CHAPTER V

U. S. CHILDREN'S BUREAU
SAN FRANCISCO REGIONAL OFFICE
1952–1955

REGIONAL MEDICAL SOCIAL CONSULTANT

This office had representatives of all major agencies in Health, Education and Welfare. In addition to Children's Bureau (CB), there were the U.S. Public Health Service, the Bureau of Public Assistance, Vocational Rehabilitation, etc. The CB staff included one person representing Social Services (Child Welfare). The head of the health team was the Regional CB Medical Director with staff of one nursing consultant, one medical social consultant, one administrative methods person (accounting; business management, etc.). (The usual nutrition consultant position was unfilled as the Chief CB Nutritionist in DC preferred to carry the Region on a part time basis.) In this particular Region, I held a unique position functionally, as I was the only social worker in health. By agreement, I had to serve as on-call social worker for the programs in the Public Health Service. As this worked out, I did this primarily with Mental Health and sometimes with tuberculosis control or heart disease. (See Insley, 1977).

The Regional Medical Director was Dr. Edith P. Sappington. In addition to being an M.D., she also had a D.P.H. and had been in San Francisco Regional Office (R.O.) since passage of the Social Security Act of 1935 (as amended). The Regional Nursing Consultant, when I went to San Francisco, was Gertrude M. Church who had, in addition to her R.N. and a specialty in maternity and pediatrics, a Master's degree in Mental Health Nursing from Teachers College, Columbia University. Before I left San Francisco, the Regional Nursing Consultant was Marie C. Goik who had an R.N. and B.S. in Public Health Nursing and M.S. in Mental Health Nursing. Marvin Stromberg with a background in accounting, was Regional Administrative Methods Consultant. The nutritionist who gave us part time service was Marjorie Haseltine, Chief of Children's Bureau Nutrition, an internationally known nutritionist and cook book author.

The R.O. Health Services CB had responsibility for the states of California, Arizona, Oregon, Washington, Nevada, Alaska, and Hawaii. We were responsible for monitoring and providing professional consultation to the Maternal and Child Health (MCH) and CCS programs (Title V of the Social Security Act). In Oregon, the Crippled Children's Program was located in the University of Oregon Medical School. At that time, the Crippled Children's Services (CCS) in Arizona was located in a separate state agency. All other MCH and CCS programs were located in State Health Departments. Alaska and Hawaii were still territories. In Arizona, considerable time was devoted to consultation to U.S. Department of Interior Indian Health Services, public health and hospital services for Pima and Papago Indians living on reservations. This assistance was provided to, and at the request of Indian Health Service staff in the Arizona area office.

Much planning and communication with State agencies, Central Office, and review of State plans were carried out by the Health Services staff on a team basis. A member of the team, regardless of discipline, would have major responsibility for completion of certain reviews and recommendations as well as complete responsibility for getting his/her own discipline's input into the reviews and recommendations. Each staff member, therefore, carried responsibility for his or her own discipline, but while in the office or in the field, they were aware of all aspects of the programs and could communicate with or without other R.O. staff directly with higher level staff in Regional or Central Offices about urgent administrative actions. Within the bounds of budget, politics and available time, an effort was made to plan and carry out all consults—office and field—as a team.

Before Federal funds could be released each year, the Regional Office had to approve the plan and budget. Often this involved negotiations to assure that states met the legal regulations, and hopefully other recommendations of our staff, within the bounds of budget, politics and available time, etc.

In order to understand how the R.O. functioned in relationship to the Central Office (CO) and the Regional Director (who represented what was later called Health and Human Services), it is necessary to know something of the administrative structure of the department and of the laws, particularly of the Social Security Act Title V. The Regional Director was appointed by the Secretary of Health, Education and Welfare (H.E.W.). He was kept informed of major activities in the various agencies, i.e. Children's Bureau, Public Health Service, Bureau of Public Assistance, etc. Activities with political implications were of particular interest to him. I recall that he forbade us to go as a team of four or five from CB for orientation of the new nursing consultant and me because the Regional Director thought it might cause comment in an election year. Likewise, I went to him when I was alone in the office and had to delay plan approval for some action by a State because it violated a regulation. When I was in Hawaii the first time, the Regional Director caused me to have to accept an invitation to the home of his special representative there. No new staff member could be appointed by the R.O. without the formal written (usually a telegram) concurrence—actually a formality only. Similarly, the concurrence of the CB Regional Medical Director was obtained before a new staff member was appointed to his/her staff. This was done with considerable passage of information and discussion, although the final decision was clearly up to the appropriate staff member of the Central Office, i.e. by the Chief Social Worker in the Health Division for Regional Medical Social Work positions. Regional Office staff were administratively responsible to the Regional Medical Director but technically responsible to their counterparts in the Central Office.

At the time I joined the Children's Bureau, it was responsible for administration of Title V of the Social Security Act, Maternal and Child Health Services, and Services for Crippled Children. These were grant-in-aid programs to the States and to Puerto Rico, Virgin Islands, Alaska, and Hawaii. Each state or equivalent was allotted a certain amount of money based upon a formula. These funds were called "A" funds, which had to be matched and were automatically granted unless the state violated a part of the law. For example, Arizona "A" funds were deposited in the Federal treasury for many years because of racial discrimination against Indian children. There were also funds called "B" funds which were available without matching State

funds. We also had funds called "Reserve Fund B" created by Dr. Martha Eliot which were not spelled out in the Social Security Act. These funds were granted through the State agencies. They did not require matching funds as they were not intended to support the regular activities of the MCH and CCS programs. They were intended to extend and improve the programs through demonstrations and professional education. The selection of areas to emphasize and the major approval lay in the hands of the Central Office with the R. 0. only offering some consultation as well as help in selection. Rheumatic fever, cerebral palsy, cardiac surgery, and premature infant care had been introduced into the MCH and CCS programs by demonstration projects under Reserve Fund B. We had a project at the University of Washington Medical School to teach medical students about child development through a clinical center for well-children. We had an MCH teaching project at the University of California (Berkeley) School of Public Health and another at University of California at Los Angeles. All of the public health teaching projects required the employment of qualified multi-discipline staff including social work.

While I was there, we set up an additional project at University of California at Berkeley with a grant to the graduate School of Social Work in cooperation with the School of Public Health, which already had an MCH grant, to provide internships for social workers who had completed the master's degree in social work. They would be placed for a year in a local health department under the guidance of a faculty member who had previously worked for the State Health Department and was now to be on the School of Social Work faculty. We also set up an annual meeting open to social workers in public health in the Western Regions. Primarily because of distance, my experience in public health and my close working relationship with the Chief of Social Work in the State Health Department, the Regional Office carried major responsibility in setting up this Reserve Fund B supported project. Normally, C.O. would have done this.

The necessity to channel Reserve Fund B grants through the state agencies created some difficulties. For example, in California, the Director of the CCS program was only mildly interested in social work education, and complained frequently. This was quite understandable as she had to justify her budget and explain why this CCS money was going to the university when she was running out of money to pay for the medical care of children. After a few years, the States requested Congress to change the law so that direct grants could be made for training to institutions for higher learning.

I should mention here that the CCS program in Arizona, situated in a single separate state agency, had only just been granted federal CCS funds after many years in which the "A" funds (allotted to each state by the Social Security Act) had been held in the Federal treasury and the "B" funds had been allotted to Utah and New Mexico for the care of Arizona Indian children denied care due to discrimination by the Arizona pro Racial discrimination was prohibited in CCS by federal law. The program now accepted Indian children but was not too well organized as yet. Two social workers were employed. We met with staff and attempted to help them to establish more community relationships and improve administration.

EXAMPLES OF DUTIES OF MEDICAL SOCIAL CONSULTANT

Review State plans for conformity to Federal regulations, conformity with Merit System Standards, budget justification, special attention to social aspects, pluses and minuses about social work activities, write up findings and recommendations from disciplinary point of view.

Take responsibility for complete review of certain State plans and for recommendations based upon input from other disciplinary staff in Regional Office.

Study statistical reports and determine whether methods of evaluation such reporting of handicaps in birth records have been recorded—i.e. to pick up congenital deformities for early case finding and referral to Crippled Children's Service (CCS) program.

Deal with State Merit Systems regarding classification plans for State programs; help States to prepare job descriptions, recruit staff, attend to need for inservice education for individuals and groups.

Distribute professional materials pertinent to the needs of professional staff bibliographies, names of professional people with similar problems and solutions; training material and information about workshops for State and local staff and material regarding accredited training for staff.

Research: Keep State and University staff apprised of research pertinent to their work and identify State and local and University study proposals suitable for application to research staff of Central Office (CO) Maternal and Child Health (MCH).

Stimulate State, local and University staff to apply for research and service grants from CO.

Make suggestions as to services not available from C.O. MCH for specialized professional consultation.

Stimulate interest in Children's Bureau White House Conference (every 10 years).

Attend staff conferences in Washington, DC.

Provide technical social work consultation to social workers in the States, to social work faculty in Schools of Public Health in the Region, and to Schools of Social Work as requested.

Develop training and service projects in the States—short term to service local and national social work in public health.

My two papers in *Concepts of Mental Health and Consultation: Their Application in Public Health Social Work* by Caplan (1959) describe much of the process of consultation and team consultation as carried out in the Regional Office. (See Insley, 1959a,1959b).

When I arrived in the Regional Office (R.O.), the Regional Nursing Consultant was also w to the R.O., though she had previously been in the Chicago R.O. and had been on leave to an M.S. in Mental Health Nursing. We had to be introduced to the States for which the gional CB Medical Director had planned a full team visit to Hawaii. The Regional Director E.W. forbade us to all go together because it would look bad to spend so much money to send ur people (it was a presidential election year and the politicians did not recognize disciplinary ecialties), so the Nursing Consultant and I had to go by ourselves. The great influence of the B Regional Medical Director was such that we were very much respected although sometimes sted. We provided consultation on Day Care, School Health, Premature Infant Nurseries, child velopment studies, administration of Crippled Children's Clinics, hospital pediatrics units, rsing, and medical social services. We visited the islands of Maui, Hawaii, and Kauai, as well Oahu. The State Health Department was located in Honolulu. We gave a workshop for all the blic health nurses in Hawaii (the Nursing Consultant dealing with school health, and I dealing ith behavior problems of school age children). I found that the only social worker with MCH d CCS was not prepared to stand up to the Medical Director and did not know how to develop r job. I therefore arranged to have Hawaii send her to Boston to the Massachusetts Health partment which had a CB supported training project in Public Health Social Work. (See assachusetts Department of Public Health, 1961). She spent an academic year in public health ith MCH and CCS supplemented by advanced courses at Simmons College School of Social ork. (She had already graduated from Boston University School of Social Work.) The State of awaii had a policy to send social work students to different schools to get various points of ew.

Before I left Hawaii, my office notified me that I would be going to Alaska, which had quested an emergency medical social visit, as their social worker had given notice. There had been no medical social consultant visit for four or five years. It was near the close of the fiscal year and extra travel funds had been offered from the Central Office. Thus, I went immediately to Alaska upon my return from Hawaii. There I spent a little over three weeks traveling over the Territory with the social worker who was leaving. In order to save travel money, I stopped off on a visit to the Washington State Health Department where I learned of a faculty member of the University of British Columbia who was interested in Alaska. Before I left there, I talked with her and with Alaska so she could have an interview in Juneau, where she took the job.

The Oregon State Crippled Children's Director had requested the R. 0. to assist in doing a "program review" which meant a relatively in-depth evaluation of its program. The R. 0. had spent hours analyzing the material we had sent the State asking for an analysis of congenital deformities from birth records, services provided to children by diagnosis, etc. About ten days before an entire staff team was to leave for Oregon, we discovered that all the plans for the review had been sent by a secretary to the wrong state. To further complicate matters, the CCS director had resigned and been replaced by an orthopedic surgeon with NO experience except private clinical practice. I had never visited the CCS program. I was scheduled to visit the Oregon State Health Department for the U.S. Public Health Service to meet with a new social worker in Tuberculosis Control. I completed my visit to her at the Oregon State Health Department early so that I arrived at the Crippled Children's Office at the Medical School one

day before the other members of the R. 0. team. This meant that I would be the first to meet the new CC Director after he had received the huge stack of material describing our proposed program review with the proposed evaluation forms to be filled out in analysis of clinic, hospital, and administrative services. When I arrived at the medical school, I was ushered into the office of the CCS Director. After I sat down, he said, "You know I have had contacts with the Federal government before—with the Income Tax, with the Narcotic Control, and now you."

I saw the social workers briefly that first day but they were not too pleased with me because I had spent all day, including lunch, with the Medical Director. It was obvious that this was the only possible course of action—to take advantage of the opportunity to help him understand the philosophy of the Children's Bureau and how he could relate to this part of the Federal government. This was a very clinical program located in a Medical School rather than a health department. I let the social workers know that I felt they should spend less time on administrative activities and details of financial eligibility. When our other team members arrived, we carried out our plans for the visit by discussing the detailed schedules rather than carrying out the observations and assessments.

I might mention here what occurred on my visit to the Health Department which preceded the CCS visit. At lunch with the social worker new to the Health Department, and the only social worker in that agency, she confided in me that she was living alone in a top floor apartment, had no family in Oregon and was afraid she might commit suicide. So my activities were of a rescue rather than a professional consultation nature.

On one occasion, when I was going to Alaska to the Health Department Central Office in Juneau, I had to take with me two children returning home from Stanford University Hospital, both with letters from the Medical School and from the California Health Department stating that they were safe to travel. One patient was a 13 year old Eskimo girl from Little Diamede Island (across the Bering Straits near Russia). She had had pulmonary tuberculosis and a minor cardiac defect. The other was an 11 month old Caucasian boy with incomplete correction of congenital heart defects going home to await sufficient growth and development to permit further surgery. The girl had a problem on the plane because the toilet at that time did not flush and she had been taught in the hospital to flush—going home now to a place where the toilets probably still do not flush. I parted company with the girl in the Seattle airport at 4 A.M. because she was afraid to leave me until I found a nice mother with two children going on North. I placed the baby in foster care in Seattle for a week while I visited the Washington State Health Department. There he developed an upper respiratory infection and I had to arrange for medical care. On the way to Juneau he went into congestive failure, with no oxygen for infants, and we narrowly escaped being fogged in on Prince Edward Island. The pilot called ahead for a doctor to meet the plane and take the baby to a hospital. After being released from the hospital, a sanitarian took him on to Fairbanks. You can believe I relived this experience whenever anyone questioned my principle that a family member's way should be paid for all children being sent out of state for medical care.

I had to deal with many State Merit Systems (like Civil Service), primarily because social work positions in health departments, especially in MCH-CCS in which most social work

positions were located, required a minimum of a Master's degree from an accredited school of social work. As these positions were usually classified with all other social work positions in the state agencies, there was frequently need to provide justifications and often Federal support for the setting and maintenance of standards in health departments. (See American Public Health Association, 1950).

We made "program reviews" from time to time, sometimes on a Federal initiative and sometimes on request from the States. Those reviews were usually made by the full regional staff of the CB health services and sometimes involved the Public Health Service staff as well; thus, all public health services receiving funds through CB and Public Health Service (PHS) were included. These involved collection and analysis of all kinds of data from the state concerned—narratives and state plans and other reports, statistics, budget figures, and observations planned and scheduled by regional office and State staff. There were usually visits planned not only to State offices, but to clinics, hospitals, rehabilitation facilities, state institutions, special schools, etc. When all the data had been analyzed over several months, the program review culminated in a summation visit and a written report. Naturally, I participated in all of these activities with CB staff, occasionally with chronic disease or tuberculosis staff, and frequently with Henry Schumacher, the psychiatrist who was Chief of Mental Health for PHS in R.0.

Once in a while I carried out some activities usually assigned to a state social worker in an effort to demonstrate what might be gained by employing a social worker. At that time there were no social workers in the Arizona State Health Department. I occasionally gave consultation to some of the public health nurses in the course of visits. The Director of Public Health Nursing then invited me to give two workshops for the public health nurses on each side of the State. The topics they had chosen were: how to get patients to follow the doctors' recommendations, and how to terminate services to a patient. I obtained their permission to include our new nursing consultant, Ms. Goik, as my co-faculty member. These involved a good deal of role playing and revealed some interesting insights into the state and local health departments. The discussion of the question about termination revealed a health department policy which required each nurse to make one more visit after she had reported to her supervisor that she had completed the services. This, of course, my colleague and I could understand but not accept in the light of the fact that a large portion of the public health budget was based upon numbers of nursing visits!

Our office maintained considerable contact with the Indian Health Service which was then administered by the Department of the Interior. There was an Area Office of the Indian Health Service and an Indian Health Hospital in Phoenix, Arizona. There were also clinics on the various reservations and another hospital in Tucson. I recall visiting in Phoenix, with Edith Sappington and the Area Medical Director, when it was over 105 degrees on the Pima and Papago reservations as well as at the Phoenix Hospital. Green vegetation was high on the Pima Reservation which had ample water while the Papago was a desolate dry desert. The Papagos lived in primitive huts with clay water bottles hanging from the edges of roofs. There was no central source of water, only an occasional small well.

The Interior Department had employed an Anthropology Consultant to advise on methods of helping the Indians, particularly the Papagos. Under his guidance, a model privy had

been built on the grounds of the Health Center. It was never copied. Why? My inquiries revealed that the wood needed to build such a privy, plus the cost of hiring a wagon to bring the wood onto the reservation, cost more than the annual income of a Papago family. At the hospital in Tucson, it was said that Indian mothers insist on staying when their children are hospitalized. Why? Is it some cultural, native reason? I said most mothers in New York City, San Francisco, Chicago, etc. would like to stay with their babies.

After this visit, Edith Sappington and I met with our Central Office staff and representatives of the Indian Health Service, Department of Interior in Washington, D.C. When we gave our first recommendation, that being to arrange for wells to be dug on the Papago Reservation, the Indian Health staff were not pleased. They pointed out that we were supposed to have been observing what needed doing from a health standpoint!

In the second year of my stay in San Francisco, the Department of Interior contracted with the graduate School of Public Health in Pittsburgh to conduct a "study of Alaska's health needs." This was really a strategy employed by a group of public health physicians interested in demonstrating that Indian Health Services should be transferred from the Department of the Interior to the U.S. Public Health Service. The personnel employed by Interior unfortunately consisted of physicians and nurses who were often unable to perform their professional duties in the "lower 48" due to alcoholism, drug addiction, or general incompetence, whereas the Public Health Service could order its commissioned professional personnel anywhere to serve on Indian reservations, in hospitals or clinics. Dr. Parran formerly Surgeon General of the United States and Dean of the School of Public Health, was director. Dr. Crabtree, a long time PHS staff member, then assistant dean at Pittsburgh, was on the team along with Dr. Sam Wishik, head of MCH at Pittsburgh School of Public Health. Other members of the team included Dr. Ruth Freeman, Professor of Public Health Nursing at Johns Hopkins; the Chief of Sanitary Engineering from the Massachusetts State Health Department; the Director of Massachusetts General Hospital; and the Director of Tuberculosis Control from the Cleveland Health Department. Pittsburgh had no social work staff in its School of Public Health and the plan called for social work to be covered by Dr. Freeman. Despite the fact that the ground rules excluded federal staff from participation, the Alaska Health Department, especially their Director of Public Health Nursing, objected to sharing the nurse on the team and the Health Department requested that I be on the team. They knew me from my previous visit to Alaska. Dr. Martha Eliot, Chief of the Children's Bureau, agreed to assign me to this study.

