WHY PREVENTIVE HUMAN SERVICES IN MASSACHUSETTS HAVE SUFFERED MORE FROM GOVERNMENT CUTBACKS THAN EMERGENCY SERVICES: AN EXPLORATION OF THE VALIDITY, HISTORY AND IMPLICATIONS OF A DIFFERENTIAL FUNDING EXPLANATION

by

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Submitted to the Department of
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ABSTRACT

Human services are classified along a continuum from proactive primary prevention services to reactive emergency services. The former have suffered more than the latter in the wake of the government human service cutbacks of the 1980s. This imbalance is partly explained by the fact that emergency services, being supported by all levels of government and by private philanthropy, have a broader funding base than primary prevention services, which depend heavily on dramatically reduced Federal funding.

The development of the American conception of social welfare is traced from seventeenth-century Calvinism through the residual view prevalent in the nineteenth century, which limited government intervention to the most desperate cases, to the institutional view of the twentieth century, characterized by a concern with the welfare of society as a whole. The Reagan cutbacks and accompanying emphasis on the "truly needy," are seen as an unfortunate retreat to the residual view.

Documentation of the effects of the recent cutbacks involved analysis of state and Federal budget information as well as data gathered by the Massachusetts Institute of Technology Impact 2½ study in interviews with human services agency directors in nine communities in Massachusetts.

Thesis Supervisor: Dr. Donald A. Schon

BIOGRAPHICAL SKETCH

Louise Krakow Freilich was born in Wilmington, Delaware, in 1957 and grew up in Newton, Massachusetts. In 1975 she entered the University of Pennsylvania and was graduated magna cum laude in Urban Studies in 1979. Following two years as a research assistant at the Hebrew Rehabilitation Center for Aged, Department of Social Gerontological Research, in Boston, she entered the Master in City Planning program of the Massachusetts Institute of Technology. While at MIT, she served as a research assistant for the human services study of the Impact 2½ Monitoring Project.

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CHAPTER I
Background

1.0 Introduction

Over the past fifty years, as the notion of what constitutes human services and social welfare has expanded, government, at all levels, has played an increasing role in the human services system. Over the last few years, however, many human services programs have faced cutbacks in funding from Federal, state and municipal sources. The impact of these cutbacks at the community level has been the subject of investigation of the Massachusetts Institute of Technology Impact 2½ study, Monitoring the Impact of Municipal, State and Federal Budget Cuts on Human Services in Massachusetts. This study, based on interviews with directors of human service agencies in nine communities (six cities or towns and three Boston neighborhoods), investigated the ways in which agencies and coalitions of agencies are affected by and are coping with government cutbacks. The study uncovered many service cutbacks caused by Federal, state and municipal budget cuts. For instance, in the aftermath of Proposition 2½, many municipalities decreased funding for education and recreation programs. Additionally, Federal cuts in Comprehensive Employment Training Act (CETA), Maternal Child Health, and Community Development Block Grant (CDBG) funds, to name a few, forced service reductions the communities studied.

From conducting interviews in several communities, it seemed that service reductions were not balanced across the board. It seemed that preventive kinds of

[1]Project Director--Langley C. Keyes. Research Staff--Louise Freilich, Lauren Seymour, Jean Strain and Jane Unger. Sponsored by the Committee of the Permanent Charity Fund, Inc. and the Godfrey M. and Sarah A. Hyam Trust Foundation, Inc.

services were cut more often than emergency services and that human service providers increasingly focused on emergency services and crisis situations.

In this thesis, I will show that preventive services have faced a disproportionate share of government cutbacks. Economic, political, institutional and historical factors are discussed which foster the resiliency of emergency services funding. In this thesis, I emphasize the historical factors and argue that the resiliency of emergency services funding is due, in part, to the fact that emergency services, funded by all levels of government and the private sector, have a historically broad funding base, whereas preventive services are funded primarily by the Federal government and the municipalties, which have been affected by major domestic spending cuts and Proposition 2½. I will do this using Massachusetts and Federal budget information, as well as material from the community case studies.

1.1 The Concept and Importance of Prevention

The current emphasis on emergency services reflects a curative or medical model orientation rather than a public health orientation. Public health or "preventive medicine" deals with "the problem of controlling the level of disease in a population by focusing its resources in an active preventive manner than passively waiting for difficulties to present themselves to a remedy" (Caplan, 1968, p. 10). Public health activities are intended primarily to maintain the health of society as a whole, rather than to cure sick individuals (Schwartz, 1977). Public health services and later, other human services, have been categorized along a continuum from primary to tertiary prevention (Beck, 1959). Primary prevention activities, which will hereafter be called preventive services, occur before the disease attacks, and seek to prevent the problem from occurring. Primary prevention includes health promoting services such as education, recreation, nutrition education and employment development, as well as specific protection activities to prevent a specific condition, comparable to immunization against a specific disease in medicine. Rapoport (1961) provides examples of specific protection measures to protect children from the development of psychopathy due to prolonged and early maternal separation and deprivation, measures including increased parental visiting in pediatric hospitals, increased home treatment, homemakers at a time of crisis to keep children from being placed out of the home, and modification of adoption laws and procedures to facilitate earlier adoption (Rapoport, 1961). Secondary prevention includes early case findings and prompt treatment activities taking place during the early stages of the disease, thus limiting the duration of the problem. Tertiary prevention includes disability

limitations and rehabilitation activities occurring in the advanced stage of the disease which attempt to limit the impact of the problem. Secondary and tertiary prevention activities emphasize treatment and cure of already present problems.

Not only can human services be categorized along a continuum from primary to tertiary prevention, they can also be categorized along a continuum of level of planning from mostly proactive to mostly reative. Emergency services, which are the most reactive services, provide basic necessities such as food, clothing, and shelter for persons in crisis, and medical or psychiatric attention in life-threatening situations. A crisis, which in its simplest terms is defined by Caplan as "an upset in a steady state" (Rapoport, 1965), can be caused by such diverse events as an eviction, losing a job, running out of money with which to buy food, a suicide attempt or a drug overdose. Emergency services, in seeking to limit the duration or impact of a problem, can be classified as secondary prevention or tertiary prevention, depending on the circumstances.

Human services, thus, can be classified along continuums of primary to tertiary prevention and proactive to reactive planning, as shown in Table 1. While other classifications of services are possible, Table 1 classifies human services as primary or secondary/tertiary prevention according to definitions found in the social work and mental health literature. Preventive services fall into the proactive, primary prevention box while emergency services fall into the reactive, secondary and tertiary prevention box. Non-emergency, secondary and tertiary prevention activities fall somewhere between.

In modern society, a wide range of human services has been developed. In the past, human services were narrowly defined as "the provision of a variety of

TABLE 1

Model of Intervention

	Public Health Model Primary Prevention	Medical Model Secondary/Tertiary Prevention
Mostly proactive	PREVENTIVE SERVICES Education Recreation Weatherization Health Promotion Nutrition Education Employment Development Advocacy Transportation Development	Income Support Outreach Information and Referral Consultation Daycare Early Intervention Special Education Fostercare/Adoption Protective Services Homecare
		Residential Care Rehabilitation Legal Services
Mostly reactive		EMERGENCY SERVICES Detoxification Crisis Hotlines Emergency: Food Fuel Clothing Shelter Psychiatric Medical

services required by persons of limited income in an industrial society who would otherwise succumb at the minimum to starvation or severe distress" (Morris, 1977, p. 6). In other words, in the past human services were emergency services. Since that time, various factors such as increased employee mobility, female entry into the work force, the changing role of the family, increased stress due to urbanization and industrialization, the expanding concept of equity, and the belief in technology and science as problem solvers have fueled the recent explosion of human services (Morris, 1977). The definition of human services has been broadened to include a range of preventive, treatment rehabilitative and emergency services. Kahn (1973, p. 16) describes the functions of social services in modern society:

1. To strengthen and repair family and individual functioning with reference to ongoing roles.

2. To provide new institutional outlets for socialization, development, and assistance, roles that once were--but are no longer--discharged by the nuclear or extended family.

3. To develop institutional forms for new activities, essential to individuals, families, and groups in the complex, urban society even though unknown in a simple society.

Kahn (1973, p. 16) stresses that "the very facts of economic growth and technological change depend upon and in turn, stimulate major social changes. Such changes demand new institutional provision for meeting the affectional, socialization, developmental--as well as rehabilitative--needs of people."

The growth in human services has accompanied the change in conception of social welfare from "residual" to "institutional" discussed by Wilensky and Lebeaux

(1965). The "residual" concept holds that social welfare institutions should attend to temporary and emergency problems which arise when the normal structures of supply, the family and the market, break down and fail to provide adequately for human needs. The "institutional" concept sees the welfare services as regular, ongoing, and essential features of modern industrialized society. The institutional view implies no stigma, no emergency, no "abnormalcy." Social welfare becomes accepted as a proper, legitimate function of modern industrial society in helping individuals to achieve self fulfillment (Wilensky and Lebeaux, 1965). Preventive services, as well as treatment services, are critical in the broader "institutional" view of social welfare. Cutbacks in municipal, state and Federal funding for human services, such as those identified in the community case studies, reduce the ability of agencies to provide the full range of services needed in their communities. Furthermore, greater cuts in the preventive end of the continuum of service lead to a greater proportion of crisis problems.

1.2 Why Emergency Services Are Emphasized

Even though the whole continuum of services is interrelated, emergency services are emphasized at the expense of preventive services. There are several reasons why this may be so. These reasons concern the financing of services, as well as the specific characteristics of emergency and preventive services.

One reason is that agencies often emphasize services for which there are payment mechanisms. Camayd-Freixas (1982) notes that in the area of community mental health, "the already visible trend is one where reimbursable work and third party-supported clients will be given preference. That is, community mental health centers may tend to focus their work on activities reimbursable by medicare-medicaid and health insurance, and on a clientele eligible for this support" (p. 15). He further stresses that "Center-based, formal, appointment-structured, short term therapy and group work may be emphasized at the expense of outreach and preventive services or those offered at alternative service sites such as the school or homes" (p. 16). This demand characteristic thus limits innovativeness, flexibility and the development of new programs.

Additionally, the nature of preventive and emergency services causes governments, charitable organizations, and the general public to place a higher priority on emergency services, especially in a time of diminishing resources. Emergency services have the following characteristics: 1) they are visible, 2) they are immediate and do not require extensive outreach, and 3) they serve a humanitarian need that society feels obligated to meet. Preventive services, on

the other hand, tend to be seen as having the following characteristics: 1) they are intangible, 2) the link between preventive services and future needs is not always clear, 3) they meet a less immediate need, and outreach is therefore very important.

Crises provide a sense of urgency and immediacy, and thus emergency services are considered to serve a more immediate need. Crises land on an agency's doorstep, whereas agencies have to work to reach out to people to provide effective preventive services. Wittman (1961) notes:

> It has been found - as in the case of Salk vaccine - that the availability of the means of prevention is not enough. There must be an intensive educational program or people will not avail themselves the benefit of a scientific discovery, even when their own health is involved (p. 21).

In addition to emergency services being visible and urgent, people feel an obligation to do something about a crisis. Rapoport (1965) talks about the availability and use of interpersonal and institutional resources in a crisis situation.

> It has been noted that a major upset in a system - be this in an individual, family or community group - tends to arouse supporting features and to mobilize energy for reaching out by others in the social network (p. 30).

Rapoport notes that this support has been dramatically demonstrated in times of disaster.

A report in Oxfam America's Winter 1983 newsletter reflects the perception of many (or at the very least of the U.S. Treasury Department) that preventive services do not meet clearcut, humanitarian need. The Treasury

Department rejected Oxfam America's request for a license to aid further preventive projects in Laos and Kampuchea (licensure for all financial transactions including humanitarian aid is required under the Trade with the Enemy Act). The four projects were "a bee-keeping cooperative that supplies honey as a food supplement to kindergartens and hospitals; a rice-seed co-operative; and agriculture extension and seed multiplication programs at Cartho University in the Mekong Delta" (Oxfam America News, 1983, p. 1). The applications and appeals were rejected because the projects were "deemed to be developmental in nature" and not to "satisfy the State Department criteria for projects addressing an immediate, well-identified humanitarian need" (Oxfam America News, 1983, p. 3). In other words, giving a starving man a fish (emergency services) is considered humanitarian, while teaching a starving man to fish (preventive services) is not. While there is some division of opinion as to whether society is obligated to provide full employment, employment training, recreation, family counseling, etc., there seems to be a consensus that society has a responsibility to intervene in cases of disaster or starvation.

Another explanation for why preventive services may be cut disproportionately lies in the objective of such services. While curative and emergency services do not seek to change society but rather to adjust the individual, preventive services often seek to change society and its institutions. Emergency services support the status quo while preventive services can be used to change the status quo.

While the above explanations provide a general explanation for why emergency services are emphasized, the fact that preventive services are cut disproportionately given that cuts are being made demands further attention. The

decision to cut a service can be made at several levels. At the agency level, an agency, especially one with multiple sources of funding, may have some discretion as to which of its programs to cut. At this level, emergency services may be emphasized for any of the reasons discussed above. At the funding source level, a government can cut back or eliminate the funding it provides for a particular program. In this thesis, I do not attempt to explain the decision making process that occurs at the various levels of government or within an agency. Rather, I show that preventive services have faced a disproportionate share of the cutbacks as a function, among other things, of greater cuts in Federally and municipally funded programs than in state funded programs. Most preventive services are Federally funded, whereas emergency and other direct services are funded by both state and Federal governments. Emergency services, thus, have a broader funding base with which to withstand cutbacks.

1.3 The Roles Various Levels of Government Play in the Provision and Funding of Human Services

In the United States, the three levels of government and the voluntary sector form a partnership in which each level of government and the voluntary sector shares in both the financing and administering of social welfare programs. Often, confused sharing of responsibility among several levels of government and multiple, overlapping planning centers exist (Morris, 1977). Nevertheless, the various levels of government have somewhat different roles with regard to the funding and provision of human services.

Local government, for instance, has not traditionally been involved in the funding of human services, although some local governments have administered general assistance welfare payments (Taylor, 1977). The Federal and state governments have provided impetus for local involvement in social service delivery systems through a variety of grant programs, some of which have required a portion of local funding. The IMPACT 2½ human services study found that the municipal budgeting for human services, no matter how broadly defined, is quite limited and, with some exceptions (e.g., Boston, Cambridge, Worcester), is of relatively minor significance in the overall human services picture. (This conclusion is discussed in the project's application for second year funding.) Different cities and towns take on varying amounts of responsibility for the funding and provision of human services depending on the particular problems, needs and resources in the municipality. Education remains a local responsibility, with much of the funding coming from local tax revenues. Additionally, local governments

often provide such preventive services as recreation and public health programs. Some of the funding for these services comes from the state and Federal governments in the form of grants or general revenue sharing. Municipal governments have been involved to varying degrees in the provision of income maintenance, child welfare, health, mental health, mental retardation, and elderly services. Money for municipal human services comes both from local tax revenues and from the state and Federal governments. It is therefore difficult to determine the exact source of funding for municipal programs. In its Handbook on Human Resources Policy Planning, the League of California cities outlines eight role options for local government. These are: (1) interagency liaison, (2) monitoring and evaluation, (3) information and referral, (4) program initiation and planning, (5) program demonstration, (6) contracting for services, (7) direct service provision, and (8) non-service delivery using existing powers of regulation and taxation (Gardner, 1977). The League of California Cities stresses that cities can make their greatest impact, not by delivery service, but by using political leadership to generate improved service and policy in those agencies already responsible for the solution of social problems, and by maximizing the responsiveness of their existing services through legislation, zoning regulations, police policies and recreation programs (Gardner, 1977). From the role options, it is clear that local responsibility for human services need not include direct funding or provision of services. The pattern in individual localities varies greatly, but in Massachusetts, as already mentioned, municipalities, for the most part, play a small role in the funding of human services.

