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This paper discusses the use of court-imposed standards for public mental hospitals as a method of improving public mental health services. The standards set out in Wyatt v. Stickney are examined, and the author concludes that if implemented nationally such standards would transform the public hospitals. In addition, implementation would alter the power structure of mental health workers, effect the allocation of state and federal funds, and influence the larger system of mental health services. Socio-economic characteristics of public mental hospital patients, and an assessment of present care in this system are presented as central issues in mental health policy and planning.

Introduction

Conditions in our nation's state hospitals* have been less than therapeutic since their establishment over a century ago. While most states report having standards and/or licensing for psychiatric facilities, this cannot be taken as evidence of decent care: In 1969 Alabama reported having standards for the state mental hospitals, but the poor care and treatment received there has since been made public. Efforts by professional and lay organizations to fulfill standards which would provide adequate care and treatment have largely failed to transform the public hospitals.

Fifteen years ago the suggestion was made that adequate care and treatment of the mentally ill should be a constitutional right. The grounds for such a right were developed through a number of legal actions and it was confirmed in an Alabama U.S. District Court case, Wyatt v. Stickney, in 1971. In addition to declaring a constitutional right to treatment Federal Judge Frank Johnson Jr. mandated and defined adequate care and treatment. The standards set out in the Wyatt order of 1972 (hereinafter "the Wyatt standards") were the first such standards issued by a court, and by far the most comprehensive and ambitious set of standards issued by any body in this country. Previous standards did not approach the scope or authority of the Wyatt order. The Wyatt standards are not

* "State hospitals," "public mental hospitals," or "public hospitals" in this paper refer to state and county hospitals for mentally ill adults.
only guiding the upgrading of services in Alabama,\textsuperscript{5} but they serve as a model to other states struggling with the same issues.

This paper will examine the Wyatt standards as mental health policy. An overview of conditions in the public hospitals, the characteristics of the people who use them, and an analysis of the standards will be presented.

**Assessing the quality of care in public hospitals**

Since the beginnings of institutionalization for mental illness in the early 1800's, mental health professionals have generally agreed that outcome depends on certain factors including hospital size, staff-patient ratio, the opportunity for individual attention, and the hospital's psychological and physical environment. The most favorable outcome has been associated with hospitals no larger than one or two hundred beds where there is sufficient staff to give individualized treatment and where a comfortable, supportive environment exists.

Private hospitals\textsuperscript{*} have aimed for these conditions with considerable success, while public hospitals have typically fallen far short of the ideal and in many cases have provided the antithesis of what was considered to be therapeutic care. This paper is limited to an examination of the public system of care; however, the existence of a dual system of care must be noted as a factor in standard setting and implementation. Events affecting public care occur within the larger framework of public and private systems. So long as a private system exists which provides adequate care and treatment (for those fortunate enough to have access to it) there may be little incentive for policy makers to convert the public system. The following discussion is presented with a recognition of this larger framework.

The majority of hospitalized mentally ill people in the country utilize public mental hospitals. There were 324 state and county hospitals in 1971 with about 340,000 inpatient residents at the end of the year. There were approximately 745,000 patient care episodes\textsuperscript{**} in public hospitals in 1971.\textsuperscript{6} Public hospitals are typically larger than what has traditionally been considered optimum:

\textsuperscript{*} "Private mental hospitals": operated privately by an individual, partnership, corporation, or non-profit organization; includes non-profit and for-profit hospitals.

\textsuperscript{**} "Patient care episode" is a measure of utilization of facilities developed by N.I.M.H. "Patient care episodes are defined as the number of residents in inpatient facilities at the beginning of the year. . . . plus the total additions to these facilities during the year." (N.I.M.H. Utilization of Mental Health Facilities 1971. (Series B, No. 5) Dept. of Health, Education & Welfare: Washington, D.C. 1972, p. 2.)
The number of residents per hospital ranged from a few hundred to over a thousand.\textsuperscript{7} Gross overcrowding, a characteristic of public hospitals, has been reduced in recent years, but may still exist in some regions.

Staff size and composition, a critical component of care and treatment, has not been ideally determined. There is however general agreement regarding the numbers necessary to provide a minimum level of treatment, and it is generally agreed that the public hospital system falls short. Staffing patterns very widely: In 1974 the geographic region with the lowest staff-patient ratio had half the number of staff per patient population as the region with the highest ratio.\textsuperscript{8}

Per diem costs, or "Daily Maintenance Expenditures per Resident Patient," can be one indication of the level of services offered in a hospital. Per diem costs include: clothing, room and board; all professional treatment including medical services and medication.

When Wyatt v. Stickney was initiated in 1970, the per diem cost in Alabama was $7.00 and the national average was $15.00.\textsuperscript{9} Wyatt testimony and media coverage at that time revealed the gross neglect and destitute condition of patients in Alabama state hospitals. The following graph indicates that in 1970 fourteen states spent only about $5.00 per day more than Alabama, and sixteen spent about $10.00 more. Only four states spent $30.00 or more per day.

![Figure 1.10 Daily Maintenance Expenditures Per Resident Patient, State Hospitals (1970)](image)

-49h-
A general picture of the level of care in state hospitals can be inferred from this data.

In 1973, daily expenditures per patient ranged from $10.00 to $65.00, averaging $25.00. Twenty-four states exceeded the average—seven states spent $40.00 or more per day—and only three states (Mississippi, S. Carolina and W. Virginia) spent less than $15.00.11

Per patient expenditures in public hospitals have been steadily increasing, probably due to decreasing patient population,12 increased salaries, and inflation. Despite this trend, the percentage of the total state expenditures which each state spends to maintain its public mental hospitals has decreased steadily since first measured in 1957. There has been an average decrease of 13% from 1966 to 1970:

![Figure 2.13 State Hospital Allocations As A Percent of Total General State Expenditures, U.S. Average.](image)

While the 2.20% spent in 1970 represents more dollars than the 3.31% spent in 1956—approximately seven billion and three billion nationwide, respectively—the percentage increase in other categories (e.g., highways, education, utilities) has been much greater. It should be noted that the decrease in percentage spent on mental health has occurred at the same time as the expansion of services. Community services have been funded primarily by the federal government but required a gradually larger share from the states.

A final indicator in assessing care is mortality rate: in 1973 the mortality rate for public mental hospital patients was slightly over 7%.15 No comparable figures exist for private hospitals or institutions in general, but the mortality rate is slightly under 1% in the general population.16 A possible explanation for the high rate in public hospitals is the poor medical attention resulting from 1) inadequate numbers of qualified medical personnel and 2) inability to give individual care due to staff shortages in general.17
Characteristics of public hospital patients

Utilization of state hospitals is similar to utilization of public psychiatric inpatient facilities in general as to socio-economic characteristics. In addition to state hospitals, public psychiatric inpatient facilities include Veterans Administration (VA) inpatient services, general hospitals, residential treatment centers for emotionally disturbed children, and Community Mental Health Centers (CMHCs). Where possible, data on state hospitals is presented separately; otherwise it is included in "all public inpatient services" data.

Public hospitals make up only 17% of all public inpatient services but account for about one third of admissions and about three quarters of resident patients in inpatient services.  

The most striking feature of the public hospital patient population is the racial composition. The majority of admissions are white—in 1969, 300,000 were white, 60,000 non-white. However, the chart on admission rates to these hospitals (Figure 3. on following page) reveals that the non-white* rate is about one and a half times that of the white rate within each age group.

This disproportionate representation is consistent throughout public inpatient facilities (see Table A. on following page).

The disproportionate representation of non-whites in total admissions does not necessarily mean that the incidence of mental illness is higher among this group. The effect of racism on institutionalization rates, and studies of prevalence of mental illness in different racial groups, suggests that race is not directly related to mental illness. Race may be related to hospitalization rates, as it is closely linked to socio-economic status. Further data reveals a close tie between hospitalization and socio-economic status.

Figure 4. (see page ) illustrates marital status, sex and age characteristics of public hospital patients.

A survey of educational backgrounds of public hospital patients reveals the pattern shown in Figure 5. (see page ).

Heads of "female-head" families are more likely to be hospitalized than heads of husband-wife families, and in general heads of families who are aged 18-24 have a higher admission rate than older "heads." Admission rates for persons from small families are highest, and decrease as family size increases. Adults living alone had higher admission rates than those living with friends or

*This term is loosely used in data collection and reporting, sometimes excluding Spanish-Americans and other minority groups, sometimes including them. It can be assumed that it gives a conservative estimate of minority representation.
Figure 3.20 Admission Rates By Age, Sex, and Color, State Hospitals (1969).

TABLE A.21 Admission Rates Per 100,000 Population By Sex and Color, All Public Inpatient Services (1971).

<table>
<thead>
<tr>
<th>Color</th>
<th>Admission Rates</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td></td>
</tr>
<tr>
<td>Males</td>
<td>481</td>
</tr>
<tr>
<td>Females</td>
<td>248</td>
</tr>
<tr>
<td>Non-white</td>
<td></td>
</tr>
<tr>
<td>Males</td>
<td>930</td>
</tr>
<tr>
<td>Females</td>
<td>512</td>
</tr>
</tbody>
</table>
Diagnosis is not of itself a factor in conditions of care and treatment, although attitudes about a particular diagnostic label certainly can affect conditions. One third of all admissions to state hospitals are diagnosed Schizophrenic, the most debilitating and "incurable" mental disorder.
In further regard to diagnoses, it was determined that over 1500 patients residing in Alabama state hospitals were geriatric patients who required no psychiatric treatment and should have been in nursing homes, and over 1000 patients were mentally retarded, requiring services not appropriate to the supposed purpose of mental hospitalization. It is apparent that, regardless of diagnosis, some percentage of patients in public mental hospitals should not be there; that is, if the purpose of these hospitals is indeed to treat psychiatric disorders.

In summary, the data suggests that hospitalization for mental illness is closely related to race and socio-economic class. In their study of Social Class and Mental Illness, Hollingshead and Redlich have reported that of persons under treatment, both the incidence and prevalence of psychoses increases with each successively lower class. They conclude that

the excess of psychoses from the poorer area is a product of the life conditions entailed in the lower socio-economic strata of the society.

However, since their sample consisted only of persons in treatment (representing only 5% of all persons needing treatment, according to the Mid-Manhattan study) their conclusions apply only to people in treatment, and might more appropriately be stated thus: diagnosis and hospitalization for severe mental disorder is related to socio-economic status.

Noting that the admission rate for blacks has been double that of whites for at least forty years, NIMH suggests that the rates are affected by "the differential availability of mental health care, because of social and economic factors." Private psychiatrists care for between 750,000 and 1,200,000 persons annually, yet the fact that almost 40% of public hospital admissions in 1969 reported no previous psychiatric care supports the suggestion that public mental hospitals are the primary mental health facility for the lower classes.

Therefore, there exists a demonstrated--and widely recognized--need for change within the public mental hospital system and within the larger system of mental health care.

Possibilities for change prior to Wyatt

Although professionals and laymen were aware of the conditions in public hospitals, efforts to improve them have not been effective. Proposed standards--e.g., the American Psychiatric Association (APA), the Joint Commission of Accreditation of Hospitals (JCAH)--have had little effect on these generally impoverished hospitals: they could not meet standards so were not accredited; as a result they could not attract qualified staff, thus further lowering the quality of care. Exposes--such as Albert Deutch's classic The Shame of the States--and official reports alike changed conditions very little.
A major change, the large reduction in hospital populations in recent years, has been cited as an improvement. But community resources were not developed to meet the needs of these former patients and pre-release planning was often nil. The former patients were often worse off than when hospitalized because the communities where they were "placed" became more antagonistic toward them. The increased number of staff per patient in the hospital theoretically has benefitted the remaining population but without other improvements could scarcely transform the total system.

A second major change, the Community Mental Health Center (CMHC) movement, has no doubt affected conditions at the state hospitals, but indirectly and in a limited way. The CMHC Act--the most comprehensive federal intervention in mental health care to date--did not address the quality of care and treatment in state mental hospitals. As an alternative and preventative measure to extended care, the CMHC Act provided funding and guidelines to develop a community mental health system. Subsequent funding was granted for mental hospital programs which would "improve the quality of care and . . . provide in-service training for the personnel manning the institutions." Also, as a result of the CMHC movement, hospital staffs were in some instances augmented by CMHC personnel and programs were supplemented by the establishment of CMHC units within the state hospital. These events tended to positively affect the conditions at the hospital, but were part of an effort directed at integrating hospital services into community services, not improving hospital conditions.

The CMHC Act sought to make treatment more available, earlier, and at low cost to consumers. This thrust has had considerable success according to NIMH figures: while the total number of patient care episodes has more than doubled in the past twenty years,

state and county mental hospitals, which accounted for half of the patient care episodes in 1955, now account for only about a fifth of the yearly episodes . . . (whereas) outpatient psychiatric services . . . now account for the largest proportion of patient care episodes.

However, data on persons utilizing CMHCs suggests that hospitals and CMHCs serve slightly different groups of people: the educational level of hospital patients is lower, with only a small percentage completing high school compared with about half of all CMHC clients completing high school; male admission rates far outnumber female admissions to hospitals while the admission rates are about equal for men and women in CMHCs.

The enactment of Medicare and Medicaid also represented an attack on the quality of public mental health services, supposedly to upgrade services for the poor. But public mental patients under 65 were arbitrarily excluded from Medicaid benefits and even patients over 65 couldn't receive benefits if the hospital in which they were "treated" didn't meet the standards set by Federal regulation. Medicare coverage is limited to 190 days--a lifetime maximum--for
psychiatric hospitalization, whereas other medical conditions may recur and be covered for each spell of illness. These restrictions have served in many cases to perpetuate inadequate conditions, and have been cited as an example of racism on the part of the government due to the disproportionately high use of public hospitals by blacks.

The Wyatt Standards

The Wyatt order defines adequate care and treatment as comprised of three areas: a humane psychological and physical environment; a certain number of qualified staff; and individual attention. The standards are divided into improvements in each of these three areas; in addition, the standards address what has been termed "sanism" by Morton Birnbaum, who first suggested "a right to treatment":

Sanism is the irrational thinking, feeling and behavior patterns of response by an individual or by a society to the irrational—and too often, even to the rational behavior—of a mentally ill individual.

Birnbaum emphasizes that sanism prevails no less among mental health professionals. It has been suggested that, universally,

It is difficult to empathize with the mentally ill. It is unnatural . . . to share the feelings of someone who does not talk about the same subject at the end of a sentence as he did at the beginning, who sees and responds to things we do not see, whose mood, reason and very identity may change from moment to moment. These unfortunate people are uncanny, disconcerting, and inevitably alien to us. They invite rejection.

Birnbaum observes that sanism is

. . . An unnecessary and disabling oppressive burden that is added by our bigoted and prejudiced sanist society to the very real affliction of severe mental illness.

The fact that the Wyatt standards are the only comprehensive and specific proposal with power to provide adequate care and treatment in the nearly two centuries of public care of the mentally ill supports Birnbaum's conclusions.

The Wyatt standards attack many specific manifestations of sanism that have persisted in public hospitals. Whether established for staff's convenience—e.g., the use of uniforms or communal garments for patients rather than personal clothing—or simply out of a sense of extreme indifference—e.g., the apparent assumption that mental patients don't care about their surroundings—many daily routines have degraded, restricted unnecessarily, exploited, and deprived patients. The Wyatt standards address these routines in Standards 1-20; entitled "Humane
Psychological and Physical Environment."

The Wyatt standards in general provide that any deviation from their pro-
visions must be justified by the hospital staff and can only be of limited dura-
tion. For example, Standard 4 assures visitation rights

except to the extent that the Qualified Mental Health Profession-
al responsible for formulation of a particular patient's treatment
plan writes an order imposing special restrictions. The written
order must be renewed after each periodic review of the treatment
plan if any restrictions are to be continued.

Standards 1-20 are briefly presented below:

1. Patients have a right to privacy and dignity.
2. Patients have a right to the least restrictive conditions necessary
to achieve the purposes of commitment.
3. No person shall be deemed incompetent to manage his affairs . . .
   solely by reason of his admission or commitment to the hospital.
4. Patients shall have the same rights to visitation and telephone
   communications as patients at other public hospitals. . . .
5. Patients shall have an unrestricted right to send sealed mail. . . .
6. Patients have a right to be free from unnecessary or excessive
   medication. . . .
7. Patients have a right to be free from physical restraint and iso-
   lation. . . .
8. Patients shall have a right not to be subjected to experimental
   research. . . .
9. Patients have a right not to be subjected to treatment procedures
   such as lobotomy, electro-convulsive treatment, aversive reinforcement
   conditioning or other unusual or hazardous treatment. . . .
10. Patients have a right to receive prompt and adequate medical
    treatment. . . .
11. Patients have a right to wear their own clothes and to keep and use
    their own personal possessions. . . .
12. The hospital has an obligation to supply an adequate allow-
    ance of clothing to any patients who do not have suitable clothing of
    their own. . . . Such clothing shall be considered the patient's through-
    out his stay in the hospital.
13. The hospital shall make provision for the laundering of patient
    clothing.
14. Patients shall have a right to regular physical exercise several
    times a week.
15. Patients have a right to be outdoors at regular and frequent
    intervals. . . .
16. The right to religious worship shall be accorded to each patient
    who desires such opportunities. . . .
17. The institution shall provide, with adequate supervision, suitable opportunities for the patient's interaction with members of the opposite sex.

Standard 18 addresses the issue of institutional peonage, a longstanding concern of civil libertarians and many mental health workers. Institutional peonage can be defined as the uncompensated patient labor at a task which otherwise would have to be performed by a hospital employee, e.g., mopping floors, laundering clothes, etc. This labor has been defended as "therapeutic" or called "job training", and has been typically required of patients. When compensated, such work has been paid for in insufficient and degrading ways: a few cents an hour; extra cigarettes; special consideration for release; or privileged status.

Standard 18 defines the circumstances under which patient labor is appropriate, and sets out rules governing labor. The first rule sets the general limits:

No patient shall be required to perform labor which involves the operation and maintenance of the hospital or for which the hospital is under contract with an outside organization. Privileges or release from the hospital shall not be conditioned upon the performance of labor covered by this provision. Patients may voluntarily engage in such labor if the labor is compensated in accordance with the minimum wage laws of the Fair Labor Standards Act...

The second rule covers those tasks which might be deemed therapeutic; a third rule permits personal housekeeping activity; and the last rule states that payment for labor cannot be applied to hospital fees.

Standards 19 and 20 describe minimum physical facilities and nutrition which must be available to patients. Standard 19 covers various areas of patient life including sleeping quarters, lavatories, day rooms, etc., as well as the temperature and ventilation of these areas. Details such as "one tub or shower for each 15 patients" are set out, similar to JCAH standards. The overall goal of Standard 19 is that:

facilities . . . designed to afford patients with comfort and safety, promote dignity, and ensure privacy . . . make a positive contribution to the efficient attainment of the treatment goals of the hospital.