Dr. Parran came to San Francisco to talk with me about my assignment. He told me he did not know why the Alaska Health Department had requested social work participation. We talked about that. It happened that Dr. Parran and I traveled from Juneau to Anchorage on our way to our first team meeting. This enabled me to describe some of the health related problems illustrated by case examples I had collected from social workers in Alaska. It was quite clear from all I had been able to gather that one of the main missions of our survey was to focus upon tuberculosis control. If oral medications were proven effective when taken regularly, could the Native population of Alaska be "trusted" to take it? If hospitalization for tuberculosis were recommended, under what circumstances would the Native population agree to go South in Alaska (Sitka) or outside the Territory for care? These were the questions assigned particularly to

me. After having visited all over Alaska, much of it by "bush plane," in this case a 1931 Pilgrim with a "new" motor, I came to the not unsuspected conclusion that Alaska Natives are like the rest of us. We found a group of Innuit people (Eskimos) who had been given oral medication in defiance of the directive from Department of Interior physicians. They had continued to take the medications. I found that, with the exception of very old Native people who should be supplied with seal oil as part of their diets, adult patients would go anywhere for treatment with one proviso—that patients would be restored to their families after completion of medical care. This proviso had serious implications which could be a deciding factor in acceptance of medical recommendations requiring travel away from native villages. Experience had shown that children were frequently sent to orphanages run by missionaries who changed their name s and did not keep track of their identities so the children could be returned to their families when parents returned home. Communication and travel were other factors which contributed to family break up. I had seen evidence of this myself in the past as I was given responsibility for escorting a 2-1/2 year old boy from the tuberculosis hospital in Seward to the airport in Anchorage where he was supposed to be met by a bush pilot and taken to his native village. The pilot did not come for several hours. I spent my time trying to teach the child to walk in a pair of shoes borrowed from a local orphanage. The success of all this was dependent upon a paper luggage tag pinned to the child's coat. I visited hospitals in Alaska and the States before and after the time spent in Alaska to follow up on the families of patients sent outside the Territory—tuberculosis and mental hospitals in the States.

A case example which impressed my colleagues as to cooperation and coordination of agency services was that of a 12 year old girl with tuberculosis of the bone. She had been sent to the University of Chicago whose medical school needed teaching material on such problems. Upon her return, the Health Department asked the Welfare Department to place her in foster care near a source of continuing medical supervision. Without informing the Health Department, the Welfare Department decided that separation from her family was not right and so sent her out to the remote village where her family lived in one underground room much of the year. When a public health nurse later discovered her, the diagnosis was miliary tuberculosis. I had traveled on a plane with the social worker who was escorting her to a hospital in Sitka from the bush plane which had taken her to Anchorage. Several of us on the team went to visit the Indian Health Hospital in a remote area (Bethel) where the physician had provided oral medication for several years. We stayed several days and nights (it was light 24 hours), spending most of our time searching through medical records, hunting for those patients to learn the outcomes. An interesting sidelight was that we saw evidence that the names of patients were usually changed to English from Eskimo which illustrated the charges of policies which contributed to the break up of families.

We went to Kotzebue, northeast of Nome. The physicians from Boston and Cleveland, the nurse from Baltimore and I went by bush plane (I 93 1 Pilgrim which the pilot assured us had a new engine since 193 1). From there we traveled out by sea plane pilot and two or three passengers. We went to Shishmareff right on the ocean, having to land on the beach and leave while the tide was out. This village was supported by fishing and hunting. The only "fresh" water was a large pond with melted ice which had to be guarded from the dogs. This was a village allotted, according to the missionary system mentioned earlier, to the Lutherans. There were two

Caucasians—man and wife, school teachers from the Bureau of Indian Affairs (BIA). I was introduced to the "welfare representative" who was paid on a case by case basis to determine eligibility for public assistance. He was a carpenter who had been "outside" in the Army for two years so his English was good. He, followed by two small children and a dog, took me to his home, a wooden house with several rooms, all above ground. First he told me the two children were adopted because he and his wife had no children. They had one now. He asked if it were unusual for a wife to become pregnant after adopting a child. I told him it certainly was not peculiar to Alaska or Eskimos. He seemed very pleased to see me as he had several problems with his public welfare work. One problem was a woman with a baby. As she was unmarried, she had no man to fish and hunt for her. "Some people" (the school teachers) said she could not get ADC because she was not married. The other was a man who had been injured while hunting. The family had been receiving public assistance funds, but the period of disability would be over after the fishing season ended and there would be no work until the ice went out next spring. I told him the woman and her baby had to eat just the same as everyone else, that he should find her eligible for ADC. As for the man, I offered to have the two physicians with me sign a statement that he would be unable to work until the next spring. He could cite his conversation with me on the woman's record and send the note from the doctors along with his report to Nome where the social worker in charge of Northern Alaska had her office. I also said I would see her there. One day we went from Kotzebue in two hydroplanes to a village down river where I found the family of a child I had seen in the hospital in Sitka on my way North. That evening we sat in the home of the Village Headman to listen to the "Medical Hour" on a powerful battery radio. This radio hour was beamed all across northern Alaska to provide medical advice to people in far away villages, mines, etc. At the end of the hour, there were several announcements including one by Dr. Freeman, our Nursing Consultant, who was in Kotzebue. She sent a message that the Chief of Police in Nome wished to see me as soon as possible. Later that day we went to an island in the Kotzebue harbor to watch the Eskimos skin the seals, the insides of the skins (which they eat), and boil the oil—an interesting but smelly procedure.

Next morning, I caught a ride with two business men who had chartered a plane to Nome. The Chief of Police in the "Black Maria" (or "Paddywagon") met me at the airport in Nome. He took me directly to some padlocked Quonset huts from which young Eskimo girls had been removed to the Federal prison with their infants (Alaska was not yet a state). These girls had been serving the sexual needs of servicemen from the nearby Air Base. After viewing a couple of these huts with unwashed dishes, unemptied slop pails, and even a serviceman's hat still on the bedside table, I declined further observation suggesting the immediate need for a sanitarian to deal with the problem. We then visited the girls and their infants in the jail. That evening, the Chief and I visited every saloon in Nome mainly to detect and deal with any underage customers. Before parting from the Chief, I gave him my assessment based upon my observations and what he had told me. I made some suggestions about resources in Alaska and said I would report all my findings to the appropriate Federal agency dealing with the various problems identified: Maternal and Child Health, Child Welfare, venereal disease, sanitation, prisoners, justice, juvenile delinquency, mental health, alcoholism, Bureau of Indian Affairs, Air Force.

During our trip, Dr. Parran had kept in close touch with Washington, DC to check on the progress of legislation which had been introduced into Congress to transfer Indian Health to the Public Health Service. We were in Fairbanks near the end of our trip (lasting one month) when his evening phone call yielded word that the bill had passed. Our findings and recommendations were useful to the PHS in planning for the service which they could so much better provide because, unlike Interior, it was a health agency and also had the legal right to order commissioned corps professional staff to any place for any length of time.

I was certainly wholeheartedly in favor of the transfer of the health services. One example occurred while I was on this trip. The Bureau of Indian Affairs (BIA) Chief Social Worker came to Alaska at the same time, although I did not know he would be there until I ran into him in the airport. He was interested in following up on a recommendation by his office that no surplus commodities be distributed to the Native population. Their rationale for this was that the Native peoples would "just give them to the dogs." This was discussed with Dr. Parran and I convinced him that the Native people should be given the commodities. The Native people did not care for the butter and meat, but there would be no fishing or hunting if the dogs were not fed.

During the time I was in San Francisco, I traveled to Washington, DC on at least two occasions to attend National Staff Meetings of the Children's Bureau. These consisted of perhaps one all bureau staff meeting with Dr. Eliot, several All Division staff meetings, and several Section staff meetings. These meetings were used to inform staff of national developments and potential events (particularly political) relevant to our programs. They also provided an opportunity for field staff to report on developments in their Regions and to be a forum for interchange by all present. Outside speakers and/or CB part-time consultants were often involved. I remember that one year, Dr. Grete Bibring, Chief of Psychiatry at Beth Israel Hospital, met with the Health Division staff.

Copies of all field reports by Regional Office staff (required for every visit to a state and including all official visits within the state) were forwarded to Central Office. I realized how important they were when Miss Baker told me that the Division Director, Dr. Lesser, had made special mention of my report on my first visit to Alaska Health Department. Central Office staff visited Regional Offices and sometimes joint visits were made on a team or disciplinary basis. I believe Doris Siegel, the Social Work Training Consultant, may have visited me once with reference to work on the University of California (Berkeley) proposed training project for which I carried major responsibility. remember a visit by Miss Baker in my second year in San Francisco in addition to the usual courtesy discussions with the Regional Director, the CB staff, and the Regional Medical Director. We also made a visit to the Director of Social Work and her staff in the State Health Department (Esther Spencer) and talked with the Medical Social Work staff member in the School of Social Work (Ruth Cooper). The visit lasted several days, most of which we spent away from the overcrowding and lack of privacy at the office. I am sure Edith Sappington gave one of the delightful parties she always planned for visitors from the Central Office.

Dr. Martha Eliot came to visit the Regional Office usually in conjunction with visits to state health and welfare officials in the Region and elected officials who might b influential in support of legislation or federal budgets relevant to Children's Bureau interests. Other than one or two other visitors from Washington, DC, no social plans were requested or planned except for the usual dinner party at Dr. Sappington's to which all professional staff of Children's Bureau Regional Office were invited. Although Dr. Eliot may have asked staff some questions which had not been covered earlier in her visit, the principal topics before, during and after the drinks and food were a rundown she gave on the current and probable political influences on our programs and her own plans for new or expanded programs. On one occasion, she spent considerable time describing her planned strategy for creating and funding a new Division in the Central Office—Juvenile Delinquency. While many outsiders looked upon Martha Eliot as a motherly, late middle- aged lady in an unfashionable blue jersey dress and ground-gripper shoes with straight hair pulled back in a knot, we saw her as a smart, powerful, aggressive politician.

As another example of Central Office-Regional Office relationships, I will cite a visit I made with the Regional Medical Director, Dr. Sappington, to the Oregon State Department of Health. This visit took place shortly after I reported for duty in the Regional Office. I think I may have been included for orientation purposes. The stated reason for the visit was to discuss infant mortality in Oregon. The first and foremost activity on the visit was, however, a conference with the State Health Officer who was at that time the president of the State and Territorial Health Officers Association—the most powerful political group in the public health field. I don't remember specifically, but the subject had to do with federal legislation affecting the MCH/CC program and/or budget. No sooner were we seated in the office of Dr. Ericson than he reached under his blotter and took out a hand written letter from "Martha" (Dr. Eliot). No one else was present at this political discussion. After this we did meet with the MCH Director and discussed various topics including infant mortality. There seemed to be no immediately urgent new problem in that area as Oregon then had the lowest infant mortality in the U.S. (Later I learned that the rate for Native American Indian reservations in that state was as bad as Arizona, which then had the highest rate).

ALASKA

When I first came to the Region, Alaska Health Department had one social worker who had been there four or five years. She was a graduate of Tulane School of Social Work. She had worked in the Crippled Children's Service program in Alabama or Mississippi. She had left there, by request I think, because she had told the newspapers that the Crippled Children's Service was determining financial eligibility before diagnostic studies had been completed, a practice which was prohibited by Children's Bureau regulations. (Without knowing the diagnosis, there is no way to know how much it will cost to take care of the child.) I went to Alaska, at the State Health Office's request, to help them to replace her, as she was leaving to marry a man in Nome and become the Welfare Department Social Worker for the northern region of Alaska. My visit took place in summer, lasted about three weeks and was devoted to talks with State Health Department staff, Welfare Department staff, Bureau of Indian Affairs, Vocational and Rehabilitation, etc. I visited the Orthopedic Hospital in Sitka, the Tuberculosis

Hospital in Seward, and the Health Department offices in Anchorage, spending the balance of time in Juneau where the main office was located.

I put the Health Department in touch with a faculty member of the University of British Columbia who wanted to go to Alaska. She went to Juneau to see Dr. Albrecht, the Health Department Director, took the job, and reported for duty by the end of the summer.

The job in the Health Department was located in the Central Office, was generalized, and consisted mainly of consultation and cooperation with Welfare, Indian Health field staff, and resources in the "lower 48," such as hospitals, sanatoriums, and State CCS programs which handled patients who had to be sent out of the Territory for care.

HAWAII

In June of my first year, I went to Hawaii for about three weeks. There was only one social worker, Arline Wong, in the MCH/CCS Office. She was a graduate of Boston University School of Social Work, had been in the Health Department about two years, and had no other experience. The MCH/CC Director, expected her to perform tasks related to financial eligibility, to provide direct case work services in all kinds of CC clinics—rheumatic fever, orthopedic, etc. She, the Director, was a very bright, very hard working, very controlling, Board certified pediatrician. She told my nursing colleague that she had heard of her degree in mental health and did not think she approved. To me she said at our first meeting that she did not care for social work as it seemed like psychiatry to her. The other pediatrician talked freely with me and made it clear that Arline was not the only one with problems in the agency. I think the Director found the powerful and well prepared public health nursing division director difficult to accept. Arline and others were caught in the middle. Some of the nurses did not like to refer patients to her, understandably since she could not possibly handle all the problems. When I discussed with the Director, her reply was to complain to the Assistant Director of Public Health Nursing saying that she had issued medical orders that patients with problems were referred to Ms. Wong.

While there were some other social workers in the Mental Health Division, MCH/CSS situation was such that there was no immediate hope of a productive relationship. I explained to the Director that Ms. Wong needed more help than I could give her in one visit per year, but that I thought she had professional potential. I therefore arranged to send Arline to Massachusetts to spend a school year at the Children's Bureau supported Medical Social Work Training Project in the State Health Department, and take two advanced courses at Simmons School of Social Work with the semester to followed by observation at Health Departments on the mainland. All of this was paid for by the Hawaii Health Department.

As it turned out, I was in the Central Office in DC by the time Arline completed her time at the Massachusetts Health Department. In June, she married her fiance, the sports editor of the principal Honolulu newspaper, and I arranged their honeymoon to include, as I recall, the Connecticut and District of Columbia Health Departments.

WASHINGTON

When I first visited the Washington State Health Department with the Regional Office staff, there was a Chief Social Worker, a well-trained and experienced person seemed to be doing pretty well in her job but was not too happy far from her home base New England to which she returned soon after my visit. There was at least one other good social work staff member who also left soon after my visit to go to the California Health Department. As I recall, there was still one social worker in Eastern Washington and two or three others.

We were supporting a special project at the University of Washington Medical School for the purpose of teaching child development. The vehicle for the teaching was a special clinic for well babies run by the Pediatrics Department and servicing a clientele children of faculty. Margaret Mykut, the social worker on the project, was a graduate of the University of Washington School of Social Work whom I had met before since her field work supervisor had been a fellow student of mine. She saw all the families and discussed the cases with the medical students. With my usual bias toward clinical teaching which features social histories taken by medical students, I asked the Medical Director if they had tried that. I suggested that as potentially helpful as they might practice where social work was not readily available. He said he preferred Mrs. Mykut to teach the students so they would learn respect for social work. Dr. Sappington remarked that my ideas were valuable as I had taught Harvard medical students.

On the last visit I made to Washington State Health Department, I found the social work situation had deteriorated. As I recall, there was no Chief Social Worker and only two or three social work staff. Much of the social workers' time seemed to be consumed with what I considered nonsocial work clerical-like tasks, i.e. telephoning to make appointments for patients, etc. Despite this and much to my horror, the School of Social Work had students placed there for field instruction. I told the MCH/CCS Director and the social work staff that I felt there should be a realignment of duties. Clerical staff should be assigned so that social workers could devote their time to duties appropriate to social work. When I spoke with the School of Social Work, I found that they were either not aware or did not care about the practice in the Health Department.

My previous identification with the Washington State Health Department, I think, may have influenced my reaction to the condition of the social work services. I may well have allowed my professional mask of objectivity to slip. In any event, the MCH/CCS wrote Dr. Sappington to request that I not return. Dr. Sappington replied that the MCH Director need not be concerned as I was being promoted to Chief Social Worker in Central Office.

OREGON

When I made my first visit to the Oregon Crippled Children's Division of the University of Oregon Medical School, there were, as I recall, four or five social workers all stationed in the Central Office. One of them was a classmate from graduate school and a close personal friend. As I have mentioned, the circumstances of my visit were such that I spent almost the entire first day with the Medical Director explaining the Children's Bureau and preparing him for the arrival of the rest of our team from the Regional Office. Although I spoke with the social workers and

assured them that I would be spending more time with them, I think they were not too pleased that I spent so much time with the Director.

The CCS Division of the Medical School was separate from the Medical School Hospital which at that time had a Social Service Department whose Chief was not professionally trained, as I recall. The CCS ran its own clinics in a separate building and in various parts of the state. So far as I remember, the social workers seldom attended the clinics away from Portland where the staff, other than some physicians, were local health department personnel which did not include social work.

The CCS social service seemed to function more like a clinical program with a field outreach rather than as a public health program. Like the Washington State Health Department social workers, the Oregon CCS staff seemed to devote considerable time and effort to duties not requiring social work skills, such as determining financial eligibility on an individual basis. They did, however, provide a considerable amount of social casework.

ARIZONA

The Arizona Health Department had never, and did not then, have any social work. The MCH Nursing Consultant (nurse-midwife) was very accepting of social work and invited me there but she had her hands full as she actually ran the MCH program for its inadequate medical director. The Director of Public Health Nursing was not too keen on social work especially after the Mental Health Psychiatrist for the Regional Office told her that all public health nurses would soon be replaced by social workers. He thought that was a joke!

The CCS program had, I think, two social workers. They had no experience in health and their agency was just getting on its feet so consultation to them was pretty basic.

The Indian Health Hospital had no social service department at that time. The only social worker for Department of Interior was a child welfare worker who seemed concerned to such an extent with money grants from Indian service, etc., that she took no responsibility and did not seem to have any interest in some serious social problems of patients in the Phoenix Indian Hospital. I discussed this with our Child Welfare representative in San Francisco Regional Office. It is noted that social work became a part of rehabilitation in Phoenix Indian Hospital when Indian Health was transferred to Public Health Service.

NEVADA

When I was in the Regional Office, Nevada did not have any social work in the state office in Reno or in Las Vegas. I did go there several times with the team. The first time I went there alone, I met with the MCH Director. He was quite elderly with an oxygen tank in the event of need in his office and a silver eyelid brace necessitated by a stroke. He wrote down everything I said. Why I went to Nevada I do not recall. There were several reasons possible to account for it: 1) Dr. Sappington wanted me to see the Child Health Services in Reno and Las Vegas; 2) she wanted to expose them to social work; 3) she felt they should be told something or simply

reminded of the Regional Office; or, and this might have really been the reason, 4) to test my interest and willingness to deal with matters not particularly concerned with social work. Dr. Sappington had no use for people who allowed concern for their own disciplines to override concern for total programs.

CALIFORNIA

While I was in the Children's Bureau Central Office receiving orientation, I learned that Esther C. Spencer, whom I did not know, had just been appointed Chief Social Worker in the California Health Department. Her presence in the California State Health Department in San Francisco provided the only real and continuing professional social work stimulation for me outside of my contacts with Edith Baker and occasional visits to Children's Bureau Central Office.

Esther Spencer was born and brought up in Boston. I believe she graduated from Smith College School of Social Work, had worked for the Veteran's Administration in a hospital in North Carolina, and had also worked for the U.S. Public Health Service in Tuberculosis control while stationed in Boston.

Esther and I came to San Francisco within a few months of each other. Edith Baker offered to write to her formally announcing my appointment. We hit it off immediately and maintained close communication all the time I was in the San Francisco Regional Office. We were both much interested in the organization and development of public health social services, the processes involved and education for same. We were both intrigued with the process of consultation, particularly program consultation. We often analyzed our discussions, paying particular attention to our roles as consultant and consultee. I had more experience in public health than she did, but she was very intelligent and analytical so that I profited a great deal from the opportunity to discuss planning and implementing social services and professional education for same.