The state is involved in the provision and funding of a range of direct services. Most state-funded services fall into the categories of secondary or tertiary prevention rather than primary prevention. The Commonwealth of Massachusetts funds or administers many services, including counseling, adoption, fostercare, respite care, homecare and institutional care. Human services expenditures comprise about half of the state budget (Strain, Note 6). Much of the funding for these services comes from the Federal government.

The Federal government has funded not only secondary and tertiary prevention services but also primary prevention efforts. The Federal role in funding human services grew rapidly during the 1960s and 1970s, with large increases occurring in the areas of public assistance, employment, health and social services. Federal expansion during the last quarter-century also spurred increased state and local involvement in human services funding.

The voluntary sector funds a range of services from family counseling to crisis intervention. Agencies, both religious and nonsectarian, such as the Salvation Army, local churches, and Traveler's Aid Society, are especially instrumental in providing funds for people in crisis situations--the hungry, the homeless, and the transient--and in helping these individuals to connect with government-funded agencies and services where appropriate.

Preventive and emergency services can thus be differentiated in terms of who funds the service. In this thesis, I will show that the primary funders of preventive services, the Federal government and the municipalities, have faced more severe cutbacks than have Massachusetts and the voluntary sector, the

primary funders of emergency services. The notion that the location of cutbacks along the continuum of services is related, in part, to the current funding pattern for human services raises some interesting questions. 1) Are the cuts in preventive services at the community level primarily due to Federal and municipal cutbacks? 2) Has there always been the present division of labor among the three levels of government and the voluntary sector in the funding of human services? 3) If the funding pattern has changed, how did the change(s) come to be? 4) What does this differential funding pattern tell us about the array of human services that will be supported in the future? 5) What does it mean in terms of human services policy currently and in the years ahead? These are the questions with which I will deal in this thesis.

1.4 Methodology

I will draw on material presented in the IMPACT 2½ community case studies and information concerning Massachusetts and Federal funding for human services to substantiate (1) that proactive preventive services have suffered more than reactive emergency services and (2) that municipally and Federally funded programs have fared worse than state funded programs.

The IMPACT 2½ Monitoring Project study, Monitoring The Impact of Municipal, State and Federal Budget Cuts on Human Services in Massachusetts, looked at the effect of governmental cutbacks on human services in nine communities including three Boston neighborhoods. The research staff attempted to cover eight target populations in the study: youth; women, children and families; elderly; minorities; emergency; handicapped; offenders and substance abuse. Considerations used in choosing target populations within a community included (a) the size of the group, (b) the existence of interagency coordination or innovative service approaches, (c) the existence of a variety of agencies which serve the target population and (d) losses in service to the population. Ultimately, the nine community case studies covered six of the eight target populations; services to offenders and the handicapped were not chosen in any of the nine communities. Each community case study is divided into several sections. The first section in each case study provides an overview of the services available in the community, demographics and information about the existence or nonexistence of the eight target populations in the community. The remaining sections of each case study describe the effects of cutbacks on the major agencies in the community providing services to selected target populations. These sections of the case studies address the manner in which agencies and coalitions of agencies

serving selected target populations are affected by and are coping with budget cutbacks.

The case studies are descriptive in nature, looking at what is happening in nine communities due to cutbacks. Each case study provides an overview of services in the community and a focused look at services to one or two particular target populations in the community. By itself, each community case study draws a picture of major cutbacks that were incurred by agencies serving persons in the community. By itself, a case study may present policy implications relevant to a particular community and thus open up new areas for discussion in a neighborhood or municipality. Assessed together, the case studies can serve to paint a larger picture of the effect of cutbacks in the human services arena.

Several steps were used in analyzing the case study material. To begin, I read all of the drafts of the community case studies and noted relevant observations in relation to preventive and emergency services. These observations included an increased emphasis by social service agencies on emergency services and multiple problem families, an increased demand for emergency services caused by unemployment and the recession, and noticeable cuts in preventive services such as the closure of the U.S. Public Health Service facility in Brighton.

Next, I mapped out in detail the cutbacks in two of the communities (Jamaica Plain and Quincy) in which I had personally conducted the research. In Jamaica Plain, information was available concerning the effects of cutbacks on the major agencies serving youth and the major agencies serving the elderly in the community. The material in this thesis is divided similarly into a section concerning Jamaica Plain youth services and a section concerning Jamaica Plain

elderly services. In Quincy, agencies were selected which provide a significant amount of emergency services or services to substance abusers. Once selected, agency directors were asked not only about emergency or substance abuse services, but rather about all the services they provide. Since the agencies investigated for the Quincy case study provide a variety of services to a range of age groups, Quincy service providers are considered as a group in this thesis. Thus, to determine whether preventive services have been cut more than emergency services and whether the preventive services have been primarily funded by Federal and municipal governments, the thesis focuses on three groups: Jamaica Plain youth service providers, Jamaica Plain elderly service providers and Quincy human service providers.

Next, I mapped out the available information concerning service cutbacks for each group. The data were broken down by agency, program, type of service, who funds the service, and whether and how cutbacks had occurred. Tables with this information are located in the appendix. The tables thus generated were then used to develop summary tables of kind of service by governmental funding source and by level of cutback (increased, decreased or stable funding). The summary tables act as brief summaries of the more detailed appendix tables. The summary tables are useful in determining that proactive preventive services have suffered more than reactive emergency services and that Federally and municipally funded programs have been cut more often than state funded programs.

The appendix tables were also used to develop summary tables of who funds each kind of service. These tables are useful in determining that differential funding exists, i.e., that the three levels of government and the private sector pay for different kinds of services.

Problems are inherent in putting data gathered in a study to a use other than that for which it was originally intended. Several such problems were encountered in using the case study material to document cuts in preventive services, and thus, I do not claim to have escaped the problems inherent in secondary analysis of data. Four such problems deserve comment. First, the agencies analyzed do not represent all the agencies in the community. Rather they represent the major agencies in the community providing services to a particular target population, as discussed above. The agencies within the target populations were chosen according to the following four considerations: (1) agencies that refer clients to each other, (2) frequently used agencies, (3) agencies that have experienced losses in funding and (4) agencies successful in shifting to new sources of funding. While the considerations for choosing target populations and agencies represent a reasonable way to choose agencies for community case studies, they are not necessarily the method by which one would choose agencies for a study of preventive versus emergency cutbacks. Nevertheless, studying the major agencies in a community can provide insight into relevant trends.

Second, comparable information concerning extent of cutbacks was not always available across programs and kinds of service. Thus, the summary charts indicate only increased, decreased, or stable funding rather than being more specific about percentage and dollar amount of cutbacks. The summary mapping was done in this way since the agencies analyzed do not represent all the agencies in the community. However, knowing that recreation services were reduced by two agencies in a community but having detailed information about only one of the agencies, I can still observe a decrease in recreation services. Thus, the mere fact that funding has increased, decreased or remained stable provides important information.

Third, determining who funds a program is often difficult, especially when an agency has multiple sources of funding for a variety of programs. Sometimes judgments had to be made concerning primary funding source, or more than one funding source had to be listed. Here too, it would have been desirable to know precisely what proportion of funding came from what funding source thus allowing for more precision in the analysis. Additionally, a decline in funding from one source can sometimes be made up with funding from another source without necessitating a reduction in service. When known, replacement funding sources are recorded in the appendix tables. Furthermore, in some cases the state merely acts as a vehicle for Federal funds rather than as an originator of funds. Thus the question of who funds a service is a complex one which has been simplified for the purpose of this analysis.

Fourth, data were collected during 1982 concerning FY82 and FY83 cutbacks. This meant that programs that had ended prior to data collection were not always discovered. Additionally, agencies sampled were relatively traditional agencies. The sampling frame resulted in a conservative reporting of the impact of cutbacks in the communities and thus strengthens rather than weakens the argument of this thesis.

1.5 Organization of the Thesis

The remainder of this thesis is divided into three chapters. Chapter II is a historical chapter addressing the evolution of the current human services funding pattern. Chapter III presents an analysis of findings from the community case studies and information concerning Federal and Massachusetts human services budgets. Chapter IV discusses the findings in light of the historical presentation in Chapter II.

CHAPTER II
History

2.0 Introduction

This chapter explains how it came to be that different levels of government and the private sector fund different kinds of human services on the prevention to emergency continuum. By juxtaposing the history of human services and public welfare philosophies with the evolution of government and private roles, the chapter illustrates how each level of government, when it became involved in human services, focused on the mode of service delivery being emphasized at that time. Thus the state, which became involved at a time of increasing institutionalization, continues to fund institutions, prisons, mental hospitals, and state schools for the retarded. The Federal government, on the other hand, became involved at a time when the conception of what constitutes human services was expanding to include a larger share of preventive services. Thus the Federal government is the primary funding source for preventive services, and recent Federal cutbacks are having an impact on those services. Social welfare originally consisted only of the provision of reactive, emergency services. Later, treatment and rehabilitation services for the individual were added. Finally, in recent years, the concept of social welfare has broadened to include primary preventive services.

2.1 Local Responsibility During the Colonial Period

During the American Colonial period, human services, such as they were, were handled by local governments and financed through local taxation. The early settlers had imported the Elizabeth Poor Law of 1601, a law which placed the operations of public assistance in the hands of local secular authorities and established a system of taxation. The Poor Law distinguished between the deserving and undeserving poor by recognizing three categories of needy and appropriate treatments for these groups: the able bodied, who would be put to work and punished for refusing to work, children, who would be apprenticed, and the infirm, who would be supported through "indoor" relief (institutionalization) or "outdoor" relief provided in private homes. The most common form of assistance during this period was to board the poor in the homes of private citizens at public expense (ACIR, 1980, p. 4).

The American colonists brought with them not only seventeenth-century England's laws, but also its underlying Calvinist philosophy. According to this philosophy, need was a natural and inevitable part of the human condition, poverty was divinely destined, and the poor were thus not responsible for their condition. Since poverty gave wealthy persons the opportunity to do good (give charity) and to serve society and God, poverty was not to be eliminated; rather, the poor were to be pitied and helped. Thus, the "colonial assemblies quickly acknowledged public responsibility for those unable to care for themselves, making the taxpayers of each locality responsible for their support" (Trattner, 1979, p. 16).

Towns retained exclusive responsibility for public welfare for over 200 years until the early days of American independence, when county almhouses and

workhouses were created. This development stemmed from a change in philosophy that occurred in the eighteenth and early nineteenth centuries. The Great Awakening, a religious revivalist movement which rejected the Calvinistic doctrine of predestination and postulated salvation through faith, repentance, and conversion, the Enlightenment, which stressed that all men possess reason, and the American Revolution with its emphasis upon human equality, called attention to poverty and inequality in the New World but also stimulated distrust of the poor.

> The Enlightenment, by helping to wear away the notion that misery and want were endemic to society, made it appear as though the poor were personally responsible for their condition. The same was true for the American Revolution; by fostering the belief that poverty need not exist, it encouraged a harsh and suspicious view of the poor. God's will was no longer a satisfactory explanation for defective social conditions, especially in America, a land of abundance and virtually unlimited resources, where work was more plentiful then elsewhere, especially crowded England. Observers concluded that no one ought to be poor, and there was little tolerance for the able-bodied pauper (Trattner, 1979, p. 48).

Thus, by the early nineteenth century, the predominant philosophy viewed accumulation of wealth as a moral virtue and dependency as a vice. Since it was felt that institutions would cost less and would serve as a greater deterrent to dependency, this philosophy led to use of indoor relief or institutionalization as the major mode of public assistance. However, a single town, especially a small town, lacked the resources and the client population to merit its own institution, and hence the impetus for a county role. In 1824, New York State passed the County Poorhouse Act, which transferred public assistance responsibility from the towns to the counties. This first move toward centralization of public assistance in America exemplifies both the growing emphasis on institutional care and the shift of responsibility for public welfare to higher levels of government.

2.2 The Evolution of State Involvement in Public Welfare During the Nineteenth Century

The transference of public welfare responsibility from town to county had taken 223 years, but the "evolution of state aid to the poor was slower still, exhibiting the classic tendency toward incremental assumption of greater responsibility and authority" (ACIR, 1980, p. 7). Original state welfare activities complemented rather than interfered with local responsibility. For example, state activities at the end of the eighteenth century and during the nineteenth century included aiding the poor who did not meet the residency requirements of any local jurisdiction, providing natural disaster relief to farmers and settlers, and providing benefits to veterans of the Civil War. However, as shocking accounts of life in the county almshouses became publicized, reformers demanded that the state step in. Not only were the reformers upset about the wretched physical conditions in the county almshouses; they were also dissatisfied with the fact that all types of indigent persons were "dumped" there without regard to age, disability, or criminal record. As a result of these reformers' efforts, many states established institutions for people in need of specialized care or treatment. During the nineteenth century, state institutions for the mentally ill and the physically handicapped as well as those for the feeble minded and the deaf came into existence. Additionally, many states founded juvenile reformatories and state orphanages. In the 1860's, many states enacted laws mandating the removal of children from county almhouses.

As described above, states became involved in public welfare at a time when institutionalization was the major mode of service. It should not be surprising, therefore, that much of state funding continues to fund institutions. For example,

in Massachusetts during FY83, $282 million is being spent on state hospitals for the mentally ill and state schools for the mentally retarded. This $282 million represents 25 pecent of the total amount that the Commonwealth has allocated for human services for the year.

In addition to financing institutions, the states funded major emergency relief efforts during the nineteenth century. The Civil War created enormous relief problems which could not be blamed on their victims, and hence governments and private charities showered assistance on the needy, temporarily reversing contemporary philosophy by providing direct public aid. Laws were enacted enabling localities to raise funds for the relief of sick, destitute and wounded soldiers and their families, and beginning in 1862, states in both the North and the South appropriated large amounts for relief (Trattner, 1979). The efforts of private citizens were also critical during the war. In 1861, volunteers organized the U.S. Sanitary Commission, the nation's first important public health group, to deal with the fifth, disease and lack of adequate medical personnel in the army camps and hospitals. Even the Federal government became involved in the war's emergency relief effort by creating the Bureau of Refugees, Freedmen and Abandoned Lands in 1865. The bureau was authorized to administer a program of temporary relief for the duration of the war and one year thereafter. Over President Andrew Johnson's veto, Congress extended the bureau for six years beyond the initial authorization.

The Civil War represents the exception rather than the rule of the nineteenth century. As Trattner notes, "The Freedman's Bureau showed that the Federal government could provide for the welfare of people on a broad scale when poverty and hardship could (or would) not be treated locally" (Trattner, 1979, p. 73).

However, the bureau was ahead of its time and atypical of Federal involvement in social welfare in the nineteenth century. On the private charity side, the idea that distress was an individual moral matter took hold once again after the war. Direct public aid given in force by the localities and states during the war was again considered distasteful.

Thus, trends in social welfare in the nineteenth century can be summed up as follows: Poverty continued to be considered a vice requiring moral correction. Care in state-financed institutions for distinct categories of the poor became the norm. This shift of responsibility for care to the higher level of government was prompted by the perceived inadequacy of both the county almshouse system, which provided no specialized care, and the physical conditions of the almshouses themselves. Despite the efforts of some reformers, the Federal Government, excepting temporary involvement during the Civil War and the creation of the National Board of Health in 1879, persistently denied having social welfare responsibility. It would take developments in the twentieth century for a substantial Federal social welfare role to emerge.

