HEALTH AND WELFARE SERVICE

IN

THE MODEL CITIES NEIGHBORHOOD

INSTITUTE OF REGIONAL AFFAIRS
WILKES COLLEGE
WILKES-BARRE, PENNSYLVANIA

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Institute of Regional Affairs

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TABLE OF CONTENTS

PAGE

PAGE

PAGE

LIST OF TABLES

LIST OF TABLES (CON'T)

APPENDIX

PREFACE

During the initial years of planning for the Model Cities Neighborhood in Wilkes-Barre much research was conducted. However, many problems revolving around integration, coordination, and duplication of services still existed. It seemed apparent to those working on the Model Cities problems that what had already been developed during the initial planning year should be carried just one step further, that is specifically identifying where the problems occur (each agency), and more importantly the cause and recommended course of action, which hopefully would lead to both better coordination and integration of services.

Heretofore, studies were conducted and reports issued that examined the effectiveness of the social service delivery system from the standpoint of the agency provider. Missing as an important component of such studies was information on how the consumers of the social services see these basic services in the light of their needs. This obviously could only mean a beginning based on tangible, visible, permanent, sincere examples of respect and concern for the people of the Model Cities Area, for it has become crystal clear that the hopes embraced in the Model Cities concept could not possibly be fulfilled without the first-hand knowledge and experience of a self-determining Model Cities community.

Because the Wilkes-Barre Model Cities Agency is determined to avoid misunderstanding that would inevitably result from ignoring the residents of the Model Cities neighborhood, it undertook an evaluation of the social services in

the Model Cities community. Clearly then, this study was not only undertaken to add knowledge on what residents of the area view as the most pressing social service problems, but also to obtain data which could assist the Model Cities Agency to plan and coordinate the resources to effectively meet the needs of the people and to contribute to an improved social service delivery system.

In order to accomplish this result, it was felt that a more objective research project could be implemented by utilizing an independent community resource which could supply research and evaluation without being unduly influenced by existing or proposed relationships of the already established social service institutions. Wilkes College, its academic resources already an integral part of the total community, was selected to undertake an evaluation of the social services in the Model Cities Neighborhood. Therefore, a contract was entered into between the Model Cities Agency and the Institute of Regional Affairs, a multi-purpose College organization that coordinates all activities in the social science field.

The Institute undertook a nine-point program in its evaluative effort of the social service delivery system in the area. Because of the enormous task confronting the Institute of Regional Affairs within a limited time constraint, the study was divided into components that could be more easily performed.

In order to provide necessary and specific information of present social services in the Greater Wilkes-Barre area, particularly as they relate to the Model Cities Neighborhood, the Institute utilized the services of two members

of the Department of Sociology. Professors Jaroslav G. Moravec and Raymond M. Weinstein were invited to perform the following services:

- Prepare a service profile of all agencies and institutions providing social services.
- Analyze and classify these services in terms of the problem they seek to solve.
- Describe and analyze the present relationships between services.

Under a contract with the Institute of Regional Affairs, Peat, Marwick, Mitchell & Company (PMM) was engaged to evaluate the social services presently provided to the residents of the Model Cities Neighborhood Area. James Reynolds, Consultant of the Philadelphia office of Peat, Marwick, Mitchell & Company, concerned himself with the following services relating to the perceptions of the residents of the area toward the social service problems:

- Identify the degree of adequacy and effectiveness of social services in meeting community needs.
- Analyze any gaps or deficiencies in present social service systems including services not offered but needed.
- Report the amount and type of services provided to the Model Neighborhood Area.

Walter Niehoff, Associate Director of the Institute whose specialty is urban management, assumed the responsibility to:

- Develop a complete social service record-keeping system which would provide a current index of existing conditions: physical, social, and personal.

Philip R. Tuhy, Associate Director of the Institute in planning and development, undertook to:

- Explore and recommend facilities needed for services and their geographic location.

Everyone involved in the project pooled their talents and energies to:

- Analyze and evaluate the effectiveness of existing services in solving the problems they purport to solve through surveys and interviews with consumers.

Because the recommendations coming out of the project were intended to be a basis for the application to the third action year and because this project was approved near the end of the second action year, a very tight schedule was set up in order to accomplish the objectives. It soon became apparent that a comprehensive research evaluation as originally contemplated would require more than three months. Nevertheless, although a much more extensive analysis of major data would have been desired, enough information was compiled and sorted out on the social service agencies and the attitudes of the MNA residents toward their social service needs that recommendations could validly be made on the adequacy and effectiveness of the social service delivery system in the Model Neighborhood Area.

It should be noted that just as the study got underway, a Comprehensive Human Service Center was established in the Model Cities Area. By the middle of January, 1971, it already housed the Eyeglass and Hearing Aid Bank, The Consumer Protection Office, and The Revolving Loan Bank. Within another month representatives of the State Department of Public Assistance,

the Family Service Association, and the Catholic Social Services expect to be located in the Center to make additional human social services available to residents of the Model Cities Neighborhood.

Note should be made too that a $250,000 medical clinic for the Neighborhood Area is expected to be operative sometime during the summer. The land has been purchased and preliminary drawings made. This privately owned clinic is expected to conform to a growing nation-wide trend of placing under one roof every possible medical service so that consumer patients in the Area can avoid costly admission to hospitals.

In making this study, the Institute of Regional Affairs accumulated a store of debts, some of which can now be happily acknowledged. The Model Cities Agency helped in many ways. William A. Schutter, Model Cities Director, gave much clear and useful advice when the initial design of the investigation was in the discussion stage and throughout the study. Source of the heaviest demands for assistance fell on Mrs.Margaret N. McDermott, formerly Human Resources Coordinator, who was unfailingly agreeable and helpful at all times.

Likewise, the Institute received the fullest cooperation from all the social service agencies, institutions and boards whose help was needed in the preparation of this report. In particular, Charles J. Reynolds, Jr. and Harold Sherman, Director of Research and Planning and Executive Director respectively of the Welfare Planning Council read and helped to improve the instrument used to garner data from the social service agencies and institutions.

It was not originally anticipated that residents of the MNA would be engaged on this undertaking, but that the residents would become deeply involved in reviewing the results of the project, so that they could provide in-put into what they felt needed to be accomplished in making available services more responsive to the needs of the residents. It was subsequently determined that the participation of the residents could be utilized in the interviewing process. Although there were some misgivings over engaging their services, everyone associated with the study concluded that the MNA resident interviewers performed in a most competent manner.

The Institute also gratefully acknowledges the work of the Wilkes College interviewers, some of whom gave up holiday recesses in order to secure the data from the social service agencies and institutions.

Alfred S. Groh of the Wilkes College faculty and editorial consultant to the Institute worked over the manuscript during the various stages of writing.

The bulk of the credit, as always, should be given those individuals who performed the actual work of researching the problem, assembling, analyzing and evaluating the mass of data, and preparing the manuscripts of the various sections of this project report. This project was in every sense of the word a team effort, requiring the closest coordination and cooperation. Therefore our greatest appreciation must be extended to team members Mr. James Reynolds, Consultant, Peat, Marwick, Mitchell and Company, Professors Jaroslav G. Moravec and Raymond M. Weinstein of the Wilkes College Department of Sociology,

and Professors Philip R. Tuhy and Walter H. Niehoff of the Department of Political Science and Associate Directors of the Institute of Regional Affairs at Wilkes College. Their combined contribution should provide a firm base for the establishment and expansion of a productive social service program within the framework of the Wilkes-Barre Model Cities Project Area.

Significant contributions were made by unnamed individuals whose identity cannot be revealed.

Finally, it must necessarily be stated that the findings and recommendations in the study are strictly of the Institute, and therefore the Institute of Regional Affairs assumes full responsibility for securing the data, its analysis, and the recommendations that are the product of that analysis.

Hugo V. Mailey
Director
Institute of Regional Affairs

INTRODUCTION

"Model Cities is a new approach. It relies on local initiative and local commitment. It places the onus on the Federal government to position itself to respond to city defined strategies and programs. The program reflects a candid admission that categorical assistance programs, whether emanating from Federal Departments in D. C. or the Region, have, despite some real accomplishments, not measurably affected the quality of urban life."

The above statement is by Floyd H. Hyde, Assistant Secretary, Model Cities and Governmental Relations, U. S. Department of Housing & Urban Development, in the Preface to Model Cities Program by Marshall Kaplan, Gaus, and Kahn--a study conducted for HUD (Praeger Publishers, 1970).

The Model Cities concept, in general terms, is a beautiful and timely projection. What poor man could be against its multifaceted community services? What poor man could reject the idea of a concentrated attack on poverty, inferior education, unemployment, and slum housing? Who would oppose more legal aid for the defenseless, better health services for the poor--just to mention a few ingredients of the Model Cities idea. No one is against such a program in principle.

The present Model Cities concept is not the first noble idea supposedly to help the disadvantaged. The history of modern society is replete with the failures of ideas of equal worth and urgency. Some of these failures represented the best thinking of prominent names, and experts in their particular

fields; some represented great wealth; some represented immense political skill and influence; while others were well-known for their sympathy for the poor and the powerless. But most of them had one thing in common: they thought that they, and only they, were capable of working out the solutions to the needs of the poor.

That is why in spite of the sincerity of many fine people, the Model Cities program in many cities is looked upon with suspicion by thoughtful poor people. A "Delivery System" to the poor meant that they were to sit quietly by while "they", with alternatingly warm and stern paternalism, delivered the poor what "they" thought the poor needed. To "them," the advice and consent of the poor was not needed; and, when volunteered; it was not heeded.

The prime purpose of a Model Cities program is to take a wide range of federal, state, and local programs--anti-poverty programs, urban renewal, job training, educational assistance, welfare, and so forth--and pull them together into a concentrated attack on all the problems of a small area. This, it was hoped, would lead to a breakthrough that would point the way to solving the broader urban malaise. In the bureaucratic argot, it was to be post holing (a concentrated effort on a few people) rather than leaf raking (a scattered effort that hits a lot of people, but doesn't do much for any of them).

This kind of notion goes to the heart of the Model Cities concept: the need to coordinate the various programs so as to achieve maximum impact. Somebody who lives in a slum is likely, at any given time, to be in poor health,

have a bad job or no job at all, live in a miserable house, be poorly educated, and so on. But the agencies that administer programs designed to alleviate these conditions have tended to end up fighting one another rather than cooperating. The Office of Economic Opportunity runs job training, education and welfare programs; the Labor Department also runs its programs. And all of these often involve the same poor "clients" in the model neighborhoods. Multiply this many times over and the lack of coordination becomes utterly clear.

Not surprisingly, each of these agencies thinks it knows best how to run its type of program. Moreover, each agency wants to spend its available money according to its own philosophy and priorities.

The result in many cases is that the Model Cities legislation turned out to be not a newly forged instrument for urban rehabilitation but a smorgasbord. While Model Cities has resulted in new and productive relationships with residents, much more needs to be done to find better and more effective ways to solve the problems of a community or area. The governmental agencies must convincingly show that they are concerned with the community people rather than with politics. And by the same token, the powerful social service institutions must convincingly demonstrate that they, too, are primarly concerned with the people who are their neighbors as well as with achieving the long range goals of the institutions.

It has now become imperative that our concern be with the application of the programs: how and by whom these programs are going to be admin-

istered; and who will have the determining, ultimate voice in the structuring and in the crucial decision-making processes involved.

Social welfare delivery systems are the programs by which necessary services--health care, welfare, education, legal aid, housing, employment opportunities, etc.--are channeled to the people who need them. It is increasingly and alarmingly clear that many, if not all, existing delivery systems are outmoded and incapable of making substantial headway against massive urban problems, including poverty, illness, inadequate education, and substandard housing, to name a few. There is a question as to whether new programs involving new methods and approaches are needed to respond more effectively to present-day problems. Perhaps what is needed is a fresh start, and not new cliches and new rhetoric about maximum feasible public participation, etc., etc, etc.

Facts are a prerequisite at every stage for:

1. The conceptualization of a problem
2. The planning of a program to alleviate the problem
3. The implementation and evaluation of the programs established to solve the problem.

Unfortunately, facts have not always been used to best advantage. Rather than informing, facts have been used to misinform, often with suspicious consequences. Incorrect facts have often been the basis on which Model Cities programs were built.

Study must be the first step in removing the burden of suspicions

placed on the shoulders of governmental social agencies and the major private social institutions. Study must be the first step in preventing a sound concept from becoming just another failure in a long chain of failures. The singular object of study must be to let the Model Cities community play a meaningful and determining role in the definition of "success" in a program for the people of the Model Cities community.

PART I

SOCIAL SERVICES OF AGENCIES AND INSTITUTIONS

A. INTRODUCTION

To provide specific information of the present human services now provided in the Greater Wilkes-Barre area, particularly as they relate to the Model Cities Neighborhood, the researchers began by compiling a complete list of the agencies and institutions. The initial source utilized was the Model Cities application originally submitted to the U. S. Department of Housing and Urban Development. The list extracted from various parts of the application was added to by perusing the 1968 Diagnostic Survey conducted by the Welfare Planning Council for the Model Cities Agency.

Both of the sources were then cross-checked against two other sources- the 1970 Luzerne County Yearbook, the annual Handbook of the Sunday Independent and HELP, a directory of the Welfare Planning Council. The Sunday Independent publication lists all Federal, state, county, and city offices located in Luzerne County. In addition, the Handbook contains a listing of all welfare agencies - public and voluntary in Luzerne County. HELP is the directory prepared by the Council, a voluntary citizens organization financed by the Wyoming Valley United Fund. The Council, composed of both individuals and organizations interested in cooperative community planning, studies health, welfare and recreation needs of the community and initiates planning leading toward the development of more effective and more adequate social services.

A final listing of 69 social service agencies and institutions was finally arrived at after deliberation on the inclusion of several doubtful agencies. After the survey was completed and a final review was made, it was found that five rather important social service agencies had been omitted.

In all, 74 agencies and institutions were included as providing social services to the general citizenry in Wilkes-Barre and the Model Cities area.

This part of the project was carried out in four stages:

1. Construction of an interview schedule
2. Collection of data
3. Analysis of data
4. Preparation of final report

B. THE INSTRUMENT

As is true in other parts of the report, decisions must always be made at the beginning of any research that are regretted in the analysis and writing. This is the very nature of research. Decisions used to be made on the evaluation of the data on the social service agencies, the type and amount of services by the agencies, the constraints under which the agencies operate, the clientele of the agencies, the interrelationships of the social service agencies, and the service gaps that exist resulting either in a lack of services or ineffective delivery of social services. Again, it must be stated that judgments were made not with a view of being critical of the agencies, but rather in a constructive spirit with a view to helping those in need of the services.

The interview schedule was first discussed with representatives of the Welfare Planning Council and the Wilkes-Barre General Hospital. A first draft was constructed containing 34 questions aimed at obtaining data on the number and source of clients, the objectives of a service as stated in law or charter, the eligibility requirements for client service, the budget, personnel, and the relationships with other social service agencies. Although the number of questions remained at 34, in the second draft, certain of the questions were refined for specificity. The final and third draft of the interview schedule contained 35 questions as a result of further consultation and refinement. The questions were grouped in topical sequence to provide information on:

1. Purpose and goals
2. Kinds of services
3. Orientation of service objectives
4. Target population and geographical area
5. Eligibility requirements of clients
6. Personnel and budget
7. Relationships with other agencies

Interviewers were instructed on the use of the instrument both during the testing stage and prior to the use of the instrument out in the field. Consultation with the interviewers was continuous throughout a 20-day period while the interviewers met with the representatives of the social service agencies.

A total of 69 interviews were conducted in the field work. Data were

collected from an additional 5 agencies because these agencies had been omitted during the 20-day period which began November 1, 1970. After careful analysis, 3 of the agency profiles were discarded on the basis of lack of relevancy to the Model Cities area, insufficiency of data, and/or out-of-town orientation. The final analysis of data and classification involved 72 social service agencies, 26 of these agencies in the health field and 46 in the welfare field.

C. THE INTERVIEWERS

All interviewers who worked on the social service agency profile were Wilkes College students majoring in Sociology or Psychology. Each interviewer was assigned a minimum of five agency questionnaires. The professional agency director was forwarded an introductory letter stating that the IRA was undertaking a study of the agencies in the Model Cities Neighborhood and also setting forth the purpose of the study. The agency professional was informed by this letter of October 30, 1970, that within two weeks, an interviewer would call to make arrangements to visit to secure the data on the questionnaire. In no instance were the interviewers refused information. As a matter of fact, many agency people called the researchers or the IRA to express feelings of cooperation.

D. CLASSIFICATION OF SOCIAL SERVICE AGENCIES

A classification of social service organizations based on a single dimension is not only futile but risky. Certainly to classify on a single basis has the advantage of simplicity; yet, this advantage is also its weakness since every social service organization is multifunctional even though a single activity may dominate. Unless it can be shown that the selected service activity accounts for a substantial portion of the funds, clients, and energies of a social service organization, the utility of a unidimensional classification is severely limited. The recognized drawbacks of single dimension typologies have led to efforts to construct classifications based on more than one variable. An approach in this direction has been to develop profiles or patterns. Profiles are valuable since they provide a graphic method of locating salient attributes of various social service organizations vis-a-vis each other.

Of course, there are many ways of classifying social service organizations. But classification, despite the way it is sometimes treated, is not an end in itself; it is a means of enlarging our understanding about the complex subject of social service agencies. Little is gained; for example, by categorizing them by budgets unless this information enables us to predict performance. It may be interesting to know how many organizations provide supportive income maintenance, but this kind of knowledge without further application has little relevancy to effectiveness or adequacy of service.

One way of classifying social service organizations is to treat them as

governmental and non-governmental. This has a special relevancy as between public and voluntary agencies, especially as concerned with the source of funding. Mutual aid, the church, organized private benevolence, and the state have been and still are the fundamental resources for the care of the poor. Today, the order of importance is in reverse. Moreover, in this current era, the distinctions between governmental and non-governmental have become increasingly obscure especially with the development of the private, non-profit-making corporation as the instrument of social change and with the major funding source actually being the federal government. Resultantly, the term of quasi-public organization has come into vogue.

Using another base for differentiation, organizations that provide social services may be classified into four main groups: (1) agencies designed primarily to give social service to clients, either as individuals or in groups (i.e., social welfare departments, family and children's societies, YWCA, Boy Scouts); (2) organizations which offer social services as well as other services (i.e. American Red Cross, Salvation Army); (3) organizations which are basically designed to offer other services, but which maintain an auxiliary department of social work (i.e. hospitals, clinics, juvenile courts, vocational rehabilitation services); and (4) organizations that are not rendering direct services to individuals or groups but are set up to assist other social agencies (i.e. Welfare Planning Councils).

In modern society, whenever the breadwinner is unable to work, cannot obtain work, or is taken by death, outside help is necessary to provide that economic security. The basic idea is to provide money where there is none or when the individual and/or his family become dependent. Direct income maintenance can be provided by one of three approaches--public assistance, social insurance, or a pension system. If the individual can produce his own income, then activities that lead in this direction should be emphasized- restoring his health, improving his state of mind, providing him with skills, etc. These are poverty related activities in that it is difficult to break the poverty cycle. The problem is an entirely different one if the individual is not rehabitable and a likely candidate for self support. In that case, the objective is to secure for each human being, rehabitable or not, a decent standard of health, proper living conditions, and the highest degree of self respect.

Social Service organizations developed out of the felt needs of a community. These organizations are the expression of felt needs by particular communities of interest. Consequently, there are in every city a considerable number of organizations dedicating their efforts in a general or specific health and welfare area and focusing their available resources on that particular interest.

In some instances, the functions and operations of these agencies are clearly defined, while in others the scope of their operations is so broad that it is not always possible to identify what specific services are provided. However, the values which underlie these agencies are quite clear--health or the

state of well-being and the value work ethic or income.

Since the Institute of Regional Affairs analysis indicated that virtually all needs of the residents of the MNA involve some type of health factors or economic considerations, the broadest classification of service organizations has been made into health services and welfare services. The former is concerned primarily with matters relating to the physical, mental, and emotional health of the individual and families, while the latter includes those organizations dedicated to assuring emotional well-being and to assisting in restoring or providing income to persons in need, or to assisting them in finding the means to attain a level of income necessary for their general health and well-being. The basic interdependency of these two types of services must, of course, be recognized, since the problem of an individual or family may be essentially one of health, but insufficiency of income may be the cause or contributory of the health problem and vice versa.

In each of the foregoing broad categories, the specific agencies differ considerably in the nature of services rendered. Consequently, a further sub-classification is required to facilitate identification of the agency most appropriate to the problem on hand. Health and welfare services are direct or indirect, depending on the client relationship. Some agencies in both of these fields are of the special interest type. Additionally, because of the special nature and magnitude of their functions, certain services should be classified as institutional, to distinguish them from those which are provided on an at-home basis.

These two broad types of social service delivery systems - health and welfare - will facilitate comparisons in certain criteria such as cost factors, funding resources, and eligibility requirement which will provide the broadest factual base for analysis and evaluation.

Within the framework of the twofold grouping, the various types of specific services rendered by the agencies are listed in order to reveal any gaps or duplications in service available to Model Neighborhood Area residents. This grouping and functional classification, together with a more detailed breakdown of services further provides the key to selection and location of the most appropriate agency available to the resident according to the nature of his problem through a central referral system.

E. SOURCE OF FUNDING

The social service agencies have been classified by source of funding because streams of funding, both public and private, are the foci of health and welfare organizations. Availability and accessibility to funds create new programs, perpetuate old programs, modify ongoing programs, influence health and welfare planning as well as other activities of health and welfare organizations. Some of these funding streams create new relationships among the funding agencies, and the funded agency and other similarly funded agencies. Such relationships may create competition or cooperation; restrictiveness or freedom in program administration; or, even a closed system for other organizations and the people that the organizations serve.

HEALTH SERVICES

I. DIRECT MEDICAL SERVICES
   A. Hospitals
      1. Wilkes-Barre General Hospital
      2. Mercy Hospital
      3. Nesbitt Memorial Hospital
      4. Wyoming Valley Hospital
      5. Veterans' Administration Hospital
      6. Valley Crest

   B. Clinic Services
      1. Kirby Health Center
      2. Public Health Center

II. DIRECT MENTAL HEALTH AND/OR RETARDATION SERVICES
   A. Hospitals
      1. Retreat State Hospital
      2. White Haven State School Hospital

   B. Clinics
      1. Luzerne/Wyoming Counties' Mental Health Center #1
      2. Children's Service Center of Wyoming Valley

   C. Information and Referral
      1. Luzerne/Wyoming Counties' Mental Health/Mental Retardation Program

III. INDIRECT HEALTH SERVICES
   A. Pennsylvania Department of Health Regional Office, Region II

   B. Wilkes-Barre City Department of Health

IV. ADVOCACY SPECIAL INTEREST SERVICES
   A. American Cancer Society
   B. Arthritis Foundation
   C. Cystic Fibrosis Foundation
   D. Luzerne County Mental Health Association
   E. Multiple Sclerosis Foundation
   F. Muscular Distrophy Association
   G. National Foundation -- March of Dimes
   H. Tuberculosis Society
   I. Northeastern Pennsylvania Heart Association
   J. Luzerne County Association for Retarded Children
   K. American Red Cross

WELFARE SERVICES

I. ECONOMIC SECURITY SERVICES
- A. Income Maintenance
  1. Social Security Administration
  2. Veterans' Administration
  3. Luzerne County Board of Assistance

- B. Jobs and Training
  1. Bureau of Employment Security
  2. Concentrated Employment Program

II. FAMILY, CHILDRENS', AND CUSTODIAL CARE SERVICES
- A. Family Social Services
  1. Family Service Association of Wyoming Valley
  2. Wyoming Valley Council of Churches -- Meals on Wheels
  3. Catholic Social Services
  4. Planned Parenthood Association
  5. Jewish Welfare Agency
  6. Luzerne County Bureau for the Aging
  7. Adult Welfare Services and Project Reach Out for Life (Luzerne County)
  8. Visiting Nurses Association of Wyoming Valley
  9. Homemakers Service of Luzerne County
  10. Commission on Economic Opportunity

- B. Children's Welfare and Educational Services
  1. Luzerne County Child Welfare Services
  2. St. Michaels Home for Boys
  3. St. Stanislaus
  4. Headstart

- C. Institutions
  1. Home for Homeless Women
  2. Sutton Home

III. DIRECT REHABILITATION SERVICES
- A. General
  1. United Rehabilitation Service
  2. Wayside Mission
  3. Salvation Army
  4. Bureau of Vocational Rehabilitation

WELFARE SERVICES, CONTINUED

B. Special Group
   1. Crippled Children's Association
   2. Bureau of Visually and Physically Handicapped
   3. United Cerebral Palsy
   4. Alcoholics Anonymous
   5. Pennsylvania Association for the Blind

IV. DIRECT LEGAL AND CORRECTIVE SERVICES
   A. Governmental
      1. Adult Probation, Luzerne County
      2. Juvenile Court, Luzerne County
      3. Domestic Relations Court, Luzerne County

   B. Consumer
      1. Legal Services Association
      2. Legal Aid Society

V. COMMUNITY CHARACTER BUILDING GROUP SERVICES
   A. National Affiliation
      1. Boy Scouts of America
      2. Girl Scouts of America
      3. YMCA
      4. YWCA

   B. Local Affiliation
      1. Catholic Youth Center
      2. Georgetown Settlement
      3. Jewish Community Center

VI. SPECIAL INTEREST SERVICES
   A. Pennsylvania Veterans Commission

   B. Federation for the Blind

VII. INDIRECT WELFARE SERVICES
   A. Pennsylvania Department of Public Welfare, Region II, Scranton

   B. Commission on Economic Opportunity

Examples of funding streams are:

OEO →	CAP Agency →	Creation of variety of poverty programs for the sake of activity
Title N-A →	Day care →	Creation of large variety of day care programs
Hospitals →	Blue Cross payment for hospitalized patients →	In-patient care

It is obvious from Table 1 that more agencies and institutions are engaged in welfare services than in health services. It should also be noted that many agencies and institutions have more than one source of income - sometimes all governmental, sometimes all voluntary, and more times than not a combination of both. For instance, hospitals have a variety of sources including Federal (Medicare), state (Medicaid), Blue Cross payments, payments by patients, and private insurance.

TABLE 1

AGENCIES BY SOURCE OF FUNDING

Source of Funding	No. of Agencies	Health	Welfare
Federal	3	1	2
State-Federal	6	3	3
County-State-Federal	11	3	8
County-Federal	2	0	1
County-State	1	0	1
County	2	0	2
City	1	1	0
Voluntary	37	12	25
Voluntary-Federal-State	3	3	2
Voluntary-Federal-State-County	2	2	0
Voluntary-State	2	1	1
Voluntary-City	1	0	0
TOTAL	72	26	46

One is immediately struck by the high number of social service organizations that receive funds from some level of government, reiterating the earlier statement that a change from voluntary to governmental funding of social service is going on. A significant phenomena is the development of new agencies that use governmental funding: the quasi-public organization. One should also note the high number of social service agencies, especially in welfare, that continue to rely on voluntary sources of funding. The "voluntary" source of funds needs some clarification, for it is quite varied even though the predominant source is the United Fund from which 27 health and welfare agencies receive money. No agency receives United Fund monies only. For instance, Homemakers Service receives United Fund monies combined with county funds and client fees. The "voluntary" sources are drives, dues, endowments, special events, voluntary contributions, fees, investments, church collections, and private insurance payments. One can only speculate on the effect funding availability has on current or proposed programs, and how, in many instances, planning is designed to use that funding availability.[1]

F. THE FINDINGS--SOCIAL AGENCIES

1. Introduction

Presentation and analysis of the data provided by the health and welfare agencies serving the Model Neighborhood Area reveals several partially valid, though nonetheless useful, evaluative criteria. Among these are the

cost per client, the number of clients per employee, the nature of the core and peripheral services, and the eligibility requirements of each agency.

Admittedly, comparison of agencies on these bases has vital drawbacks. Perhaps the most obvious is the lack of uniformity in the method of reporting expenditures and services rendered by health and welfare organizations. For instance, one agency may treat an individual client as a service unit, while another agency may treat a family comprising several individuals, all of whom receive service, as a service unit. Moreover, there are some agencies who treat an individual coming to them for service as individual units of service each time that individual appears and utilizes the service.

Comparison of agencies on the basis of expenditures per service unit, regardless of the definition of the term, is equally useful, but also limited. This basis certainly opens up vast areas and questions for the community and the professionals in the field to do more research. Returning to the point, assuming that two or more agencies provide exactly the same quality of service, comparison of the expenditures per service unit would have considerable validity. However, since the quality of services of all the agencies has not been, and cannot currently be, determined and compared, such comparison is little more than speculation. The greatest dollar expenditures per client or family do not necessarily mean either the best or the worst quality of service. Lowest cost per client does not indicate poor service, although there may be a

direct correlation between low cost and low quality of service. Low cost per service unit may indicate that the organization is attempting to do too much in too many different directions, or it may indicate that the organization relies heavily on volunteers to operate.

Case-load per employee is another criteria which should be applied with similar caution. It is reasonable to conclude that the number of clients which a given employee can service well depends upon a number of factors, including the number and variety of services which the employee is expected to render, the work time required by the nature of the service, the ability and dedication of the employee, or the characteristics of the individual or family involved.

Consideration of the core and peripheral services of an agency likewise supplies a useful criteria for comparison, provided experience is used to buttress the formal statements of services reported by the agencies. It appears perfectly valid to expect that a given agency may rate high in the quality, or services may be "extra-curricular" offshoots of the core ones, and therefore, performed perfunctorily and low in quality. Again, one agency which treats a given service as a peripheral service may provide a higher quality than one which treats it as its principal function.

All agencies have eligibility requirements which determine whether or not an individual or family should receive assistance. It is sometimes assumed, and often erroneously, that the agency providing the easiest

requirements will be the most readily available and of most effective service to the client. This may or may not be true, but only experience will provide the answer in any given instance. To prevent intake flooding, other measures are sometimes employed. However, because of the nature of personal and family problems, and the characteristics of many Model Neighborhood Area residents, a knowledge and comparison of the eligibility requirements of similar agencies does provide another useful criteria for selecting the appropriate agency by a particular client.

The tables which follow summarize the data assembled in the many varying forms by the health and welfare agencies in this community. A comprehensive view of the whole body of data does show a great impact on a study of the community. The application of a more thorough and analytic process to this body of data could very well question and perhaps dispel some of the myths that have been accepted for years.

2. Cost per Client

a. Health Services

Available data, summarized in Table 2, indicate a wide variation in the cost per client for health services by agencies serving the City. Dividing the agency's current operating budget by the number of clients served during the past year shows a spread ranging from a low of $5.39 to a high of $7928.58 per client. This variation may be misleading because the cost per client obviously depends upon many factors, including the nature and quality of the

service performed. Retreat State Hospital has the highest cost per client and the Tuberculosis Society the lowest, but the wide spread is due to the fact that the Hospital provides complete custodial care for some 700 patients while the TB Society's costs involve expenditures for 6,488 chest x-rays only.

Costs per client are also influenced by whether the services are direct, indirect, or special interest. Hospitals and clinics perform direct services, and the table shows that the Kirby Health Center with an annual budget of $129,000 provides direct clinical service at a per client cost of $6.79. The hospitals also provide direct services for which per client costs range from a low of $107.14 at the Wilkes Barre General Hospital to a high of $351.76 at Luzerne County's Valley Crest. This wide difference is undoubtedly due primarily to the difference in institutional functions, the former dealing with customary hospital functions while the latter is mainly custodial, and only partially medical in nature.

The special interest services also vary considerably in per client costs, ranging from $5.39 for x-rays by the Tuberculosis Society to $600.00 per client served by the Multiple Sclerosis Foundation whose services to each client are much more comprehensive and extensive.

Direct services by hospitals providing only medical treatment also vary considerably in per client costs. Mercy Hospital, operating under an annual budget of $6,000,000.00, and serving about 8,524

patients, has a per client cost of $703.89, while the larger Wilkes Barre General Hospital, also operating under a $6,000,000.00 annual budget, serviced 11,000 in-patients and 45,000 out-patients as a per client cost of $107.14. In this case, the data do not indicate whether the difference in cost is because Mercy may not have included out-patient costs, or for other reasons.