The California Health Department had a long history of social work involvement as there were several staff already on board when Esther arrived. It was a generalized service rather than one that was administratively placed in one particular area such as MCH, CCS, chronic disease, communicable disease and the like, or one that did not encompass the entire health department in its areas of practice. Although I worked for Children's Bureau with legal responsibility and funding only for MCH/CCS, I strongly believed in such a generalized service and still do. In this instance, the Social Service occupied a special unit in the organization of the Health Department comparable to Public Health Nursing, etc. The state social work staff, except for one in Los Angeles Regional Office, were all stationed in San Francisco for the sake of continuity to particular programs such as MCH, CCS, communicable disease, etc. As all of the well-developed counties employed social work staff in their health departments, the state staff acted as consultants to the local health officers and to their social workers where these existed. The state local relationships therefore resembled those of the federal state relationships. I am reminded that the state social work staff were known to question the desirability of Esther's sharing so much with me about what was going on in relation to their services.

At the time I carne to the Regional Office, Children's Bureau MCH funds were used to support the MCH teaching unit at the Graduate School of Public Health in Berkeley. There was a strong relationship between Edith Sappington and the physicians in the School of Public Health, particularly Dr. Jessie Bierman, the Professor of MCH, and Dr. Pauline Stitt, former MCH Director in Hawaii who was a student at that time and also a close associate of Dr. Sappington. There was a social work position on the MCH grant, Leona McGan. She may have already been there or she came soon after I did. I was also engaged soon to try and develop a social work training grant with the School of Social Work in Berkeley. I was in a strategic position to involve Esther Spencer in these activities. We worked very closely together with the two schools in the University and Esther was able to involve local health departments around the San Francisco Bay area which we intended to use for field placements of the students in the social work training project. As we worked it out, one of Esther's social work staff left the Health Department and went on the payroll of the School of Social Work, financed, as I recall, with Reserve Fund B CCS funds through the State Health Department. This project aimed to experiment with provision of a social work internship for students already having a master's degree in social work. Jean Hoodwin, Esther's former staff member, supervised the interns and taught the course for them, drawing upon material from the Schools of Social Work and Public Health and her own background in the Washington State and California State Health Departments. After completion of the internships, the students would receive a certificate which Esther saw to it was acceptable for credit in the California State Merit system. The internship finally failed because there was no degree attached to it which created a problem for interns wanting to work in other states. The funds were then used for stipends for post master's social work students in the School of Public Health. I mention this experience here because it illustrates what can be accomplished with a cooperative network of social work at the federal, state, local and university levels.

Except for attendance at Children's Bureau staff meetings, I only recall attendance at one out-of-state professional meeting. It was convened and financed by the National Foundation for Infantile Paralysis (now March of Dimes). (See National Foundation for Infantile Paralysis, 1957). 1 was invited by Kathleen Allen, Chief Social Worker, National Foundation for Infantile Paralysis (NFIP). The meeting was held at the Harriman estate on the Hudson River. Travel was paid by the NFIP.

Shortly before I joined the staff of the Children's Bureau the Medical Social Work Section had a meeting (June, 1951) to discuss the social work services in the MCH and CCS programs. (See U.S. Children's Bureau, 1953). The meeting was planned by Edith Baker and Doris Seigal carried responsibility for much of the detail work. As the resultant publication was to receive widespread distribution, which included distribution by all our Children's Bureau Regional Medical Social Consultants, the draft was sent to the Regional staff before it went to the printer. I objected to the material on page IO and 1 1 of the draft on the grounds that the analysis of functions did not include administration of social services in the agency. Having worked in a state health department for someone with administrative title and responsibilities; having insisted upon same as a condition of taking the job in Richmond; having worked in a federal job for a Chief Social Worker; and having been geographically and closely associated with the California

State Health Department, I could hardly do otherwise. A slight addition was made in the publication.

While I was in San Francisco, I wrote a paper on the Richmond Home Care Program at the request of the Editor of *The Child,* at that time the official publication of the Children's Bureau. I was very displeased with the paper, "Sick Children Benefit from a City's Home Care Program," as it appeared in *The Child.* (See Insley, 1953). The editor had "dumbed it down" in accordance with CB policy at that time. The article was illustrated with a picture of an older physician although the article emphasized the teaching of young medical students. (Later, a new editor came when *The Child* was superseded by *Children* and the policy of writing for a nonprofessional audience was changed.)

In the fall of 1953, Ms. Baker offered me the job as her assistant and also told me that she would have to retire at age 70. Her birthday was the last of September 1954. I have recently come upon a carbon copy of a letter I wrote to her on January 13, 1954. This letter lays out all the pros and cons affecting my decision. In the telephone calls which followed the letter, I refused the offer. Eileen Lester, the Regional Medical Social Consultant in Atlanta, transferred to the Central office to accept the position as Assistant chief of Medical social Work Section. My letter explaining my refusal is available in the Syracuse and the Schlesinger libraries. (See Insley, personal communication, 1954).

In the summer 1954, about the time I completed my assignment to the study of the health needs of Alaska, I was offered Ms. Baker's position. As Ms. Baker had told me, she expected Dr. Eliot to select an older person with a national reputation, i.e. someone like Harriett Bartlett. I agreed to go to DC to discuss the offer before making up my mind. I met with Dr. Eliot, Dr. Lesser, Eileen Lester (Ms. Baker's assistant who had transferred to Central office from Atlanta Regional Office to take the position I had refused), and various other staff of Children's bureau. Interestingly enough, the one interview I remember clearly was with the physician who would, on paper at least, be my administrative supervisor. She warned me against taking the position, saying that Edith Baker would "live here in DC telling you what to do." I said, "No one tells me what to do—Miss Baker or anyone else." I later learned that she had been Regional Medical Director for Children's Bureau in Atlanta, where she had expected Eileen Lester to do a lot of her work. Subsequently, after I had taken the position, Eileen and I agreed that any requests for help from the physician would have to go through me. As it later turned out, Dr. Lesser wrote all my performance evaluations—all positive!

Not having had time to complete my responsibilities to the Regional office, I could not report for duty in the Central Office immediately after Edith's retirement in September. I did attend the national staff meeting in the Central Office in my new capacity in the late autumn, but did not move to DC until late winter.

EDITH BAKER

At this point, I would like to note that Edith Baker did not just fade out. By late fall, she had become a consultant to the DC Health Department whose Director of MCH/CCS was Dr. Ella Oppenheimer, an old friend and colleague of Dr. Eliot and Ms. Baker. Soon Edith Baker was appointed chief Social worker in MCH/CCS, the only social work unit in the DC Health Department. Besides her social work appointment, she assisted Dr. Oppenheimer by writing the grant requests to the Children's bureau for MCH/CCS. She continued in this position until well after her 80th birthday. The monographs and papers on file in the Syracuse University Library will show that she was very active in public health social work during these years (e.g. a workshop on social work at Tulane where she gave the principal paper (see Baker, 1960); a workshop put on by her office in DC Health Department on Mental Retardation Social Services complete with a visit to the Kennedy White House for participants; an article in Child Welfare, etc.) (A list of works by Edith Baker, all of which are available in the Schlesinger Library in Cambridge, Massachusetts, is included with this document).

CHAPTER VI

U.S. CHILDREN'S BUREAU
U.S. PUBLIC HEALTH SERVICE
WASHINGTON, D.C. 1952-1980

Children's Bureau duties were written in language similar to the Public Health Service job description, but the content was not the same as for the Public Health Service. The way I list the duties at the Children's Bureau would not be approved by any personnel office, but I will describe what I was expected to do.

1) To be the Chief of the Section of Medical Social Work. This title I inherited from Edith Baker. It was selected to distinguish this Section from Child Welfare which was called the Division of Social Services. Much later I tried to use the title "Public Health Social Work." My duties, except for cooperation with other offices, were administratively confined to the Division of Health Services.

2) To recruit and select social work staff for the Division of Health Services in the Central and Regional Offices.

3) To supervise the staff of the Medical Social Work Section which at various times ranged from an Assistant Chief with one secretary to an Assistant Chief with a Medical Social Work Specialist in Professional Education, a Medical Social Work Specialist in Hospital Social Service, and two secretaries.

4) To secure the official concurrence of the Children's Bureau Regional Medical Director and of the Regional Director for the appointment of Regional Medical Social Consultants.

5) To provide technical supervision of the Regional Medical Social Consultants who were administratively responsible to the Regional Medical Directors.

6) To represent the Children's Bureau, the Division of Health Services, or the Medical Social Work Section on all matters pertaining particularly to social aspects and social services in health, as well as other matters pertaining to MCH/CCS in accordance with expertise, special interest or designation.

7) To be responsible for the Children's Bureau's interests and activities in relation to social work education for the health field and for the social aspects of professional education for other health disciplines.

8) To work with the Reports Division in relation to its responsibilities for publications, review of professional speeches, cooperation with media, etc.

9) To work with the Research Division with respect to internal and external studies including bio-statistics, health problems and health services.

10) To assist the International Division with recruitment and selection of professional backup for social workers to be sent on overseas assignments related to MCH/CCS; to arrange and provide professional back-up for social workers coming to the United States for formal training or observation; to meet with social workers and other health services disciplines coming to the U.S., etc.

11) To give consultation to graduate schools of social work, schools of public health, and medical schools wishing to develop long term or short term institutes and workshops with MCH and CCS grants.

12) To provide consultation to institutes of higher learning regarding content related to family and child health.

13) To prepare guidelines for social work practice in Maternal and Child Health and Crippled Children's Services (MCH/CCS) programs to be used as suggested standards by state and local health departments, and as educational tools for schools of social work and schools of public health. These guidelines were to be distributed widely and used for consultation. Material such as this had been used from the earliest days after the Social Security Act in relation to required qualifications and suggested duties of state staff, and were reorganized from time-to-time with growth and development of program services.

ADMINISTRATIVE CHANGES CB & PHS

When Dr. Martha Eliot resigned as Chief of the Children's Bureau, she told me in a personal conversation that she was leaving because she felt she could no longer perform the duties of the position.

She gave an example. She and Dr. Arthur Lesser had to testify in a congressional budget hearing. She was asked a question and could not think of a good reply immediately, so she turned to Dr. Lesser and he answered the question. Martha went to the Harvard School of Public Health as professor and head of Maternal and Child Health. Dr. Lesser was Acting Chief in the wake of her departure as Chief of the Children's Bureau.

In my opinion, Dr. Lesser should have been appointed Chief after Dr. Eliot since he had been in the Children's Bureau for many years, had excellent relationships in and outside of government, and was especially skillful in his dealings with individual legislators, as well as Senate and House committees.

Dr. Lesser was acting chief until Katherine B. Oettinger, the first real political appointee to head the Children's Bureau, was appointed. Mrs. Oettinger was a social worker who had been in State Mental Health in Pennsylvania. Just before coming to the Children's Bureau, she had been Dean of the Boston University School of Social Work. She remained in her new position as a kind of figure head guided by experienced members of the Bureau staff. Dr. Lesser became her Deputy Chief. She was later transferred to another position as nominal head of Family Planning.

This position came with less administrative responsibility and a full time PHS physician to assist her.

The next Chief appointed was Fred Deliquadri, a social worker who was Dean of the School of Social Work at Columbia University. His tenure was brief. The Office of the Chief fell next into the hands of Jules Sugarman from Head Start. He was a man who publicly stated and was known to be someone who disliked social workers.

In 1963, the Children's Bureau, which had been in the Social Security Administration under the Department of Health, Education and Welfare since 1953, was transferred to the Welfare Administration, a new agency in the DHEW. The Director of the Welfare Administration, Ellen Winston, was not a friend of public heath. I remember that we had made a special grant to the North Carolina Health Department to hold a short-term training institute for social workers on adolescence. Dr. Winston, then State Director of Public Welfare, decreed that no social workers on her staff could attend unless they took annual leave.

Two years later, the Children's Bureau was transferred to the Social and Rehabilitation Service which administered the Vocational Rehabilitation Service. It had been rumored for some time that the Director expressed interest in adding the Crippled Children's Service to her vocational rehabilitation program, which was supposed to take patients not served by CCS, which could only serve children up to 21 years of age. It was often said that the OVR preferred patients such as men with hernias who could be shown to be able to go back to work after brief periods of medical care. In addition to reports from others, I encountered a similar situation in Virginia when I tried to refer a young quadriplegic man to OVR and he was refused on the grounds that he had not finished high school.

In August, 1969, the functions and legal responsibilities for programs were changed by administrative order. (See Hutchins, 1994). Since the Children's Bureau had been set up by an act of Congress, it could not be abolished except by act of Congress. Its responsibilities under the Act of 1912 were transferred to the Office of Child Development, Child Welfare, and Juvenile Delinquency, which remained in the Social and Rehabilitation Service. The Maternal and Child Health and Crippled Children's programs, Title V of the Social Security Act, were transferred as Maternal and Child Health to the U.S. Public Health Service, Health and Mental Health Administration, which had been created in 1968 to include all health services to individuals. We then moved our offices from 3rd and Independence Avenues (close to Capitol Hill) to Rockville, Maryland. This was seen as a geographical handicap separating the Children's Bureau staff and advocates from those who presided over laws and budgets affecting MCH.

Staff members tended to look upon the transfer as positive because we would be in a health agency and would get away from the turmoil we had undergone in the last few years. On the negative side were the disruptions in our personal lives (for me, a daily commute of 25 miles each way) as well as in staffing and practice. The latter was confirmed for me by a conversation I had with Dr. Crabtree, an old-time Public Health Service officer. He said he had often argued with Martha Eliot, when he was Assistant Surgeon General to Dr. Parran, about use of a kind of check list approach required of the states by the PHS in contrast to the detailed state plans required by the Children's Bureau. This conversation took place when Dr. Crabtree, then Dean

of the Graduate School of Public Health at the University of Pittsburgh, was trying to recruit me to the faculty. He said then that experience had demonstrated that Dr. Eliot was right—the Children's Bureau requirements for state plans were much better than the PHS check lists.

In 1977, the Director of the Bureau of Community Health Services in U.S. Public Healt Service, where Maternal and Child Health was located, decided to abolish the Disciplinary Sections in the Bureau. With the exception of the Chief of Nutrition, who would be appointed t supervise many of the staff of the current sections, most were unalterably opposed to the break up of the Sections. A document was prepared and signed by the dentists, social workers, nurses, etc., protesting and explaining the reasons for our objections. The documents are available in th Syracuse Library.

The reasons for our objections to the reorganization planned were that the changes also included the setting up of new groupings of staff dedicated to different age groups or problems be solved such as adolescence, handicapped children, maternity, etc. Since there were, for example, only 2-1/2 social workers, two dentists, two nurses, etc., with each member of the staf assigned to just one section, some sections were left without the participation of the multi-discipline staff team.

This problem was taken up by Bureau staff of the various disciplines concerned with th agency administration as well as the Bureau Director. Many people outside the government wrote to the agency administrator, the Bureau Director, and then Surgeon General protesting th abolition of the disciplinary sections. It was even taken up to APHA but the timing was off (it happened just before the APHA annual meeting).

In the end, we lost out. The disciplinary sections were gone. This well may have been d in part to the fact the PHS staff were said to suspect that former Children's Bureau staff did not approve of the way programs were managed by PHS staff in the Bureau of Community Health Services (BCHS.). Needless to say, the new organizational plan created many problems having to do with lack of clarity in lines of authority and responsibility. Although I was no longer a Section Chief, and officially had no supervisory responsibility for social workers, I still remain the Chief Social Worker in the Bureau of Community Health Services. Juanita Evans and I maintained a united front. Because of this and presence of MCH staff and some others we had come to know, we kept on working together much as we had before. Although there were time when staff in the Bureau did not agree as they had before, we really managed fairly well under the circumstances.

The USPHS job description for my position after the abolition of the Medical Social Work Section was that of Social Work Program Specialist GS185-14, which is described as "principal specialist in social work, providing leadership and guidance for the social work aspects of all Bureau programs". (See U.S. Public Health Service Job Description, no date).

SOCIAL WORK STANDARDS

While there had been standards for medical social work in hospitals, there had been no officially accepted standards beyond those promulgated by the Children's Bureau until a committee of the American Public Health Association (1950), a sub-committee of the Committee on Professional Education in cooperation with the American Association of Medical Social Workers, prepared and published "Educational Qualifications of Medical Social Workers in Public Health Programs." (See American Public Health Association, 1950). Beatrice Hall, Regional Medical Social Consultant in the New York Regional Office, served on the committee to prepare this statement. I felt this statement of standards, produced by the professional association for all of public health practice, was of the highest importance for us in our attempts to maintain standards of social work practice in state and local health departments, such a statement would be far better as a tool to achieve compliance by state health departments, than the recommendations by federal agencies. Therefore, I directed our staff to use this statement as basic standards, which were subsequently joined with guidelines specific to particular MCH & CCS programs.

I was responsible for the social aspects in the guidelines for all program services in addition to the preparation and distribution of guidelines peculiar to social work. While it was a generally accepted fact that all MCH/CCS programs and projects needed multi-disciplinary teams (usually consisting of medical, nursing, social work and nutrition at minimum), it had to be stated in writing which disciplines would be included. It was necessary to monitor all written guidelines and consultation plans, and to see that all requirements concerning social work were enforced.

Some examples of the guidelines are as follows:

1. Prior to approval, All MCH projects in schools of public health were required to have a social work faculty member position.

2. Prior to approval, all University Affiliated Facility (UAF) training projects were required to have a social work faculty member eligible for at least an associate or assistant professorship in the schools of medicine and social work. (Note here that we could not require a particular degree, but we could recommend a doctorate and would require the lowest acceptable rank.) In interdisciplinary projects, usually headed by a high level medical faculty member, it was sometimes quite difficult, even with team approval, to enforce requirements for social work education and experience commensurate with the rank of associate professor. This was often further complicated by the fact that some of the social workers in medical schools, hospitals, and even in the schools of social work involved in projects were not accustomed to standing up for such requirements.

3. All projects must include social work education. I made that decision as a result of a meeting of our staff in Health Service for the purpose of deciding what staff would be

required. Our Nutrition Section Chief wished to include Nutrition students in only a selected few UAF projects.

4. All project grants to universities must meet the required standards for short term as well as long term grants.

5. Social work staff in state and local programs and projects were expected to have at least a Master's degree from an accredited school of Social Work. Federal staff could work directly with State Merit Systems, if necessary, to provide help in establishing or supplying appropriate classification of positions. Support staff for social work, such as neighborhood representatives, could be employed with whatever education and experience their particular jobs required.

COOPERATION WITH SOCIAL SERVICE DIVISION, CHILDREN'S BUREAU

The Social Service Division (SSD) operated in a completely opposite manner from the Health Division. No professional staff member was supposed to request a conference or accept a request for a conference from anyone outside of the Social Service Division without permission of the Director or, in her absence, of his or her supervisor. I could send a memo to the Director of SSD, but she always addressed communications intended for me to Dr. Lesser, which usually resulted in delay and confusion. She spoke with me when the matter concerned one of her staff. I think medical social work may have had an easier time communicating with child welfare since we were all social workers. When Dr. Lesser was Deputy Chief of the Children's Bureau, he frequently sent for me to interpret verbose memoranda filled with "social work" language which had been composed by some child welfare staff and sent from the SSD Director's Office. He particularly objected to their wanting projects to look into the causes of pregnancy. He said, there was one cause.

There were serious differences in philosophy. The SSD believed that all families should make at least a token payment for day care on the grounds that people really only appreciate what they pay for. Dr. Lesser and I did not agree with this. I could only think of some families I had seen in the cotton fields in southern California, many of them migratory laborers with many children. There I saw infants between the clutch and the brake on the floors of cars parked beside the fields. Dr. Lesser said he wondered how people reconciled such views with sending their children to public schools.