2.3 The Early Twentieth Century and the Emergence of the Federal Role

During the nineteenth century, the Federal government's role in social welfare had been minimal. In fact, in 1854, President Franklin Pierce had openly opposed any Federal responsibility for the poor by vetoing a bill, written by reformer Dorothy Dix, which would have appropriated 10 million acres of Federal land to the states to help pay for the construction and maintenance of mental hospitals. President Pierce argued that the bill was unconstitutional:

> If Congress has the power to make provision for the indigent insane, . . . it has the same power for the indigent who are not insane . . . I cannot find any authority in the Constitution for making the Federal Government the great almoner of public charity throughout the United States (Trattner, 1979, p. 59).

Pierce's veto was upheld, and Federal involvement in social welfare was slowed for many years.

The states, during the first three decades of the twentieth century, had moved gradually into the provision of direct public assistance to specific categories of the poor such as the blind, mothers, and the elderly, but appropriations for such relief prior to the Social Security Act of 1934 were small or nonexistent. In Government and Social Welfare, Vasey describes the inadequacies of state programs for special assistance, inadequacies which clearly indicated a need for a Federal role:

1) Only thirty of the fifty-one jurisdictions (states and territories) had legislation permitting or providing old age assistance;

2) Within this thirty, one third of the counties did not provide old age assistance;

3) In most of the counties where assistance was provided, the qualification requirements were highly restrictive, and lack of funds resulted in long waiting lists;

4) Forty-five states authorized aid to dependent children, but it was provided in less than half of the local units in these states; and

5) In the twenty-four states with laws for public pensions to the blind, only two-thirds of the counties participated in these programs (Vasey, 1958, p. 29).

What tipped the political balance in favor of a major Federal role in social welfare, however, was not the inadequacies of the state system of relief, but the national crisis of the Great Depression. Although a National Board of Health had been created in 1879 to deal with issues of public health, and the U.S. Children's Bureau had been created in 1912 to investigate problems of child welfare, the Federal government did not become involved in public welfare in any major way until the Great Depression. At the height of the Depression, in the spring of 1933, approximately fifteen million Americans were unemployed (ACIR, 1980). The massive relief problems and involuntary unemployment of that magnitude could not be handled by state efforts alone.

The problems of the Depression required a grand-scale solution. Proponents of bills to provide Federal relief "argued that the depression had resulted from a nationwide economic breakdown and, therefore, required a nationwide solution" (ACIR, 1980, p. 19). President Franklin D. Roosevelt's New Deal provided this nationwide solution. The Federal Emergency Relief Act of 1933 (FERAct), which made $500 million of Federal funds available to the states for emergency

unemployment relief, signified a new definition of the Federal role. President Roosevelt articulated this new definition during a 1934 speech:

> If, as our Constitution tells us, our Federal government was established among other things "to promote the general welfare," it is our plain duty to provide for that security upon which welfare depends (As quoted in ACIR, 1980, p. 23).

Numerous relief and jobs programs made up the New Deal. The Civilian Conservation Corps (C.C.C.) took thousands of unemployed young men off the streets and out of rural slums and put them to work on reforestation and flood and fire control. The Public Works Administration (P.W.A.) provided employment for millions of citizens in vast public works programs created to stimulate depressed industries, especially construction. The Works Progress Administration (W.P.A.) provided jobs for the unemployed, including artists, musicians and scholars. These were among the many measures taken which indicated Roosevelt's willingness to use Federal resources to battle the Depression and assist those in need through no fault of their own. The Social Security Act of 1935, an act which remains the basic Federal cash assistance law today, created nationwide old age insurance, unemployment insurance, three programs of categorical cash assistance (old age assistance, aid to dependent children and aid to the blind) and several programs of social and health services.

The Federal role emerged in response to a national crisis that the states were incapable of handling alone. The Advisory Commission on Intergovernmental Affairs observes that:

> Federal entrance into the realm of welfare had not been achieved by the "usual" series of increments. Rather, crisis and strong Presidential leadership had established a Federal welfare role in one giant step (ACIR, 1980, p. 26).

However, Federal involvement in social welfare since 1935 has to a great extent been characterized by incremental growth.

2.4 1936 to 1981 -- Incremental Growth of the Federal Role and the Changing Conception of Social Welfare

Between 1935 and 1960, most of the emergency relief programs initiated during the Depression were dismantled, leaving only the basic income maintenance programs (Morris, 1979). However, despite the fact that War and post-war economic expansion and growth in the gross national product created the belief that substantial government intervention was no longer necessary, expenditures for income maintenance programs remained high. Despite the growing affluence and prosperity in America, Congressional studies undertaken in the 1950's showed that many low-income families "had been left behind in the progress of America" (Trattner, 1979, p. 248). Writers in the late 1950s and early 1960s, such as John Kenneth Galbraith, Gabriel Kolko, Dwight McDonald and Michael Harrington, portrayed the persistence of mass poverty amidst abundance. As Trattner (1979) observes in his history of social welfare in America:

> The 1960 census figures provided scholars and writers with the raw material to factually discover or rediscover what the civil rights movement and the rising relief rolls already were beginning to indicate -- that the New Deal and World War II had not eradicted poverty, and it had not withered away (p. 251).

Poverty, it was realized, would not be obliterated by relying on market forces and income maintenance programs alone. In 1956, when Congress amended the Social Security Act to give statutory recognition to the provision of social services to families on relief, social services were for the first time defined as something different from the administration of the relief program. In matching local funds for the provisions of these services, the Federal government accepted the idea that personal social services beyond income provision merited Federal support (Morris,

1979). Further amendments to the Social Security Act in 1962 (the Public Welfare Amendments) increased the Federal share of funding for social services to 75 percent. These amendments indicated a shift toward the provision of preventive services. Morris (1979) writes:

> In a new departure, the staff was also to be used to prevent other vulnerable persons threatened with financial instability from becoming economically dependent. Unmarried persons, deserted families, families with adults potentially able to support themselves but currently not doing so, children with special problems, and the aged or disabled were cited as categories of persons justifying the attention of these newly sanctioned services. They were supposed to help parents improve home conditions, assume wider responsibility for the guidance of their children, and improve the management of their financial resources (p. 120).

The Great Society programs of the 1960s attempted to address the paradox of persistent mass poverty amidst abundance by using a "service strategy" rather than an "income strategy." In 1964, President Lyndon B. Johnson proclaimed a war on poverty to "strike at the causes, not just the consequences of poverty" (as quoted in ACIR, 1980, p. 52). Morris (1979) notes that:

> Underneath the rhetoric promising a campaign to abolish poverty lay an important shift in national policy, namely the move from subsistence to prevention . . .
>
> Job stimulation and cash relief were no longer seen as sufficient to reduce poverty and allow the market its old dominance. Deficits in education and in opportunity also had to be overcome by such short term programs. Therefore, government financing was expanded to include adult education, special employment programs, remedial planning, various child care programs designed to relieve parents and to start children early on constructive careers, migrant services, youth corps for out-of-school youths to condition them to employment, counseling services, work experience opportunities and the like (Morris, 1979, pp. 49-51).

The 1960s and 1970s were a period of growth in Federal funding for social welfare. Increases occurred in the areas of public assistance, employment, health and social services. The growth of public assistance expenditures was especially great. In 1960, total Federal public assistance grants to the states were just over $2 billion. By 1980, over $13 billion was being spent on Aid to Families with Dependent Children (AFDC) and Supplemental Security Income (SSI) (ACIR, 1981). In addition, the Food Stamps Program, which was non-existent in 1960, received an FY80 appropriation of $9.5 billion (Ibid.).

The Federal role in unemployment policy also grew during this period. Starting with the passage of the Area Redevelopment Act in 1961, the Federal government has created an array of economic development, public service jobs and employment training programs. Total federal outlays for these programs amounted to $25 billion in FY 1980 (Ibid.).

Federal involvement in health care also grew during the 1960s and 1970s. In addition to the Medicaid and Medicare programs in 1965, grant programs were enacted to train health professionals, support the development and operation of particular services such as primary, emergency, and mental health care, and to aid particular populations such as migrant workers, the mentally ill, and victims of black lung and hypertension. Public health also received attention, with general grants to the states for public health activites, and specific grants for immunization, flouridation, rodent control, and prevention of lead paint poisoning and venereal disease (Feder et al., 1982, p. 273).

In the area of social services, the Public Welfare Amendments of 1962 initiated a period of rapid growth in the financing of social services. Between 1967 and 1971, Federal funds made available under the 1962 amendments grew from $242 million to $776 million (Gutowski and Koshel, 1982). Between 1971 and 1972, they doubled to $1.688 billion. In 1972, a national ceiling of $2.5 billion for social service expenditures under this program was enacted, and in 1975, a social services block grant was created under Title XX of the Social Security Act, giving states more latitude in designing social services programs. The 1960s and 1970s saw the creation of several other major social services programs, including a number of community-based programs funded by the Office of Economic Opportunity and its successor, the Community Services Administration. In addition, the Older Americans Act of 1965 established a Federal financing mechanism for locally based social services and nutrition programs for the elderly. Although the 1970s saw the development of several new social services programs such as the ACTION Volunteer program (1973) and the Legal Services Corporation (1974), there was no corresponding growth of resources (Gutowski and Koshel, 1982). A modest decline in the real value of Federal support for social services between 1978 and 1981 preceded the more significant reductions under the Reagan Administration.

The Federal entry into social services funding in the 1960s and 1970s encouraged the expansion of state and local funding and provision of services. From 1951 to 1975, state and local government was one of the major growth sectors in the American economy (Peterson, 1982). Real spending by that sector grew in each of those years, even when adjusted for population growth (Peterson, 1982). In the early 1950s, school and highway construction led public spending by

state and local governments. During the 1960s, school operating costs were the main cause of state and local budget expansions. Through much of the 1970s, state and local government emerged as the administrative agents for carrying out Federal policy. State and local governments have become cost sharing partners with the Federal government for many programs. Thus, while the Federal government was the big spender in the human services arena of the 1960s and 1970s, state and local human services funding also grew significantly.

In the period between 1935 and 1981, the concept of what constitutes social welfare had changed in several ways. In Social Welfare: Charity to Justice, Romanyshyn (1971) writes of the changes that have accompanied our movement from a pre-industrial society characterized by economic scarcity toward a complex interdependent society.

> The transition of welfare in its charity role to the broader contemporary and more positive view may be seen on a continuum as a gradual movement from a residual to an institutional concept, evolving from the notion of gratuity to that of citizen right, from special programs for the poor to a concern with the universal needs of the population, from minimum to optimum provisions and services, from individual to social reform, from voluntary to public auspices, and from welfare for the poor to the concept of a welfare society (p. 34).

These changes in conceptions of social welfare imply a shift from subsistence activities to preventive activities. Implicit in the Romanyshyn quotation is the emphasis on development and optimizing of potential. In fact, the institutional view of welfare is sometimes called the developmental view (Romanyshyn, 1971). This view "is predicated on the assumption that a modern industrial society

requires a variety of services as first line supports to enable individuals to cope successfully with a changing economic and social environment and to assure the stability and development of social institutions" (Ibid., p.34). When the residual view of social welfare is used, an individual must be sick, poor or needy before he is served. The concept of prevention does not have a place in the residual view.

As American society grew more complex during the twentieth century, an institutional conception of social welfare began to replace the residual view. During this time, the Federal government became increasingly involved in funding human services, especially preventive services. The institutional conception of social welfare, with its emphasis on the social health of the society as a whole, necessitated a prominent Federal role in human services, because the Federal government alone had the authority and the wherewithal to achieve such comprehensive goals.

2.5 Reagan's Economic Recovery Program -- A Retreat to the Residual View of Social Welfare

While the quarter century preceding the Reagan Administration represents movement toward the insititutional conception of social welfare, the policies and Federal cutbacks under President Reagan represent a retreat to the residual view. The residual view "assumes that welfare programs exist to meet the emergency needs of individuals when they are incapable of providing for themselves through the normal institutions of the family and the market" (Romanyshyn, 1971, p. 4). In promulgating the residual view, the Reagan administration is rejecting the view that social welfare programs should attempt to meet the physical, social and psychological needs of total populations living in a complex society, and that long-term planning can prevent future wants.

Since assuming office in 1981, President Reagan has stressed several points with regard to the Federal role in social welfare. He has stressed the need for increased state and local involvement, the importance of the private sector, and the responsibility of society to the "truly needy."

During the Presidential campaign, Reagan argued that the policy partnership between state and local governments had gone awry, and during his 1982 State of the Union address and budget message, he reiterated this point:

> During the past twenty years, what had been a classic division of functions between the Federal Government and the States and localities has become a confused mess. Traditional understandings about the roles of each level of government have been violated (Peterson, 1982, p. 158).

The Reagan Administration has given priority to reversing the historical growth in Federal aid to states and localities while providing them with greater flexibility in spending Federal dollars. The administration has done this by consolidating categorical programs into block grants, and providing lower levels of funding for the block grants than had previously been available through the categorical programs. Peterson (1982) illustrates the depth of the transformation in state-local relations with the Federal government proposed by the Reagan administration:

> In 1980, Federal aid constituted almost 25 percent of state and local expenditures. If all of the administration's proposals were to come to fruition by 1991 -- a scant decade and a year later -- the Federal aid share in state and local budgets would be reduced to 3 to 4 percent (p. 159).

Peterson goes on to note that a disengagement of this scale involving grant cutbacks, program swaps and Federal withdrawal from shared funding arrangements "would not only reverse the last two decades of Federal intrusion into state and local affairs, which President Reagan lamented in his budget message, but would reduce the Federal role in state and local budgets to levels unknown since 1933" (p. 159). Others have also commented on the shift in state-local and Federal roles. For instance, a New York Times news analysis following Reagan's first year in office noted that a range of local, state and Federal authorities believe that a decline in the Federal role is likely to continue at least for the remainder of the Reagan term, and that state and local governments will be increasingly on their own as they were during most of the nation's history (Herbers, 1982, p. 1).

Another of the central goals of the Reagan Administration has been to reduce the role of government in American society and to increase reliance on private institutions to meet public needs. In January 1982, a major airplane crash in Washington caused President Reagan to invoke the heroic efforts of volunteer rescuers to exhort business and civic leaders to display the same "spirit of voluntarism" in finding private substitutes for government welfare programs (Raines, 1982, p. 1). It is interesting to note that President Reagan needed to point to voluntary giving during a crisis (the airplane crash) to exemplify the spirit of American voluntarism. The Reagan Administration believes that non-profit organizations, which provide many public goods and serve as the major vehicle through which private charitable resources and voluntary efforts are brought to bear on community problems, should inherit many of the functions from which government is pulling back. The administration feels that the expansion of government has weakened voluntary organizations and that a contraction of government will stimulate their rebirth (Salamon and Abramson, 1982). The same two basic elements judged necessary to revive the economy, budget cuts and tax cuts, are considered necessary to revive "the American spirit of voluntary service." It is argued that reducing Federal involvement in fields which used to be the exclusive preserve of private, non-profit institutions but into which the Federal government has inappropriately moved, will expand the opportunities for action on the part of the voluntary sector. The proposed tax cuts, it was believed, would provide the taxpayer with more money with which to make charitable contributions (Salamon and Abramson, 1982).