Standard 20 states that "patients, except for the non-mobile, shall eat or be fed in dining rooms" and sets out minimum nutritional requirements.

Implementation of rights in Standards 1-20 would be very costly. (It should be noted that while most states recognize patients' rights in varying degrees, implementation is not assured.) Standard 18 alone, governing patient labor,
would be enormously expensive: a Pennsylvania state official has stated that there is no justification for having patients work without compensation, however, institutions legitimately complain that lack of staff, lack of monies, primitive equipment and increasing admissions have necessitated patients to work.46

In Pennsylvania a lawsuit brought by patient-workers at various state hospitals has resulted in a consent decree specifying conditions of patient employment. In May 1974, when the lawsuit was filed, there were 6,000 patients in the state working 30 or more hours per week for little or no remuneration. By December 1974 there were 400 patient workers. Since patients are now permitted to work only 15 hours a week and must be paid at least the rate for handicapped workers, the economic effect of this legal action is indeed enormous.

The standards governing physical facilities--Standard 19--would also require large financial commitment. Most hospitals do not now provide the semi-private accommodations set out therein, and for many hospitals major renovations would be necessary to meet fire and safety requirements, maintain comfortable temperatures, and provide minimum numbers of bathroom facilities.

Some standards merely require changing hospital patterns (albeit not a simple undertaking) rather than large financial output: rights to privacy and dignity; visitation, telephone and mail use; the right to wear their own clothing; the right to be outdoors and have regular exercise; the right to interact with members of the opposite sex.

Other standards impinge on what has traditionally been defended by professionals as their exclusive domain: the use of medication (Standard 6), physical restraint (Standard 7), research (Standard 8), and treatments (Standard 9) such as lobotomy, shock, and aversive conditioning. The American Psychiatric Association, in their "Position Statement on the Question of Adequacy of Treatment" stated that "It is the responsibility of the physician to determine the appropriate treatment techniques to fit the individual patients' physical and psychological needs, assets and circumstances,"47 and "The definition of treatment and the appraisal of its adequacy are matters for medical determination."48 In an amicus brief filed with the Wyatt court regarding amendments to Section 9, the A.P.A. maintained this bias,49 while other professional organizations expressed closer allegiance with Judge Johnson's intent.50

Standards 21-24 are entitled "Qualified Staff in Numbers Sufficient to Administer Adequate Treatment." Standard 21 requires that all professional staff meet state licensing and certification requirements. Standard 22 provides for "substantial orientation training" for non-professionals and on-going inservice training for all staff. Standard 23 requires supervision of non-professionals by professionals.
Standard 24 required the following minimum number of staff per 250 patients:

<table>
<thead>
<tr>
<th>Classification</th>
<th>Number of Employees</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unit Director</td>
<td>1</td>
</tr>
<tr>
<td>Psychiatrist (3 years' residency training in psychiatry)</td>
<td>2</td>
</tr>
<tr>
<td>MD (Registered physicians)</td>
<td>4</td>
</tr>
<tr>
<td>Nurses (RN)</td>
<td>12</td>
</tr>
<tr>
<td>Licensed Practical Nurses</td>
<td>6</td>
</tr>
<tr>
<td>Aide III</td>
<td>6</td>
</tr>
<tr>
<td>Aide II</td>
<td>16</td>
</tr>
<tr>
<td>Aide I</td>
<td>70</td>
</tr>
<tr>
<td>Hospital Orderly</td>
<td>10</td>
</tr>
<tr>
<td>Clerk Stenographer II</td>
<td>3</td>
</tr>
<tr>
<td>Clerk Typist II</td>
<td>3</td>
</tr>
<tr>
<td>Unit Administrator</td>
<td>1</td>
</tr>
<tr>
<td>Administrative Clerk</td>
<td>1</td>
</tr>
<tr>
<td>Psychologist (Ph.D.) (doctoral degree from accredited program)</td>
<td>1</td>
</tr>
<tr>
<td>Psychologist (M.A.)</td>
<td>1</td>
</tr>
<tr>
<td>Psychologist (B.S.)</td>
<td>2</td>
</tr>
<tr>
<td>Social Worker (MSW) (from accredited program)</td>
<td>2</td>
</tr>
<tr>
<td>Social Worker (B.A.)</td>
<td>5</td>
</tr>
<tr>
<td>Patient Activity Therapist (M.S.)</td>
<td>1</td>
</tr>
<tr>
<td>Patient Activity Aide</td>
<td>10</td>
</tr>
<tr>
<td>Mental Health Technician</td>
<td>10</td>
</tr>
<tr>
<td>Dental Hygienist</td>
<td>1</td>
</tr>
<tr>
<td>Chaplain</td>
<td>.5</td>
</tr>
<tr>
<td>Vocational Rehabilitation Counselor</td>
<td>1</td>
</tr>
<tr>
<td>Mental Health Field Representative</td>
<td>1</td>
</tr>
<tr>
<td>Dietitian</td>
<td>1</td>
</tr>
<tr>
<td>Food Service Supervisor</td>
<td>1</td>
</tr>
<tr>
<td>Cook II</td>
<td>2</td>
</tr>
<tr>
<td>Cook I</td>
<td>3</td>
</tr>
<tr>
<td>Food Service Worker</td>
<td>15</td>
</tr>
<tr>
<td>Vehicle Driver</td>
<td>1</td>
</tr>
<tr>
<td>Housekeeper</td>
<td>10</td>
</tr>
<tr>
<td>Messenger</td>
<td>1</td>
</tr>
<tr>
<td>Maintenance Repairman</td>
<td>2</td>
</tr>
</tbody>
</table>

While the APA, the JCAH and other standard-setting bodies have long recognized the correlation between number of staff and treatment success, they typically did not specify numbers because they recognized that minimum levels
would not be met. Instead they recommended "staff sufficient in number and skills to meet the needs of the patients and to achieve program goals." 51

The Wyatt standards 52 would improve staff ratios in many states, although comparison with the U.S. average in selected categories indicates the following:

<table>
<thead>
<tr>
<th>TABLE B. 53 Wyatt Staff Ratio Standards And State Hospital Staff Ratio, U.S. Average (1973).</th>
<th>Wyatt</th>
<th>U.S. Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatrists</td>
<td>1.4</td>
<td>2.4</td>
</tr>
<tr>
<td>Physicians (M.D.)</td>
<td>2.8</td>
<td>1.2</td>
</tr>
<tr>
<td>Psychologists</td>
<td>2.8</td>
<td>1.3</td>
</tr>
<tr>
<td>Social Workers</td>
<td>4.9</td>
<td>2.8</td>
</tr>
<tr>
<td>Registered Nurses</td>
<td>8.4</td>
<td>7.1</td>
</tr>
</tbody>
</table>

Wyatt proposes about half the number of psychiatrists as are now on staff: the number of R.N.s would increase slightly; the number of social workers would be increased by about two-fifths; the largest increase would be more than double the number of M.D.s and psychologists now on staff.

A breakdown of the U.S. average reveals a wide range of professional staff ratio, between geographic regions and within geographic regions. The highest-staffed region is compared below to the lowest-staffed region, with the range within each region also presented:

<table>
<thead>
<tr>
<th>TABLE C. 54 Staff Ratio Range: Highest and Lowest Staffed Regions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Highest Staffed Region</td>
</tr>
<tr>
<td>-------------------------</td>
</tr>
<tr>
<td>Region VIII</td>
</tr>
<tr>
<td>Psychiatrists</td>
</tr>
<tr>
<td>Physicians</td>
</tr>
<tr>
<td>Psychologists</td>
</tr>
<tr>
<td>Social Workers</td>
</tr>
<tr>
<td>Registered Nurses</td>
</tr>
</tbody>
</table>

The range within each professional category nationwide reveals a wide disparity, the lowest existing ratio in each category being far below Wyatt, the
highest far above except for M.D.s.

<table>
<thead>
<tr>
<th>Staff Ratio Range: Highest and Lowest State In Each Staff Category.</th>
<th>Wyatt</th>
<th>Highest Ratio</th>
<th>Lowest Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatrists</td>
<td>1.4</td>
<td>14.3 (Colo.)</td>
<td>0.1 (Ala.)</td>
</tr>
<tr>
<td>Physicians</td>
<td>2.8</td>
<td>2.5 (Ariz.)</td>
<td>0.4 (Nev.; Haw.)</td>
</tr>
<tr>
<td>Psychologists</td>
<td>2.8</td>
<td>7.5 (Colo.)</td>
<td>0.3 (Miss.)</td>
</tr>
<tr>
<td>Social Workers</td>
<td>4.9</td>
<td>9.4 (Iowa)</td>
<td>0.7 (Miss.)</td>
</tr>
<tr>
<td>Registered Nurses</td>
<td>8.4</td>
<td>30.0 (Alas.)</td>
<td>3.3 (Miss.)</td>
</tr>
</tbody>
</table>

The magnitude of the task of meeting Wyatt staffing standards is illustrated through a comparison of Minnesota and Mississippi:

<table>
<thead>
<tr>
<th>Population, Cost, Staff: Mississippi and Minnesota.</th>
<th>Miss.</th>
<th>Minn.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Patients Under Care (1974)</td>
<td>10,524</td>
<td>13,590</td>
</tr>
<tr>
<td>Average Daily Census</td>
<td>4,181</td>
<td>4,229</td>
</tr>
<tr>
<td>Annual Number of Patient Days</td>
<td>1,526,045</td>
<td>1,543,604</td>
</tr>
<tr>
<td>Daily Expenditures Per Resident Patient</td>
<td>$9.99</td>
<td>$23.52</td>
</tr>
<tr>
<td>Full Time Equivalent Inpatient Staff</td>
<td>2,165</td>
<td>3,488</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Staff Ratio: Mississippi and Minnesota.</th>
<th>Wyatt</th>
<th>Miss.</th>
<th>Minn.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatrists</td>
<td>1.4</td>
<td>0.5</td>
<td>0.6</td>
</tr>
<tr>
<td>Physicians</td>
<td>2.8</td>
<td>0.5</td>
<td>1.8</td>
</tr>
<tr>
<td>Psychologists</td>
<td>2.8</td>
<td>0.3</td>
<td>1.0</td>
</tr>
<tr>
<td>Social Workers</td>
<td>4.9</td>
<td>0.7</td>
<td>2.9</td>
</tr>
<tr>
<td>Registered Nurses</td>
<td>8.4</td>
<td>1.4</td>
<td>9.8</td>
</tr>
</tbody>
</table>

Minnesota is close to the national average ($25) in daily expenditures per resident patient, yet has about half the recommended staff ratio except for nurses. Therefore it can be conjectured that the majority of states—which spend $15.00 to $30.00 per day—would have to increase staff. That the size of increase would be substantial is indicated by comparing Minnesota to Mississippi. Though they
serve about the same number of patients, Mississippi has 1,300 less professional staff and is considerably lower than Minnesota in staff-patient ratio. Apparently, Mississippi would have to hire 1,300 new professional staff just to reach Minnesota's staffing level. Since Minnesota's staffing level is itself considerably lower than Wyatt standards (except for nurses) and would have to increase its staff as well, it is evident that thousands of additional professional personnel alone would be required to meet Wyatt standards nationwide.

Standards 25-34, "Individualized Treatment Plans," seek not only to prevent the mass treatment which has often resulted in institutionalization and neglect, but also to assure accountability for each patient. Prompt and appropriate treatment are mandated for hospital and post-hospital care, and documentation and approval is required at every step. This would entail not only increased staff and services, but decreased professional autonomy as discussed above.

Judge Johnson stipulated that upon admission the patient and her family receive a written copy of the standards, and that a copy be posted on each ward. The Court also established seven-member "human rights committees" at each state hospital and appointed the members. The Committees are responsible for reviewing research proposals and rehabilitation programs "to ensure that the dignity and the human rights of patients are preserved." The committee is also charged with assisting patients who "allege that their legal rights have been infringed or that the Mental Health Board has failed to comply with judicially ordered guidelines."

The Wyatt standards apply primarily to inpatient psychiatric services. They recognize the need for after-care (Standard 34) and continuity (Standards 26 & 27), but are limited to hospitals and do not address community care. However, Wyatt does attack practices stemming from the fact of hospitalization: even after release from the hospital, former mental patients are frequently arbitrarily restricted in many activities. Wyatt states that

No person shall be deemed incompetent to manage his affairs, to contract, to hold professional or occupational or vehicle operator's licenses, to marry and obtain a divorce, to register and vote, or to make a will solely by reason of his admission or commitment to the hospital. (Standard 3)

Implementation would afford former mental patients greater status and greater access to goods and services.

Effects of the Wyatt Standards

The fundamental concept of adequate care and treatment established by the Wyatt standards is hardly new: humanitarians since the early 1800's have recognized the necessity of a humane psychological and physical environment, a large proportion of staff to patients, and individualized care in treating mental
illness. Private mental hospitals are modeled on this concept of treatment. Public mental hospitals, however, operating at the lowest possible cost, have provided the bare minimum in surroundings and staff, and individualized treatment is impossible under those conditions.

Prevailing attitudes toward a particular group of people are an important dynamic in policy development and implementation. Unfortunately, patients in public mental hospitals suffer doubly; discriminated against on the basis of their affliction or label, and subject to further discrimination on the basis of their racial and socio-economic backgrounds.

It appears, through the failure of previous standard-setting efforts, that adequate care and treatment in public mental hospitals can only be assured through Federal judicial and/or legislative decisions. For instance, even though Alabama has vigorously opposed compliance with Wyatt standards, many changes including a substantial increase in daily maintenance expenditures have occurred as a result of Federal intervention. The former Alabama mental health commissioner has stated that

The tradition of appealing to the Constitution to expand narrow conceptions of civil rights . . . still may be the last hope of mental patients and their caregivers, against what remains in most states as continuing neglect and absurd funding priorities set by state governments.

There is no doubt that national implementation of the Wyatt or similar standards would drastically change the public mental hospital system. They would alter the power structure of mental health workers and the pattern of labor distribution, effect the federal and state distribution of economic resources, and influence the role of the public hospital in mental health services.

It is feasible that a shift or redistribution of power could occur in two ways: First, as increased decision-making is given to patients, Human Rights Committees, Technical Committees, Review Committees, in-hospital legal staff, ombudsmen, etc., the mental health professional's realm of authority is reduced and their decisions subject to review and veto. Since psychiatrists have traditionally hoarded power in the hospitals, Wyatt standards could result in a greater interdependence among all staff, i.e., power once held by psychiatrists being shared by all disciplines and levels. Wyatt speaks of "mental health professional" and does not single out psychiatrists as the ultimate authority.

Second, new careers and directions may emerge: if there simply are not enough professionals available and/or willing to enable public hospitals to meet the staffing standards, there could result a strong push for paraprofessional training and utilization, and a real evaluation of this kind of contribution. This would not only result in a different staffing pattern but would open up jobs and career opportunities for non-professional staff, resulting in a change in
their status and economic situation as well. In addition or alternatively, a scarcity of professionals for public hospital positions might prompt professional training programs to re-examine their concept of service; perhaps professional care would begin to be regarded more as a national rather than a regional or otherwise restricted resource.

These possibilities exist despite the status quo stance of Wyatt in this area. The Wyatt order unintentionally caters to the prestige interests of medical and mental health professionals, few of whom have any interest in state hospitals anyway.61

Current funding on both federal and state levels would have to change in order to implement Wyatt standards. It is difficult to compare existing N.I.M.H. data on public hospital staffing with the Wyatt standards in order to determine the gap between current services and adequate services. However, it seems a reasonable estimate based on existing data that the vast majority of state and county hospitals would fall below minimum standards in some areas, and perhaps half of the hospitals would have to undertake major staffing recruitment and building renovation programs to comply. In Alabama, the state immediately had to raise a $2 million bond to correct fire hazards and hire an initial 500 employees in order to avoid court appointment of a master to oversee compliance with standards.62

Would the Wyatt standards eliminate or reduce the disparity between public and private hospitals? Fully implemented, they would dramatically improve the public hospitals but they would not close the gap in at least two areas: staff to patient ratio and hospital size. Since private hospitals now employ five times the number of professionals per 1,000 patients as public hospitals63 and the Wyatt standards would primarily raise the lower-staffed public hospitals to the level of the higher-staffed public hospitals, the gap would remain.

The Wyatt standards attempt to affect the quality of life as well as availability of treatment staff: privacy, pleasant and stimulating surroundings, and adequate space are all included, but the standards are applied to existing facilities--large institutional buildings, relics of "warehousing" policies, located far from the community they serve. Wyatt takes no position regarding the size of the facility although this factor has long been recognized as crucial to treatment outcome.

Aims of Hospitalization

Further evaluation of Wyatt standards--or any policy regarding public mental hospitals--is based on the long and short term aims of hospitalization; the role of the hospital itself and the purpose of "care and treatment" in the hospital.
The status of the public mental hospital was uncertain during the first years of the CMHC movement, but seems to be generally regarded now as a necessary component in a comprehensive system. Considerable research has been done on how the state hospital can be made relevant and effective. Acceptance of the hospital is by no means unanimous: a number of groups advocate dismantling the system, and some states are moving in that direction. National implementation of the Wyatt standards could terminate this debate: the mobilization of funds, labor, renovations, etc., necessary to convert the nations hospitals into treatment facilities would not only firmly establish them but may alter the direction of future planning for mental health services. A recent article regarding the Wyatt standards noted that:

Its reordering of state fiscal and policy priorities to meet pressing needs in mental health has been appropriately hailed as an important legal precedent; its focus, however, is exclusively on the allocation and expenditure of state funds for mental health institutions. Given finite resources for mental health services, this emphasis is inconsistent with the general shift toward community-based mental health programs.

The author recommends the application of Wyatt standards with appropriate modification to all mental health services as a way to "prevent the diversion of funds and resources from community mental health programs, and accomodate and promote alternatives to institutional residential care."

Apropos of this issue, Judge Johnson introduced a very important treatment goal as a constitutional right in Standard 2: "the least restrictive conditions necessary to achieve the purposes of commitment." This concept has thus far not been defined, but has attracted the attention of mental health planners and lawyers active in patients rights. The implementation of this standard would cut to the core in the present contest between the public mental hospitals and CMHCs for funds and other resources.

Finally, serious consideration must be given to the dynamics determining hospitalization. Two divergent approaches to the phenomenon seem apparent: one is based on the assumption that hospitalization is a necessary consequence of a medical/psychological condition; the other is based on the assumption that hospitalization is a consequence of a sociological condition.

