hated him too. He would then smile back and leave, slamming the door behind him. On a few occasions, before leaving, he would grab something off my desk, ask if I needed it, and if I said yes, he would run out with it. I made no move, and in a minute or two he would return, toss it on my desk, and run out again."

He was almost literally "courted"—with small gifts, with reassuring interpretations of his fears, with friendliness—but, most important of all, we were not afraid of him and he knew it. An important step forward was taken when during one of the interviews Jerry's therapist swung around in his chair to talk on the telephone and turned his back while Jerry held a knife in his hand. It was through this gesture that Jerry learned that his impulses could be kept under control—that it was safe to begin to form a relationship with another person.

Teachers, cottage parents and clinicians seem to have taken in stride his explosiveness, his violence and his hatred over and over again. Tolerance but firmness, and indifference to his challenges describe our handling of this child.

At the same time, in a hundred different small ways, gestures, gifts, interest in his future, we communicate our liking to him. He knows we are aware of his hate and destructiveness. There are recognized for what

they are--but the door to human ties is kept open.

"Too Little and Too Late"

The story of Jerry tells many things, points up many morals, and raises many questions. One or two of these may help spell out the task we face. His story suggests that gross family disorganization leads to foster care; that unsuccessful placement intensifies the problem; that frequent replacement magnifies the illness. Foster placement is becoming less and less a social arrangement for children in need of a home and more and more a psychological tool for children in need of treatment. Placement must be recognized as a child guidance and child rearing process and must to a greater extent than is now the case incorporate the best practices of the child guidance movement--comprehensive diagnosis before treatment is undertaken, skilled supervision and periodic evaluation. Placement is not a panacea but can be a very effective instrument if responsibly used.

We may ask ourselves, if Jerry had been in the hands of such competent workers, if a careful diagnosis had been made earlier, if observation had been more complete, could we have better understood the beginnings and extent of his problems; could this have yielded more clues to treatment and more hope for the boy? If this had been done, could he have been spared the painful experience of being replaced in thirty-one foster homes in thirty-six months? If the standards of the community and agency were as good as they should be, would he have been shunted between nine different workers? Poor placement may swing the balance

between a life in the community as against the reformatory or state hospital.

The story of Jerry, with the sharp difference in professional opinion about the nature of his problems, reveals in a striking way the border-lines of our knowledge. The starkness of his emotional deprivation cannot be denied, but there may be other factors to account for his problems--about which we can only speculate--"innate tendencies," "basic predisposition" or "x." We have never nailed them down, seen them under the microscope or in the test tube. Until we do we must continue to work with what we know while we search for the unknown.

We must bring to each child all the professional service that may be of help while we continue to make every effort to add to our knowledge and know-how through analysis of what we do and assessment of what does and does not work. In my own experience I have watched a number of children like Jerry who, after many attempts to help them, have been given up as hopeless. Then I have seen some of these gradually begin to absorb the consistent understanding with which they are surrounded, first a few drops fearfully, then ever so slowly a growing capacity for give and take with those around them. The process is a slow one and many years, sometimes almost decades, should be allowed for it. But as yet there are no alternatives.

The case of Jerry also highlights some of the changes that are taking place in our work with children. Our approach to their problems is characterized by greater breadth and depth. We survey a much broader field and we probe more deeply. We are no longer preoccupied with pathology. We search not only for the degrees of illness but more than

ever for the evidence of health. If we are going to heal we must build upon the healthy residue, upon the strengths of the child and his family.

On the one hand we are more sophisticated, on the other more realistic. We have lived through and moved on beyond a stage of over-simplification in our thinking about causation and treatment. This does not mean that we have abandoned faith in children or surrendered our conviction that they can best be helped by restoring what has been denied. We have merely begun to question whether this is the total answer--whether other methods and strategies can also help. We are just beginning to fashion research tools with which to check our assumptions. More systematic formulation of our theories and methods and critical appraisal of our results are becoming part of our professional practice.

When we think of what we do for Jerry and other children in trouble like him, the only conclusion which is possible is "too little and too late." Insufficient funds, lack of professional personnel, are but two of the obstacles to an adequate job.