The Reagan Administration has consistently emphasized the notion of the "truly needy," a notion consistent with the residualist, minimalist view of social

welfare. The administration's major budget priorities for FY82 were to rebuild the nation's "defense capability," and to maintain the "social safety net" intended to protect the elderly, unemployed, poor and veterans. The major programs identified in the social safety net were Social Security, Medicare, basic unemployment benefits, SSI, AFDC, and veteran's income security and health care (Palmer and Mills, 1982). The principle of sparing these programs from any cuts which would affect the most needy was largely honored in the cuts originally specified but was less strictly observed in later proposals (Ibid.). Substantial cuts were proposed for those entitlement programs not in the safety net, particularly these newly added or greatly expanded during the 1970s. Cuts in such programs as Medicaid, food and nutrition, extended unemployment benefits, trade adjustment assistance and housing assistance were designed to "refocus benefits on the truly needy and retarget programs on their intended purposes" (Palmer and Mills, 1982, p. 71). In addition to preserving the social safety net and revising entitlements to eliminate unintended benefits, seven other guidelines served as rationales for specific cuts in the administration's Economic Recovery Program. These were: (1) reduce subsidies to middle and upper income groups, (2) recover allocable costs with user fees, (3) apply sound economic criteria to economic subsidy programs, (4) stretch out and retarget public sector capital investment programs, (5) consolidate categorical grant programs into block grants, (6) reduce Federal overhead, personnel costs, and program waste and inefficiencies, and (7) impose fiscal restraint on other programs of national interest such as arts, humanities, science and technology (Palmer and Mills, 1982). It was argued that cutting back school lunches, student aid, housing finance, and other programs which subsidize middle and upper income groups would "arrest what has heretofore been an unfortunate national drift toward universalization of social benefits" (as quoted in Palmer and

Mills, 1982, p. 71). Thus, the Federal cutbacks under the Reagan Administration clearly represent a philosophical shift from the preceding quarter century. The government's role is seen as one of providing assistance to needy individuals rather than one of seeing to the social welfare of society as a whole. This philosophical shift implies that emergency services will be emphasized and preventive services will be deemphasized. It implies that only when problems become crises, and not before, will action be taken.

2.6 Summary

The responsibility for social welfare has gradually shifted to the higher levels of government, moving from the counties to the states in the nineteenth century and from the states to the Federal government in the twentieth. The lower levels of government have not totally been relieved of responsibility for public welfare functions as the higher levels have assumed responsibility. In fact, lower levels of government have sometimes expanded their responsibilities as higher levels of government have entered the picture. Stein (1971) succinctly sums up the nature of these shifts in responsibility.

> (Localism) lent itself to transplantation to the American colonies. It took a long time for higher levels of government to enter the picture and frequently they did not displace the lower levels but shared costs and responsibilities with them . . . Each level tended to use the level below it, imposing standards on it and sharing costs. The need for higher levels came from the changing nature of poverty (p. 43).

Higher levels of government have become involved in social welfare because (1) crises such as the Civil War and the Great Depression posed relief problems that were beyond the resources of lower levels of government, and because (2) care provided at the lower levels of government was perceived as inadequate and/or inequitable. The current roles of each level of government can be traced to the method of care being emphasized when it got involved in funding human services. For example, state governments, which remain heavily involved in institutional care, entered the human services picture at a time when institutions for specific populations were the mode. The beginning of major Federal involvement in human services occurred during the Depression, when income support programs for specific categories of poor persons were increasingly viewed as an important social

welfare tool. The significant expansion of the Federal role during the 1960s was accompanied by a broadening of the concept of social welfare to the institutional view, which calls for a full range of services, including preventive services. Thus, 1981 found the Federal government funding many of the available preventive services. The cutbacks initiated by the Reagan Administration represent a retreat to the residual view of social welfare. As shown in the following chapter, these cutbacks strongly affected preventive services.

CHAPTER III
Analysis

3.0 Introduction

This chapter is divided into two sections: (1) a discussion of human services budget changes, and (2) illustration of trends reflected in the case studies. In the course of these sections, I show that there have been disproportionate cuts in preventive services, and that the "differential funding" thesis presented in the first chapter is a reasonable partial explanation of why preventive services have suffered compared to emergency services. In other words, I attempt to show that one of the reasons why preventive human services in Massachusetts have been cut more than emergency services is that preventive services, in general, are funded by those levels of government (Federal and municipal) which have experienced the more significant budgetary cutbacks.

3.1 Human Services Budget Changes

The main purpose of this section is to show that Federal funding for domestic human services programs declined, while overall state funding for human service programs was maintained during the FY81 to FY83 period. Information about Federal human services cutbacks was obtained through newspaper articles, while information about state funding for the Commonwealth's departments that provide human services was available in the draft of a state overview written for the Impact 2½ Monitoring Project Human Services Study (Strain, Note 6). Changes in overall municipal funding for human services are not examined, because aggregate data concerning local human services expenditures are not readily available.

Table 2 shows the changes in state budget appropriations for Massachusetts departments which provide human services. In FY82, in the human services area, "the budget hit AFDC most heavily, attempted to trim the administrative structure of the Department of Mental Health, and provided no cost of living for human service providers" (Strain, Note 6, p. 6). The FY83 budget

> took measures to replace funding expected to be lost at the Federal level in various community health programs including maternal and child health programs and flu vaccine, made further attempts to control administrative costs in the Department of Mental Health, provided monies to help offset the cost of inflation to daycare providers and mental health and retardation direct service workers, and provided increases for additional services in the Division of Youth Services and Department of Corrections (Strain, Note 6, p. 7).

As shown in the bottom two lines in Table 2, overall state funding for human services in real dollars was cut only slightly during the FY81 to FY83 period. Total

TABLE 2
Changes in State Budget Appropriations[a] (in millions)

DEPARTMENT	FY1981	FY1982	% change FY81-FY82	FY81-FY83	% change FY81-FY83
Executive Office of Human Services (EOHS)	1.45	1.28	-15%	6.61[b]	+355%
Department of Social Services (DSS)	184.71	192.14	+4%	197.00	+7%
Department of Mental Health (DMH)	444.75	484.85	+9%	509.17	+14%
Department of Public Health (DPH)	105.18	100.56	-4%	117.07	+11%
Division of Youth Services (DYS)	26.24	26.99	+3%	30.57	+16%
Department of Corrections (DOC)	65.75	76.08	+16%	96.35	+46%
Office for Children (OFC)	5.90	5.06	-14%	4.98	-15%
Massachusetts Commission for the Blind (MCB)	20.38	34.36	+13%	36.86	+21%
Massachusetts Rehabilitation Commission (MRC)	8.65	8.18	-5%	5.25	-39%
Executive Office of Elder Affairs	62.58	72.82	+16%	78.04	+25%
Department of Education: Special Education	26.90	25.49	-5%	29.66	+10%
Total Human Services funding	962.49	1027.76	+7%	1111.56	+15%
Total Human Services funding without DOC	896.74	951.68	+6%	1015.21	+13%

a. Figures based on Executive Budget Recommendations for FY83 and Senate Ways and Means, No. 1900.

b. Increase in EOHS can be attributed to the transfer of the Office of State Health Planning (OSHP) from DPH in 1982, a reserve of $500,000 for children otherwise ineligible for EOHS services, $1,200,000 in cost of living increases for staff in mental retardation, and $1,500,000 for direct care staff in mental health and retardation.

Source: J. Strain, 1982 draft report.

state human services funding increased in nominal terms by 15 percent (from $962,490,000 in FY81 to $1,111,560,000 in FY83. Some of the increase can be attributed to growth in Department of Corrections (DOC). However, even excluding the DOC from the calculations, one finds that nominal state human services funding increased by 13 percent from $896,740,000 in FY81 to $1,015,210,000 in FY83. (See last line of Table 2.) Three things are important to remember in this context. First, costs of human services increased by more than 13 percent between FY81 and FY83, so that even an increase in nominal funding for state human services represents a decrease in real funding. Second, some of the increases during FY83 were intended to replace expected Federal losses. Third, the overall increase in state human services funding was not distributed evenly across departments. Thus, the Massachusetts Rehabilitation Commission and the Office for Children experienced cutbacks (39 percent and 15 percent respectively), while the other departments experienced increases ranging from 7 percent (at the Department of Social Services) to 25 percent (at the Department of Elder Affairs). The Department of Corrections funding increased 46 percent during the two-year period. The state budget process has an effect on the distribution of human services across the continuum of prevention to emergency services. For example, money allocated to the Department of Public Health (DPH) will most likely be spent on preventive services since that is the focus of the DPH. The complexities of the state budget process, however, are beyond the scope of this thesis.

While real state funding for human services was declining only slightly, real Federal funding for human services programs declined dramatically. As John Herbers notes in a New York Times article:

> In his first year, Mr. Reagan succeeded in trimming the role of the Federal establishment more than many of his critics thought was likely or possible. He did it primarily by bringing about deep cuts in social and urban development programs that had been enacted over the previous half century in Democratic and Republican administrations (Herbers, 1982).

For FY82 Congress left the big programs such as Medicaid intact, though at reduced levels, and consolidated 57 programs in welfare, community development, health and education into nine block grants, also at reduced levels (Herbers, 1982). Table 3 (Camayd-Freixas, 1982, p. 12) shows the changes in Federal appropriations for entitlement programs and basic services between FY81 and FY82. Here again, the bottom line is critical. For FY82 overall funding for these services and programs fell $18.533 billion or 19 percent from $96.909 billion to $78.533 billion. Examples of major cuts in preventive services include CETA (60 percent reduction), Health Planning (50 percent reduction), Community Services Administration (33 percent reduction), Child Nutrition (31 percent reduction), Community Health (22 percent reduction) and Preventive Health (16 percent reduction).

The reduction in Federal funding for human services is quite large when contrasted with the slight increase in Massachusetts funding for human services. At the community level, Federal cutbacks have been strongly felt. In the case study communities, CETA cutbacks and reductions in funding for the antipoverty agencies (Community Services Administration funding) were particularly significant. The CETA cutbacks affected community agencies at two levels. At one level, the CETA cutbacks caused an actual reduction in employment services available to community residents. At a second level, since many non-profit

TABLE 3
Changes in Appropriations:
Entitlement Programs and Basic Services (in billions)

PROGRAMS	FY1981	FY1982	CHANGES
AGRICULTURE AND NUTRITION			
Food Stamps	11.5	10.3	-$1.200,-10%
Child Nutrition	1.6	1.1	-$0.500,-31%
Food for Peace	1.2	1.0	-$0.200,-18%
Women, Infants and Children	0.9	0.9	no change
EDUCATION			
Title I	3.12	2.82	-$0.300,- 7%
Handicapped	0.874	0.931	+$0.057,+ 7%
Bilingual	0.161	0.138	-$0.023,-14%
Federal Impact Aid	0.757	0.437	-$0.320,-42%
Student Financial Aid	3.801	3.351	-$0.450,-11%
Student Loan Subsidy	1.631	1.131	-$0.500.-30%
HEALTH AND HUMAN SERVICES			
Title XX	2.99	2.4	-$0.590,-19%
Community Health	1.02	0.788	-$0.232,-22%
Community Services Administration	0.525	0.348	-$0.177,-33%
Preventive Health	0.338	0.284	-$0.054,-16%
Health Planning	0.126	0.062	-$0.064,-51%
Head Start	0.818	0.912	+$0.094,+11%
HOUSING AND COMMUNITY DEVELOPMENT			
New Public Housing	24.9	17.3	-$7.600,-30%
Operating Subsidies	1.07	1.16	+$0.090,+ 7%
Community Development Block Grants	3.69	3.46	-$0.230,- 6%
Urban Development Action Grants	0.68	0.5	-$0.180,-34%
LABOR			
CETA	7.6	3.2	-$4.400,-60%
Trade Adjustment	1.66	0.238	-$1.422,-85%
Occupational Safety and Health Administration	0.13	0.111	-$0.019,-14%
Mine and Health Safety Administration	0.098	0.092	-$0.006,- 6%
WELFARE, MEDICAID, AND INCOME ASSISTANCE			
Aid to Families with Dependent Children	7.29	6.39	-$0.900,-12%
Medicaid Grants	16.58	17.43	+$0.850,+ 5%
Low-income Fuel Assistance	1.85	1.75	-$0.100,- 5%
TOTALS (in billions)	96.909	78.533	-$18.376,-19%

Source of data: Rogers et al., 1982.
Table reprinted from Camayd-Freixas, 1982, p. 12.

agencies used CETA workers, the cutbacks also caused a reduction in staff in those agencies. When assessing the impact of Federal, state and municipal cutbacks on human services in the nine communities, the Federal cutbacks seemed to be major. This finding is consistent with the facts presented above: that real Federal funding for human services has been cut drastically while Massachusetts funding for human services has declined only slightly, certainly not compensating for Federal cuts. Programs funded by the Federal government and the municipalities have therefore, on the whole, fared less well than those funded by the state.

The discussion above is not meant to imply that state-funded programs and agencies have not had their share of financial worries, but rather, that these worries have generally not been caused by budget cutbacks. Many of the financial concerns of state-funded programs uncovered in the case studies were due to bureaucratic or philosophical factors rather than dollar cuts. Some examples of these problems are presented below:

(1) The Commonwealth of Massachusetts shifted many daycare openings from preschool to after-school slots in order to provide women in the Work and Training Program with daycare. The shift occurred suddenly and left many daycare centers with unfilled slots and financial problems.

(2) The Department of Social Services (DSS), in an effort to provide care in the least restrictive setting for its clients, has been referring fewer clients to group homes. The group homes operate on a closed referral system, receiving referrals only from state agencies. The rate set by the Massachusetts Rate Setting Commission is based on 85% occupancy.

(3) A detoxification center is unable to receive more slots from the Department of Public Health, Division of Alcoholism, even though its occupancy rate has increased, and the agency is serving more clients.

(4) A halfway house for alcoholics where the clients do not work is unable to get a higher daily rate than a traditional halfway house where clients work and are able to pay rent.

The financial difficulties encountered by the directors of state-funded programs have largely been caused by factors other than funding cutbacks. The fact that programs funded by the state have fared better than those funded by the Federal government and the municipalities still holds. This fact will be explored further in the discussion concerning the case studies.

3.2 What the Case Studies Show

This section will use case study material to show that preventive services have been cut more than emergency services, that different levels of government fund different kinds of services, and that Federally and municipally funded programs have been cut more than state and privately funded programs. The section will be divided into four subsections. The first will deal with Quincy data (Freilich, Note 3). The next two will deal with Jamaica Plain elderly services and Jamaica Plain youth services respectively (Freilich, Note 2). The final subsection will discuss supporting material from the other case studies. The subsections describe general conclusions from the case studies, and present the summary tables that were derived according to the methodology presented in Chapter I.

3.2.1 Quincy

Quincy, with a 1980 population of 84,743, is the largest community on Boston's South Shore. The fact that has dominated the human services picture between 1980 and 1982 in Quincy is growing unemployment, which has created new demands on social service agencies in the area. According to Massachusetts Division of Employment Security (DES) statistics, unemployment in Quincy rose from 5.2 percent in 1980 to 7.1 percent in 1982. (DES figures are annual averages of monthly rates.) The unemployment picture in Quincy has especially affected the demand for services at agencies providing emergency services. Agencies such as Quincy Community Action (the local antipoverty agency) and the Salvation Army have encountered increased demand for their services. The Salvation Army is finding that even "middle class" households are now in need of help. For many agencies in Quincy, therefore, the increased demand for services is more noticeable than dollar cutbacks. Even without cutbacks, when an agency is experiencing greater demand for its services, it has fewer dollars with which to serve each client. In agencies where cutbacks have been made, emergency services have survived. In the area of mental health services, for example, emergency services have been maintained at the expense of other mental health services.