According to the first approach a person is hospitalized in order to be treated for the medical/psychological condition and it is expected that hospital treatment will improve or even cure the condition. Within this "medical" framework, the racial and socio-economic characteristics of public hospital patients might be explained by pointing to the increased risk to health and mental health.
entailed by poverty conditions and severe emotional stress experienced by non-white and poor groups in this culture.\textsuperscript{67}

According to the second approach to the phenomenon of hospitalization, a person is hospitalized primarily as a result of racial and/or socio-economic characteristics. The homogeneity of public hospital patients in this regard may result from a tendency to institutionalize certain groups: the former mental health commissioner of Alabama has stated that

> In Alabama, curiously, the counties that send the most patients to state hospitals are usually the same ones that send the most criminals to the state prisons. The decision about which asylum the aberrant citizen will reside in is frequently a toss-up. Demographic profiles of populations hiding out in state hospitals and in state prisons would show important properties in common: low socioeconomic, educational, and vocational levels; . . . \textsuperscript{68}

It may be that non-institutional mental health services are not available to this group, at least not to the extent that services are available to other groups. Regardless of orientation--medical or social--policy makers cannot escape the social component of public hospital use. Yet policies have been made and implemented as if hospitalization were a purely medical decision and in fact as if hospitalization were proven to be necessary and beneficial for all those hospitalized.\textsuperscript{*}

Mental health knowledge is limited particularly regarding psychosis, and current treatment of mental disorders can best be characterized as an ongoing experiment. Bruce Ennis addressed this point in the following statement regarding standards:

> Adding more psychiatrists to mental hospital staffs may confer the aura of adequate treatment, but not necessarily the substance. Perhaps it would be wiser to utilize resources for basic empirical research into the "causes" of mental illness. Only by learning more about what mental illness is can we intelligently determine which types of treatment are adequate.\textsuperscript{69}

\textsuperscript{*} The Wyatt opinion does not challenge the medical definition of mental illness; however, diagnosis is as dependent on social, cultural, political, and economic factors as is hospitalization. For a discussion of social and medical components in the process of diagnosis, see Peter Sedgwick, "Illness-Mental and Otherwise" and Robert M. Veatch, "The Medical Model: Its Nature & Problems" in The Hastings Center Studies, Vol. 1, No. 3, 1973. A political and economic analysis of hospitalization is presented in Michael Foucault's Madness and Civilization (New York: Random House, 1973), and Andrew Scull's Decarceration: A Radical View (forthcoming book, Prentiss-Hall).
Mental health professionals have not demonstrated that hospitalization is beneficial and in fact some data and studies suggest that hospitalization is detrimental. David Rothman proposes the following:

Enough energy has already been spent on tinkering with institutional programs for the deviant. Let us instead cast out new nets, try to devise programs not because we see the prospect of ultimate cure but because we acknowledge our ignorance and think we may be able to devise better strategies for coping with it.70

The conditions in public mental hospitals need attention: full implementation of standards such as Wyatt would unquestionably improve conditions for hospitalized patients. However, implementation would also push mental health services in a direction which may not be desired. Thoughtful policy planning in the area of standards is necessary if this country hopes to finally eliminate "the shame of the states."

FOOTNOTES

10. Ibid.
11. Ibid., p. 10.
12. Ibid., p. 15, 16.
15. NIMH, Statistical Note 106, p. 7.
18. NIMH, Utilization..., op. cit., p. 4.
19. NIMH, Socio-Economic Characteristics of Admissions to Inpatient Services of State and County Mental Hospitals, 1969 (Series A, No. 8) (Wash., D.C.: DHEW,
20. Ibid., p. 6.
21. NIMH, Utilization..., op. cit., p. 25.
23. NIMH, Socio-Economic..., op. cit., p. 8.
24. Ibid., p. 9.
25. Ibid., pp. 2 - 10.
29. Ibid., p. 242.
31. NIMH, Socio-Economic..., op. cit., p. 7.
32. Ibid., p. 11.
33. APA, op. cit.
36. NIMH, Utilization..., op. cit., p. 16.
37. See Text, above, for source of hospital data.
40. Ibid., pp. 4 - 5.
43. Ibid., p. 108.
44. Ibid., p. 106.
47. APA, op. cit., p. 103.
48. Ibid., p. 102.
51. JCAH, op. cit., p. 41.
52. The Wyatt ratios were converted by the author, for comparison, to "average full time equivalent staff per 1,000 patient days" used by NIMH. Based on national averages (see Statistical Note 106, op. cit.) it was estimated that a 250 patient unit would average 200 patients on a daily basis. See Statistical Note 109, op. cit., p. 36, for formula.

53. See above and Statistical Note 109, op. cit., pp. 4 - 34.

54. Ibid.

55. Ibid.

56. Ibid.

57. Ibid.


60. Stickney, p. 460.

61. Ibid., p. 458.


66. Ibid., p. 37.


68. Stickney, op. cit., p. 458.


DIFFERENTIAL UTILIZATION OF THE HEALTH CARE DELIVERY SYSTEM
BY MEMBERS OF ETHNIC MINORITIES

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Research and statistical reports of the 1960's strongly attested to the underutilization of the health care delivery system by members of ethnic minorities. For example, a 1968 national report on hospital utilization showed that a larger proportion of white persons was hospitalized than were persons of 'color.' This was found to be true regardless of sex and age; but "... as family income increased, the rate for white persons and those of other races became closer." This fact not withstanding, each income level saw whites using hospitalization more than persons of 'color.' Reasons for this difference in utilization were offered by the authors of the above report: "It is ... not just the orientation of physicians nor the age and sex of a person that dictates whether he will be hospitalized. Of prime consideration is one's realization or knowledge of his own condition and his attitudes toward disease, illness, and the medical profession." Although cultural factors were not offered as reasons for the difference in utilization, Suchman in his 1964 report on the Sociomedical Variations Among Ethnic Groups, interpreted his findings of underutilization to be the result of cultural factors that influenced attitudes toward illness and the medical profession.

Although statistical reports and research of the 1960's indicated a lesser utilization of the health care system by members of ethnic minorities when compared to members of the compact majority, there was mention in the aforementioned 1968 statistical report of the increase in ethnic minorities utilization of hospitalization over that reported in 1965. This fact of an increase in utilization over a three year span suggested to this writer the possibility that there no longer would be found a significant difference in utilization over a 6½ year span. This possibility became the impetus for a library search through research published in the 1970's on ethnic minorities' utilization of the health care delivery system.

The initial questions guiding the search were

What is the pattern of utilization of the health care delivery system by members of ethnic minorities?

Which variables seem to be associated with levels of utilization?

The purpose of this paper is to explore answers to the above and related questions as they are found in research of the 1970's.

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Definitions of Terms:

There are four concepts that descriptively must be defined: Ethnic Minorities, Compact Majority, Underutilization, and the Health Care System.

For the purposes of the author's exploration of published research, ethnic minorities were Mexican, Black, American Indian, Puerto Rican, and Oriental groups which are found in the United States. Each of these ethnic groups has a recognizable culture, except for the black group. Yet, this group also can be said to have a sub-culture. Furthermore, each minority, except the Puerto Rican group, has distinctive physical characteristics that identify its members as belonging to one ethnic group as opposed to another group. Even though the members of the Puerto Rican group cannot be distinguished readily from other Latin or often, Black groups, they do have subtle cultural, historical and lingual characteristics that differentiate their Puerto Rican group membership from other Latin and Black group memberships.

These five ethnic groups, when taken singularly, are considered to be in the minority, although if all members of the five groups were totaled ethnic minorities might comprise the majority in this country.

In addition to cultural and physical characteristics, each of these groups legally are considered non-white except the Mexican group. However, all have been in an inequitable position in this country, with respect to free access to education, employment, housing, and political representation.

The compact majority is comprised of all remaining members of ethnic and non-ethnic groups whose members are classified as "white" or Caucasian. On the whole, they have access to all of the opportunities that this country provides. In this paper, the term, "compact majority," will be used interchangeably with the term, white.

Whereas the above descriptive definitions of ethnic minority groups versus the compact majority were helpful to the author as she examined the research of the 1970's, the research reports apparently did not always find these definitions useful for their purposes. For instance, one national report on hospital utilization used the terms, "color" and "white." The term, "color," may be a step above the once usual term, "non-white," but it still fails to differentiate the groups so classified. Therefore, it is not any clearer than the term, "non-white."

Another deviation from the author's definition was that used by one of the studies on American Indians. This study ignored the fact that a person born of an Indian person and a white person legally is considered to be a member of the white racial group. Perhaps the researchers were attuned to the possibility that these persons are also in an inequitable position and therefore included them in their study of American Indians.

The definition of the concept, underutilization, seems to rest on the compact majority's average rate of utilization. Thus, underutilization is
a rate of utilization that falls below the compact majority's average, just as overutilization is a rate that is above the compact majority's average. Even when utilization rates are derived within minority ethnic groups, the interpretation of the information almost always relates to the majority standard. Unfortunately, the compact majority's average often is considered to be the normal occurrence. Thus, when the occurrence rate is above or below the white average, it is considered to be abnormal. Yet, such a judgment is misleading because we don't know what rate of utilization under what circumstances helps to prevent the onset of any illness or to treat an existing condition that can only be provided by members of the health care delivery system.

The Health Care Delivery System was viewed as including services directed toward the prevention or improvement of biologically and/or psychologically damaging conditions. Also included were services directed toward the maintenance of a level of health. Such services are offered through hospitals, clinics, nursing homes, or by private practitioners. Thus, the professionals providing care are medical doctors, nurses, psychologists, and medical and psychiatric social workers.

Findings:

The findings to be reported were culled from research and statistical reports published in the 1970's. All addressed the question of utilization of some service within the health care delivery system by 1) specifically Blacks, American Indians, and Mexicans who reside in this country. (No research could be found on health system usage by Puerto Ricans and Orientals.) or 2) all ethnic minorities.

The question -- What is the pattern of utilization of the health care delivery system by members of ethnic minorities; and what variables are associated with levels of utilization -- received answers according to factors both external and internal to the health care delivery system. Major external variables to be examined are attitudes toward health care providers and the health care system; culture; and social environmental factors. Internal variables to be examined include the availability of service and attitudes of health care professionals. It is recognized that variables which are external and internal to the health care delivery system interact with one another to produce an over-arching constellation which can explain utilization patterns.

External Factors

Attitudes: Gylys and Gylys showed that lower income Blacks did not hold negative attitudes toward medical institutions or the medical profession. No significant difference was found between the attitudes of low-income Blacks and those of middle-class whites. As a matter of fact, low income Blacks tended to place considerable trust in the medical care delivery system and its professionals. They believed, perhaps naively, that they would receive the same quality of medical care in a public clinic as they would from a private physician.
Cultural Factors: Only with Fuentes' study on Mexican migrant laborers was there an indication of cultural factors influencing the use of health care services. Ready access to services was offered through mobile health care units. Yet the Mexican male, in particular, did not avail himself of the care but rather waited to seek attention until he had such a severe illness that hospitalization was required. Thus, these Mexican males had to remain in the hospital longer than their white counterparts. A potentially plausible interpretation is that the cultural factor "machismo" operated to prevent the men from seeking care for minor health problems and to seek care only when illness had progressed to the point that they could not work or otherwise function outside the hospital.

Socio-Economic Status: Most of the research on ethnic minorities did indicate an association between income and/or social class and utilization rates of health care services. This association was found whether the study was about American Indians, Mexicans, or Blacks. Lack of income was associated particularly with the underutilization of health care services. To illustrate, in one study of low income Black people, it was found that they tended to rank order priorities for the expenditure of their monies. The use of sparse funds to meet expenses connected with searching for higher paying job opportunities took priority over its use in seeking out-patient medical services or for hospitalization. Even when money is expended for health care, it is in terms of crises. That is, when impairment of functioning becomes so pervasive or so obvious in the immediate situation that the individual feels that problem stands out above the rest, some action is taken. It flows from this that seeking health care services for preventative or rehabilitative purposes is a relatively low order priority for the poor regardless of ethnicity.

Insofar as the utilization of public and private health services having economic determinants, it is noteworthy that the majority of ethnic minority groups use publicly sponsored health care; whereas, the majority of the compact majority use health services under private auspices.

Furthermore, it is not surprising to find that middle income Blacks tend to operate as do their white counterparts; that is, they utilize the health care system in much the same manner as does the compact majority. Middle class Blacks are more akin to middle class whites than either to lower socioeconomic Black or white classes.

Internal Factors

Availability of Health Care: Several studies have sought to learn if the availability of health care services made a difference in utilization by members of ethnic minorities of those services. Some of these studies actually supplied services in certain geographical areas deemed more accessible to the target ethnic groups in order to examine whether the services would be utilized. However, with some ethnic groups, even with greater availability, the utilization of the service was less than expected. For example, in a research and demonstration project with American Indians, antepartum, post-
partum and new born care were offered on an out-reach basis by a team of nurses, medical doctors, and social workers. A large proportion failed to keep appointments regularly. Yet, even among those who kept appointments on a consistent basis, the morbidity and mortality rates were not significantly different from those who did not keep appointments. This discouraging finding makes one wonder if medical care, alone, is as effective as we are led to believe. The researcher of the study tended to think that medical care, alone, was obviously ineffective in reducing morbidity and mortality. Yet they did find a decrease in those rates that had been found ten years earlier. The only interpretation that seemed credible was that there had been an improvement in the general living conditions of these Indians and that such an improvement allowed for improved health not the availability and utilization of the health care delivery system.  

Implications from such findings point to the necessity of improving living conditions among American Indians, as well as other ethnic minorities, as essential to reduction in morbidity and mortality rates. Of course, prerequisite to an improved status of living conditions is the elimination of social inequities affecting employment, education, housing and political representation.

Another study that sought to learn if the availability of medical services would affect the utilization of those services, supplied services within three different geographical areas of Los Angeles. These areas were comprised of poor Blacks, poor Mexican-Americans, and poor members of the compact majority (this latter group was used as a control). The comparison of utilization rates of these three groups revealed the highest level of use to be among the Black group. This high rate by Blacks was found also to apply in a different study on psychiatric hospital admissions; whereas, a low utilization rate was found for Mexican Americans. "It is interesting to note that when compared with their representation in the general county population [Sacramento] Afro Americans were considerably over-represented in this sample and Mexican Americans were under-represented." The interpretation is offered here that Blacks have had a longer history in coping with the inequities of our American system in order not only to utilize health services, but also to make available other basic social opportunities. Thus, when a service is made available to them, they will use it. On the otherhand, Mexican-Americans are just beginning a concerted effort to eliminate these inequities and poor whites have not identified inequities around which they, as a group, can unite in battle.

Attitudes of Health Care Professionals: Attitudes of health care professionals often prevent the seeker of service from receiving that service. Medical doctors' attitudes about preference for the location in which their practices were to be established was examined in one study. It was found that physicians desired to set-up practice in a community which reflected the income level to which they aspired and the ethnic group of which they were members. Given such preferences, coupled with the fact that the prejudices of the compact majority have assured that poverty exists disproportionately in ethnic minorities, one can expect that private medical care would not be readily available to ethnic minorities.
The attitudes of physicians about committing patients to hospitals also was found to be biased against members of ethnic minorities, particularly poor members. Markson's study, "A Touch of Class? A Case Study of the Geriatric Screening Process" revealed that physicians tended to turn away persons of low income or ethnic minorities, or those who did not look like them.

A common assumption among health care professionals has been that the poor of ethnic minorities do not keep medical appointments. One study tested this assumption by putting a group of Spanish speaking women who, for the most part were receiving public assistance, in a group therapy program conducted in Spanish. It was found that the majority did keep appointments. Since this common assumption was not supported by the Spanish speaking poor, it is possible that additional testing with other poor members of ethnic minorities would not support the assumption either. Thus, it may be found that the assumption that the culture of ethnic minorities, combined with the culture of poverty is an invalid rationalization for not delivering health service to the poor of ethnic minorities.

Summary and Conclusions

There are differences in the utilization of the health care delivery system both within ethnic minorities and among ethnic minority groups. Within the Black ethnic group, the differences related to levels of income. Blacks of the middle class behaved with respect to the use of health care services as the white middle-class. It is suspected that the same relationship between utilization and income also would be found in the other ethnic minority groups.

When health care services deliberately were made available to ethnic minorities, differences in utilization were found among poor members of ethnic groups. Poor Blacks increased their rate of utilization; whereas, Mexicans did not use the services to the same extent. Only with Mexicans was there found evidence to support the notion that cultural factors may prevent usage of the health care delivery system. Yet, it might be expected that when Mexicans have a longer history of united struggles against barriers to their receiving needed services, they too will increase their utilization rates of health care services.

The situation presented by American Indians suggests that improvement in the basic living conditions, not the utilization of the health care delivery system, is the key to their improved health status. Since unemployment has been higher among Indians than other ethnic minorities, they have been unable to lift themselves up without outside help. Also, as the Mexicans, it is only recently that they have had leaders to present their case to the compact majority.

Yet the effects of unemployment, as seen among the Indians, suggests that as long as there is inflation and unemployment poor members of ethnic
minorities may fall more heavily on a rank ordering of priorities for the expenditure of limited funds, as did the poor Blacks in Gylys' and Gylys' study. For the poor of all ethnic minorities, as well as the compact majority, health care may be the last priority. And considering the finding from the study on American Indians that utilization of the health care delivery system was not associated with a lowering of morbidity and mortality rates, placing health care at the bottom of one's expenditure priority list may be justified.

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3. Ibid., p. 8.
6. Ibid., p. 311.
8. Ibid., p. 2.


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COMMUNITY PLANNING ORGANIZATIONS COPING WITH THEIR PROBLEMS:
THE CASE OF THE WELFARE COUNCIL

by

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ABSTRACT

Community welfare councils, sharply attacked in the 1960's, have survived, while many of their competitors have lost ground. Understanding their survival may help community planning agencies and planners. This study combines data from a survey of community welfare councils with data from a longitudinal study of a single council. The basic problem of councils is conceptualized as value precariousness, following Clark and Selznick, and data are provided that tend to confirm the existence of this problem among councils. The ways in which councils cope with the problem are described in some detail. Finally, the findings are compared with three similar studies.

The community welfare council is an institution which has existed for over 50 years. It began in the larger communities of the United States. Today there are over 450 Councils across the country. For many years, they were the only organizations that carried out any community-wide health and welfare planning at the local level.

In the past ten years, a number of new community planning organizations were created, some in specialized areas such as mental health, juvenile delinquency or poverty, and others of a wider scope. These new planning organizations were competitive with the welfare council, often sharply critical of its performance.

The Council is of interest not only because local community planning and coordination are critical issues, but because the survival of local planning organizations is problematic. Most Councils have persisted, while the community planning organizations developed in the 1960's are now passing from the scene. Delinquency planning under the aegis of the President's Committee on Juvenile Delinquency and Youth Crime is no more. Community Action and Model Cities programs are in serious difficulties in many localities.

Councils must be understood in the context of what is known about community planning organizations generally, with an eye to uncovering some of the critical problems this type of organization must solve if it is to survive. Although organizational survival is not sufficient, it is certainly necessary for community planning. The problems with which the Council copes may well be the ones which were fatal to other planning organizations. It is from this perspective that we
approach the study of the Council.

