

Resource development and social work: funding early intervention through homemaker services for brain-damaged children in Jerusalem

Eliezer D. Jaffe and Rivka Jaffe

Practitioners are often frustrated by their frequent inability to find resources for promising projects and innovative work. Resource development had never been recognized properly as a social work skill, although utilization of community organization methods to press for resources is about as close as the profession has come to this subject. Without systematic learning of specific skills, social service workers, therapists included, are able to implement only a fraction of what can actually be accomplished. A rich body of knowledge exists concerning fundraising and resource development but this has not yet been wedded to the social work curriculum (Lauffer, 1983; Jaffe, 1988; New Israel Fund, 1987; Council on Foundations, 1985; Foundation News, 1985; Independent Sector 1986a; 1986b; The Third Sector, 1988; Ben-Meir, 1988; Tobin, 1987).

The funding of the Early Intervention Project for Special Children in Jerusalem is a good case in point, illuminating the role of private philanthropy in developing and institutionalizing a badly needed service to brain-damaged infants and their families. The project was seen as a crucial preventive and supportive effort to prevent unnecessary child placement and to ease family distress by providing subsidized home services (Compher, 1983; Maybanks and Bryce, 1979; Jones, 1976; Hirsch, et al., 1976; Jaffe, 1983).

This article describes how the funding for this important catalytic project was secured and how the programme was implemented, and it reviews some interim results. It presents the case for recognizing

resource development skills as necessary tools for social workers in all areas of practice.

The Homemaker Early Intervention Project

The birth rate in Israel of special children is 3 percent of the total birth rate, which at present is 298 infants born annually in Israel, and includes those born with Down's syndrome. Brain-damaged infants account for about fifty children annually in Jerusalem (Jerusalem Child Development Center, 1987). The birth of such children puts undue stress upon a family, causing grave problems to proper normal family functioning.

In the past few years, it has been determined that great importance is to be connected to early intervention as close to birth as possible, in order to start on a programme to ensure potential developmental progress. Few families are capable of dealing with the day-to-day attention constantly demanded by the problems of raising special children because of the emotional demands placed on them, coupled with the physical requirements of such children, and meeting the financial burdens of hiring outside help to cope. On the other hand, there are families that are distinguished by great devotion to a handicapped/special child, albeit at the expense of other, normal, siblings.

At present, parents of special children who have been certified as such by the National Insurance Institute (Bituach Leumi) receive grants only after a child reaches the age of 3. The National Insurance Institute (1988) is presently urging a revision of the law to include cases where there are serious physical handicaps, starting at an earlier age. Much of this change is a result of the project described in this article.

In 1979 an effort was made to aid brain-damaged children, especially those seriously mentally handicapped and kept at home, through the assistance of assigned homemakers funded by the Jerusalem Municipality. This programme functioned for a year and ceased due to lack of funding. Since then, and in view of recognized need coupled with the lack of services to child and family in dire need when such infants are born, the Matav homemaker organization sought funding for reinstating the limited and short-term experimental project (Jaffe, 1979).

In November 1986, a large one-time grant was received by the Matav Homemakers Association from the Berman Foundation of Canada to institute a revolutionary broadened programme of

Eliezer D. Jaffe, D.S.W., is Professor of Social Work at the Hebrew University of Jerusalem, Paul Baerwald School of Social Work, Mt Scopus, Jerusalem, Israel 91905. Rivka Jaffe is Director of Homemaker Training at the Matav Homemaker Association of Jerusalem, Israel.

assistance for infants from birth to the age of 3, by providing subsidized homemaker services to needy households. The programme 'covered' every needy family with a brain-damaged child under 3 born in Jerusalem, Jewish and Arab alike, for five years.

Philanthropy and child care innovation

It is important to describe the unique role of private philanthropy in launching the programme for filling the needs described earlier. Without funding, the well-intentioned conceptual and empirical work could never have taken place. The following is a brief narrative of how funding was secured.

Helen and Joe Berman of Toronto spent their 1986 Passover in Israel. But unlike other tourists, they came with a remarkable determination to find a charitable project which would speak to them personally and would make an impact on needy families.

The day after they arrived, Joe Berman called Eliezer Jaffe from his hotel room, mentioned reading the book, *Giving Wisely* (on non-profit organizations in Israel; Jaffe, 1982a), and asked if they could get together.

Our first breakfast at the King David Hotel was a get-acquainted session. Helen and Joe spoke movingly of people they had helped in the past, and especially about the network of cottages and the summer camp they established for retarded and brain-damaged Jewish children in Canada. Helen's husband, Joe, brought a good businesslike accountability approach to his philanthropic interests, and the two of them together made a rare team.