In Quincy, the best example of preventive services being cut more than emergency services is the South Shore Mental Health Center. (See Table 4.) The agency's Child Outreach Team, which provides emergency psychiatric services to children and adolescents, was not cut. In fact, DMH added a case management component to this program for FY83. Similarly, the agency's adult emergency psychiatric services have been maintained. The agency consolidated administration of the Continuing Treatment Program and the Crisis Intervention Team but

TABLE 4
South Shore Mental Health Center--Changes in Funding and Services

Agency	Program	Type of Service	Target Population	Who Funds	Comments about cuts
South Shore Mental Health Center					Overall agency revenues fell 12.8% from $4,700,000 in FY82 to $4,100,000 in FY83.
	Early intervention program	early intervention	high risk children	DMH	Not Cut.
	Developmental daycare	daycare	special needs children	local school systems	Not cut.
	Respite care program	respite care	special needs children	DMH	Not cut.
	Mission Possible	counseling	court involved youth and their families	Mass. Commission on Criminal Justice (MCCJ)	MCCJ funding cut 45% from $110,000 in FY81 to $60,000 in FY82.
	Randolph Coop	counseling, case management, emergency services	Randolph high school students	Randolph School Dept.	Not cut.
	Child and Family clinic	counseling	children and their families	DMH	Service reduced in FY82.
	School Consultation Program	consultation/ education	special needs children	local school systems	50% reduction in funds from Quincy School Dept.

(table continued)

TABLE 4 (continued)

Agency	Program	Type of Service	Target Population	Who Funds	Comments about cuts
South Shore Mental Health Center (cont'd.)	Child Outreach Program	emergency psychiatric	children and adolescents	DMH and third party payments	Not cut. DMH added a case management component for FY83.
	MR Services	counseling, case management, OT, PT	mentally retarded	DMH	$149,000 budget has remained relatively stable.
	Milton Satellite Program	child and family services	all ages	Federal operations grant	$75,000 program eliminated in FY82.
	Manet Community Health Center Satellite	child and family services	all ages	Federal operations grant	$20,000 program eliminated in FY82.
	Germantown service worker	outreach	Germantown residents	CDBG	$18,000 cut eliminated this service in FY82.
	Adult outpatient	counseling	adults	DMH	17% cut from $450,000 in FY82 to $375,000 in FY83.
	Residential services	residential	adults	DMH	Level funded at $750,000 but services reduced due to inflation. Closed one eight-bed program.
	Continuing Treatment & Crisis Intervention Team	emergency psychiatric	adults	DMH	Modest increase in funding, Consolidation of administration.

experienced modest increases in funding for the two programs. At the same time that adult and children's emergency services were being maintained and enhanced, non-emergency services were being cut. The Milton Satellite Program, a $75,000 program providing child and family services, was closed in FY82. Due to cuts in funding, the South Shore Mental Health Center also found it necessary to eliminate child and family services provided at the Manet Community Health Center, eliminate the outreach worker serving the Germantown neighborhood, reduce adult outpatient counseling ervices, abandon plans to open a satellite office in Randolph, discontinue an apartment program for adults in Quincy, and close an eight-bed residence for the chronically mentally ill. Consultation/education services to the local school departments have also been reduced as a result of municipal funding cutbacks. It should be pointed out that the mental health center had some discretion in deciding which services to cut as a result of the loss of the Federal operations grant. The director of the center worked with personnel from the area office of DMH to establish service priorities.

Another clear example of a preventive kind of service being cut is the South Shore Council on Alcoholism's Family Alcoholism Counseling and Education (FACE) program, which was eliminated in FY82. This eight year old program, funded by the Department of Mental Health (DMH), had provided services to children and spouses of alcoholics. The idea of helping a person deal with and understand another person's problem is preventive, and the loss of this program thus represents a loss of a service on the preventive side of the scale.

The South Shore Mental Health Center (SSMHC) also provides evidence that the actual cutbacks have been in Federal and municipal funding rather than in state funding. Due to the loss of its Federal operations grant, the agency's total

revenues fell from $4.7 million in FY82 to $4.1 million in FY83. The Germantown service worker was eliminated because of a cut in Federal CDBG funds. Over the past few years, the center has received a 50 percent reduction in funds from the Quincy school Department for consultation/education services. While the mental health center's state funding has not been reduced, neither has it been increased to make up for Federal and municipal losses.

Summary Table 5 shows two things, that prevention services have been cut more than emergency services, and that the different levels of government and the private sector have different roles in funding human services. The tables, from which summary Table 5 and the remaining tables in this chapter were derived, may be found in the Appendix. In relation to prevention being cut more than emergency services, the D's (decreased) on Table 5 tend to fall on the top half of the page while the S's (stable) and I's (increased) tend to fall on the lower half of the page. In particular education, consultation/education, and recreation, (preventive services) all faced cutbacks. Federal Department of Energy funding for emergency fuel assistance, state Department of Elder Affairs funding for crisis intervention assistance, and state Department of Public Health funding for a drug crisis hotline also were cut despite being intended for emergency services. Since one of the selected areas of study for the Quincy case was emergency services, it is not surprising to find some examples of cuts in energency services in Quincy. However, it should be reemphasized that, in Quincy, the increased demand for emergency services stood out more prominently than dollar cutbacks in funding for such services.

Stable programs which received little change in funding between FY81 and FY83 included an emergency shelter for teenagers, residential care, respite care,

TABLE 5

Quincy Human Services

	Kind of Service	Who funds?	Funding Decreased, Increased or Stable
PROACTIVE PREVENTIVE SERVICES	Recreation	Municipal Private	D
	Education	Municipal State	D
	Advocacy (housing)	Federal	D
	Consultation/Education	Municipal	D
	Weatherization	Federal	S
	Income Support	Federal	D
	Counseling	State Private	D
	Outreach	Federal State	D I
	Daycare	Federal State	I S
	Residential	State	S
	Respite Care	State	S
	Detoxification	State	S
	Crisis hotline	State	S
	Emergency cash assistance	Private Federal	S D
REACTIVE EMERGENCY SERVICES	Emergency Shelter	State Private	S
	Emergency Psychiatric	State	I

detoxification, daycare, and a weatherization program. These services fall mainly in the category of secondary and tertiary prevention and, with the exception of weatherization, none can clearly qualify as programs of primary prevention. Only three programs investigated in Quincy received increased funding. Survival, Inc., received funding from DMH to start a new outreach program for deinsitutionalized adults, DMH added a case management component to the emergency psychiatric services for children and adolescents at the South Shore Mental Health Center, and the Federal government increased its funding for the Headstart program run by the Quincy Community Action Organization. With the exception of the Headstart program, which has been spared by Federal cutbacks, the programs with increased funding fall squarely on the emergency side of the prevention to emergency continuum.

Table 5 also helps to illustrate that municipal, state, and Federal governments and the private sector have different roles in the funding of human services. The question of where state and municipal funding originally comes from makes this observation a little less firm than the one concerning heavier cuts in preventive services. Nevertheless, it is fair to note that there is not much overlap between what the state, the Federal government, and the city of Quincy fund, that the private sector funds many of the emergency services (food, clothing, shelter, emergency fuel assistance) in Quincy, that the state tends to fund secondary and tertiary prevention services including emergency psychiatric services, and that preventive services, such as recreation, consultation/education, and weatherization, tend to be funded by the City of Quincy or the Federal government.

Table 6 shows that Federally and municipally funded services have been cut more often than state funded services. The municipal column on the table shows only decreases in funding, the Federal column mainly reflects decreases in funding, while the state column is much more balanced, with decreases, increases and level funding.

TABLE 6

Summary of Kinds of Service by Governmental Funding Source

What has happened between FY81 and FY83?

Quincy

Municipal		State		Federal	
Kind of Service	Funding Increased, Decreased or Stable	Kind of Service	Funding Increased, Decreased or Stable	Kind of Service	Funding Increased, Decreased or Stable
Recreation (Council on Aging, Youth Commission)	D	Counseling	D	Income Support	D
		Emergency Cash Assistance	D	Outreach	D
		Education	D	Emergency Cash Assistance	D
		Crisis Hotline	D		
		Emergency Shelter	S		
Consultation/ Education	D	Residential	S	Advocacy (housing)	D
Special Education Support Staff	D	Respite Care	S	Weatherization	S
		Detoxification	S	Headstart	I
		Outreach	I		
		Emergency Psychiatric	I		

3.2.2 Jamaica Plain

Jamaica Plain, an urban neighborhood with a 1980 population of 39,441, is home to 7.0 percent of the City of Boston's population. The neighborhood is extremely heterogeneous with respect to age, income, race, and national origin. Approximately 20 percent of the population is Black, and 30 percent is Hispanic. The elderly (65 years of age and over) represent 14.4 percent of the areas total population. Youth also are a sizable group in Jamaica Plain. Currently, youth aged 11 to 20 comprise 12 percent, and those under 21 comprise 30 percent of the community's population. (Lichtenstein, 1982). Elderly and youth were the target populations investigated in the Jamaica Plain case study, since both were large groups which had suffered losses in human services funding.

Jamaica Plain Elderly Services

The section of the Jamaica Plain case study on impacts of cutbacks on elderly services draws several general conclusions. The study found the major reductions in funding to be in the areas of cultural/recreational and mental health services for the elderly. It also observed some reductions in transportation, information and referral, nutrition and legal services for this population. Additionally, cutbacks in general municipal services such as libraries, parks, school programs, police and fire, as well as Federal cutbacks for such general programs as public transportation, legal services, antipoverty agencies, and Community Development Black Grants (CDBG) were described as having a disproportionate effect on the elderly. At the same time, homemaker services, which are funded by the state and administered by its network of homecare corporations, were found to have survived relatively well.

Cuts in preventive services formed a large part of the picture in Jamaica Plain. Cutbacks in recreation and socialization services were most noticeable. The Mayor's Commission on Elder Affairs was forced to cut back funding for several such services when the City's contribution to the Commission's budget was cut from $2.1 million in FY81 to 1.7 million in FY82. This reduction affected the Commission's funding for recreation and socialization programs as follows:

1. The Commission is still involved in helping the 200 senior clubs throughout the city, but the emphasis of this assistance has narrowed. Whereas the commission used to pay for trips and entertainment for the clubs, it is now involved primarily in program development, technical assistance and cost sharing activities. Seniors now have to pay for many of the trips that were previously free.

2. The Elder Arts Program has been reduced, and its format changed. Instead of using professional performers and teachers, the program now relies on older performers on a volunteer basis.

3. The Special Trips Program, which provided free day trips for groups of seniors, has been eliminated. However, the Commission continues to provide some cost sharing for special trips.

The Council of Elders, Inc., a large private non-profit agency serving seniors in an area which includes Jamaica Plain, also reduced its funding for recreation services due to a cutback in Federal CDBG funds. The Council's Enrichment Services Program was cut 40 percent in FY82, causing reductions in staff, clients, and activities. One victim of this cut ws an activities program for the elderly run by the Boston Indian Council (BIC), a Jamaica Plain agency serving Native Americans of all ages including the elderly. Only a very small percentage of BIC's clientele will go to other agencies for activity programs since many of the older Native Americans speak only their native languages.

Preventive mental health services for the elderly were also affected by cutbacks. The Massachusetts Mental Health Center's Positive Aging Services Program budget fell from about $500,000 in FY80 to about $200,000 in FY83. These losses have come from losses of Federal National Institute of Mental Health (NIMH) training money, the loss of a $200,000 Federal Administration on Aging (AoA) grant for the development of a comprehensive assessment and resource center, and losses of two of its three state contracts and 4½ of its ten state-funded positions. The Positive Aging Services Program ran several programs that can be considered preventive in nature. The AoA-funded resource center is a case in point. The AoA grant funded work which brought together the two homecare corporations in the catchment area, the Council of Elders, and ten nursing homes,

and developed a methodology and training program for case management for the elderly. Although selected as one of five national exemplary models, the project grant was not renewed in February, 1982. The resource center involved the coordination of many agencies in the planning and delivery of case management services.

The resource center was not the only program that the Positive Aging Services Program was forced to eliminate; a psycho-geriatric day treatment program, which served to prevent institutionalization, was also eliminated. This program served twenty-five persons a day with a staff of five. The program staff worked intensively with severely ill institutionalized patients. After about six months of treatment, these patients had generally moved on to nursing homes or other community residential placements. In the wake of funding cutbacks, the geriatric day treatment program was consolidated with a quarterway all age program at the Massachusetts Mental Health Center. All five staff members of the geriatric day treatment program left the center. Many of the program patients have stopped coming, some have had to be rehospitalized full-time, some have become sicker mentally and physically, and the patients remaining are no longer getting the same care and services. In other words, deprived of a well planned accessible program targeted to their special needs, clients face preventable illness and institutionalization.

In addition to eliminating the day treatment program and the comprehensive assessment and resource center, the Positive Aging Services Program has had to reduce its consultation/education services to other agencies. Thus, the program's ability to provide preventive services has been reduced, and it is increasingly forced to react to crisis situations.

Information, referral and advocacy provided by neighborhood senior service workers at the Little City Hall have also been reduced due to the city cutback of funds for the Mayor's Commission on Affairs of the Elderly. Boston's Little City Halls were closed after the passage of Proposition 2½. Each Little City Hall had a neighborhood Senior Service Coordinator, whose job it was to make senior shuttle reservations, arrange special trips, and help neighborhood seniors in dealing with service agencies. With the closing of the Little City Halls, the Neighborhood Senior Service Coordinator Program was merged with the Community Field Services Program, and one Commission employee now handles two neighborhoods. Thus, neighborhood service staff work provided by the Commission has been reduced to less than half of its previous level.

While the above examples and Table 7 show that cuts have been made in preventive services for the elderly in Jamaica Plain, what has happened to emergency services is not clear from the available data. Since the Jamaica Plain community case study looked specifically at elderly services and youth services (age-specific services), cuts or increases in funding for emergency services (non-age specific services) were not uncovered. General information obtained for the overview section of the case study did reflect a growing demand for emergency services in Jamaica Plain, as in Quincy. The Jamaica Plain Area Planning Action Acouncil (APAC) received increased requests for emergency assistance during FY82. The need for emergency food has grown to the point where the APAC has applied to five foundations for money to establish an emergency food pantry in Jamaica Plain. The APAC is also currently putting out a directory of emergency food pantries in Boston. Thus, demand for emergency services is growing, and there is at least some evidence that agencies are responding to this new, immediate demand. Despite the fact that Table 7 does not provide information

TABLE 7

Jamaica Plain Elderly Services

	Kind of Service	Who funds?	Funding Decreased, Increased or Stable
PROACTIVE PREVENTIVE SERVICES	Education/Training	Federal	D
	Recreation	Municipal Federal	D
	Advocacy	Municipal	D
	Health Promotion	Municipal	S
	Nutrition	Federal	D
	Consultation	State	D
	Information and referral	Municipal	D
	Transportation	Municipal Federal	S D
	Conservator-Guardianship	Federal	S
	Other Support	Federal Municipal	D
REACTIVE EMERGENCY SERVICES	Homecare	State	S
	Daycare	State	D
	Counseling	State	S
	Protective Services	State	S

about emergency services (as defined for this thesis), it does provide information about the funding pattern of services and about which services have been cut.

The services in Table 7 are arranged along the continuum of proactive primary prevention to reactive emergency services. Funding for such clearly preventive services as recreation, education, and advocacy has been reduced. The D's on Table 7, which signify decreases in funding, fall mainly in the upper half of the table, while greater stability (more S's) is reflected further down along the service continuum. Elderly services that were cut include recreation (social clubs, trips, Elder-Arts program), support (mobile-market, Identi-Guard Program, Visiting Aides, Home Repair), transportation (Title III-B), information and referral (senior service workers, Boston Seniority, Service Directory for Older Bostonians), advocacy (senior service workers), education (NIMH training grants), consultation (Positive Aging Services Program) and nutrition. Jamaica Plain elderly services that were not cut include health promotion (annual hearing and eye examinations), counseling, protective services, homecare and transportation (Senior Shuttle). The study did not uncover any increases in funding for elderly services. Thus, the available information follows the basic pattern; more preventive services are cut more than the less preventive services.