Methodology

The survey data for this study come from a questionnaire sent to executive directors of welfare councils and councils of social agencies in 1963, under the auspices of the United Way of America, then called United Community Funds and Councils of America. Of the 364 questionnaires sent out, 154 were returned. In the main, it was councils in small cities which did not respond (only 14 percent, while in cities over one million, 95 percent responded). In all cases the executive was the informant, reporting on the council. Questions covered included a broad range of items. The size of the staff, their educational backgrounds, the nature and extensiveness of the programs that the councils undertook, the nature of the councils' structure, and the size and occupational backgrounds of the members of the boards of directors were all included (Tropman, 1972).

The case study is based on data collected between October 1962 and December 1963. It rests heavily on an examination of documents, dating for the most part between 1940 and 1963, which were catalogued and classified. The documents included internal memoranda, correspondence, formal reports of studies, brochures, and working papers. In addition, the minutes of the council's board of directors were reviewed, with emphasis upon the requests for study and action directed to the council, and the council's disposition of these requests. All of the council's studies and reports were gathered, listed, and read. Special attention was given to the identification of crises in the council's history, factors relating to their emergence and the ways they were resolved. In addition, information was collected from a random sample of council members active in November 1963, with a response rate of better than 70 percent. The questionnaire inquired about attitudes and opinions related to planning for local social welfare programs, the length and type of participation in the council, and basic demographic characteristics of active members. In addition, a number of open-ended interviews were conducted with members to probe and explore matters that were left ambiguous by the documentary and survey data.

The Problem: Precarious Values

Basically, the Council and perhaps other agencies engaged in interorganizational planning and coordination suffer from what Clark has called precarious values (Clark, 1956; Selznick, 1957). Operationally, precarious values are indicated by four conditions: (1) Vague goals and values, (2) Numerous goals, (3) Marginal legitimacy of goals and values and of leaders, and (4) Weak support for the autonomy of leaders.

How do these four conditions indicate the precariousness of values? First, 1

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1For further details on methods used in collecting these data, see Tropman (1967:27-46) and Cox (1968:261-267).
when goals are vaguely articulated, there is great uncertainty about whether
particular actions help achieve goals. Some degree of ambiguity may be neces-
sary in external relations to impede mobilization of opposition, but those respon-
sible for their pursuit must be clear what they are after if they are to judge
the effects of particular decisions.

Second, when goals are numerous, leaders may be left with little sense of
direction. Numerous goals without priorities provide leaders with an opportunity
to claim success for the achievement of any number of goals which may, neverthe-
less, be quite peripheral to the central values and interests of the organization.
Attention will be given to what can be achieved rather than to what is of central
importance, and the organization may drift away from its major commitments. The
elaboration of goals may facilitate organizational survival when important values
are unattainable, but it signifies the precariousness of central values.

Third, if advocates command little authority, the goals they support have
slim backing. If particular values themselves are of little importance in a
society, they are in danger of displacement. If there is wide disagreement on
goals, conflict is likely to drain away efforts that might otherwise be directed
toward their achievement.

Finally, when leaders are preoccupied with maintaining sources of support,
fending off incursions into their domain and attacks upon their integrity, they
have little time and energy to pursue goals. Under these four sets of conditions,
then, goals and values are likely to be precarious.

What evidence is there that the Council's values are precarious?

Vague goals and values. To the degree that the Council's goals are vague,
one would expect to find employees assigned to general, non-specific job categories.
This appears to be the case. In our study of 154 welfare councils, out of an
average of 3.6 professional employees, 2.3 of them are assigned to a general
category, "Executive, Planning and Administration", while 1.3 are classified under
specific task categories such as Social Service Exchange or Information and
Referral Service. The national organization of welfare councils urges its members
to employ social workers trained in community organization in its executive posi-
tions (United Community Funds and Councils, 1962). This training places more
emphasis on organizing community resources to meet needs than it does upon know-
ledge of particular social problems, services or population categories. The
Council's domain is defined as encompassing a wide variety of social problems which
are never exhaustively identified, leaving its boundaries highly ambiguous (United
Community Funds and Councils, 1965).

Numerous goals. The one Council studied in detail was engaged in no less
than 77 activities between 1960 and 1963. In April of 1963, that Council reported
that it was engaged in 16 major activities. Any one of these activities might
produce numerous recommendations which the Council would have some responsibility
to implement.
Marginal legitimacy. In 1963, the mean income of councils was around $84,000. This budget is not a large one, and suggests marginal support from American communities. Particularly in smaller communities under 200,000, the budget is small, averaging around $17,000. This level of funding, per capita considerations aside, is simply insufficient to support adequate planning and coordinating machinery. Hence, the level of funding, especially in smaller communities, suggests a dubious legitimacy.

A second way to look at marginal legitimacy is to ask if Councils act to implement their study recommendations. Rightly or wrongly, Councils have a reputation for ineffective foot-dragging, though specific ones are known to be effective. The data from the study of 154 Councils indicate some support for this impression. Council executives rated their activities on a scale of 0 (nothing had been done) to 7 (the Council had made some recommendations and had taken action to implement them). The median score for five groups of activities studied was 1.94 which suggests that Councils were not moving to implement their recommendations too strongly. Using a different measure, 22 percent of the Councils took action to implement recommendations on some topic. Even in this group we do not know whether the action was successful. This suggests that Councils do not enjoy a degree of legitimacy sufficient to really move on implementation.

Limited financial support and minimal implementation of study recommendations raises questions about the Council's legitimacy, but says little about the sources of that weakness. It may be that there is conflict over the goals pursued by Councils. The importance attached to such goals may be limited, or leaders may be able to claim only limited authority and respect.

Our case study of one Council suggests that this Council from time to time became involved in controversial matters such as birth control and national health insurance. Although the salience of these issues was high, agreement on the values represented by them was low. The majority of the activities in which the Council engages—efforts to improve rehabilitation services for the handicapped, for example—are of modest concern to most people, except those directly affected.

Legitimacy may be assessed by the extent to which the Council can attract top community leaders to the board. The data from our study of 154 Councils reveal that 36.9 percent of the Council board members are rated "top community leaders" by Council executives. While no exactly comparable data are known, Seeley's work suggests that welfare councils have fewer top community leaders than either the Red Cross or the Community Chest.2

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2Seeley (1957:284,307-310) found that 43.8 percent of the campaign leaders for the Red Cross in Indianapolis in 1955 were recruited from among persons and families described as "civic leaders," "well-to-do," "solid citizens," and whose family heads were executives or professional men of high status. This percentage figure also includes persons of higher rank. The comparable figure for the Community Chest in that year was 36.3. Because our Council data were estimates made by Council executives without any definitional criteria or actual count of such
Although welfare councils may not have the same proportions of high status volunteers as other similar organizations, they do at least have some. On this basis it can command a measure of legitimacy based on consensus among civic leaders. But much of its appeal for legitimacy is based on professional grounds. Most of the professional staff (66 percent) and even more of the executives of Councils (80 percent) hold masters' degrees in social work. While this training provides professional qualifications, the social work degree does not have the prestige of the M.D. nor the recognition of the law degree. Further, many other people, laymen and professionals, make claims to expertise in areas overlapping social work. Thus, it is reasonable to conclude that the social worker's ability to speak authoritatively on matters within his domain and have his professional opinions widely accepted is marginal.

Marginal autonomy of leaders. Our study of 154 Councils shows that 88 percent of the funds that support councils come from local community chests or united funds, varying between 96 percent in smaller communities and 79 percent in larger ones. Leaders must consider the effects of their actions upon their major source of funds. While most Councils, including the one we studied intensively, enjoy close and generally cordial relations with supporting Chests and Funds, their autonomy is thereby constrained. Actions offensive to major contributors are frowned upon. Substantial resources must often be devoted to completing agency studies and other tasks for the Chest or Fund. There are ways to finance non-profit organizations that involve considerably less reduction in the autonomy of leaders, such as obtaining gifts and bequests which are invested, the income being used to provide operating funds; and soliciting small amounts from multiple sources rather than large amounts from a few sources.

It is not uncommon for councils to be preoccupied with the reorganization of their formal structure. The Council we studied intensively underwent three major and two minor reorganizations during the period between 1940 and 1963 and another major reorganization occurred after the study was terminated. These reorganizations were responsive to changes in the Council's environment, particularly changes in Community Chest and United Fund organization. The Council's leaders were exposed to irresistible pressures that diverted large amounts of time and energy away from the definition and pursuit of the Council's planning and coordinating objectives, and thus limited the freedom of action of its leaders.

leaders, while Seeley's data are based on ratings made by his research team using carefully defined criteria applied to each leader, we believe that the Council data overestimate the proportion of top community leaders active in welfare councils. Furthermore, those on boards of directors tend to be a more select and high status group than those who are active in the various committees of Councils, which committees are analogous to the campaign organization of the Red Cross and the Community Chest, on which the Indianapolis data were based.

See Hodge, et al. (1966). Although this study did not examine "welfare council executives" or "social workers," extrapolation from the data strongly suggests that the professional staff of welfare councils falls below physicians
The Council's mode of operation is designed to maximize interference with independent action by its leaders. The Council's major operating values include democratic participation of a large and widely representative group of people in a very substantial number of committees that hold frequent meetings and extend their deliberations over periods of months and sometimes years. It is hard to imagine a formal process better calculated to reduce leader autonomy, yet it must be remembered that this process is regarded as a major operating value of the Council.

To sum up, the autonomy of the Council's leaders is restricted by their dependence on a single source of funds, irresistible external pressures, and commitment to active volunteer participation. These divert effort from planning local health and welfare programs. The limitations on their freedom springs in part from the marginal legitimacy of professionals that staff welfare councils and from the limited numbers of prestigious community leaders that Councils have been able to attract. The low level of autonomy and legitimacy of leaders has contributed to the precariousness of the Council's values together with vague and numerous goals, and the minimal importance attached to most of the Council's activities. Much of the Council's mode of operation and structure must be seen as attempts to master these conditions of its existence.

Coping with Precarious Values

The Council uses a variety of mechanisms that clarify goals, reduce their number, heighten their legitimacy and strengthen leaders. In effect, these are mechanisms that, intentionally or otherwise, assist the Council in reducing to some extent the precariousness of its values.

Formal Structure. The pattern of representation, committee structure and (2nd rank) and lawyers (11th rank). "Welfare worker for a city government" ranked 44th and "sociologist" ranked 26th.

4 There is, of course, a very important dilemma here. While the autonomy of leaders is essential in the effective pursuit of major substantive planning goals, such autonomy conflicts with a major value of welfare councils—democratic procedures. While some planning objectives are only attainable through participation (e.g., actions requiring full commitment to operating goals and active and detailed compliance with procedures by the participants), in much planning where policy making and operations are done by different people and political or bureaucratic processes are used to influence decisions, participation is wasteful of time and effort and occasionally counterproductive. Before this dilemma can be resolved, welfare councils must decide which of their values are most important—effective planning or democratic processes. This problem is discussed in detail by Rein and Morris (1962).
roles may contribute to the legitimacy of an organization's decisions. The Council seeks to "represent" various sectors on the board. In our study of 154 Councils we found that the 4,770 board members could be classified in nine different "community sectors." The distribution of proportions falling into each sector did not vary much when councils serving communities of varying sizes were studied separately. People drawn from business and industry were most frequent (34 percent), followed by local professionals—doctors, lawyers, etc.—(22 percent) and members of the health and welfare professions (12 percent). People drawn from other sectors—public administration, religion, higher education, the mass media, labor, and elected officials—were represented in decreasing proportions ranging from about 8 percent to about 2 percent in that order.

In our case study we found that, in 1963, 55 percent of its leaders and 40 percent of its active members had served on the board or committees of the United Fund or one of its predecessors. Fifty-six percent of that Council's active members were employees of health and welfare agencies and 30 percent were volunteers in agency activities. They were drawn from all parts of the county served by the Council, roughly in proportion to the distribution of the population in the county. Wide representation serves to strengthen the legitimacy of the Council's decisions.

The Council we studied intensively appointed 24 committees representing various interests. Three represented welfare professionals employed in health, welfare and recreation, respectively. One brought together representatives of councils in each of six localities. Four were concerned with the so-called "common services" such as the volunteer bureau and the welfare information and referral service. Several were engaged in making studies of welfare agencies that had applied for admission to the United Fund. The rest were involved in a variety of activities associated with particular agencies or fields of service—adoptions, hospital planning, homemaker service, etc. Thus, through the proliferation of committee activities, the Council accommodates a wide range of welfare interests, allowing each to pursue its objectives through the Council. This signifies the recognition of the Council as a legitimate vehicle through which various welfare interests may gain a hearing from the community.

Finally, the Council under intensive study recognized rather explicitly that its recommendations were frequently ignored, and tried to do something about this by distinguishing between the roles appropriate to welfare professionals and other "interested" parties such as agency board members, on the one hand, and "disinterested" citizens and community leaders, on the other. It recognized the need for greater participation by community leaders, that they and other disinterested citizens should have final responsibility for the Council's recommendations, and that welfare professionals and those representing particular agency interests should serve in a consultative or advisory capacity on study committees.

5 Although planning organizations that seek general community acceptance may find that structural approaches such as these enhance their legitimacy, other types of planning organizations that base their support on a competitive pluralistic doctrine and pre-determined objectives or on expertise would find structural
Decision making criteria and processes. One way an organization may protect its weakly supported values is to adopt methods and procedures for reaching decisions that enhance their legitimacy. Welfare councils are service oriented, that is, they respond to requests from others rather than having firm agenda of their own (Zald, 1966). The Council we studied intensively received 96 requests for decision or action between November 1960 and June 1962. All but 23 percent of the 71 requests to initiate activity came from sources outside the Council. To some degree, following the request of someone else legitimizes Council action in a particular area.

Welfare councils give considerable evidence of respect for "the facts." Typically, they maintain research departments to search them out, and bolster their recommendations with facts. They endeavor to elicit the participation of professions, affected parties and disinterested citizens from various walks of life in interpreting the facts and formulating recommendations. Where there is a conflict, Councils believe that the best interests of the whole community rather than the interests of particular groups should prevail. They search for general rules which can be universally applied under stipulated conditions, rather than making decisions on an ad hoc basis. Councils regard themselves as neutral and unbiased vehicles through which wise recommendations may be formulated rather than as partisans of particular points of view. In addition, they emphasize that their planning activities threaten no one because Councils are dependent upon voluntary compliance with their recommendations. Open channels of communication, with community decision-makers and the public, involving "education," "patient negotiation, persuasion and a meeting of minds based on the logic of the situation" is regarded as necessary to bring about favorable action on Council recommendations (Harper and Dunham, 1959:363,393). All of these factors tend to enhance the legitimacy of the Council's recommendations.

Relations with other organizations. Legitimacy may be enhanced by developing relations with other organizations either through (1) structural connection, (2) funding relations, (3) rendering services or (4) overlapping membership. Welfare councils have sought such relations with community chests and united funds, welfare agencies, and welfare professionals and interest groups.

Among the 154 Councils we studied, 53 percent were structurally independent of the Fund, 23 percent were quasi-independent (which means that there were two separate organizations with the same executive) and 21 percent were merged with the Chest or Fund (which means that the Council was simply a department of the Chest or Fund). Independence drastically decreased with community size. Further, as noted above, 88 percent of the funds supporting Council operations comes from Chests or Funds, again in somewhat greater proportions among Councils serving smaller communities. In our case study, we found that in 1963, 55 percent of the leaders and 40 percent of the active members had served on the board or committees of the Fund or one of its predecessors. We also found that the Council had met many requests from the Fund for studies of agencies applying for admission to the mechanisms such as those described here counterproductive (Rein and Morris, 1962).
Fund, for advice on budget requests from agencies and for counsel on improving the efficiency and effectiveness of agencies with which the Fund was dissatisfied.

In many cases, welfare agencies created welfare councils. In our case study, this was true. While early in its history, nearly all the agency representatives were drawn from Chest-supported agencies, the balance had shifted by 1962 to about 1/3 each from Chest-supported, other private and public agencies. In 1962, only 11 percent of the Council's 385 active members were nominated by welfare agencies. However, this was compensated for, to some extent, by the fact that 86 percent of the Council's active members were either employees of welfare agencies or volunteers in agency activities. Finally, the Council responded regularly to agency requests for studies of their operations, support of their interests, etc.

Welfare professionals (apart from the agencies that employ most of them) and interest groups looked to the Council, in our case study, as a platform from which they might articulate their objectives, garner support, etc., adding to the legitimacy of the Council as a center in the community for welfare planning and coordination.

While the mechanisms discussed above reduce the precariousness of the Council's values to the extent that they enhance the legitimacy of its goals and activities and of its leadership, they go only part way toward clarifying and reducing the number of goals and make no contribution toward enhancing the autonomy of its leaders which are also crucial in strengthening the Council's values.

Goal Reduction and Clarification. Given the Council's service orientation, its responsiveness to requests from various community groups, particularly the Chest and Fund, welfare agencies, welfare professionals and interest groups, the Council faces a major problem in reducing its work to manageable proportions and selecting from among the requests it receives those which are consistent with its goals and values and with its survival.

The Council we studied in depth dealt with this problem in three ways. First, it centralized its decision-making. Second, it justified withholding additional resources, especially to its most powerful and insistent constituent, the United Fund. Finally, it developed new sources of funds to expand its resource base.

By 1950, the Council had abandoned a pattern of permanent staff allocation to semi-autonomous committees representing particular fields of practice (e.g., family and children's services). It centralized decision-making in its board of directors, delegating responsibility to a program committee directly responsible to the board. It developed criteria for selecting appropriate projects; assigned priorities to various projects that were proposed and found desirable; set limits on the tenure of study committees; and delegated to the Council's executive director responsibility for recommending appropriate projects and priorities.

Although it had been unsuccessful in doing so in the past, in 1961 the Council

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6 See footnote 5.
was able to reject insistent demands by the Fund that it conduct a comprehensive study to plan for the long-range development of all local welfare services. The Council acknowledged that such a study was desirable, but pleaded inadequate funds and staff, and asked the Fund to provide money to hire additional personnel. Further, the Council argued that it was not available solely for service to the Fund but also had responsibilities to public and other non-Fund supported private agencies.

The Council was able to expand its resources by borrowing staff from other agencies and by obtaining funds from sources other than the United Fund. In 1962, the Council we studied closely received 41 percent of its support from state and federal agencies, city government, a foundation, fees, and a few other minor sources. While this did not reduce the number of goals the Council pursued, it had the same effect by increasing the Council's capacity to handle additional activities. In comparison to other welfare councils, this one received a very high proportion of its support from sources other than the United Fund.