The Director of the Social Service Division decided to give up the requirement that child welfare funds could be used only for staff with master's degrees in social work while I insisted upon keeping the master's degree as the basic requirement for professional social work in health services. I considered that it was a mistake to allow federal funds to be used for professionally untrained staff. Formerly, these funds had been used primarily to provide staff for training and supervision.

I got along well with Mildred Arnold, the Director of the Social Service Division. She was always nice to me even when I went to her about some problem with her staff, as I had to do

in regard to their Specialist in Mental Retardation. He came from an institutional setting and did not make clear that he was speaking only for child welfare in relation to social work training. I got along with Annie Lee Davis (later Sandusky), who used to be the specialist on children in their own homes (see Davis,1953) but was by now, supervisor over most of the other specialists. Bessie Trout, in charge of training, was the child welfare staff member with whom the Medical Social Work Section had most communication. Just once, as I recall, I was asked to speak about new developments in the health field of interest to social work. The audience consisted of teachers of child welfare. I elected to speak about genetics and family planning. No one expressed interest in the topics.

As I have said, the Division of Health Services and the Division of Social Services were very different. Despite what one may have expected, considering the professional agency ties and location on the same floor in the same building, our cooperation was not close. Health Services was made up of a variety of disciplines while the Social Service Division was made up entirely of child welfare specialists, even the staff responsible for administrative matters like accounting. The Health Division operated in almost every respect as professional staff members who were free to do their jobs and to make independent contacts with other people in or outside Children's Bureau, government agencies, private agencies, Regional Offices, state agencies, etc. We were expected to know when we needed the help or guidance from other staff.

COOPERATION WITH RESEARCH

In accordance with the 1912 Act creating the Children's Bureau, the duties of the Children's Bureau would be "to investigate and report upon all matters pertaining to the welfare of children and child life among all classes of our people." The Social Security Act as originally passed in 1935 did not authorize the use of Maternal and Child Health, Crippled Children's Service and Child Welfare Services for extramural research. It was not until the 1960s that the Children's Bureau was authorized to use MCH and CCS funds for extramural research with the proviso that basic health research remained the province of the National Institutes of Health in the U.S. Public Health Service with applied MCH health research to be carried out by the Children's Bureau.

We had within the Children's Bureau the capability to collect basic statistics such as data on populations, census tracts, etc., in relation to incidence and prevalence of infant and maternal deaths, prematurity, and congenital deformity, and to work with state health departments to set up reporting systems through birth and death records, laws relating to reportable diseases, and to cooperate with the work of the U.S. Public Health Service Communicable Disease Center. Eleanor Hunt, Ph.D., Columbia University in physical anthropology, was in charge of most of this. We talked a lot to each other, and I had real respect for her intelligence and contribution. A good many of our conversations centered around questions she had about social and psychological problems.

I was not personally involved in any of the intramural research. I know that some of the staff in the Office of the Chief made a study of some child welfare services (adoption, I think). Since the subject lay in the province of the Social Service Division, I was not consulted. It was

probably just as well since I would have found it necessary to criticize the research design which looked at agency outcomes without regard for the variations in the training of professional staff who provided the services.

Helen Witmer was Director of Research when I first came to Washington, DC. Later, the person who was employed as Director of the Research Division was a Ph.D. psychologist who had been in charge of research for a large private family agency in Chicago. In my experience, I considered him difficult, not a team worker, and someone whose word could not be relied upon. He acted toward many others as though they were beneath him. In one instance, I had talked with him about a grant to study social work in public health which would involve the National Association of Social Workers, with the actual direction of the research to be carried out by the Graduate School of Public Health in Pittsburgh. When I brought the proposed applicants in by arrangement with him, he scarcely listened although he had previously agreed with me that they had the necessary qualifications. He simply said there would be no funding for this. Another time, Dr. Helen Wallace, the Chief of Maternal and Child Health at the University of California School of Public Health, wanted to make a study of the health needs of children in foster care. The idea never went anywhere since Dr. Gershenson said it was "not needed." At that time we could find no past studies, but of course there have been some since. The only time I ever came out on the winning side had nothing to do with research but with a MCH project which he tried to derail. The MCH staff in the Chicago Regional Office talked with me about the possibility of financing a comprehensive program for teenage girls on the south side of Chicago with Maternity and Infant Care funds. The Chicago Board of Health, from which Lucile Ish, Regional Medical Social Consultant, had just come to the Children's Bureau, had just completed a research project funded by the National Institute of Mental Health on this subject. It was proposed that a grant for this purpose be added to the Maternity and Infant Care project in the Chicago Board of Health. The Maternity and Infant Care project could not at that time provide professional social workers and nurses with necessary degrees as required by such a project. (The spoils system was then prevalent in Chicago Civil Service—political appointees who were approved by Mayor Daly's machine.) It was suggested that the Board of Health contract with the national office of the Florence Crittendon Association to set up and operate the project.

The Regional Office asked me to talk with Mattie Wright, the social worker who had directed the social work in the Mental Health Project. Mattie came to DC where I arranged for her to talk with Kay Oettinger, then Chief of the Children's Bureau. It all sounded quite approvable. Soon the Regional Office notified us that Dr. Gershenson, our Research Director, was in Chicago talking with his friends in the school system about the desirability of their refusing to cooperate with the Board of Health and saying that the whole idea was wrong. He said teenage services were child welfare and therefore inappropriate for funding by Maternal and Child Health. This led to a strongly worded memorandum from Mildred Arnold, Chief of the Social Services Division, to Mrs. Oettinger, stating that it was perfectly appropriate to use health funds to support comprehensive services to teenage girls.

Betsy Herzog, who I think was a social anthropologist, was very helpful to us especially in relation to matters pertaining to social services, and I think our feelings were mutual. From the Medical Social Work Section she gained a different perspective than she first had from the

Social Service Division, whose specialist in that subject at that time came from a background in a private church related social agency. Betsy was willing, in fact probably proud, to be on programs for Maternal and Child Health Social Work Institutes, speaking on subjects related to pregnancy as well as to research. (See Herzog, 1968).

The Chief of Research did not go with the Health Division to the Public Health Service. The person in charge was a statistician who had a degree in public health. Other staff exercised control and all professional staff participated in reviewing, making recommendations, attending meetings, and stimulating and/or attempting to stimulate development and submission of research grants. Outside review panels were assembled to read projects and staff recommendations. Individuals came in seeking assistance to formulate research grants by a group of different disciplines.

I was very much disappointed that we had so few research applications from social work. A notable example of social work research we were able to fund was that of Elizabeth Elmer's on child abuse. As I recall, the most prolific producer of social work research in MCH was Steven Paul Schinke, Chief Social Worker in the University of Washington MCH supported University Affiliated Mental Retardation Child Development project at the Medical School in Seattle. Most of his research was not submitted to MCH but was funded by other services such as the U.S. Public Health Service, National Institutes of Health. Many reports of his work have been published and several are available in the Virginia Insley Collection at Syracuse University Bird Library, Special Collections. (See Schinke, 1979).

My major problem with the lack of social work research was the absence of material to document the value of social service. Once in a while some research at least partly attributable to social work, though not by social workers, was produced. For example, the work of Jean Bedger, who worked for Mattie Wright in the Chicago Maternity and Infant Care supported Crittendon Comprehensive Care Center, showed that the outcome of pregnancy could be influenced so that the rate of premature births for poor African American unmarried mothers would be the same as that for white middle class married mothers. Too often we saw projects submitted by nonsocial workers to study services pioneered by social work. For these reasons, Juanita Evans and I promoted and supported the workshop for social workers which resulted in the publication *Applied Social Work Research in Maternal and Child Health—Instrument for Change,* which was held in Philadelphia in May, 1980. (See Rauch, 1981, and Insley, 1981).

COOPERATION WITH REPORTS

The Reports Division was one with which the Medical Social Work Section had considerable interaction. When I first came to the Children's Bureau there was a policy in force that all Children's Bureau publications had to be written to be easily understood by the general public who were, I believe, thought to be less than high school graduates. I experienced the results of this with a paper I wrote on the use of home visits by medical students as the vehicle for teaching community medicine. My paper had been seriously compromised not only in the editing but also in the use of an elderly physician's picture as he supposedly sat by the bed of a child even though my paper dealt with a teaching program for young physicians. (See Insley, 1953).

By the time I transferred to the Central Office, a new editor had been appointed and the monthly publication changed from *The Child* to *Children*. It was recognized that the readers of *Children* were primarily professionals. It, therefore, was written for this readership. The publications for the general public such as *Prenatal Care*, *Infant Care, Your Child from One to Six, The Adolescent in Your Family*, etc. were written in nonprofessional language.

The new editor of *Children*, Kathryn Close, was a professional writer with whom we worked closely. At her request we reviewed articles submitted for publication. We suggested possible authors. Below, I recall some subjects covered although I may not remember the proper names of the articles.

"Barriers to Prenatal Care" by Esther Spencer, M.S.W., and Howard Monahan, M.S.W., California State Health Department.

"Prenatal Care in a Rural Area" by Kazuye Kumabe, M.S.W., M.P.H., Hawaii Health Department.

"Comprehensive Services for Teen Age Pregnant Girls" by Mattie K. Wright, M.S.W., Crittendon Comprehensive Care Center, Chicago Board of Health.

"Social Services for Child with Congenital Heart Disease" by Harold Richmond, M.S.W., Clinical Center, National Institutes of Health, U.S. Public Health Service (Harold was a beginning case worker).

We worked closely with a man who prepared small pamphlets designed to inform parents of handicapped children of the nature of such diseases and the help available. These, of course, had to be written with special sensitivity.

On at least one occasion, we persuaded the Reports Division to print the report of a workshop for social workers in mental retardation projects for which we could find no other means of financing. The workshop itself had been assisted by a supplemental MCH grant to a state mental retardation project.

On several occasions, when publication of MCH workshops were deemed of such significance, we were able to arrange to have them reprinted by the Children's Bureau. One example was *Concepts of mental health and consultation: Their application in public health social work* with supplemental chapters in public health social work by me. (See Caplan, 1959). This volume contained all but one article from a publication of the MCH Social Work Training Project at the University of California, Berkeley, School of Social Work. The one article omitted was in the appendix to the publication and dealt with abortion which was considered unsuitable at that time for a government publication. A paper I gave on consultation at another workshop was included in the Children's Bureau issued publication. This publication was entitled *Program Consultation (see* Insley, 1959b) and had been originally given in 1956 at a National Association of Social Workers sponsored workshop.

Another publication reprinted by the Children's Bureau was entitled *Mothers at Risk* edited by Haselkorn (1969b), which was originally the report of an MCH funded workshop held by Adelphi School of Social Work.

We also arranged for the reprinting of articles from outside journals that we considered relevant to social work practice. All of the reprinted publications. workshops, journal articles, as well as extra copies of workshops not reprinted were sent to state and local health department social workers, schools of social work, schools of public health, National Association of Social Workers (NASW), American Public Health Association (APHA), etc.

In the government, it is common practice to employ speech writers. Kathryn Close, the Editor of *Children,* used to say she wondered if Patrick Henry were to be buried today, his monument might say " 'give me liberty or give me death'—prepared by...." Though staff in the Division of Health Services frequently discussed papers they were preparing with each other, I doubt that many requested this assistance because many of our papers were presented to professional audiences, frequently of particular disciplines. When someone like Dr. Martha Eliot, Chief of the Children's Bureau, had to give a paper, she might have the speech writer confer with various staff members to assemble background material or send for certain staff members for their suggestions.

Once we had a new Chief of the Children's Bureau who insisted upon selecting and employing her own speech writer. She was slated to give a speech at the opening meeting of the National Conference of Social Work in Chicago. About two days before it was to be given, Dr. Lesser told me that the entire speech had been found unacceptable. It was to be rewritten by the staff. He and I were to write that portion dealing with health services. I could have either MCH or CCS and he would take the other. The Social Service Division would do the part on Child Welfare; Juvenile Delinquency Division would do theirs, etc. I forget how many hours we were given, but I do recall that it was already after noon. He had already requested his secretary to collect some recent speeches from various sources which were relevant to the current status of our health programs. By cutting and pasting and adding some material of our own, we produced our documents written separately in the required time, put them together and handed them in as one. When I arrived in Chicago, I learned that the Chief of the Reports Division had accompanied the Chief of the Bureau, and they were devoting the day and evening to practice reading the document. Even though the staff had often joked about her inability to pronounce words like "phenylketinuria," she did pretty well, although she did say "majority group" when the text read "minority group."

The Reports Division also had responsibility for review of all public speeches and papers to be published. I had a policy for myself to prepare a speech I planned to give before I went to the meeting since I knew from experience that I would find it harder to write afterward. If it was to be published, I brought it back and had it cleared afterward. The Reports Division was supposed to see that the final copy of the paper was seen by the author, but occasionally they slipped up as did the man in the Reports Division with my paper in *Mothers at Risk.* (See Insley, 1968b). On page 50, he added the words "after delivery" on the 3rd line, thus distorting the meaning of the point I wanted to make. As I recall, I prepared and cleared one paper before

giving a speech. This was a paper on family planning which I gave at the annual meeting of the Catholic Hospital Association. (See Insley, 1968c).

I spoke at many meetings but seldom wrote papers I would have to clear. I spoke at all of the MCH supported workshops for social workers if I was in attendance, and I usually was. I also spoke at meetings of the State Medical Social Consultants, Social Work Section of APHA, NASW conferences, etc. Although I sometimes made notes, I always, or nearly always, spoke entirely "off the cuff." This was not only because I was lazy or found it inconvenient to write but because much of what I said would not have been cleared by Reports or approved by the final authorities. I spoke, for example, about recent legislation, funding legislation, the desirability of writing to Congressmen and state officials for or against laws or budgets. I urged writing to support the filling of Regional Medical Social Consultant positions by the Public Health Service. I also answered questions about controversial subjects which I could not or should not have answered in writing.

In addition to her willingness, even pleasure, at receiving suggestions from Medical Social Work for papers in *Children,* Kathryn Close was willing to provide some consultation, and she even attended some MCH social work conferences to speak about writing skills.

One of the biggest undertakings I ever shared with Reports Division was the editing of the publication *Concepts of mental health and consultation: Their application in public health social work.* I did this with Dorothy Bradbury, one of the senior writers in the Reports Division.

The staff of the U.S. Public Health Service Bureau of Community Health Services were mostly the same people as in the Children's Bureau which had responsibility for publications, writing and reviewing papers, etc. When the Health Service staff left the Children's Bureau, all of the publications for parents and the magazine *Children* were left in the Children's Bureau. This was not a good idea, which was soon demonstrated when the Children's Bureau brought out a publication on sickle cell anemia which not only contained some racially unattractive illustrations but was based upon faulty medical information.

We were able to continue with reprints of some proccedings of MCH social work workshops. We made another reprint of *Concepts of mental health and consultation: Their application in public health social work*, PHS#2072. We reprinted *Evaluation of social work services in community health and medical care programs,* (see Jackson, 1978), from University of California, Berkeley, based on the Proceedings of the 1973 Annual Institute for Public Health Social Workers, reprinted 1977, and 1978. This publication, as you can see from the reprint history, bore out the opinion that it should be reprinted regularly because of its wide interest beyond social work. We reprinted the report of *Proceedings—Working conference on minimum review criteria for professional social work practice* (see Stein et al, 1978) held in April, 1976, by the MCH Social Work Training Program at the University of Pittsburgh, DHEW Publication # (HSA) 78-5223. A training manual for social workers in University Affiliated Training Projects, prepared by the social workers in these projects and originally issued by the projects in Miami and Kansas City, was widely distributed because of its relevance to social work beyond the University Affiliated Facility (UAF) projects. (See McGrath et al, 1976). A publication was

issued which consisted of some references to consultation, prepared by my assistant, Mary Watts.

In 1976 or 1977, I had an interesting experience which harkened back to the refusal to reprint Dr. Gerald Caplan's paper on abortion. I sent the piece I wrote on MCH for the 1977 *Encyclopedia of Social Work* to be cleared. The initial clearance was refused because I mentioned "abortions." I then took it up with Grace Angle, Arthur Lesser's Deputy (he was Chief of MCH in the Bureau of Community Health Services). She refused to clear it on grounds that it was against government policy to write about abortions. As I considered this to be far out of date, I awaited Dr. Lesser's return and showed it to him. He said his only criticism would be that I should have said more about abortions. (See Insley, 1977).

COOPERATION WITH INTERNATIONAL

In the Children's Bureau, we had a physician, Sarah Dietrich, who was in charge of international health activities—that is, she coordinated such activities, dealing herself with medical matters and using special disciplinary staff for other matters. There was a woman in the Social Security Administration who, I think, must have had some strong political connections because she was a power to be reckoned with in relation to international activities. She was not a social worker, but she seemed to decide, I guess with advice from social workers in child welfare and public assistance, much of what would happen about social work. She did, however, refer distinctly medical social worker personnel activities to me.

I was asked on one occasion to find a social worker to send to Peru on a long-term assignment to help with social work education. At that time there were few well qualified with Spanish or Hispanic backgrounds. I consulted Faustina Solis in California, offered her the job and, when she refused, asked for other suggestions. She had none. I finally settled on someone of Italian background who agreed to take Spanish lessons before she left.

On another occasion, I was asked to find a social worker to go to Peru on a short-term assignment (several months) to give consultation to the Medical School. I was able to persuade Beatrice Phillips (now Sachs), from Boston's Beth Israel Hospital, to carry this out. When Bee came to Washington for orientation, my mentor in International was very much pleased—more, I think, because she thought Bee's looks and dress would appeal to the physicians in Peru than because of her professional qualifications. Bee took her husband with her and I got good marks for my contribution to Peru's medical education.

We had some long-term trainee social workers such as a woman from Taiwan for whom I recommended attendance at a School of Social Work in Boston because I knew that Boston was held in great regard for the training of professional health workers, including social workers of Chinese backgrounds from Hawaii and Taiwan. Some students, whose educational and language skills enabled them to enter graduate schools, we sent to schools of social work. With these students, we sometimes planned observation during vacations at which time we sent them to spend days or weeks at appropriate health services. If there were MCH supported workshops

being held while students or observers were here, we sent them to those and to other short-term training or national meetings.

I recall a woman, an "assistance social-medical", born and educated in France. She was referred to me , but it turned out her husband was a high official in a north African country so the State Department handled her directly as a VIP. It was sometimes quite difficult to deal with the State Department, which tended to treat foreign visitors as political tourists instead of professionals looking for increased specialized knowledge of hospitals, clinics, social work education, and the like. One social worker brought with her a short list of the hospital social service departments she wished to visit. She especially wished to visit Washington University Hospital and clinics in St. Louis but was told she could not go there because the visit conflicted with a visit the State Department had scheduled to the Grand Canyon. Niagara Falls was another place some of the social work "visitors" were forced to see.

In the Public Health Service, Dr. Katherine Bain, who had been in the Office of the Chief in the Children's Bureau, was in charge of International in the MCH in Bureau of Community Health Services.

I remember two social workers who came here from the Philippines. Both had master's degrees from U.S. schools of social work and had been working in public health / welfare assigned to family planning. At least one of them went to Louisiana which, strangely enough, at that time had the most extensive network of family planning services in the United States. One of them wanted to talk with the official in charge of family planning in U.S. Aid for International Development (A.I.D.). I made an appointment with the Director. She was not pleased with her conference with him. The concern of these social workers was that the United States A.I.D. bought birth control pills, probably from the lowest bidder. All the pills were alike when different types of pills should have been made available to suit the medical indicators for different women. Because many women became ill from taking the pills, it discouraged other women from coming to the family planning clinics.