The above data, although it presents a general picture of cost per client illustrates the point that more analytical study is required to determine what is included in the cost of a case - medication, nursing care, administration, food, maintenance, etc. Nor does the data reveal how much utilization each institution makes of expensive equipment. The Office of Comprehensive Health Planning of Northeastern Pennsylvania has been created to identify and assist in meeting regional and local health needs. The Office has encouraged and promoted the establishment of a Wyoming Valley Hospital Council to consider approaches to group purchasing hopefully resulting in considerable savings to the area hospitals and therefore to the MNA residents. Perhaps the Council will be the mechanism for assessing the health services expenditures and other factors, such as equipment, etc., and analyzing where monies could be better spent.

One additional comment needs to be made on the foregoing fund data. There are many agencies - governmental and voluntary and both health and welfare - which engage in some aspect of prevention; and yet

there is no way to know for certain how much - great or little - is actually spent for prevention and what agencies do the spending in Luzerne County, Wyoming Valley, Wilkes-Barre, or the Model Cities Neighborhood.

there is no way to know for certain how much - great or little -

is actually spent for prevention and what agencies do the spending

TABLE 2

HEALTH SERVICES SERVING MODEL NEIGHBORHOOD AREA
BUDGET, SOURCE OF FUNDING, NUMBER OF CLIENTS, COST PER CLIENT

HEALTH SERVICES	BUDGET	SOURCE OF FUNDING *	NO. OF CLIENTS	COST PER CLIENT
I. DIRECT MEDICAL SERVICES				
A. Hospitals				
1. Wilkes-Barre General Hospital	$ 6,000,000.00	V.F.S.	11,00 in patients 45,000 out-patients	$ 107.14
2. Mercy Hospital	6,000,000.00	V.F.S.	8,524	703.89
3. Nesbitt Memorial Hospital	3,700,000.00	S.F.	7,000	528.57
4. Wyoming Valley Hospital	1,612,296.00	V.F.S.	3,745	430.52
5. Veterans' Administration Hospital	9,700,000.00	F.	4,370	2,219.68
6. Valley Crest	1,525,881.00	Co.S.F.	500	3,051.76
B. Clinic Services				
1. Kirby Health Center	129,000.00	V. S.F.	19,000 approx.	6.79
2. Public Health Center				
II. DIRECT MENTAL HEALTH AND/OR RETARDATION SERVICES				
A. Hospitals				
1. Retreat State Hospital	3,700,000.00 (8-month)	S.F.	700	7,928.58
2. White Haven Hospital **				
B. Clinics				
1. Luzerne/Wyoming Counties' Mental Health Center	1,200,000.00	Co. S.F.	1,600	750.00
2. Children's Service Center of Wyoming Valley	340,000.00	V.F.S. Co.	700 families	485.71
C. Information and Referral				
1. Luzerne/Wyoming Counties' Mental Health/ Mental Retardation Program	1,500,000.00	Co.S.F.	2,246	- - -
III. INDIRECT HEALTH SERVICES				
A. Pennsylvania Dept. of Health Regional Office, Region II	1,514,885.00	S.F.	N/A	- - -
B. Wilkes-Barre Department of Health	75,000.00	V.	7,560	9.92

there is no way to know for certain how much - great or little -

is actually spent for prevention and what agencies do the spending

[illegible] Wilkes-Barre, or the Model

TABLE 2 CONTINUED

HEALTH SERVICES SERVING MODEL NEIGHBORHOOD AREA
BUDGET, SOURCE OF FUNDING, NUMBER OF CLIENTS, COST PER CLIENT

HEALTH SERVICES	BUDGET	SOURCE OF FUNDING *	NO. OF CLIENTS	COST PER CLIENT
IV. ADVOCACY SPECIAL INTEREST SERVICES				
A. American Cancer Society	$ 29,010.00	V.	153	189.60
B. Arthritis Foundation	- - -	V.	248	- - -
C. Cystic Fibrosis Foundation	1,450.00	S. F.	65	22.31
D. Luzerne County Mental Health Association	19,000.00	V.	N/A	- - -
E. Multiple Sclerosis Foundation	12,000.00	V.	20	600.00
F. Muscular Dystrophy Association	10,000.00	V.	300	33.33
G. National Foundation -- March of Dimes	10,000.00	V.	43	232.56
H. Tuberculosis Society	35,000.00	V.	6,488 x-rays	5.39
I. Northeastern Pennsylvania Heart Association	48,000.00	V.	300	160.00
J. Luzerne County Association for Retarded Children	23,700.00	V.	none directly	- - -
K. American Red Cross	190,000.00	V.	1,544 veterans servicemen and their families.	123.06

* KEY--

C - City
Co. - County
F. - Federal
S - State
V - Voluntary

** Questionnaire not returned at time of publication.

there is no way to know for certain how much - great or little - is actually spent for prevention and what agencies do the spending in Luzerne County, Wyoming Valley, Wilkes-Barre, or the Model Cities Neighborhood.

These questions are raised because the data are not in themselves conclusive but do suggest other questions for study. As the data now stand, the MNA residents can only view, with some justification, the great disparity in costs per client as beyond their reach.

b. Welfare Services

Having advised extreme caution in evaluating health service agencies on the basis of their cost per client ratio because of the great variations in the nature and extent of their services, an even stronger word of caution is necessary in the evaluation of welfare services on that basis. Even a cursory examination of Table 3 on welfare services shows such a range of variables among welfare services, that to compare on the basis of cost per client would be like comparing completely unrelated items. The only justifiable conclusion warranted by the data is that Welfare service costs per client range from a low of $.63 for character building activities at the Georgetown Settlement to more than $1,500.00 per client for direct rehabilitation services at the Bureau of Vocational Rehabilitation. Obviously, there is no basis for comparison but this wide range certainly does make a good argument for preventive activities.

The Commission on Economic Opportunity expended $583.33 to

provide each of 1,200 clients one of an undesignated number of family social services. In the same fiscal period, the Planned Parenthood Association expended $33.86 for each client. It is not valid to compare the former which performs a large variety of services with the latter whose functions are restricted to a single purpose.

Even though their services may be quite similar in character, it would be invalid to compare the $30.34 per client expended by the Legal Aid Society with the $108.33 spent for each client by the Legal Services Association, simply because their approach, clientele, and method of operation differ in so many respects.

It would be more valid to make a comparison when each reaches the same target population. But this will not be possible because the Legal Aid Society may be "phased out" because of lack of United Fund support.

In spite of the reservations above, certain observations are clearly obvious. Exclusive of the CEO, there is at least $709,070 expended in the community for family type social services, ranging all the way from $13.33 per client to $318.58 per client (exclusive of Council of Churches).

If only Family Service, Catholic Social Services, Jewish Welfare Agency, Homemaker Service, and Visiting Nurse Association are considered (all of which are United Fund Agencies), the per client cost goes from $33.86 to $318.58. All of these agencies are predominately involved in removing family tensions due to lack of finances, poor health, personal disagreements, loss of income, etc.

If direct rehabilitation services are considered, the cost per client

TABLE 3

WELFARE SERVICES SERVING MODEL NEIGHBORHOOD AREA
BUDGET, SOURCE OF FUNDING, NUMBER OF CLIENTS, COST PER CLIENT

WELFARE SERVICES	BUDGET	SOURCE OF FUNDING *	NO. OF CLIENTS	COST PER CLIENT
I. ECONOMIC SECURITY SERVICES				
A. Income Maintenance				
1. Social Security Administration	$ - - -	F.	77,000	$ - - -
2. Veterans' Administration	- - -	F.	- - -	- - -
3. Luzerne County Board of Assistance	18,000,000.00	F. S. C	16,328	$1,102.40
B. Jobs and Training				
1. Bureau of Employment Security	- - -	F. S.	15,000	- - -
2. Concentrated Employment Program	1,200,000.00	F. S. C.	1,200	1,000.00
II. FAMILY, CHILDREN'S, AND SUPPORTIVE CARE SERVICES				
A. Family Social Services				
1. Family Service Association of Wyoming Valley	95,018.00	V.	880 families	107.98
2. Wyoming Valley Council of Churches--Meals on Wheels	34,000.00	V.	100 churches	340.00
3. Catholic Social Services	102,056.00	V.	3,014	33.86
4. Planned Parenthood Association	8,000.00	V.	600	13.33
5. Jewish Welfare Agency	21,181.00	V.	160	132.38
6. Luzerne County Bureau for the Aging	100,000.00	F. S. C.	1,600	62.50
7. Adult Welfare Services and Project Reach Out for Life (Luzerne County)	97,044.00	F. S. C.	1,500	64.70
8. Visiting Nurses Association of Wyoming Valley	179,771.00	V.	1,311	137.13
9. Homemakers Service of Luzerne County	72,000.00	V.	226 families	318.58
10. Commission on Economic Opportunity	700,000.00	F. S. C.	1,200	583.33
B. Children's Welfare and Educational Services				
1. Luzerne County Child Welfare Services	1,049,992.00	F. S. C.	1,500	64.70
2. St. Michaels Home for Boys * *	...	V.	—	...
3. St. Stanislaus Institute	- - -	V.	95	- - -
4. Project Headstart * *	...	F.	...	...

If direct rehabilitation services are considered, the cost per client ranges from $8.33 to $2,000. Of course, again the rehabilitation service of

TABLE 3

CONTINUED (2)

WELFARE SERVICES SERVING MODEL NEIGHBORHOOD AREA
BUDGET, SOURCE OF FUNDING, NUMBER OF CLIENTS, COST PER CLIENT

WELFARE SERVICES	BUDGET	SOURCE OF FUNDING*	NO. OF CLIENTS	COST PER CLIENT
C. Institutions				
1. Home for Homeless Women	$ - - -	V.	40	$ - - -
2. Sutton Home	- - -	V.	21	- - -
III. DIRECT REHABILITATION SERVICES				
A. General				
1. United Rehabilitation Service	approx. $ 1,000,000.00	F.S.C.V.	500	2,000.00
2. Wayside Mission	- - -	V.	1,000	- - -
3. Salvation Army	100,000.00	V.	12,000	8.33
4. Bureau of Vocational Rehabilitation	3,500,000.00	F.S.	2,300	1,521.74
B. Special Group				
1. Crippled Children's Association	113,000.00	S.V.	781	144.69
2. Bureau of Visually and Physically Handicapped	900,000.00	F.S.	8,000	112.50
3. United Cerebral Palsy	41,000.00	S.V.	150	273.33
4. Alcoholics Anonymous	- - -	V.	- - -	- - -
5. Pennsylvania Association for the Blind	27,000.00	V.	362	74.59
IV. DIRECT LEGAL AND CORRECTIVE SERVICES				
A. Governmental				
1. Adult Probation, Luzerne County	- - -	S.C.	500-600	- - -
2. Juvenile Court, Luzerne County	350,000.00 - 400,000.00	F.S.C.	600	625.00
3. Domestic Relations Court, Luzerne County	86,590.00	C.	10,000	11.55
B. Consumer				
1. Legal Services Association	65,000.00	F.S.C.	600	108.33
2. Legal Aid Society	23,000.00	V.	768	30.34

TABLE 3

WELFARE SERVICES SERVING MODEL NEIGHBORHOOD AREA

BUDGET, SOURCE OF FUNDING, NUMBER OF CLIENTS, COST PER CLIENT

CONTINUED (3)

WELFARE SERVICES	BUDGET	SOURCE OF FUNDING*	NO. OF CLIENTS	COST PER CLIENT
V. COMMUNITY CHARACTER BUILDING GROUP SERVICES				
A. National Affiliation				
1. Boy Scouts of America	$ 141,885.00	V.	10,000	$ 14.19
2. Girl Scouts of America	189,265.00	V.	11,310	16.73
3. YMCA	175,000.00	V.	2,900 paying 90,000 non-paying	
4. YWCA **	. . .	V.	. . .	. . .
B. Local Affiliation				
1. Catholic Youth Center	124,764.00	V.	6,209	20.09
2. Georgetown Settlement	10,000.00	V.	16,000	.63
3. Jewish Community Center	300,000.00	V.	1,600 families	187.50
VI. SPECIAL INTEREST SERVICES				
A. Pennsylvania Veterans Commission	- - -	C.	4,500	- - -
B. Federation for the Blind	3,000.00	V.	1,200	2.50
VII. INDIRECT WELFARE SERVICES				
A. Pennsylvania Department of Public Welfare, Region II, Scranton **	. . .	F.S.	. . .	. . .
B. Commission on Economic Opportunity	700,000.00	F.	1,200	583.33

* KEY

C. -- City
Co. - County
F. - Federal
S. - State
V. -Voulntary

** Questionnaire not returned at time of publication.

If direct rehabilitation services are considered, the cost per client ranges from $8.33 to $2,000. Of course, again the rehabilitation service of the Wayside Mission is far different than that of the United Rehabilitation Service.

Initial costs may show larger expenditures in certain programs than in others because certain ones are deliberately initiated on low cost projections (mostly using volunteers) to demonstrate viability before the larger community decides to take on a greater responsibility for the support.

3. Case Load

A word of caution must be given to the reader so that he can judiciously use the data that follows. The case load, or the number of clients served by each employee in a health service agency is frequently used to determine efficiency and quality of such service. However, it is erroneous to assume that the smaller the case load of an employee the higher the quality of service, or, conversely, the larger the case load the lower the quality. The wide range of case loads per employee in the health service agencies in the City should be evaluated in relation to many factors, including the nature of the service rendered as well as the professional or voluntary status of the employee.

a. Health Services

The 9 employees of the Kirby Health Center, which operate as a clinical staff, served 19,000 clients or 2,111.1 clients per employee. This is doubtless due to the fact that less time is required for each client by the

nature of the service rendered. In the same sense, the 2 employees of the Luzerne/Wyoming Counties Mental Health/Mental Retardation Program served 2,246 clients, or, 1,123.0 per employee, primarily because this service is informational and referral in nature.

Valley Crest, administered by the County, has the lowest client-employee ratio of 2.5 among the direct service by hospitals. This ratio should not be compared with the other hospitals because the nature of their services differs completely.

On the surface, the direct medical service case load of employees at the Wilkes-Barre General Hospital (108.5) appears to be out of line with the other hospitals cited in the table. However, in addition to caring for 11,000 in-patients with varying periods of stay, the General Hospital services 45,000 out-patients requiring short visits. The other hospitals listed do not indicate the number of out-patients, and it may therefore be the reason why the case load per employee for long-stay in-patients is considerably lower than shown. Data were not sought, nor were they offered, as to which activities were handled on an out-patient and in-patient basis.

Excluding the Wilkes-Barre General Hospital, the Mercy Hospital has the highest case load per employee with 292 employees handling 8,524 patients, or 29.2 per employee. At Nesbitt Memorial, 413 employees care for 7,000 patients, resulting in a case load of 17.0 per employee. Wyoming Valley Hospital with approximately one-half the number of employees and patients as Nesbitt, has a case load of 19.7 patients per employee.

To return to a point made in a previous section, there is no clear definition of a case or service with either medical or mental health service. Nor can

TABLE 4

HEALTH SERVICES SERVING MODEL NEIGHBORHOOD AREA
NUMBER OF EMPLOYEES, CLIENTS, AND CASE LOAD

HEALTH SERVICES	NO. OF EMPLOYEES	NO. OF CLIENTS	CLIENTS PER EMPLOYEE
I. DIRECT MEDICAL SERVICES			
A. Hospitals			
1. Wilkes-Barre General Hospital	516	11,000 in patients 45,000 out patients	108.5
2. Mercy Hospital	292	8,524	29.2
3. Nesbitt Memorial Hospital	413	7,000	17.0
4. Wyoming Valley Hospital	190	3,745	19.7
5. Veterans' Administration Hospital	340	4,370	12.9
6. Valley Crest	200	500	2.5
B. Clinic Services			
1. Kirby Health Center	9	19,000	2,111.1
2. Public Health Center	22	- - -	- - -
II. DIRECT MENTAL HEALTH AND/OR RETARDATION SERVICES			
A. Hospitals			
1. Retreat State Hospital	207	700	3.4
2. White Haven State School Hospital*			
B. Clinics			
1. Luzerne/Wyoming Counties' Mental Health Center	40	1,600	40.0
2. Children's Service Center of Wyoming Valley	28	700 families	25.0
C. Information and Referral			
1. Luzerne/Wyoming Counties' Mental Health/Mental Retardation Program	2	2,246	1,123.0
III. INDIRECT HEALTH SERVICES			
A. Pennsylvania Department of Health Regional Office, Region II	122	not applicable	- - -
B. Wilkes-Barre City Department of Health	8	7,560	945.0

To return to a point made in a previous section, there is no clear definition of a case or service with either medical or mental health service. Nor can ... otherwise--clearly spell out what

TABLE 4
HEALTH SERVICES SERVING MODEL NEIGHBORHOOD AREA
NUMBER OF EMPLOYEES, CLIENTS, AND CASE LOAD

CONTINUED

HEALTH SERVICES	NO. OF EMPLOYEES	NO. OF CLIENTS	CLIENTS PER EMPLOYEE
IV. ADVOCACY SPECIAL INTEREST SERVICES			
A. American Cancer Society	2	153	76.5
B. Arthritis Foundation	1	248	248.0
C. Cystic Fibrosis Foundation	not applicable	65	- - -
D. Luzerne County Mental Health Association	2	not applicable	- - -
E. Multiple Sclerosis Foundation	1	20	20.0
F. Muscular Dystrophy Association	1	300	300.0
G. National Foundation -- March of Dimes	1	43	43.0
H. Tuberculosis Society	1	6488 x-rays	6,488.0
I. Northeastern Pennsylvania Heart Association	3	300	100..0
J. Luzerne County Association for Retarded Children	1	none directly	- - -
K. American Red Cross	30	1,544 servicemen, veterans and their families	51.5

* Questionnaire not returned at time of publication.

To return to a point made in a previous section, there is no clear definition of a case or service with either medical or mental health service. Nor can any person or group--professional or otherwise--clearly spell out what activities belong to a "provision of a service". There is no specificity as to what must occur before a case is closed. Length of time could be a part of the definition, and yet no professional would agree to the use of this single criterion.

If the above is so true of "normal" service, an "emergency" hospital service is just as vague and indeterminate if not more so. To illustrate, a patient may need a family doctor to certify admission. If no family doctor can be procured, admission is rejected, as so often happens to the MNA residents. What then? Is this (no family physician certification) an emergency?

The comments made in the foregoing are as applicable to mental health organizations as to hospitals.

Among the special interest health services, most have indicated only one employee, indicating that much of the work is done by non-listed voluntary personnel. The American Red Cross shows 30 employees handling the needs of 1,544 servicemen, veterans, and their families, with each employee serving 51.5 clients. The single employee of the Muscular Dystrophy Association, serving 300 clients, has a case load of 300 per employee.

From the Table 4 it appears that the case load handled by the single

employee of the Tuberculosis Society is 6,488, which is the highest case load shown. This figure represents only the x-ray service which is performed by special personnel, while the one regular Society employee provides an unspecified number of other services for clients.

If certain clinics are in the process of phasing out, one could assume that the problems previously handled by them no longer exist. However, if the problems still plague the community, especially the poor and/or welfare client, there is no way of knowing what agency or agencies now service those clients.

The data present the number of clients served and not the refusals or rejections. Subsequent data in Part II of this study would indicate that the rejections are in sufficient numbers to warrant the feeling among the MNA resident that the health problem is "worsening." The reasons for these could be due to a number of reasons that require a further in-depth study.

b. Welfare Services

Evaluation of welfare agencies is not justified on the basis of the number of clients served by each employee but on the nature of the service rather than on the attributes of the client. Although some of the agencies listed in the following table perform some functions which are somewhat similar, each has its own distinctive type of client, kind of service activity, and each differs in the amount of time required by the nature of the service for each client.

The case load for family social services ranges from 7.8 for Homemakers

Service of Luzerne County which has 29 employees serving 226 families to 300.0 clients for each of the two employees servicing 600 families for the

TABLE 5

WELFARE SERVICES SERVING MODEL NEIGHBORHOOD AREA
NUMBER OF EMPLOYEES, CLIENTS, AND CASE LOAD

WELFARE SERVICES	NO. OF EMPLOYEES	NO. OF CLIENTS	CLIENTS PER EMPLOYEE
I. ECONOMIC SECURITY SERVICES			
A. Income Maintenance			
1. Social Security Administration	37	77,000	2,081.1
2. Veterans' Administration	340	4,370	12.9
3. Luzerne County Board of Assistance	104	16,328	157.0
B. Jobs and Training			
1. Bureau of Employment Security	50	15,000	300.0
2. Concentrated Employment Program	25	1,200	48.0
II. FAMILY, CHILDREN'S, AND SUPPORTIVE CARE SERVICES			
A. Family Social Services			
1. Family Service Association of Wyoming Valley	8	880 families	110.0
2. Wyoming Valley Council of Churches -- Meals on Wheels	8	100 churches	12.5
3. Catholic Social Services	9	3,014	33.5
4. Planned Parenthood Association	2	600	300.0
5. Jewish Welfare Agency	2	160	80.0
6. Luzerne County Bureau for the Aging	10	1,600	160.0
7. Adult Welfare Services and Project Reach Out for Life (Luzerne Co.)	7	1,500	214.3
8. Visiting Nurses Association of Wyoming Valley	15	1,311	87.4
9. Homemakers Service of Luzerne County	29	226 families	7.8
10. Commission on Economic Opportunity	23	1,200	52.2
B. Children's Welfare and Educational Services			
1. Luzerne County Child Welfare Services	22	12,000	545.5
2. St. Michaels Home for Boys *			
3. St. Stanislaus Institute	24	95	4.0
4. Project Headstart *			

Service of Luzerne County which has 29 employees serving 226 families to 300.0 clients for each of the two employees servicing 600 families for the [illegible] Association. Doubtless, this is a wide spread in work

TABLE 5

CONTINUED (2)

WELFARE SERVICES SERVING MODEL NEIGHBORHOOD AREA
NUMBER OF EMPLOYEES, CLIENTS, AND CASE LOAD

WELFARE SERVICES	NO. OF EMPLOYEES	NO. OF CLIENTS	CLIENTS PER EMPLOYEE
C. Institutions			
1. Home for Homeless Women	6	40	6.7
2. Sutton Home	-	21	- -
III. DIRECT REHABILITATION SERVICES			
A. General			
1. United Rehabilitation Service	30	500	16.7
2. Wayside Mission	5	1,000	200.0
3. Salvation Army	4	12,000	3,000.0
4. Bureau of Vocational Rehabilitation	55	2,300	41.8
B. Special Group			
1. Crippled Children's Association	7	781	111.6
2. Bureau of Visually and Physically Handicapped	7	8,000	470.6
3. United Cerebral Palsy	10	150	15.0
4. Alcoholics Anonymous	N/A	- -	- - -
5. Pennsylvania Association for the Blind	2	362	181.0
IV. DIRECT LEGAL AND CORRECTIVE SERVICES			
A. Governmental			
1. Adult Probation, Luzerne County	4	500-600	137.5
2. Juvenile Court, Luzerne County	18	600	33.3
3. Domestic Relations Court, Luzerne County	6	10,000	1,250.0
B. Consumer			
1. Legal Services Association	3	600	200.0
2. Legal Aid Society	1	768	768.0

Service of Luzerne County which has 29 employees serving 226 families to 300.0 clients for each of the two employees servicing 600 families for the

TABLE 5

CONTINUED (3)

WELFARE SERVICES SERVING MODEL NEIGHBORHOOD AREA
NUMBER OF EMPLOYEES, CLIENTS, AND CASE LOAD

WELFARE SERVICES	NO. OF EMPLOYEES	NO. OF CLIENTS	CLIENTS PER EMPLOYEE
V. COMMUNITY CHARACTER BUILDING GROUP SERVICES			
A. National Affiliation			
1. Boy Scouts of America	7	10,000	1,428.6
2. Girl Scouts of America	-	11,310	706.9
3. YMCA	60	2,900 paying, 90,000 non-paying	1,550.0
4. YWCA *			
B. Local Affiliation			
1. Catholic Youth Center	6	6,209	1,034.8
2. Georgetown Settlement	5	16,000	3,200.0
3. Jewish Community Center	40	approx. 1,600 families	40.0
VI. SPECIAL INTEREST SERVICES			
A. Pennsylvania Veterans Commission	2	4,500	2,250.0
B. Federation for the Blind	1	1,200	1,200.0
VII. INDIRECT WELFARE SERVICES			
A. Pennsylvania Department of Public Welfare, Region II, Scranton *			
B. Commission on Economic Opportunity	23	1,200	52.2

* Questionnaire not returned at time of publication.

Service of Luzerne County which has 29 employees serving 226 families to 300.0 clients for each of the two employees servicing 600 families for the Planned Parenthood Association. Doubtless, this is a wide spread in work load, but perfectly valid and understandable in view of the difference in the type of services rendered.

If just the "family type" agencies are considered, the range begins at 33.5 for Catholic Social Services to 110 for the Family Service Association.

The rehabilitation work of the United Cerebral Palsy (15.0 clients per employee) is far different than that of the Salvation Army (3,000 clients per employee).

In spite of the fact that the case load per employee in itself is no indication of the relative efficiency or effectiveness of even the most similar agencies, the data does offer a point from which the ordinary MNA resident makes comparisons and arrives at conclusions sometimes justifiable and sometimes not.

4. Core and Peripheral Services

a. Health Services

As indicated in the following summary table, 25 surveyed agencies provide a wide range of health services within the City. In most instances, the type of core services provided can be readily identified by the name of the agency. Peripheral services are usually directly related to or flow from the core services, and, in fact, may justifiably be included as core in some instances.

The major services currently provided include comprehensive acute medical and surgical care for in-patients and out-patients, diagnostic and nursing service for communicable and chronic diseases, and maternal and child health, immunization, mental health, and varying kinds of assistance in specialized diseases. Except for the hospitals, a significant number of health agencies devote considerable effort to professional and public education in their respective fields, although it is difficult to tell for whom it is intended.

Nearly all of the core services identified by this study relate to those for acute illness or handicap. Therefore the foci of health services systems are the negative of health.

Six agencies provide general acute medical and surgical service, while Valley Crest provides medical, but not surgical service. Only the Public Health Center of Luzerne County provides diagnostic and nursing service for communicable and chronic diseases and maternal and child health. Two hospitals, Wilkes-Barre General and Retreat provide psychiatric care. Three other agencies provide such treatment on an out-patient basis, either directly or by referral. There appears to be little or no overlapping of services among the specialized health agencies. It is noteworthy that only the Kirby Health Center provides a dental service for children.

Fourteen of the 25 agencies included in the tabulation provide professional and/or public education in their respective fields.

Surprisingly, the table indicates very little duplication of services, except, of course in the case of hospitals and agencies dealing in mental health

problems. But this can be expected since health service is an admitted misnomer, though it makes for a clean administrative definition. Clients (or patients) are readily lost in this kind of vertical arrangement.

Note should be made that fund raising, an integral part of administrative operation of any organization, is included as a service. It is highly doubtful if such an activity can be labelled a health service. To compound the difficulty in interpreting the data, some agencies placed fund raising as core and others as peripheral. Certainly where funds are expended is a much more significant yardstick of commitment to a health service. It would appear that many agency respondents had difficulty in distinguishing between core and peripheral service.

Several other points can be deduced from the data that may help to clarify the data submitted. Emergency care, as listed by several institutions, could mean only for those who have a family doctor admit them. It could also conceivably mean first aid treatment to a street or home accident. The peripheral services provided by an institution such as Retreat State Hospital are for patients only, and therefore very limited. A service like cardiology is ordinarily utilized only to ascertain the ability of a patient to withstand shock treatment.

Finally, it should be stated that it was not the province of the interviewer to question data submitted, although in the analysis and evaluation of data many questions concerning the accuracy and pertinence of data arose.