Enhancing the Autonomy of Leaders. Centering control in the hands of a cadre of leaders seems antithetical to the principal values of welfare councils, which place great emphasis on wide representation and participation in decision-making. However, the phenomenon of leadership control in democratic organizations is well known, and it would be surprising if the facts were otherwise in welfare councils. Although we cannot be sure how widespread the phenomenon is among welfare councils, we are reasonably sure that within wide limits the staff, most of whom were social workers with close ties to other welfare professionals, was substantially in control of the Council we studied intensively. The proportion of the Council's active members nominated by organizations (mainly welfare agencies) diminished from 46 percent in 1940 to 11 percent in 1962. Thus fewer members were responsible for protecting salient agency interests, making it easier for staff to influence decisions. After 1957, individuals rather than organizations became members of the Council, and they were counseled to use their best judgment rather than trying to reflect the views of the agencies with whom they may have been associated, again leaving a void which was filled by the Council's staff. Not only was the decision-making process centralized, as noted above; key staff members were placed in crucial advisory positions to committees, and were generally deferred to by volunteers who typically regarded themselves as "laymen."

How is staff control maintained? First, long association between volunteers and Council staff developed attitudes of trust and respect. The average length of association of the Council's volunteer leaders was eight and one-half years in 1962. Other active members had been associated with the Council for an average of four and one-half years.

Second, staff advise in selecting volunteers for committee assignments. Given

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7Michels' work (1949), first published in 1915, is the classical study which demonstrates the precariousness of democratic processes even in voluntary associations that are committed to a democratic ethic.
the long background of the average leader in Council affairs, they know a great
detail about the policies and problems of welfare programs and are familiar with the
viewpoints of Council staff. Given the staff's role in their selection, they are
likely to support decisions consistent with staff views even in the absence of sug-
gestions from staff members.

Third, and probably most important, the Council's staff is in a key position
to control the content of communications to volunteer decision-makers. A staff
member generally prepares a "charge" to guide a committee's work, selects "experts"
to testify before committees, organizes relevant data for committee review, prepares
drafts of reports and recommendations, etc. Although it is possible for volunteers
to overrule staff decisions, in practice committees are highly dependent upon such
staff inputs.

Finally, there is some indication that, as a price for their influence, staff
members avoid the salient interests of volunteers, especially when a proposal would
mobilize controversy. In this way, the Council staff, in tacit coalition with wel-
fare professionals, can advance their professional interests within the limits of
existing consensus.

Comparison with Other Studies

How do our answers compare with the conclusions reached in other studies?
We have been able to find only one other study of a community welfare council (Baker,
et al., 1973). However, there are a number of studies of community planning as a
process and its problems (Burke, 1965 and 1967; Callahan, 1973; Gilbert, et al.,
1973; Head and Drover, 1970; MacRae, 1965, Perlman, 1961), and a few studies of
other community planning organizations (Marris and Rein, 1973; Seeley, 1957; Warren,

One way to view our analysis is that it reflects the difficulty in achieving
the objectives of community planning. Whether studies focus upon community plan-
ning as a process or upon the community planning organization, nearly all reflect
the difficulty in achieving community planning objectives. The major difference
between our analysis and most other studies is that our focus is upon what is re-
quired to cope with a selected range of organizational problems which we found to
be characteristic of community welfare councils. Most other studies ask how plan-
ning organizations or planners can achieve their objectives; we ask how such organ-
izations are able to maintain themselves. We have selected three studies that
have special significance for brief attention here.

Reform and Its Problems

One question asked about Councils is why they have not been more successful in
introducing reforms in the local community. The work of Marris and Rein (1973),
while not focusing directly on councils, provides some perspective in this regard.
Their study concentrates on strategies for achieving social reform aimed at reduc-
ing delinquency, poverty and related social problems, with special emphasis on the
dilemmas experienced by the organizations in pursuing reform. In our terms, change
aimed at reducing poverty, etc. is a precarious value. The ways in which social reform organizations meet the difficulties arising from their efforts are analogous to what we have called coping.

The Philadelphia Center for Community Advancement (PCCA), used by Marris and Rein as a case study in the problems of reform-oriented organizations, provides several insights which parallel our own. The Center, which was in the process of formation at the time of the study, threatened to abort over the inability to obtain agreement between the funding source and the city government on the formal structure for planning. Because the problem of representation and the respective roles of various participants was never resolved, the Center found it extremely difficult to reach decisions. In contrast to the community welfare councils which pride themselves in the breadth of their representation, PCCA was torn with disension over the appropriate formal structure for planning, who should participate, and the roles—planning, decision-making, advising, etc.—to be played by the various interests. One problem faced by PCCA—the participation of representatives of the target community—was not an issue during much of the period of our case study. Another important difference between PCCA and the welfare councils is that the former was bent upon major reform, guided by a theoretical perspective drawn from the social sciences. PCCA intended not only to plan changes but to gather within itself the authority to carry those plans forward into action. The welfare councils recognize they have no authority other than "the power of persuasion." They hope to be given a hearing by the various centers of decision, once they have formulated their recommendations, but recognize that they have no more than the right to educate, to urge consideration of their views by those who carry ultimate responsibility.

The service orientation of the welfare councils stands in marked contrast to PCCA and most of the other social reform projects studied by Marris and Rein. The leaders of these reform efforts had a more or less clearly formulated agenda they wished to pursue, while the welfare councils are largely responsive to external demands. Various interests use the welfare councils as vehicles for articulating and pressing their interests in the community. The Councils themselves are, by and large, viewed as neutral until they have adopted a position after a study process.

The kinds of internal influence exercised by the staff of the welfare council we studied intensively seldom have an opportunity to develop in the context of the newly emerging social reform organizations Marris and Rein studied. Perhaps in their later stages, when reform had been abandoned for ordinary service delivery, some of the mechanisms of staff influence may have developed, but this was not highlighted in Marris and Rein's study. Because of the salience of the interests involved for the various participants in social reform, it would have been surprising if staff had developed the same degree of control as it exercised in the welfare council we studied closely. Also, the degree of internal consensus found in most welfare council activities was not to be found in these social reform efforts. Yet the council we studied was in a dilemma. It could push reform to a point, but not too far. And indeed, it may well be most effective in picking up the thrusts developed by the now
defunct "reform" organizations and carrying them forward. Community consensus has shifted over this period and the welfare council is able to take advantage of the new consensus that forms around specific issues even if it is incapable of shaping that consensus.

Community Decision Organizations

Warren and his colleagues reflected a general concern with councils in the 1960's. They note that there was a feeling among many leaders of social reform organizations "...that the existing organizations in its (social planning) field, particularly the community welfare councils, were unable to innovate sufficiently to bring about system change..." (Warren, 1967:267). In this respect, however, the council did not appear to differ from the other group of organizations in the local community which Warren and his colleagues called community decision organizations (CDO's). They studied CDO's in nine cities between 1967 and 1972 (Warren, et al., 1974). They define CDO's as "organizations legitimated for making decisions and/or taking action on behalf of the community in specific sectors of concern." Among CDO's available for study, they chose the public school systems, urban renewal agencies, health and welfare councils, community action agencies, Model Cities programs, and community mental health planning organizations. They studied interaction, cooperation, innovation and participation among these organizations as they pursued social reform. While they would probably agree that social reform is a precarious value, they would not agree that the failure to achieve reform objectives is due to weak institutional supports for those values. Instead, they would argue that the "institutionalized thought structure" which provides the context for the operations of all CDO's—the view that American society is essentially sound in its organization, that residual social problems arise from the inability of a relatively small number of individuals to cope with the reasonable demands of the society, etc.—is strong and unchallenged by any of the CDO's and that failures to achieve sound reform are attributable to the tacit acceptance of the institutionalized thought structure which constrains action within socially defined limits. On the infrequent occasions when it is challenged, impressive sanctions are mobilized against the transgressors.

It has not been our task to explain the failure of the welfare council in achieving social reform. Rather, we asked a more limited question: How does the welfare council manage to survive in the context of its precarious values? And we answered this question with an analysis of the mechanisms used by the council in coping with its precariousness. These features of the welfare council can also help us understand why it has accomplished so little in the way of reform. For example, reform is hard to come by when decisions are made by those who are the targets of reform. The fiction of rationality in decision making obfuscates the significance of existing patterns of operation for the maintenance requirements of organizations to be reformed, and discourages the mobilization of political influence. Finally, the autonomy and influence of the welfare council's leaders is, as we have suggested, grounded upon and limited by the implicit rule that the salient interests of volunteers are not to be violated.
The Open Systems Approach

Of the three studies reviewed here, the recent study by Baker and his associates comes closest to our own, both in its focus upon the community welfare council as an institution and its concern with the problems faced by welfare councils in coping with the conditions of their existence (Baker, et al., 1973). Instead of beginning with an analysis of the precariousness of the council's major values and asking how it is able to cope with the problems flowing from that precariousness, Baker and his colleagues characterize the welfare council as an open system in a turbulent environment. From an analysis of the literature on open social systems, they identify five central dilemmas that councils must struggle with if they are to maintain themselves: (1) boundary control vs. boundary permeability; (2) variety vs. homogeneity of personnel, member agencies, constituencies, ideologies, issues, etc.; (3) differentiation vs. integration of internal structure and functions; (4) input vs. output constituencies, i.e., responsiveness to demands of those that provide resources vs. those who use the products of the council's activities; and (5) proactivity vs. reactivity or formulation of organizational agenda internally vs. responsiveness to external demands of funding sources, etc. In general, their conclusion is that the welfare council and other such open systems will move toward one or the other end of each of these polarized dimensions or adopt some mixed pattern depending upon specifiable conditions which they face.

Clearly, many of our findings may be reinterpreted in open system terms. Perhaps the major reason for the precariousness of the council's values is the openness of the council to external pressures. Leaders may state goals vaguely to diminish awareness of irresolvable conflicts resulting from the differing demands of various constituencies. Numerous goals are a way of responding to as many different demands as possible. Limited autonomy of leaders reflects their vulnerability to external demands.

Many of the mechanisms we found councils using to cope with their precariousness parallel resolutions of the dilemmas Baker and his colleagues observed in the welfare council they studied. Our discussion of the council's formal structure parallels Baker's analysis of the variety of inputs and internal differentiation. We found the welfare council to be widely representative of various sectors of the community, including the council's input constituencies, and we also found considerable internal differentiation in the form of committees and role differentiation of different types of participants (e.g., agency representatives were advisory; community leaders were given final responsibility for decisions). The council's service orientation may be interpreted as a form of boundary permeability and reactivity, in Baker's terms, while its efforts to locate universal decisional criteria are an indication of its efforts to integrate its decisions. The welfare council's patterns of relating to other organizations is a reflection of the openness of its system and the permeability of its boundaries. Our discussion of the council's efforts to limit and clarify its goals may be understood as a reflection of the process of integration and an attempt to become somewhat more proactive and homogeneous.
in the problems it tackled. At the same time, the council's efforts to obtain funds from sources other than the United Fund and to borrow staff from other agencies reflected attempts to enable the council to react to a wider variety of demands placed upon it. Mechanisms for enhancing the autonomy of leaders may also be understood as integrative and proactive strategies.

One element of Baker's analysis that is conspicuously missing from ours is the dilemma of response to input vs. output constituencies. Our analysis did not lead us into an examination of this problem, although some raw data are available that bear upon it. We believe this reflects the historical period of our study, the fact that output constituencies—service agency clientele and ordinary citizens—were not an organized force able to bring negative sanctions to bear upon the welfare council until the mid-sixties. In fact, the concept of an output constituency was created by Warren about 1967 in an effort to understand community decision organizations (Warren, 1967).

Conclusions

Now that some of the high expectations of community planning (or community decision) organizations of the 1960's have been moderated, it is a good time to examine the problems of these organizations. Clearly, the critics of the welfare council fared no better, and in terms of organizational maintenance, worse, than the organization they criticized. That experience lends some support to Warren's notions of what happens when the "institutionalized thought structures" are challenged. On the other hand, the councils do try to represent and embody some other definitions of the problem, within an acceptable context. Baker and his associates, in proposing an open system model, come closest to presenting the kind of structure the council uses to survive. Using the open system approach, the council can engage in a series of coping mechanisms which retain it as a balanced, non-partisan organization. Our findings with respect to the council's strategies for survival are quite consistent with the open system approach.

We found that councils were able to cope with their problems by adopting (1) patterns of broad representation; (2) decision-making processes that encourage wide participation and maintain the image of the Council as neutral and non-threatening; (3) relations with other organizations that lend legitimacy to the Council's leaders and decisions; (4) methods for clarifying and reducing the number of goals and activities; and (5) approaches that enhance the autonomy of the Council's leaders.

The welfare council is only one of many locality-based organizations which may be called community planning or decision organizations. Others include city planning departments, councils of churches, hospital planning councils, model cities agencies, etc. To understand the success or failure of local planning will require comprehension of the community planning organization, both as an organization and as an actor in an inter-organizational network. This report contributes something to the first requirement. Knowledge of the welfare council should contribute to an understanding of the larger class of community planning organizations to which it belongs.
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COMMUNITY ORGANIZATION PRACTICE:
AN ELABORATION OF ROTHMAN'S TYPOLOGY

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ABSTRACT

Four change approaches encompass much purposive social change at the community level: locality development, traditional planning, advocacy planning and social action. Locality development and traditional planning are similar on at least six dimensions, as are advocacy planning and social action. On two other dimensions similarities exist between locality development and social action and between traditional planning and advocacy planning. If social change practitioners are to select the most effective strategies for the situations in which they will act, it is essential that they understand the characteristics and assumptions of these approaches.

Introduction

For those concerned with community organization, there is a sense in which the 1950's can be characterized as the decade of locality development and the 1960's as the decade of social action. If current trends continue social planning may achieve ascendency in the 1970's. This paper takes account of this growing concern for planning and raises the question -- planning for whom? Specifically we are concerned with the growing emphasis on advocacy in social planning and with the implications of this for a heuristic model of social change strategies. Beginning with Rothman's typology, we show how it can be elaborated to more accurately depict current changes in social planning and then suggest some implications of the new model for understanding, selecting and mixing change strategies.

Rothman's Typology

In his important and much cited paper, "Three Models of Community Organization Practice," Jack Rothman suggested that three models (and combinations thereof) can be used to describe much of the activities of persons and groups involved

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2Ibid.

-541-
in purposive social change at the community level. He called these locality development, social action and social planning.

Rothman's locality development model is basically the "community development" approach which has received much attention in United Nations publications on village level development activities and in the literature in rural sociology and social work. Among the important characteristics of the locality development approach are its emphasis on development of indigenous leadership, local initiative, self-help, and participation by large numbers of community members. The roles of the change agents usually include those of enabler, coordinator and teacher of problem-solving skills. Locality development projects usually involve specific task goals (e.g., building a community facility, such as a school), plus more general process goals concerned with developing community problem solving capacity. Examples of the locality development approach listed by Rothman include: "neighborhood work programs conducted by settlement houses; village level work in some overseas community development programs, including the Peace Corps; community work in the adult education field; and activities of the allied 'group dynamics' professionals." The locality development approach is further summarized in Appendix Table 1. (Our Table 1 is an elaboration of Rothman's Table 1.1.)

Turning now to Rothman's social action model, familiar examples include much of the early labor union activity, the civil rights activities of the Student Non-violent Coordinating Committee, welfare rights advocacy of the National Welfare Rights Organization, and the work of Saul Alinsky's Industrial Areas Foundation. The social action approach:

"... presupposes a disadvantaged segment of the population that needs to be organized, perhaps in alliance with others, in order to make adequate

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5 Ibid.; Rothman, op. cit.

6 Rothman, 1972, ibid.

demands on the larger community for increased resources or treatment more in accordance with social justice or democracy. It aims at making basic changes in major institutions or community practices. Social action as employed here seeks redistribution of power, resources, or decision making in the community and/or changing basic policies of formal organizations.  

The social action approach is characterized by the use of contest strategies; change agent roles include: activist-advocate, agitator, broker, negotiator, and partisan. Additional characteristics of the social action approach are listed in Appendix Table 1.

The social planning approach is concerned with the application of technical skills and expertise to public problems, with emphasis on rational, deliberative decision making and planning. The approach is task oriented and community participation is usually not emphasized. As visualized by Rothman social planners gather facts, analyze situations, and use their technical skills to develop and implement programs.

"The approach presupposes that change in a complex industrial environment requires expert planners who, through the exercise of technical abilities, including the ability to manipulate large bureaucratic organizations, can skillfully guide complex change processes."  

Social planning is used at various levels of government and in numerous public agencies. In recent years the social planning approach has received much attention in the areas of urban renewal and health planning.

Rothman's framework is useful as a guide both for analysis and for action. It is not without problems, however, and it is our contention that some changes in the framework provide additional insights and make it even more useful.

Elaboration of the Typology

The major problem lies in Rothman's social planning model. Within the field of planning a distinction is increasingly being made between what we will call "traditional" planning and "advocacy" planning. While both approaches are based on
the application of technical skills to the planning process, in other respects they are very different. Some of these differences are indicated in Table 1 in the Appendix. In row 2 of Table 1, we see that while the traditional planner is concerned with substantive social problems such as health and housing, the advocate planner is not only concerned with these but also with disadvantaged populations, with social injustice, deprivations and inequality. In row 4 of Table 1 the traditional planner tends to emphasize collaborative or campaign tactics while the advocate planner is more likely to use conflict or contest tactics. Row 5 indicates that the most significant practitioner roles for the traditional planner are fact-gathering, analysis, and program implementation. The advocate planner emphasizes these but also performs activist-advocate roles. In row 7 traditional planners are usually employed or sponsored by members of the power structure while the power structure is a target for action for advocate planners (even though advocate planners are sometimes employed in "establishment" positions). The traditional planner usually defines the total community as the client system or constituency while the advocate planner is primarily concerned with the interests of a population segment (row 6). The traditional planner is likely either not to be concerned about whose interests are being served or to assume that the interest of community members are reconcilable, to the advocate planner community interests are not easily reconcilable (row 9). And so on ... (See Appendix Table 1).

Splitting social planning into traditional planning and advocacy planning makes it possible to present the four change approaches in a four-fold table. When the approaches are arranged as in Figure 1, some important relationships between the approaches appear. Most importantly we see that on one set of dimensions (the vertical dimensions) traditional planning and locality development are similar and can be paired; advocacy planning and social action can also be paired. On another set of dimensions (the horizontal dimensions) the two planning approaches are paired (similar) and locality development and social action are paired. Examination of these vertical and horizontal dimensions (Figure 1) reveals that the covariation of the dimensions (and thus the pairing combinations) is not merely coincidental.