During this period, the American Public Health Association obtained a contract to provide handling of international personnel to provide or receive consultation on family planning. There was no social worker on their team. The nurse on their team, a former colleague of mine at the Children's Bureau, asked me for suggestions as to a social worker to provide consultation in the Philippines. She had selected Geraldine Gourley from the School of Public Health in North Carolina. Ms. Gourley was the MCH faculty social worker who had actually worked for me as a Regional Medical Social consultant and been approved by me as a faculty member in the School of Public Health, but she had no direct experience in a family planning service and no experience in the Orient. I suggested Kazuye Kumabe, D.S.W., M.P.H., formerly with the Hawaii State Health Department and then on the faculty of the Schools of Social Work and Public Health (both positions supported by federal MCH funds). She had worked directly in family planning and had extensive experience in relation to Oriental students at the university and consultation visits to the Orient. After the APHA group had suggested Geraldine Gourley and the Filipinos had refused, I was asked to give more information about Mrs. Kumabe and she

provided the consultation requested. The Philippine government later asked her to return. (See Kumabe, in press).

Some of the social workers kept in touch with us for years after they had been here and we tried to send them material which would be helpful to them. Even after I retired, some letters were forwarded to me from social workers in the Philippines.

We never knew what might be required of us in our interviews. I kept a map of Africa in my office because the names of countries changed so often and I tried to find out which languages the visitors spoke which was mainly related to the European countries to which new African nations had been colonies. We saw tall men with little round hats and floor length garments made of white cotton with little blue flowers printed on them and ladies over 6 feet tall with intricate corn rows and graduate degrees from the Sorbonne. They included many physicians, some educators, government officials and social workers who came to the office for several hours or several days. All were rotated to the different disciplines.

Looking back, I regret that medical social work was so seldom included in the visits for social workers from countries such as England. In 1978, I saw a paper written by Matilda Goldberg, a prominent social worker in England, in which she suggested the possibility of primary health care as suitable setting for social work services. Perhaps they could have thought of this sooner had we had more opportunities to talk with them.

COOPERATION WITH OFFICE OF VOCATIONAL REHABILITATION

Margaret Ryan, who was the Medical Social Work staff member in the Office of Vocational Rehabilitation, and I were friends. So far as social work was concerned, they were interested primarily in grants for social work education, although several state rehabilitation agencies did have social workers. In some plans, for example, Virginia Commonwealth University (formerly Richmond Professional Institute of the College of William and Mary) supported a group of students with stipends plus the salary of the supervisor and related costs. They had one such project at the University of California (Berkeley) School of Social Work. Mildred Alexander, an old friend of mine from Boston was the Project Supervisor. We had worked together on the staff of the Social Service Department at Beth Israel Hospital. Margaret Ryan proposed to have a workshop for social workers through the Office of Vocational Rehabilitation grant to the School of Social Work in Berkeley. She suggested that we might cooperate in this activity since we also had a grant to that School of Social Work and would be interested in the topic as it affected handicapped children. I was enthusiastic and we planned together for the workshop. Syracuse has a copy of the workshop proceedings which focused on hearing impairment. (See Godfrey, 1963).

"PERSONAL APPEALS"

In the Children's Bureau Division of Health Services, the Medical Social Work Section and Regional Medical Social Consultants had responsibility for handling all "personal appeals" correspondence. Almost every letter addressed to the President about health services for a particular child or family, and many letters addressed to members of the House or Senate, found

their way to our office. The efficient handling of this correspondence was rated very high on the scale of priorities because of the political implications. I always called the Regional Office immediately. They called the states. The states called the local authorities and contacts were made with the patients, families, or concerned citizens. We did not stand on ceremony and called the writers ourselves rather than put up with delays. We always notified relevant state MCH/CCS agencies. The resulting letter to the Senator or Representative was carefully calculated to draw attention to the state MCH/CCS agencies' ability or inability to provide needed services. The ability of a state Crippled Children's Services (CCS) agency to care for children with particular categories of disease rested upon the state plan. These letters created a lot of work for the secretaries in our office because the letters had to be in an approved format and worded very carefully. I considered these letters worth the effort because most of the people were pretty desperate and often were unable to locate resources.

Occasionally, a particular letter would trigger the development of new resources. One letter I recall was about a deaf child for whom the family could find no nursery school. The letter was sent to a state social work consultant stationed in southern California. Through her contact with this family, she discovered a wider group with the same problem which resulted in the creation of a nursery school for deaf children. Those letters were able to highlight deficiencies in the ways some state agencies publicized their services, did not reach out, set up barriers at intake, or needed to expand the scope of their programs.

I valued the opportunity to talk with the offices "on the Hill" to interpret our programs or even to compose replies they could send. It is important to remember that all of our legislators are supposed to be interested in their constituents as well as all having families and friends whose children may have medical problems. Everyone knows about the Kennedy's and mental retardation, but not many know that Hubert Humphrey had a Mongoloid grandchild or that the Children's Bureau got substantial funds for heart surgery when Eisenhower was president.

The Public Health Service preferred to set up a special clerical unit to send out form letters to answer personal appeals. This bothered me when I recalled a letter from a pregnant patient who also had cancer and was not under medical care. She made the mistake of including her sympathies for the Kennedy's loss of an infant. The White House correspondence section classified it as a letter of sympathy and did not send it to the Children's Bureau for three months.

PARENT EDUCATION

Ruth Taylor, Chief of the Nursing Section of Children's Bureau Health Services, had become very interested in parent education as developed by Allene Auerbach at Teachers College, Columbia University, New York City. Ruth referred her to me to consider the possibility of developing special parent education for the parents of handicapped children. This eventually developed with a special project grant to Al Katz at the School of Public Health, University of California at Los Angeles. Al, a social worker, was on the faculty at the School of Public Health. He had for many years been actively involved with the Hemophilia Parents' Organization and had written a book on parent groups of handicapped children. The project,

supported by a Reserve Fund B Crippled Children's Services grant was a short-term project which, unfortunately I think, had no material consequences.

HOSPITAL SOCIAL SERVICES

Many social workers, including some highly visible Deans of schools of social work, associated the Children's Bureau only with Child Welfare, which actually accounted for about one-third of federal grant-in-aid funds administered by the Children's Bureau. Many social workers in health associated the Children's Bureau with the Crippled Children's Services (CCS) program. Although Edith Baker and her staff were held in high regard, I believe that the social workers in the CCS programs were not perceived positively by social workers in more traditional positions in hospitals. Just before I came to work for the Children's Bureau, a meeting was held in Central Office in Washington, DC, planned by the Medical Social Work Section, in an attempt to bring about a better relationship between hospital social work departments and social workers in the CCS programs. This was a national meeting of representatives of hospitals and CCS programs, together with national leaders such as Harriet Bartlett.

That the CCS program was arranging and financing care in hospitals all over the country was a fact that was missed, for some reason, by hospital social workers, whose orthopedic, pediatric, and plastic surgery staffs were involved with the CCS program and were responsible for the care of children in the same hospitals.

When I was in Washington State as a beginning worker, I was assigned to handle State Health Department social work relationships with the Children's Orthopedic Hospital. Children not eligible for care at that hospital were transferred to the CCS program due to age or other reasons. The reason for this assignment was that I had been a classmate and personal friend of the Social Service Director with whom the Health Department staff seemed to have communication problems.

When I was in the Children's Bureau Regional Office in San Francisco, Esther Spencer, the Director of Social Services in the California State Health Department, asked me to accompany her to a conference with the Director of Social Service of the University of California Medical Center. The purpose was to discuss the failure of that department to provide social services to Alaska children for whom the California Health Department was acting for the Alaska CCS program by arranging care which could not be provided in Alaska. These children were far from home, without family or friends, in a strange culture with problems I well understood from my experiences at the Swedish Hospital in Seattle, and which Mrs. Spencer and I felt any social worker should understand. The Director of the Social Service Department said they had a department policy to not see any patient unless referred by a physician and these patients had not been referred. When I drew her attention to the fact that the hospital and Health Department payment schedule routinely charged for social services for all CCS patients, the Social Service Director did not believe me. A visit to the accounting department settled the problem which would be left to Mrs. Spencer to handle in the future.

When I first came to the Central Office of the Children's Bureau and reviewed all the social work positions in special projects, I found that Johns Hopkins Hospital, whose Social Work Department Director was then the same as the one mentioned above at the University of California, had several social work positions financed in special projects by the Children's Bureau. One position was filled by a worker without a master's degree, which was approved as a part of a Medical Education project in a specialized medical area where the project plan called for a social worker with a M.S.W. and experience preparing her to teach medical students. The director was not aware that several of her staff positions were financed in whole or in part by special project funds coming directly, not through state agencies, to the hospital. I informed her that we would withhold payment for any social work position not meeting the standards described in the project plan and budget, namely, a master's degree plus appropriate experience.

While some outpatient services were provided in public health departments, all in-patient and many outpatient services were provided by hospitals in the Crippled Children's Services program and in Maternal and Child Health (MCH) Services such as maternity care, premature and high-risk nurseries, Maternity and Infant Care, Children and Youth, congenital heart, hemophiliac, cystic fibrosis, etc.

I decided we would be in a better position to influence the standards of social services, for which our programs were responsible, if we had on our staff someone who could be identified as a leader in hospital social service on the basis of recent responsible experience in that field. In 1966, I was fortunate to hire Mary Jean Clark, a graduate of the University of Indiana School of Social Work (with a postmaster's year at the University of Chicago), who came directly from the position of Director of Social Service at Children's Memorial Hospital in Chicago, where she had been for 10 years, following 10 years as Director of Social Services at the Lying-In Hospital of the University of Chicago. About this time we had the Maternity and Infant Care, Children and Youth, and the beginnings of Family Planning. We had another new staff member, an obstetrician unfamiliar with public health, but able to communicate well with Mary Jean.

During her time with us, Miss Clark was able to stimulate and help grantees to produce three workshops on hospital social services. The first workshop was held in 1970, and was published under the title *Delivery of social work services in pediatric hospitals* with a grant to Children's Memorial Hospital in Chicago in 1971. (See Key, 1971). The second workshop was titled *Social work services in pediatric hospitals* and held in Indianapolis under auspices of the Social Service Department, University of Indiana Medical School in 1972. (See Lewis, 1972). The third, held at Yale-New Haven Hospital in 1974, was published in 1977 with the title *The first national workshop on the delivery of hospital social work services in obstetrics/gynecology and services to the newborn.* (See Breslin, 1977). This last included family planning.

When the National Association of Social Workers (NASW) was engaged in writing "Standards for Social Work in Health Care Settings," Elizabeth Watkins, who was Chairperson for American Public Health Association (APHA), was unable to attend many of the meetings because NASW would not fund her travel, so I sat in for her. As usual, the majority of the

members were from hospitals. The representative from the American Hospital Association (AHA) had paid staff who came from the field of child welfare with no health or hospital experience. Had it not been for several Directors of Hospital Social Work Departments such as Sinai Hospital in New York, which had an MCH hemophilia project, the group with whom I first met would have paid me no attention (particularly the representative of the AHA). In a final meeting, I told a smaller group that social workers in public health would never agree to a standard which permitted the substitution of an untrained or partially trained social worker for a fully trained person. I used as an example our refusal to fund an inadequately trained social worker as chief project worker in any of our hospital projects or in any other social work position supported by MCH/CCS funds. With Elizabeth Watkins as Chairman, the representatives of Public Health also included Stanley Kissel, Chief of Social Service Department Clinical Center, National Institutes of Health, Public Health Service. Stan and I were both involved with hospitals as well as public health. We contributed to strengthening the standards for hospitals as well as public health.

As time went on, new programs and emphases caused us to become more and more involved in hospital services. In the Maternity and Infant Care program, grant recipients were limited to Health Departments, the program had been difficult to administer in locations where Health Departments were not interested. Consequently, the Children and Youth legislation permitted grants directly to teaching hospitals. Other new programs and diagnostic groups included in both MCH and CCS increasingly involved hospitals as major components of services, i.e. cardiac surgery, intensive infant care, perinatology, etc.

CHILD AMPUTEE PROJECTS

This was a Crippled Children's Services Reserve Fund B supported activity to study ways in which child amputee services could be improved. It involved cooperation with the Veterans' Administration (VA) Engineering Services to learn how to design prosthetic appliances for children. This was based upon the VA's experience in designing prostheses for adult amputees and called for miniaturization of the adult prostheses. In addition to the research in cooperation with the VA, two other projects were funded to provide and study services to child amputees. The University of Michigan was funded to provide prosthetic services to children from other states and territories. Among other things, they produced a film showing how to provide and train child amputees in accordance with knowledge of child growth and development. The film, for example, showed why it is essential to provide a passive extremity to a partial arm as soon as a baby begins to move its arms and legs, and certainly as soon as it is begins to reach out to touch the sides of a play pen. This, of course, meant giving the child a self image of two arms as early as possible. If you readers are not acquainted with the reason for this, you should know that a child without arms will start using feet if not helped to use upper extremity appliances as early as possible. Children from many states were referred to and served by the Michigan Amputee Project.

A personal experience during a field visit to the Puerto Rico Health Department will illustrate the effects on children served by the Michigan Project. I attended a Crippled Children's Services clinic where a four year old child with no arms and one leg was seen because two

artificial arms with which she had been supplied in Michigan had just been returned after having been away for three months for repair. This child, when fitted with the repaired prostheses which she had been trained to operate by her back muscles, reached out to some small blocks on the examining table and stacked them up in an even tower. The child's mother said her daughter had been hard to feed while the arms were gone as she had learned to feed herself before they failed to function.

In the Health Division, we were very pleased with the success of this. Arthur Lesser, the Chief of the Health Division, wanted to take one of the miniaturized infant arms to show the Congressional Budget Committee our success, but he was advised not to display this beautiful, little cosmetic prosthesis because of the possible ill effects on the committee members through their seeing what resembled an amputated hand. Not only did we learn of the child development aspects, we also learned that mechanized hook hands are important and more useful than cosmetic prostheses.

The other locale of our amputee projects was the Pediatric Department of the University of California at Los Angeles Medical School. This project, unlike Michigan, took children only from a small area of a few states. While Michigan employed a social worker, UCLA laid great emphasis upon the social work component. In this project, the pediatrician and the social worker responded in person to calls from all over their area. The social worker, Wilma Gurney, responded to these calls and provided on-site services to parents with amputee infants still in the hospital and follow-up in the amputee clinics. Wilma Gurney made significant contributions to social work literature about early intervention learned through her teaching at the Medical School and her case work service to patients and families. (See Gurney, 1962b).

HIGH RISK INFANTS

When I first joined the Children's Bureau, the Medical Social Work Section was very involved in working with the Society for the Prevention of Blindness. Many premature babies had been blinded by an excess of oxygen which had been introduced into nurseries before there was sufficient knowledge of its possible ill effects.

Through the intervention of Ruth Breslin (Yale-New Haven Hospital) and other social workers involved in high risk nurseries, I was invited to a meeting at Yeshiva School of Social Work promoted and funded by the National Foundation for Infant Paralysis (NFIP). It seemed odd as this school had demonstrably no one in charge of health on its faculty. It was later learned that one of the grants staff at NFIP was married to a psychologist at Yeshiva. It also came out that the NFIP was promoting the idea that a new professional social work group be formed around this area of practice. The social workers in attendance were primarily those in leadership positions in a few outstanding teaching hospitals across the country, e.g. Yale and Stanford. The group recognized what they saw as an attempt to manipulate them and strongly expressed disapproval when asked to decide about the suggested social work organization.

Interest in high risk infants continued in the Children's Bureau and in the Public Health Service when the neonatal intensive care program was transferred to MCH. Out of funds for this,

Centers were created to provide multi-discipline training in several places in the country. Trainees included social workers. (See Breslin, 1977).

EXAMPLE OF PREPARING FOR IMPLEMENTATION OF POSSIBLE LEGISLATION

The Congress was considering a comprehensive mental health bill in which consideration was being given to inclusion of money to fund a mental health program for disturbed children through the U.S. Children's Bureau. The Children's Bureau had not sought this legislation. Dr. Lesser discussed this with me and I said I did not think we should seek it with our present staffing pattern, as our record, in my opinion, showed little success in incorporating psychiatric services into Maternal and Child Health and Crippled Children's Services programs. The one psychiatrist we had on the staff left as soon as he had completed his training analysis. He had left while I was still in San Francisco where he had become Director of the Child Guidance Clinic at Mt. Zion Hospital. I knew he had not considered the Children's Bureau a positive experience.

Within the next few days, it appeared that the Congress was moving toward inclusion of the Children's Bureau in the mental health bill. Dr. Lesser, then Deputy Chief of the Children's Bureau, held a meeting in his office including: Mildred Arnold, Chief of the Social Service Division; Martin Gula, one of her staff assigned as specialist in institutional care of children; and myself. He directed Martin and me to drop everything and spend an entire week writing up a proposed program which he could present "on the Hill" if the Children's Bureau was included when the bill passed. At the last moment, the Children's Mental Health section was transformed into some kind of survey assigned to the National Institute of Mental Health (NIMH).

MENTAL RETARDATION

In the early years of the Children's Bureau, a study had been made of retarded children. Many years later came an upsurge of interest in this group of children. Major factors having to do with this were personal/political and parental/professional. The Kennedy family included a retarded sister of the president. Hubert Humphrey had a mongoloid grandson. The National Association for Retarded Children, under the professional leadership of its director Gunnar Dybwad, had become politically significant as a pressure group nationally as well as in state and local elections. Dr. Dybwad, a social worker, was an extremely adept politician. When working with Congress to devise means of raising money for services to retarded children, he was a regular (sometimes daily) visitor to Dr. Arthur Lesser, the Chief of the Children's Bureau Division of Health Services.

The staff of the Division of Health Services spent hours in the offices and in the field. In the San Francisco Regional Office, for example, we visited state institutions for the retarded, talking with directors about their populations and problems. It became evident to us, as it did elsewhere in the country, that the screening of children for admission was inadequate. There were children who were not retarded and had not been screened properly. We found it was true that many physicians recommended institutionalization of infants, often suggesting that parents not see those children who appeared retarded. We learned that a good many orthopedists and

others without any special knowledge about retardation rejected children for care on the grounds that they "could not profit from rehabilitation." This, in fact, was written into the policies of some state Crippled Children's Services agencies. Often children were blind or hard of hearing or had diseases such as cerebral palsy.

It was finally decided that, if we received the money in the Children's Bureau, we would concentrate upon improvement of diagnostic services and professional education. We would try to prevent problems in the community. We would not attempt to support institutional care where the money would be wasted on continuation of a poor substitute for prevention.

The Children's Bureau did receive the money for mental retardation although a determined effort had been made by many mental health supporters to have it given to the National Institute of Mental Health. The decision to have it go to the Children's Bureau was heavily influenced by the parent groups who said they had seen their children put at the bottom of the waiting list by child guidance clinics and had experience with their children's physicians who had no understanding of the problems involved.

The first two things the Children's Bureau did were to work with state Crippled Children's Services agencies to remove barriers of services to retarded children and to set up demonstration diagnostic sites in several states. As I recall, some of these sites were Washington, DC, Seattle, Miami, Los Angeles, and Honolulu. Our goal was to have one in every state. We believed that one very significant factor in the professional lack of interest the parents had detected was that the problem of handling mental retardation is not really solvable by a single discipline. For this reason, all the clinics we helped to create were required to have a multi-discipline staff including at least a pediatrician, a nurse, a social worker, a nutritionist, and a psychologist, with medical consultation available from other specialists as required, i.e. neurologists, geneticists, psychiatrists, etc. All children were to be accepted with deviations from normal developmental standards due to any cause, i.e. physical, mental, social, cultural, etc. (See Lesser, 1965).