TABLE 6

CORE AND PERIPHERAL SERVICES
HEALTH SERVICES

NAME OF AGENCY	CORE SERVICES	PERIPHERAL SERVICES
	HOSPITALS	
Wilkes-Barre General Hospital	Comprehensive medical and diagnostic care for acute illness	Emergency care Psychiatric care
Mercy Hospital	Comprehensive medical care for an acute illness Special services such as: inhalation therapy physical therapy cardiology	Education for nurses
Nesbitt Memorial Hospital	Acute medical and surgical care	Obstetrical care Emergency care Ancillary medical services
Wyoming Valley Hospital	Medical care for patients Surgical services	Obstetrical and related services Emergency care
Veterans'Administration Hospital	Comprehensive physical and mental in-patient care Out-patient medical service	Emergency service Social work service
Valley Crest County Home	Complete medical service except surgery	Physical therapy Occupational therapy Diagnostic service Intensive care-coronary disease

TABLE 6 CONTINUED (2)

CORE AND PERIPHERAL SERVICES
HEALTH SERVICES

NAME OF AGENCY	CORE SERVICES	PERIPHERAL SERVICES
	HEALTH CLINICS	
Kirby Health Center	Immunization against communicable diseases Controlling food and water quality	Dental clinic for children under 13 years of age Chest x-rays testing
Public Health Center of Luzerne County	Diagnostic and nursing services in communicable diseases, chronic diseases, and in maternal and child health	
	MENTAL HOSPITALS	
Retreat State Hospital	Providing psychiatric services	Providing general medical services for patients only Providing special service in surgery Providing special occular care Providing consultation in cardiology
	MENTAL CLINICS	
Luzerne/Wyoming Counties' Mental Health/Mental Retardation Program	Diagnosis & treatment of mental disorders both in out-patient care and in short term in-patient hospitalization Emergency care and after care	Education and consultation
Children's Service Center of Wyoming Valley	Out-patient psychotherapy Partial hospitalization Diagnosis & treatment of psychological, some neurological and psychiatric malfunctions and dysfunctions	Consultation to schools and juvenile court Training of psychiatric social workers and training of clinical psychologists and child psychiatrists

TABLE 6 CONTINUED (3)

CORE AND PERIPHERAL SERVICES
HEALTH SERVICES

NAME OF AGENCY	CORE SERVICES	PERIPHERAL SERVICES
INFORMATION AND REFERRAL		
Luzerne/Wyoming Mental Health and Retardation Program	Planning and development of programs concerning mental health and retardation	Referral services
INDIRECT HEALTH SERVICES		
Pennsylvania Department of Health, Region II	Preventive medical services Environmental control (sewage, etc.) Enforcement of laws protecting the environment Individual rehabilitation	Education
Wilkes-Barre City Department of Health	Bacteriological and chemical analysis of food and water	Checking sewage systems Immunization
ADVOCACY SPECIAL INTEREST ORGANIZATIONS		
American Cancer Society	Informational service concerning the danger of cancer Multiple services such as transportation, medication, dressings Reach to recovery program for mastectomy	
Arthritis Foundation-Eastern Pa. Chapter	Raising funds for research Orthopedic help to patients Weekly clinics	Education

TABLE 6 CONTINUED (4)

CORE AND PERIPHERAL SERVICES
HEALTH SERVICES

NAME OF AGENCY	CORE SERVICES	PERIPHERAL SERVICES
Cystic Fibrosis Foundation Anthracite Branch	Physical and medical assistance to those afflicted	Financial support to parents Raising funds for research Education
Luzerne County Mental Health Association	Educational programs for specialized groups	Organizing volunteer program at Retreat State Hospital
Multiple Sclerosis Foundation	Necessary equipment for afflicted persons Fund raising for research Hope Club for individuals afflicted by multiple sclerosis	
Muscular Dystrophy Association of N.E. Penna.	Medical equipment for persons afflicted by muscular dystrophy Psychological and attitudinal support	Raising funds for research
National Foundation-March of Dimes Wyoming Valley Chapter	Fund raising campaign for research Medical services for those having birth defects Post-polio care	Scholarships to graduate students Education
Tuberculosis Society Wyoming Valley	TB tests in schools Mobile x-ray units Research on respiratory ailments	Christmas Seal Campaign Education

TABLE 6 CONTINUED (5)

CORE AND PERIPHERAL SERVICES
HEALTH SERVICES

NAME OF AGENCY	CORE SERVICES	PERIPHERAL SERVICES
Northeastern Pennsylvania Heart Association	Professional and public education concerning the disease of heart and circulatory system	Special funds in emergencies to persons suffering from heart conditions Diagnosis of rheumatic fever
Luzerne County Association for Retarded Children	Education concerning the needs of retarded children Information bureau and referral	Seminars on mental retardation Education
American Red Cross	Organizing blood drives and collecting and dispensing blood Help to armed forces' families	Services during disasters Educational program in first aid and swimming Nursing program for nursing aides Program for Red Cross volunteers

TABLE 7

CORE AND PERIPHERAL SERVICES
WELFARE SERVICES

NAME OF AGENCY	CORE SERVICES	PERIPHERAL SERVICES
	INCOME MAINTENANCE	
Social Security Administration	Processing claims and providing payments Unemployment, medical, and general assistance	Informing public about eligibility, benefits, etc.
Veterans' Administration	Information, screening and referral service for veterans and their survivors	Help in emergencies Processing applications for Viet Nam bonus Securing educational benefits
Luzerne County Board of Assistance	Financial assistance to eligible clients General assistance in meeting medical needs Administration of Federal Food Stamp program	Counselling
	JOBS AND TRAINING	
Bureau of Employment Security	Unemployment compensation Placement for job ready applicants Counselling for those not job ready Work training and job placement Job orientation program	Day care for children of working mothers Mutual referral with the Bureau of Vocational Rehab.
	FAMILY SOCIAL SERVICES	
Family Service Assoc. of Wyoming Valley	Family as a group and individual counselling	Training of social workers Participating in community planning of the effective welfare delivery system

TABLE 7 CONTINUED (2)

CORE AND PERIPHERAL SERVICES
WELFARE SERVICES

NAME OF AGENCY	CORE SERVICES	PERIPHERAL SERVICES
Wyoming Valley Council of Churches	Providing chaplain services for hospitals and nursing homes	Organizing and executing meals on wheels
Catholic Social Services of Wyoming Valley	Family counselling or individual counselling	Monitoring community problems and influencing legislation concerning social welfare
Planned Parenthood Association	Education regarding family planning and birth control Providing birth control devices and pills	PAP smear test, pelvic and breast examination Referral
Jewish Welfare Agency	Consultation and help in various family and individual problems	
Luzerne County Bureau for the Aging	Operating two Senior Citizen centers Counselling and referral	Organizing foster care for elderly Organizing and coordinating programs for elderly
Adult Welfare Services and Project Reach Out for Life (Luzerne County)	Processing applications for admission to Valley Crest Placement of infirm in nursing homes	Processing admissions of alcoholics to the alcoholic unit in Danville Supplying transportation and clothing to TB patients Paying burial services
Visiting Nurses Assoc. of Wyoming Valley	Professional nursing and related services to patients in homes Counselling and health education to families	

TABLE 7 CONTINUED (3)

CORE AND PERIPHERAL SERVICES
WELFARE SERVICES

NAME OF AGENCY	CORE SERVICES	PERIPHERAL SERVICES
Homemakers Service of Luzerne County	Help to families in times of stress such as illness, convalescence, or other cases of emergency	
Commission on Economic Opportunity of Luzerne County	Reaching the poor Organizing the poor Tutoring, consumer education, manpower, housing, legal	Information and education
CHILDREN'S WELFARE AND EDUCATIONAL SERVICES		
Luzerne County Child Welfare Services	Protective services to children neglected or abused Foster family care Institutional care	Adoption services Service to unmarried parents Day care service
St. Michael's Home for Boys	Institutional care for dependent or neglected children	Medical and dental service Social work service with children and their families
St. Stanislaus Institute	Institutional care for dependent or neglected children	Remedial scholastic program for educationally deprived child Providing work-study experience Medical and dental service Social work services with children and their parents
Project Headstart	Part-day program for pre-school age children who are economically deprived	Medical and dental services Social work services with family and child

TABLE 7 CONTINUED (4)

CORE AND PERIPHERAL SERVICES
WELFARE SERVICES

NAME OF AGENCY	CORE SERVICES	PERIPHERAL SERVICES
	INSTITUTIONS	
Home for Homeless Women	Residential care for women 70 years of age and over	Infirmary for sick Work placement outside the agency
Sutton Home for Aged and Infirm Men	Residential care for the aged and infirm	Medical care Recreation
	GENERAL REHABILITATION	
United Rehabilitation Services	Rehabilitation of handicapped Sheltered employment	Day care Half-way house
Wayside Mission	Rehabilitation of alcoholics	Assistance to the people in need Rehabilitation through work
Salvation Army of Wyoming Valley	Recreation and activities not provided by the community	Emergency relief Assistance in the form of food, clothing, toys Home for unwed mothers
Bureau of Vocational Rehabilitation	Medical and vocational diagnosis Counselling and physical rehabilitation Training and job placement	Miscellaneous services to handicapped persons
	SPECIAL GROUP-REHABILITATION	
Crippled Children's Association	Diagnosis and treatment of orthopedic conditions of crippled children Operation of kindergarten and nursery school	Diagnosis and treatment of speech disorders Diagnosis and treatment of cerebral palsy

TABLE 7 CONTINUED (5)

CORE AND PERIPHERAL SERVICES
WELFARE SERVICES

NAME OF AGENCY	CORE SERVICES	PERIPHERAL SERVICES
Bureau of Visually and Physically Handicapped	Vocational rehabilitation and job placement Services to blind persons	Remedial eye care-eye pathology Home teaching for adult blind persons
United Cerebral Palsy	Physical, emotional, and vocational support to persons afflicted by CP	Operation of day care center for CP
Alcoholics Anonymous	Rehabilitation Group therapy on fellowship level	
Pennsylvania Assoc. for the Blind	Glasses to those who are not covered by Bureau of Visually and Physically Handicapped	Vision screening and public education to prevent blindness
	CORRECTIVE GOVERNMENTAL	
Adult Probation, Luzerne County	Supervision of parole and probation Pre-sentence investigation	Work and training placement
Juvenile Court, Luzerne County	Court hearings for children in trouble with the law and pre-sentence investigating Court-commitment of children to institutions Probation services for children Adjudication reissues about children: dependent, neglected or delinquent	

TABLE 7 CONTINUED (6)

CORE AND PERIPHERAL SERVICES
WELFARE SERVICES

NAME OF AGENCY	CORE SERVICES	PERIPHERAL SERVICES
Domestic Relations Court, Luzerne County	Entry and enforcement of financial support Hearings to reconcile married couples	Enforcement of visitation of father Referrals of cases for counselling, psychiatric help, etc.
	LEGAL CONSUMER	
Legal Services Association	Legal help to indigent clients in civil matters	General concern with injustice and inequity Information concerning legal matters of economically deprived
Legal Aid Society	Legal aid to clients involving mainly land-lord-tenant relationships	
	CHARACTER BUILDING GROUPS	
Boy Scouts of America	Organization of community's groups to sponsor scouting units Training adults for assuming roles in the program	Program for boys to insure physical fitness, character Year round camping program
Girl Scouts of America Penn's Woods Council	Organize Girl Scout troops Organize camping program	Training adults and girls in leadership Community services by Girl Scouts
Young Men's Christian Association	Recreation and physical fitness building Helping in educational process	Spiritual guidance
Young Women's Christian Association*		

TABLE 7 CONTINUED (7)

CORE AND PERIPHERAL SERVICES
WELFARE SERVICES

NAME OF AGENCY	CORE SERVICES	PERIPHERAL SERVICES
Catholic Youth Center	Recreation services mainly for group activity	
Georgetown Settlement Association	Meeting place and recreation center for local organizations	Nursery school
Jewish Community Center of Wyoming Valley	Providing recreational opportunities	General educational programs Organizing social events
SPECIAL INTEREST SERVICES		
Pennsylvania Veterans Commission	Burial services Assisting veterans in need	Providing all veterans with flags & grave markers
Federation for the Blind	Information and referral services for the blind Maintenance of advocacy interests for blind	Socialization
INDIRECT WELFARE SERVICES		
Penna. Dept. of Public Welfare, Region II, Scranton*		
Commission on Economic Opportunity		

* Questionnaire not returned at time of publication

b. Welfare Services

Forty-three separate agencies provide a wide range of welfare services to residents of the city. The types of service range from single- purpose public and private organizations to public and private multi-purpose groups. The following table lists these organizations and indicates that while each has a core function or functions, each also provides a multitude of different services which are peripheral to the primary general service by which the agency is best known.

Five agencies are concerned solely with provision of economic security, including income maintenance, jobs, and training. Sixteen agencies, both public and private, concentrate their effort on family, children's welfare and educational services, and institutional care. The core services of four agencies involve direct general rehabilitation, and five devote their total effort to specialized areas of rehabilitation. Direct legal and corrective services are the sole function of three county governmental services, and two private agencies. Character building activities are the basic function of seven agencies, while four agencies provide special interest or indirect welfare services.

This table appears to warrant the conclusion that the city has available what seems to be adequate coverage of the broad categories of welfare services. Examination of the tabulation will indicate that, together with the related peripheral services, some of which are duplicated, the number and variety of services available appears adequate. Of course, the significant question

in so far as the MNA residents are concerned, is the availability of these services when needed.

Examination of the table suggests a major concern with families and children and sixteen agencies provide this kind of service. Clearly many groups in the community carry the same values but this raises the question, why these groups do not come together to form a more unified delivery system of services.

The same comment can be made with the character building activities, rehabilitation, and legal services.

The immediate conclusion from the table of services may be a sense of satisfaction. The community does have quite a number of organizations providing a wide range of services. We are not as certain that we can deduce from the data the scope of these services, whether the response is a satisfactory one, the broadness of the coverage, and the people actually reached by the service.

The core services of the organizations demonstrate the immediate concerns of the organization. The table suggests preoccupation with services that offer "help" and "advice" to people who need it or who ask for it. It may be that the organizations included in the table are attacking only symptoms of problems by providing services.

5. Type of Service

a. Health Services

The data that follow identify the specific core and peripheral health

TABLE 8

TYPE OF SERVICES OFFERED TO MODEL NEIGHBORHOOD AREA HEALTH SERVICES

SERVICES	AGENCIES	ELIGIBILITY REQUIREMENTS
MEDICAL TREATMENT--HOSPITALS		
General medical care	a. Wyoming Valley Hospital	a. Need for hospital care other than for chronic illness
	b. Retreat State Hospital	b. Mentally ill, 16 years of age, and Pennsylvania residency
	c. Nesbitt Memorial Hospital	c. Need for medical care
	d. Mercy Hospital	d. Need for medical care
	e. Valley Crest County Hospital	e. Need for skilled nursing care, 20 years of age, and indigent
	f. Veteran's Administration Hospital	f. Need for medical care, and veteran
Emergency treatment	a. Wyoming Valley Hospital	a. Need for hospital care other than for chronic illnesses
	b. Nesbitt Memorial Hospital	b. Need for medical care
	c. Veteran's Administration Hospital	c. Need for medical care, and veteran
	d. Wilkes-Barre General Hospital	d. Need for medical care
Obstetrical treatment	a. Wyoming Valley Hospital	a. Need for hospital care other than for chronic illness

TABLE 8 CONTINUED (2)

TYPE OF SERVICES OFFERED TO MODEL NEIGHBORHOOD AREA
HEALTH SERVICES

SERVICES	AGENCIES	ELIGIBILITY REQUIREMENTS
	MEDICAL TREATMENT--HOSPITALS	
	b. Nesbitt Memorial Hospital	b. Need for medical care
Surgical treatment	a. Wyoming Valley Hospital	a. Need for hospital care other than for chronic illnesses
	b. Retreat State Hospital	b. Mentally ill, 16 years of age, and Pennsylvania residency
	c. Nesbitt Memorial Hospital	c. Need for medical care
Occular treatment	a. Retreat State Hospital	a. Mentally ill, 16 years of age, and Pennsylvania residency
Intensive care--cardiology	a. Nesbitt Memorial Hospital	a. Need for medical care
	b. Valley Crest County Home	b. Need for skilled nursing care, 20 years of age, and indigent
	c. Mercy Hospital	c. Need for medical care
Physical therapy	a. Valley Crest County Home	a. Need for skilled nursing care, 20 years of age, and indigent
	b. Mercy Hospital	b. Need for medical care

TABLE 8 CONTINUED (3)

TYPE OF SERVICES OFFERED TO MODEL NEIGHBORHOOD AREA
HEALTH SERVICES

SERVICES	AGENCIES	ELIGIBILITY REQUIREMENTS
MEDICAL-- DIAGNOSTIC AND PREVENTIVE		
Rheumatic fever	a. Heart Associatibn	a. Heart or circulatory disease
PAP smear test	a. Planned Parenthood Association	a. Age 18 or over, otherwise accompanied by adult
Immunization	a. Kirby Health Center	a. None
	b. Wilkes-Barre Dept. of Health	b. None
Remedial eye care	a. Bureau of Visually and Physically Handicapped	a. Need for services and 30% of visual functioning
	b. Pennsylvania Association for the Blind	b. 10% vision or less
Vision screening	a. Pennsylvania Association for the Blind	a. 10% vision or less
Cerebral palsy	a. Crippled Children's Association	a. Physician's certification
	b. United Cerebral Palsy Association	b. Cerebral palsy
Chest X-ray	a. Kirby Health Center b. Tuberculosis Society	a. None b. Need for X-rays or respiratory help
Orthopedic disorders	a. Crippled Children's Association	a. Physician's certification
	b. Arthritis Foundation	b. Physicians' recommendation.
Speech disorders	a. Crippled Children's Association	a. Physicians' certification

TABLE 8 CONTINUED (4)

TYPE OF SERVICES OFFERED TO MODEL NEIGHBORHOOD AREA
HEALTH SERVICES

SERVICES	AGENCIES	ELIGIBILITY REQUIREMENTS
	MEDICAL ADVOCACY GROUPS	
Medical equipment for persons with muscular dystrophy	a. Muscular Dystrophy Association	a. Muscular dystrophy
Medical equipment	a. Multiple Sclerosis Society	a. Multiple sclerosis and indigent
Dental clinic for children under 13	a. Kirby Health Center	a. None
Birth defects	a. March of Dimes	a. Polio, birth defects, and in financial need of help
Orthopedic disorders	a. Crippled Children's Association	a. Physician's certification
Polio (infantile paralysis)	a. March of Dimes	a. Polio, birth defects and in financial need of help
Speech disorders	a. Crippled Children's Association	a. Physician's certificate
Cerebral palsy	a. Crippled Children's Association	a. Physician's certificate
Hospitalization for alcoholics	a. Alcoholics Anonymous	a. Desire to stop drinking
Cystic Fibrosis	a. Anthracite Branch of Cystic Fibrosis	a. Child with cystic fibrosis
	HEALTH RELATED SERVICES	
Birth control devices and pills	a. Planned Parenthood Association	a. Age 18 or over, otherwise accompanied by adult

TABLE 8 CONTINUED (5)

TYPE OF SERVICES OFFERED TO MODEL NEIGHBORHOOD AREA
HEALTH SERVICES

SERVICES	AGENCIES	ELIGIBILITY REQUIREMENTS
Fund raising for medical research	a. Muscular Dystrophy Association	a. Muscular dystrophy
	b. Anthracite Branch of Cystic Fibrosis	b. Child with cystic fibrosis
	c. Multiple Sclerosis Society	c. Multiple sclerosis and indigent
	d. Arthritis Foundation	d. Physician's recommendation
	e. March of Dimes	e. Polio, birth defects, and in financial need of help
	f. Tuberculosis Society	f. Need for X-rays or respiratory help
Nursing care for elderly	a. Lutheran Children's Bureau	a. Lutheran background preferable but not absolutely necessary
Infirmary for the sick	a. Home for Homeless Women	a. Age 70 or over, admission fee of $4000., and relinquishment of assets
Nursing and Medical services to home patients	a. Visiting Nurse Associations	a. Under care of physician and need for nursing care (for patients not totally dependent)
General assistance for medical needs	a. American Cancer Society	a. Physician's approval
	b. Public Health Center	b. Need for help
	c. Luzerne County Board of Assistance	c. Need for public assistance according to current regulations

TABLE 8 CONTINUED (6)

TYPE OF SERVICES OFFERED TO MODEL NEIGHBORHOOD AREA
HEALTH SERVICES

SERVICES	AGENCIES	ELIGIBILITY REQUIREMENTS
Environmental control	a. Pennsylvania Department of Health, Region II	a. None
	b. Kirby Health Center	b. Mandatory
	c. Wilkes-Barre Department of Health	c. Mandatory
Consultation for cardiology	a. Retreat State Hospital	a. Mentally ill, 16 years of age, and Pennsylvania residency
Blood drives and dispensary	a. American Red Cross	a. Immediate need for blood
Research on respiration ailments	a. Tuberculosis Society	a. Need for X-rays or respiratory help
	MENTAL HEALTH SERVICES	
Diagnosis for psychological or psychiatric disorder	a. Children's Service Center	a. Under 21 years of age with psychological problems
	b. Mental Health Center #1	b. Need for mental health services and local residency
Psychotherapeutic assistance	a. Childrens Service Center	a. Under 21 years of age with psychological problems
Psychiatric consultation to schools and juvenile court	a. Children's Service Center	a. Under 21 years of age with psycological problems
Group therapy for alcoholics	a. Alcoholics Anonymous	a. Desire to stop drinking

TABLE 8 CONTINUED (7)

TYPE OF SERVICES OFFERED TO MODEL NEIGHBORHOOD AREA HEALTH SERVICES

SERVICES		AGENCIES	ELIGIBILITY REQUIREMENTS
Psychological and emotional support to handicapped persons and their families	a.	Muscular Dystrophy Association	a. Muscular dystrophy
	b.	United Cerebral Palsy Association	b. Cerebral palsy
Out-patient treatment for mental disorders	a.	Children's Service Center	a. Under 21 years of age with psychological problems
	b.	Mental Health Clinic #1	b. Need for mental health services and local residency
Hospitalization for mental disorders	a.	Retreat State Hospital	a. Mentally ill, 16 years of age, and Pennsylvania residency
	b.	Veteran's Administration Hospital	b. Need for medical care, and veteran
	c.	Wilkes-Barre General Hospital	c. Need for medical care
	d.	Children's Service Center	d. Under 21 years of age with psychological problems
	e.	Mental Health Center #1	e. Need for mental health services and local residency
Care or treatment for mentally retarded children	a.	Children's Service Center	a. Under 21 years of age with psychological problems

TABLE 8 CONTINUED (8)

TYPE OF SERVICES OFFERED TO MODEL NEIGHBORHOOD AREA
HEALTH SERVICES

SERVICES		AGENCIES	ELIGIBILITY REQUIREMENTS
Planning and developing mental health and retardation programs	a.	Luzerne-Wyoming Mental Health and Retardation Program	a. Mental disability
	b.	Mental Health Association of Luzerne County	b. None
HEALTH EDUCATION AND INFORMATION			
Health education	a.	Heart Association of N. E. Pennsylvania	a. Heart or circulatory disease
	b.	Visiting Nurse Associations	b. Under care of physician and need for nursing care (for patients not totally dependent)
	c.	Anthracite Branch of Cystic Fibrosis	c. Child with cystic fibrosis
	d.	Mental Health Center #1	d. Need for mental health services and local residency
	e.	American Red Cross	e. None
	f.	Mental Health Association of Luzerne County	f. None
	g.	Tuberculosis Society	g. Need for X-rays or respiratory help
Mental Health education	a.	Luzerne County Association for Retarded Children	a. Mentally retarded (IQ 80 or less)
Public education for the prevention of blindness	a.	Pennsylvania Association for the Blind	a. None

TABLE 8 CONTINUED (9)

TYPE OF SERVICES OFFERED TO MODEL NEIGHBORHOOD AREA
HEALTH SERVICES

SERVICES	AGENCIES	ELIGIBILITY REQUIREMENTS
Professional education	a. Heart Association of N. E. Pennsylvania	a. Heart or circulatory disease
Health information	a. American Cancer Society	a. None
	b. Arthritis Foundation	b. Physician's recommendation
	c. Pennsylvania Department of Health, Region II	c. None
	d. March of Dimes	d. Polio, birth defects, and in financial need of help
	e. Tuberculosis Society	e. Need for X-rays or respiratory help
Mental Health information	a. Luzerne County Association for Mentally Retarded	a. Mentally retarded (IQ 80 or less)
Youth education	a. American Red Cross	a. None
General Public educational programs	a. Heart Association of N. E. Pennsylvania	a. Heart or circulatory disease

services provided by agencies serving within the city and the bases for client eligibility. The types of service are:

Medical services--treatment--hospitals

Medical services--diagnostic--and preventive

Medical service--advocacy groups

Health related activities

Mental health services

Health education and information

1. Medical Services--Treatment--Hospitals

Medical treatment may be both long term and short term, or out-patient in nature. It is clear from analysis of data that the health services systems are focused on provision of care for acute illnesses rather than on preventive measures. The crux of this situation will be to create change from treatment to prevention.

2. Medical Service--Diagnostic and Preventive

In many senses these services may still be in embryo. Diagnosis may be made with no place for the patient to obtain treatment. Preventive medicine may still have a long way to go if certain environmental elements are cared for, but attention is not paid to additional elements.

3. Medical Service--Advocacy Groups

Many of the organizations in the next table provide a small amount of direct services and concentrate on research functions which do not go on

locally. Their value to the community is that they call attention to those causes which may well be the battle cry of tomorrow.

4. Health Related Activities

The health related activities listed below are offered by organizations which support diagnostic and treatment plans for individuals and families who might otherwise not receive such treatment and diagnostic service. However, there can be no complacency about these health related services; they may offer what looks clearly as adminstrative or program responsibilities but there is little actual overlap in their activities. Many clients in need may well be lost because of this lack of overlap.

5. Mental Health Services

These activities are those which begin with the cry for help and follow through with out-patient or hospitalization of the patient if necessary. The scope of these activities can be total for some patients while for others it can be partial. Many of these are new services in many ways and there is the need to expand these activities without sacrificing the quality of the service, a real challenge to an organization.

6. Health Education and Information Services

Health education and information services are those provided by all agencies to some extent. However, some of these organizations focus more upon reaching the general public with their particular interest than do others. Many of these activites are carried by advocate groups who justify

their existence in the community by these public information campaigns.

b. Welfare Services

The data presented in this section show the specific services rendered by welfare agencies and indicate the requirements for client eligibility.

The types of service are:

Economic security and income maintenance

Vocational training, referral, and placement

Counseling, placement and referral, family children and institutional

Rehabilitation

Legal and corrective

Recreational and community

Welfare education and information

1. Economic Security and Income Maintenance

The two main kinds of economic security programs providing cash income when earned income stops are:

1. social insurances
2. public assistance payments

The overall goal for each is income provision to individuals or families when earned income is not available. There are a number of basic differences between the two. Social insurance is prepaid. To apply, a person need only file a claim to benefits toward which he contributed. There is no investigation of resources. With public assistance payments, a person makes application

receiving benefits based on need, which carries with it its own peculiar kind of stigma. The person receives payments toward which he does not contribute.

Included in this section are direct payments other than those already mentioned ranging all the way from Christmas assistance to a one-time cash bonus to Vietnam veterans. Cystic Fibrosis patients receive payments in the form of treatments and equipment. Home for unwed mothers provided by the Salvation Army is not provided locally but out of town, and is a service perhaps beyond the reach of most MNA residents.

2. Vocational Training, Referral, and Placement

These services endeavor to help individuals get job training and prepare them for jobs in the open market.

The needs for vocational training are usually identified by school systems but training is closely connected with certain requirements for welfare services.

CEP is probably best geared for hard core unemployed who are poor but those who are not poor are not so fortunate! There is a great need for close relationships among all agencies offering vocational training to link up with other organizations providing payment.

3. Counseling, Placement Referral - Family, Children, and Institutional Serivces

These services include the full gamut of those services expected to be provided by social welfare service organizations. Besides the emphasis on working with individuals and their families, there is considerable effort in working with these individuals and their families in groups. These services

differ from those providing income maintenance and social insurance and vocational training in that they do not endeavor to directly obtain employment or income for these individuals but do facilitate in every way possible the provision of such services as are necessary. These organizations attempt to strengthen families in their relationships internally by relieving family tensions. There is more internal focus on the dynamics of emotions in these services since emphasis is placed on optimum functioning in relationships.

Of course, it goes without saying that the individual must be ready to adapt himself or herself to various situations, especially those where the person is no longer maintained in his or her own home.

4. Rehabilitation

These programs focus more on what agencies can do or achieve for certain clients accepted into the agency systems. To become eligible for services, the individual either must be born with a handicap (congenital) or the handicap must have been acquired. A great deal of funding is available today for such services.

Some rehabilitation services have a tendency only to accept those individuals who show potential to use most fruitfully the resources of the agency. This may not create a client centered service because the intake requirements are adjusted to suit what the agency can do rather than what the individual may be able to do. This is economic use of resources, but it goes without saying that many potential clients are lost because of focus on those who will respond more readily to resources.

5. Legal and Corrective

These services have not fully developed in the community and are not likely to grow beyond their present level unless the state or federal governments change orientation. Legal services in the advocate role are new to the local scene but the activity and social change being generated by the Legal Services for the Poor group will have far-reaching effects for all those concerned. Legal services in its advocate role cannot be extended to cover a broader base of people than the defined poor. However, this base may well expand in time to include those whose income levels are slightly more than present requirements.

Corrective services are not particularly wanted by those who recieve them and it isn't likely that many people will want to recieve them. In view of situations as they now stand with drug problems in the community and especially the concern in the MNA, there will be expanded need for professional personnel to work with those offenders who are involved.

6. Recreational and Community Services

These services are the ounce of prevention so necessary to develop positive attitudes in youth and adults. Such services can encompass activities for Senior Citizens, young Adults, married couples, besides the youth everyone immediately pictures. Actually all community people can benefit from some form of recreational services. The "not so well to do" do not always have recreation services and community services. They have trouble finding a room for activities in local public facilities.

TABLE 9

TYPE OF SERVICES OFFERED TO MODEL NEIGHBORHOOD AREA
WELFARE SERVICES

SERVICES		AGENCIES		ELIGIBILITY REQUIREMENTS
ECONOMIC SECURITY AND INCOME MAINTENANCE				
Financial and other assistance to veterans or their families	a.	Veteran's Affairs Bureau	a.	Veteran of armed forces
	b.	American Red Cross	b.	Member of armed forces
	c.	Pennsylvania Veteran Commission	c.	Need for help and veteran with honorable discharge
Financial assistance to insured persons	a.	Social Security Administration	a.	Insured under the law and retired, disabled, or deceased
	b.	Wayside Mission	b.	Need for available services
Categorical cash payments to individuals showing need	a.	Luzerne County Board of Assistance	a.	Need for public assistance according to current regulations
Financial and other assistance for Christmas	a.	Salvation Army	a.	None
	b.	Family Service Association	b.	Residency in Luzerne County and need for family counseling help
	c.	Catholic Social Services	c.	None
Financial assistance to persons with heart conditions	a.	Heart Association of N. E. Pennsylvania	a.	Heart or circulatory disease
Financial assistance to blind persons	a.	Federation for the blind	a.	10% vision or less

TABLE 9 CONTINUED (2)

TYPE OF SERVICES OFFERED TO MODEL NEIGHBORHOOD AREA
WELFARE SERVICES

SERVICES	AGENCIES	ELIGIBILITY REQUIREMENTS
ECONOMIC SECURITY AND INCOME MAINTENANCE		
Financial assistance to Cystic Fibrosis patients	a. Anthracite Branch of Cystic Fibrosis	a. Child with Cystic Fibrosis
Unemployment compensation	a. Bureau of Employment Security	a. Unemployed, underemployed, poor, or in need of better job
Burial expenses and services	a. Veteran's Affairs Bureau	a. Veteran of armed forces
	b. Adult Welfare Services	b. Age 18 or over, infirm or indigent
Social Security payments	a. Social Security Administration	a. Insured under the law and retired, disabled, or deceased
Food for the Needy (Meals on Wheels)	a. Wyoming Valley Council of Churches	a. Protestant church in need of help with programming and small yearly contribution
Food Stamp Program	a. Luzerne County Board of Assistance	a. Need for public assistance according to current regulations
Processing applications for Vietnam Bonus	a. Pennsylvania Veteran Commission	a. Need for help and veteran with honorable discharge
Scholarships to graduate students	a. March of Dimes	a. Polio, birth defects, and in financial need of help
Transportation and clothing for tuberculosis patients	a. Adult Welfare Services	a. Age 18 or over, infirm or indigent

TABLE 9 CONTINUED (3)

TYPE OF SERVICES OFFERED TO MODEL NEIGHBORHOOD AREA
WELFARE SERVICES

SERVICES	AGENCIES	ELIGIBILITY REQUIREMENTS
ECONOMIC SECURITY AND INCOME MAINTENANCE		
Shelter or residential care for aged or infirm	a. Sutton Home for Aged and Infirm Men	a. Aged, small admissions fee, and not totally dependent
	b. Home for Homeless Women	b. Age 70 or over, admission fee of $4000, and relinquishment of assets
Day care services	a. Luzerne County Bureau for the Aging	a. Residency in Luzerne County and age 50 or over
	b. United Rehabilitation Services	b. Limited abilities
	c. Luzerne County Child Welfare District	c. Need for services for child
	d. Concentrated Employment Program	d. Income less than $1800 a year ($500 extra for each dependent) and living in target area, plus employabilities
Nursery School	a. Georgetown Settlement Association	a. None
Home for unwed mothers	a. Salvation Army	a. None
Disaster or emergency services	a. American Red Cross	a. Immediate need of blood
	b. Pennsylvania Veteran Commission	b. Need for help and veteran with honorable discharge

TABLE 9 CONTINUED (4)

TYPE OF SERVICES OFFERED TO MODEL NEIGHBORHOOD AREA
WELFARE SERVICES

SERVICES	AGENCIES	ELIGIBILITY REQUIREMENTS
	c. Salvation Army	c. None
VOCATIONAL TRAINING, REFERRAL, AND PLACEMENT SERVICES		
Vocational training in general	a. Bureau of Employment Security	a. Unemployed, underemployed, poor, or in need of better job
	b. Concentrated Employment Program	b. Income less than $1800 a year ($500 extra for each dependent) and living in target area
Training of social workers	a. Family Service Association	a. Residency in Luzerne County and need for family counselling help
Training of psychiatric social workers	a. Children's Service Center	a. Under 21 years of age with psychological problems
Training of nurses	a. Mercy Hospital	a. Need for medical care
	b. American Red Cross	b. Immediate need of blood
Training of adults as scout leaders	a. Girl Scouts, Penn's Wood Council	a. Ages 7 to 17 and female
	b. Boy Scouts of America	b. Ages 8 to 17 and male
Work-study programs	a. Saint Stanislaus Institute	a. Child that is dependent, neglected, or orphaned

TABLE 9 CONTINUED (5)

TYPE OF SERVICES OFFERED TO MODEL NEIGHBORHOOD AREA
WELFARE SERVICES

SERVICES	AGENCIES	ELIGIBILITY REQUIREMENTS
VOCATIONAL TRAINING, REFERRAL, AND PLACEMENT SERVICES		
Vocational counselling	a. Bureau of Employment Security	a. Unemployed, underemployed, poor, or in need of better job
Referrals for employment or vocational training	a. Federation for the Blind	a. 10% of vision or less
	b. Concentrated Employment Program	b. Income less than $1800 a year ($500 extra for each dependent) and living in target area
Vocational placement	a. Bureau of Employment Security	a. Unemployed, underemployed, poor, or in need of better job
	b. Home for Homeless Women	b. Age 70 or over, admission fee of $4000, and relinquishment of assets
	c. Adult Probation Division	c. Age 18 or over and criminal offender
	d. Concentrated Employment Program	d. Income less than $1800 a year ($500 extra for each dependent) and living in target area
	e. Bureau of Visually and Physically Handicapped	e. Need for services and 30% of visual functioning
	f. Pennsylvania Association for the Blind	f. 10% vision or less

TABLE 9 CONTINUED (6)