We know that in community after community decent care and treatment cannot be provided because of insufficient funds. The wealthiest city in the world, although its expenditure for the care of dependent and delinquent children exceeds $30,000,000 per annum, still fails to provide for at least 1000 such children who are denied the care they need. They are allowed to continue in situations of neglect in their own homes or are cared for in makeshift arrangements.

The lack of funds is not the only obstacle. "We can't get professional workers" is the cry of many of the leaders in child welfare throughout the country but we have as yet no effective plan for meeting

the situation. Fewer and fewer young people are being recruited into the professional schools. While the work itself is interesting enough and holds many kinds of satisfactions, it also makes disproportionate demands upon the intellectual and emotional resources of the worker. The scientific and professional base is continually expanding and to keep abreast of this calls for large personal investment. Then, too, there are anxieties and frustrations which stem from the sponsorship, support and administration of social work as a governmental or philanthropic enterprise. But in spite of these and other disadvantages we have not mentioned, social work is still among, if not the, lowest paid professions. By offering such meager salaries we are, in effect, asking the worker to make a financial contribution to the service. He cannot be expected to be both philanthropist as well as professional at the same time.

We bemoan the recidivism of the young delinquent, the large number who return to anti-social behavior after a period of institutional treatment. We do not face the fact that the treatment was insufficient both in quality and duration. We do not provide the necessary tools to those entrusted with the rehabilitation of these youngsters. No trustee or administrator of any of our training schools, which on any one day contain 60,000 delinquents, could say that he has at his disposal sufficient personnel with the necessary professional skills to cope effectively with the problems of these youngsters and do all that is possible to re-educate them for social living. Nor have we ever recognized that some youngsters will need as much as a decade of treatment to get over the delinquent habits which have become part of the

way in which they meet the demands of living. We continue to operate on the assumption that a year or even six months of custodial care will suffice.

There are other more subtle factors which stand in the way of satisfactory care. By and large the organized community is unable to resolve the conflict between the right of the parent to his own child and the needs of the child. The understanding which the professional child welfare field can now bring to important decisions in the care of children, such as separation from their parents, is far ahead of the traditional community attitudes in this regard. Just as in the case of Jerry, I have seen children again and again removed from care too soon and returned to an unfavorable home because of the fear of community pressure and attitudes and then have seen the official or judge rationalize his action as being in the best interests of the child.

Prevention

All of us who pause to think of the stream of frightened, anxious and angry children whose needs we have been discussing must wish to help each one of them to the fullest extent possible and beyond that, to eliminate the causes back of their difficulties. This is so because we know that we do not have sufficient ability to heal every child and we also know that for a long time the number that we can help is limited. We cannot therefore be content until we do everything possible to prevent the difficulty in the first place.

Prevention is a magic word and brings vistas of the elimination of typhoid fever and malaria and how recent startling discoveries will soon stamp out the plague of polio. We have as yet no such nuclear discoveries in the field of mental health. There are so many factors that enter into the making of a life of a human being that we may never be able to achieve in the psychological field anything like the things we have done in the field of physical medicine.

If what we are is a product of life experience, then prevention in an absolute sense is beyond our reach. To achieve it we would not only need to know what kind of world produces healthy and strong human beings but also how to go about building it. Since prevention in this sense is not a practical possibility, we must reconcile ourselves to more limited goals. When we do so we find that just as in treatment, so also in prevention we do not fully utilize what we know. We can do much more than we are doing to build a better world for all children, to achieve a much higher universal standard of child nurture and rearing. Much of the necessary knowledge to achieve this goal is at hand.

We know that from generation to generation children are not different in their endowment. The difference lies in their social experience. One of the most important elements in that experience is adequate mothering during early years. This basic principle which has been disseminated by Bowlby and others provides us today with the most fruitful starting point for prevention. It provides us a basis for strengthening family life as well as community services. It means working for arrangements which make it easier for the mother to remain at home with the child during the first years of his life. It means reducing separation

between parents and children wherever possible, and where separation becomes necessary, it means minimizing the damage through careful preparation. It has also meant the development of professional mental health programs for the preschool child. Child development centers, as they are called, are springing up in many communities to help parents, as well as members of the child rearing professions, to deal more intelligently with the problems of young children.