Our colleagues in service and professional education, including social work, told us we would never succeed in staffing our new mental retardation services. This proved to be untrue, perhaps because of the multi-discipline approach and the diagnostic nature of the service. Soon these clinical services became very popular professionally when, almost concurrent with the establishment of these clinics, research began to identify many different genetic diseases causing mental retardation, some of which could be prevented. Phenylketinuria, for example, could be treated by a diet requiring major social adjustments for families. (See Hall & Young, 1977).

It is interesting that many significant developments in maternal and child health had their beginnings in mental retardation. Among these are the Maternity and Infant Care Projects to prevent birth defects, the University Affiliated Child Development Mental Retardation Projects, and other grant projects in services, education and research related particularly to genetics.

As the mental retardation program was being planned, Eileen Lester, my assistant, took major responsibility. I had agreed to have her spend half time during the planning phase—really we both spent considerable time assisting Dr. Lesser. We developed a position description for a

staff specialist in mental retardation. Eileen was offered this position but refused as she preferred to remain in a social work position. The person finally employed, Rudolf Hormuth, was a social worker with a strong background in work with mental retardation parent groups. The qualifications for the position were interdisciplinary—social work, nursing or psychology. He was not attached to the medical social work unit.

The Health Division of the Children's Bureau, which would administer the grants for mental retardation diagnostic clinics and University Affiliated Facility training projects, also received money for several new positions—a clinical psychologist and a nursing specialist in mental retardation. Later, this money was also used to provide nursing, nutrition and social work specialists in professional education, all of whom had doctorates. Elizabeth Watkins was then added to the Medical Social Work Section which at that time consisted of myself, my assistant, Mary Watts, and our hospital social service consultant, Mary Jean Clark.

Many social workers asked me about the activities of the Social Service Division (Child Welfare) in the Children's Bureau with reference to mental retardation. While that division had no responsibility for administering grants arising from this legislation, they did receive one position to be devoted to child welfare services to mentally retarded children. The person in that position came from the institutional field and seemed to devote most of his interest and time to that area. We were really not on the same track, since the Health Division had determined to emphasize early intervention and prevention by setting up diagnostic clinics to keep children out of institutions, professional education programs for the same purpose, and more inclusion of the mentally retarded in Crippled Children's Services programs.

During the planning and into the time of helping grantees get started, most of our consultation and negotiation took place through multi-discipline team visits including disciplinary representatives from medicine, nursing, nutrition, psychology, and social work, plus Mr. Hormuth (our mental retardation specialist), and one of our administrative methods consultants (fiscal and business management). We often added specialized consultants on a part-time basis, such as a geneticist, a biostatistician, a psychiatrist, a pediatric neurologist, our physical or occupational therapist, and our dental consultant. The purpose of the training projects was to provide child development knowledge on an interdisciplinary basis.

Through all the years of the Children's Bureau, and through several years in the Public Health Service, every annual report and resubmission of the project plans (every five years) was reviewed by all of the multi-discipline staff who provided written reviews with recommendations for and against changes in program, staff, funding, etc. Later, in the Public Health Service, one staff member would be responsible for each project. If I, for example, were the one assigned, I would be responsible for collecting information from everyone else interested and for preparing an overall review. I would travel, money permitting, to visit my projects especially to keep in touch with developments. I would make the recommendations for the consideration of the director and would also be responsible for contributing to other staff members' project reviews for social work. The reviews of staff members were not confined to matters directly concerning their own disciplines, but of necessity included many matters of concern—e.g. salaries, research, community relationships, professional qualifications, etc.

The mental retardation legislation provided funds for construction of facilities to be administered by the Public Health Service Hospital Construction Program. As the Children's Bureau Maternal and Child Health division would be expected to provide funding for staff of these facilities, it was agreed that Children's Bureau staff would review grant applications and send a staff member on each site visit. I recall I went on visits to the University of Alabama Medical Center, Birmingham, and Einstein Medical Center in New York City.

The visit to Einstein included two or three staff of USPHS, myself from Children's Bureau, and an outside panel consisting, as I recall, of a physician, social worker, psychologist, and nurse. Although I was not there to represent social work particularly, I naturally recall more about the social worker who was from a mental retardation program in California. These visits were arranged quite formally, usually taking place in the Dean's office or adjacent conference rooms and involving the medical and high level administrative officers. (Construction grants involve much more money than service project grants—usually millions.) Because the MCH guidelines for staffing required multi-discipline professionals and were to be for training (defined by us as professional education), the top persons from various disciplines were to be interviewed at the site visit.

As was all too often the case, the medical school failed to appreciate the full significance of the requirement for participation by other disciplines. In this instance, the nurse who was included told the nurse on the outside panel in their one-on-one interview that she was not equipped to and did not want to cooperate with a project to train master's level nurses. The medical school staff expected the social work training to take place in an allied children's social service nearby rather than in the medical setting. The Dean of Yeshiva School of Social Work had been called in to represent social work. He told the whole group that they already had a training grant from the National Institute of Mental Health (even that was incorrect as I know he referred to a child welfare grant). I was assigned the psychiatry representative for lunch and he entertained me well, including telling the story of how the butter had been brought in for Eunice Shriver when she came to lunch in the faculty Kosher dining room.

The New Jersey Chapter of the National Association of Retarded Children, which included a nationally prominent and politically powerful mother of an institutionalized retarded child, requested Dr. Lesser to speak at their annual meeting. As he was already booked elsewhere and Rudolph Hormuth, our specialist in Mental Retardation was also unable to attend, I became the speaker, having to devote my Sunday morning to a meeting in Trenton. It was the only time I ever had to deliver a paper someone else had written. To make matters worse, the State Director of the Crippled Children's Services was present and became the butt of numerous complaints from parents with whom I wished I could openly agree.

MATERNITY AND INFANT CARE PROJECTS

For a long time, the staff of the Children's Bureau Division of Health Services had talked about our desire to get funding in some way for maternity care. There had been no such special funding since Emergency Maternity and Infant Care (EMIC). For some reason, maternity care did not seem to have the same political charisma as child health care. As we did whenever a new

angle came up and we thought what use we could make of it, we thought of maternity care. When mental retardation became politically fashionable, we hit the jackpot. By pointing out that the numbers of prenatal visits could be related (though for no scientifically known reason) to the outcome of pregnancy—that premature babies were known to have more neurological defects including mental retardation—we could demonstrate the logic of funding prenatal and delivery services as a very useful means of assuring correction of medical problems before another pregnancy and of providing family planning services. All Maternity and Infant Care projects provided family planning either through their own services or regularly arranged referrals to other agencies such as Planned Parenthood. The grants went first to Public Health Departments. (See Haselkorn, 1968b; Insley, 1968b; Lesser, 1968; Jackson et al., 1979; Insley, 1979a; Zemzars & Ritvo, 1979 and Watkins, 1978).

FAMILY PLANNING

Family planning legislation was passed in June, 1968. For years we had been forbidden to refer to birth control or "family planning" in any government publications. A member of the staff of the Children's Bureau Social Service Division personally kept watch to see that no such references appeared in Children's Bureau publications. Maternity and Infant Care projects, in the meantime, had been using MCH funds to provide family planning services. When Family Planning legislation first surfaced, there were two significant meetings which I recall. The first was a small gathering involving MCH and Family Planning staff in Health, Education and Welfare (HEW), together with an official representative of the Vatican—a Jesuit faculty member from Georgetown University. There were perhaps less than twenty members of this group. It was agreed that the Catholic Church would not attack HEW for providing family planning services if HEW would agree not to provide abortion services. The second meeting, I recall, included the Central Office Children's Bureau staff of the Health Division with the Children's Bureau Regional Office Medical Directors. The subject of family planning services to men was raised. I was very unpopular because I advocated services to men since they seemed to me to be a party to "family" planning. The same subject arose several years later after our transfer to the U.S. Public Health Service. At that time, we had a new and short time female pediatrician from the New York City Health Department as MCH Director in the Bureau of Community Health Services. She told me our Chief of Administrative Services (a man) had informed her that no "family planning" services for men could be financed by MCH Services. I explained why this was not true.

Much of the family planning services were financed by Maternal and Child Health, but additional funds provided for these services were handled by a special unit which dispensed Public Health Service grants for family planning. Later, the principal office for Family Planning was moved "down town" to the level of the Secretary's Office, and a woman who had been prominent in anti-abortion, anti-sex education, and the like was brought in as Director. (See Haselkorn, 1968a; Insley, 1968b and Insley, 1968c).

While we had the Office of Family Planning in the Bureau of Community Health Service, we could communicate with the pediatrician in that Office, Dr. Kitty Naing, but we were never too successful in working closely with them because all major decisions were made by the

nonmedical administrator who really ran the office. We could, of course, continue to work on family planning since many such activities were supported by Maternal and Child Health funds and operated in Maternity and Infant Care, Children and Youth, and other MCH programs and projects.

In setting up standards, including staffing patterns for family planning clinics, we attempted to adhere to the usual MCH patterns, hoping wherever feasible, to build family planning into existing comprehensive health services, and working, wherever possible, toward multi-disciplinary staffs and multiple community relationships.

In the beginning, we encountered special problems having to do with social workers, not the staff in health services, but other social work individuals and groups, about the possible use of pressure on clients of social agencies, particularly welfare departments. Some saw genocide directed at poor people, especially at poor members of minority groups. It was necessary to inform, assure, reassure and have regulations forbidding the acceptance of birth control as a factor in eligibility for any kind of social services, financial assistance, etc. We gave assistance to social work groups wishing to provide in-service education to social workers not in health services, as well as those in health. Scanning the list of social workers invited to attend the workshop on family planning held at Adelphi School of Social Work, one can see that the group included a considerable number from social agencies and welfare departments. In addition to three national or regional social work workshops devoted entirely to family planning, there was a good deal of content included in other MCH social work workshops, such as the one at Yale on Hospital Services in OB-GYN. (See Gorman, 1970, 1977; Haselkorn, 1968a).

I gave a paper at a workshop on Family Planning at Adelphi School of Social Work and another at the annual meeting of the Catholic Hospital Association. (See Insley, 1968a & Insley, 1968c). I spent considerable time on that subject in the course of my work related to social work in other countries. I recall sending several people to observe in Louisiana the highly developed family planning clinics all over the state. Family planning was also the subject when I recommended Mrs. Kumabe to provide the consultation to the Philippines. The Medical Social Work Section produced a publication—an annotated list on family planning. (See Watts, 1968).

I served on the Ambulatory Care/Family Planning Committee of the American Public Health Association. This was a committee of the Maternal and Child Health (MCH) section of the American Public Health Association (APHA) which met several times a year, mostly in D.C. Once we met in San Juan, Puerto Rico, where we were royally treated by the MCH and Family Planning staff. The Chairman was Dr. Ed Gold, a prominent member of ACOG (Academy of Obstetrics and Gynecology), formerly with Maternity and Infant Care in New York City, then with the School of Public Health in Berkeley, and finally head of OB-GYN at Rhode Island Medical School, and someone with whom I always enjoyed working. On the committee were a Health Educator from the U.S. Public Health Service (who was Director of Family Planning), a nutritionist from MCH, a lawyer/lobbyist from Planned Parenthood, two or three nurse midwives, and off and on a couple of other physicians. There was one member who was personally opposed to birth control for religious reasons. The lawyer was a far out feminist who opposed the committees' desire to recommend the addition of any services not strictly related to

the prevention of pregnancy, even though such additions would be offered but not required. What the committee wanted the clinics to offer would include such things as PAP tests, diabetic screening, nutrition counseling, smoking counseling (interaction of birth control pills with tobacco), and social services. The lawyer argued that women only wanted birth control advice and it would be insulting to them as women to offer any other services. She was, of course, alone in her objections since experience had shown that these preventive services had been highly successful so far with family planning clinics finding cases of diabetes, cancer, etc. We had some interesting discussions about the desirability of hiring administrative staff to permit nurses to devote their time to professional duties, which point of view surprised the physicians.

CHILDREN AND YOUTH PROJECTS

After we had succeeded in establishing programs to provide maternity and infant care and family planning, we set out to try to obtain funds for another segment of MCH concern, health services for preschool and school age children. It was clear to the Children's Bureau that school health services for which some states were spending tremendous sums of money (millions) were, in most cases, of little or no value. Children were given screening tests and physical examinations, especially eye, ear and dental exams on annual or biannual schedules. Reports of these exams were sent to parents. If parents could not or would not pay for implementation of the recommended health services, nothing was accomplished. I think it was in 1963 or 1964 that Arthur Lesser wrote a pamphlet to be published by the Children's Bureau about this problem. Since the chances were slight of influencing Congress for the intended year of its issuance, it was deliberately held back one year pending a more favorable political climate. In 1965, the Congress passed the legislation which became known as the Children and Youth projects, which were to provide comprehensive medical care to children and youth.

Special projects were provided for 75% of federal support to state and local health departments, schools of medicine with participation of schools of dentistry, and to teaching hospitals affiliated with such schools. Federal regulation defined medical care to include medical and dental screening, prevention services, treatment, correction of defects, after care, and treatment of emotional disorders. It was required that these health services be coordinated with other state and local health, welfare and education programs.

All of these projects included social workers on their staffs along with physicians, nurses, nutritionists, dentists, and auxiliary personnel such as speech and hearing specialists, psychiatrists, psychologists and whatever medical specialists were needed for particular situations. The primary social workers in these projects were required to have master's degrees in social work. In many instances, social work assistants, including neighborhood representatives, assisted the professional social workers, particularly in respect to community outreach.

We were able to influence the inclusion of content about social work in Children and Youth projects in many of the MCH sponsored social work workshops for social workers later. (See Hall & St. Denis, 1972, 1975; Jackson, 1978 and Stein et al., 1978). In 1993, Velma Anderson, the social worker who received the American Public Health Association's Public

Health Social Worker of the Year award, planned the award session at the annual meeting. She arranged for a presentation by the Medical Director of the Children and Youth project where she had been chief social worker, along with a social work staff member who worked for her there, before their project in East Los Angeles was eliminated by loss of funding. She had the session taped.

I was able to exploit an unusual opportunity offered by the Children and Youth (C & Y) projects never before possible in any Children's Bureau supported health services. The C & Y project professionals were required to establish certain census tracks for their operations, and to report in advance the incidence and prevalence of certain demographic data such as infant and maternal mortality, births out-of-wedlock, teenage pregnancy, juvenile delinquency, etc. The Children's Bureau had a contract with the Minnesota Systems Review company to keep track of the Children and Youth projects. These data included information on the services delivered, including social work services. A not very experienced social worker was employed on their staff, but we arranged for her to be given guidance by Florence Stein, Director of Social Service at Roosevelt Hospital in New York where there was a Children and Youth project. The material published by Children's Bureau in respect to the C & Y data from Minnesota Systems included social work services. Through the Maternal and Child Health Social Work Training Grant to the University of Pittsburgh School of Public Health, an invitational workshop was held which was really stimulated by the Children and Youth data and was widely distributed under the title *Minimum review criteria for professional social work practice* to suggest means to account for social work services. (See Stein et al., 1978).

To my way of thinking, one of the most important, if not the most important lesson from the Children and Youth projects was that each year the projects cost less per patient than the year before. At the beginning, hospital costs were high because children had not received preventive services. As the preventive services were provided in subsequent years, the costs per patient were reduced. It is interesting to observe the fact that these preventive services were comprehensive services which included not only medicine and social work, but the services of all other professional disciplines in health services.

The Children and Youth projects were eventually abolished by the failure of the federal and state governments to provide necessary financing. It is my opinion that the program which demonstrated cost effectiveness should not have been dropped and should have been used as a model for the use of preventive services nationally.

CHILD ABUSE

This problem began to emerge as a national concern while I was still in the Children's Bureau and became more of a concern just as we were moving over to the Public Health Service where the Medical Social Work Section carried almost sole responsibility. It appeared that no one else was particularly interested. Mary Jean Clark was much interested and spent considerable time on the subject. It was interesting to me that the agency chose this time to try to dispense with her services. Through a contract with the Public Health Social Work Training Project at the University of Pittsburgh, an interdisciplinary meeting was held with leaders in the child abuse

field (pediatrics, nursing, nutrition, social work, psychiatry, and law). On the basis of this meeting, a publication was prepared. (See University of Pittsburgh, Graduate School of Public Health, no date). This publication has been revised and new publications have followed. I and my successor, Juanita Evans, have carried responsibility as official representatives of the Public Health Service on matters pertaining to child abuse and neglect. (See Fassett, 1976).

SUDDEN INFANT DEATH SYNDROME

Interest in the problem of Sudden Infant Death Syndrome (SIDS) arose at a time of administrative crisis in Maternal and Child Health (MCH) due to a reorganization and a new Medical Director from outside federal service. It lasted only a few months, but the usual team operations were disrupted. The person appointed to lead on this problem was a nurse who had recently come to our Nursing Section from a Regional Office and who had then decided to leave that section and accept an administrative, non-nursing job.

Within the Program Services Branch of MCH in which Social Work was then located, the Branch Chief, a pediatrician, was very much interested in Sudden Infant Death Syndrome, and was the only other person in Program Services Branch interested in SIDS besides the Medical Social Work Section. She was British and had contact with an outstanding British physician, the Chief Pathologist in Sheffield, who had researched and written about the SIDS problem. In his principal study, he had provided nursing visits to new mothers almost immediately after their discharge from the hospital, and transportation to bring their infants to the hospital for follow-up. These services to new mothers were given without a request from the mothers for either nursing visits or transportation.

Social work visits were also made which provided, as he put it, "chats with the mums," which frequently revealed facts about the mothers' histories which included social pathology heretofore unknown. A case in point, which he cited, was the social work "chat" which led to the finding that a new mother had formerly been a baby sitter accused of suffocating an infant.

A control group was offered services but not followed up intensively unless they were specifically requested. The outcome of this research project revealed a significantly higher incidence of child abuse in the control group. The pediatrician in our office had arranged for a federal grant to bring the physician from Sheffield to the United States to visit and provide consultation. He spent some time with Public Health Service staff and our invited professional guests. The Medical Social Work Section was very favorably impressed.

From the outset, there were serious problems regarding federal help for SIDS programs, primarily due to the fact that there were two competing parent groups. I was asked to give some consultation to the staff member responsible for SIDS since she had no previous experience with parent groups. Another difficulty within MCH arose from the fact that this staff member, because of her own convictions or pressure from parents' groups, was unalterably opposed to the thought that there could be <u>any</u> association of SIDS and child abuse/neglect. Unlike most other program areas, SIDS activities were not well coordinated and control remained primarily in the hands of one person.

It is interesting that a pediatrician at the Children's Orthopedic Hospital in Seattle, who had been chairman of one of the most powerful parent's groups and an aggressive spokesman nationally for the separation of SIDS from child abuse/neglect, ended up in recent years with a published paper linking the two.

DOMESTIC VIOLENCE

When the problem of domestic violence began to emerge as a national concern, the Department of Health, Education and Welfare (DHEW) created an office designated as the lead for domestic violence. To the best of my recollection, it was located in the Children's Bureau after Health Services had been transferred from Children's Bureau to Public Health Service. In the few meetings to which I was invited to represent the Public Health Service, it appeared that the staff who were new to government were more interested in discussing general feminist concerns (including assurance that no men would be hired) than planning any specific services or actions to prevent the problem of domestic violence. I collected some information on the services available, as well as characteristics of the population of shelters. I had several conferences with the person appointed by Public Health Service who, I think, had more significant responsibilities to take up her time (I represented the Bureau of Community Health Services). During the time I was in the Public Health Service, nothing really came of any of this interest. I, and Juanita Evans after me, carried responsibility for this area for the Bureau of Community Health Services and Juanita, later, for the Public Health Service as well.