TYPE OF SERVICES OFFERED TO MODEL NEIGHBORHOOD AREA
WELFARE SERVICES

SERVICES	AGENCIES	ELIGIBILITY REQUIREMENTS
COUNSELLING, REFERRAL AND PLACEMENT SERVICES FAMILY AND CHILDREN		
Adoption services	a. Lutheran Children's Bureau	a. Lutheran background preferable but not absolutely necessary
	b. Luzerne County Child Welfare District	b. Need for services
Referrals for counselling or psychiatric help	a. Domestic Relations Division	a. Need for help in the area of domestic relations
	b. Luzerne County Association for Retarded Children	b. Mentally retarded (IQ 80 or less)
	c. Luzerne-Wyoming Mental Health and Retardation Program	c. Mental disability
Referral service for veterans	a. Pennsylvania Veteran Commission	a. Need for help and for veterans with honorable discharge
Referrals for health or welfare	a. Luzerne County Bureau for the Aging	a. Residence in Luzerne County and age 50 or over
	b. Planned Parenthood Association	b. Age 18 or over, otherwise accompanied by adult
Placement for hospitals or nursing homes	a. Adult Welfare Services	a. Age 18 or over, infirm or indigent

TABLE 9 CONTINUED (7)

TYPE OF SERVICES OFFERED TO MODEL NEIGHBORHOOD AREA
WELFARE SERVICES

SERVICES	AGENCIES	ELIGIBILITY REQUIREMENTS
COUNSELLING, REFERRAL AND PLACEMENT SERVICES FAMILY AND CHILDREN		
Placement of children in foster homes	a. Lutheran Children's Bureau	a. Lutheran background preferable but not absolutely necessary
	b. Juvenile Court	b. Neglected or delinquent child under age 18
	c. Luzerne County Child Welfare District	c. Need for services
Placement of elderly in foster homes	a. Luzerne County Bureau for the Aging	a. Residency in Luzerne County and age 50 or over
Processing applications for hospital admission	a. Adult Welfare Services	a. Age 18 or over, infirm or indigent
COUNSELLING SERVICES		
Counselling to unwed mothers	a. Lutheran Children's Bureau	a. Lutheran background preferable but not absolutely necessary
	b. Saint Stanislaus Institute	b. Child that is dependent, neglected, or orphaned
Counselling to neglected and orphaned children	a. Luzerne County Child Welfare District	a. Need for services
	b. Saint Stanislaus Institute	b. Child that is dependent, neglected, or orphaned

TABLE 9 CONTINUED (8)

TYPE OF SERVICES OFFERED TO MODEL NEIGHBORHOOD AREA
WELFARE SERVICES

SERVICES	AGENCIES	ELIGIBILITY REQUIREMENTS
	COUNSELLING SERVICES	
Counselling for family or individual problems	a. Catholic Social Services	a. None
	b. Jewish Welfare Agency	b. Local residency
	c. Family Service Association	c. Residency in Luzerne County and need for family counselling help
	d. Veteran's Administion Hospital	d. Need for medical care and veteran
	e. Visiting Nurse Associations	e. Under care of physician and need for nursing care (for patients not totally dependent)
	f. Homemaker's Service of Luzerne County	f. Disability, illness, elderly without relatives, or family stressful situation
	g. Pennsylvania Veteran Commission	g. Need for help and veteran with honorable discharge
Religious or spiritual guidance	a. Wyoming Valley Council of Churches	a. Protestant church in need of help with programming and small yearly contribution
	b. YMCA	b. Membership in organization, age 7 or over and male

TABLE 9 CONTINUED (9)

TYPE OF SERVICES OFFERED TO MODEL NEIGHBORHOOD AREA
WELFARE SERVICES

SERVICES	AGENCIES	ELIGIBILITY REQUIREMENTS
	COUNSELLING SERVICES	
Health and welfare counselling	a. Jewish Welfare Agency	a. Local residency
	b. Luzerne County Bureau for the Aging	b. Residency in Luzerne County and age 50 or over
	c. Luzerne County Board of Assistance	c. Need for public assistance according to current regularities
	REHABILITATION SERVICES	
Rehabilitation services for alcoholics	a. Salvation Army Men's Social Service Center	a. Treatable handicaps
	b. Alcoholics Anonymous	b. Desire to stop drinking
	c. Wayside Mission	c. Need for available services
Sheltered employment	a. United Rehabilitation Service	a. Handicapped position
Half-way house	a. United Rehabilitation Service	a. Handicapped position
Hope Club for persons with multiple sclerosis	a. Multiple Sclerosis Society	a. Multiple Sclerosis and indigent
Vocational rehabilitation for visually handicapped	a. Federation for the Blind	a. 10% vision or less

TABLE 9 CONTINUED (10)

TYPE OF SERVICES OFFERED TO MODEL NEIGHBORHOOD AREA
WELFARE SERVICES

SERVICES		AGENCIES		ELIGIBILITY REQUIREMENTS
		REHABILITATION SERVICES		
	b.	Bureau of Visually and Physically Handicapped	b.	Need for services and 30% of visual functioning
	c.	Pennsylvania Association of the Blind	c.	10% vision or less
General rehabilitation services for cerebral palsy patients	a.	United Cerebral Palsy Association	a.	Cerebral Palsy
Rehabilitation services for handicapped persons in general	a.	United Rehabilitation Services	a.	Handicapped position
	b.	Bureau of Vocational Rehabilitation	b.	Employable and handicapped
	c.	Bureau of Visually and Physically Handicapped	c.	Need for services and 30% of visual functioning
Home teaching for blind adults	a.	Bureau of Visually and Physically Handicapped	a.	Need for services and 30% ov visual functioning
General rehabilitation	a.	Salvation Army Men's Social Service Center	a.	Treatable handicaps
	b.	Pennsylvania Dept. of Health, Region II	b.	None
Remedial education	a.	Saint Stanislaus Institute	a.	Child that is dependent, neglected, or orphaned
Occupational therapy or vocational rehabilitation	a.	Valley Crest County Home	a.	Need for skilled nursing care, 20 years of age, and indigent
	b.	Wayside Mission	b.	Need for available services
	c.	Bureau of Vocational Rehabilitation	c.	Employable and handicapped

TABLE 9 CONTINUED (11)

TYPE OF SERVICES OFFERED TO MODEL NEIGHBORHOOD AREA
WELFARE SERVICES

SERVICES	AGENCIES	ELIGIBILITY REQUIREMENTS
LEGAL AND CORRECTIVE SERVICES		
Legal protection or aid	a. Legal Aid Society of Luzerne County	a. Individual determination based on financial status
	b. Federation for the Blind	b. 10% vision or less
Parole and probation supervision	a. Juvenile Court	a. Neglected or delinquent child under age 18
	b. Adult Probation Division	b. Age 18 or over and criminal offender
Pre-sentence investigations	a. Adult Probation Division	a. Age 18 or over and criminal offender
Marital hearings	a. Domestic Relations Division	a. Need for help in the area of domestic relations
Enforcement of visitation rights and financial support	a. Domestic Relations Division	a. Need for help in the area of domestic relations
Legal protection of neglected children	a. Juvenile Court	a. Neglected or delinquent child under age 18
	b. Luzerne County Child Welfare District	b. Need for services
Court hearings for juvenile delinquents	a. Juvenile Court	a. Neglected or delinquent child under age 18

TABLE 9 CONTINUED (12)

TYPE OF SERVICES OFFERED TO MODEL NEIGHBORHOOD AREA
WELFARE SERVICES

SERVICES	AGENCIES	ELIGIBILITY REQUIREMENTS
LEGAL AND CORRECTIVE SERVICES		
Legal assistance to indigent persons	a. Legal Service Association	a. Residency in Luzerne County, limited income, and case of civil nature
General legal concern with injustice and inequality	a. Legal Service Association	a. Residency in Luzerne County, limited income, and case of civil nature
Enforcement of environmental laws	a. Pennsylvania Department of Health, Region II	a. None
CHARACTER BUILDING GROUP		
Recreational services for handicapped persons	a. Federation for the Blind	a. 10% vision or less
	b. United Cerebral Palsy Association	b. Cerebral palsy
	c. Pennsylvania Association of the Blind	c. 10% vision or less
Camping programs	a. Girl Scouts, Penn's Wood Council	a. Ages 7 to 17 and female
	b. Boy Scouts of America	b. Ages 8 to 17 and male
Physical fitness programs	a. Boy Scouts of America	a. Ages 8 to 17 and male
General recreational services	a. YMCA	a. Membership in organization, age 7 or over and male

TABLE 9 CONTINUED (13)

TYPE OF SERVICES OFFERED TO MODEL NEIGHBORHOOD AREA
WELFARE SERVICES

SERVICES	AGENCIES	ELIGIBILITY REQUIREMENTS
	CHARACTER BUILDING GROUP	
	b. Catholic Youth Center	b. Age 8 and over
	c. Georgetown Settlement Association	c. None
	d. St. Stanislaus Institute	d. Child that is dependent, neglected, or orphaned
	e. Jewish Community Center	e. Membership in center
	f. Salvation Army	f. None
Meeting place for organizations	a. Georgetown Settlement Association	a. None
Organization of social activities	a. Luzerne County Bureau for the Aging	a. Residency in Luzerne County and age 50 or over
	b. Jewish Community Center	b. Membership in center
Organization of community groups for scouting	a. Girl Scouts, Penn's Wood Council	a. Ages 7 to 17 and female
	b. Boy Scouts of America	b. Ages 8 to 17 and male
Community planning for effective welfare delivery systems	a. Catholic Social Services	a. Age 8 and over
	b. Family Service Association	b. Residency in Luzerne County and need for family counselling help

TABLE 9 CONTINUED (14)

TYPE OF SERVICES OFFERED TO MODEL NEIGHBORHOOD AREA
WELFARE SERVICES

SERVICES		AGENCIES		ELIGIBILITY REQUIREMENTS
CHARACTER BUILDING GROUP				
Community services by scouts	a.	Girl Scouts, Penn's Wood Council	a.	Ages 7 to 17 and female
Senior Citizens Centers	a.	Luzerne County Bureau for the Aging	a.	Residency in Luzerne County and age 50 or over
Community programs for the poor	a.	Commission on Economic Opportunity	a.	Need for services, income limitations, and participation in long range goals
Community services to youth	a.	Luzerne County Association for Retarded Children	a.	Mentally retarded (IQ 80 or less)
WELFARE, EDUCATION AND INFORMATION SERVICES				
General public educational programs	a.	YMCA	a.	Membership in organization, age 7 or over and male
	b.	Family Service Association	b.	Residency in Luzerne County and need for family counselling help
	c.	Commission on Economic Opportunity	c.	Need for services, income limitations, and participation in long range goals
	d.	Jewish Community Center	d.	Membership in center
Information concerning legal matters	a.	Legal Aid Society	a.	Individual determination based on financial status

TYPE OF SERVICES OFFERED TO MODEL NEIGHBORHOOD AREA
WELFARE SERVICES

SERVICES	AGENCIES	ELIGIBILITY REQUIREMENTS
WELFARE, EDUCATION AND INFORMATION SERVICES		
	b. Commission on Economic Opportunity	b. Need for services, income limitations, and participation in long range goals
	c. Legal Service Association	c. Residency in Luzerne County, limited income, and case of civil nature
Agricultural education	a. Luzerne County Agricultural & Home Economics Association	a. Client need for services and agency's availability of resources
Home economics education	a. Luzerne County Agricultural & Home Economics Association	a. Client need for services and agency's availability of resources
Youth education	a. Luzerne County Agricultural & Home Economics Association	a. Client need for services and agency's availability of resources
Educational assistance to rural governments	a. Luzerne County Agricultural & Home Economics Association	a. Client need for services and agency's availability of resources
Job orientation programs	a. Concentrated Employment Program	a. Income less than $1800 a year ($500 extra for each dependent) and living in target area
Family planning and birth control information	a. Planned Parenthood Association	a. Age 18 or over, otherwise accompanied by adult

TABLE 9 CONTINUED (16)

TYPE OF SERVICES OFFERED TO MODEL NEIGHBORHOOD AREA
WELFARE SERVICES

SERVICES	AGENCIES	ELIGIBILITY REQUIREMENTS
WELFARE, EDUCATION AND INFORMATION SERVICES		
Social Security information	a. Social Security Administration	a. Insured under the law and retired, disabled, or deceased
Vocational information	a. Bureau of Employment Security	a. Unemployed, underemployed, poor, or in need of better job

7. Welfare Education and Information

These services really are geared to the possibility and the probability that someone somewhere within the community may need to use a service connected with the information and hopefully will be steered to that service by the public education route. These services should be functions of every agency which provides service in the community. Without this kind of dissemination, little may ever be communicated about programs. If the programs are not known, nobody will find it out as is mentioned in another part of this study.

6. Eligibility Requirements

a. Health Services

In order to understand the narrative on eligibility requirements that follows, the reader is asked to turn to Table 8.

Despite the wide range of health services rendered by the 25 agencies, the availability of a particular service to a client or patient depends primarily upon the type of eligibility requirements established by each agency. The accompanying summary table, in most instances designates the special requirements of given agencies, but it should be understood that there may also be some general requirements common to all or most of the agencies which have not been included in the response to survey.

Residence within the service area is required in all instances, except that Retreat Hospital extends its services to any resident of Pennsylvania. There is some feeling in the minds of many that the facility is for local residents only.

Other requirements vary considerably. Hospitals normally charge for service, although without exception all perform gratis services in special cases, although,"special" case is not defined. This may have a very specific meaning for the disadvantaged and Model Neighborhood Area residents.

Two agencies specifically indicate they have no financial requirements. The two agencies serving veterans or members of the Armed Forces also have no financial criteria. Hospitals indicate that they provide service for acute, but not chronic illness, while only the Public Health Center of Luzerne County specifies assistance in chronic cases, and even this might well be limited.

Indigency is necessary for care at Valley Crest, but at least three agencies require financial responsibility according to ability to pay. Financial requirements are often a hidden requirement, the equivalency of patient liability. Property and other assets may well be fair game, especially at public institutions, not just a diagnosis of a disability that requires hospitalization.

A few services are available only upon recommendation of a physician, which as has already been pointed out earlier, could and does have adverse consequences for the poor.

Age limits are established by a few agencies, one serving only those 16 years or over, one under 20 years, and one over 20.

All in all, it may seem that eligibility requirements are specific when they really are not so, especially when requirements are hidden and veiled.

Often times, the eligibility criteria are vague (illness), or it is doubtful that what an agency stated as an eligibility requirement is truly one (anyone who requests).

b. Welfare Services

Table 9 is the source for the discussion on eligibility requirements in the Welfare Services that follows in the next several pages.

The number and variety of welfare agencies is immaterial unless the residents of Model Neighborhood Area are eligible to receive them, and as Table 9 indicates, this eligibility depends upon a variety of criteria established by each agency. Initial examination of welfare services eligibility requirements shows that two criteria are nearly universal requirements: age and income. These qualifications form the bases of the means test that either permits entry into a particular agency system or prohibits entry.

The table shows that some eligibility requirements are common to most agencies. For example, residence in the community area is virtually universal, and in many instances there are age groups restrictions. Thus the Boy and Girl Scouts limit membership between the ages of 7 or 8 to 17 years, and custodial care agencies specify definite minimum age requirements, such as 50 or over, or use the general term "aged".

Of special importance to Model Neighborhood Area residents requiring welfare services is the economic status or income requirement. Agencies providing only or mainly counselling services generally have no such limitations, or charge a nominal fee. The Salvation Army is especially notable for providing

its numerous services "in case of need" but fixes absolutely no income minima, nor does it charge fees. Many of the character building groups charge dues and/or fees. Governmental agencies, such as Social Security and the Concentrated Employment Program, restrict eligibility to those earning not more than $1,800, with perhaps additional allowance for dependent children. The Legal Aid Society, assisting mainly in family or landlord-tenant cases, bases eligibility upon financial status, while the Legal Services Association of Luzerne County requires indigency, and provide services only in cases not involving those which may generate fees. The Sutton Home for the Aged and Infirm Men required " a small entrance fee", while the Home for Homeless Women require an admission fee of $4,000 and an agreement that all assets become the property of the agency upon the death of the client.

Of late, the means test has fallen into some disrepute because of the way the test was administered. Many efforts have been made to eliminate a means test as a way of determining who could or should enter into agency services.

Eligibility factors also center on certain groups which at times have created a great deal of pressure for satisfaction of their demands, hence the proliferation of organizations serving veterans.

7. Interagency Relationships

In order to identify relationships between services, the following criteria were utilized:

(1) Source of Referrals
(2) Relationships with Similar Agencies
(3) Relationships with Governmental Agencies

The tables on the pages that follow depict the cross-tabular relationships of agencies and the three focal concerns listed above. The ensuing discussion will concentrate primarily on the dominant patterns that have emerged from the data analysis.

Again it must be strongly reiterated that the tables on the aspects of interagency relationships must be viewed with extreme caution. It must be remembered that since time was of the essence, it was impossible to request and examine the substance of a "purchase agreement." It just was not possible to analyze a hidden pattern of competition between and among agencies and institutions. Often times, these patterns exist in a very passive way and are really dominant patterns. Referral sources indicate flow of clients into a system of sources but it does not necessarily identify the actual relationships among agencies. How else can you explain the "shopping around" that clients do to get help from agencies that have similar functions.

The data on referrals and relationships, if taken alone, is a beginning point. If this data were combined in a meaningful manner, with the information on funding sources relationships, cooperative and otherwise services can better be understood.

a. Health Services

For hospitals, coordinated services exist between all but one institution, while relationships with state and federal governmental agencies are uniformly presented with all institutions, probably as a result of Medicare and Medicaid, though the relationship is not precisely spelled out. The use of purchase

TABLE 10

INTERAGENCY RELATIONSHIPS
HEALTH SERVICES

Social Service Agencies	Source of Referrals			Relationships with Similar Agencies				Relationships with Governmental Agencies		
	Self	Other Agencies	Other Sources	Coordinated Services	Purchase Agreement	Cooperative Relationships	Other	Federal	State	Federal
HOSPITALS										
Wilkes-Barre General Hospital			X	X		X	X		X	X
Mercy Hospital	X		X	X	X	X		X	X	X
Nesbitt Memorial Hospital			X						X	X
Wyoming Valley Hospital			X	X			X	X	X	X
Veterans' Administration Hospital	X	X	X	X	X			X	X	X
Valley Crest County Home	X	X	X	X				X	X	X
HEALTH CLINICS										
Kirby Health Center	X	X	X			X			X	X
Public Health Center	X	X	X			X		X	X	X
MENTAL HOSPITALS										
Retreat State Hospital	X	X	X	X	X	X		X	X	X
White Haven State School Hospital*										

TABLE 10

CONTINUED (2)

INTERAGENCY RELATIONSHIPS
HEALTH SERVICES

Social Service Agencies	Source of Referrals			Relationships with Similar Agencies				Relationships with Governmental Agencies		
	Self	Other Agencies	Other Sources	Coordinated Services	Purchase Agreement	Cooperative Relationship	Other	Local	State	Federal
MENTAL CLINICS										
Luzerne/Wyoming Counties Mental Health Center #1	X	X	X					X	X	X
Children's Service Center of Wyoming Valley		X	X	X		X				X
INFORMATION AND REFERRAL										
Luzerne/Wyoming Counties' Mental Health/Mental Retardation Program	X	X	X			X		X	X	X
INDIRECT HEALTH SERVICES										
Pennsylvania Department of Health Regional Office, Region II	X	X	X	X		X		X	X	X
Wilkes-Barre City Department of Health	X	X	X			X			X	

TABLE 10

CONTINUED (3)

INTERAGENCY RELATIONSHIPS
HEALTH SERVICES

Social Service Agencies	Source of Referrals			Relationships with Similar Agencies				Relationships with Governmental Agencies		
	Self	Other Agencies	Other Sources	Coordinated Services	Purchase Agreement	Cooperative Relationship	Other	Local	State	Federal
ADVOCACY SPECIAL INTEREST ORGANIZATIONS										
American Cancer Society		X	X	X		X				X
Arthritis Foundation	X	X	X	X				X	X	X
Cystic Fibrosis Foundation	X		X						X	X
Luzerne County Mental Health Association	N/A	N/A	N/A			X	X	X		
Multiple Sclerosis Foundation	X	X		X		X		X		X
Muscular Dystrophy Foundation	X	X	X			X		X	X	X
National Foundation-March of Dimes		X	X					X	X	X
Tuberculosis Society										
Northeastern Pennsylvania Heart Association	X	X	X			X		X	X	X
Luzerne County Association for Retarded Children			X	X		X		X	X	X
American Red Cross	X	X		X		X		X		

agreements appears rather limited among hospitals as is true with cooperative relationships. Among hospitals, the referrals from other agencies appears minimal.

Health clinics, because of the nature of the service, show a trend toward cooperative relationships and coordinated services, though purchase agreements are conspicuously absent.

The largest class of health service agencies, listed as advocacy special interest organizations, presents a very interesting picture concerning relationships with similar social service agencies. These agencies seem to rely on a variety of sources for referrals. Although some manifest not a single one of the coordinated and cooperative services, advocacy special interest organizations utilize purchase agreements. Relationships with local, state, and Federal governmental agencies seem to abound among these advocacy groups. It should be pointed that the essence of the relationship re-coordinated services, cooperative services, and governmental agencies is not precisely revealed. The cardinal point to bear in mind is that the relationships with governmental agencies at the various levels of activity are meaningless unless money streams are significantly attached to such relationships.

b. Welfare Services

The data on the economic security agencies reveal multi sources of referrals, maximum coordinated and cooperative relationships with similar agencies and with Federal, state, and local governments. There is no indication of the use of purchase agreements with these agencies.

The interagency relationships among the family and children's organizations are of particular significance in this study because of the impact of their activities on the Model Neighborhood Area residents. The data does indicate little coordinated services and few purchase agreements among these organizations. Relationships with other agencies really exist only superficially since these agencies theoretically could exist without the others except Project Headstart and CEO. These systems do not rely on each other for support and what they do with each other at their parameters does not require a great deal of activity unless, of course, one system threatens another. These groups are given lifeblood by a certain community of interests among the citizenry and each group of citizens desires to maintain its own identity.

The family and children organizations include a wide variety of voluntary organizations which provide total care service as well as partial care, referral service, etc. These social services seem to utilize many sources of referrals. However, purchase agreements and coordinated services with similar agencies is very minimal. Almost all of these organizations have a working relationship at all levels of government.

The rehabilitation organizations are in quixotic position in that their goals and objectives can easily be subsumed into health organizations. Many services of these organizations are medical in nature but the foci is to generate individuals who tend to be self supporting despite handicaps, mental or physical. Referral sources of these groups are open to all categories. Competition, rather than coordination and cooperation, seems to be the keynote among the

rehabilitation agencies, even though many of them depend on the same source of funding - the United Fund. Rehabilitation organizations seem to relate poorly to each other, as in other services, because the first priority is given to their own organizational perservation and protection. As one local worker put it, "Each organization here will try to expand its range of services to preserve its own turf."

The legal and corrective agencies are most likely to be isolated services from the others, since few people choose to use these services, but have them thrust upon them. Consequently little is done to have an impact on these organizations at a local level. The court related agencies do show some inclination toward coordination and cooperation, indicating that other similar agencies may be performing some of their tasks. Yet, purchase agreements are not signified in the data. It is significant that the Legal Services Association has what appears to be a negative relationship with similar agencies, not only because it is new on the local scene, but because of its role as "advocate of the poor."

Basically the community character building services are preventive in nature, accentuating positive values in development. These agencies show an interest in cooperative relationships with other social service agencies, while in their relationships with governmental agencies, they focus on local and state government. They evidence a wide source of referrals.

G. SUMMARY OF FINDINGS

There is a wide variation in the cost per client for health services by agencies serving the city, including the hospitals, the clinics, and the special

TABLE 11

INTERAGENCY RELATIONSHIPS
WELFARE SERVICES

Social Service Agency	Source of Referrals			Relationships with Similar Agencies				Relationships with Governmental Agencies		
	Self	Other Agencies	Other Sources	Coordinated Services	Purchase Agreement	Cooperative Relationship	Other	Local	State	Federal
INCOME MAINTENANCE										
Social Security Administration	X	X	X	X		X		X	X	
Veterans' Administration										
Luzerne County Board of Assistance	X	X	X			X			X	X
JOBS AND TRAINING										
Bureau of Employment Security	X	X	X	X		X		X	X	X
Concentrated Employment Program	X	X	X	X		X		X	X	X
FAMILY SOCIAL SERVICES										
Family Service Association of Wyoming Valley	X	X	X		X	X	X	X		
Wyoming Valley Council of Churches-Meals on Wheels		X	X	X				X		
Catholic Social Services	X	X	X			X		X	X	X
Planned Parenthood Association	X	X	X	X		X			X	X
Jewish Welfare Agency	X		X			X	X	X	X	X
Luzerne County Bureau for the Aging	X	X	X	X		X		X	X	X

TABLE 11 CONTINUED (2)

INTERAGENCY RELATIONSHIPS
WELFARE SERVICES

Social Service Agency	Source of Referrals: Self	Other Agencies	Other Sources	Relationships with Similar Agencies: Coordinated Services	Purchase Agreement	Cooperative Relationship	Other	Relationships with Governmental Agencies: Local	State	Federal
Adult Welfare Services	X	X	X			X		X	X	X
Visiting Nurse Association	X		X	X		X		X	X	
Homemakers Service of Luzerne County		X	X			X	X			
Commission on Economic Opportunity	X	X	X	X	X	X	X	X	X	X
CHILDREN AND INSTITUTIONAL										
Luzerne County Child Welfare	X	X	X			X		X	X	X
St. Michael's Home for Boys										
St. Stanislaus Institute	X	X	X					X	X	X
Project Headstart										
INSTITUTIONS										
Home for Homeless Women			X							
Sutton Home for Aged & Infirm Men	X	X								
GENERAL REHABILITATION										
United Rehabilitation Service		X						X	X	X
Wayside Mission	X		X					X	X	X
Salvation Army	X	X	X					X		
Bureau of Vocational Rehab.	X		X	X	X	X		X	X	X

TABLE 11 *CONTINUED (3)*

INTERAGENCY RELATIONSHIPS
WELFARE SERVICES

Social Service Agency	Source of Referrals			Relationships with Similar Agencies				Relationships with Governmental Agencies		
	Self	Other Agencies	Other Sources	Coordinated Services	Purchase Agreement	Cooperative Relationship	Other	Local	State	Federal
SPECIAL GROUP-REHABILITATION										
Crippled Children's Association		X	X				X	X	X	X
Bureau of Visually and Physically Handicapped	X	X		X	X	X				X
United Cerebral Palsy	X	X	X			X		X	X	X
Alcoholics Anonymous		X	X			X			X	
Pennsylvania Assoc. for the Blind	X	X	X	X		X		X	X	
CORRECTIVE GOVERNMENTAL										
Adult Probation Division, Luzerne County			X	X		X		X	X	X
Juvenile Court, Luzerne County		X	X	X		X		X	X	X
Domestic Relations Court, Luzerne County	X	X	X			X		X	X	X
LEGAL CONSUMER										
Legal Services Association		X	X					X	X	X
Legal Aid Society			X			X				
CHARACTER BUILDING GROUP										
Boy Scouts of America	X	X	X	X		X		X	X	X

TABLE 11 *CONTINUED (4)*

INTERAGENCY RELATIONSHIPS
WELFARE SERVICES

Social Service Agency	Source of Referrals: Self	Source of Referrals: Other Agencies	Source of Referrals: Other Sources	Relationships with Similar Agencies: Coordinated Services	Relationships with Similar Agencies: Purchasing Agreement	Relationships with Similar Agencies: Cooperative Relationship	Relationships with Similar Agencies: Other	Relationships with Governmental Agencies: Local	Relationships with Governmental Agencies: Federal	Relationships with Governmental Agencies: State
Girl Scouts of America	X	X	X		X	X		X	X	X
YMCA	X	X	X	X		X		X	X	
YWCA*										
Catholic Youth Center	X	X	X	X		X		X		X
Georgetown Settlement			X			X	X		X	
Jewish Community Center	X						X	X	X	X
SPECIAL INTEREST SERVICES										
Pennsylvania Veterans Commission	X	X	X	X		X	X	X	X	X
Federation for the Blind	X					X			X	X
INDIRECT WELFARE SERVICES										
Pennsylvania Department of Public Welfare, Region II, Scranton*										
Commission on Economic Opportunity	X	X	X	X	X	X	X	X	X	X

*Questionnaire not returned at time of publication

interest organizations. The data do not reveal what is included in the cost of a case. The wide variance in costs, justifiable or not, could be a cause of great concern with many Model Neighborhood Area residents. The wide range in cost per client found in health services exists in the welfare services, except that the consumer may not be as aware of this fact with the welfare services as with the health services.

There is a wide range of case load per employee in the health and welfare agencies. There is the possibility that the refusals or rejections in both delivery systems could be attributable to a high case load per employee depending on the service or agency, but this requires thorough study.

The proliferation of health and welfare services among a considerable number of autonomous agencies active within the Model Neighborhood Area poses a number of problems, one of which is the selection of the most appropriate health agency to which the Model Neighborhood Area resident should be referred. Some agencies perform a single specific type of service not performed by others. In such instances, there will be no difficulty in referral simply because there is only one agency available. But, in most instances, agencies perform a number of services, some of which are core services covering a wide range, while they also provide peripheral services incident to the core services. In a number of agencies, the core and peripheral services are the same or quite similar.

Both long term and short term hospital treatment are provided locally. Diagnostic and particularly preventive medical activities may still be in an infancy stage. The data do appear to indicate that health related activities do have

some overlap. Most of the health education and information services are carried on by the special health advocacy group.

Economic security programs exist in abundance. Vocational training, referral, and placement services appear to be linked up with organizations providing payment. Social welfare organizations that attempt to strengthen family relationships are found in the city. The rehabilitation agencies are client centered because of the intake requirements. At present, the legal services available to the poor are being expanded so that the Model Neighborhood Area residents can make more use of them. Recreational and character building agencies do offer a variety of programs for special interest clientele. Many agencies do make strong efforts to publicize their programs, although the information may not always reach those in need.

Residence, age, and income appear to be the most often used eligibility requirements for health services, sometimes specifically stated and sometimes veiled. The means test is a much more restricted eligibility requirement in the welfare field than in the health field.

Referral sources indicate a flow of clients into both the health and welfare services, however, this data should not be taken alone but in combination with other data to understand the true relationship between and among agencies. The use of purchase agreements appears to be rather limited in Luzerne County. Health clinics do manifest some inclination toward cooperative relationships and coordinate services. A special interest advocacy health organization relies on many sources of referrals, but many do not report any coordinating or cooperative

sources with other agencies.

There is little or no use made of purchase agreements among the welfare services. Only further study can reveal whether the coordinated and cooperative relationships among voluntary welfare organizations are superficial. The character building agencies do show some inclination toward a wide source of referrals.

It has become so common as to be trite to end summaries of data with hard comments on what the data does not reveal, or perhaps to raise the hard questions and implications that stem from the data. It should be noted that these are not brought to the fore simply for the scholarly purpose of knowing something that we do not know, but for the practical necessity of finding ways to meet public responsibility for providing sorely needed social services with the greatest effective efficiency.

From the study data it is not possible to obtain accurate dollar expenditures for individual clients or families. The information collected lends itself to a great deal of speculation. The greatest dollar expenditures per client or family do not necessarily mean the best possible care for the dollars expended. On the other hand low dollar expenditures per client or family raise the question of scope and adequacy of service in addition to raising other issues such as an organization trying to do too much in too many different directions, or whether the organization relies heavily on volunteer services for agency operation. Perhaps what is needed is not only more adequate support for both the health and welfare delivery systems, but more efficient administration of the resources now expended. This may be more crucial than the general public realizes.

It would appear that an individual must be sick to become healthy. One need only look at the low cost of preventive programs (though not always easily discerned from the data) versus the high unit cost of some kind of institutional placement. There seems to be such a strong intent on spending literally thousands of dollars per year for an individual for institutionalization and yet pinch pennies to shore up a family situation wherein the original problems were generated. Though the availability of money can make a difference in life style, how it is spent is just as significant. Preventive dollars seem to be at a minimum. The data would seem to carry with it the challenge to change the foci of the health and welfare systems to more positive systems of prevention. Relating this more realistically to the data at hand, the systems will have to change their duties of operation from what is now a core service to what is now a peripheral service, since at present prevention is either non-existent or hidden as a peripheral function.