From our work with children in residential centers we have gleaned other clues to preventive effort. As we try to creat healthy and healing experiences for them we are forced to define their psychological needs. Then we have to think through how social institutions can best be designed to meet children's needs and promote their growth. If our public schools could be examined in the light of the things we have learned about children, many changes would have to be made and prevention would be significantly advanced.

As we move outside the home into the community we see the many factors which influence the well-being as well as the attitudes of parents and children--how they are molded by forces outside themselves. We see the price children pay for the existing confusion in the spheres of personal and social values. No child can be more than the adults who are part of his life. Children have a right to expect their parents to be <u>for</u> certain things and <u>against</u> others. So long as adults are confused we cannot expect certainty on the part of children. We are in a transitional stage here as in many other aspects of our common life. Sweeping social changes in our present world have shaken fundamental values and standards of public morality. In facing the problem

of values we must not be caught in a drift toward reaction. We are beset by advocates who ask us to turn back the clock; to return to the more rigid patterns of living; to legislate that the mothers remain at home; to punish parents. I for one believe that out of the present confusion we will arrive at a new synthesis and stabilization which will conserve some of the gains we have made and represent a more liberal covenant of inter-personal relations.

Our experience in many areas of social work, medical care, public assistance, recreation, family and child welfare, has established the possibilities of effective protection of families and children. We can do a great deal more to protect those children who are less able to meet the pressures and demands of living--the so-called vulnerable, the child in the disorganized family, the child already disposed to delinquency, the child presenting difficulty at school.

While we do not have the tools at our command today to stamp out delinquency, we do know enough to reduce it, to cut it by half or more in a particular neighborhood. We know that a mobilization of the positive interest of parents and others in a given community combined with the efforts of organized social work will, within a very short time, substantially reduce the number of children who get into difficulty.

There is evidence that certain measures in health and economic fields have already reduced the extent of a historic social problem--the problem of the dependent child. The experience of the foster care field in our own country in recent decades reveals some startling facts. In spite of the increased use of foster homes and institutions for children who are emotionally disturbed, the proportion of children in the United States

living apart from parents or close relatives in some kind of substitute home arrangement has declined since 1933. This is true despite the social and family disorganization resulting from economic depression and two world wars.

As we survey the possibilities of preventive effort we must not lose sight of the close relationship between prevention and treatment at this stage of our knowledge. They are and must remain two aspects of a single effort. The same understanding and the same values must govern both of them. Treatment of each single child carries its own deep moral and spiritual significance. It is a measure of our civilization. Human values cannot be equated in terms of numbers.

We must also remember that treatment programs touch a large portion of our child population. Thus we have seen that in any one year there are a million or more children receiving help through organized agencies. The quality of the treatment they receive has an immediate bearing on the well-being of a large section of our population. The basis for prevention must grow out of the knowledge gained in treatment. Only as we see how the multiplicity of social and economic forces influence the growth of a single child can we begin to assess the soundness of the varied aspects of our social order. In other words, treatment can provide the touchstone of the soundness of social and human institutions.

There is still one other consideration. Each child is a link in the chain of social relationships. When unhealthy, it breeds other unhealthy relationships and pathology moves on from generation to generation.

We have barely touched upon the manifold possibilities for preventive effort. Practically very little is being done and the smallest fragment

of the potential is being realized. This is not only true of the efforts which promote better mental health for children through the improved practices of those responsible for child care, but almost equally of the activities which bring help to children before their problems become serious.

The smallness of the efforts is not only due to lack of funds but more so to lack of readiness, lack of knowledge, of conviction and vigorous advocacy of such programs.

What is true of prevention is even more true of research. Do the youngsters we treat get better? If so, why? Is it because of what we do for them? Or do they outgrow it? If some get better and others do not, is it because of differences in the human material? These are but a few of the obvious questions--but incredible though it may seem, few agencies have answers and almost none have any that are complete or scientifically proven. Most agencies have never had any funds or time to spare from the continued pressure for more and better services. Our child helping professions are young and most of us are busy learning how to do better jobs and treatment. Our training has not included nor have we had time to learn much about technical research methods. Moreover sound research in our field presents problems of method which are far from having been fully solved. At the same time, our responsibility as well as our opportunity are great and we have no choice except to begin to see research as a basic obligation.