EQUAL EMPLOYMENT OPPORTUNITY AND MINORITY/ETHNIC ISSUES

At the time I joined the Public Health Service, concerns were arising about equal employment opportunity, affirmative action and all kinds of issues related to race and ethnicity. Concerns about women came later. All staff were supposed to be interested and committed to Equal Employment Opportunity (EEO). Some were committed, some were not, and many did not seem to really care. For myself, I had been trying to practice this as witness my attempt to get Ruth Taylor (an African American woman) to replace me in San Francisco, to select Lucile Ish (an African American woman) for the Regional Office in Chicago, to select Tom Tucker (a white male) for Charlottesville, to replace Lucile with Barbara Alexander (an African American woman), and to accomplish the appointment of Ethel Davenport (an African American woman) in Atlanta and also another African American, Louis Doss (Martin) in Chicago.

We had a biostatistician, Otis Turner, who was very talented in his field, an African American gentleman, and a gentle man. He was assigned as Bureau of Community Health Services (BCHS) Equal Employment Opportunity Officer. He was quite different from the people who then headed the Public Health Service EEO Office whose staff was, as I recall, all African American and all male. At that time, they planned a retreat to discuss EEO with the leadership of a multiracial contractor. "Multiracial" meant, in this instance, both African American and white. Attendance would be mandatory and rooms would be shared without regard for choice of roommates. As the plan developed, it became evident that the largest groups in attendance would be staff of the Public Health Service Equal Employment Opportunity Office

plus professional and clerical staff of BCHS. I complained to Otis, our only African American professional, that I thought we should reach out to include more professional African Americans including at least one physician, nurse, social worker, psychologist, nutritionist, etc., to match our staff. Otis agreed with me but could not obtain permission from E.E.O. to do this. With his concurrence, I arranged to have Lucile Ish, former Regional Medical Social Consultant in Chicago and later in the Regional Director's Office representing minority affairs, attend our retreat at the expense of the Chicago Regional Office. When I learned that Arthur Lesser, Director of MCH, would have a private room, I also arranged that Lucile and I would each have a private room. The meeting was really a shambles ending up with the contractor group disagreeing on strategies along their racial lines.

When I returned from this meeting, I checked with the E.E.O. Office about a request I had made to find a secretary from a minority group. The only name they sent was that of an Hispanic lady of advanced years who would only be available to the Medical Social Work Section on a part-time basis since she had permission to take several sociology courses dealing with delinquency. Through my own efforts, I then located a capable African American secretary who had been reduced a couple of grades upon arriving at the Public Health Service because she wanted to work near where she lived in suburban Maryland (her husband was on the faculty of the University of Maryland Dental School). With great difficulty in dealing with personnel, and finally intervention at the Health, Education and Welfare departmental level, I was finally able to employ her at one grade higher than she had been receiving (which also was one grade lower than she received before coming to the Public Health Service).

The Public Health Service (PHS) had appointed a young African American physician who had just completed his first year internship in a PHS hospital as Director of Family Planning. He was obviously not professionally acceptable to the obstetricians and gynecologists whose cooperation was necessary to the program. He was sent on an international health assignment and replaced by an African American female health educator.

Soon after this, Mattie Wright, an African American woman who had been Director of the Crittendon Center in Chicago, was appointed Director of E.E.O. in the Office of the Assistant Secretary for Health. She soon replaced the African American male Public Health Service Commissioned Officer who had been the Director of EEO for the Public Health Service nationally. Because of our prior relationship as grantor and grantee of MCH funds in the program for teen age pregnant girls, and my greater knowledge of the federal agencies, she and I communicated frequently. At one point, the Public Health Service decided to appoint a white male as agency representative to a Health, Education and Welfare interagency task force on EEO. Mattie objected and I was appointed as Public Health Service representative. This did not sit well with my immediate superior, the former Chief of Nutrition Services.

A review of monographs resulting from MCH supported activities shows numerous papers on ethnic concerns in Maternal and Child Health / Crippled Children's Services (MCH/CCS) social work services. One, which was devoted entirely to this subject, was a MCH grant to the Schools of Public Health and Social Work at University of North Carolina to hold a national meeting called Removing Cultural and Ethnic Barriers to Health Care. (See Watkins &

Johnson, 1979). The theme of the Annual Meeting of Medical Social Consultants was Health Care Delivery to Meet Changing Needs of the American Family (see St. Denis & Doss, 1977) at which there were special presentations covering African American, Appalachian, Hispanic American and Native American families (1977). The Social Work Training Project in Hawaii produced: *Ethnocultural factors in social work and health care: A selected annotated bibliography*. (See Kumabe & Bickerton, 1982). Kaz Kumabe, the senior author of this publication, had long been helpful to me in connection with this subject. She had given a paper at the North Carolina workshop previously mentioned. When the Chief Social Worker in the Virginia State Health Department called me for help in explaining family planning methods to new immigrants from the Far East, I was able to call on Kaz to provide them with copies of pamphlets used in Hawaii Family Planning in Vietnamese language with Vietnamese typewriters.

When the National Health Service Corps of the Public Health Service began to accept some social workers (due to efforts of Medical Social Work, particularly of Juanita Evans), we paid special attention to the inclusion of minority and women applicants, especially those of American Indians for whom special preference was included in the program guidelines.

During this same period, MCH/CCS began to require that all training projects must report on the numbers of minority students receiving stipends. MCH/CCS projects were intended to use their stipends to prepare students for leadership. We in Medical Social Work made it clear that minority status was not sufficient but that students chosen for stipend support must also have potential for professional leadership.

The above examples relate particularly to events in the Public Health Service. As mentioned at the beginning of this section, I had already practiced EEO in the Children's Bureau by hiring the first African American social worker in the Children's Bureau Regional Offices and the first male social worker in the Children's Bureau Regional Offices. The part of this document devoted to the staff of the Children's Bureau and Public Health Service Medical Social Work will show the backgrounds of African American Regional Social Workers whom I selected. My selection of Juanita Evans to follow me as Chief Social Worker, the position to which I had devoted the best part of my professional life, could in no way have been influenced by her ethnicity but only by her outstanding qualifications to succeed me, although it had been a real advantage in getting Howard University to accept her as Chief Social Worker for the Georgetown University Mental Retardation Project.

The Regional Medical Director of Maternal and Child Health (MCH) in Seattle, an African American obstetrician who had no Medical Social Consultant assigned to his office, asked me to come to Seattle to make some visits with him—one to the University Affiliated Mental Retardation Training Project at the Medical School in Seattle and one to the Oregon State Health Department in Portland.

The problem presented by the MCH Division of the Oregon State Department of Health was as follows. The Director of the MCH Division wished to hire a Medical Social Consultant to function in relation to the entire state MCH program. There was a medical social work position

in the federally assisted Maternity and Infant Care Project in Portland but no social work position existed on the state level except in this Maternity and Infant Care Project hospital. The Family Planning Program in the state was seen as being in urgent need to establish such a position. The problem, however, was that the entire state was under a freeze which prohibited establishing new positions and filling existing positions which were vacant. The MCH Director was requesting us to help him justify and fill a medical social consultant position.

On the first morning of the visit, the MCH Director informed me that the Medical Social Worker in the Maternity and Infant Project had just had surgery and had only been discharged from the hospital a few days before. She had, however, offered to come in to the office to see me. It appeared from what he said that she really wanted to see me. The Regional Medical director was delayed so I went ahead and met with the social worker. She was an experienced, middle-aged, white woman who had come from out-of-state to take this position. After a brief period of getting acquainted, she informed me that she had a problem she would like to discuss but felt very reluctant to do so and actually felt she could not reveal it unless I agreed not to tell anyone else. As the problem was clearly related to the Health Department program, I told her I could not agree to conceal what she told me. After all, I told her, there would be no possible point in her telling me since I would be in no position to act or stimulate action to correct the problem. She then revealed that the hospital, which was in a neighborhood which had become a Black ghetto, was sponsored by the Lutheran Church hospital and had a good many Roman Catholic obstetricians on its staff. These physicians professed disapproval of abortions but in practice they recommended sterilization for African American women, but not often for white women.

At the close of our conference the social worker and I met with the Regional Medical Director (RMD) and the Maternal and Child Health Director, a white male pediatrician. I assisted the social worker to state the problem she had described to me. The MCH Director turned to the RMD and asked if he had known of this. The RMD admitted that he had known. When we went to lunch, social worker not included, the MCH director asked the RMD why he had never brought this problem up if he had known about it. I answered him by saying, "You really must know why."

The three of us then went to the State Office Building a few blocks away to meet with the State Health Officer. There the MCH Director was surprised to learn that the State Health Officer had formerly been a RMD for MCH in the Chicago Regional Office when I was in the Children's Bureau Central Office. He had arranged to have the Budget Director meet with us to discuss the justification for a social work position at the state level in MCH. I had informed myself of the lifetime cost of a newborn retarded infant admitted into their state institution, and using mental retardation and family planning as examples, I was able to convince the Budget Director of the cost effectiveness of social work.

Before we left the MCH Director's office he had invited the RMD and me to dinner at his home. When we were in the State Office, the Health Officer had informed us he was planning to invite us to his house since I was a former colleague. The MCH Director then felt it incumbent upon him to invite the State Health Officer and his wife to come to his house.

When the RMD and I arrived at the MCH Director's house, there was another couple there along with the State Health Officer and his wife, the RMD and me. The other young man was introduced as a social worker. After the drinks had been served and some conversation about the weather, etc., the RMD said he wondered if it wasn't about time to come out with the purpose of our gathering. It all came out then that the MCH Director wanted to hire this young man who had worked with him in a previous State Health Department.

The next night the RMD invited a young African American, who was the Assistant Hospital Administrator at the hospital where the Maternity and Infant Care project was, to have dinner with us at our hotel. He told me the hospital had a vacancy on its social work staff and that a young African American social worker had been referred by the Graduate School of Social Work She was told, however, that the position was filled when it was not. I informed the School of Social Work. The RMD, who had to leave before I did in the morning, came by my room briefly at the door to thank me before he left.

The State Health Department received permission to hire a social worker at state level for Maternal and Child Health.

EXAMPLES OF MEETINGS ATTENDED

APHA Maternal and Child Health Section

In PHS I attended a meeting sponsored by APHA Maternal and Child Health Section to discuss professional education for Maternal and Child Health in Graduate Schools of Public Health. A publication resulted that was titled *Professional education for maternal and child health* (see American Public Health Association, 1963) which is an APHA project generated document.

I was invited by Dr. Sam Wishik, a pediatrician and faculty member at Pittsburgh School of Public Health, to be on a panel for the Maternal and Child Health Section APHA at the annual meeting. As I recall, the subject had to do with pediatric services to handicapped children.

Pennsylvania Public Health Department

I was invited to this annual meeting in State College by Thomas Tucker, the Chief Social Worker in the Pennsylvania State Health Department. I no longer have either a copy of a paper or my notes for this presentation, the subject of which was consultation. (Tom Tucker later was hired by me for our Regional Office in Charlottesville, R.O. III).

Virginia State Public Health Department

I was invited to this annual meeting in Roanoke by the Chief Social Worker in the State Health Department. His name seems to have escaped me probably because he was not very effective and was soon replaced.

National Catholic Hospital Association, Philadelphia

I presented " Program developments in family planning" at an annual meeting of the National Catholic Hospital Association (NCHA) held in Philadelphia. The original of this paper was taken by the press room. The other typed and federally cleared copies of this unpublished paper are in the Schlesinger and Syracuse Bird Libraries. (See Insley, 1968c). This paper was presented in the first year after passage of the Family Planning Legislation providing program and funds to the Children's Bureau (Maternal and Child Health). The meeting was well attended, pretty well filling a large banquet room. A nun from a hospital social service in a St. Louis Catholic Hospital presided. The other presenter at this session was a Catholic priest. While my speech described legislation and federal programs for "family planning," he spoke of "birth control" in fairly explicit (for that time) and extremely positive terms. The audience was very vocal—nuns, hospital administrators, nurses, proponents and opponents of rhythm and other contraceptive methods. The Social Work Consultant of the NCHA invited me to speak.

Pittsburgh

The Pittsburgh Montefiore Hospital was a major grantee for the U.S. Public Health Service Chronic Disease Program for training of health and hospital personnel on an ongoing basis. Children's Bureau provided funds there under a grant to develop and support a home care program for children. I went on this occasion, as did pediatrician Dr. Pauline Stitt, to speak about home care of children in one of this Public Health Service project's training programs.

Beth Israel Hospital, Boston

I attended an anniversary of the hospital which opened in 1928. I spoke on home care though I could not locate a copy of the paper I gave. Cecil Sheps was now the Hospital Director and Bee Philips was Director of Social Service.

NASW, Pittsburgh

A copy of the newsletter containing an article and picture related to this event is in the Syracuse University Library. I spoke at their annual meeting.

National Conference of Social Work, Los Angeles

I was invited to preside at one of several sessions devoted to health services for the elderly and chronically ill which was suggested by Mrs. Lucile Smith who was on the medical social work staff of the U.S. Bureau of Public Assistance.

Maryland Chapter, NASW

The Sixth Fall Conference was held in November of 1979 entitled "Issues in the Care and Treatment of Children" in honor of the Year of the Child. I gave the keynote address, "Maternal and Child Health: Planning Services for Prevention and Treatment." (See Insley, 1979b).

North Carolina Consultation Institute

I was invited by the Public Health Service to become a member of a team to respond to a request for training in consultation by the State Health Department. The other members of the team, all from the U.S. Public Health Service, consisted of a public health nurse who had organized the institute; a psychiatrist (analyst) who was the Regional Mental Health Representative in Kansas City (Dr. Maddox, who had recently had a paper on consultation published in the APHA Journal); and a sanitary engineer. The group assembled consisted of all the professional staff of the State Health Department. These included the State Health Officer with his guest, Dr. Applewhite, (who was said to have been the first local health officer in the U.S.), all of the public health nursing consultants, all of the sanitarians, and others such as nutritionist, health educator, social worker, etc.

This institute, while all was friendly socially, was not too successful in my view. The large group of sanitarians related well to their disciplinary representative who really did not involve himself in the details of the consultation process with which the other leaders were concerned. It was soon obvious that the nurses were becoming more and more defensive as Dr. Maddox propounded his methods and theories. It was clear to me that he had never worked in a department of public health (many mental health authorities in the states were not in health departments). Seated on the platform during the discussion between him and the audience after his speech, I was unable to break into what was a serious problem in communication. During the following break ,I spoke with the Director of Public Health Nursing and learned the nature of the problem. For example, Dr. Maddox insisted that supervision and consultation were incompatible. I learned that their job descriptions as State Public Health Nursing Consultants called for supervision of the nurses in the local health departments. None of the State nurses had felt comfortable to stand up and tell Dr. Maddox this so that it could be discussed.

Maternity Center, NY

A number of health professionals, mostly nurses, nurse midwives and some physicians, were interested in trying to reorganize maternity clinics to achieve better quality and efficiency through provision of service according to the needs of individual patients. It was envisioned that

each new registrant would be seen by each member of a multi-disciplinary team—obstetrician, nurse, social worker and nutritionist. A plan would then be made for the prenatal period which of course would be subject to change if the patient's situation changed. According to each patient's needs, one person on the team would be assigned to see the patient and refer to the others if needed. Those with complications, for example, might see the physician on each visit. Those with a major social problem or nutritional problem might see the social worker or nutritionist, and the nurse midwife or physician every other visit.

A two day meeting was held at the Maternity Center in New York City. The Chiefs of OB/GYN from all the major hospitals in New York City were invited and attended. The group also included nurse midwives and a few others such as an OB/GYN MD Hospital Director from Pittsburgh, plus a couple of nutritionists and social workers. The principal meeting was confined to the Chiefs of OB/GYN plus Dr. Arthur Lesser, pediatrician (my boss), who was the chairman of this meeting; the OB/GYN Hospital administrator (from Magee in Pittsburgh as I recall), one nurse resource person and myself. The discussion was lively but the progress was nil. Only one Chief, from Lincoln Hospital, as I recall, saw merit in any change. Someone (Dr. Hellman, I think) really summarized the meeting's conclusions when he said there are so many examining rooms, so many residents, so many patients, so much time, and that is it—no change possible. Some statements were also made by physicians to the effect that the nurses and social workers should work directly for the OB/GYN and not for their separate departments.

"Princeton Institute" Public Health and Social Work

This was a project supported by the National Institute of Mental Health (NIMH) which involved a grant to the Council on Social Work Education (CSWE). Grace White was the project director. There was a book published describing this project. It is usually referred to as the "Princeton Institute." I no longer have a copy of the book but I feel sure there are some available in the libraries of schools of social work.

Some other social workers in public health and I did not feel that this conference met our expectations. The presenters were nearly all physicians and their presentations were okay as such. What was missing was input by social workers to show how the public health principles are applicable to social work practice. Perhaps it would have been better to have had a program director who had some experience in public health.

Florida Mental Health Consultation Workshop

Joanna Gorman, then Chief Social Worker in the Mental Health Program, Florida State Health Department, invited me to take part in an Institute for Social Workers in the Child Guidance Clinics in Florida. (There are many of these spread across the state.) There would be three presenters—a social worker from the Texas State program, a psychiatrist (analyst) from the hills of South Carolina or Tennessee, and me. On the first day we would each present material on consultation, one at a time, followed by some discussion among us. On the second day, three social workers from the State Child Guidance would present their reactions to our presentations.

The psychiatrist proved to be a great asset socially, as well as professionally, since he brought along his banjo. It was an interesting cultural experience for me as the group gathered informally in the evening to sing songs in the Southern style such as the "Church in the Wildwood" and "The Old Rugged Cross"—distinctly not acceptable to fellow guests in the hotel.

This was the first time I had met Joanna Gorman with whom I was to share many good working relationships as she moved to the MCH supported social work faculty position at the School of Public Health in Berkeley, and to the Pittsburgh School of Public Health for her doctorate, during all of which she was often in leadership positions in public health social work. She died while on the faculty of the School of Social Work in Tallahassee, Florida.

NASW Public Health Social Work

In response to requests from social workers in particular fields of practice, the NASW set up a project to enable the practitioners in various fields of practice to justify their identification as "fields of social work practice." A copy of the report of the committee charged with the responsibility to justify public health as a "field of practice" for social work is available in the Syracuse University library (NASW, 1963, "Report on Public Health as a Field of Practice"). It resulted in a report, one section of which was composed by each member of the committee. I believe I wrote the section directed to "compatibility with social work" in the outline required by NASW for the Committee Reports.

State And Territorial Health Officers Association (ASTHO)

I attended meetings of the State and Territorial Health Officers Association to represent the Children's Bureau. As there were not enough staff in our Division of Health Services for more than one person to cover all the concurrent meetings, each one of us would be assigned to a different group. I remember the last one I attended had to do with what was called "Home Care." When I contributed the idea that home care should include a variety of disciplines including a physician, I made no headway. It turned out that the meeting was dominated by public health nurses whose real interest was in securing payment for nursing visits from Medicare. I was right in being concerned about this although there was nothing I could do but report the situation as I saw it. In retrospect, I blame this meeting—what led up to it and what occurred as a result—for the subsequent drop over the years in home visiting for prenatal, postpartum, and infant health visits by public health nurses, under both public and private auspices.

I found it very interesting and useful to attend the general meetings of the ASTHO as a means of knowing what was going on nationally. In the Public Health Service, I had no opportunity to attend.

University of Pittsburgh, School of Social Work

With a grant from the National Association of Social Workers, carrying on from a project formerly supported by the American Association of Medical Social Workers, Celia Moss Hailperin planned a workshop for social workers in health and medical care, and social work

education. I was invited to give a paper on consultation. This paper was subsequently incorporated into a publication called *Concepts of Mental Health and Consultation: Their Application in Public Health Social Work* by Gerald Caplan. This publication was first issued by the Children's Bureau and later reissued by the Public Health Service. It was a very popular publication as it was reprinted three times.