The computer and statistics have taken control of much of our lives, but there may be times when the statistics are made to say what we want them to say, All agencies are more concerned with the year-end total of the number of clients served, even if a telephone call must be counted as a service performed and/or client served. But the orientation in a rehabilitation agency is a slight variation of client count. Most rehabilitation agencies tend to be as agency centered as the income maintenance services. Most of these organizations may be careful not to accept for service anyone they believe they cannot succeed with.

Consequently, a premium must be placed on a client showing determination to overcome handicaps. Is there a restrictive intake process over and above the stated eligibility requirements? If the agency can't anticipate success that will show statistically, do they forget about the prospective client? If so, what agency gets to service this "left-over?"

The volume of organizations concerned with somewhat the same problems should cause considerable concern about the utilization of resources. How wise is it to use the small percentage of the total income in the city devoted to welfare in the way that it is used?

There may be a justification for the maintenance of separate organizations for similar services if there is a clear probability that the interests of the special group would be lost or disregarded, but this philosophy must be carefully examined in its application.

As matters stand now, it is futile for agencies providing similar functions to purchase services from each other. It is in the best interest of an agency to expand staff and services rather than spend resources to get same services from another agency. Self-preservation and self-interest require this.

Most of the character building agencies are developments of the settlement house concept which is now being recycled into use in many parts of the country as neighborhood centers with a trained staff, not only to give help when needed, but also to provide appropriate social experiences for those who use the facility and its programs.

Seven agencies listed in the study concern themselves with prevention since they concentrate on character building activities. What is so different among these that justffies the existence of all seven? Are the differences irreconcilable? Or do these organizations continue to provide these services because a generation or so ago, there was a genuine need that no longer exists? How responsive are these agencies to today's children? Have these agencies made their programs really available to those they are trying to reach? Are they aiming at the deprived, or are they directed toward middle class values and services only? If these character building agencies are not related to poor people, why are they not identified to the community as middle class oriented?

Most startling of all the data collected and collated is the absence of a single place where an individual or a family with a problem or problems can call to find out where to go for help with the problem. Many of the health and welfare organizations are aware of the dimension of the problems and needs for services, but it is literally an impossible task for everyone to be aware of everyone else's programs. The truth of the matter is that the poor and the disadvantaged are compelled to "shop around" until the frustration overwhelms them. More often than not, the subculture of the disadvantaged is characterized by resignation to living with a problem rather than "shop around" in vain. No effort has been made to coordinate these services and programs from the delivery level to the middle management (supervisory) level, and to the administrative level, in the local community.

The purchase agreement is not a social welfare phenomenon in Luzerne County perhaps because of the development of large, strong voluntary services, possibly because of the religious factor and the availability of religious institutions to take on the more obvious needs. When services really got going, they were public services. Whether or not purchase agreements could be a useful tool to provide better service, except for individual case situations, may never be known. Whether an effective health and welfare delivery system can be constructed with the utilization of purchase agreements as a first step is open to debate, as is the question of whether the purchase agreement is the final end product of a well organized health and welfare delivery system.

One of the chief reasons for any means test at all has not been perversity, but the fear that general availability of a service, particularly income maintenance, would consume all the resources of our social and economic system. Whenever monies were to be saved in the past in the public assistance system, restrictive requirements were added which reduced the general availability of public assistance resources. Significantly, in this time when individual rights have gained increasing recognition, and as welfare rights groups press for more acceptable administration and grant levels, restrictive requirements are not being added but the entire welfare system is breaking apart from the pressures of finding resources to meet the needs. This is not to be interpreted as endorsement of restrictive requirements, but merely to elucidate what occurs when a system relies too heavily on "keeping people out" to keep operating.

Fixing of public responsibility for certain kinds of services has had the effect of creating public agencies to provide the services as well as the result of separating out many needs from other needs, and separating people from their family systems in a sense. Again, this has been an effect of eligibility requirements that many agencies are now taking steps to counter. In some instances the separation of certain family members from the rest of the family has been used to gain recognition of genuine needs of such individuals and to create a kind of lobby for them. Children have been identified separately from their parents to draw attention to the specialized needs of childhood and youth.

Restrictive requirements have been the source of such an underlying fear that most services do not really move toward the social utility concept. Perhaps the one single summary comment from all the data presented in Part I should be the question: DO THE DATA INDICATE THAT WE ARE WILLING TO FINANCE, WITH EFFICIENCY, THE OPERATION OF A VALUE SYSTEM THAT WE ENDORSE?

PART II

PERCEPTION OF SOCIAL SERVICE PROBLEMS AND NEEDS

A. ASSUMPTIONS AND METHODOLOGY

Two assumptions framed the analysis by model neighborhood area residents of the MNA residents' perception of social service needs. First, it was assumed by the PMM researchers that the social structure of a person influences his perception of needs. Therefore, the perception of social service needs by that individual is a consequence, at least in part, of how he perceives either his personal or community situations. For example, individuals are more likely to perceive of a need for health care if they have had persistent health problems. On the other hand, a person who has not experienced a need for social services, may regard them as necessary, depending upon his definition of social problems.

The second assumption concerns the utilization of social services, i.e. a priori, that the utilization of available services by MNA residents was a function of one's perception. In evaluating the consumer end of social services, for instance, it is not enough merely to know about the availability of services and the numbers who complete various programs. More importantly, if the MNA residents do not perceive of any benefits derived from using services, as experienced at the personal or community levels, they may not avail themselves of services being offered.

The first step then in defining the goals of the survey was to formulate an exploratory hypothesis on the attitudes and/or perceptions of the respondents

from the standpoint of either their personal or community situations.

Thirteen areas of basic services were considered in the study:

- . Addiction
- . Aged
- . Children
- . Consumer
- . Education
- . Health
- . Housing
- . Jobs
- . Legal
- . Public
- . Recreation and Training
- . Welfare

B. THE INSTRUMENT

The interview schedule utilized in the Model Neighborhood Area Survey consisted of 137 questions - including both demographic and perceptual questions. It was arranged in the following order:

1. Instruction sheet
2. Demographic and informational questions
3. Questions concerned with perception of service problem areas individually classified by thirteen separate sheets

The interview schedule consisted of both open - and closed -end type questions in order to elicit from the respondents three things:

1. Perception of the thirteen service categories as related to either personal or community problems
2. Indication of whether the problems are getting "better," "worse," or remaining the "same"
3. Comments of interviewee concerning services they were utilizing

The findings were systematically treated in the following steps:

1. Classified data according to perception of community and personal levels
2. Tabulated responses by service area in terms of "better," "worse," and the "same"

3. Compared responses of six neighborhood areas to service category

4. Interpreted findings by grouping the consensus of both perceptions of community and personal problems according to "worse," "better," "no consensus," and the "same"

5. Analyzed content of comments of the respondents based on an optimistic-pessimistic continuum

The most delicate chore of a researcher is to interpret the results of his survey so that the validity of his interpretations is beyond questionable dispute. Arbitrary decisions are made in the classification of the data, but such decisions are always well-intentioned and made with a view to credibility and acceptance.

If the "worse" responses exceeded 50% of the total number of responses within a social service category it was classified as "worse". The one exception to this general rule is the housing category, wherein the "worse" responses, as a perceptual problem at the personal level, rated 48%. A 2% variance cannot be considered too significant when 60% of the respondents perceive of housing as a problem at the community level.

The "no consensus" designation was applied to those service categories where a clear picture could not be discerned because of the unusual combination of responses at the community and personal levels. Certainly the "worse" responses do not exceed 50%, and yet when the "worse" and "same" responses are combined, either at the community and/or at the personal level, the responses exceed 50%.

When the highest number of responses in a social service category

fell into the "same" designation even though it was less than 50% of the responses, the service category was placed in the "same" class.

If the responses were highest in the "better" grouping, even though less than 50%, then the social service category was classified as "better."

C. THE INTERVIEWERS

Interviewers were paired together, with at least one interviewer a resident of the neighborhood. The rationale for this approach was that more interesting answers would be elicited to informational and attitudinal questions once the respondent felt comfortable with the interviewer. In addition, it was presumed that indigenous residents would be unlikely to offend respondents with personal questions.

The interview schedule was pre-tested in twelve hours of training sessions conducted for the interviewers by the professional staff of PMM. During these sessions, the interviewers were oriented to the techniques of interviewing. Just as importantly, through role-playing activities, credibility of the interview schedule was briefly pretested. Where it was believed that answers could not be anticipated adequately, available space for the interviewers to insert written responses was provided. Answers to questions requiring expressions of the respondents' perceptions of problem service categories, based on either their community or personal situations, were arranged on a "BETTER," "WORSE," or "THE SAME" classification scheme.

D. SOCIO-ECONOMIC CONSIDERATIONS

In looking at MNA, the researchers sought to ascertain the attributes of the residents by seeking answers to questions such as the following:

1. Is the area suburban, small-townish, or rural?
2. What kind of people live in the area?
3. What employment opportunities are there?
4. What kind of housing is available?
5. What is the educational background of the residents?

By disaggregating the MNA into six areas, it was found to be a medium sized city with both good and poor residential areas. In addition to residential areas, the land uses consisted of commercial, industrial and institutional mixes. Land use patterns also were characterized by a number of vacant buildings, particularly in the Iron Triangle, Southeast, and Central areas. However, along Market Street, the lineal extension from the central business district of Wilkes-Barre, there was a mix of occupied and vacant commercial establishments. Many of the respondents lived in the rear of or above these commercial buildings. This neighborhood profile corresponds closely to many of the Model Cities target areas.in medium sized cities where the population density is not excessive.

1. Marital Status, Sex and Progency

The characteristics of the 536 respondents tend to take on a domestic pattern. For example, 86% of the respondents were female, of which 68% were married. Of the households, 54% had a family size no larger than two children.

The exact areas of the Model Neighborhood Areas in which the interviewing was to be conducted were then delineated. The selection of six areas, although essentially an arbitrary decision, was based on consideration of the following factors:

1. The Model Neighborhood Area had already been divided into six neighborhood associations to maximize citizen participation in the Model Cities Program and
2. The concentration of low income residents was dispersed almost equally among the six areas.

The random selection of streets within each Area was then performed. In order to do this, an equal number of streets to each Area was arbitrarily assigned. Nine streets from each of the Areas were then selected. Using the city street index, the addresses on each street per area were tallied. Finally, through simple random sampling, the lottery method was utilized by selecting every alternate address for the survey sample.

Active interviewing began on November 23, 1970, and was completed by December 11, 1970. The interviewers were required to report at 9:00 A.M. every day for the first week at the Model Cities Agency. During the first week, this reporting procedure was adhered to so that interview schedules could be checked daily and any questions raised by the interviewers could be answered. In total, 564 interviews were conducted. That figure, of course, was reduced to 536 because 28 interview schedules were considered to be unsatisfactory. After careful evaluation and analysis,and some additional surveying, it was determined to completely discard them without affecting the final results.

Such a profile points out that the households of the MNA tend to have the predominant pattern of the conjugal, nuclear family structure. While there are low income residents in the MNA, a large segment of the population consists of working class and middle class types. These characteristics were reflected in the demographic profile of the MNA.

TABLE 12

MARITIAL AND FAMILY CHARACTERISTICS
OF RESPONDENTS IN
MODEL NEIGHBORHOOD AREA

Maritial Status	Number	Percent
Married	367	68
Single	34	6
Divorced	23	5
Widowed	112	21
Total	536	100
Sex of Respondents		
Male	78	14
Female	458	86
Total	536	100
Number of Children		
One	70	25
Two	81	29
More than two	131	46
Total	282	100

It should be noted that the 21% widowed category reside in the interstice between the Iron Triangle and central areas where the O'Karma Public Housing Project is located. This again points out the pattern of isolation of the conjugal family. Moreover, it suggests a trend toward the isolation of the aged from the rest of the MNA residents.

2. Population Density and Home Ownership

As mentioned previously, there does not seem to be a density problem with respect to the residential use of land in the MNA. The overriding pattern seems to be competition for residential space in terms of the physical desirability of the Area. This pattern stands in strong relief when comparing home ownership to rental properties. The data indicate that home ownership is highest in the most desirable area (Northeast) of the MNA, and lowest in the least desirable area (Central).

In the MNA as a whole, 43% of the respondents owned their homes and 57% rented. The following table reflects a breakdown of owners and renters in the six neighborhood areas.

TABLE 13

TYPE OF HOUSING RESPONDENT OCCUPANT
IN
MODEL NEIGHBORHOOD AREA

	Number in Sample						Total	
Type	NW	NE	SW	SE	C	IT	Number	Type
Own	36	67	1	45	20	64	233	43
Rent	22	54	80	31	62	54	303	57

3. Education and Employment

To understand how the MNA residents perceived their social service needs, it was important to obtain the education and employment profile of the respondents. This is important precisely because lack of education tends to keep the consumer of social services from knowing what service is available, as well

as how to avail himself of that service. Furthermore, unemployment or under-employment determines differential accessibility to social services in terms of need. High unemployment, for instance, may indicate a greater need for basic social services.

The education and employment characteristics of the respondents suggest that these social indexes are mutually supportive; i. e., 60% of the respondents have a high school education, and 43% are employed with the bulk of them engaged in industrial work. However, the significant fact in the employment index was that 57% of the respondents are receiving some form of public assistance. This finding appears to have some correlation with the percentage of those respondents who are aged, rent, and need basic services. Moreover, the public assistance recipient would assumingly have a broader need for varied social services.

TABLE 14

EDUCATION AND EMPLOYMENT ATTRIBUTES
OF RESPONDENTS IN MODEL NEIGHBORHOOD AREA

	Number	Percent
EDUCATION		
College	23	4
High School	325	61
Grade School	188	35
Total	536	100
EMPLOYMENT		
Public Assistance	306	57
Industrial	101	19
Commercial	58	11
Institutional	71	13
Total	536	100

E. THE FINDINGS - RESPONDENT PERCEPTIONS

From the data garnered by the use of random sampling selection techniques, the social service categories are catalogued in the following groupings:

Worse	No Consensus	Same	Better
. Addiction	. Health	. Consumer	. Aged
. Housing	. Jobs	. Legal	. Children
	. Training	. Public	. Education
			. Recreation
			. Welfare

1. "Worse" Responses

The two catagories that were perceived by the respondents as social service problems getting "worse" both in terms of their community and personal situations were:

. addiction
. housing

a. Responses to Addiction Category

Of the 536 respondents in the total sample, an exceedingly high number, or 82%, perceived of addiction as worsening at the community level. The 82% represents 274 responses to the question: "Do you see addiction as a community problem in which more service is needed?" At the personal level, 62% of the resident respondents viewed this problem as getting worse, as reflected in the 101 responses given to the same question.

TABLE 15

RATIO RESPONSE DISTRIBUTION
ON
ADDICTION

	Community	Personal
Better	3	4
Worse	82	62
Same	15	34

The comments of the respondents regarding addiction generally focused on it as a problem affecting the community. However, there was little specificity concerning what agencies could do to reduce the problem. Rather the opinions were mainly impressionistic. For example, among the comments mentioned most frequently were:

- "Very disgusting that the kids of today are taking such a destructive thing."
- "The law can do more than they are doing to rid our community of this menace."
- "There is a definite need for a drug clinic in our community."
- "Our neighborhood is being used for the sale of drugs."

b. Responses to Housing Category

The next table reflects a definite concern about housing as a problem which is getting worse, particularly as a community problem.

TABLE 16

RESPONSES TO HOUSING
PERCENT OF RESPONDENTS

	Community	Personal
Better	20%	18%
Worse	60%	48%
Same	20%	34%

A concern about the housing conditions in the MNA was expressed by 60% of the respondents. The object of such concern was largely the unfavorable treatment tenants received from the Public Housing Authority. Of particular interest was the fact that the terms of the Authority did not express such a feeling as much as the non-tenants. Among the tenants, there seemed to be pervasiveness of indifference and/or an attitude of not speaking too negatively about their situation.

An analysis of pertinent comments ranged from "nothing being done by the Housing Authority" to "need more housing unity in the MNA." The following is a sampling of the respondents' remarks:

."O'Karma housing director is a tyrant and the rents are too high."

."Too many homes are unfit to live in."

."A greater need for more housing for low income families."

."Too many dilapidated houses along Market Street."

."The aged fear the Housing Authority."

."Living in O'Karma is like living in a concentration camp."

2. "No Consensus" Responses

Those service categories, which were perceived as getting worse at both the community and personal levels but do not exceed 50%, were classified as "no consensus." These services consisted of:

- Health
- Jobs
- Training

a. Responses to Health Needs Category

With respect to health as a service and/or problem area, more than 60% of the 536 respondents responded to it at the community level, and 43% of the total sample responded in terms of personal perceptions.

TABLE 17

RESPONSES TO HEALTH
PERCENT OF RESPONDENTS

	Community	Personal
Better	30%	34%
Worse	43%	27%
Same	27%	39%

While the data do not suggest any clear-cut pattern regarding the poorness of health services, many respondents' comments indicate the need for qualitative improvement in the delivery of such services. The common observation focused on the relationship between perceptual immediacy of health needs and the responsiveness of health care delivery systems. Second, there was a general tendency in the responses to criticize the increasing health care costs at hospitals and clinics. The following excerpts reflect the latter two

orientations:

- "For the money you have to pay, you would think the services would be much better."
- "It's a shame how long you have to wait in hospital emergency rooms."
- "Something must be done soon about how long the elderly and children have to wait for treatment."
- "Poor sanitary conditions and the 'indifferent' attitude of the doctors at hospitals."
- "Everything about health care services is bad."
- "Local doctors will not even handle emergency cases for public assistance clients."
- "Nursing services are terrible."

b. Responses to Job Category

It should be noted that there may be more than just a casual relationship between the jobs and training service areas. The data indicate, based on 28% of the total sample responding, that either the majority of the respondents were employed and under-employed or had received training and were later employed. The next table generally reflects the perceptions of two types of respondents: (1) those who are employed, whether full-time or marginally, and (2) those who are temporarily employed and receiving some kind of employee compensation.

TABLE 18

RESPONSES TO JOBS
PERCENT OF RESPONDENTS

	Community	Personal
Better	36%	32%
Worse	35%	26%
Same	29%	42%

The survey profile of perceptions of both jobs and training tends to reflect good, bad, and ambivalent feelings. The researchers offer a plausible explanation for this ambivalence. If a person needed a job and was placed, the Employment Service was obviously satisfactory. Certainly, a key intervening variable would be the urgency of employment. On the other hand, if a person had marketable skills and sought employment help, but experienced undue lag-time in being placed on a job, the Service was perceived as being poor.

The following interview comments demonstrate the ambivalence mentioned earlier:

- "We need more jobs for people on relief to get them off welfare."
- "The attitude of the employment service agencies is rotten and they are of no help."
- "There are plenty of jobs available, if people wanted to work."

c. Responses to Training Category

The next table clearly implies that training is not perceived as a serious problem at either the community or personal levels, as manifested by the 32% of the respondents. If perhaps suggests that those persons receiving training may have employment or they are at least satisfied with the training experience.

TABLE 19

RESPONSES TO TRAINING

	Community	Personal
Better	62	43
Worse	6	6
Same	32	51

Illustrating the jointed comments of the respondents are the following:

."There is no job after completion of the training period."

."CEP (Concentrated Employment Program) is so desperate for candidates that they should be investigated."

3. Same Responses

Of the 536 respondents reacting to community and personal problems and/or service areas, approximately 42% perceived of these situations as being substantially "the same." This bloc of respondents assigned "the same" to the following classification service categories:

. Consumer
. Legal
. Public

The data indicate that the respondents viewed the above social service categories as remaining substantially "the same" regardless of whether they were better or worse. To that end, if the categories were "better" in the past, this optimistic attitude was reflected in many of their observations. On the other hand, if the services were "bad" in the past, the observations of the respondents indicate that there has not been any significant improvement in the quality of these services in the present.

Significantly, also, most of the pertinent comments reflect an apparent dissatisfaction with the quality of services in the area of public services. With consumer and legal services, however, an analysis of the data suggests that the respondents were ostensibly indifferent. This attitude quite possibly could be attributed to the respondents not perceiving such areas as exigent concerns regarding their community and personal situations.

a. Responses to Consumer Category

Despite the fact that consumer problems regarding the purchase of goods tend to be a concern in large urban areas, the most prevalent tendency in the MNA was relevant to people on public assistance. This, moreover, was peculiar to the Department of Public Welfare's Food Stamp Program. The respondents believed the program was still generally unresponsive to the welfare recipients, since the stamps are not redeemable for non-edible consumer items such as soap, toilet items, cigarettes, etc.

TABLE 20

RESPONSES TO CONSUMER
PERCENT OF RESPONDENTS

	Community	Personal
Better	34	21
Worse	25	28
Same	41	51

b. Response to Legal Service Category

The survey profile on legal matters represented, ranged from advice to requesting action on such matters as insurance claims, divorce, and consumer

problems. Most of the service was sought from the Legal Services Program. Common perceptions held, usually pertaining to personal matters, were evenly distributed between satisfaction and dissatisfaction. In regard to the latter response, the feeling was that the agent offering the legal help was incompetent. The conclusion, therefore, was that private legal counselling can render a more effective service.

TABLE 21

RESPONSES TO LEGAL
PERCENT OF RESPONDENTS

	Community	Personal
Better	43	34
Worse	11	8
Same	46	58

Respondents' remarks had more of a tenor of dissatisfaction rather than satisfaction. Some of the comments, for instance, were as follows:

- "Some people need legal help from the Legal Services Program, but cannot receive it because they are not low income persons."
- "Legal Services is doing a terrible job."
- "We need help with workmen's compensation to collect what is rightfully ours."
- "The courts and police can provide better assistance."
- "There are not that many people, who have legal problems, for whom assistance is not available."

c. Responses to Public Service Category

The data on this set of responses revealed that more than 55% of the respondents were highly opinionated about this category. Even though they may have viewed the level of services, both community and personal, as being about "the same," the tenor of their responses indicated general dissatisfaction. Therefore, what may appear to be an almost even division on the community level of services - 31%, 31%, and 38% - could be misleading without an understanding of the undertone and intensity of the responses.

TABLE 22

RESPONSES TO PUBLIC SERVICES
PERCENT OF RESPONDENTS

	Community	Personal
Better	31	33
Worse	31	25
Same	38	42

"City Hall," the agency provider of public services, was seen as either being incompetent or lacking sufficient resources to meet the needs of the MNA respondents on many respondents. The three functions of Wilkes-Barre City that raised the most negative responses were in public works, (streets and sanitation) and public safety (police).

In response to the public services category, the prevailing negativism manifested itself in such comments as:

- "The police are slow to respond to calls from O'Karma housing."
- "Garbage and refuse are not picked up frequently enough."

. "Some of the small 'lanes' in the central Heights area are being used as dumping grounds."

. "Snow removal is terrible."

. "There are too many roaming dogs in the area."

. "They never clean streets nor tow away vandalized cars."

. "The police are good but their hands are tied."

4. "Better" Responses

This section of the survey findings presents the perceptions in which the respondents perceived that either their personal, community, or both, situations were getting better with respect to the problem and/or service category. Those categories in which the 536 respondents perceived of conditions and services as getting "Better" consisted of the following:

- Aged
- Children
- Education
- Recreation
- Welfare

a. Responses to Aged Category

Although the survey profile indicates that the aged person was not over-represented in the survey, there was considerable response to an awareness of problems of the senior citizen as evidenced by a 59% response to the question, "Is this a problem in the community?"

TABLE 23

PERCENTAGE DISTRIBUTION OF RESPONDENTS
TO
BASIC SERVICE FOR THE AGED

	Community	Personal
Better	47	46
Worse	19	16
Same	34	38

Despite this sensitivity to the problems that exist for older people (as regards community problems or personal problems respectively), 47% (community) and 46% (personal) of the respondents indicated that the situation for the aged is getting better. Only 19% and 16% (using the same community and personal perceptions as above) stated that the situation of older people was getting worse. In their comments on this category, respondents generally did not identify the problems with a specific agency, although the Social Security offices were mentioned several times. Among the comments mentioned more than once were:

- "More dollars needed than is provided by Social Security."
- "Tax rebates should be given to older persons owning homes."
- "Daytime recreation programs would be useful."
- "Older persons' pride must be handled before help can be accepted."
- "Transportation (even to and from shopping areas) is a problem for them."

a. Responses to Children

Reflecting on the demographic characteristics of the respondents, one

is compelled to note that about 75% of the survey sample had children in their homes, indicating a familiarity with the subject matter being surveyed in this area.

This area (together with the area of education) received most favorable comments of all thirteen social service subject areas. There were a number or specific recommendations and problems, but about 60% of the respondents felt that the situations both community and personal, involving children, were getting better, as indicated in the table below:

TABLE 24

RESPONSES TO CHILDREN
PERCENT OF RESPONDENTS

	Community	Personal
Better	65	56
Worse	8	6
Same	27	38

The fact that less than 10% of the respondents felt that situations revolving around children were worsening (rather than remaining "the same") confirms the attitude of optimism about the community's services for children. The specific comments about children's problem situations seemed to focus on teenagers ("they need sport facilities, like basketball and football"; "drinking is a major problem for teenagers") who are also the focus of the problem areas dealing with drug addiction.

With regard to child-serving agencies, several respondents complained about the "red tape" and the persistence of overlapping agency jurisdictions,

citing a major need for consolidation of child services and increasing communications between education, counseling, recreation, and police services.

The word "respect" appeared quite often in the respondents comments about children, reflecting the feeling that "this younger generation doesn't learn the proper respect for established ways and procedures..."

c. Responses to Education Category

This subject area received the highest, most positive rating from the survey population. Less than 10% felt that educational services were worsening at either the community or personal levels. The detailed tabulation reveals the following:

TABLE 25

RESPONSES TO EDUCATION
PERCENT OF RESIDENTS

	Community	Personal
Better	71	60
Worse	7	9
Same	22	31

This very positive attitude towards formal education systems was reinforced by many of the volunteered comments, although specific examples of further improvements were also given:

. "Retire older teachers and hire more younger ones"

. "Overcrowded classrooms"

. "More supervision is required during school playtimes"

In addition, several of the respondents commented upon the existence of supplemental educational programs which were more designed to spend money that was available than to accomplish needed objectives. Several respondents

suggested that investigation was required of various "grants" that had been given to community educational facilities. These suggestions, however, must be weighed in the light of the excellent "report card" being given to the area's educational facilities by the surveyed population.

d. Responses to Recreation Category

The data indicate that slightly more persons surveyed felt positively about recreational services than felt negatively. The volume and type of critical unmet need was much less than would be anticipated, reflecting a high degree of satisfaction with existing recreational programs and services.

Since this subject area comes in for early, if only surface criticism in nearly every community survey, the findings, shown on the table that follows, must be considered quite positive:

TABLE 11

RESPONSES TO RECREATION
PERCENT OF RESPONDENTS

	Community	Personal
Better	42%	40%
Worse	30	23
Same	28	37

Supervision, to prevent vandalism and to relieve working parents, was noted as an unmet need by many respondents. Focus was upon the teenager in this area, seconding the point made with regard to children, that this age group was the greatest perceived source of problems. Specific criticisms of the Recreation Department and the Cub Scouts centered about the geographic narrowness of the services of these agencies. Specific criticism was also voiced

at the absence of park-like areas for recreation and the use of certain recreation facilities near areas of danger (the railroad tracks near Lehigh and Hill Streets).

e. Responses to Welfare Category

To be particularly noted with reference to the responses on the welfare social service need is the fact that more than half of the respondents (57%) were receiving some type of public assistance.

This social service area is classified as one of the five in which the positive attitudes of the survey population exceeded the negative comments or attitudes. Yet in this inclusion in this select group with education, children, the aged, and recreation is but a matter of only a few percentage points.

TABLE 26

RESPONSES TO WELFARE
PERCENT OF RESPONDENTS

	Community	Personal
Better	46	41
Worse	24	21
Same	30	38

What is unusual, also, is that the minority (24% and 21%, respectively) who felt that the welfare system was worsening was very vocal and cited many

different types of shortcomings. There seemed to be fundamental political and personal negative feelings about welfare recipients, which is voiced by this minority. Among the major problems citied were:

1. That there were many persons receiving welfare who did not deserve it and,conversely,
2. That people in true need were not on the rolls.

Additional criticism of the basic system assumptions was widespread, including such allegations as:

- "Investigators are lax in their work and too nosey"
- "Requirements that welfare recipients be compelled to work"
- "Payments should not exceed what a man could earn at $2.00 per hour"
- "Need day care centers so that mothers on welfare can work"
- "Need consumer education to help recipients spend money wisely."

The failings, such as were noted by the respondents, are more structural and basic to the welfare system, than mere service reforms of improvement suggestions as is the case in other subject areas covered by the survey.

F. GEOGRAPHICAL ANALYSIS OF FINDINGS

An examination of the data by neighborhood area denotes some interesting patterns about social service needs. The most negative view of services at both the community and personal levels appears to have the highest

incidence in the Iron Triangle, Southeast and Central neighborhoods of the MNA. The ranking of those services, by area, which were viewed as getting "worse" appears on the two tables that follow:

TABLE 27

COMMUNITY PERCEPTION OF "WORSE" RESPONSES
BY
SELECTED CATEGORIES AND NEIGHBORHOODS

ADDICTION		HEALTH		HOUSING		JOBS	
Iron Triangle	62	Southeast	43	Iron Triangle	58	Iron Triangle	34
Southeast	49	Iron Triangle	30	Southeast	47	Southeast	23
Northwest	46	Northwest	26	Central	33	Northwest	15
Southwest	29	Central	15	Northwest	27	Central	12
Central	23	Southwest	13	Southwest	17	Southwest	8

TABLE 28

PERSONAL PERCEPTION OF "WORSE" RESPONSES
BY
SELECTED CATEGORIES AND NEIGHBORHOODS

ADDICTION		HEALTH		HOUSING		JOBS	
Iron Triangle	16	Iron Triangle	18	Iron Triangle	41	Iron Triangle	17
Central	15	Central	9	Central	22	Southwest	8
Southwest	11	Southwest	8	Southwest	7	Southeast	7
Southeast	4	Southeast	7	Southeast	6	Central	7
Northwest	1	Northwest	4	Northwest	3	Northwest	1

If income data could have been obtained from the respondents, a more discriminating profile could have been obtained on those persons who viewed services as getting "better" or as remaining the "same." The basic services, such as recreation, children, and education, could have been considered either

as amenities or investments, and then matched to income levels. As amenities, these services directly increase the consumption by individuals. In that case, however, they are not a means to the attainment of other resources; rather, they are themselves an important component of the level and quality of living. On the other hand, as investments, they are the bases for improving the capacity of individuals to gain access to resources through the private market. To illustrate, better education services or improved transportation to jobs increase the earning capacity of the individual or of the family. Therefore, if some kind of measure could be constructed that would discern whether these services were amenities or investments, a more accurate determination could be made as to whether or not people actually see these services as getting "better" or as remaining the "same."

G. SUMMARY OF FINDINGS

Substantial numbers of respondents in the Model Cities Neighborhood commented that services were better in the service categories dealing with children (child, recreation, and education) and/or the aged. The latter group has improved its services, and yet a third of the respondents see their situations merely as the same. Although the welfare service was placed in the "better" category, it could well have been placed in another category. Only a few percentage points would have dropped it into the "No Consensus" rating. Of significance is the fact that a quarter of the respondents not only rated it "worse" but expressed very strong feelings about the shortcomings of the welfare system.

The only summary comment that can be made concerning services rated the "same" is that the respondents exhibited either indifference as in the case of consumer and legal services or dissatisfaction as in the case of public services.

If the findings are considered from the community level alone, then the conclusion could be deduced that the major pessimistic comments indicate a general decline in the quality of life. The evidence for such a negative view is found in the fact that addiction, housing, and health are rated "worse" at the community level. Addiction and housing are rated "worse" at the personal level as well.

A word should be said about those services which were given the "same" rating, either at the community or personal level (or both for that matter). These services would include health (personal), jobs (personal), training (personal), consumer (community and personal), legal (community and personal), and public (community and personal). If life generally improves for everyone in the society, but a respondent views conditions as remaining the "same" at the community and/or the personal level, it doesn't necessarily mean that his lot is now or will be a happy one. Viewing life as the "same" is not to equate it with improvement, for what may be the "same" today may be "worse" tomorrow.