Compared with traditional planning and locality development, change agents using advocacy planning or social action are more likely: to view members of the power structure as targets for action rather than as allies or employers (IA in Figure 1), to assume that the interests of the various population segments are in conflict rather than reconcilable (to see issue dissensus rather than issue consensus or issue difference) (IB in Figure 1), to claim to be serving only a population segment rather than the interests of all community members (IC), to see persons they are serving as victims rather than consumers or citizens (ID) and,  

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13 Ibid.
I. Vertical Dimensions
A. Orientation toward power structure—as allies or employers or as targets.
B. Extent to which interests of population segments are viewed as reconcilable.
C. Extent to which client system is assumed to be the entire community rather than a population segment.
D. Extent to which those in whose interests change is to occur are viewed as citizens or consumers rather than victims.
E. Willingness of change agents and partisans to use conflict (or contest) strategies.
F. Degree of commitment required of change agents and partisans.

II. Horizontal Dimensions
A. Task oriented vs. process oriented.
B. Emphasis on rational-technical analysis and decision making.

FIGURE 1 A Framework for Analyzing Change Strategies at the Community Level.

thus, they are more likely to use conflict or contest strategies, rather than collaborative or campaign strategies (II). Because their activities are often controversial and they are subject to reprisals, if they are to continue their activities over an extended period of time, change agents and partisans involved in social action and advocacy planning must have a high level of commitment (IF).

Compared with locality development and social action, change agents using either of the two planning approaches are somewhat more likely: to be task oriented rather than process oriented (II A in Figure 1) and to emphasize rational-technical decision making based on research and expertise (II B).

Because of these pairings of strategies on the two sets of dimensions the likelihood of moving directly from one strategy to another (and the likelihood of mixing strategies) is greater if the two strategies are adjacent than if they are diagonally opposite in Figure 2. This is because strategies which are adjacent are similar on at least some of the eight dimensions discussed above (on one set) while strategies which are diagonally opposite are different on all eight dimensions (on both sets). Thus, for example, change agents using traditional planning would be more likely to move to locality development or advocacy planning than to social action, since either of these moves would only require change along one set of
dimensions rather than both. This is not to suggest, however, that change or mixing strategies across the diagonals on Figure 2 is impossible but rather that it is less likely. Even when adjacent strategies are combined this must be done very carefully because of differences between them.

The author's experience in rural places has been that decisions to emphasize social action often result in antagonisms which restrict one's ability to use locality development both concurrently and later. On the other hand, decisions to emphasize locality development usually result in reduced willingness to use the contest strategies which characterize the social action approach, because the use of such strategies might threaten the consensus, "good will," and open communications which are so important in locality development. This is not to suggest that these strategies cannot be mixed but, rather, that if they are this must be done very carefully since the tactics, and the very assumptions on which the approaches are based, are different.

Our presentation so far shares a problem with Rothman's presentation. This is the problem of possible reification of the approaches (strategies). The four approaches are ideal types and are presented as an aid for categorizing, analyzing and understanding activity. In reality, change agents can be expected to mix strategies. And any particular change agent or group of partisans will not necessarily assume the same position on all of the dimensions in either the horizontal or vertical sets. For these reasons it is useful to also present the framework in terms of only the dimensions and without the labels of the four ideal-typical approaches. This we have done in Figure 3.

Some may find Figure 3 more satisfying than Figures 1 and 2 since Figure 3 more explicitly suggests variation along continua rather than discrete categories of action. Figure 3 suggests that in characterizing a change program it may be more accurate to describe it in terms of the eight dimensions rather than simply in terms of the four categories or approaches. Many, if not most, change programs will involve substrategies or tactics which will differ from each other on one or more of the eight dimensions.
I. Vertical Dimensions
A. Orientation toward power structure -- as allies or employers or as targets.
B. Extent to which interests of population segments are viewed as reconcilable.
C. Extent to which client system is assumed to be the entire community rather than a population segment.
D. Extent to which those in whose interests change is to occur are viewed as citizens or consumers rather than victims.
E. Willingness of change agents and partisans to use conflict (or contest) strategies.
F. Degree of commitment required of change agents and partisans.

II. Horizontal Dimension
A. Task oriented vs process oriented
B. Emphasis on rational-technical analysis and decision making.

FIGURE 3. Paired Dimensions of Social Change

A Note on Advocacy Planning

In a recent book edited by Cloward and Piven,1\textsuperscript{4} Piven is very critical of advocacy planning, arguing that while advocacy planning is growing as a method of practice, so far it has accomplished little for the poor and the movement is potentially detrimental to their interests.

"Although the language is new, this kind of advocacy follows a long tradition of neighborhood councils in the sums, ... In the past such participation absorbed slum leadership and rendered it ineffective. That may well be the chief result of current planning advocacy. It deflects conflict by pre-occupying newcomers to city politics with procedures that pose little threat to entrenched interests. It is a strategy which thus promotes political stability in the city. But if the force of the poor depends on the threat of instability, planning advocacy does little to promote equity."\textsuperscript{15}

\begin{footnotes}
\footnotetext{15}{Piven, Frances F., "Whom Does the Advocate Planner Serve?" in Cloward, Richard A. and Piven, Frances F., \textit{ibid.}, p. 46.}
\end{footnotes}
Piven's reaction is in part a reflection of her notion of advocacy planning. In her view, advocacy planning is long on planning and short on advocacy. In the framework of this paper, her conception is one which emphasizes similarities to traditional planning (the two horizontal dimensions) and de-emphasizes similarities to social action (the six vertical dimensions). That this is her view, is further suggested by the examples of advocacy planning she cites and by the following:

"Implicit in the advocate planner's view also is the notion that the urban poor can influence these decisions once they are given the technical help of the planner -- or better still, once they actually learn the technical skills of planning."\(^{16}\)

Thus, it appears that Piven is criticizing only some forms and applications of advocacy planning rather than the idea itself. Our reaction is shared by Hartman\(^{17}\) and Arnstein\(^{18}\), both of whose views of advocacy planning emphasize social action.

"It seems to me, however, that she is describing only one kind of advocacy planning and that her observations ought to be considered not as a put-down to advocacy planners generally but as a corrective, at a time when the movement is still in its formative stage, to what clearly can be reactionary results from their work."\(^{19}\)

Arnstein\(^{20}\) suggests that in comparison to an older model of advocacy planning, "which was conceived and originally promoted by well-meaning, socially oriented city planners and architects," newer approaches have developed which view "the planning process per se as only one prong" in a three prong community change approach.

"Such an advocacy planning model does not preclude street strategies. On the contrary, it incorporates them into a community group's spectrum of possible actions and reactions to be drawn upon when appropriate. It recognizes that the issue is not whether the poor need sticks or pencils to achieve social equity. The fact is that they need both: sticks to gain and hold the attention of powerholders, and pencils to articulate their priorities and aspirations."\(^{21}\)

\(^{16}\)Ibid., p. 46.
\(^{19}\)Hartman, op. cit., p. 59.
\(^{20}\)Arnstein, op. cit., pp. 54-55.
\(^{21}\)Arnstein, ibid., p. 55.
The issues raised by Piven are important because whether the impact of advocacy planning is reactionary or not may well depend on the extent to which "pencils" rather than "sticks" are used. At one end we have traditional planning which tends to be reactionary, at the other is social action. When the two are combined we have advocacy planning, in which, as Hartman suggests, "above all the advocate planner should employ his professional skills as a node around which political organizing can take place." That such an approach can bring about important social change is exemplified by the experiences of the Health Policy Advisory Center (Health-PAC) in New York.

Selecting Strategies

If community change practitioners are to be effective, it is essential that they select strategies on the basis of careful and realistic assessment of the structure and dynamics of the situations in which they will act. To do this they must be aware of the range of approaches which are available to them and of the characteristics and assumptions of these approaches. Hopefully they will be more effective in the selection of tactics and action if they carefully consider the four approaches and the eight dimensions discussed here.

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22Hartman, op. cit., p. 62.
APPENDIX

Table 1
FOUR APPROACHES TO SOCIAL CHANGE AT THE COMMUNITY LEVEL

<table>
<thead>
<tr>
<th>Locality Development</th>
<th>Traditional Planning</th>
<th>Advocacy Planning</th>
<th>Social Action</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Goal categories of community action</strong></td>
<td>Self-help; community capacity and integration (process goals)</td>
<td>Problem-solving with regard to substantive community problems (task goals)</td>
<td>Problem-solving with regard to substantive community problems, shifting of resources (task goals)</td>
</tr>
<tr>
<td><strong>2. Assumptions concerning community structure and problem conditions</strong></td>
<td>Community eclipsed, anomie; lack of relationships and democratic problem-solving capacities; static traditional community</td>
<td>Substantive social problems: mental and physical health, housing, recreation</td>
<td>Disadvantaged populations, social injustice, inequality</td>
</tr>
<tr>
<td><strong>3. Basic change strategy</strong></td>
<td>Broad cross section of people involved in determining and solving their own problems</td>
<td>Fact-gathering about problems and decisions on the most rational course of action</td>
<td>Fact-gathering about problems and decisions to represent interests of client population</td>
</tr>
<tr>
<td><strong>4. Characteristic change tactics and techniques</strong></td>
<td>Consensus: communication among community groups and interests; group discussion</td>
<td>Consensus</td>
<td>Campaign or contest</td>
</tr>
<tr>
<td><strong>5. Salient practitioner roles</strong></td>
<td>Enabler-catalyst, coordinator; teacher of problem-solving skills and ethical values</td>
<td>Fact-gatherer and analyst, program implementer, facilitator</td>
<td>Fact-gatherer and analyst plus activist-advocate, partisian</td>
</tr>
<tr>
<td><strong>6. Medium of change</strong></td>
<td>Manipulation of small task-oriented groups</td>
<td>Manipulation of informal organizations and data</td>
<td>Manipulation of data and of program support by client population</td>
</tr>
<tr>
<td>Locality Development</td>
<td>Traditional Planning</td>
<td>Advocacy Planning</td>
<td>Social Action</td>
</tr>
<tr>
<td>----------------------</td>
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</tr>
<tr>
<td>7. Orientation toward power structure(s)</td>
<td>Members of power structure as collaborators in a common venture</td>
<td>Power structure as employers and sponsors</td>
<td>Power structure as external target of action: oppressors to be coerced or overturned</td>
</tr>
<tr>
<td>8. Boundary definition of the community client system or constituency</td>
<td>Total geographic community</td>
<td>Total community or community segment</td>
<td>Community segment</td>
</tr>
<tr>
<td>9. Assumptions regarding interests or reconcilable differences</td>
<td>Common interests</td>
<td>Common interests or reconcilable differences</td>
<td>Conflicting interests which are not easily reconcilable: scarce resources</td>
</tr>
<tr>
<td>10. Conception of the public interest</td>
<td>Rationalist-unitary</td>
<td>Idealist-unitary</td>
<td>Realist-individualist</td>
</tr>
<tr>
<td>11. Conception of the client population or constituency</td>
<td>Citizens</td>
<td>Consumers</td>
<td>Victims</td>
</tr>
<tr>
<td>12. Conception of client role</td>
<td>Participants in interational problem-solving process</td>
<td>Consumers or recipients</td>
<td>Constituents and consumers or recipients</td>
</tr>
</tbody>
</table>

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*This table is an elaboration of Table 1.1 in Rothman, 1972, op. cit., pp. 26-27.*
DILEMMAS OF PLANNING AND SELF-DETERMINATION

by

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ABSTRACT

Self-determination is examined as the premier social work value. It is argued in this paper that the positive or negative impact of planning is dependent on who is planning what for whom, and that not planning may be a more serious threat to self-determination than planning.

This paper examines social planning in an advanced industrial society and its consequences for self-determination. There has been a recurring concern that the individual's self-determination is threatened by: 1) powerful, elitist, economic, and political groups who influence decisions on the basis of self-interest (see Mills, 1969; Auerbach, 1969); and 2) bureaucracies where important decisions are made on the basis of institutional need (see Newman, 1952; Cohn, 1965). In more recent years one finds in the professional literature, as well as in the political dialogue of the American people, a fear of elitist professional planning groups who make decisions based on knowledge of the planning process, knowledge of the service system, or on social science evidence (see Moynihan, 1969; Gyarfas, 1969; Agnew, 1972). The publication of B. F. Skinner's Beyond Freedom and Dignity (1972) enlivened this discussion. This paper will examine self-determination in the context of social work practice and the impact of social planning on self-determination.

SELF-DETERMINATION AND SOCIAL WORK PRACTICE

Origin: Self-determination originated in social casework literature and has continued as a central value in that area of practice. An examination of the social group work literature reveals rare reference to the concept, and its complete absence as a central theme. The recent community organization literature has included the concept as a central theme, although its use is usually attached to a community, an organization, a race, or a social class, rather than the individual as in the social case work literature.
Self-determination was first mentioned in the literature in the 1930's (Perlman, 1965:411). Its appearance in the literature at that time has been attributed by Perlman (1965:411) to: 1) the liberating force of Freudian psychology, 2) the progressive education movement as influenced by John Dewey, and 3) the rise of totalitarian governments. While it may first have appeared in the literature in the 1930's, the concept is grounded in the unique American experiment with classic liberal economic theory. While social worker's motivating values of "helping one's fellow man" etc. are rooted in the Judea-Christian tradition, self-determination as a value has its origins in the the parallel birth of Calvinism and capitalism. The placement of self-determination as the premier social work value is part and parcel of the frontier's "rugged individualism" (see Kahn, 1969, Chapter 1).

Definition: A major problem with the use of the term self-determination is that it is sufficiently abstract to be used in a variety of ways for a variety of purposes without communicating specific meaning. As such, it is difficult to operationalize into precise practice behaviors. Perlman (1965), who has written a thought provoking paper on self-determination, defined the concept in the context of a "realistic view of freedom". "Freedom, in essence, is the inner capacity and outer opportunity to make reasoned choices among possible, socially acceptable alternatives" (Perlman, 1965:421).

This definition is useful for the purposes of this paper in that it qualifies self-determination within the reality limits of the individual and the society. Until recently, such consideration of the society as a qualifier of self-determination was unique in casework literature. Neither the self-determination limitations of the individual nor the society are considered in much of the community organization literature.

Limitations: Self-determination has had at least two distinct consequences from the perspective of social work practice: 1) that in direct client intervention social workers should not determine client outcome, and 2) that clients should have the social and economic opportunities required in order to be and do exactly what they want to be and do. In the extreme form of each, the first suggests a value free form of intervention while the latter suggests equality and an increasingly complete form of social control.

Neither complete equality, nor value free judgments create an ideal condition for assuring individual choices. Social goals and a system of social control that protects the right of each individual to maximize his ability to determine his destiny is required. "The guarantees of civil liberties that are built into democratic political systems...are essential to the achievement of positive freedom but are a form of social control" (Faunce, 1968:157). The dilemma is described by John Stuart Mill as, "the practical question /is/ where to place the limit--how to make the adjustment between individual independence and social control" (Quoted in Faunce, 1968:157).
Self-determination in contemporary American society is very limited. Perlman (1972:210) states, "I believe self-determination is nine-tenths illusion, one-tenth reality." An individual's self-determination in any society is limited by the established laws, mores, prejudices, social customs, economic systems, and social institutions and structures of that society. In this advanced industrial society, it is also limited by dramatic technological and social changes and increasing complexity. The changes might be summarized as the process of technologicalization, institutionalization, nationalization, industrialization, urbanization, bureaucratization, secularization, centralization and internatinalization.

Other limitations of self-determination in this society that specifically effect poor people (and which, to a degree, also effect Blacks and women), include 1) a long history of prejudice which seems to have changed only in its subtlety during the last 100 years, 2) the market place as the central distribution center of rights, privileges, goods, and services coinciding with a lack of equal opportunity for all people to compete in that market place. The additional impact of planning on the above indicated encroachments must be evaluated.

SOCIAL PLANNING IN A COMPLEX INDUSTRIAL SOCIETY: THREAT OR OPPORTUNITY?

Social planning has the potential for both limiting and enhancing self-determination. Increased social planning in our society is assumed which provides the opportunity for the social work establishment to: 1) try and combat it, 2) be neutral to it, or 3) participate in it and therefore influence its process and method.

Social planning potentially limits the individual's control over his own life and forces him to conform to the dictates of others. However, simultaneously it also potentially benefits and greatly expands the scope of choices open to people. National old-age "insurance" programs, public school education, equal opportunity laws and policies, income security programs all limit certain individual freedoms while at the same time providing additional opportunities.

Rousseau's distinction between "natural liberty" and "civil liberty" would perhaps be useful here. The "body politic" forms a "social compact".

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1 This paper assumes increased social planning. Considerable discussion has occurred regarding the contribution of social science to planning. The advocacy of planning must be tempered with the basic fact that we now have limited knowledge to utilize in the planning process. Evaluation of the results of social provision in this country should make social planners extremely humble. However, planning does exist and is having increasing impact on our society. (See for example; Kahn, 1969: Chapter 1; papers written in response to Moynihan, 1970 in Zurcher and Bonjean, 1970; Haveman and Margolis, 1970.)
This "social compact" creates the state. Rousseau saw this "social compact" as ultimately not taking away from individuals but as an advantageous exchange. The exchange is "natural liberty" for "civil liberty"; the "power to harm others" for "security for ourselves". What a man loses by the social compact is his "natural liberty", and an unlimited right to everything he tries to get and succeeds in getting. What he gains is "civil liberty" which is limited by the "general will" (Rousseau, 1946). By surrendering certain individual privileges, new opportunities are made available and the individual can gain much more in available choices (Olsen, 1968:346). To generate "civil liberty", societies develop laws that limit "natural liberty". Is it therefore good to give up "natural liberty" for "civil liberty"? Is it appropriate to support planning that may be restrictive, yet provides people with additional choices? It depends. It depends on the trade off...what is given up for what pay off. In addition, in a democratic society it depends on who is planning what for whom and with what kind of sanction. Social planning's impact on self-determination is neither positive nor negative in and of itself. Therefore, it may be appropriate to object to some social planning endeavors, while being neutral or supportive of others.

Planning Versus No Planning: The rejection of planning in a contemporary industrialized state would suggest a grim prognosis for its citizens. In the face of the irresistible forces of modern technology and industrialization, bureaucratization, specialization, complexity, sheer growth in size, and interdependence, the dangers of not planning are critical. Not planning implies that individuals accept consequences of these inevitable forces. Robert Heibroner (1976) has recently argued that economic planning is not only necessary, it is the only option we have. While he recognizes the dangers that planning carries such as constriction of freedom as the consequence of a reckless proliferation of controls, he argues that it would be "foolish to ignore the risks associated" with a refusal to plan. These risks include an inability to limit inflation, an absence of energy, dangerous atmospheric pollution, or a rush to political extremism as a consequence of economic frustration or failure. Individual self-determination is greatly hindered by unemployment, chaotic urban public education, racial and sexual discrimination, and being old and poor simultaneously.

Man now has increasing capacity to transform social structures and institutions, rather than accommodate to or merely protest, the social structure he encounters. Amitai Etzioni has argued that earlier barriers that blocked man's quest for self-mastery and social mastery have been tumbling down. New discoveries in the social sciences provide man with new options and freedom to choose his destiny (Etzioni, 1968). As the technology of knowledge increases in power and influence, planning based on this knowledge will increase. Rather than destroying human choice, the use of social science knowledge can be used in planning to create new social structures to maximize the potential for a self directed society. The social work profession can participate in the leadership for this planning through the
further development of planning as a social work method, and the introd-uc-
tion of the concept into all aspects of social work practice.