At the end of our meeting, I mentioned a number of possible projects that seemed relevant to their interests, trying to serve as honest broker, matching their needs as donors to the needs of various non-profit organizations which fill a gap in Israeli social services.

One of the many areas I suggested was the need for providing more homemaker services to families (primarily mothers) of brain-damaged infants and young children, including Down's syndrome children. Many mothers of these children are emotionally and physically exhausted from caring for their children, and municipal funding does not enable them to obtain enough help to ease the tremendous burden during the first three years of care. More services are available for these families when the children are older; then the Israel National Insurance and Ministry of Education became more actively involved.

This subject greatly aroused the Bermans' interest, and I offered to set up a meeting with the heads of the Matav Homemaker Service

Association in Jerusalem so that they could explain the situation at first hand.

Two days later the Bermans met Matav's director, Sarah Azrieli, and Rachel Doron, chief social worker. They were told about current needs for brain-damaged infants, and obtained detailed replies to excellent questions.

When we finished our breakfast meeting, the Bermans asked Matav to prepare a written proposal for a project, for discussion three days hence.

Three days later, Matav had prepared a simple, down-to-earth proposal for guaranteeing homemaker service to every needy family in Jerusalem with a brain-damaged infant for the next five years. There was a maximum plan and a minimum plan, as Matav had no idea how much the Bermans were willing to help out. I helped Matav to frame the data on needs, presentation of the cost per child, and suggested ways of providing proper accountability regarding administration of the grant, should it be obtained.

The third meeting (breakfast again), involved a beautiful presentation of the proposal by Azrieli and Doron, and discussion of details requested by the Bermans, who made pertinent suggestions.

When the discussion was over, Joe Berman looked at his wife Helen, she looked at him, they nodded to each other, and Helen announced with unconcealed motherly emotion that they were committing \$200,000 to the maximum, five-year Matav proposal.

This case description of resource brokerage is not an isolated event, and has been repeated many times in Israel and other countries, wherever knowledge of services needed is coupled with the communication and building of relationships with potential funding sources. Like social work, this requires knowledge, art and skills.

Description of the intervention programme

The contract between the donors and the Matav Homemaker Association included the following goals:

- (a) Early intervention with families requiring assistance to a special infant child under the age of three.
- (b) Concerned involvement with child-development programmes, including counselling and guidance to the parents.
- (c) Services offered with no preconditions relative to race, religion, area, sex and economic background of the clients.
- (d) Public relations efforts which bring the programme to the

public's and the government's attention, in the search for broad-ranging future support in manpower and finances.

(e) Evaluation and review of perceived needs and goals of the programme, and areas for future study and planning.

During the initial phase of the project, an interdisciplinary steering committee of senior professional social work, medical and nursing practitioners was established to clarify policy regarding eligibility criteria (e.g. age of child, diagnosis, service plan, etc.), to review referrals and to assess personal needs. An orientation and educational programme was designed for new homemakers working on the special project, and evaluation data were systematically recorded. A nurse was employed to oversee implementation of the project. Also, efforts were undertaken through public relations media to inform people, both orally and in writing, in all related institutions and agencies throughout the greater Jerusalem area of the availability of services.

In reviewing the past two years of operation, a wealth of new material has been generated relative to the children referred, the source and types of referrals, services provided, training needed, costs involved, and many other related variables. During this period 131 children were referred to the homemaker project. Table 1 presents the referral sources for these children.

All applicants were referred to an admission committee, along with a complete description of the case and the special problems involved, a medical diagnosis, social evaluation, and parents' consent forms.

TABLE 1
Sources of referral for services

Referral source	Number	Percentages
Child Development Center	78	59.5
Municipal Social Welfare Department	20	15.4
East Jerusalem District Office of the Welfare Department*	7	5.4
Hadassah Hospital, Mt Scopus	7	5.4
Neve Adam Association for Retarded Children	4	3.0
Bikur Cholim Hospital Rehab. Center	4	3.0
Akim Hateneh Day Center for Retarded	9	6.8
Alyn Hospital for Handicapped Children	2	1.5
Total	131	100%

*This district office of the Jerusalem Social Welfare Department serves primarily Arab residents.

The review committee, consisting of public figures and representatives of social agencies and disciplines especially recruited for the project and serving without pay, studied the case records, and developed a preferred plan of treatment according to the criteria for admission to the programme.

The committee meets monthly and considers on average ten new referrals. In an average week there are twenty-seven homemakers who deal with special children on a part-time basis. They take care of thirty-five families, who have a total of thirty-eight special children. The average number of hours provided per family is 2.5 daily.