The negative view of services at the community level appears to have the highest incidence in the Iron Triangle and Southeast Sections of the MNA.

In evaluating the perception of the consumers of basic social services,

the data collected suggest that the gaps between services and needs were a consequence of:

1. the presentation of the service by the agency provider

and

2. the consumers' experience of that service.

For example, the data reflected an increasing concern about addiction, Undoubtedly much of this concern has been generated by the news media. However, it also appears obvious that the residents have not been made aware of any agency that provides addiction rehabilitation services so as to allay their apprehensions. For the consumer to understand and interpret addiction as a problem or service need presented in the news media implies that the listener is not being made aware of what is available services exist at this point in time. The pessimistic comments of the respondents concerning the unresponsiveness of service agencies to this problem hint at the unavailability of service resourses to focus on the problem.

There are two aspects that affect a consumer's perception of social services based on his experience with the agency provider. First, what happens to the consumers who apply for a service? And, second, how does the agency treat them?

The data findings on the "worse" responses to health serve as a good sounding board to these questions. The MNA respondents expressed concern about the unresponsiveness of health delivery systems. This perception was ostensibly a consequence of their experience in seeking health care.

Their comments imply that health agencies (hospitals and clinics) vary in their understanding of and openness to various modes of individual behavior. It is a known fact that low income people of all ages consult doctors, dentists, and medical specialists less frequently than do the non-poor. Therefore, given emergency conditions, the responsiveness of the provider tends to be a function of the consumer's past utilization rate which is contingent upon social class position. In most cases, according to the findings, the poor consumer was either excluded or spent long periods of time waiting.

Another point frequently mentioned regarding the responsiveness to the appeal for health services was that some doctors will not take public assistance clients. These persons are usually the ones who have a history of inadequate health. Hence, a more in-depth analysis of the availability of health services to this group in the MNA might reveal the inequality in the distribution of health services and physicians among the six neighborhoods within the MNA.

PART III

STRATEGIES IN SOCIAL WELFARE OLD AND NEW

Change is the lifeblood of any political, social, or economic system. Health and welfare programs as major components of our social life have undergone change too. Traditionally, our social welfare programs have rested on the concept of charity rather than on the concept of special rights. The value has been on voluntarism rather than on public (governmental) responsibility. It is not that poverty, the poor, or the disadvantaged have been rediscovered in Wyoming Valley, particularly in the Model Cities Area. It is just that subtle changes have finally caught up with the general citizenry hereabouts. The response locally is to be found in the change in thinking about the United Fund and its constituent agencies, and particularly in the Welfare Planning Council.

A. THE PAST IN REVIEW

The structure of welfare organizations differs in those agencies established under public auspices from those which are of voluntary or private nature. Public agencies are established by individuals or philanthropic, religious, fraternal, or humanitarian groups; their management is the responsibility of a board of directors, and they are supported mainly by contributions, donations, endowments, trust funds, and often by participation in the distributions of a United Fund.

In Wyoming Valley, the foundation of private social agencies and the continuation of their activities in the past has been based upon the recognition of the need for a service in the local community. Originally, philanthropists, a

group of interested citizens, or a church society became aware of the need for some type of social service, such as a family welfare agency, a children's protective society, or an organization to aid unmarried mothers or crippled children.

There would be an investigation into what resources existed in the community and what institutions or facilities were missing before the establishment of a new social agency was encouraged or supported. But still, individuals or groups of citizens concerned with social and health conditions in the community took the initiative, if they were able to secure the necessary moral and financial support, for a new enterprise in health and welfare work, such as a mental hygiene association or a vocational guidance clinic.

In contrast to public agencies, which according to statutory provision have to accept every client who meets the legal requirements for eligibility, these voluntary agencies were not under obligation to service every applicant. The social workers in the private agencies were convinced that their work would be most effective if the persons who came to the agency fully understood the conditions under which the agency could serve them, what the nature and limitations of the service were, and if the applicant himself decided whether or not he wished to use these facilities.

It wasn't long before the social and health needs of the various groups of the population were considered by a council of social agencies or a Welfare Planning Council. Both the United Fund and the Welfare Planning Council were created to coordinate the services of all the agencies in the delivery of the services and fund-raising whenever the latter was a community wide activity. The

United Fund soon developed into the one single fund-raising agency in behalf of many health and welfare agencies. It was a result of taking on this support function as one of its main tasks of making allocations to the member agencies that eventually led the United Fund to study the role of the various agencies in the Wyoming Valley Area.

The Fund did develop over the years what seemed to a logical set of standards and objectives for the allocation of the United Fund dollars. However, often times informal reasons or criteria frustrated the more formal, stated criteria. Factors such as professionalism, previous budget, administration, budget consideration, and clients served, were always considered in an informal way, along with the presentations made by community and influential people who spoke for a social agency. The prestige of the agency, historic or current, and the plain human sympathies of those on the allocation panel were a factor. They may have participated in or used the services of an agency. The representative of an agency might have been more skillful in presenting its needs. Also, it was always easier to enlist support for a direct, personal service.

Perhaps more importantly, the past history of allocations became an immutable pattern, difficult to change radically, reduce, or eliminate. The desire for orderly change would become a typical defense mechanism of social agencies. The truth of the matter is that informal reasons may have been used because neither priorities nor guidelines had been adequately developed, adopted, or implemented with any muscle.

Then, too, volunteer workers for the United Fund developed a certain "tit for tat" rationale concerning fund raising that could more charitably be labeled a "philosophy of flexible concern" meaning no more than "I'll work to raise funds for your agency if you will work to raise funds for me."

Although there may not have been constraints in reference to ethnicity, religious beliefs, degree of professionalism, the number of clients served, etc., there certainly were "understandings." In the allocation process, these did operate, but not always to keep an agency out of the Fund, although it should be emphatically stated that this community, and the Fund, have a minimum of bias.

Probably the two most serious constraints have been professionalism and the number of clients served. The lack of professional qualifications (Jewish Welfare) has posed a problem. And yet, the Agency may have done a good job in the past in dealing with people problems. There has always been a feeling at allocations time that the Salvation Army was really operating a religious enterprise and with a bookkeeping system that "left much to be desired." But many felt that it performed a social as well as a religious service. In spite of a recognition of the fact that the United Fund was supporting a religious operation, cognizance had to be taken of the fact that many community leaders were very much interested in the success of the "Army." Planned Parenthood has never been a United Fund agency and may never be, by choice, as well as by opposition from the Catholic Church.

People on the allocations panels have been influenced by their ancestry

and religion. Regard for professional operation has run the gamut from cold calculation to warm, undiscerning emotionalism. This has delayed the consolidation of some agencies with related functions.

The agency's spokesman may state that the constraints do not relate to agency goals, objectives, or functions, and may have regarded these constraints as inconsequential. The fact of the matter is that they do relate to the goals and functions. Even if Catholic Social Services did not consider family counseling for Catholics its own perogative, Catholics would feel more comfortable with the agency. An Orthodox Jewish person would tend to go to the Jewish Welfare Agency. The goals and functions must, of necessity, be geared to the type of people they serve - based either on ethnics, age, religion, particular problem, etc.

Agencies have not in the past always shown an awareness of goals and and often confused objectives as goals, compounding this difficulty by being unable to clearly define the parameters of the responsibilities. As one person put it, "Rehabilitation is rehabilitation. What difference does it make who does it?" Agencies have had grandiose goals and kidded themselves on their actual impact. Both the Red Cross and the Salvation Army do disaster work. If it is the province of one or the other, is there any justification for spending the Fund dollar twice? There would not be if goals were clear to all agencies.

The problems as to goals are posed by changing goals in a changing society. Should the Community continue to put money into an activity such as Council House when such activity is now government financed? It has been the

habit of many agencies to stay in a comfortable rut and not discard outmoded programs that do not anymore fit the goals of today.

Many of the problems of the voluntary agencies are caused by legislative procedures about which they can do nothing. Public health and welfare programs have influenced the activities of the voluntary organizations profoundly. Many of the old activities of the voluntary organizations have been taken over by the public agencies, and therefore the voluntary agencies must constantly readjust their sights. Therefore, their function may change from actually supplying the service to playing "watch dog" when the service becomes public.

The public health and welfare system is influential in respect to United Fund agencies in a number of ways. Firstly, it takes on the burden of the welfare cases, and leaves other areas of income and need to the community agencies. To the extent that public funding meets needs, the rest of the community needs become the province of the United Fund Agencies. In many instances, public funding is used to purchase services from United Fund agencies. This in turn frees volunteer dollars for more extended use to those not covered by public funding standards.

Public funding can change the direction of the volunteer dollar and does force voluntary agencies to reexamine their goals in the light of availability and the nature of public funding.

The United Fund agencies' influence has been substantial if not at times overwhelming. The United Fund and the Welfare Planning Council have been able to get health and welfare agencies to change procedures and legislation in

in order to offer services that people need. Very often voluntary organizations lead the way to changes in restrictive requirements later adopted by public agencies. For example, Family Service Association provides services to all families who ask or need these services, regardless of ability to pay. The public welfare system also appears to be moving in that direction toward the creation of a public family services agency.

United Fund agencies have voiced needs and started services. An example is Homemaker Service which came first by the Junior League out of a private agency and now has been adopted and is used by public welfare. United Fund has been a strong constructive critic of many Federal and state programs and has mobilized a substantial bloc of public opinion on occasion. What is has not done, hampered perhaps by limited funds and some lack of vision within itself, has been to volunteer and be in the forefront of new approaches.

There may have been a time (coal companies, bankers, leading citizens) were capable of exerting influence through allocations procedure. But no particular group could be considered powerful today, although there are some individuals who may be.

If the Family Service Association receives a high allocation it may not necessarily be because certain individuals have not only been the presidents of the association, but also chairmen of the United Fund drives and presidents of the Welfare Planning Council. Rather the high allocations are due to the fact that the agency has been considered by many people in the community as doing a very effective job of counciling. Coincidentally, these same individuals who

have headed the United Fund and the Welfare Planning Council have also been instrumental in raising the level of the agency.

On the other hand, no single influential person or group could save the Legal Aid Society allocation. Allocations to the Jewish Welfare Agency have not been due to any single person, but rather due to the United Fund Allocation Committee feeling sympathy toward its director for past performance. The same is true with the Salvation Army.

As a matter of fact, there have been instances of counter reactions to influence. A group of 59 community-minded people and individuals who serve on the Allocations Committee is too diversified a group to influence let alone control.

There may be a feeling that neither the Welfare Planning Council nor the United Fund approached the Model Cities Agency to offer assistance. This is true, but the law and the concept written into it not only prevented the agencies going to the MNA, but neither could the MNA initiate communication with the agencies. It is the feeling of the voluntary agencies that when Model Cities was first conceived, the basic assumption was that the old institutions of whatever category -- economic, political, social, etc. -- had failed to meet the human problems. Therefore, out of this concept developed the idea that innovative plans, policies, and programs had to be the road to meet problems. New agencies, institutions, and programs had to be developed. Therefore, the corollary assumption was that "restructuring" the old institutions would not be enough to accomplish the objective. Consequently, there was no communication

between the social service agencies and Model Cities Agency.

Research and consultants were given priority in the early days of Model Cities Agency. After the consultants advised MNA that some of the old agencies, if restructured, could serve a useful purpose, communication began, i.e. Human Resources Center was as a recommendation of just such a recommendation.

At the same time that communications between the United Fund agencies and the Model Cities Agency began, the United Fund and the Welfare Planning Commission began an intensive study on goals, objectives, priorities, and allocations of the member agencies. It was the feeling of many that a reappraisal should be made of both the agency goals and the requests for money. This two pronged attack - one on a restudy of the old traditional social service agencies and the other predicated on innovation and new concepts, have brought the two groups together for what perhaps can be the development of a more effective and humane health and welfare delivery system for the residents of the MNA.

The feeling was also extant among many board and staff members of the Welfare Planning Council, the United Fund, and social service agencies that the Model Cities Organization is essentially an administrative body and not an operating body. In other words many agency people have felt that as such a body, the Model Cities Area purchased services. Aware of this fact and also realizing that some agencies would have allocations difficulties and that others may want to enlarge their programs, the United Fund has recently encouraged its agencies to seek Model Cities funds in those areas where the program objectives coincide with the program objectives of Model Cities.

B. GUIDELINES AND PRIORITIES

If the United Fund and the voluntary field is to survive, it became clear to its Board and that of the Welfare Planning Council that it would have to exhibit an aggressive and dynamic leadership role in solving community health and social problems. This means a more dynamic mission than merely raising funds for a group of agencies, or supplementing public programs, or reducing the number of campaigns, all of which may be commendable in themselves.

Steps in this direction were taken when, in 1967, the United Fund reached a decision that it needed a priorities plan to help in allocating funds raised in its annual campaigns. It was decided that no one from the outside could really tell a community what its priorities should be. It was the conviction of those working with the Fund that these are decisions each community must make for itself in terms of its own problems, assets, and aspirations.

In attempting to develop a priorities plan, it took the work of many dedicated people over two years to prepare a priorities plan. There were twelve persons primarily involved, six from the United Fund and six from the Welfare Planning Council. This committee drafted a Position Paper which was shared with the agencies before it was presented to the Board of the Fund for its approval. Each agency was asked to review the paper. It searched for material from other areas and from other United Funds, but none was to be found. They had hoped to find something they could use "right now" but there was none.

The United Fund was faced with answering the following questions when determining allocations through a priorities plan:

1. What services do we want or should we provide to meet our community needs?

2. What are the most important services which the Fund should be supporting?

3. Are Fund dollars being used to support services which could and should be supported by public funds?

4. Are funds now being appropriated to services in relation to their importance?

5. By what criteria should agencies and the services they provide be evaluated?

The "Position Paper" declared that:

A priorities system should be part of the community planning process, for priority planning is actually a refinement of community planning. Priority planning is never completed; it is a continuing process. Knowledge of needs, agency programs and service standards is fundamental.

It is important that agencies understand and accept the criteria and procedures employed. Agencies have autonomy and can directly influence the success or failure of any priorities plan.

The system must be flexible, and adapted continuously to changing conditions and increased knowledge. Changes in needs, in service methods, and in community values will change priorities. Increased knowledge will provide a basis for a better evaluation of needs and services.

Implementation of a priorities plan will place additional requirements on member agencies and the organization developing the plan. The Fund and Council are committed to invest the staff time to its development and maintenance.

A priorities system is concerned with services -- not agencies. Since many agencies offer more than one service (some of which may rank high, some low), it is necessary to be able to separate the cost of these services.

A priorities plan--

starts with an analysis of community needs and problems and services designed to solve, whether currently existing or not.

ranks the needs with respect to their importance.

evaluates the adequacy and effectiveness, both quantively and qualitatively, of existing services.

assesses the gap between need and present levels, both with respect to existing services and services which should be developed.

determines how services should be administered and financed, whether by voluntary or tax dollars.

makes recommendations as to which services should be initiated, which expanded, which modified, and which curtailed or eliminated.

Guidelines were then prepared containing seven components, a summary of which is presented below:

1. Objectives for Agency Services: Stress was placed on relevant community social ills, approaches, prevention of family and/or individual breakdowns and services in building character. Priority was to be given to those services which serve the low income and disadvantaged.

2. Responsibility for Voluntary Support: Emphasis was placed on client self-support if possible. More important perhaps was the point made that agencies should not seek funds for state mandated services, but should complement those services. A total community approach --public and voluntary-- to community needs was underscored.

3. Effectiveness of Agency: Agencies were asked to continously evaluate the effectiveness of their programs and identify gaps in both services and areas served.

4. Efficiency of Operation: Management efficiency, consolidation of services, employment of consumers of services, and the development of multi-purpose service centers were given a marked accent.

5. Board and Membership: Consumer participation on governing boards and effective citizen involvement were given a high priority.

Note should be made of these guidelines in the light of later sections of this study.

The "Guidelines" were then converted into a rating sheet form. Agencies were not asked to fill out the rating form, but to answer the questions that would enable a reviewer to make an evaluation of the agency relative to the areas defined. The narrative form of the response was expected to include service statistics if they were considered pertinent to an understanding of a program, other pertinent data, and especially the purpose of the agency as stated in the bylaws of the agency. The agency was expected to clearly state its activities as related to the objectives of the agency and its responsibility to the community for community support. This was an attempt to look at the profile of the agency and the community service being rendered.

After the rating material was received by the Central Allocations Committee, the responses were reviewed by a number of individual panelists who were knowledgable people in the community not connected with any United Fund agency. These evaluations were compiled and submitted for use by the Central Allocations Committee and Conference Groups. The results, in and of themselves, were not to be the determining factors for allocations. However, they were important in developing the priorities which all agencies have agreed must guide the United Fund in allocating limited voluntary dollars for the future.

This is the first time an attempt has been made to rate agencies as to pre-established community goals. The Fund is making an effort to base decisions on a relationship to those community goals. Hopefully this would provide the information and tools necessary to allocate community resources.

C. GOALS

Consistent with the guidelines and priorities, a number of goals were reviewed and adopted by the United Fund-Welfare Planning Council which will have a very significant impact on the delivery of social services in Wyoming Valley and particularly in the Model Neighborhood Area. Some of these goals are set for the current 1971 United Fund year while others are more long distant.

The number one goal for 1971 is the merger of the Visiting Nurse Association and Wyoming Valley Homemakers Service, Inc. into the Home Health Services of Luzerne County. The goal is (a) to finalize formation of the new agency and admit it as a member agency, and (b) to market this organization to include the Visiting Nurse Association of Pittston as capabilities grow in 1971. The purpose of the new organization is to provide a more comprehensive home health care program. In this manner, it is hoped to take better advantage of maximum public and private financial support; e.g. Social Securities Benefits "Home Health Aides" and Blue Cross coverage, and eligibility medicare services. The improved relationship between Home and Health Services and hospital care is expected to develop from the merger. The 1971 allocations were made for only six months, with March 17, 1971 set

as the activation date for the new organization.

A second goal of major import is the deactivation of Council House and its program of out-patient hospitalization merged with Luzerne/Wyoming County Mental Health Center since the resocialization program will be merged with United Rehabilitation Services resocialization program. The United Rehabilitation Services resocialization program now handles many of the Council House clients. The major objective is to develop United Rehabilitation Service into the single rehabilitative service in Luzerne County. Of course, the merger is contingent on the United Rehabilitation Service's program capability to absorb additional services and Council House's willingness to join its resocialization program into a new program. A one year timetable is set for the coordinated program.

Goal number three involved transferring the United Cerebral Palsy Day Care Program to United Rehabilitation Services in order to provide additional medical and physical orientation to the Day Care Program. The United Rehabilitation Service staff and program capabilities are expected to handle clients in wheel chairs, etc. Again, a time limit of one year has been set for the transfer.

Consolidation of the Luzerne County Association for Retarded Children and the Luzerne County Mental Health Association has been set as Fund priority four. The direct service programs, such as the Clergy, Clinic and Day care are expected to be turned over to the Luzerne/Wyoming County Mental Health Center and/or the United Rehabilitation Service. The purpose of this

action, no doubt meeting state and National Board opposition of both organizations, is intended to provide organizational strength and leadership. It is expected that the new organization will be better able to devote more time to its primary function in monitoring public funding.

United Fund priority number six will also be of significance to the Model Neighborhood Area residents, for this objective contemplates that all Family Service Agencies (office oriented agencies) will be housed in one building. The agencies eventually contemplated for consolidation are Family Service Association, Catholic Social Services, and Jewish Welfare Agency. All three of these agencies have a long community history of separate operation. It is expected that this single family service agency can make better use of voluntary dollars in office administration so that more dollars can be used for client services. It is expected that a joint answering service and office equipment can result in initial savings. The joint approach will make it possible to obtain benefits of public and private funding for total community services. The separate agencies have all experienced a fact of life that government sources hesitate to individually purchase service on separate contracts. Although no time table has been set up for this merger, a continuing review through 1971 can remove any obstacles that may arise. It is the hope of many associated with the joint planning, that the merger can come to fruition by 1975.

Other priorities include the establishment of allocations to all Character Building Agencies on the basis of need, the consolidation of Red Cross Chapters, identification of Salvation Army funding as community service. Allocations to

recreation and character building agencies will be combined in the "ability-to-pay" support. A system of analysis is expected to be developed for those who need assistance to participate in the activities of these agencies. In the case of the Salvation Army, the social program will be separated from the primarily religious activities. One of the purposes of this review is to better coordinate its activities and community services with those already established, and thus make better use of United Fund dollars.

Another recent decision of the United Fund-Welfare Planning Council relates to the Legal Aid Society, sponsored by the Bar Association and a long time member agency of the United Fund. It was primarily funded by the United Fund up until 1966 when the Office of Economic Opportunity began to provide funding. During the past two years, the Commission on Economic Opportunity claimed that the Legal Aid Society was not conforming to essential guidelines necessary to continue Federal funding, culminating in the withdrawal of Commission on Economic Opportunity funding in March of 1970. The United Fund was then faced with two Legal Service Agencies: the newly proposed Legal Services Association sponsored by the Commission on Economic Opportunity and the Legal Aid Society.

Although the handling of divorce cases was a bone of disagreement, of greater concern to the Commission on Economic Opportunity was the fact that the Legal Aid Society did not commit itself to the reform of laws that worked a disadvantage to the poor, and the Society did not have anyone defined as poor by the Commission on Economic Opportunity on the Board of the

Legal Aid Society.

The Luzerne County Commissioners, after discussion with representatives of both organizations concluded to continue support for the Society for the year. Since the action of the Commissioners of funding the Society left the Commission on Economic Opportunity program with no local share to provide the 20% necessary to receive Federal funds, the United Fund allocated funds to the Legal Services Association taking them from the Legal Aid Society.

During the discussion on the issue, reference was made to the Guidelines in respect to the use of voluntary dollars as they duplicate or as public dollars become available. This is a classic example where service had been provided through voluntary giving for twenty years and finally became such an obvious need that the public sector assumed responsibility for providing the service. It is typical of a situation where a governmentally funded service supplants a locally-sponsored activity in the interest of community betterment. It was the feeling of Board members that maintenance of two duplicative service groups wastes local and public money through the costs of duplicate staff and administrative expense.

PART IV

RECOMMENDATIONS

A. INTRODUCTION

Daniel P. Moynihan, counsellor to the President on Urban Affairs, writing in the May 23, 1970 issue of Saturday Review stated, "This nation is moving from a services strategy to an income strategy. A services strategy, in rough terms, is one that seeks to make up presumed deficits in the behavior of one set of persons by providing them the counsel, advice, and example of another set of persons with presumed surpluses of such behavior. The terms of trade are, in essence, advice in return for deference."

He goes on to state that the services strategy is characterized by the fact that out of selfless beginnings evolved vested interests. Therefore, the purveyors of services acquire an interest in the maintenance of demand.

The point that he makes is that services should be for everyone, not just the poor. His blunt point is that segregated services deteriorate.

And that is really the focus of these final words. Social services should be community services, not poor people's services, available to everyone. It is difficult to construct the components of a model social services system delivering health and welfare benefits because of the primitive nature of our knowledge and understanding relating to the social services. Given this stage of development, perhaps a statement of problems helps point the way.

First, we cannot seem to agree on the scope or definition of social services; what they are or who they are for. Are services only to make up for individual deficiencies and, therefore, to aim at rehabilitation, or are they also to include services which enhance normal growth and development? Should they be remedial, preventive, rehabilitative? Or, should they be developmental? This latter concept, which conceives of social services as social utilities, opens the way for consideration of a large spectrum of community-sponsored facilities and activities, such as day care, supervised play lots, home helps, and many more.

Our second problem is our inability to rationalize in any way the current organization of social services. Services programs have grown up historically, accidentally, publicly sponsored or privately endowed, geographically determined, professionally controlled, and often heavily regulated from above or outside.

Third, we cannot measure adequately the effectiveness or know precisely the results of social services. We are very largely at the mercy of the professionals' imprecise and impressionistic evaluation of their own services. This is an adequate base from which to determine future policy, particularly when community resources are scarce and alternatives must be defined and analyzed.

According to the 1968 Report of the Steering Committee of the Arden House Conference on Public Welfare stated, that "The vast majority of the welfare population is either too young, too old, too sick, or too disabled to be self-supportive." If a hard analysis of the MNA populations even tends to be described as above, as unpleasant and unpalatable as that fact may be, then a reappraisal of the health and welfare systems is a must.

B. HUMAN SERVICES DELIVERY SYSTEM

1. A Model Medical Care System

The preceding discussion leads to the formulation of a model medical care system. This system should emphasize decentralization outreach, multiple services readily available, and the use of the indigenous non-professional as the prime human resource of the delivery system.

Access to health is important and a major determinant of use is accessibility. The reverse may not be true. Creating access does not necessarily elicit use. Technology may lead to better care, but the truth of the matter is that the great majority of ailments can be managed in a simple rather than in a complex setting.

In the past, provision of health care was grounded on a system of care by the private practitioner and free choice of physician by the patient. Private care will no doubt continue to exist along with a social health delivery system. The legislation to influence a change to the latter system is already on the books:

. Amendments to Social Security Act

Medicare and Medicaid

Health care for pre- school and school age children

Health care for crippled children

Maternal health care

. Regional Medical Program

. Comprehensive Health Planning Program

. Child Health Act

Maternal child health program for low income services for retarded children

. Economic Opportunity Act

Neighborhood health centers in low income areas

This latter Act has direct applicability to the Model Neighborhood Area. The centers can provide complete and accessible medical care, with emphasis on preventive medicine and family planning services. This type of primary health service delivery at the neighborhood level appears to be the wave of the future. Public, voluntary, trade union, profit and non-profit group arrangements in neighborhoods are increasing as is group practice by physicians.

A breakthrough has already been made in the field of mental health with the Mental Retardation and Mental Health Act of 1963, which provides for prevention, treatment, and rehabilitation services for the mentally ill. Lacking, however, is a clear relationship between the new mental health model and social and health services in a community. The mental health facility must be easily accessible, convenient, familiar and accessible to neighborhood residents. It should not only be a treatment center but perhaps a coordinating center for many health and welfare services.

The foregoing pieces of legislation, and many others, have the beginnings of a health system revolving around preventive medicine.

If preventive medicine is to be more than a myth, it must be organized at the three levels of service. The first level, the outreach system, would

include shared health and welfare services. The staff would support the outreach system. The central health facility would be a comprehensive neighborhood health center operated under contract by local practitioners, a local community hospital, or some combination of these. The neighborhood health center would provide appropriate diagnostic and therapeutic services, and would educate whatever necessary. The third level of service would be in a local hospital with or without a close clinical service, staff, and educational tie to the program. All of these services must be closely related physically, functionally, and psychologically to other human services.

The basic thrust of a model health model should permit the disadvantaged access to the mainstream of health servides and to utilize more fully all existing health services. Within this dual framework, the model must revolve around several key programs:

1. A community health center.
2. Develcpment of a group health practice whether in a facility owned and administered by a non-profit health group or profession owned.
3. Use of trained resident aides to prevent and reduce the impact of illnesses in the Model Neighborhood.
4. Development of a prepaid medical, mental, and dental care program.

The success of preventive medicine revolves around the health center which is easily distinguishable from the present health delivery system:

1. "Walk-in" versus appointment usage of services.
2. Demand for services versus supply.
3. Continuing comprehensive care versus acute episodic care.

Examples of health functions which might be carried out in a decentralized system in the neighborhood center include school health program, inoculations, routine well-baby and early childhood care, mental health services, medical and dental screening services, pre- and post-natal services, family planning and counseling involving health problems, and simple emergency services.

The citizenry who in a community health center neighborhood signed up would be covered by a capitation system paid in advance either through public sources, through a combination of self-payment and public support, or entirely through self-payment.

The World Health Organization's definition of health is a "state of complete physical, mental, and social well-being and not merely the absence of disease." If the WHO definition is to be more than mere words only a system of preventive medicine can provide the complete medical, dental, and community outreach service that the MNA residents deserve. It is within the context of this model medical care system that a medical services system should be established for the MNA residents. An integral part of this model health program should be a pre-paid comprehensive health insurance plan for the residents.

2. A Model Welfare Care System

Welfare today is caught in a confusion of objectives-objectives which are as vague and contradictory as are personal and societal attitudes toward the poor. Some people think it is wrong to be poor, so they demand a welfare program which is harsh and punitive. Others think we should do something

for the poor-but not too much. They advocate a welfare program which provides just enough food, just enough clothing and just enough shelter to get along. Still others see the poor primarily as potentially productive citizens. For them, a rehabilitation program geared to helping the poor make up their deficiencies is the proper course to follow.

In a model welfare delivery system, efforts should be directed toward the original and still the basic function which is to supply money where there is none. First things must come first, and for a MNA resident, many of whom are on welfare, money is first, the rest follows. Therefore, the financial assistance and the social service functions of a welfare care program must be separated. Each is made to stand on its own; two separate functions with two separate objectives. Public aid then becomes an independent financial transaction, conducted in a simple, direct manner with the goal of providing sufficient income where it is needed. Social services are offered independent of the public aid on a community-wide basis to everyone. Eligibility for services thus becomes desire for service, and not label of income. This means that the services must be available to the rehabilitable as well as the non-rehabilitable - to the poor as well as the non-poor.

Based upon this conviction, the rest follows. If everyone, not just those living below the financial aid eligibility level, can and should benefit from day care centers, family counseling, homemaker services, skill training services and the like, then efforts should be directed toward making the important welfare services more susceptible to economies of scale, elimination

of duplication, wastage of human energies, and overlapping administrative procedures. The rigidities of present welfare resource allocation schemes must be reviewed with a view to reducing socially disruptive activities in a whole neighborhood.

The essentials of a model welfare component will be distinguished by the following characteristics:

1. Human services will be oriented to client rather than professional need.

2. Combinations of diverse welfare services will be available at a single site.

3. The system maximizes local citizen responsibility.

4. The two vertical level welfare service organization includes an outreach system and close collaboration with those agencies not located in a neighborhood.

5. Maximum use can be made of newly trained indigenous non-professionals in delivery service and in facilitating the clients movement in the system.

6. Greater emphasis can be placed on prevention in all services at both levels.

Only through a comprehensive center in the social service area can emphasis be placed on the need to improve the range, quantity and quality of traditional welfare services. Only through such a consolidation of welfare services in the center - both public and voluntary - can:

1. consideration and review be given to revising eligibility requirements associated with many services in order to increase their use to the MNA residents.

2. increased awareness of the array of welfare programs be developed.

3. both the Federal and State governments be encouraged and influenced to decentralize select functions and activities.

An early detection system through out-reach can inform the center when certain life stresses occur. These life stresses are frequent precedents or precipitants for maladaptation. Examined across the life span, such an early crisis detection system might include birth, early socialization experiences, entry into school, pre-puberty, adolescence, leaving school and/or entering the work force, marriage, children, the involutional period, aging, and death. Each of these life events would activate the staff of the center to invite the involved person to participate or to make home visits to reach out and offer service.

Voluntarism in welfare is still a uniquely strong tradition, although many far-reaching patterns of public - private relationships have developed. Welfare agencies will continue to and accept government funds for support for new programs and for innovative approaches to old problems.

The model welfare care system will therefore include both the voluntary agencies and the public agencies.

The new approaches will be characterized by:

1. Decentralization into neighborhoods.

2. Involvement of more non-professionals.

3. Role of advocates.

The public funds already make it possible for the voluntary agencies to serve new populations with new or restructured programs. Not only have these voluntary agencies broadened their programs, they have broadened their boards and councils as well. The thrust of the new public funds has compelled these agencies to engage in aggressive case finding. Citizen participation and maximum decentralization are key points in the new welfare strategy.

It is expected that the more planned approach in combating social problems will relate to complete social development. Continuum of core and comprehensive services will be designed more and more. Therefore preventive and therapeutic services will be effectively combined.

The key objective in future welfare strategy will be for all-poor and non-poor. In this kind of a setting, social services will increasingly be considered public social utilities. Only if the needed welfare services in the Model Neighborhood Area are provided within the framework of this model welfare delivery system can the residents hope to achieve a better life.

C. CONSUMER PARTICIPATION

Consumer participation is a vital concern today because it involves almost every major issue now before the American public. In its simplest terms, it means citizen power - the strategies of redistributing the social control of institutions among all the people of a community. It implies the "open door" approach to everyone's inclusion in the opportunities to determine how information is shared, goals and policies set, resources

allocated, programs and services operated, and benefits parceled out.