The Problem of Legitimacy: As planning increases in our society, the
problem of legitimacy will also increase in significance. There is minimal
literature on appropriate criteria for evaluating legitimate social planning.
Criteria implicit in the logic of his paper would be based on the value of
a self-directed society. It would include an evaluation of the trade-off
of giving up individual rights for additional individual choices. In
addition, a particular planning endeavor should be evaluated as to the self-
determination cost and benefit in the context of the cost and benefit of
planning versus no planning. Legitimate planning is based on issues of who
plans what for whom, under what sanction, and with what resources. As
dependence on rational thought and empirical evidence increases and as we
become more self-conscious of the kind of society we have, we can plan the
kind of society we prefer.

Summary: A self-directed society is desirable and can be achieved through
the development of social structures supportive of such a society. Not
planning may be a more serious threat to self-determination than planning.
If the profession of social work does not respond to the planning possibili-
ties before it, someone else will. Non-involvement increases the capacity
for contemporary social, economic and technological phenomena to control
man. Collaborative involvement can increase the capacity of planning
technologies to extend freedom and maximize the capacity of man to control
his destiny.

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THE PRACTICE IMPLICATIONS OF INTERORGANIZATIONAL THEORY FOR SERVICES INTEGRATION

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ABSTRACT

The interorganizational theories of Litwak and Rothman and Levine and White are utilized to suggest the need for practitioners, involved in services integration efforts, to consider the situational variables of size, resources, awareness of interdependence, and type of task exchanged. The effect of these variables upon the formality and autonomy of linkage mechanisms between human service agencies is illustrated in terms of a regional services integration project in Minnesota. Implications are presented for practitioners who are attempting to coordinate services.

Services integration has been a focus of current attempts to reform the human service delivery system in over 20 states. However, it is increasingly evident that services integration is not a cure-all and that knowledge is generally lacking about which coordinating mechanisms are most effective. One difficulty has been that practitioners have often attempted to implement the concept of services integration without utilizing adequate planning or social science research to identify the situational variables that affect interagency cooperation. While HEW has examined the effect of the environment, the project objectives, the director, and the staff on the success of services integration, the impact of structural factors on ways to integrate services has not been adequately analyzed.1

Interorganizational theories, which indicate how two or more formal organizations relate to each other, can be useful in assessing the structural variables that affect the problems and the potential of cooperation among agencies. Likewise, a multifactor analysis of interorganizational networks can aid practitioners in predicting the most effective ways for organizations to link with each other. In particular, the interorganizational research of Litwak and Rothman and Levine and White suggest guidelines for the practitioner. Levine and White state that cooperation between human service agencies is essential, given scarce resources; however, domain consensus, or agreement upon the agencies' goals and functions, is a prerequisite to cooperative exchange.2 Litwak and Rothman differentiate eight types of coordinating technologies among organizations and factors governing the
adoption of each linkage mechanism. They distinguish ad hoc, informal contacts as well as formal linkages, such as rules, community councils, or interagency boards, as effective ways to coordinate. Litwak and Rothman found that the extent of formality and of autonomy of any linkage mechanism varies with the situational variables of agency size and number, the degree of agency awareness of interdependence, and the standardization of the element being coordinated among the organizations.³

By drawing upon the work of Litwak and Rothman and Levine and White, this article attempts to begin to bridge a gap between interorganizational theory and services integration practices. Throughout this article, the HEW definition of services integration will be used:

the linking together by various means of the services of two or more service providers to allow treatment of an individual's or family's needs in a more coordinated and comprehensive manner.⁴

Since both Litwak and Rothman's and Levine and White's theories assume the desirability of organizations that are semi-autonomous and partially interdependent, the concept of a confederation is first presented. The effect of the situational variables of size, awareness, and standardization upon the formality and autonomy of coordinating linkages in a regional integration project in Minnesota is then assessed.

Confederation of Semi-autonomous Agencies:

Several states, concerned with efficiency and accountability, have operationalized services integration by organizing separate departments into a single administrative unit or "umbrella agency".⁵ Critics of such efforts contend that services integration creates centralized superagencies, thus eliminating the flexibility of decentralized services, and promotes efficiency, thus sacrificing the consumer's freedom of choice. Likewise, service providers tend to resist services integration, fearful that it will eliminate their discretion and autonomy toward clients. Thus, a critical issue is achieving a balance between the isolation and the integration of human service agencies.

In contrast to a unitary system approach, Litwak and Rothman's theory points to the creation of a confederation of semi-autonomous agencies. The confederation approach recognizes that human service agencies are independent in some areas and have their own characteristic power base, funding source, and locational identity; however, agencies are oftentimes interdependent for obtaining information, clients, staff, or funds; they are thus partially interdependent and need to cooperate for each to attain its own goals.

Accordingly, maintaining some distance between formal organizations, rather than having them cooperate too closely or merge, may be desirable. The concept of distance is basic to a confederation and has implications for practitioners who face financial or legislative pressures to consolidate services. In the confederation approach, the two extremes of a merged unitary system or of complete independence among organizations are viewed as ineffective. Since our society values democratic decision-making
processes and a "marketing" approach toward services, not only efficiency, then the human service system must allow some consumer choice and flexible decentralized services, while also improving service accessibility and continuity. In other words, agencies need to maintain their unique identity, goals, and means, while nevertheless coordinating in some limited areas.

A confederation allows pluralism and some conflict or competition among agencies, rather than attempting to set a single goal or sharp priorities among service providers. For example, within a confederative context, both social action and direct service agencies or youth probation and law enforcement pursue their goals, but link in areas which do not threaten their autonomy. Thus a confederation does not eliminate consumer choice, but creates what Rein terms purposeful duplication.

Likewise, the confederative approach recognizes that attempting to coordinate all aspects of service delivery is inefficient. Instead, it distinguishes whether the elements to be exchanged are standardized-nonstandardized. Coordinating standardized tasks, such as data-processing, can achieve economies of large scale. However, nonstandardized jobs, such as direct service or regional planning, often involve uncertainty, complexity, and the need for flexibility. In such cases, it is most efficient to allow agencies' autonomy by establishing face-to-face coordination among them.

Applying the confederative approach can resolve some problems created by a unitary consolidation of agencies. In addition, Litwak and Rothman's theory suggests organizational characteristics and conditions that influence whether agencies link effectively in some areas while maintaining distance from organizations in others. From a review of the Minnesota services integration experience, some guidelines are suggested for determining optimal linkages among service providers.

The Minnesota Human Services Act

In 1973, the Minnesota legislature passed the Human Services Act, permitting the establishment of a single county, multi-county, or regional Human Services Board with the authority to develop linkages between welfare, public health, corrections, and mental health. A confederative approach was possible under the Act, since decision-making rested at the local level and since county commissioners, service providers, and citizens were to plan for and deliver services in a manner consistent with local needs. However, the Act also aimed to achieve economies of large scale through establishing multi-county programs and unitary personnel, budgetary, reporting, and planning systems. In terms of Litwak and Rothman's theory, the Human Services Board structure was a formal linkage mechanism responsible for coordinating both standardized and nonstandardized elements to be exchanged among agencies.

In a seven-county, northeastern region in spring 1974, the County Commissioners voted to establish a pilot planning board, which would conduct a services assessment and develop a plan for integrating services across counties and across service areas, for relating with state agencies, and for involving consumers. Several months later, the Commissioners voted not to establish a permanent Human Services Board, primarily
because of agency and county resistance to the Board. Litwak and Rothman's theory suggests that such resistance is a likely response to attempts to implement an inappropriate coordinating technology. In this instance, the proponents of services integration did not adequately take account of the inequality of resources among counties and agencies, the agency executives' low awareness of the need to cooperate, the complexity of the planning task, and the agencies' protection of their autonomy. These variables, which are critical anchorpoints for organizations as they engage in interorganizational efforts, are elaborated upon in the remainder of the article.

**Resource Asymmetry**

According to Litwak and Rothman, near equality of power is a precondition for effective cooperative efforts. In the Minnesota case, such resource symmetry was absent.

The rural northeastern region, in which services integration was attempted, encompasses an area larger than several states. While the region's geographical size in itself makes coordination difficult, inequality of resources within and between the seven counties magnifies this difficulty. Power relations, as measured by the size of agency budget and staff, are unequal or asymmetrical. One county has a budget six and one-half times as large as the total combined budgets of the other six counties. In turn, the welfare agency within the wealthier county has a budget over twice as large as all the combined welfare budgets. The smaller counties fear domination by the more powerful county. Although the county with excess resources has the capacity to initiate linkages, it fears having to pay a disproportionate share of the costs without receiving any perceived benefits.

In addition to suspicions among counties, the four service areas that encompass 26 agencies are also protective of their clients and monetary resources. The large welfare agency, which accounts for over 90 percent of the county's human services budget, is especially concerned with expanding their domain in terms of population served, services rendered, and problems treated. Both counties and agencies were likely to resist surrendering any of their autonomy to a coordinating board, which they viewed as a potential "super-agency."

**Low Awareness of Interdependence**

According to Litwak and Rothman, awareness of partial interdependence among organizations is also a basic precondition for coordination. Sufficient awareness exists when agency executives develop policies or assign personnel to be responsible for interacting on an ongoing basis with other organizations. In the Minnesota case, such awareness was lacking.

Agency and county interactions are characterized by mistrust and by what Levine and White term domain dissensus, by disagreement over functions, populations served, ideologies, and evaluation of agency effectiveness. Agencies frequently compete for scarce resources. For example, the welfare departments and area mental health boards tend to disagree over who should provide mental health services. The public health department perceives their preventative approach to conflict with

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what they define as welfare's crisis orientation. Agencies and counties exchange some services through purchase of service agreements, joint programs, and joint planning; however, even though they frequently interact, they are more aware of their conflict and differences than of ways they can help each other through facilitative interdependence. In fact, agency directors, who were interviewed by the Board Planning staff, were often unaware of their agency's total number of linkages within and across counties. Much interaction is ad hoc, initiated by individual workers to meet particular clients' needs. According to Litwak and Rothman, the lack of an agency written policy setting forth the conditions for cooperation suggests low awareness of their interdependence. Therefore any attempt to cooperate had to bridge at several levels these barriers of competition, hostility and low awareness.

Utilizing the generic variables from Litwak and Rothman's theory, the regional situation appears to be characterized by more awareness of competition then of facilitative interactions; by many interactions between the 26 agencies; and by an asymmetrical distribution of resources among agencies and counties. In addition, any integrating mechanism would have to coordinate both standardized (e.g., budgeting) and nonstandardized (e.g., planning for service delivery) elements among the agencies.

In the Minnesota case, both service providers and county commissioners feared a seven-county Board with statutory administrative and fiscal authority, numerous functions, and permanent staff, and thus voted against it. The Board structure did not adequately take account of the existing power relations among agencies and counties and their needs to be semi-autonomous. According to Litwak and Rothman, the board as a linkage mechanism was too formal and autonomous, given the conflict, mistrust, threats to survival, and resource asymmetry among agencies. Likewise, the Board was assuming responsibility for nonstandardized tasks, such as planning for service delivery and rearranging the personnel systems, which threatened agency identity. Yet, the formal Board did not allow for sufficient informal, face-to-face interactions in order to reduce such threats to agency autonomy. The Board structure is most appropriate for coordinating standardized tasks, not unpredictable ones such as planning.

When agencies perceive their survival to be at stake, an ad hoc arrangement between agencies would be most appropriate as an initial way to coordinate services. This mechanism might bring agency professionals and commissioners together periodically to share common concerns and to begin to talk about and plan for services integration. Informal, face-to-face linkages that are low in autonomy are necessary to minimize the threats to domains and to increase gradually the agencies' awareness of their facilitative interdependence and of their potential benefits from cooperating. Implementing such personal interaction is time-consuming; however, more lasting payoffs are likely than with a top-down formal approach, such as occurred when the Minnesota legislature quickly passed the Human Services Act, without involving Commissioners and professionals in its formulation.

In the regional situation, it was also unrealistic to attempt to link seven counties which have such extreme disparities in resources and power. In order to avoid merger, the agencies (and/or counties) involved should be nearly equal in resources; in this situation, it would have been more effective to involve a smaller
number of counties and service providers. As the service providers would interact in an informal, ad hoc arrangement and undertake some nonthreatening fact-finding tasks, their awareness of interdependence between agencies would probably increase; with increased awareness of the benefits from cooperation, providers would be more likely to implement gradually a formal coordinating technology suitable for standardized tasks.

Conclusion

Litwak and Rothman's interorganizational theory thus suggests that practitioners need to consider the following variables in their attempts to implement services integration.

1. The existing relationships between the involved agencies (and/or counties): facilitative or competitive partial interdependence, domain consensus or dissensus. When the situation is characterized by competition, informal ad hoc face-to-face interactions are necessary to reduce threats to agencies' domains; in turn, some mechanisms are necessary to resolve conflicts between agencies.

2. The awareness of partial interdependence among agencies (and/or counties) is more critical than the number of interactions per se. If awareness is low, formal coordinating technologies will be too threatening to the agencies. Practitioners should begin by sharing nonthreatening tasks; this process could gradually increase awareness. The executives of agencies can also play a critical role in increasing awareness by developing policies and assigning personnel for coordinating purposes.

3. Resource asymmetry between the units to be coordinated. If units with asymmetrical resources attempt to coordinate, domination by the more powerful organization and eventual centralization are likely outcomes. Size per se is less important than linking units with fairly equal budgets and staff to allow mutual benefits. Agency coordination may be more easily attained than services integration, since resource disparities are more likely among service areas than among agencies within service areas.

4. Type of tasks to be coordinated.

Complex tasks directly associated with service delivery are more difficult to coordinate than standardized support services, such as accounting procedures. Attempts to coordinate should begin around standardized tasks, such as data collection and exchange. Differentiating types of tasks to be linked means that only certain agency tasks would be coordinated and thereby allows semi-autonomy among agencies (and/or counties).

Interorganizational analysis has not been widely applied to practice situations, particularly with any amount of foresight rather than afterthought. Hopefully, this brief review of some basic concepts has indicated a potential usefulness of some interorganizational theories to practitioners who are faced with decisions regarding the coordination and integration of human services.
NOTES


4. op. cit., Integration of Human Services in HEW, p. 5.

5. Examples of such efforts are the Department of Human Resources, District of Columbia; Human Resources Coordinating Commission, Kentucky; Executive Office of Human Services, Massachusetts.


7. op. cit., Levine and White, p. 584.


9. The other alternative would be for the State to mandate coordination. Although coordination of some type would take place, the conflicts and mistrust would probably persist under mandated service integration.

10. The state Planning Agency sought the support of the three state departments, the Governor's Office, legislative staff, and the Association of Minnesota Counties for the Human Services Act, but made little attempt to involve county commissioners or local service agency professionals. The Human Services Act did not undergo thorough scrutiny in House or Senate committees and, in fact, was passed less than a month after it was introduced into the legislature.
CONSULTATION AS A MODE OF FIELD INSTRUCTION

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ABSTRACT

In recent years both pedagogical and pragmatic considerations have prompted numerous experiments in field instruction for social work education. A novel approach used by one school is based on a consultation model. In this mode of field instruction a faculty based field instructor serves as a consultant to the student placed in a community agency. The relationship between consultee and consultant is distinctly different from that which exists between a student and a "teacher," "instructor," or "supervisor" in traditional field placements. Rather than a hierarchical, obligatory relationship, there exists between consultant and consultee a coordinate, facultative relationship in which the consultant's role is primarily that of problem-solving. Advantages of this approach include maximization of faculty resources, increased school control of field learning, utilization of a greater variety of field agencies, and facilitation of student choice in developing programs for learning as recommended by numerous reformers in professional education.

I. The Need for Experimental Approaches to Field Instruction

During the past decade there has been a proliferation of theory, research, and experimentation regarding modes of field instruction. This effort has been brought about by several factors.

The first set of reasons for the experimentation in field instruction modalities are educational in nature. Many of the newly tried ideas have been attempts to deal with the shortcoming of the traditional type of curriculum model sometimes referred to as the work model. One widely recognized problem with the traditional model has been the dichotomy of class and field. The need for linkage between class and field has long been recognized. For instance, in 1951 Rollis and Taylor wrote that "the objectives of field teaching should be identical with those of classroom work and should be as carefully organized into teaching units." As schools have sought to establish this linkage and provide the most effective balance and timing possible between the knowledge base and practice or skill components in social work education, numerous experiments in field instruction have been tried.
Many of these experiments also reflect the attempts of schools to act on the growing conviction in social work education that schools must carry primary responsibility for their total curricula, including field instruction. Based on this conviction ways have been sought to utilize school employed or full-time field instructors rather than agency personnel to provide the desired field learning experiments for the students. The importance of faculty field instructors has been voiced by numerous social work educators. Briar, for example, advocates the use of faculty members or mentors in teaching centers as the best means of giving the school control over all the students' learning experiences. Also, Cassidy maintains that the use of faculty field teachers does more than make sure the students "are getting it" in practice placements; more importantly, total curriculum development is enhanced as representatives of both modes of learning participate in the planning of content, sequence, timing, etc.

Another reason for experimentation with field instruction is the theory subscribed to by many social work educators as to how adult learning occurs. Through his analysis of the "three levels of learning," Walter Kindelsperger has provided a theoretical base for understanding the types of learning which may take place in the class and in the field and the consequent planning of the appropriate experiences in each. The learning which the student encounters in the classroom (both cognitive and cognitive-vicarious) should be paralleled by learning experiences from empirical events in the field (cognitive-vicarious-social learning). In seeking this paralleling, schools have given careful attention to the development of field placements, often with novel results. Furthermore, since field learning is conceptual learning (learning of generalizations drawn from specific, related experiences), it is important that these experiences be carefully planned, varied, and intense. With the traditional field instruction model these criteria are often unmet; the usual field agency is able to provide only a narrow, limited experience.

Beyond these educational reasons there are other practical considerations which have brought about experimentation with modes of field instruction. The lack of available agencies to provide field training and the lack of qualified field instructors have constituted problems for some schools. Increasing student enrollments and the opening of new schools with consequent demands for more agencies and field instructors have magnified these problems. Schools have coped with these problems by using preceptors in agencies without qualified instructors, by using faculty teachers as field instructors in some capacity, by using group "supervision," by using multiple agency placements for the individual student, and so on. Some of these field arrangements have been based on sound educational premises, while others have reflected reckless attempts to accommodate every student with some type of placement.