Adelphi

I wrote and delivered a paper, "Some Implications of Recent Legislation for Social Work," first printed by the Adelphi University School of Social Work in 1966, and reprinted by the U.S. Children's Bureau in 1968. The conference , Mothers at Risk, at which this was given, was supported by Children's Bureau MCH funds as a means of education about maternal and infant care (M & I).

As reported in the volume, *Family Planning: The Role of Social Work*, I gave a paper entitled "Patterns of Program Development in Family Planning." The conference, convened by Adelphi School of Social Work in 1968, was also supported by Maternal and Child Health funds from the U.S. Children's Bureau. The meeting included social workers from various fields of practice since the aim was to inform and gain the cooperation of a wide group of social workers who did or should become involved in family planning.

Berkeley

At a workshop for social workers in the West, the MCH supported Social Work Training Project at the School of Social Work, University of California, Berkeley, put on a workshop on prevention. Bob Jackson, then Project Director, asked me to give a paper. The paper, "Prevention and Public Health Social Work," appears in the publication resulting from this meeting, *Social Factors in Prevention*. (See Jackson et al., 1979).

I was invited to prepare the material on "Maternal and Child Health" for the National Association of Social Workers' publication, *Encyclopedia of Social Work*, for 1971 and 1977. (See Insley, 1971 & 1977).

SOCIAL WORK EDUCATION AND SOCIAL WORK TRAINING PROJECTS

Originally, support for social work education came only from use of federal funds to the states (grants-in-aid) whereby the states could use Maternal and Child Health (MCH) and Crippled Children's Services (CCS) funds to send students (those who were expected to come to work for state MCH and CCS programs) and staff members to graduate school. Since Children's Bureau standards called for a year of hospital experience before employment by the state, the Children's Bureau Medical Social Work Section often helped state agencies to place students or staff without this qualification in hospitals for some exposure to hospital social service. The only documented report of this still extant is the one Roberta Peay and I wrote on her internship at the Beth Israel Hospital where the Children's Bureau arranged to place her for a year following her master's degree at Columbia University School of Social Work. The South Carolina State Health

Department paid for her graduate education and the salary she would have received in the Health Department during her stay at Beth Israel.

Later when I was in Central Office, I recall helping the Maternal and Child Health Director in South Carolina to decide to pay to send their Chief Social Worker to the University of Pittsburgh School of Public Health. I recall explaining that we would not approve the School of Public Health using project stipend fees from MCH Reserve Fund B to pay for the education of a social worker already on a state staff. Both of these instances paid off as the intern sent to Beth Israel ended up her career as Chief Social Worker for the Heart and Lung Institute and Child Development (Genetics) at the National Institutes of Health; the Chief Social Worker for the State Health Department returned to do an excellent job in furthering the development of the social services there so effectively that South Carolina soon had the lead in social work staff in the nation, not only in numbers but in coverage of all Health Department programs.

Without the fact that Edith Baker had firmly stood for a minimum educational standard of a master's degree from an accredited school of social work for state staff in MCH and CCS, the use of federal funds for this was not easy to justify. The requirement of one year of supervised hospital experience had been recommended by advisors such as Harriet Bartlett and was based upon the fact that the social work staff in most public health agencies at that time were ill equipped and too busy to provide supervision to workers just out of school. I eliminated this standard because of developments in social work practice in public health.

Edith Baker's consummate skill in negotiating made expenditures of federal funds for education of social workers possible. The Children's Bureau had a policy of permitting payment for training for specialized education only; that is, no basic professional education could be financed. No funds could be paid for a student to obtain a degree in medicine or nursing—only post doctoral for physicians (for example, pediatric neurology). At that time, there were no accredited bachelor level social work degrees so Edith decided to equate the first year of graduate school as basic and the second as specialized in medical social work. This opened up the possibility of change which I later developed into a policy whereby we would allow payment for the entire two years of social work education for a Master's Degree. This was based upon my finding that students could end up with an impossible double commitment if any other field had financed the first year.

Beginning about 1947, when the first social work education projects were funded by Reserve B money to the Louisiana Health Department with Tulane School of Social Work, and the Illinois CCS with the School of Social Service Administration at the University of Chicago, it has been possible to provide stipends without commitment to any state but only to MCH/CCS in public health. Stipends have been a part of all MCH supported projects in schools of social work through direct grants to these schools, through association with grants to University Affiliated Training projects, and to MCH projects in schools of public health. These still remain in the project plans. Budgeted provisions for stipends enabled social work students to gain master's and doctoral degrees in social work, public health, or in combination with public health master's or doctoral degrees.

Almost immediately after Tulane and Chicago were funded, Edith Baker began to fund them for short term training of social workers in MCH/CCS on a national or regional basis. Several times in Chicago, as in 1948, the training was directed to faculty members providing specialized content on health in schools of social work. In Boston, Miss Baker arranged a seminar for social work faculty on child development sponsored by the staff of the Harvard School of Public Health and its MCH Training Project. A later institute, planned by the Harvard School of Public Health Social Workers and some Boston practitioners, was sponsored by the Tulane Social Work Training project. Most of the short term training projects for social workers have been sponsored through existing grants to MCH Social Work Training projects at schools of social work, schools of public health or University Affiliated Training (UAF) projects or hospitals. These short term training projects continue today. There are over fifty publications that have resulted from these projects and they are available in the Virginia Insley Collection at the Syracuse University Library.

In addition to the contribution to schools of social work through attendance of faculty at MCH sponsored meetings designed especially for them, faculty members have been included in most of the regional and national social work meetings held by MCH projects. In some instances, projects have planned special meetings to design curriculum guides for social work schools in relation to special areas of emphasis, e.g. the University Affiliated Training Projects at the medical schools in Miami and Kansas City. Social workers in MCH projects, state and local health departments, and faculty in graduate schools were also included in regional and bi-regional workshops open to all disciplines. (See Appel, 1978).

Social workers on the faculties of MCH projects and through the international services of the children's bureau and the Public health service provide orientation for international visitors of many disciplines, and are responsible for planning orientation, observation and accredited training in school of social work and schools of public health. No direct grants were made with MCH/CCS funds for training of international students, because U.S. A.I.D. does this.

When I first came to Children's Bureau, by law all grants of MCH/CCS had to go to the state agencies which administered the funds. This was a very difficult requirement. For example: (a) a CCS director with no overwhelming interest in social work education had to explain to the State Budget Office why she was providing funds to a State University School of Social Work when she was simultaneously requesting more funds to pay for medical care of handicapped children; (b) a serious problem arose as a result of personality conflict between the MCH professor and the social work faculty member on a MCH project at a school of public health. As a result, I had an appointment with the Dean of the School of Public Health and the people involved and because protocol had dictated that the State Health Department be notified, the MCH Director came to the meeting along with the State Director of Public Health Nursing.

University faculty, while they certainly did want to have a good working relationship with state officials, did not appreciate such incidents as I have given as examples, nor did they relish uninvited suggestions about curriculum. Much to my satisfaction, the states lobbied successfully to change to direct training grants to universities.

Unlike the National Institutes of Mental Health (NIMH), whose unit on Professional Education under the leadership of Milton Wittman, and the Veteran's Administration under the leadership of Roger Cumming, the Children's Bureau, and Public Health Service had no means of separating out the costs of any one training for any one discipline in its MCH multidiscipline training projects. The costs of single discipline projects could be reckoned or the number of stipends given but many more students than those on stipends were trained and the single discipline projects were far, far in the minority with multidiscipline projects running into millions of dollars for a single project, such as a University Affiliated child development project.

UNIVERSITY AFFILIATED TRAINING PROJECTS

In these projects funded as part of our mental retardation grant program, one of the principal decisions, which had to be made in setting up guidelines and requirements to be met for approval, had to do with the fundamental interdisciplinary nature of the projects—an aspect upon which all staff were in agreement. As I recall, we decided that each project must have at least three disciplines, that all training must be accredited by the appropriate professional bodies, and that agreements could be worked out with other universities if the main recipient of a grant did not include a needed discipline. Stipends would be provided. Details regarding disciplinary training were set by each discipline involved on our staff. Requirements, therefore, differed for the various disciplines. All projects must have the disciplines on staff but need not have formal training of all disciplines. All disciplines involved in professional education had to meet the standards for professional education in their own disciplines and meet the standards for appointment to the faculty of the university which was the recipient of the grant. In the case of social work, I set the requirement that every University Affiliated (UAF) center funded by the Children's Bureau must provide for social work education (two year master's degree program), and that the chief social worker in the project must meet the qualifications for associate or assistant professor (usually a doctorate) in both the medical school and the school of social work. This usually resulted in a regular faculty appointment in the medical school and an adjunct appointment in the school of social work when the schools of social work and medicine were in separate universities. No social work faculty could be approved without joint approval by both schools. Stipends could be awarded to applicants selected jointly by the chief social worker in the project and the school of social work. Students spent the second year of graduate education in field work in the project. The schools of social work were advised regarding the appropriate content on child development, genetics, handicapping conditions, prevention, etc.

It is obvious that a great deal of negotiation was necessary to assist the universities who wished to apply to meet the requirements. In a place like the University of Washington, for example, the university had a long history of Maternal and Child Health grants from Children's Bureau, and had accredited schools of social work, nursing, etc. At Georgetown University, the Medical School became the grant recipient although it had no school of social work, no speech and hearing, no master's level pediatric nursing and to my knowledge, no actual program in clinical psychology or nutrition. In the case of social work, the problem was solved only when agreements were reached with both Howard and Catholic Universities for equal numbers of students in social work.

We involved the directors of social service in the hospitals where projects were being considered, and wherever feasible, required involvement with social service departments where these existed and maintained professional standards. In most instances, the project social work staff were considered members of the staff of the hospital social service departments. Exceptions did exist such as the Fernald State School (the oldest institution for the retarded in the U.S.) where the State Mental Hygiene Department did not require a master's degree in social work. The grant there was routed through Massachusetts General Hospital with social work from Simmons College.

Workshops of various kinds for one or all disciplines were held by most of the projects. At the University of Miami, together with the University of Kansas, two workshops were held in which faculty members from schools of social work involved with UAF's, representation from the Council on Social Work Education, and federal social work staff developed guidance material for social work in UAF's. The resulting publication (Graduate Education in the University Affiliated Facility) was widely circulated and was used beyond the official UAF groups in many places where interdisciplinary professional education in the health field was being planned or carried out. Two other projects—Johns Hopkins and Ohio State—held meetings to discuss social work training in UAF's. Georgetown held a national meeting for social workers concerned with the relationship of child health and education.

When Wilbur Cohen was Secretary of Health, Education and Welfare, the chief social workers in the various agencies involved with social work training, i.e. Public Assistance, Vocational Rehabilitation, Veterans' Administration, NIMH, etc, used to meet with him occasionally. As there were no training moneys aside from that which was attached to particular programs, we felt he should try to secure some uncommitted grants for social work. He refused this, but said he would try to get some for Corrine Wolfe's shop (Public Assistance). We then asked if he would help us to get the Public Health Service to set up a special grant program aspect of their general program which supported health personnel. This he also refused saying that he considered all medical and psychiatric social workers to be nothing but handmaidens to the physicians. Milton Wittman (NIMH), Roger Cumming (Veterans Administration), Margaret Ryan (Vocational Rehabilitation) and I were very disgusted, particularly as Wilbur always set himself up as a social worker and even belonged to NASW (blanketed in when it was formed). He did get the money for public welfare and I think it all went to undergraduate training for public assistance.

An interesting note about the Children's Bureau and social work training standards has to do with the requirement for training of staff for Child Welfare Services. The Social Service Division, like the Medical Social Work Section, had required a master's degree in social work for staff paid by Child Welfare Service funds. Many of the staff paid for by these funds had positions of leadership as directors, supervisors and trainers of less educated staff. I believe, as do many other social workers, that abandonment of these standards is one of the reasons for deterioration in public welfare social services, particularly child welfare and A.D.C.

When I started work in the San Francisco Regional Office of the Children's Bureau, there were social work training projects at Tulane and the University of Chicago. We started work on developing the project at the University of California Berkeley while I was in the Regional Office. After that, we started to work with the University of Pittsburgh. These two projects differed from the first two in that they called for actual course work in a school of public health and field work in a public health department. Both were cooperative projects between schools of social work and schools of public health. California started with an internship for students already having a master's degree in social work. The internship was not a success due to lack of an academic degree, so the project had to be changed to provide an MPH for students with social work degrees. Pittsburgh offered options which assured that graduates would have Master's Degrees in both social work and public health plus doctorates in either for those who elected to add one or the other. This project has probably supplied more social work faculty than any of the other MCH/CCS supported training projects. These two and other projects were funded with special project MCH/CCS Reserve Fund B. Later, by requiring social work education as a feature of interdisciplinary training, grant funds could be used from special projects such as university affiliated mental retardation, pediatric pulmonary disease, etc. (See West, 1989).

Many short term training programs on a regional basis or specialized topics were included in grant projects or added to long term training projects. Publications based upon these were sent to all schools of social work, schools of public health and state health departments. Some were reprinted as government publications when the demand grew too large for the supply included in the grant. I believe that all or nearly all are available in the Bird Library at Syracuse.

MEDICAL SOCIAL CONSULTANTS IN PUBLIC HEALTH—ANNUAL MEETING

From the outset, the Children's Bureau plans for implementation of Title V of the Social Security Act Multidiscipline Regional Offices were included. Edith Baker saw to it that social workers were included in these offices and that social work staff must be included by the States, especially in the Crippled Children's programs. At that time, 1935, there were only two health departments, Massachusetts State and Los Angeles County, which employed social work staff. The people whom Edith hired for her own staff came primarily from hospitals as did the social workers appointed by the States. When I worked in the San Francisco Regional Office, I had seven states including Alaska and Hawaii. My predecessors had twice as many. All of the social workers in federal and state public health programs came from clinical backgrounds and were therefore, accustomed to one patient at a time instead of an entire state, county or city. They were consequently in need of professional guidance which could not be given effectively through one or two visits a year from a federal consultant. In many instances, the social workers in public health were the only medical social workers in the state. Supervision and in-service education were impossible and there was at that time, very little accumulated knowledge about social work in public health.

In order to try to provide for help in the situation described above, Edith Baker set up annual meetings for social workers in MCH and CCS programs. These meetings lasted 2 1/2 or 3 days and were held just before the Annual National Conference of Social work. This enabled the

social workers to meet with their colleagues to discuss problems they were all encountering in their new settings and to profit by the broader reach of the National Conference. It also had the practical advantage that no one else in the health Department wanted to attend. The Children's Bureau gave technical and some financial help to state workers to attend and to participate in planning the content. Minutes were kept and papers were printed for distribution. Other social workers in public health were welcome and representatives of national health agencies such as National Foundation for Infantile Paralysis (now March of Dimes), National Tuberculosis, Cystic Fibrosis, Cerebral Palsy, etc., attended regularly.

The annual meetings of Medical Social Consultants in Public Health continued until 1977. Reports of many are available in the Bird Library at Syracuse.

As social workers became more numerous and achieved higher status in health departments, a social work section was established in the American Public Health Association, the logical outcome of the Annual Meetings of Medical Social Consultants in Public Health.

CO-STEP

The Public Health Service has a program designated CO-STEP designed to interest students in short-term experiences in health professions employed by the Public Health Service. This is primarily a recruitment device for the commissioned corps. The agencies interested must agree to provide a meaningful professional experience and the agency must pay the costs. Juanita Evans and I were given information about social workers applying for this program since we had signified our interest in having one assigned. We selected one young man for the summer between his first and second year at the University of Georgia. Bruce, the CO-STEP student, had been an enlisted Army social work assistant. He had worked his way through college and was using his Army experience as a means to finance his graduate education. We were pleased with Bruce's performance in his summer experience but not pleased when the School of Social Work asked us to accept Bruce in a field work placement for his second year in the School of Social Work. After a great deal of pressure by the School of Social Work in Athens, Georgia, we agreed to provide his second year of field work with the understanding that his supervision would be shared between Juanita and me. We found it difficult to provide Bruce with meaningful experiences. We gave him research projects to review and other kinds of projects. He did well in view of his limited professional background. His major problem was that he had no experience in social case or group work which would have helped him to understand the roles played by the participants in our inter professional conferences. At such conferences, when Juanita and I purposely seated ourselves at different places so we could communicate with nonverbal signals, Bruce did not understand. We gave him a good grade in his field work mainly because he was really smart and we felt he had excellent potential. We were not too pleased to hear that the University of Michigan had offered him a full stipend to get his doctorate immediately after he received his M.S.W. However, after I had retired, Juanita received a letter in which he said he had decided to take a job involving social case work which he felt he had missed. He later wrote her that he was on the faculty of the Florida State University School of Social Work and would welcome the opportunity to act as a reviewer of MCH projects.

After our experience with Bruce, I decided we would never take any more CO-STEP or field placement students except doctoral candidates from graduate schools of social work or public health. Since we really did need some help from staff who were knowledgeable about research in relation to social work in public health, I communicated with local schools of social work for suggestions. Catholic University School of Social Work came up with a candidate for CO-STEP who was a doctoral candidate in the School of Social Work and a part-time faculty member. This trainee, Cathy Bishop, spent the summer as a CO-STEP. Since she had not completed her dissertation and also had a family, she asked at the end of her training period if she could work for us. Since she was a friend and neighbor of his, the Director of MCH was sympathetic to the idea that we needed a part-time assistant. She came to work for MCH, primarily in genetics and then in handicapped children before she left to join a university.

NATIONAL HEALTH SERVICE CORPS

The National Health Service Corps (NHSC) training program was set up in the Public Health Service for the purpose of supplying physicians in rural and economically deprived areas where there were not enough physicians and none could be recruited because the economic situation would not support adequate salaries. Some other health personnel were included such as nurses and nutritionists. A relatively small number of slots were granted to social workers. The trainees accepted into this program had to meet requirements for admission into the Commissioned Corps of the U.S. Public Health Service and had to agree to work for the Public Health Service upon graduation for a required period, which meant going anywhere the Public Health Service chose to send them. They had also, of course, to meet the requirements in the appropriate graduate schools and maintain acceptable grades. When social work was added to the National Health Service Corps, the Medical Social Work Section had responsibility for review of applications, and for monitoring student programs, especially of the graduate schools of social work where they were enrolled. Considerable emphasis was placed upon race, particularly where Native Americans were concerned. From the start of our involvement with this program, Juanita Evans took major responsibility which was particularly fortunate since she was there after I retired to follow up on the placement of the social work students in health departments when they had completed their master's degrees.

In the years 1952-1980, Children's Bureau and Public Health Service provided some financial support for long term training to at least 33 graduate schools of social work from Seattle to Miami, Boston to Honolulu. Some funds were provided through direct grants of Reserve Fund B, some through inclusion as the social work component in University Affiliated Mental Retardation (Child Development) projects and in one instance (Pittsburgh) by inclusion in a direct grant to a school of Public Health. Schools of social work were also recipients of short term training grants, institutes, workshops, etc., for social workers as were schools of medicine, hospitals and health departments. Content of these short term training projects was printed and distributed to all schools of social work, schools of public health, professional organizations such as the National Association of Social Workers, the American Public Health Association, at no charge. Many were reprinted by the federal government and copies of all are available in the Collection at Syracuse University.

NOTE:

The programs and activities which I have described in this document were selected to give the readers some idea of the nature and breadth of interest of the U.S. Children's Bureau and U.S. Public Health Service, particularly in the field of Maternal and Child Health. The list is not exhaustive. Some programs not included would be poliomyelitis, hemophilia, pediatric pulmonary care, rheumatic fever, retrolental fibroplasia, speech and hearing, pedodontics, physical and occupational therapy and adolescent health. References to these and all others not mentioned here will be found in the Virginia Insley Collection in the Bird Library at Syracuse University and some at the Schlesinger Library on the History of Women in America at Radcliff College in Cambridge, Massachusetts.