Table 8 shows a division between what the state, the Federal government and the City of Boston fund. City money mainly goes for recreation, transportation, information and referral, and health promotion services. Federal money for elderly services (Title III of the Older Americans Act) goes for congregate nutrition sites, home delivered meals, transportation to nutrition sites, in-home services, and legal services. In Massachusetts, state funding for elderly services flows through the

TABLE 8

Summary of Kinds of Service by Governmental Funding Source

What has happened between FY81 and FY83?

Jamaica Plain Elderly

Municipal		State		Federal	
Kind of Service	Funding Increased, Decreased or Stable	Kind of Service	Funding Increased, Decreased or Stable	Kind of Service	Funding Increased, Decreased or Stable
Recreation	D	Day treatment	D	Recreation	D
Support	D	Consultation/ Education	D	Education/ Training	D
Information & Referral	D	Counseling	S	Support	D
Advocacy	D	Protective Services	S	Nutrition	D
Economic	S	Homecare	S	Transportation	D
Health Promotion	S			Conservator-Guardianship	S
Transportation	S				

homecare corporations for case management and homemaker services. The Commonwealth of Massachusetts is unique in this respect; many other states use Federal Title III dollars for homecare services as well as all other elderly services that they provide. Homecare, while not primary prevention, seeks to limit the impact of illness and prevent or delay institutionalization by providing services in the home. In Massachusetts, homecare is funded by the state, and therefore has not been cut back. This fits the pattern that state-funded services have been less subject to funding reductions than have Federally and municipally funded programs. This pattern is supported by the information in Table 8; the Federal and municipal columns show more decreases in funding.

Jamaica Plain Youth Services

The case study uncovered many cutbacks in services for Jamaica Plain Youth. Reductions in employment and recreation services were particularly severe. Additionally, cutbacks in funding to the neighborhood's health centers were found to have had an impact on youth because a large proportion of the centers' clienteles are young. The case study also noted a decline in the amount of residential care in the neighborhood due to lack of sufficient referrals from DSS.

Federal CETA cuts caused a twenty to forty percent reduction in the number of summer jobs for Jamaica Plain youth for 1982 and the elimination of the Neighborhood Employment Center's (NEC) in-school work program for FY83. The city Neighborhood Development and Employment Agency's (NDEA) youth funds were reduced from $12 million in FY81 to $0.4 million in FY82. NDEA supplemented this funding with Title II money and spent a total of $1.3 million for youth services in FY82. In Jamaica Plain, the NEC's budget fell by almost 50 percent to a FY82 level of $55,000, and the staff was cut from six full-time equivalents to three. Bendick (1982) describes the preventive nature of youth employment services:

> If a young person fails to make a good initial connection with the labor market, a vicious cycle may be set in motion. He or she may develop bad work attitudes and habits, as well as a poor work record, and become increasingly unemployable. Improved initial labor market experiences may therefore have a high payoff throughout the adult years. In addition, providing employment opportunities to that group is sometimes seen as a way to reduce street crime and social unrest (p. 250).

Employment services for Boston youth are clearly preventive, and the cuts in these services were severe.

Recreation, another preventive service, was also hit hard by cutbacks. Neighborhood House, a small non-profit agency, eliminated its youth recreation program. The effect of this cut was compounded by a reduction of the city of Boston's Parks and Recreation Department to about fifty percent of its former size, elimination of after-school recreational activities aside from regular competitive sports at Jamaica Plain public schools, and cutbacks in recreational programming at Jamaica Plain's Community Schools. The Community Schools reduced their programming (for all ages) at each of three sites from forty hours per week to twenty-five. Reductions in programming were particularly severe for youth. The Agassiz Community School reduced its teen programs from four nights a week to one. Structured recreational activities for two hundred teens at Jamaica Plain High were lost, as was the entire adult and teen recreational program at the Agassiz School.

Health promotion services for youth were also affected by cutbacks. In calendar year 1981, the Martha Eliot Health Center, which serves a predominantly Hispanic population, experienced three waves of reductions, which reduced the staff from 65 to 45 full time equivalents (FTEs). In 1982, four more FTEs were eliminated. In FY82, the health center provided physician time (6 hours per week) to five Boston schools, but this program was eliminated in FY83. Children's Hospital will be sending an intern, so needs will continue to be identified. However, the director of Martha Eliot noted that since the health center provides a range of services, an estimated five to fifteen children per year will not receive the prolonged follow-up care that they would get if the health center were able to continue its school physician program. Additionally, the ability of the health

center to provide follow-up outreach and coordination with other agencies has been hampered by cutbacks in its own and other agencies' funding. The increasing need to focus on revenue generating activities was stressed by the director.

Brookside Park Family Life Center has had similar difficulties to those of the Martha Eliot Health Center. A cap on expenditures imposed by Brigham and Women's Hospital (Brookside's licensing body) for FY83, the loss of a $155,000 Federal Section 330 grant, and other cuts in some of the health center's smaller grants resulted in Brookside's projected FY83 budget ($2.0 million) being about 10 percent lower than FY82's budget. Due to these cuts, Brookside lost about ten of its approximately sixty FTEs during FY82.

The effect of these cutbacks on preventive services is well exemplified in Brookside's Family Services Department. This department, with four components (educational, social services, mental health, and speech threapy), has lost many positions over the past three years. The educational component, which provides advocacy, screening, testing and core evaluation work, has gone from 2.5 FTEs three years ago to 0.5 FTEs. The Social Services component has been reduced to ten percent of its former size from 5 FTEs to 0.5 FTEs. The social services workers used to see every family that registered at Brookside. Now, they take on new cases only when a problem arises.

Table 9 shows which kinds of services have been cut. The increases in daycare and counseling represent increases in Department of Social Services (DSS) funding to the Community Schools. Since not all agencies providing daycare and counseling were studied, the table does not prove that there was an increase in

TABLE 9

Jamaica Plain Youth Services

PROACTIVE PREVENTIVE SERVICES

Kind of Service	Who funds?	Funding Decreased, Increased or Stable
Recreation	Municipal	D
	Federal	D
	Private	S
Health Promotion	Municipal	D
	Federal	D
	Private Insurance/Fees	I
Employment	Federal	D
Outreach	Federal	D
	State	S
Family Life Education	State	D
Daycare	State	I
Counseling	State	I
Residential	State	D

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funding for daycare and counseling throughout Jamaica Plain. The decrease in residential care can be attributed to a decline in the number of DSS referrals, a decline which caused the Volunteers of America, Inc., to close one of its three eight-bed group homes in Jamaica Plain during the summer of 1982.

Table 9 reflects the lack of clarity about funding source discussed in the methodology section. Many of the agencies serving youth in Jamaica Plain get their money from multiple sources, including private sources. For example, the Ecumenical Social Action Committee (ESAC) gets 33 percent of its money from the private sector (including the United Way), while Neighborhood House receives 57 percent of its funding from the private sector. In analyzing these agencies, it is somewhat difficult to determine that money from a particular source goes to a particular program. Finally, Table 10 shows that all municipally and Federally funded programs studied have faced cutbacks, while state funded programs have fared better. The reduction in state-funded residential care represents a referral problem rather than a dollar cutback.

TABLE 10

Summary of Kinds of Service by Governmental Funding Source

What has happened between FY81 and FY83?

Jamaica Plain Youth

Municipal		State		Federal	
Kind of Service	Funding Increased, Decreased or Stable	Kind of Service	Funding Increased, Decreased or Stable	Kind of Service	Funding Increased, Decreased or Stable
Recreation	D	Counseling	I	Employment	D
		Daycare	I	Recreation	D
Health Promotion	D	Family Life Education	D	Health Promotion	D
		Residential	D	Outreach	D

3.2.3 Supporting Evidence from the Other Case Studies

The other community case studies provide additional evidence which supports the ideas in this thesis. In particular, preventive services such as education and health have been very much affected by cutbacks. Additionally, within agencies, there has been a shift toward treatment of severe or emergency cases. This section provides a few examples from the other case studies.

In Springfield, as in Quincy, funding for education was cut back (Unger, Note 9). A ten percent decrease in the Springfield school budget resulted in the loss of 375 out of 1800 teachers. Service cuts in the department focused on preventive services. Programs eliminated included the reading center at the Tapley School, instrumental music, foreign language at the elementary level, the environmental education program, and junior high school athletics.

Preventive health care was affected in many of the communities. The Springfield Health Department, funded by the city of Springfield, took a twenty percent cut in its funding in FY82 from $1,065,000 to $843,000. In Allston-Brighton, the Federal government closed the U.S. Public Health Service facility in November 1981 (Freilich, Note 1). This closure left the Joseph Smith Community Health Center without a place to send indigents for X-rays, extensive lab tests and specialty work that the health center cannot provide. The Joseph Smith Community Health Center and the St. Elizabeth's Hospital will need to absorb the costs of additional free care necessitated by the closure.

The community case studies provided several examples of agencies which are now focusing on severe or emergency cases. Cuts have forced the Spanish

American Union in Springfield to focus on multiple problem families rather than on prevention, the agency's original objective. In Lexington, the Minuteman Homecare Corporation is now focusing on the most needy and severe cases (Unger, Note 7). At the Arlington Youth Consultation Center, there is a push to see clients on a short- term basis. At the Mystic Valley Mental Health Center, there has been a shift toward treating the most needy clients, those who are hospitalized and disabled. The mental health center is finding it increasingly difficult to provide preventive care in the face of budget cuts.

These are just a few examples of agencies where preventive services have been cut and where emergency services are being stressed. The case studies also reflect a growing demand for emergency services, especially in communities where unemployment is growing. The information from the other case studies thus seems to support what was found in the Jamaica Plain and Quincy case studies.

3.3 Summary

The findings of this chapter can be summarized as follows:

(1) Within governmental funding, preventive services have been cut more than emergency services.

(2) Programs funded by the Federal government or the municipalities have been cut more than state-funded programs.

(3) Municipal, state and Federal governments and the private sector pay for different kinds of services, with the Federal government and municipalities tending to fund primary prevention services and the state and private sector tending to fund emergency services.

(4) Real Federal funding for human services has substantially declined.

(5) Real Massachusetts funding for human services has declined only slightly.

The final chapter discusses these findings in light of the history of government involvement in social welfare described in Chapter II.

CHAPTER IV
Discussion

In many ways, the material I have presented concerning the funding of human services has made a complex problem appear simpler than it really is. Programs often have more than one funding source, and state and local governments receive sizable proportions of their money from higher levels of government, making it difficult to pinpoint the exact origin of funds. Agencies retain some discretion to shift money around and selectively maintain programs when funding from a particular source is cut, thus sometimes making it difficult to link a particular staff or service reduction to a particular funding cut. As noted previously, the evolution of the governmental roles in human services is not a purely linear process; rather, state and local governments have reacted to and interacted with the Federal government as it has become increasingly involved in the human services arena. Some states, such as Massachusetts, have played leadership roles in social welfare, and have taken on far more responsibility for funding social services than required by the Federal government. Despite all of these complicating factors, emergency services have generally been resilient, while preventive services have been disproportionately cut.

The resiliency of emergency services is due to historical, ideological, institutional and political factors. The historical factor has to do with the broader funding base for emergency services discussed in Chapter II. Emergency services have existed throughout American history, and thus the private sector, the state, and the Federal government are often involved in funding these services. Major preventive programs, on the other hand, are a more modern phenomenon, and

hence, funding for these services comes primarily from the Federal government, the newest funder in the human services field. Consequently, the Federal cutbacks have had a major effect on preventive services and a less dramatic effect on emergency services. This imbalance is exacerbated by increasing reliance on the private sector to take on the functions that the Federal government is abandoning. Leaving aside the question of whether the private sector has the wherewithal to pay for these functions, it seems that reliance on the private sector, which historically has not funded many preventive services, will further increase the dominance of the emergency side of the scale. The joint effect of cutbacks and reliance on the voluntary sector causes a disproportionate emphasis on crisis.

Ideologically, emergency services have always been part of the social welfare concept. As the social welfare concept expanded to an institutional view, preventive services became important. The policies and rhetoric of the Reagan Administration are consistent with and favor the residual view of social welfare, in which government dealt only with the individual not being cared for by the market or the family.

While this thesis does not discuss in detail the institutional and political factors contributing to the resiliency of emergency services, it is possible to make some speculations here. From an institutional perspective, emergency services may be more resilient because they do not attempt to change the status quo. Preventive services, on the other hand, if effective, could ultimately change the way agencies do business. For instance, in the health field, if nutrition, health education, and environmental quality were emphasized, there might be less need

for curative medicine. This country's health care system, and to a great extent, its whole human service system, is predicted upon curing illness rather than promoting health. Promoting health represents a new way of doing business, and organizations resist change. The fact that preventive services attempt to change society and its institutions may be an important reason why preventive services are slow to gain acceptance and are the first to fall prey to budget cutbacks.

From a political point of view, since preventive services seek to prevent disease and breakdown, much of the benefit from these services accrues in the future, and it is often difficult to measure these benefits. Even when the benefits of preventive services can be shown to exceed the costs, as in the case of weatherization programs, it is politically difficult to secure government funding for any program without short-run tangible benefits.

The disproportionate cuts in preventive services are very disturbing. The fact that preventive services have faced more severe cuts than have emergency services seems to deny the interconnections of the different kinds of services and the fact that emergency and preventive services support each other. An ideal system of human services requires the entire range from preventive to emergency. Mechanisms for feedback, outreach and interdisciplinary coordination are also important. Prevention services attempt to minimize the occurrence of emergencies by improving the health and mental health of the total population. Part of adequate prevention is assuring that resources and services exist in case of emergencies.

Metaphorically, human services can be seen as a bridge with primary, secondary, and tertiary prevention supports. When any one of these supports is

removed, the bridge is weakened, and the other supports are strained. The bridge metaphor illustrates the connection between prevention and crisis, that intervention at a time of crisis can prevent further breakdown, and that a cut in one part of the system affects the whole system.

The Reagan Administration's policies represent a withdrawal of the Federal government from human services. This retrenchment must be examined in light of the reasons why higher levels of government originally became involved in human services. These reasons, which are equally valid today, had to do with inadequacies, inequities, and inefficiencies at the lower levels of government. Counties built almshouses because towns were unable or unwilling to support non-residents. States built institutions for specific populations both in response to the poor conditions in the county almshouses and to a new idea that care could be better provided if specific categories of dependents were segregated. The Federal government became involved in social welfare both in response to the crisis of the Great Depression and the inadequacies and inequities of the state systems of relief.

Equal access to care of minimal quality across communities and states provided impetus for state and then Federal involvement in human services. Gutowski and Koshel (1982) note that concern over equity was an important reason why the locus of financial responsibility for the poor moved from communities to states and eventually to the Federal government. The issue of equity remains of critical importance today and represents one of the key dilemmas in returning responsibility for human services to the states and localities.

In addition to the equity considerations, a belief that the national social welfare problem was beyond the domain of state and local governments was also an

important catalyst for Federal entry into human services funding. As observed in a New York Times (1982) editorial:

> Poverty is a national phenomenon. Economic opportunity in one region and decline in another propels waves of migration. These economic forces are far beyond the control of local governments (p. 22).

A third advantage of Federal involvement in human services is that the Federal government has a broader lense for evaluating its goals and establishing public policy priorities than do the lower levels of government. At least theoretically, the Federal government has the welfare of all Americans in mind and is in the best position to consider social costs and benefits of programs, especially preventive programs. Preventing or reducing the need for more expensive forms of care is an important benefit of many types of social service programs (Gutowski and Koshel, 1982), and the Federal government should have a strong financial interest in this objective.