Consumer participation is not new because it has long been found that consumer - provider relationships have political, psychological, and educational dimensions. There's ample evidence from the experience around the nation that such a wholesome relationship can remove the mutual distrust and lack of understanding that often times exists between consumer and provider. Because consumers are no longer willing to passively allow providers to control their destinies, health and welfare programs as human service programs must seek the valuable input of the poorest, richest, and the worst frustrated clients at the policy, planning, and operational levels for one reason only - to retain or maintain solid neighborhood area support.

Therefore, the organization and method of providing the needed services must be consumer, rather than professionally, or bureaucratically-oriented. Community services must be dictated by the needs of the citizens in the community, and not by the prior presence of a particular agency, nor by the imperialism of a certain profession. There must be a strong element of community control in the planning, organizing, and providing of services. The toughest, but perhaps most indispensable aspect of that control involves the development of a constructive partnership between the purveyors and the consumers of social service.

There remains, however, a great deal of reluctance by professionals to accept this principle, and consumers may even be slow to insist on its adoption. The problem of consumer participation is further compounded

because it may be unclear just "who" properly represents the consumer's point of view.

Perhaps the most serious difficulties lie in finding ways to "open up" the responsible roles in both the decision and delivery processes. The two vital areas that call for more rapid breakthroughs are:

1. In neighborhood and community representation of the advisory boards that determine policies, programs, and services, particularly at the neighborhood levels.

2. In the development of additional and new community service workers trained for effective participation in decision-making situations and qualified to help relieve the shortages in manpower, especially in the health field.

With citizen participation, neighborhood-based services have had promising payoffs because of their value as important outpost terminals that can link entire health and welfare systems to gaps in full community coverage. The input of the consumer would require his perception of the amount of benefit which he believes he is receiving or will receive from a service program. Such utilization is inextricably tied to the mode of presentation used by the agency and the actual benefits it confers on the user and on others who have utilized the service programs. More individuals are likely to continue with a service program if the reason for particular treatment is made understandable to them. For agencies to plan around a prospective client seriously limits and handicaps the effectiveness of the service being provided. But once residents have participated actively in the planning approaches, and understands from the inside the benefits that he will derive from a human services delivery system, he becomes citizen "advocate" and becomes part

of a vital new force in his neighborhood community.

A mere cursory glance at the data on the attitudes of respondents in the Model Neighborhood Area toward all human services suggests that one of the major reasons for gaps and deficiencies with the present delivery systems is the lack of the input of the consumer/user for whom those services are and intended in the first place. The consumer of social services in the Model Neighborhood Area should be the proper judges of what kinds of services they want, how they want them delivered, what form they should take, and in what setting they should be provided. Consumer participation in the MNA will mean that the residents should plan and direct the activities of both the community health center, which should be preventive medicine oriented, and of the Human Services Resources Center, which should be client oriented. Of course, if either or both of these proposed centers become mere referral offices, then the possibilities of consumer participation will unfortunately be limited.

D. HUMAN RESOURCES SERVICE CENTER

The earlier Diagnostic Survey illustrated the obvious lack of coordination existing among social service agencies and consequently the under utilization of the services of the agencies by the Model Cities residents. As a result of the Survey results, the goal was set up of making these social services more relevant, responsive, accessible, and available to the persons they were designed to help.

In addition to the Diagnostic Survey, social service agencies were

requested to provide information on services to the MNA residents. The response from the agencies did not indicate any high degree of cooperation with the Model Cities Agency. Most of the welfare agencies that did co-operate stated that the MNA residents showed greater utilization of the social services than the Diagnostic Survey results revealed. The reasons for the variance in the two sets of data are speculative and inconclusive.

The group meetings that followed the Survey seemed to have a better vehicle in discovering unmet social service needs in the Area. Most of the complaints dealt with inadequacies of present services; delays in getting service; problems in getting to services located outside the neighborhood; a lack of sensitivity to people and a failure to treat persons seeking help with dignity and respect. Many of the latter are reflected in the minutes of the Health and Welfare Committee and resident meetings.

One of the problems uncovered was that many people in the MNA were not aware of all of the programs available to them. It was too much to expect that people will make a conscious effort to become familiar with all of the many fragmented programs and services available to people who need help until such time as a problem or a crisis develops. Even professional workers in agencies may not know the details of eligibility requirements and services of all other agencies.

It was found that although many agencies provide information and referral services, there is no one single central information and referral

where people can obtain guidance or help with their total problems.

As a follow-up of the survey and meetings, the Agency developed both five-year and one-year objectives listed below:

Five Year Objectives

1. Complete administrative integration of all public welfare services in the Model Cities Neighborhood.

2. Establishment of effective consumer participation in the development and operation of services.

3. Improve services to a point where consumer complaints are negligible.

4. Increase individual capacity to solve their own problems and to control their own lives.

One Year Objectives

1. Initiate program to consolidate various service agencies and departments.

2. Begin establishing the necessary functions and selecting alternate site locations for a Comprehensive Human Service Center.

3. Develop central intake and eligibility determination for all services coming under jurisdiction of the Department of Public Welfare at the State level.

4. Establish a Consumer Protection Service, including the development of a system for investigating, analyzing and reporting complaints.

The methods to accomplish these objectives were two in number:

1. Consumer Protection Service

To develop within the community a service which would coordinate the various consumer protection measures presently in existence and to encourage agencies to initiate programs for which they have the capacity. This service

would be responsible for making known to the residents all of the various social services which are available and how the residents can take advantage of them.

2. Comprehensive Human Service Center

To develop, within the target neighborhood, a model of a comprehensive, family-centered, human service program under one administration so that families could receive the whole range of services needed and available in solving their problem or problems in an integrated manner. The intent is to provide a location where a person could start the process of getting help with any problem. Not all services needed would necessarily be located in the neighborhood nor under the control of the center staff, but the first responsibility of the staff would be to see that people get service. The staff was to become more the advocate of the consumer than has been the traditional practice in most agencies.

A work program was prepared to demonstrate on a pilot basis that:

1. a full range of social services could be provided to families on a neighborhood basis,

2. existing agencies could be brought together on a coordinated basis to efficiently deliver these services, and

3. an aggressive approach to delivery services directly to the neighborhood could be effective.

Consistent with this program, a Human Resource Program was to be established within the existing site office by purchasing the staff services of the "Human Service Task Force." These personnel were to provide a neighborhood delivery system for the following service agencies:

1. Welfare Planning Council
2. Catholic Social Services
3. Family Service Association
4. Luzerne County Child Welfare Services
5. Wyoming Valley Visiting Nurse Association
6. Luzerne County Board of Assistance

The staffing was to consist of six senior supervisors, operating on a

8 hour day, 1 day per week basis with the aide of two caseworkers from the agencies. However, the exact number of these ancillary personnel would have to be finally determined by the case load volume of each participating agency. Upon receipt of supplemental grant funds, the CDA would purchase the contract services of the Human Service Task Force.

The five-year objectives table toward the complete administrative integration of all public welfare services in the Model Neighborhood was set up as follows:

INITIAL CONDITIONS 1/68-12/68	YEAR I 7/69-6/70	YEAR II 7/70-6/71	YEAR III-V 7/71-6/74
Efforts of service agencies lacking co-ordination in M. N.	Establish human services program and process 250 M. N. residents in system	Evaluate processing of 250 M. N. residents and improve where necessary	Utilize prior year experience in formulating proven techniques and methods

Although somewhat behind schedule, a Human Services Center was opened in December, 1970 on South Hancock Street in the Model Cities Area, operating on a $45,000 budget, staffed with two personnel.

Other Model Cities components were located in the same quarters: The Revolving Loan Fund operated by the Family Service Association and the Eyeglass and Hearing Aid Bank operated by the Pennsylvania Association for the Blind. The Revolving Loan Fund is a very limited activity which is aimed at providing emergency funds for moving expenses for persons moving into public housing. The Eyeglass and Hearing Aid Bank, administered by

the CDA Human Research Officer, provides preschool and school age children with service in audiology and opthmology.

A citizen's advisory committee of 18 residents from the Area was established to offer the consumer view to the Human Resources Program.

The Human Resources Service Center is a rather modest beginning toward the model welfare care system out-lined in a previous section of this study. A successful Human Resources Service Center must be constructed by the Model Cities organization if it is to accept the human responsibility to help those who need help in order to achieve and maintain their potential for a fulfilling life. The ideal obviously would be to include in such a Center branches of all the agencies listed under the Health and Welfare classification. Not only is the ideal never attained, some of the agencies are on the way to being merged or phased out. Moreover, some of the agencies are advocacy organizations which do not deliver an actual service beyond referral or education.

It would appear that the minimum that such a Human Resources Service Center should embrace would be all those agencies categorized as family and children oriented. The proposed Home Health Services and the proposed consolidation of all family service agencies, both presently being undertaken by the United Fund and the Welfare Planning Council are steps along the way to such a Center, even though limited to family and children's problems. It should be pointed out that the MNA residents should not be made to wait an unduly long time before the "family" agencies are brought into the Human

Resources Services Center. The proposed mergers of some of these agencies may encounter seemingly insurmountable barriers at the beginning stages of discussion. The inter-relation of the "family" parts of the Center can only be fostered by an administrative structure which contained all of them.

The savings and the possibility of government funds should be a strong incentive in encouraging the structural expansion of the Center. Perhaps an added incentive to the agencies might be that many of the services that can be offered in such a Center need not be given in the context of a caseload delivery systems although casework itself has a significant role to play as one method in the delivery of social services. Only in such a Human Services Center can greater emphasis be placed on group and community organization methods.

As a beginning toward an enlarged and fully developed Human Resources Services Center, a Community Referral Office should be created with a specific program of information and referral. Such an office can be instituted even before the "family oriented" agencies have fully established residency in the Center. A complete record system providing accurate and reliable information, discussed in a later section of this study, would be maintained by this office. The experience of this office with all health and welfare agencies over a significant period of time will reveal which agencies are most readily available and which provide the best service to clients of the MNA. Such experience should provide both subjective and objective evaluation as the Center expands. A great deal of variation could be reduced for the local community

if reporting requirements were to be made uniform through this referral office. While the tasks carried on by the Office may be those which could be carried by volunteers, the need for accuracy and reliability of information would suggest the utilization of personnel on a paid basis, in a setting tending to provide a unification of health and welfare services.

Just as importantly, the whole Out-Reach system, also discussed in a later section, could be easily operated out of the Referral Office and eventually out of Human Resources Services Center.

It goes without saying and emphasizing the ridiculous that a $45,000 is wholly inadequate for the kind of structure proposed above.

Some of the gaps in the social welfare delivery system that a Referral Office and Human Resources Services Center could more clearly identify and possibly assist in filling, or at least calling attention to them, are:

1. Lack of communication as to what facilities are available, where they are, and how they can be used
2. Inadequate adjustment services for the physically handicapped who have been institutionalized
3. Insufficient supplies for vocational training of blind persons
4. Inadequate supervision of interim housing and foster homes for physically handicapped persons
5. Lack of half-way house for those leaving prison
6. Lack of general day care program
7. Lack of knowledge of availability of services of Planned Parenthood

8. Insufficient facilities for the day care of the youth in the community
9. Insufficient care for alcoholics and drug users
10. Inadequate care for aged persons
11. Expansion of programs such as "Meals on Wheels" for elderly
12. Lack of nutritional information
13. Lack of transportation for those needing welfare services

E. COMMUNITY HEALTH CENTER

The Model Cities organization has had long range plans for a Community Health Center as part of an eight-part health component. Although the Neighborhood Health Center concept has been successfully initiated in other parts of the country, it represents a new and innovative idea for this area. The long range plan for such a center must still be given first priority.

It is a recognizable fact that the physical construction of such a Health Center in the MNA is not in itself a cure for future needs. The lack of physicians and dentists is a very acute problem. Staffing of the facility with capable medical personnel will also be a major contributory factor in determining the success of this project. Therefore training of ancillary assistants to relieve doctors and dentists of many routine tasks has been considered of equal importance.

The establishment of the health center, the training of paraprofessionals and additional research and planning are not expected to produce visible results overnight.

It has been the feeling of the Board of the Model Cities organization that a medical directory, insurance study, mobile dental unit, and emergency health service (ambulance) would be of more immediate benefit to the residents.

Both the Diagnostic Survey results and the records of at least 18 neighborhood health meetings attest to the fact that health is a serious concern of the residents. The evidence for such a facility outlined in an early proposal by the MC Agency is based on the following factors:

1. the availability of physician time
2. the physical location of physician service
3. the number of citizens going outside the area for treatment (40%)
4. the existing neighborhood physician rate
5. the lack of emergency service

It was suggested in an early proposal that the Health Center should operate basically as a satellite of a major area hospital. It was also hoped that the MH/MR program could probably be used to establish an information and referral service, although the primary focus of the information and referral service under the program should be to direct people with mental disabilities to appropriate types of help. The regulations promulgated in connection with the legislation describe the purpose of the service as "acquaint inquiring persons with the care-giving resources available in the community. Assistance is given in applying to appropriate resources, and referrals are made to the Base Service Unit where indicated." The regulations further state the "Referral and

Information Services given under the County program augment, but do not supplement services traditionally provided by every agency in the health and welfare field." By no stretch of logic can a referral service be construed to be a community health center, however.

Just recently, an announcement has been made that a group practice medical clinic will be constructed in the MNA. It is not intended that such a facility will focus on preventive medicine, nor is such a private facility expected to operate in conjunction with an Out-Reach program. This is not to demean its location in the target area. The Kirby Health Center, privately endowed, does immunizations, chest X-rays, and conducts a dental clinic. In the first place, it is not likely that any of these activities can be relocated in the target area. Secondly, the Kirby Center services are available "on demand" not on an Out-Reach program. Thirdly, the Kirby Center engages in a number of peripheral activities over a large area--probably Northeastern Pennsylvania. The Public Health Center located in the MNA does provide diagnostic and nursing services, but it is a State agency covering the whole county. The facility is not intended to offer even the minimum of treatment services. The Mental Health Center #1, outside the Model Cities Neighborhood, is just what the name implies. Located where it is, and covering two counties, it can hardly be labelled a community center.

A Community Health Center, with its focus on preventive medicine, must still be given a very high priority for the residents. The PMM consumer perceptions underscore the necessity for a center that conforms to the model

discussed earlier if life is to have any fulfillment at all for the target people.

The gaps and problems in the medical service delivery system that a Community Health Center and a Referral Office could help to identify and help to solve are:

1. Lack of communication and cooperation between professional, voluntary agencies, and general public concerning availability of services of the Pennsylvania Department of Health, Region II
2. Lack of physicians and non-existence of intern program
3. Lack of facilities for maternal and infant well-baby clinics
4. Lack preventive dental care for low income families including adults and children
5. Lack of prenatal care for low income families
6. Lack of information for lower income groups concerning the availability of medical services

F. THE OUT-REACH SYSTEM

The Out-Reach recommendation flows from all that has been said thus far and is therefore an integral part of the service delivery system--both health and welfare.

A model social services delivery system must not be process-oriented, because process-oriented programs serve agency and professional traditions and produce statistics descriptive of what an agency does, not how the client is helped. A goal orientation is particularly necessary for an efficient organization of services and for an effective evaluation of that organization and its achievements.

The only practical and feasible way to reorient any human service delivery system from agency to goal is through an out-reach system.

Neighborhood agents of an out-reach system can contact residents to inform them of available services, to discover problems, and perhaps to actually deliver needed services. The "out-reach" would have four primary functions:

a. stimulating community organization

b. providing easy access to facilities, services, and institutions

c. doing prevention and early treatment work

d. giving early diagnosis of all sorts of problems

In the early stages of experience, the "out-reach" will be expected to focus its attention on access. In time and with increased skill, prevention and even early treatment will be emphasized and may become the central responsibility.

The out-reach system can work best when manned by staffs of non-professionals who are residents in the immediate neighborhood, and are known by their neighbors. They should be intensively trained by all of the participating professions in the basic knowledge and skills necessary to provide elementary services to citizens. These "community agents" will know all the forms, offices, procedures, etc. necessary to move any medical or welfare service agency into action.

The success of the O. E. O. family-planning out-reach worker is ample evidence that Out-Reach can play an important role in the expective delivery of both medical and health services.

Variations of the concept are being tried locally with varying degrees of

success. A volunteer group of about 35 people operate "Call for Action," an organization operating through the facilities of Radio Station WILK. The purpose of the group is to aid local citizens with such problems as hospital care, poor housing, crime, narcotics, sanitation, etc. Complaints received by the volunteer on duty Monday through Friday from 11 A. M. to 1 P. M., will be referred to the appropriate agency for action. As commendable and successful as such a program is, it has many limits. The program is limited to referrals; there is no follow up: It is demand oriented. Although the station must be lauded for opening up its facility, there is a time limitation. The out-reach concept works best when it is associated with a referral office which is part of the administrative structure of either a Human Resources Services Center or a Community Health Center, or preferably both. A "Mr. Fix-It" can not conceivably be an "Out-Reach Worker."

Almost identical comments can be made about other such referral activities. The community-wide Information and Referral Service of Wyoming Valley established under the MH/MR Program did have some possibilities in that it was at least associated within the context of the law, it had a broad base within which to roam--the whole medical and welfare field. Personality involvements aside, such an office and the out-reach worker operated out of either type of centers previously mentioned. At the risk of too much emphasis, the out-reach concept is predicated not on demand, but on need.

An Out-Reach idea is an integral part of a successful, effective, and

efficient human services delivery system in both the medical and welfare fields, along with a Community Health Center and a Human Resources Services Center, if the Model Cities residents are to be freed from the tyranny of their own biology and their own environment.

G. SOCIAL SERVICE CENTER RECORD SYSTEM

A. RECORDS AND RIGHTS

One of the specific missions undertaken by the Institute of Regional Affairs as part of this report was to develop and propose "a complete social service record-keeping system which would provide a current index of existing conditions-physical, social, and personal." This phraseology projects a rather narrow view of the ultimate purpose and function of a record system, leaving the inference that its end product is merely to "provide a current index of existing conditions" in the Model Cities Area. Moreover, the simple phraseology belies the broader, if not more important, question of confidentiality of the records when a "human" information record system has been established with the noble aim of bringing the client closer to the service.

The term "Social Service Center" has a variety of meanings. Not all of these meanings raise the spectre of traffic in ill-gotten information. It is most commonly used by an individual social service agency in a physical sense to identify the place where its specialized services may be obtained. Confidentiality --- the implicit or explicit agreement between a professional and his client to maintain the private nature of their communications -- as the basic component of the client-professional relationship would not be altered in the least. Any disclosures made within the relationship

would continue to be used constructively in behalf of the client or as required by law. Social workers and health professionals in this conception of a "Center" could still jealously guard information obtained from relationships with clients.

Less commonly, it is used also in the physical sense to denote the place where a number of specialized service agencies have joined in providing a common building where a prospective client may secure a number of services, yet each agency may retain its separate identity. In this second type of "Center," old and comfortable organizational boundaries within which social workers in the past exercised control over information can still be maintained although the physical proximity to one another of the social service agencies creates many temptations even for the professionals, to follow the old rules safeguarding privacy and confidentiality. It may be that greater care will have to be exercised by the professional in this kind of "Center" situation than that in the old atmosphere when agencies were isolated from each other.

The third meaning of a "Social Service Center" denotes a conveniently located "referral" office, which may or may not itself provide actual social services, to which a person in need of assistance may turn for guidance in locating a specialized social agency equipped to assist in his particular problem. This latter concept of a "Social Service Center" has been followed in suggesting a record system in the section of the Project Report. The Model Cities Agency

may now or in the future provide physical facilities for bringing as many as possible individual service agencies under one roof for the convenience of neighborhood residents. In addition, a Model Cities Project may itself offer and perform specific services to residents on a direct basis. Regardless of these possibilities, the essential characteristic of such a Model Cities Social Service Center is that of referral, and this fact demands that there must be a central office, including specialized service agencies or not, manned by Model Cities or contracted staff, full or part-time and either professional, or part professional and part non-professional. The primary function of this staff is to provide a single and certain means through which residents of the area can secure assistance in finding solutions to their problems. The central requirement is that all Model Cities social service activities flow into and out of the Social Service Center centralized staff. It is precisely because the "referral" office could develop into a dossier type data bank that a word of caution is raised as a prefatory warning signal even before the record system is presented.

Anonymous statistical information records do not usually threaten privacy or confidentiality. They contain data on individuals either in the aggregate or as individual records identified by numbering systems that are unique to each agency or organizational unit supplying them. Dossier information systems, because they contain data (such as names, social security numbers, and home addresses, etc.) that directly identify individuals or families, present greater risks all around. Too often, the good intention of achieving

a laudable goal - a social service record-keeping system for Model Cities - causes the high-minded to lose sight of the fact that in the process it may deny the dignity of the individual, a sense of fair play, or the right of the citizen in a free society to the privacy of his thoughts and activities. In view of the vulnerability to abuse in the "referral" office, proper safeguards and guidelines will have to be established in order to protect the client-professional relationship.

B. CONCEPTUAL BASIS OF RECORD SYSTEM

A productive record system should, indeed, provide information which identifies the physical, social, and personal problems in the Model Cities Area, and should also provide a means of evaluating the progress made in resolving these problems. The dominant factor, however, in planning a record system must be the conceptual framework of the Service Center itself. What records and how they are to be managed should be established on the basis of such primary questions as the general purpose and specific functions of the Service Center, the clientele to be served, the mode of service, functional and operational participation of service agencies in the community, and the type of evaluation conducive to program progress.

Since the Service Center will be a de novo operation, subject to changes based upon future experience, the initial record system must of necessity be fashioned for an assumed Service Center concept. The following general concept may be safely assumed from conclusions of other sections of this project report:

1. An unacceptable variety and number of physical, social, and personal problems exist among the residents of the Model Cities Area.

2. Many of these problems of residents, or the general Model Cities community, remain unresolved or are worsening, either because of unawareness of their existence or intensity, or because residents are incapable of solving them without outside assistance.

3. Varying kinds and degrees of assistance are currently available to residents from governmental, community-supported, or private institutions or organizations operating in the Wyoming Valley area.

4. The crux of the problem, it is believed, is that the residents of the Model Cities Area, as well as other residents of the city, have difficulty in definitely identifying their problems and, additionally, are unaware that assistance is available, or do not know where to turn for a specific kind of assistance. In certain problem areas, there is nowhere to go for help: e.g. health services and housing - because of the nature of local conditions.

C. PRIMARY ELEMENTS OF PROPOSED RECORD SYSTEM

The primary elements of the proposed social service record system are four in number.

1. Data Bank

The Service Center should collect and properly store all the necessary data identifying all possible sources of information and every service and program available to Model Cities residents. This data bank should include comprehensive information about agencies and their programs and services, categorized into broad general service areas such as medical and dental, education, housing, employment, etc., and further subclassified for rapid location purposes into specific needs such as clothing, transportation, glasses,

temporary housing, job training, job placement, and the like. The basic information includes the name of the agency, location, telephone number, personnel contacts, hours, nature of related services, limits of service area, eligibility requirements, and financial responsibility. This data should be under constant review and updating by personnel qualified to collect, store, retrieve, and maintain information.

2. Referral Services

The primary function of the Social Service Center should be that of a referral service through which residents can be assisted in securing necessary and appropriate aid from governmental, community-supported, or private institutions or organizations whose services are available in the area. "Referral" is not to be narrowly interpreted to mean merely informing the resident where he may receive assistance. It extends to identification and definition of the specific problem, choice of the agency most likely to be of greatest and most prompt assistance, transmission of problem data to selected agency, and upon confirmation that service is available, arranging appointments for resident clients and facilitating the subsequent remedial process.

3. Follow-up

Workable routine procedures should be established for timely and prompt follow-up at each stage of a case activity to assure that both resident clients and participating agencies perform as planned, and ultimately to record at the Service Center and participating agency the conclusion and results of the case process.

4. Service Evaluation

Procedures, including appropriately simple forms, should be installed to facilitate recording of all information involving a case activity at every stage, including a summary of daily actions. This basic daily log should be designed to facilitate ease of compiling weekly, monthly, or demand reports, showing progress made on programs and a basis for evaluating the effectiveness of the service on conditions existing in the Model Cities Area.

D. COMPONENTS OF PROPOSED RECORD SYSTEM

The basic framework of the proposed Social Service Center record system includes the ten components, all of which serve a specific function essential to effective service to the Model Service residents. A description of the ten components, complete with accompanying figure and justifying purpose is presented after a summary listing:

1. Alphabetical list of major service categories
2. Service agency cards filed according to major service category.
3. Alphabetical file of service agencies showing a summary statement of their major services and eligibility requirements
4. Alphabetical list of service clue words
5. Clue word agency locator
6. Individual Case Record
7. Service tickler file
8. Appointment confirmation form

9. Daily service log

10. Weekly and/or monthly service report

1. Alphabetical List of Major Service Categories

The overall program of the Social Service Center can be clearly indicated by preparation and maintenance of an Alphabetical List of Major Service Categories in which the Social Service Center is capable of providing service either directly, or through referrals to cooperating agencies (see Figure 1). The analysis and interpretation of data showing the variety of social services rendered by existing local agencies (see section 6) provides the basic elements of such a list. Other categories, not currently covered by local agencies, but which are deemed desirable under the Model Cities Concept, should be added.

The list should be mechanically produced in a form suitable for distribution to Model Cities administrators, Social Service personnel, local independent service agencies, participating or non-participating, city civic and service organizations, appropriate public officials, Model Cities neighborhood leaders, and other interested individuals or groups.

The List of Major Service Categories serves the following purposes:

1. Places in proper perspective the Social Service Center program in relation to the general mission and policies of overall Model Cities program.

2. Delineates the bounds of Social Service Center activities and provides a basis for determination of priorities as action demands require.

3. Aids independent local agencies or organizations engaged in restricted specialized services to direct clients to the Social Service Center for assistance in matters outside of their specialization.

ALPHABETICAL LIST OF MAJOR SERVICE CATEGORIES

GENERAL SERVICE CATEGORY

FORM NUMBER _____

Figure I

4. Promotes among the residents of the Model Cities neighborhoods and the general city public a well-defined picture of the Service Center functions.

5. Provides a basic outline for public relations programs.

2. Agencies, Services and Eligibility Requirements

A master file should be maintained showing at all times the names of agencies, organizations, or individuals, local or otherwise, which are potential sources of assistance to Model Cities residents. (A previous section of the Project Report contains a listing of agencies or organizations generally known to the public.) This list provides an excellent starting point for such a master file, since they doubtlessly provide services required by Model Cities residents to a greater or lesser degree. However, as residents become accustomed to calling on the Social Service Center for assistance, significant problems may be presented which are not covered by the city-wide or popularly recognized agencies. It is, therefore, important that every effort be made to identify and file the name of all possible sources of assistance active in the city or elsewhere to fill existing gaps. Some of these can be ascertained immediately, while others will be revealed through operating experience at the Social Service Center.

The primary purpose of this record file is to provide a data bank on the nature of the operations of service agencies or organizations. The form should be printed, or otherwise produced, on standard stock paper of good quality, preferably 8 1/2 x 11", and filed alphabetically according to agency name in

manila folders appropriately separated by alphabetical guides (see Figure 2).

As shown in Figure 2, the form provides information to facilitate classification of agencies on the basis of services provided, identification of General Service Category, a detailed listing of specific detailed assistance available, eligibility requirements for services, contact names for referrals, and time of service availability.

This record is especially useful in identifying a source of assistance by reference to the file of General Service Category Agencies (see Figure 3).

3. General Service Category Agencies

This record is useful for immediate identification of all agencies providing services listed in the Alphabetical List of General Service Category (see Figure 1).

The form should be printed, or otherwise mechanically reproduced, on 3" x 5" index cards, showing the information indicated by Figure 3. One card should be filed for each general service provided by each agency listed in the file of Agencies, Services and Eligibility Requirements (Figure 2), according to the classification of services determined by the Complete List of Services Provided. Thus, an agency which provides more than one of the general services is filed an appropriate number of times under the various service classifications.

Cards for each general service category shall be filed in separate sections, each section plainly marked by a separating guide showing the title of the category, and the separators are arranged alphabetically. Within each category

AGENCIES, SERVICES AND ELIGIBILITY REQUIREMENTS

Agency Name _____ General Service Category _____

Address _____ City _____ State _____ Zip _____ Phone _____

Sponsor _____

Contact # 1 _____ Address _____ Phone _____

Contact # 2 _____ Address _____ Phone _____

Contact # 3 _____ Address _____ Phone _____

COMPLETE LISTING OF SERVICES PROVIDED
(Underscore Clue Words for Service Category)

FORM NUMBER _____

Figure 2

CONDITIONS FOR SERVICE

Eligibility requirements

Financial Requirements – Free_____ Sliding fee_____ Flat fee_____

Time Open – _____, _____ M to _____, _____ M _____ (Days)

Waiting Period For Service –

Transportation Provided to Place of Service _____

Figure 2 (cont.)

GENERAL SERVICE CATEGORY AGENCIES

General Service Category

Name of Agency Providing Service

Address | Phone

Contact # 1 | Phone

Contact # 2 | Phone

Contact # 3 | Phone

FORM NUMBER _____

Figure 3

section, the cards are arranged alphabetically according to the name of the agency providing the specific category of general service.

The usefulness of this record file may be illustrated by a hypothetical case. A resident contacts the Social Service Center, in person or by telephone, for assistance on a problem that cannot be identified more specifically than that it is medical. The Center personnel checks the General Service Category Agency file under "Medical" to identify the various agencies providing such general service. The Center personnel can then take one of two courses of action: (1) Should the Center personnel's experience suggest a particular agency among the cards lifted which could most likely assist the resident, the contacts noted on the file card could be reached by phone for consideration of the problem; or, (2) should the personnel be unable to make a choice from experience, reference to services provided could be made by consulting the Record of Agencies, Services and Eligibility Requirements (see figure 2).

4. Alphabetical List of Service Clue Words

Having established a records system to identify an appropriate service agency to aid a resident in cases when the exact nature of the problem has not been determined (Figures 2 & 3), a system of clue words is recommended to facilitate a quick and exact identification of the specific nature of the assistance required.

Clue words are those spoken by a resident during an interview which give more specific and accurate indication of the exact problem and assistance

needed than can be elicited from a general classification of the problem and service.

The meaning of "clue words" may be illustrated by a hypothetical case. A resident of the Model Cities neighborhood is concerned with a decision to remove his son from high school. During the interview, the resident may, consciously or subconsciously, hide the true reason for the decision to do so, perhaps contending that he needs the boy's financial help. However, as the conversation progresses, the resident may speak words like "pot," "speed," "bad gang," "late hours," "nervous," and the like. These expressions might well add up to the true reason -- a drug problem. "Drug," therefore, would be a clue word, which, if included on an alphabetical list of other specifically descriptive words, gives a simple and direct lead to the most logical agency which could deal with this problem (see Figure 4).

The best sources for an alphabetical list of clue words are the agencies listed in Agencies, Services and Eligibility Requirement file under the list of specific services rendered (see Figure 2). The formal list may have to be supplemented by discussion in depth with knowledgable persons in the agencies to identify the detailed and specific services rendered. Other clue words may be added as disclosed through experience of Social Service Center personnel.

The clue words should be as specific and descriptive as possible, and should be alphabetically arranged on 3" x 5" cards for ready reference, or on pages posted to be clearly visible to the Center personnel concerned.

ALPHABETICAL LIST OF SERVICE CLUE WORDS

SERVICE CLUE WORD

FORM NUMBER _____

Figure 4

5. Clue Word Agency Locator

Once a unform list of descriptive clue words is compiled, a file should be set up to provide a rapid method of locating and identifying agencies which are most likely to provide the specific service needed.

Having determined the list of specific services provided be each agency, a 3" x 5" index card should be set up for each service clue word provided by each agency. Thus, an agency that provides services described by ten clue words would have ten file cards in the file.

The clue words listed in Figure 4 are filed alphabetically, appropriately separated by indexed guides. Each clue word should have its own section, within which the service agencies providing such service are filed alphabetically,

Using this card system will enable Service Center personnel to retrieve quickly all cards indicating agencies most likely to provide particular service. The contacts listed on the card would allow the personnel to choose the agency which in his judgement could best serve, or he could make a more considered choice by checking the file on Agencies, Services and Eligibility Requirements (Figure 2).