The foster family field, in which many of you have an important part, offers an extraordinary opportunity for research in human relations. The selection of foster parents calls into play criteria and skills for the assessment of the interrelationships between family members and of the strengths and weaknesses of the family group. Careful observation of the developing ties between children and substitute parents should yield a rich harvest in the understanding of human behavior. Studies in this field, carefully conceived and designed, might throw light on basic interpersonal relationships which may be as elementary and universal as the mother-child relationship in the family of our Western culture. Most child welfare agencies do not now have and are not likely for some time to command the technical skill or funds necessary to carry on research. Co-operative arrangements among the agencies or with social science faculties of universities represent one way of meeting this situation.

Positive Trends

We are nearing the end of our discussion and it is time to pause and see where it has taken us and what lies ahead. We began with the thesis that the problems which beset children seem to be increasing in amount and severity and that this may be the result of the instability, conflict and tension which are part of our present social scene.

Through the experience of one troubled boy we tried to suggest some of the borderlines in our knowledge and practice and we went on to suggest some of the things we might do to better our situation. We have not had time to deal with the credit side--the increased energy

going into research and into building bridgeheads to prevention--with the greater sensitivity to problems of human relationships--with mounting concern and insistence on positive action--with evidence of such action on the part of government and voluntary groups. Mental illness and crime are beginning to receive the attention which they deserve as number one social problems. More than ever before, the general public is trying to understand the causes of these social diseases and where the remedy lies. Concern for remedial measures is beginning to assume an important place in the policies of our federal and state governments. Each year the President and Congress devote more time to social security, housing, education and health.

Government at all levels is assuming increasing responsibility for measures for the prevention of delinquency and the development of mental health services. Substantial beginnings are being made to train the necessary specialized personnel, such as child psychiatrists and psychologists, psychiatric social workers and nursery teachers, who are so badly needed to carry the new and enlarged child helping programs.

Two very hopeful programs have recently been established in New York State and City under the leadership of the state government. These are the Youth Board and Community Mental Health programs. They not only incorporate sound social work practices but are of sufficient size to have significant impact on the problems which they attack. Both mobilize the resources of public and private agencies serving families and children. The cost of both is met equally by state and city governments.

The Youth Board program brings to the delinquent as well as to the child prone to delinquency many kinds of preventive and treatment services. It strives to reach the delinquent child in the court, in the

school and as a member of his gang.

The Mental Health program provides more funds, I believe, than have ever previously been made available in any community for this purpose--specifically, an additional amount of $2 per capita. For the city of New York alone, it means $16,000,000 of additional funds and more than doubles the present expenditures for the services covered. Specifically, these are outpatient clinical services, inpatient psychiatric services in general hospitals, rehabilitative and educational services.

The mounting concern about child welfare and mental health breaks through in many guises--increasing attention in newspapers, on the radio, television, movie screens, the lecture platform and in the theatre, and in church sermons and dinner conversations. Sometimes with guidance and sometimes without, this quickened interest is being channeled into organized efforts directed toward important objectives.

A development which seems to hold great promise is the recently organized association of parents. Parents began to band together to do something about certain types of handicapped children whose problems then seemed beyond help. And now the movement extends to psychological problems as well. The Association for Retarded Children and League for the Emotionally Disturbed both began and, for the most part in the main continue, as parent groups. These associations have cooperatively undertaken some remedial services, but more than that, they have become articulate in presenting to legislatures and to the public in general the crying needs of the children they speak for.

The use of professional social and psychological services by an increasing number of persons from all sections of the population is another important source of understanding of interpersonal relations and the problems of children. Another new force in the battle for mental health are associations of ex-patients who are banding themselves together to work for better understanding and to press for better treatment and more research.

The nature of the problem as well as the growing pressure for solution call for new sights and new perspectives for those of us in responsible positions in the child welfare field. We must learn how to think in larger terms, with greater courage and conviction. We must be able to convince the public that when we speak for the deprived child we speak for all children. Child welfare must remain a cause and not merely an on-going community function. The outpouring of anxiety and concern which is mounting must be guided into fruitful action which not only utilizes to the fullest the scientific knowledge that we have, but is also in accord with the highest human aspirations.

Helping children is not merely the application of accepted methods and practices. Woven into these must be an abiding faith in each youngster and a continuous struggle for his salvation. Unhappy children need the same things which nurture all mankind: understanding, security and an opportunity for life.