The largest number of referrals came from the Jerusalem Child Development Center (59.5 percent), which provides diagnostic services for infants referred by mother-child health clinics and for various social service agencies. The importance of early diagnosis — and intervention — is very clear from our data. The referrals from the Jerusalem Social Welfare Department (15.4 percent) may represent previously diagnosed but unserved cases, a gap filled by the project.

Table 2 lists the reasons for referral, and shows Down's syndrome, psychomotor retardation and other birth defects to be the major types of handicap leading to referral (approximately 21 percent each).

TABLE 2
Reasons for referral to homemaker service

Diagnosis	No. of cases	Percentages
Down's syndrome	27	20.6
Psychomotor retardation	27	20.6
Birth defects (cleft palate, deformity, heart defect, etc.)	30	23.0
Premature, with defect	20	15.3
Microcephalus	5	3.8
Cerebral Palsy	4	3.0
Brain atrophy	3	2.3
Hydrocephalus	3	2.3
Meningitis	3	2.3
Cystic fibrosis	2	1.5
Epilepsy	2	1.5
Tay-Sachs*	2	1.5
Rubinstein syndrome	2	1.5
Autism	1	0.8
Total	131	100%

Only 100 of the 131 cases referred were actually accepted. Of the 31 cases rejected, 20 were over-age or otherwise ineligible, and 7 could not be served due to unavailability of a suitable homemaker. Recruitment is under way to ease this problem.

Fifty-nine percent of the children in care were 1-3 years old, and 14 percent were less than 3 months old; 56 percent were male and 44 percent female children (see Table 3).

TABLE 3
Children in care, by sex and age at referral

Age group (months)	No. of children	Percentages	Male (%)	Female (%)
0-3	14	14	5	9
3-6	8	8	3	5
6-9	8	8	6	2
9-12	11	11	10	1
12-18	19	19	12	7
18-24	15	15	9	6
24-36	25	25	11	14
Total	100*	100	56	44

* The difference between the total number of referrals (131) and the numbers presented in Table 3 (i.e. 100 children) is based on the fact that some children were rejected or could not be served immediately.

At the time of writing, twenty-two children were on a waiting list for service, pending availability of a homemaker. As children leave the programme, homemakers take on children from the waiting list. Among the reasons for discharge from the programme are placement in a rehabilitation daycare centre (27.5 percent), and attaining the age of 3 whereupon local municipal and state services become available and mandatory by law (57.5 percent). Hospitalization and death accounted for cessation of service to 12.5 percent of the children and their families. This statistic attests to the severe medical problems present in most cases referred, and the crucial need for early help and follow-up to this special group of children.

Homemaker functions

The homemaker's tasks vary, depending on the specific problems of the child and family in care. The basic goal in working with special, brain-damaged children is providing stimulation to promote physical

and mental development. Homemakers are instructed in guided play activity and physical exercises. This activity is supervised by physical and vocational therapists from the Jerusalem Child Development Center.

Homemakers are responsible for washing and feeding the child, taking them on walks, and performing many daily tasks which free the mother, even for a few hours, from her routine care of the child. The homemaker is encouraged to create a positive family relationship concerning the child where this is lacking, and to provide parents with moral and physical support at all times.

Responsibilities of the programme co-ordinator and homemaker training

The Programme Co-ordinator is a registered/graduate nurse, a public health professional chosen to train the homemakers in their work with special children and their families. She is the contact person who serves as the go-between to the referring agencies, the family and the homemaker. She personally instructs every homemaker, with emphasis on duties and responsibilities that are specific in the treatment of the children. Also, she is involved in training and directing in-service courses for the entire staff of Matav Homemakers who attend educational seminars, lectures and practical on-the-job fieldwork. Special seminars are conducted when needed in a specific area.

The following represent some of the topics included in the in-service training programme for homemakers, each subject presented by outstanding professionals in a variety of fields.

1. Growth and development of the normal child in comparison to the development of the special child.
2. Developmental examinations and testing for maturation of infants.
3. Who is a special child?
4. The premature child.
5. The importance of stimulation for the development of children, the role of the clinic in the process and the role of the homemaker.
6. The description of various syndromes.
7. Speech development in Down's syndrome children.
8. Family functioning, and attitudes and behaviour of siblings and relatives when a special child is born.
9. Toys created from items available around the house.

10. Working with an interdisciplinary team.

The co-ordinator arranges home visits first to meet the parents in order to choose a compatible homemaker properly. Then follow-up visits are arranged for purposes of evaluating the situation and progress in following the plan recommended in each individual case. She lends support to the homemaker in a professional capacity and eases periods of stress resulting from work. In addition, she provides information, statistics and reports related to the project.