6. Individual Case Record

The Individual Case Record is the most important component of the Social Service Center Record system. All problem-solving activities of the Center personnel in each particular case are determined by the pertinence and comprehensiveness of the information which it contains. It is the key to accurate

CLUE WORD AGENCY LOCATOR

Service Clue Word

Agency Providing Service

Address | Phone

Contact # 1 | Phone

Contact # 2 | Phone

Contact # 3 | Phone

FORM NUMBER _____

Figure 5

identification and definition of the resident's problem required to choose the most productive course of action. It aids in the selection of the most appropriate assisting agency, and through a system of reminders, facilitates follow-ups leading to satisfactory solution of the problem. Finally, it provides in summary form the basic information needed by the Center and Model Cities administration to identify, classify, and evaluate the prevalent nature of problems in the various neighborhoods as well as the effectiveness of programs and procedures. In short, all other records and procedures suggested in this report are but subsidiary aids to the Individual Case Record.

The Individual Case Record form (Figure 6) should be printed, or otherwise mechanically reproduced on good quality white paper, size 8 1/2" x 11", and should be stored in metal locked cabinets. From the moment a particular problem case is initiated, the form should be placed in an "active" file consisting of manila folders and arranged alphabetically according to the name of the resident, properly separated by letter guides. A separate form should be used for each problem presented by a given resident. Once a problem has been resolved, the Individual Case Record form should be so marked and placed in a second cabinet marked "Case Solved." If, after all remedial resources have been exhausted and no solution attained, such form should be similarly filed in a separate cabinet marked "Cases Unsolved."

It is suggested that all information be recorded in pencil.

Both sides of this form should be utilized. The front contains information

INDIVIDUAL CASE RECORD

Client Last Name | First | Initial | Address | Phone | Service or Information Category

Intermediary (Person or Agency) | Address | Phone | Relationship to Client

Date and time of Request | MNA Area

PROBLEM AND DISPOSITION

PROBLEM: (Underscore clue word for service category)	REFERAL:	REMARKS
	Agency Referred To Address / Phone Contact Person / Date Appt. Date / Time (REMINDER TO CLIENT THREE DAYS PRIOR)	
	Agency Referred To Address / Phone Contact Person / Date Appt. Date / Time (REMINDER TO CLIENT THREE DAYS PRIOR)	REMARKS

PROBLEM SOLUTION: (Reason if problem is not solved)

Date Completed

(Check) – Solved or unsolved

Cost to Client $_____

Date Recorded on Service Summary Form

Signature of Service Personnel

FORM NUMBER _____

Figure 6

FOLLOW-UP RECORD

Type of Contact (Walkin, Phone, Letter)	With Whom Made	Purpose	Results	Name Service Personnel

SUMMARY OF SERVICE RECORD

Service Category _____

Type Service Rendered _____

Date Problem Solved _____

Reason Problem Unresolved _____

Date filed in Soled File _____

Date filed in Unresolved File _____

Date filed on Monthly Report _____

REMARKS

required to define the problem, agency to which the case is referred, the action by which the problem was solved, or reason for failure to solve it, and, desirably, a tab or notation at the top right corner of the form to indicate the MNA area in which the case was located.

The rear of the form should be used to record each reminder, follow-up, or other steps taken throughout the pursuit of a solution, and finally a Summary of Service record for reporting purposes.

7. Service Tickler File

To ensure that action agreed upon and entered on the individual Case Record form is taken at the proper time, including making or confirming appointments, follow-ups, etc., a tickler file using 3" x 5" index cards should be utilized. The arrangement should consist of a series of twelve guides or folders with the names of the months printed on their tabs, and 31 guides or folders whose tabs are printed with 1 through 31 for the days of the month.

The tickler card should be printed, or otherwise mechanically reproduced,to include the information indicated in Figure 7 in order to insure some degree of uniformity. Action to be taken at some future date should be filed according to that date which allows sufficient time to make preparations for, or to take the appropriate action on time. Reference to the tickler file should be the first order of business of Center personnel each day.

8. Appointment Confirmation Form

As a part of the follow-up procedure which is so important to an effective assistance program, it is suggested that a routine method be established

SERVICE TICKLER FILE

Name of Client

Client or agency to be Contacted (Date)

Purpose and Method of Contact:

Make Appointment –

Confirm Appointment –

Progress Follow-up –

Other –

FORM NUMBER _____

Figure 7

to assure that any appointments made by or through the Social Service Center be adhered to by both residents and agencies. For this purpose the form shown in Figure 8 is suggested.

The form should be printed on 3" x 5" light paper stock in alternate colors of white, green, and yellow which are self-carboning, with a convenient number of sets bound into manageable pads.

The form should be completed at the time an appointment is made for the client. The white form should be retained by the Social Service agency, the green copy and the yellow copy made available respectively to the client and the agency either at that time, or at a reasonable period before the date of the appointment. The resident can be notified in person or by telephone or mail. In the case of the agency with which the resident has the appointment, the confirmation may be telephoned at the appropriate time, or mailed.

In both instances, if the confirmation is given in person or by telephone, the Social Service Center should retain all three copies with an appropriate notation that contact had been made, and the action recorded on the follow-up form on the rear of the Individual Case Record form (Figure 6).

The Social Service Center copy should be placed temporarily in the tickler file, and a follow-up contact made with the resident and the agency at the appropriate time to be assured that the appointment was kept, and to be informed of the results.

APPOINTMENT CONFIRMATION FORM

_____
Date

This is to confirm the appointment for

_____ _____
Name of Resident Address

with _____ _____
Name of Agency Address

on _____ _____
Day Date

at _____ at _____
Time Place

Please notify the Social Service Center by telephone at once if any change in plan. (Resident should notify center after appointment is completed)

FORM NUMBER _____

Figure 8

9. Daily Service Log

The purpose of the Daily Service Log is to keep a day to day record of every service action taken by personnel, individually, so that a weekly, monthly, or on demand, inventory of actions can be summarized for administrative purposes. The summarized information will indicate the types of problems and their prevalence in each MNA area, and the Model Cities neighborhood as well, the types of actions taken, and the results in solved or unsolved cases.

Each Center personnel handling an aspect of a case on any particular day should make appropriate entries on his individual log form, which are then filed for future consolidation for report purposes.

When engaged in a case by personal interview or walk-in, conference with a client or agency, or by telephone, letter, or other means, the Center personnel should enter on the day's log form the general service category involved in the transaction, and the subsequent columns simply indicate the nature of the activity by placing a stroke or check. Before the close of each day's business, each individual adds the action in each column to show daily totals.

10. Monthly Service Report

This record consists of a form based on the classifications of the Daily Service Log, and provides a summary of activities for administrative purposes (Figure 10).

DAILY SERVICE LOG

Name of Service Personnel _____ Date _____

General Service Category	Case Initiated	Case Referred	Appts. Made	Followup	Case Solved	Case Closed

TOTAL _____

FORM NUMBER _____

Figure 9

MONTHLY SERVICE REPORT

MONTH OF _____ 19___

General Service Category	Case Initiated	Case Referred	Appts. Made	Followup	Cases Solved	Cases Closed

FORM NUMBER _____

Figure 10

TOTAL _____

E. SUMMARY

The general mission of the Model Cities Social Service Center is to improve the quality of living in designated neighborhoods by assisting residents who need help in resolving problems beyond their individual capacities. Surveys conducted to compile the Project Report indicate that these needs are quantitively and qualitively extensive, and, doubtlessly, will become more so as the operation of the Center proceeds in time. While it is certain that Center services will eventually be quite comprehensive, the initial and ultimate scope of activities will be limited by such factors as future changes in the mission of the Model Cities Program, available financial resources, fluctuation in the kinds and number of service needs, and the existence of outside local service agencies willing and able to cooperate with the Social Service Center. It is, therefore, essential that the nature of services to be rendered by the Center be broadly, but clearly, defined, subject to future revision based upon accumulated experience.

APPENDIX A

SOCIAL SERVICE AGENCY PROFILE

1. Name of agency_____

2. Address and Telephone_____

3. Director or Chief Administrator_____

4. Person interviewed and Title (if different from # 3)

_____

5. What is the main purpose of your agency as stated in your by-laws?

6. What kinds of services does your agency render? Can you list these services in their order of importance or priority?

   a. _____

   b. _____

   c. _____

   d. _____

   e. _____

7. What goals or accomplishments do you seek for each of the previously mentioned services?

   a. _____

   b. _____

   c. _____

   d. _____

   e. _____

8. Considering the nature of the clients' problems; are these services mainly meeting the:

   (1) immediate needs
   (2) long range needs, or
   (3) intermediate range needs of your clients?

   List separately for each service given in question 6.

   a. _____

   b. _____

   c. _____

   d. _____

   e. _____

9. Does your agency provide services which are <u>not</u> part of the goals stated in your by-laws? If yes, what are these services?

10. In general, what is the main <u>orientation</u> of your service objectives? Does it seek:

    a. prevention _____

    b. maintenance _____

    c. rehabilitation _____

    d. education _____

    e. other goals _____

11. How do you measure the effectiveness of your agency in achieving your goals?

12. Do you receive any information regarding effects of services provided to your clients? If yes, is this information coming from:(check more than one if applicable)

a. staff meeting_____

b. board meeting_____

c. clientele_____

d. other sources_____

13. In terms of the completion of services rendered to your clients, is your program mainly oriented toward:

a. temporary service_____

b. permanent_____

c. repetitive_____

d. other_____

14. What is the "target population" that you seek to provide services for?

15. What is the geographic area served by your agency?

16. What are the clients' "eligibility requirements" in order for services to be provided by your agency?

17. During the past calendar year, approximately how many clients have you provided services for? _____

    a. How many of these were new clients? _____

    b. How many were returnees or previous clients? _____

18. What did you do with your "ineligible" clients?

    a. Were they referred to another agency? _____

    b. Were they referred elsewhere? _____

    c. given information _____

    d. other _____

19. How do you inform the community of your agency's services?

    a. paid advertising _____

    b. talks _____

    c. spot announcements _____

    d. newspaper's articles _____

    e. outreach -neighborhood workers _____

    f. other _____

20. Where are your services given?

a. main office building _____

b. home _____

c. neighborhood _____

d. clinic or hospital _____

e. other _____

21. How many people are employed in this agency? _____

a. Of these people, how many work directly with clients? _____

b. How many work in other capacities? _____

22. In terms of occupation and work performed, how do you distinguish your professional workers from your para-professional workers?

23. With this in mind, how many of your personnel are:

a. professional paid employees _____

b. para-professional paid employees _____

c. professional voluntary workers _____

d. para-professional voluntary workers _____

24. How many of your professional employees work:

a. full time _____

b. part time _____

25. In providing services, does your staff work as:

a. individuals _____

b. teams _____

c. both _____

26. For each of the services rendered (as previously listed in question #6), approximately what proportion of your manpower is expended on the different kinds of services? Explain if need be.

a. _____

b. _____

c. _____

d. _____

e. _____

27. What is your current annual operating budget?

28. How much of this is obtained from the following sources?

a. sectarian _____

b. United Fund _____

c. county _____

d. state _____

e. federal _____

f. client fees _____

g. other _____

29. Where do your referrals come from?

a. self referrals _____

b. from other agencies _____

c. from other sources (specify) _____

30. What kind of relationships do you have with other agencies providing similar services?

a. coordinated services _____

b. purchase agreement _____

c. cooperative relationship _____

d. other _____

31. Who makes policy decisions for your agency?

32. What kind of relationships do you have with governmental agencies?

a. local _____

b. state _____

c. federal _____

33. What do you see as the main problem (or unresolved social service) of the community?

a. How severe is it?

b. Does it deserve a priority in dealing with it?

34. Are you aware of any gaps in services or areas of neglected needs in the community?

35. Would your delivery system function better if you had more:

a. financial help _____

b. personnel _____

c. other _____

Name of Interviewer _____

Date of Interview _____

APPENDIX B

CONSUMER PROFILE

You are to ask the interviewee if he has any problems or if he knows of any problems in the community. If he spontaneously responds, find the appropriate category and check. On any question to which the interviewee responds, ask him if he thinks the problem is getting "better", or "worse", or remaining the "same", and mark the appropriate box. For any questions not spontaneously answered, ask him, "Do any of these present personal problems for you?" In some cases, questions may need a short explanation, e. g. what is the health services project as proposed by the Welfare Planning Council. ASSURE THE INTERVIEWEE THAT ALL INFORMATION VOLUNTEERED WILL BE HELD IN STRICTEST CONFIDENCE.

Immediately after leaving interviewee's home, write on the back of this questionnaire any comments of the interviewee which are revelant to community social services but not specifically brought out in the questionnaire, e. g., the physical condition of home, does respondent seriously want to become involved in Model Cities programs, number of people living home. Is respondent in need of special services, and what kind, etc. Make these comments short and to the point.

CODE: Sp = Spontaneous
B = Better
W = Worse
S = Same

Interviewer _____ Date _____

1. Name of Interviewee _____
2. Address _____
3. Marital Status ___ ___ ___ ___
   M S D W
4. Number of Children _____ Ages _____
5. House
   a. Own
   b. Rent
   c. Mortgage
   d. Land Contract
6. Educational Background
   a. College
   b. High School
   c. Grade School
7. Employment
   a. Place
   b. Position
8. Religious Background
9. Nationality

	Community				Personal			
	Sp	B	W	S	Sp	B	W	S

ADDICTION
(Narcotics)

1. Have you ever sought an agency for an addiction problem? Yes___ No___

   a. What agency? _____

   b. How did they assist you? _____

   c. What did you like most about their services? _____

   d. What did you dislike most about their services ? _____

   e. When did you last talk to this agency? _____

   f. For what reason? _____

   g. Were they helpful? Yes____ No____

	Community				Personal			
	Sp	B	W	S	Sp	B	W	S

AGED

1. Are you receiving any service at the present? Yes____ No____

   a. What agency?_____

   b. How did they assist you?_____

   c. What did you like most about their services?_____

   d. What did you dislike most about their services?_____

   e. When did you last talk to this agency?_____

   f. For what reason?_____

   g. Were they helpful? Yes____ No____

	Community				Personal			
Sp	B	W	S		Sp	B	W	S

CHILDREN

1. Are you receiving services of an agency at the present? Yes____ No____

   a. What agency?_____

   b. How did they assist you?_____

   c. What did you like most about their services?_____

   d. What did you dislike most about their services?_____

   e. When did you last talk to this agency?_____

   f. For what reason?_____

   g. Were they helpful? Yes_____ No_____

	Community				Personal			
Sp	B	W	S		Sp	B	W	S

CONSUMER

1. Are you receiving this service at the present? Yes_____ No_____

   a. What agency?_____

   b. How did they assist you?_____

   c. What did you like most about their services?_____

   d. What did you dislike most about their services?_____

   e. When did you last talk to this agency?_____

   f. For what reason?_____

   g. Were they helpful? Yes _____ No_____

	Community				Personal			
Sp	B	W	S		Sp	B	W	S

EDUCATION

1. Are you receiving a service at the present? Yes_____ No_____

   a. What agency?_____

   b. How did they assist you?_____

   c. What did you like most about their services?_____

   d. What did you dislike most about their services?_____

   e. When did you last talk to this agency?_____

   f. For what reason?_____

   g. Were they helpful? Yes_____ No _____

	Community				Personal			
Sp	B	W	S		Sp	B	W	S

HEALTH

Sickness or Ill Health, Finding Doctors, Clinics or Hospitals

1. Has there been a need for you or members of your family to seek health services? Yes_____ No_____

   a. Was it a hospital, doctor, clinic or program? Name_____

   b. What kind of service did you seek?_____

   c. What did you like most about the service?_____

   d. What did you dislike most about the service?_____

   e. Did you seek their services again when necessary?_____

   f. For what reason?_____

   g. Briefly tell me if they were helpful or not._____

	Community				Personal			
Sp	B	W	S		Sp	B	W	S

HOUSING

Having a Decent Place to Live

1. Did you seek the services of any local agency to find a place to live?

   Yes_____ No_____

   a. What agency assisted you?_____

   b. Who referred you?_____

   c. What services did they provide?_____

   d. What did you like most about their services?_____

   e. What did you dislike most about their services?_____

   f. When did you last talk to this agency?_____

   g. For what reason?_____

   h. Briefly tell me if they were helpful or not._____

	Community				Personal			
	Sp	B	W	S	Sp	B	W	S

JOBS

Finding Decent Jobs

1. Have you ever sought the help of agency to find a job? Yes_____ No_____

   a. What agency? _____

   b. How did they assist you? _____

   c. What did you like most about their services? _____

   d. What did you dislike most about their services? _____

   e. When did you last talk to this agency? _____

   f. For what reason? _____

   g. Were they helpful? Yes_____ No_____

	Community				Personal			
Sp	B	W	S		Sp	B	W	S

LEGAL MATTERS

Legal Matters, Courts, and Finding Lawyers

1. Have you ever sought this agency for legal matters? Yes_____ No_____

   a. What agency?_____

   b. How did they assist you?_____

   c. What did you like most about their services?_____

   d. What did you dislike most about their services?_____

   e. When did you last talk to this agency?_____

   f. For what reason?_____

   g. Were they helpful? Yes_____ No_____

	Community				Personal			
Sp	B	W	S		Sp	B	W	S

PUBLIC SERVICES

1. Are you receiving any service at the present? Yes_____ No_____

   a. What agency?_____

   b. How did they assist you? _____

   c. What did you like most about their services? _____

   d. What did you dislike most about their services? _____

   e. When did you last talk to this agency?_____

   f. For what reason?_____

   g. Were they helpful? Yes_____ No_____

	Community				Personal			
	Sp	B	W	S	Sp	B	W	S

RECREATION

Parks, Playgrounds; Programs for Children & Teenagers

1. Have you ever sought any agency for a specific program? Yes_____ No_____

   a. What agency? _____

   b. How did they assist you? _____

   c. What did you like most about their services? _____

   d. What did you dislike most about their services? _____

   e. When did you last talk to this agency? _____

   f. For what reason? _____

   g. Were they helpful? Yes_____ No_____

	Community				Personal			
Sp	B	W	S		Sp	B	W	S

TRAINING

Getting Training for Better Jobs

1. Have you ever received job training to improve your job skills?

   Yes_____ No_____

   a. What agency provided the training?_____

   b. What kind of training was this?_____

   c. Did this training help you to find better employment?_____

      Yes_____ No_____

   d. What did you like most about their service?_____

   e. What did you dislike most about their services?_____

   f. Has there been a need to contact this agency?_____

   g. For what reason?_____

   h. Briefly tell me if they were helpful or not._____

	Community				Personal			
Sp	B	W	S		Sp	B	W	S

WELFARE

Social Workers and Investigators not Giving Needed Help

1. Are you receiving this kind of service at present? Yes_____ No_____

   a. What agency? _____

   b. What kind of service(s) are they providing? _____

   c. What do you like most about their services? _____

   d. What do you dislike most about their services? _____

   e. When did you last talk to this agency? _____

   f. For what reason? _____

   g. Briefly tell me if they were helpful or not. _____

APPENDIX C

MATCHING ACENCY TO SERVICE/PROBLEM CATEGORY

Addiction	Aged	Children	Consumer	Education	Health	Housing	Jobs	Legal	Public Service	Recreation	Trng.	Welfare
	Vets. Pen.	Catholic Youth Charity	Food Stamps	Smith School	Gen. Hosp. Clinic	Redev. Auth.	B.E.P.	Legal Aid	Ambulance	YMCA	Mary-wood Coll.	Dept. of Public Asst.
	Social Sec.	Child Welfare	CEO	Head Start	Mercy Hosp.		C.E.P.	Priv. Counsel	Garbage	Model Cit.	WIN.	
	R. R. Pen.	Blind Assoc.	D.P.A.	Kings College	Medi-care		Model Cities	Family Service	Streets	Elk Club	Wik	Public Health Nurse
	Model Cities	United Rehab.		Wilkes-Barre Public Schools	Blue Cross			Public Defend.	Police	Slattery Lounge	RCA Voc.	
	Asthma Assoc.	Girl Scouts		Smith School	Kirby Health Center				Sanitation	Jewish Center	Wilkes Coll.	
		Head Start		Tutor-ial Prog.	Family Doctor				S.P.C.A.	YWCA	ECPI	
		Model Cities			Wyoming Valley Hosp.					Boy Sct.		
		CYC			Nesbit Hosp.					4-H		
					Blind Assoc.							

APPENDIX D

DEMOGRAPHIC PROFILE

	NW	NE	SW	SE	C	IT	Total	%
						103	367	68

APPENDIX D

DEMOGRAPHIC PROFILE

		NW	NE	SW	SE	C	IT	Total	%
Marital Status	M	48	71	31	70	45	102	367	68
	S	5	7	9	2	6	5	34	6
	D	1	3	10	4	3	5	26	5
	W	7	27	35	10	15	24	118	21
Sex	M	4	25	8	14	6	24	81	14
	F	52	92	74	68	66	106	458	86
No. of Children	1	7	14	3	11	13	22	70	25
	2	7	19	7	20	11	17	81	29
	3	5	7	6	5	4	11	38	13
	4	5	7	7	7	5	12	43	15
	5	5	2	2	3	1	4	17	6
	6	1	6	1	1	3	4	16	6
	7	1	3	1	-	1	1	7	2
	8	-	2	-	1	-	1	4	1
	9	-	2	1	-	1	-	4	1
	10	-	-	-	-	-	-	-	-
More than	10	1	-	-	-	-	1	2	-
House	Own	36	67	1	45	20	64	233	43
	Rent	22	54	80	31	62	54	303	57
Education	College	3	3	3	6	6	2	23	4
	H.S.	37	79	37	60	43	69	325	61
	Grade S.	20	41	42	23	16	46	188	35
Employment	P.A.	33	40	84	50	40	59	306	61
	Ind.	16	21	2	8	5	34	86	17
	Comm.	9	18	-	11	3	8	49	10
	Inst.	9	13	-	15	9	14	60	12

APPENDIX E

TABULATIONS OF PERCEPTIONS OF COMMUNITY SITUATIONS

		Addict	Aged	Child	Cons.	Educ.	Health	Housing	Jobs	Legal	Pub.Serv.	Recreat.	Training	Welfare	Total
BETTER	IT	1	34	36	8	39	20	9	20	24	33	27	43	28	322
	NW	0	1	9	0	19	3	9	13	0	3	9	18	2	86
	SE	4	33	40	13	55	13	13	22	17	26	38	41	28	343
	C	2	22	15	14	24	7	11	10	7	11	9	17	16	165
	SW	0	6	10	9	10	11	4	3	8	5	8	4	7	85
	NE	4	53	56	15	64	43	25	42	36	34	41	38	45	496
	Total	11	149	166	59	211	97	71	110	92	112	132	161	126	1,497
	%	3%	47%	65%	34%	71%	30%	20%	36%	43%	31%	42%	62%	46%	
WORSE	IT	62	12	1	1	4	30	58	34	7	19	24	5	9	266
	NW	46	16	3	0	3	26	27	15	0	24	7	1	11	179
	SE	49	10	5	3	5	43	47	23	7	22	20	3	8	245
	C	23	7	6	4	2	15	33	12	3	15	19	5	9	153
	SW	29	6	2	7	4	13	17	8	2	9	12	2	12	123
	NE	65	9	3	29	3	14	38	14	4	24	13	1	16	233
	Total	274	60	20	44	21	141	220	106	23	113	95	17	65	1,199
	%	82%	19%	8%	25%	7%	43%	60%	35%	11%	31%	30%	6%	24%	
SAME	IT	8	21	10	7	12	14	14	12	8	31	10	7	13	167
	NW	4	24	11	0	9	20	8	8	10	22	16	9	17	158
	SE	16	16	8	11	11	16	13	20	18	26	13	14	21	203
	C	4	9	4	4	4	7	4	12	6	9	11	5	6	85
	SW	6	15	15	16	14	7	10	8	13	18	10	15	9	156
	NE	10	22	21	34	14	24	22	26	42	30	30	33	15	323
	Total	48	107	69	72	64	88	71	86	97	136	90	83	81	1,092
	%	15%	34%	27%	41%	22%	27%	20%	28%	46%	38%	28%	32%	30%	
Total of 536		333	316	255	175	296	326	362	302	212	361	317	261	272	
		62%	59%	48%	33%	55%	61%	68%	56%	40%	67%	59%	49%	51%	

APPENDIX F
TABULATIONS OF PERCEPTIONS
OF
PERSONAL SITUATION

		Addict	Aged	Child	Cons.	Educ.	Health	Housing	Jobs	Legal	Pub. Serv.	Recreat.	Training	Welfare	Total
BETTER	IT	-	26	24	5	25	14	6	13	16	32	15	21	16	213
	NW	1	1	1	-	1	-	1	-	-	-	-	-	-	5
	SE	1	3	5	2	10	8	6	5	2	8	15	2	3	70
	C	2	12	9	7	15	6	5	5	4	8	6	9	12	100
	SW	-	2	5	2	4	4	2	1	3	1	4	3	2	33
	NE	3	55	54	13	60	43	22	39	29	30	42	40	40	470
Total		7	99	98	29	115	75	42	63	54	79	82	75	73	891
%		4%	46%	56%	21%	60%	34%	18%	32%	34%	33%	40%	43%	41%	36%
WORSE	IT	16	5	-	1	5	18	41	17	4	8	16	1	3	135
	NW	1	3	2	-	2	4	3	1	-	2	1	1	2	22
	SE	4	7	-	2	2	7	6	7	1	9	7	3	1	56
	C	15	5	3	3	2	9	22	7	1	11	10	4	5	97
	SW	11	6	2	4	3	8	7	8	2	3	4	-	8	66
	NE	54	8	3	28	3	13	32	12	5	26	9	1	18	212
Total		101	34	10	38	17	59	111	52	13	59	47	10	37	588
%		62%	16%	6%	28%	9%	27%	48%	26%	8%	25%	23%	6%	21%	24%
SAME	IT	9	16	5	5	10	14	6	6	10	27	9	7	10	134
	NW	-	-	-	-	1	4	1	1	1	1	-	1	-	10
	SE	29	33	27	19	31	36	34	33	27	26	23	37	32	387
	C	5	7	3	4	5	7	5	11	5	6	8	4	3	73
	SW	2	8	10	8	8	3	6	5	8	11	6	9	7	91
	NE	10	20	21	33	14	22	24	27	42	29	29	32	16	319
Total		55	84	66	69	69	86	76	83	93	100	75	90	68	1,014
%		34%	39%	38%	51%	31%	39%	33%	42%	58%	42%	37%	51%	38%	41%
Resp. Total		163	217	174	136	201	220	229	198	160	238	204	175	178	2,403
% of 536		30%	40%	32%	25%	37%	41%	43%	37%	30%	44%	38%	33%	33%	-

APPENDIX G

SOCIAL SERVICE AGENCIES

SERVING

MODEL CITIES NEIGHBORHOOD AREA

Alcoholics Anonymous

American Cancer Society

American Red Cross
Wyoming Valley Chapter

Arthritis Foundation
Eastern Penna. Chapter, Luzerne County Unit

Boy Scouts of America
Penn Mountains Council

Bureau of Employment Security
Commonwealth of Pennsylvania

Bureau of the Visually and Physically Handicapped
Commonwealth of Pennsylvania

Bureau of Vocational Rehabilitation
Commonwealth of Pennsylvania

Catholic Social Services of Wyoming Valley

Catholic Youth Center of Wyoming Valley

Children's Service Center of Wyoming Valley

Commission on Economic Opportunity of Luzerne County

Concentrated Employment Program

Council House

Crippled Children's Association of Wyoming Valley

National Cystic Fibrosis Research Foundation
Anthracite Chapter

Family Service Association of Wyoming Valley

National Foundation - March of Dimes
Wyoming Valley Chapter

Georgetown Settlement Association

Girl Scouts
Penn's Woods Council

Project Headstart

Heart Association of Northeastern Pennsylvania

Home for Homeless Women

Homemakers Service of Luzerne County

Jewish Community Center of Wyoming Valley

Jewish Welfare Agency

Kirby Memorial Health Center

Legal Aid Society of Luzerne County

Legal Services Association of Luzerne County

Lutheran Children's Bureau

Luzerne County Agricultural & Home Economics Extension Association

Luzerne County Association for Retarded Children

Board of Assistance
Commonwealth of Pennsylvania

Luzerne County Federation for the Blind

Public Health Center
Commonwealth of Pennsylvania

Bureau for the Aging
Luzerne County

Adult Welfare Services
Luzerne County Institution District

Child Welfare Services
Luzerne County

Juvenile Court
Luzerne County

Probation Office, Adult Division
Luzerne County

Domestic Relations Division
Luzerne County

Veterans Affairs Bureau
Luzerne County

Mental Retardation Program

Mercy Hospital

Multiple Sclerosis Society

Muscular Dystrophy Association

National Polio Foundation
Wyoming Valley Chapter

Nesbitt Memorial Hospital

Pennsylvania Association of the Blind
Wilkes-Barre Branch

Pennsylvania Department of Health, Region II

Pennsylvania Veterans Commission

Planned Parenthood Association of Luzerne County

Regional Office Department of Welfare

Retreat State Hospital

St. Stanislaus Institute

Salvation Army
Wyoming Valley

Salvation Army Men's Social Service Center

Social Security Administration

St. Michael's School for Boys

Sutton Home for Aged and Infirm Men

Tuberculosis Society
Wyoming Valley

United Cerebral Palsy Association of Wyoming Valley

United Rehabilitation Services, Inc.

Valley Crest County Home

Veterans Administration

Veterans Administration Hospital

Visiting Nurses Association
Wyoming Valley

Wayside Mission

White Haven State School

Wilkes-Barre General Hospital

Wyoming Valley Council of Churches

Wyoming Valley Hospital

Young Men's Christian Association
Wilkes-Barre

Young Women's Christian Association

APPENDIX H

CLUE WORDS

A

adoption services
adults
aged
agricultural education
aid
alcoholics
applications
arthritis
assistance

B

birth control
birth control information
birth defects
blind
blind adults
blood drives
burial expenses

C

camping
cancer
cardiology
care
cerebral pasly
character building
chest x-ray
children
children's educational services
children's welfare
Christmas
clinic
clothing
community groups
community services
counselling
crippled children

D

day care
dental clinic
domestic relations
direct rehabilitation
disaster

E

educational assistance
elderly
emergency
emergency treatment (medical)
employment
enforcement
environmental control
environmental laws
eye care

F

family
family planning
family social services
financial assistance
financial support
food
food stamp
foster homes

G

general medical care
general recreational services
general rehabilitation
graduate students
group therapy
guidance

CLUE WORDS (CONTINUED)

H

handicapped persons
health
health education
health information
heart
home economics education
homeless women
home patients
home teaching
hospital admission
hospitals

I

immunization
income maintenance
indigent persons
individual
infirm
injustice

J

job orientation programs
jobs
juvenile
juvenile delinquents

L

legal
legal services

M

marital hearings
medical diagnosis
medical equipment
meeting place

M

mental disorders
mental health
mental health education
mutiple sclerosis
muscular distrophy

N

needy
neglected and orphaned children
nursery school
nurses
nursing care elderly
nursing homes

O

obstetrical treatment
occular treatment
occupational therapy
orthopedic

P

Pap smear test
parenthood
parole
physical fitness
physically handicapped
physical therapy
polio (infantile paralysis)
poor
prevention of blindness
preventive medical services
probation
professional education
programs
psychiatric consultation
to schools
psychiatric help

CLUE WORDS (CONTINUED)

P

psychiatric social workers
psychological
psychological psychiatric disorder
psychotherapeutic
public education

R

recreational
Red Cross
rehabilitation
religious
remedial education to deprived children
retardation programs
retarded children
rheumatic fever
rural government

S

scholarships
scouts
senior citizens
services
sheltered employment
social activities
social security
social security payments
social workers
speech disorders
spiritual
surgical treatment

T

training
transportation
tuberculosis

U

unemployment compensation
unwed mothers

V

veterans
Vietnam bonus
visually handicapped
vocational counselling
vocational information
vocational placement
vocational rehabilitation
vocational training - general

W

welfare
welfare delivery systems
work-study programs

Y

youth
youth education