A particularly disturbing aspect of the current cutbacks is the promulgation of the idea of "truly needy." The invalidity of the "truly needy" concept is revealed by the implied existence of the untruly needy. By cutting the human services budget while claiming to continue to care for the truly needy, President Reagan is trying to persuade us that the discontinued programs were serving the untruly needy, and therefore were, at best, serving a useless function, and at worst, defrauding the taxpayer. By failing to view society as a whole, President Reagan denies the validity of the institutional concept of social welfare. I see the "truly needy" concept as a step backward in the evolution of social welfare philosophy.

On a practical level, economizing on preventive services may be costly in the long run. Examination of the current retrenchment of the Federal government reveals a lack of explicit policy and an accompanying failure to evaluate the policy. While no one in the Federal government is explicitly saying that society should not prevent problems but only deal with them after they occur, the massive cuts at the Federal level and the emphasis on the "truly needy" implies such a policy. It could well be that an evaluation comparing present and future costs and benefits would justify a portion of the current shift of emphasis toward emergency services. But this evaluation is not occurring; rather, Federal human services funding is apparently being reviewed on the basis of present cost alone. This short-sightedness means that problems will be treated only when they reach crisis proportions, probably at greater cost to society.

Of course, the Federal cutbacks could in theory be mitigated by compensatory funding increases from state and local governments and private philanthropy. However, an Urban Institute survey of block grant replacement funding in 25 states indicated that "the overall rate of state funding replacement has been low" (Peterson, 1982, p. 179). Individual and corporate giving are also unlikely to compensate for the governmental cutbacks. The average annual rate of growth in charitable giving for social services has been about eleven percent over the last five years (Gutowski and Koshel, 1982). This rate of growth would have to increase to approximately forty percent in order to offset the reduction in real Federal spending for social services that was scheduled to occur between 1981 and 1983 (Gutowski and Koshel, 1982). I think it naive to expect such a sudden dramatic growth in private philanthropy.

In conclusion, the data and discussion I have presented demonstrate the need for the Commonwealth of Massachusetts to monitor government cutbacks and their effects on its citizens. Such a monitoring process would help the state to develop priorities in its own budget. Given the Federal government's retrenchment in the human services arena, the states must play an increasingly crucial role in human services. Knowledge about where cutbacks lie on the prevention to emergency continuum would allow state legislatures and executive offices to make better informed decisions.

The suddenness of the cutbacks allowed no time for the responsibility for funding human services to shift from the Federal government to the state and local governments and the private sector. If the Reagan Administration had really wanted the private sector to expand its human services activity, it would have moved much more slowly and incrementally in implementing its policies. This suggests the need of governments to consider transition implementation problems when developing social policy.

The community case studies also showed that many private non-profit agencies rely heavily on government funding. Many writers have commented on the partnership between the public sector and the private sector in the area of social welfare. Brilliant (1973) talks about the blurring line between public and private agencies. An Advisory Committee on Intergovernmental Relations (1982) report notes that the old line between private and public concerns has been obliterated, and that the very real distinctions between Federal and state-local matters in the early 1960s have been lost. Kammerman (1983) writes that "the

conventional dichotomy between public and private sectors can no longer be maintained" (p. 5). The Federal cutbacks, which threaten the public-private partnership, point to the need to reaffirm and strengthen the partnerships among the various levels of government and beween the public and private sectors.

Kammerman (1983) stresses that "the limitations of the market . . . underscore the need for government involvement, in addition to government money, at all levels" (p. 9). The data I have presented concerning the differential funding of human services, and the resulting disproportionate cuts in preventive services, also underscore this need.

APPENDIX

ABBREVIATIONS FOUND IN APPENDIX

Federal programs and agencies

AoA - Administration on Aging
CDBG - Community Development Block Grant
CETA - Comprehensive Employment Training Act
CSA - Community Services Administration
CSBG - Community Services Block Grant
HUD - Department of Housing and Urban Development
NIMH - National Institute of Mental Health
Title III - of Older Americans Act

State programs and agencies

DEA - Department of Elder Affairs
DMH - Department of Mental Health
DPH - Department of Public Health
DPW - Department of Public Welfare
DSS - Department of Social Services
DYS - Department of Youth Services

Local agencies

AGM - Associated Grant Makers
APAC - Area Planning Action Council
DOVE - Domestic Violence Ended
ESAC - Ecumenical Social Action Committee
SSMHC - South Shore Mental Health Center
VOA - Volunteers of America

TABLE A

Quincy

Agency	Program	Type of Service	Target Population	Who Funds	Comments about Cuts - FY81 to FY83
South Shore Coalition for Human Rights		housing advocacy	minorities	Federal	Grant which paid for 2 part-time housing counselors and a part-time attorney ended in 9/82.
Quincy Community Action, Inc.	Headstart	daycare	low-income children	Federal	Not cut.
	Retired Senior Volunteer Program	employment	elderly	Federal	Not cut.
	Fuel Assistance	economic	low-income	Federal	20% cut from $2 million in FY82 to $1.6 million in FY83.
	Emergency Crisis Intervention Program	emergency cash assistance	low-income	Federal	$80,000 program eliminated in FY82.
	Crisis Intervention Assistance	emergency cash assistance	elderly	State (DEA)	$15,000 program eliminated in FY83.
	Attorney General's Office	emergency cash assistance	low-income	State (Atty. General's Office	Provided $16,000 in FY81; Cut 92% to $1300 in FY82.
	Weatherization	conservation	low-income	Federal	Not cut.
	Food Pantry	food	low-income	Donations	New program.

TABLE A (continued)

Quincy

Agency	Program	Type of Service	Target Population	Who Funds	Comments about Cuts - FY81 to FY83
Dove, Inc.	Shelter for battered women	shelter	abused women	Foundations United Way State (DSS) Norfolk County	12 Federal CETA positions eliminated in FY81.
St. Boniface's Church		emergency cash assistance budget counseling	church members	Private donations	Need for emergency assistance has increased.
Salvation Army	Preschool Enrichment Program	daycare	children		
	Adult Daycare Program	daycare	multi-handicapped seniors		
	Community recreational programs	recreational	all ages	Private donations United Way Medicaid (for Adult Daycare Program)	No service cutbacks. Demand for emergency assistance has increased.
	Religious programs	religious	all ages		
	Food Assistance	emergency	persons in need		
	Fuel Assistance	emergency	persons in need		
South Shore Halfway House	-	residential	alcohol abusers	State (DPH)	Not cut.

TABLE A (continued)

Quincy

Agency	Program	Type of Service	Target Population	Who Funds	Comments about Cuts - FY81 to FY83
Quincy Detoxification Center	-	detoxification	alcohol abusers	State (DPH)	No increase in number of DPH slots despite rising occupancy rate.
Project Turnabout		halfway house	drug abusers	State (DPH) Public Assistance, Food Stamps	In FY81, agency lost $12,000 in Federal and $20,000 in state funds. Due to welfare changes, clients lose benefits when they start working part-time.
South Shore Council on Alcoholism	Alcohol Resource Center	education	general public	State (DPH)	Not cut.
	Drunk Driver Program	education/ counseling	OUI* first offenders	Court fines	Agency now must collect fee; courts formerly did.
	Employee Assistance Program	consultation education	alcohol abusers	Employers	Not cut.
	SHARP	halfway house	hard-core alcohol abusers	State (DPH)	Ongoing low rate problem.
	Family Alcoholism Counseling and Education	counseling	children and spouses of alcoholics	State (DMH)	$17,500 program eliminated in FY82.

*OUI = Operating under the influence.

TABLE A (continued)

Quincy

Agency	Program	Type of Service	Target Population	Who Funds	Comments about Cuts - FY81 to FY83
Survival, Inc.	Outpatient Drug Counseling	counseling	drug abusing youth	State (DPH-80% DSS-20%)	Cut 43% from $30,000 in FY82 to $17,000 in FY83.
	Long-term Residential Drug Program	residential	drug abusing youth	State (DPH)	Not cut.
	Crisis Hotline	drug crisis intervention	drug abusers	State (DPH)	$22,000 program eliminated in August 1982.
	Emergency Shelter for Teenagers	emergency shelter	youth	State (DSS-60% DMH-40%)	Not cut.
	Family Support Program	counseling	youth	State (DSS)	New $120,000 program started in January 1982.
	Community Outreach Program	outreach	deinsitutionalized mental patients	State (DMH)	New $40,000 program started in July 1982.

Sources: Interviews with agency directors or staff conducted for the Impact 2½ Human Services Study: Tim O'Brien, South Shore Coalition for Human Rights; Mary Brelsford, Southwest Community Center, Quincy Community Action; Ann Shepardson, Dove, Inc; Pat Tears, St. Boniface's church; Gerald Stephens, Salvation Army; William Spinks, South Shore Council on Alcoholism; Edward Ross, South Shore Halfway House; George Donahue, Quincy Detoxification Center; Alex Marceline, Project Turnabout; Kenneth Tarabelli, Survival, Inc.

TABLE B

Jamaica Plain Elderly Services

Agency	Program	Type of Service	Who Funds?	Comments about Cuts - FY81 to FY83
Mayor's Commission on Affairs of the Elderly	Neighborhood Senior Service Workers	Advocacy Information & Referral	City of Boston	Reduced more than 50%.
	Service Directory for Older Bostonians	information	"	No funds to update directory.
	Senior Clubs	recreation	"	No longer pay for trips.
	Elder Arts Program	recreation	"	Now use volunteers rather than professional performers and teachers.
	Mobile Market	support	"	Eliminated.
	Special Trips Program	recreation	"	Eliminated.
	Boston Seniority	information	"	Eliminated comprehensive mailings to households.
	Ident-I-Guard	anti-theft	"	Eliminated.
	Sound Screen	health promotion	"	Not cut.
	Bright Eyes	health promotion	"	Not cut.
	Senior Shuttle	transportation	"	Not cut.

TABLE B (continued)

Jamaica Plain Elderly Services

Agency	Program	Type of Service	Who Funds?	Comments about Cuts - FY81 to FY83
Mayor's Commission on Affairs of the Elderly (cont'd.)	Mayor's Older Bostonian Cards	discount cards	City of Boston, Merchants	Not cut.
	Taxi discount	transportation	Taxi industry	Not cut.
	Elderly hotline	information referral	City of Boston	Not cut.
	Retired Senior Volunteer Program	employment	Federal	Not cut.
	Visiting Aides Program	support	Federal Boston	Eliminated.
	Title III Service Contracts	transportation, in-home services legal services	Federal	Cut 22% or $700,000 from FY81 to FY83.
Positive Aging Services (Mass. Mental Health Center)				Overall budget reduced 60% from about $500,000 in FY80 to $200,000 in FY82.
	Comprehensive Assessment and Resource Center	case management	Federal (AoA)	$200,000 grant eliminated in February 1982.

TABLE B (continued)

Jamaica Plain Elderly Services

Agency	Program	Type of Service	Who Funds?	Comments about Cuts - FY81 to FY83
Positive Aging Services (cont'd.)	Training grants	education of psychogeriatric workers	Federal (NIMH)	Have not been available after FY81.
	Geriatric Day Treatment Program	daycare	State (DMH)	Eliminated program. Lost 5 FTEs.
	Consultation Program	consultation/ education	State (DMH)	Reduced.
Council of Elders, Inc.	Nutrition	nutrition	Federal (Title III-c)	10% cut in FY82. Level funded in FY83.
	Transportation	transportation	Federal (Title III-b)	10% cut in FY83.
	Conservator Guardianship Program	guardianship	Federal (CDBG)	Not cut.
	Enrichment Services	recreation	Federal (CDBG)	40% cut in FY82.
	Senior Day Program	daycare	State (DPW)	Not cut.
	Home Aide	homemaker	State (DEA)	Not cut.

TABLE B (continued)

Jamaica Plain Elderly Services

Agency	Program	Type of Service	Who Funds?	Comments about Cuts - FY81 to FY83
S.W. Boston Senior Services	-	homecare	State (DEA)	10% increase in FY82. Level funded at $2.3 million in FY83.
Jamaica Plain APAC	Senior Services	recreation transportation advocacy	Federal	Have cut youth services rather than senior services.
ESAC	Senior Team	health and social services to at-risk elderly	State (DSS) United Way	Nursing services reduced from one full-time to one half-time position.
Boston Indian Council	Senior Services	recreation	Federal	Eliminated in FY83.
		nutrition	Federal	Not cut.
VOA	McCrohan House	Shared housing	Client rents Donations	Not cut.

Sources: Interviews with agency directors or staff conducted for the Impact 2½ Human Services Study: Rachel Lieberman, Mayor's Commission on Affairs of the Elderly; Bennett Gurion, Massachusetts Mental Health Center Positive Aging Services; John Green, Council of Elders; Richard Lindgren, Southwest Boston Senior Services; Mary Thompson, Jamaica Plain Area Planning Action Council, Betty Rossen, Ecumenical Social Action Committee; Cliff Saunders, Boston Indian Council; Marianne Rebel, Volunteers of America.

TABLE C

Jamaica Plain Youth Services

Agency	Program	Type of Service	Who Funds?	Comments about Cuts - FY81 to FY83
APAC	Neighborhood Employment Center	employment (CETA)	Federal	30% cut to $55,000 for FY82; 20 to 40% reduction in summer jobs for youth.
	Youth Development Program	outreach recreation (for isolated youth).	Federal (CSA)	Eliminated when CSA funds were block granted and cut 35% to $139,000 for FY82.
Neighborhood House	Daycare	daycare	State (DSS, DPW)	Small increases from DSS and United Way, FY81 to FY82.
	Summer day camp	day camp	Federal (Dept. of Agriculture, CDBG)	CDBG funds decreased from $8000 in FY81 to $5000 in FY82.
	Teen Program	recreation	Private (United Way, Associated Grant Makers, Donations)	AGM grant level funded at $20,000. Teen program eliminated.
	On-site Job Training	employment		Job training not cut.
Dare, Inc.	Group home Outreach Program	residential counseling/ outreach	State (DSS, DYS, DMH)	Overall agency budget increased. DSS and DMH funding increased. Funding from DYS has declined.
New Eng. Home for Little Wanderers	Family Life Education Program	education	State (DSS)	Cut 20% or $30,000 for FY83.

TABLE C (continued)

Jamaica Plain Youth Services

Agency	Program	Type of Service	Who Funds?	Comments about Cuts - FY81 to FY83
Jamaica Plain Community Schools	Recreation	recreation	Federal (CETA, CDBG CSA)	CDBG funds cut 40% from $87,000 in FY80 to $50,000 in FY82.* City funds cut from $105,000 in FY80 to $75,000 in FY81.*
	Daycare	daycare	State (DSS, Boston State College) City of Boston	CETA funds were cut from $75,000 in FY80 to nothing in FY82.* Boston State college funds cut from $14,000 in FY81 to nothing in FY82.*
	Counseling	counseling	Private (Donations Fees)	Action for Boston Community Development funds cut from $15,000 in FY80 to $10,000 in FY81 to $8,000 in FY82.* DSS provided $30,000 for daycare in FY82 for first time. DSS increased contribution for counseling from $14,000 in FY81 to $42,000 in FY82. *Due to these cuts, the agency reduced programming from 40 to 25 hours/week.