Two cases in point: Taliah and Raphael

The following are two examples, out of many, that describe timely intervention with families in desperate situations over extended periods who have used the Berman project in order to improve their stability and performance.

Taliah

Taliah, born November 1984, was the only child of a middle-aged family. Her father was born in Israel, her mother in the USA.

Taliah had Tay-Sachs' disease and was almost in a state of vegetative. The family also had a Down's syndrome child who had died. The mother had suffered a number of miscarriages. The home environment is depressive in the extreme. The mother, who is a new immigrant, had no outside social contacts due to Taliah's all-demanding and consuming condition.

The request for services reached us at the project office of Matav on 1 November 1986, when Taliah was aged 2. The homemaker started working on 1 December 1986, after the project approved a weekly schedule of 12 hours of service. After a number of months, at the request of the family, service was increased to 18 hours weekly, and a social worker helped the mother to accept outside employment, partly because the family's financial situation was most difficult. The home situation showed marked improvement. The parental attitude was very positive towards the child. The homemaker stopped service when Talia reached the age of 3, when the municipality, by law, took on financial responsibility. In the meanwhile, a healthy son was born to the family. Two weeks after Taliah reached her third birthday, she died of Tay-Sachs'. The family, bereaved as they were, sent a letter expressing their deep gratitude for all that had been done for them by the Matav-Berman project.

Raphael

Raphael, born in November 1987, is one of a twin birth, and is suffering from Down's syndrome. There are six other brothers at home, aged 4-15. The father suffers from atrophy of the kidneys, is attached to a dialysis machine, and is waiting for a donor kidney transplant.

The request for homemaker service reached the project office of Matav on 1 December 1987. At a meeting of the staff, 18 hours of family services per week were approved. After a house visit by the supervisor, a homemaker started working in February 1988, when Raphael was 3 months old.

When the homemaker first started working, Raphael needed continuous stimulation. The homemaker contributed greatly to family stability and to the child's progress. Raphael has made great progress. He now sits up, chatters, has begun eating solid foods, makes good contact, is well cared for by his family and by the homemaker. The mother states that without the assistance of the homemaker, she surely could not function.

Raphael was placed in a day care centre on 1 September 1988, the homemaker was released from this case and placed with another family that had been on the waiting list.

Further research on homemaker services to infants

The Homemaker Project has developed a keen interest in studying several important questions, and proposals have been prepared for research, pending the availability of funds. For example, we need to examine the influence of homemaker services on progress, attitudes of the family towards the special child, differential family vs homemaker functions, and how better to prevent the institutionalization of the special child, where unnecessary.

In addition to these subjects, we plan to pursue studies to answer the following questions:

To what extent is there a need to intervene with a homemaker's intuitive assistance to the family; the type, implementation and content of care efforts; types of co-operative effort between agency and parents; extent of success in family exploitation of financial and human resources; satisfaction of the recipient families with social services; and differences in criteria for getting aid from various groups and agencies.

Did the population most in need receive services and was the availability known to all the families of all income brackets? Do early

referrals and intervention bring significant developmental results for the child, or mostly for the parents? Can timely homemaker service to brain-damaged infants prevent (or lower) the incidence of babies abandoned in hospitals?

Summary

The applied research and social service project described here provides a case in point in favour of formal learning and utilization of skills required to locate and harness philanthropic investments for innovative, catalytic social programmes. The Homemaker Project for infants in Jerusalem has led to pressure on the state and local government to amend existing laws so that families of infants under 3 (pre-school age) will also be eligible for government funding of homemaker (and other) services.

The Berman family investment may well result in a massive policy change, benefiting thousands of infants and their families for years to come, on a national scale. In our view, brokerage between philanthropy and social work should become a new social work specialization, long neglected and long overdue.

Acknowledgement

The authors are grateful to Mrs Rachel Horovitz, Co-ordinator of the Motav-Berman Project, for providing the data presented in this article.

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תשולים גם ונבוג ילדים קטנים

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- זאת על-פי תקנות מיוחדות, שאישרה אתמול
ועדת הנבחרת המיוחדת של הכנסת.
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Effective December 1, 1991, the National Insurance Institute will pay an allowance for handicapped infants under 3 years old.

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THE ALLOWANCE WILL NOT BE PAID for infants living in an institution or with a foster family, the parents not having to meet all the expenses of their maintenance.

THE ALLOWANCE WILL BE PAID FROM THE MONTH IN WHICH AN APPLICATION IS MADE, BUT NOT BEFORE THE INFANT IS 90 DAYS OLD.

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