TABLE C (continued)

Jamaica Plain Youth Services

Agency	Program	Type of Service	Who Funds?	Comments about Cuts - FY81 to FY83
VOA	Group homes	residential	State (DSS)	Reduced no. of group homes from 3 to 2 because of insufficient referrals.
Martha Eliot Health Center	-	health	Federal	Medicaid revenues decreased 1.4% from $777,000 in FY81 to $766,000 in FY82.*
			Private (Fees, Insurance)	Maternal Child Health primary care contract cut 14% to $318,000 in FY83.*
			City of Boston	Eliminated school physician program in FY83. Was funded at $7200 in FY82.*
				*In calendar 1981, staff cut from 65 to 45 FTEs.
Brookside Park Family Life Center	Medical	health	State	Brigham and Women's Hospital's cap on expenditures is effectively a $100,000 cut in FY83.
	Dental	health	Federal	Federal Section 330 grant for $105,000 not renewed for FY83.
	Family Services	education	City of Boston	
		counseling		
		mental health		During FY82, staff was reduced 17%
		speech therapy	Private	from about 60 FTEs to 50 FTEs.

Sources: Interviews with agency directors or staff conducted for the Impact 2½ Human Services Study: Mary Thompson, Jamaica Plain APAC; Susan Sherry, Neighborhood House; David Ziemba, Jamaica Plain Community schools; Marianne Rebel, Volunteers of America; Robert Hall, Dare, Inc.; Neil Heggarty, New England Home for Little Wanderers; Robert Martin, Martha Eliot Health Center; Mark Klauk, Brookside Park Family Life Center.

TABLE D

Municipal Funding for Human Services in Quincy

Kind of Service, Agency	Known Change in Funding	Known Change in Staff or Services
Council on Aging recreation health promotion nutrition support	Formerly paid with municipal funds. Now paid with Federal CDBG funds.	Staff reduced due to shift to CDBG funding but number of programs increased.
Youth Commission recreation employment residential	Formerly paid with municipal funds. Now paid with Federal CDBG funds. Budget cut about 25% since FY80.	Lost assistant director. Have not eliminated services or programs but retained them in reduced form.
Consultation/ Education: South Shore Mental Health Center	50% reduction in funds from Quincy school dept. over past few years. Received $44,000 from Quincy School Dept. in FY83.	Service reduced proportionately.
Special Education: Quincy School Department	Overall, two years of School Dept. cuts totaled $11,000,000 or 1/3 of its budget. Minimal cuts in special education teachers.	Cuts in guidance, nursing, speech, psychology, and regular education program have impacted special education.

Sources: Interviews with agency directors or staff conducted for the Impact 2½ Human Services Study: James Lydon, Quincy Planning Department; Brian Buckley, Quincy Youth Commission; Harry Shulman, South Shore Mental Health Center; Carol Lee Griffin, Pupil Personnel Services, Quincy Public Schools.

TABLE E

State Funding for Human Services in Quincy

Kind of Service, Agency	Known Change in Funding	Known Change in Staff or Services
Counseling:		
SSMHC		
o Mission Possible	Mass. Commission on Criminal Justice funding cut 45% from $110,000 in FY81 to $60,000 in FY82.	None yet. Agency is seeking other sources of funding.
o Child and Family	Fewer state funded positions available in FY82.	Service reduced.
o Adult Outpatient	16% cut from $450,000 in FY82 to $375,000 in FY83.	Projected to provide 10,500 units of service in FY83. Will only be able to provide 8500.
South Shore Council on Alcoholism		
o Family Alcoholism Counseling and Education (FACE) Program	$17,500 program funded by DMH eliminated in FY82.	Eliminated service to about 50 families and 70 children. Agency lost 1 half-time position.
o Drunk Driving Program	Agency now needs to collect fines for program rather than the court.	None.
Survival, Inc.		
o Outpatient Drug Counseling	43% cut in DPH funds from $33,000 in FY82 to $17,000 in FY83.	Service reduced proportionately.
o Family Support Program	New $120,000 program funded by DSS. Started in January 1982.	New service.
Education:		
Council on Alcoholism Resource Center	Not cut. DPH has provided $5000 in new funds to be used for drunk driving education.	None.
FACE Program	$17,500 program eliminated; see above under counseling.	Eliminated service to 50 families and 70 children.

TABLE E (continued)

State Funding for Human Services in Quincy

Kind of Service, Agency	Known Change in Funding	Known Change in Staff or Services
Emergency Fuel Assistance		
Quincy Community Action		
o Crisis Intervention Assistance	$15,000 program funded by DEA eliminated in FY83.	Decreased.
o Attorney General's Office	Provided $16,000 in FY81. Cut 92% to $1300 in FY83.	Decreased.
Emergency Psychiatric		
SSMHC		
o Child Outreach Program	Not cut. DMH added funding for new case management component for FY83.	Increased.
o Continuing Treatment and Crisis Intervention Team	Not cut. Modest increases in DMH funding.	None.
Emergency Shelter		
Survival, Inc. Emergency Shelter for Teenagers	Not cut.	None.
Crisis hotline		
Survival, Inc.	$22,000 program funded by DPH eliminated in August 1982.	Hotline handled 600 to 900 calls per month.
Residential		
SSMHC, Residential Services	$750,000 DMH-funded program level funded.	Services decreased due to inflation. Closed one eight-bed program.
Survival, Inc., Long Term Residential Drug Program	Not cut.	None.

TABLE E (continued)

State Funding for Human Services in Quincy

Kind of Service, Agency	Known Change in Funding	Known Change in Staff or Services
Residential (cont.)		
South Shore Council on Alcoholism, SHARP Halfway House	Not cut. Ongoing problem of low rate.	None.
South Shore Halfway House	Not cut.	None.
Project Turnabout	$20,000 cut in state funds for FY82. $34,000 increase in state funds for FY83. Have simultaneously experienced losses of Federal revenue.	Accepted 13 rather than 18 clients for a two-year period.
Respitecare		
SSMHC	Not cut.	None.
Detoxification		
Quincy Detoxification Center	Not cut.	Not cut but no DPH increases despite rising demand.
Outreach		
Survival, Inc. Community Outreach Program	New $40,000 program funded by DMH started in July 1982.	New service for deinstitutionalized mental patients.

Sources: Interviews with agency directors or staff conducted for the Impact 2½ Human Services Study: Harry Shulman, South Shore Mental Health Center; William Spinks, South Shore Council on Alcoholism; Kenneth Tarabelli, Survival, Inc.; Mary Brelsford, Southwest Community Center, Quincy Community Action; Edward Ross, South Shore Halfway House; Alex Marceline, Project Turnabout; George Donahue, Quincy Detoxification Center.

TABLE F

Federal Funding for Human Services in Quincy

Kind of Service, Agency	Known Change in Funding	Known Change in Staff or Services
Daycare		
Quincy Community Action, Headstart	Not cut.	None.
Economic		
Quincy Community Action Fuel Assistance Program	20% cut from $2 million in FY82 to $1.6 million in FY83.	Per household allotment went from $750 in FY81 to $450 in FY82 to $325 in FY83.
Outreach		
SSMHC		
o Milton Satellite Program	$75,000 program eliminated due to loss of Federal grant.	Program had provided child and family services.
o Manet Community Health Center Satellite	$20,000 program eliminated in FY82 due to loss of Federal operations grant.	Lost 1 full time coordinator plus other staff time.
o Germantown Service Worker	Eliminated in FY82 by $18,000 cut in CDBG funds.	Lost 1 full-time position.
Weatherization		
Quincy Community Action	Not cut.	None.
Advocacy		
South Shore Coalition for Human Rights	HUD grant ended in September 1982.	Staff cut from 2 part-time housing counselors and 1 attorney to 1 part-time work-study law student.
Emergency Cash Assistance		
Quincy Community Action, Crisis Intervention Program	$80,000 program funded by the Dept. of Energy eliminated in FY82.	Program had provided $18,000 per year to families in crisis, up to $250/household.
Emergency Shelter		
DOVE	Lost CETA funding; moved to other funding sources.	Entire staff of 12 CETA positions ended in FY81.

Sources: Interviews with agency directors or staff conducted for the Impact 2½ Human Services Study: Rosemary Wahlberg, Quincy Community Action; Kenneth Shulman, South Shore Mental Health Center; Tim O'Brien, South Shore Coalition for Human Rights; Ann Shepardson, Dove, Inc.

TABLE G

Municipal Funding for Elderly Services in Boston

Kind of Service, Agency	Known Change in Funding	Known Change in Staff or Services
Recreation		
Senior clubs	Decreased.	City no longer pays for trips and entertainment.
Elder Arts Program	Decreased.	Now uses volunteers, not professional performers and teachers.
Special Trips	Eliminated.	Eliminated.
Health Promotion		
Sound Screen	Not cut.	None.
Bright Eyes	Not cut.	None.
Advocacy		
Senior Service Workers	Cut more than 50%.	One worker now handles 2 neighborhoods rather than 1.
Economic		
Discount Cards	Not cut.	None.
Support		
Mobile Market	Eliminated.	Eliminated.
Indent-I-Guard	Eliminated.	Eliminated.
Information & Referral		
Senior Service Workers	Cut more than 50%. See Advocacy above.	Reduced more than 50%.
Service Directory for Older Bostonians	-	Directory not updated.
Boston Seniority	Decreased.	Ended comprehensive mailings.
Government Benefits	Not cut.	Increased due to more demand.
Elderly Hotline	Not cut.	None.
Transportation		
Senior Shuttle	Not cut.	No reduction in service; Cut back on van replacement.

Sources: Interview with agency director conducted for the Impact 2½ Human Services Study: Rachel Lieberman, Mayor's Commission on Affairs of the Elderly.

TABLE H

State Funding for Jamaica Plain Elderly Services

Kind of Service, Agency	Known Change in Funding	Known Change in Staff or Services
Daycare		
Mass. Mental Health Center Psychogeriatric Day Treatment Program	Eliminated.	Lost 5 FTEs.
Council of Elders Senior Day Program	Not cut.	None. DPW continues to allocate 45 slots.
Consultation/Education		
Mass. Mental Health Center Positive Aging Services	Decreased.	Decreased.
Counseling		
Mass. Mental Health Center	-	More difficult to see clients because program was moved.
ESAC - Senior Team	DSS funding not cut.	Nursing staff reduced from 1 full time to 1 part time.
Protective Services		
Council of Elders	Level funded.	None.
Homecare		
Southwest Boston Senior Services	10% increase in FY82. Level funded at $2.3 million in FY83.	None.
Council of Elders	Not cut.	None.

Sources: Interviews with agency directors or staff conducted for the Impact 2½ Human Services Study: Bennett Gurian, Massachusetts Mental Health Center, Positive Aging Services; John Green, Council of Elders; Betty Rossen, Ecumenical Social Action Committee; Richard Lindgren, Southwest Boston Senior Services.

TABLE I

Federal Funding for Jamaica Plain Elderly Services

Kind of Service, Agency	Known Change in Funding	Known Change in Staff or Services
Recreation		
Council of Elders Enrichment Services	40% cut in CDBG funding for FY82.	Reduced staff, clients, and services.
Education		
Mass. Mental Health Center Training grant	NIMH training grants have not been available after FY81.	-
Case Management		
Mass. Mental Health Center - Comprehensive Assessment and Resource Center	$200,000 AoA grant ended in February 1982.	Eliminated program.
Support		
Visiting Aides Program	Eliminated.	-
Home Repair for the Elderly	HUD grant ended in FY82.	Service continuing with private funds.
Nutrition		
Council of Elders	10% cut in Title III(c) funds in FY82. Level funded for FY83.	Increased price of meals from $.50 to $.75 for clients.
Transportation		
Council of Elders	10% cut in Title III(b) funds in FY83.	-
Conservator Guardianship		
Council of Elders	CDBG program not cut.	None.

Sources: Interviews with agency directors or staff conducted for the Impact 2½ Human Services Study: John Green, Council of Elders; Bennett Gurian, Mass. Mental Health Center, Positive Aging Services; Rachel Lieberman, Mayor's Commission on Affairs of the Elderly.

TABLE J

Municipal Funding for Jamaica Plain Youth Services

Kind of Service, Agency	Known Change in Funding	Known Change in Staff or Services
Recreation		
Community Schools	City funds cut 29% from $105,000 in FY80 to $75,000 in FY81, cut further to $72,000 in FY82 and FY83.	From all cuts: lost 12 staff positions; programming cut from 40 hours/week at each of 3 sites to 25 hours/week, lost adult and teen recreation program at Aggasiz School, lost structured recreational activities for 200 teens at Jamaica Plain High School.
Boston Parks & Recreation Dept.	Cut about 50%.	
Health		
Martha Eliot Health Center School Physician Program	$7200 program eliminated in FY83.	Program provided 6 hours/week of physician time to Boston schools. Estimated 5 to 10 children will not get needed follow-up.

Sources: Interviews with agency directors or staff conducted for the Impact 2½ Human Services Study: David Ziemba, Jamaica Plain Community Schools; Robert Martin, Martha Eliot Health Center.

TABLE K

State Funding for Jamaica Plain Youth Services

Kind of Service, Agency	Known Change in Funding	Known Change in Staff or Services
Counseling		
ESAC - Youth and Family Counseling Program	Not cut.	-
Community Schools	DSS funding increased from $14,000 in FY81 to $42,000 in FY82.	Increased.
Dare Outreach Program	Funding from DSS and DMH has increased.	Increased.
Daycare		
Neighborhood House	DSS funding increased 19% from $48,000 in FY81 to $57,000 in FY82.	Same.
Community Schools	Started to receive $30,000 from DSS in FY82.	Increased.
Residential		
Volunteers of America	Rate was increased but didn't get enough DSS referrals to maintain 3 group homes	Closed 1 of 3 9-bed group homes; lost 4½ FTEs, 1/3 of residential program staff.
Dare		Ran 10 group homes at peak, now run 2.
Education		
New England Home for Little Wanderers Family Life Education Program	DSS funding cut 20% or $30,000 for FY83.	Decreased.
ESAC Prevocational Program	Dept. of Education funding cut from $70,000 in FY81 to $40,000 in FY82. Another 25% cut to $30,000 in FY83.	-

Sources: Interviews with agency directors or staff conducted for the Impact 2½ Human Services Study: Betty Rossen, ESAC; Dave Ziemba, Community Schools; Robert Hall, Dare; Susan Sherry, Neighborhood House; Marianne Rebel, Volunteers of America; Neil Heggarty, New England Home for Little Wanderers.

TABLE L

Federal Funding for Jamaica Plain Youth Services

Kind of Service, Agency	Known Change in Funding	Known Change in Staff or Services
Employment		
Neighborhood Employment Center	30% cut in CETA funds to FY82 level of $55,000	20 to 40% reduction in summer jobs for youth.
Community Schools	CETA funding ($75,000 in FY80) eliminated in FY82.	Eliminated.
ESAC - Youth Employment & Training	CETA funds increased 62% from $21,000 in FY81 to $55,000 in FY82, cut 27% to $40,000 in FY83.	Program maintained with other funding.
Recreation		
Neighborhood House	CDBG funds cut 38% from $8000 in FY81 to $5000 in FY82.	Youth Activities Program eliminated.
Community Schools	CDBG funds cut 42% from $87,000 in FY80 to $50,000 in FY81.	From all cuts: lost 12 staff positions; programming cut from 40 hours/week at each of 3 sites to 25 hours/week.
Health		
Martha Eliot Health Center	Medicaid revenues decreased 1.4% from $777,000 in FY81 to $766,000 in FY82. Maternal Child Health Primary Care Contract level funded at $373,000 for FY82, cut 15% to $318,000 for FY83.	Staff reduced 31% from 65 to 45 FTEs in 1981.
Brookside Park Family Life Center	$105,000 Section 330 grant not renewed for FY83.	Staff reduced 17% from about 60 to 50 FTEs in 1981.

Sources: Interviews with agency directors or staff conducted for the Impact 2½ Human Services Study: Mary Thompson, APAC; David Ziemba, Community Schools; Betty Rossen, ESAC; Susan Sherry, Neighborhood House; Robert Martin, Martha Eliot Health Center; Mark Klauk, Brookside Park Family Life Center.

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