Another practical consideration which has led to innovation in field instruction arrangements in recent years is an economic one. The cutback in federal funding of schools of social work has had implications in two direc-
tions. First, agencies which offer sound learning experiences and can pro-
vide stipends for students but which lack qualified field instructors are
now being reevaluated. Ways are now being sought to utilize such agencies,
often through the use of faculty members as field instructors. Second, the
reduction in funding has meant that some schools which have previously used
full-time faculty field teachers, as in teaching centers, are now finding it
necessary to reduce faculty size and, therefore, must reexamine their policies
on deployment of faculty members.

II. Development of Consultation as a Mode of Field Instruction in One Agency

During this past year an experimental field placement arrangement was
developed by the University of South Carolina Graduate School of Social Work.
This development was prompted by several of the reasons described above.

The need arose for a community organization field placement for two
second year students with an interest in drug abuse prevention and treatment.
The logical agency was the South Carolina Commission on Narcotics and Con-
trolled Substances. This office is concerned with the planning and co-
ordinating of all drug abuse programs in the State. At the time the place-
ment began, the Commission was in the process of preparing a State plan for
drug abuse programs which was to be submitted to the federal government as
the State's funding request. Development of the plan required extensive re-
search concerning the State's needs and resources, as well as involvement
with local communities across the State to motivate and assist them in creat-
ing drug abuse prevention and treatment plans geared to fit their particular
needs. While these types of activities offered obvious excellent learning
opportunities for community students, there was no one employed by the
Commission who was qualified as a field instructor. Because of the education-
al needs and desires of the students, the learning opportunities potentially
available in this setting, and the fact that the Commission provided a much
needed student stipend, attempts were made to discover ways the School could
use this Commission as a field placement.

It was obvious that a faculty member could not be assigned to work in
the agency or function in the manner of a field instructor in a teaching
center. Furthermore, while there were other personnel in the Commission
with professional training in areas other than social work they were not
capable of providing social work instruction. Consequently, it was decided
that agency personnel would serve as preceptors and would provide admini-
strative supervision for the students. A faculty member assumed the re-
sponsibility for the students' educational experiences in the field and the
linkage of these experiences with the rest of the curriculum. The next
question was how the faculty member could best carry out this function while
not being in or involved with the agency and with relatively little time to
devote to this task. The pedagogical device decided upon which would best
meet these criteria was that of consultation between the faculty member and
student. It then became necessary to determine how a consultation approach
would relate to the School's broader curriculum, and to decide upon the specific theoretical framework within which the consultation would take place.

III. Relation to School's Curriculum Model

Three general curriculum models have been described by Mark P. Hale who analyzed them in terms of how they differ in (1) the focus of the program; (2) the way they define and put together class and field learning; (3) the way they use faculty available to them; and (4) the agency/school set required by them. With the work model (the traditional model and the one used in our school) the chief characteristic is the involvement of the student as a "worker" in an agency. The student's "work" or "cases" are the organizing factors in his learning. The agency "supervisor" is the primary teacher and apprenticeship is the main pedagogical method. The focus is on developing skill in practice and the agency and School share in teaching this—the agency supervises the field work and the School teaches the classes. The deficiencies of this model, such as those mentioned at the beginning of this paper, have led to the development of the second model.

In the practicum model the focus is on the curriculum. The School arranges a wide variety of "field learning" experiences providing students learning in a number of service methods and in relation to curriculum areas other than direct service methods. Faculty field instructors arrange the learning experiences around a variety of services, clients, and problems. Students are based in a teaching center, a community, or in several agencies. The School assumes most, if not all, of the responsibility for field instruction. The student usually does not engage fully in a worker role and he is not an apprentice—he is a learner. Group instruction is the usual pedagogical device. (The third model, the intern model, is rarely used in schools of social work and is inappropriate for analyzing the relation of the consultation modality to curriculum models.)

Whereas our School's program is based on the work model, the placement of students in the Commission constitutes a deviation from this model. The learning structure provided to the students in this arrangement is more akin to that found in the practicum model. However, while exposed to a wide variety of experiences as in the practicum model, the students encounter a greater intensity in learning experiences in this experimental placement than is usually true in the practicum model. This intensity results from the fact that the students are involved rather heavily in worker roles in the Commission, more so than is usually the case with the practicum model. While lack of variety is a problem with the work model, lack of intensity is often a problem with the practicum model. Thus, the consultation approach used in this experimental placement avoids or minimizes the problems of each of these models while maximizing the advantages of each. While these attractive inherent features of the consultation field arrangement were apparent from the beginning, it was also recognized that in order for consultation to be a viable
form of field instruction it must be based on a theoretical framework which separates it from other modes of field instruction and which clearly delineates the activities which it includes.

IV. A Theoretical Base for the Consultation Approach

In order for consultation in any setting to take place in a deliberate, planned, goal-directed fashion it is necessary that the consultant operate within a clearly defined conceptual framework. Unfortunately, such a framework is not always used and the result is a haphazard process in which neither the consultant nor consultee knows what is happening or where the process is leading. It is essential that the consultant have a clear understanding of the structure and function of his consultation and that he communicate this beforehand to the consultee--the result is mutually understood expectations with a consequent mutual involvement in a goal-directed process.

Typologies and classifications of consultation activities have been designed by consultants from various disciplines as they have attempted to conceptualize, organize, and plan the activities they carry out during their consultation practice. The best known typology is probably that of Caplan, who classified consultation into the four following categories by problem and focus: (1) client-centered case consultation; (2) program-centered administrative consultation; (3) consultee-centered case consultation; and (4) consultee-centered administrative consultation.13

In client-centered case consultation the consultee's problem relates to the management or treatment of a particular case or group of cases. The consultant assists by assessing the client's problem and recommending how the consultee should deal with the case. The primary goal of the consultant is to communicate to the consultee how the client can be helped. The consultant is only secondarily concerned with improving the consultee's knowledge or skills so that he will be better able in the future to deal with similar problems. Similarly, in program-centered administrative consultation, the consultant's primary goal is to deal with problems of planning and administration--how to develop a new program or improve on existing one. He analyzes the situation and draws upon his knowledge to make specific recommendations as to what should be done. He is only secondarily concerned with whether or not the consultee learns something which will help him in similar future situations.14 While these two types of consultation are valid and useful in certain situations, they are not appropriate to use when consultation is being provided as a mode of field instruction. In consulting with students the field instructor must focus his efforts toward change, learning, and improvement within the student (consultee) rather than direct his efforts toward cases or program.
Since the focus of the two following types of consultation is on producing change within the consultee, both types seem appropriate when consultation is used as a mode of field instruction. Consultee-centered case consultation is concerned with the management of a particular client; however, the consultant focuses his attention on trying to understand the nature of the consultee's difficulty with the case and on trying to help him remedy this. The difficulty may be due to lack of knowledge, lack of skill, lack of self-confidence, lack of professional objectivity, etc. The primary goal of the consultant is to remedy the shortcomings he finds present so that the consultee will be better able to deal with this and future cases. The clients provide learning opportunities and the consultant is not concerned about making recommendations about the cases. Similarly, in consultee-centered administrative consultation the consultant is not concerned about making suggestions to improve the program or to remedy administrative problems. Instead, his primary goal is to deal with the consultee's shortcomings or difficulties which prevent him from being able to deal with the administrative problems. Again, the consultee's problem may be lack of knowledge, skills, self-confidence, leadership abilities, etc. Both consultee-centered case consultation (with groups and communities viewed as clients, following Lippitt et al.) and consultee-centered administrative consultation are used in the experimental field placement. It was explained to the students in advance that this approach was to be used.

It is also necessary for the field instructor who is assuming a consultation role to differentiate the activities which take place in this type of practice from activities which may occur when other methods are used. It is this distinction which, perhaps more than any other, gives consultation its favorable uniqueness as a mode of field instruction.

To begin with, the consultation approach should be distinguished from traditional agency supervision. While a supervisor has administrative responsibility for the work of the supervisee, this is not the case with the consultant. Thus, the faculty field instructor assumes no administrative responsibilities with students placed at the Commission; the students are administratively answerable to one of the staff members. A supervisor can exercise his authority and enforce decisions on the supervisee by virtue of his higher position in the power hierarchy; in consultation there is a coordinate relationship with no power differential between consultant and consultee. It was made clear to the students at the Commission that the field instructor would not invoke his power as faculty member to induce them to handle their jobs in certain ways; instead, the relationship is such that they are able to accept or reject any ideas or suggestions proffered by the field instructor. They are assumed to be responsible for their learning and it is believed that they will make appropriate use of any help given by the field instructor (whether or not he agrees with the way they may use the help). Supervision also involves an ongoing process with the supervisee's "inspecting" the supervisee's work and initiating discussion of those aspects which appear unsatisfactory. Consultation, however, is ini-
tiated by the consultee and usually takes place in an ad hoc pattern around specific problems or difficulties which arise. Thus, it was explained to the students that the field instructor would see them at a set time once a week and that it would be their responsibility to bring to this meeting any problems or difficulties which they were experiencing. The field instructor does not review their work to see what they are doing but depends on them to introduce problem areas for discussion. If they have no material to discuss, their judgment about this is accepted and no time is wasted discussing irrelevant matters.

Consultation as a mode of field instruction should also be differentiated from the "teaching" activities which sometimes occur in field placements, as in teaching centers. In traditional teaching, there is the hierarchical obligatory relationship between student and teacher. In consultation, however, the coordinate facultative relationship which exists means that the student can make of the experience what he desires and he can accept or reject what the consultant has to offer. Also, in most teaching situations, the teacher has some clear idea of the content that he wants to impart to the student, whether it be factual knowledge, skills, or values. The field instructor functioning as a consultant, however, does not approach his student with some preconceived content area which he intends to impart in a series of planned steps. Although he may have the goal of increasing the knowledge or skills of the student and perhaps evaluating the degree to which he has succeeded in this, he does not assume responsibility for imparting content unrelated to problems or difficulties which the student introduces. He believes that the student, seeking to learn and enhance his skills, will introduce for discussion those areas in which he needs help.

With this distinction between traditional teaching and consultation having been explained to them in advance, the students at the Commission recognize that the amount they can learn from the consultant is directly related to how much data they bring to him for problem-solving.

It becomes obvious by now that in this theoretical framework problem-solving is the essence of the consultant's role, regardless of which of the four types of consultation he uses. The consultant and consultee come together around the problems that the consultee brings to the relationship, and as they engage in the process of solving these problems together the consultant is able to provide his help. A consultant is able to assist as a problem solver because of his knowledge in the particular area, his skills in diagnosing causes and prescribing remedies, and the objectivity that he brings to the situation. Thus, the faculty field instructor who acts as consultant brings to the consultation experience his knowledge of social work, his skill in dealing with social work problems, and his objectivity as an outsider of the agency in which the student is placed. Equally important is the faculty field instructor's knowledge of the entire curriculum, and he draws upon this knowledge to assist the student in solving problems by relating them to relevant components of the curriculum to which the student is exposed.
In any consultation the role of the consultant and the expected relationship between consultant and consultee should be agreed upon at the beginning and should be a part of the contract, either written or unwritten. Such a contract was negotiated with the two students in our experimental placement; it has proven valuable in holding consultant and consultees to their agreed upon roles and assuring fulfillment of respective responsibilities throughout the process.

Thus far this approach to field instruction has been considered successful by all concerned—the students, the agency, and the School. The students are learning much in their placement and are relating it appropriately to classroom curriculum; the Commission is benefiting from the work done by the students and by the knowledge gained from the experience of having students; and the School is able to utilize an otherwise unusable agency which has great learning potential for students by using a faculty field instructor in such a way that a minimum of amount of time is required.

V. Potentialities and Cautions

The use of the consultation model deals with many of the problems which have prompted the use of other experimental approaches to field instruction as discussed earlier in this paper. To begin with, it does provide a wider scope of learning experiences than are normally available in field work under the traditional model. Hence, it provides one answer to the issue with which many schools have struggled—that is, in the language of standards, how to assure students an opportunity for "diversity and breadth" in field learning as well as "new knowledge and understanding in all content areas of the curriculum." While offering more variety than the traditional work model, this approach also provides more intensity than the practicum model by virtue of the fact that the student does assume full responsibility for dealing with problems as a professional worker in his placement. Relatedly, this approach to field instruction offers an answer to another problem of the traditional apprenticeship model—that is, the potential for the student to become dependent and to operate on his field mentor's practice wisdom and knowledge, rather than on his own understanding and knowledge. The consultation approach provides one means of promoting responsible learning and developing student initiative, creativity, and independence.

The use of consultation as a mode of field instruction also provides a solution to the problem of the need for linkage between class and field. Numerous educators have cited the need for the field to reflect, parallel, and build on what goes on in the class. Too few have voiced the need for feedback from the field to the class, which is equally important, particularly if we remember that historically class teaching began as an academic extension of and support to experience in the field. Usually "the structure of social work schools alienates classroom from practice by isolation," and there is the need for faculty members to be reminded of what the student's practice problems are and to share in the responsibility for
solving these. The use of faculty field teachers as consultants makes possible this two-way communication. Similarly, this model makes it possible for the School to exercise control over the entire curriculum, rather than turning over a significant part of it to someone who might or might not relate his teaching to the rest of the student's learning experiences.

Perhaps one of the foremost advantages of this mode of field instruction is the type of relationship it fosters between faculty member and student. The relationship is professional and collegial, rather than vocational and pedagogical. Briar voices the need for this type of relationship in social work education in contrast to the "I teach, you learn" relationship which is so pervasive. "...[F]aculty and students should regard themselves as professional colleagues--of unequal competence, knowledge, and status, to be sure, but colleagues nonetheless--jointly engaged in a search for better, more effective solutions to the problems and tasks confronting their profession, a search in which each of them can make a contribution."23 Briar advocates the establishing of this type of relationship in teaching centers, but admits the difficulty of doing so because it involves a departure from traditional patterns of instruction that is more attitudinal than structural in nature. However, the nature of the consultation role itself, as described earlier, necessarily creates this type of relationship.

Finally, the use of faculty field teachers in the consultation role provides a means of responding to many of the problems described in the beginning of this paper which are non-educational in nature. Increasing student enrollments have intensified the problems of lack of qualified field instructors and agencies. The consultation approach provides sound, broader curriculum-related field instruction and makes possible the use of agencies otherwise unavailable for field work. Furthermore, it provides a different means of deploying faculty members in those schools which have previously used the teaching center concept and are now faced with budgetary cuts.

A number of studies have dealt with the subject of reform in several areas of professional education.24 One common reform measure recommended by these studies is that of increased flexibility in the curriculum so that students can have more freedom to choose and develop programs consistent with their own needs and interests. These studies recommend this type of reform on the basis of such factors as the demands of society, the cost of education, and students' changing demands. Argyris and Schon, however, make the same recommendation based purely on a theory of practice directed towards effective professional education.25 Although this increased freedom of choice of learning experiences is advocated on the bases of both pragmatic and theoretical reasons, this reform is not easy to implement. The consultation model described in this paper, however, does provide a valid means of effecting such freedom of choice.

It is noteworthy that the consultation model is consistent with the theoretically based model described by Argyis and Schon, and, by its nature,
offers a viable means for applying their model. Argyris and Schon's theoretical based model is an ideal, and they acknowledge the difficulty inherent in shifting from the traditional educational model to the one they recommend. Briefly stated, Argyris and Schon describe a model for professional education in which control over the learning situation is shared by educator and learner so that both can experience psychological success. This means that the educator helps the students to help themselves to define their goals, define the paths to these goals, develop their own realistic levels of aspiration, and relate goals to their central needs. Freedom of choice and internal commitment to the choice are both conditions and consequences of this process. Unilateral protection of oneself on the part of either teacher or student is not sought. In this type of relationship both parties are minimally defensive and open to learning; they are facilitators and collaborators; and they hold their theories firmly but are equally committed to having them confronted and tested. Trust, individuality, power-sharing, and cooperation become norms, with competition being confronted when it becomes dysfunctional. As these norms are emphasized, authenticity, autonomy, and internal commitment tend to increase. In this type of learning environment learning cycles will be set in motion. That is, as individuals come to feel more psychological success and more likelihood of mutual confirmation or disconfirmation, they are likely to manifest higher self awareness and acceptance, which leads to offering valid information, which again leads to feelings of psychological success. As individuals feel higher degrees of freedom of choice, trust, and authenticity, they are more likely to test their assumptions publicly, which enables others to feel higher degrees of freedom of choice, trust, and authenticity—all of which makes everyone more willing to give valid information that enables individuals to test their assumptions. Hence; an individual's learning tends to facilitate others' learning, which in turn facilitates one's own learning.

While Argyris and Schon's model for professional education has merit, there is obvious difficulty in designing and structuring a learning situation in which it is possible to implement their ideas. The consultation model does provide such a structure. Therefore, if professional education is to move in the direction called for by Argyris and Schon and the other writers mentioned above, the consultation model might serve appropriately as a vehicle by which this progress can take place. Such usage of the model could thus extend beyond the area of social work education into all areas of professional education.

Some words of caution should be interjected however. First, not every student is able to function well in the type of relationship suggested by this consultation model. While it is the philosophical position of this writer that graduate students will take responsibility for seeking learning experiences on their own if given the opportunity, it is also recognized that all students are not able to accomplish this to the same degree. Some students need more structure, guidance and dependency relationships than others, and the consultation model might prove frightening and overwhelming.
to these students. The model requires that a student be willing and able to take responsibility for his learning; to seek out appropriate experiences; to function rather independently and autonomously; and, at the same time, to recognize his needs and deficits and to take the initiative in bringing his problems to the consultant. Furthermore, because of these reasons, the consultation model is more appropriate for second year MSW students than for first year. Because of their one year training they are closer to the point of responsible entry into professional practice and are perhaps better able to function in the role of consultees, not only in terms of their knowledge base and skills, but in terms of their professional self-concept.

Second, not every social agency is able to make use of the consultation mode of field instruction. Some agency heads would be threatened at the prospect of assuming administrative responsibility only, with the school's assuming responsibility for the students' learning experience and often becoming aware of many of the agency's problems and "secrets." Furthermore, many agencies may not be able to provide experiences of enough scope and depth for the student. As is true in considering any type of field placement, the school should inventory in advance the experiences available in the agency.27

Third, not every teacher can function in the role of consultant. Consultation necessitates a coordinate relationship between parties; otherwise the activity is something other than consultation. Hence, consultation requires an attitudinal posture which may be comfortable if not impossible for some teachers more accustomed to the hierarchial patterns traditionally found in social work education. Relatedly, some faculty members may find it extremely difficult to commit themselves to a model in which the student must assume the responsibility for his learning, and to relate to the student in a problem-solving capacity only.

If the student, agency, and school can assume the necessary philosophical positions and make the requisite logistical arrangements, consultation can serve as a mode of field instruction which is valuable to all concerned.

References

1Some of these changes and innovations are documented by Mark P. Hale, in the Social Work Education Reporter, Vol. 15, No. 3 (September, 1967), pp. 20ff.


-575-


11Ibid.

12Ibid.


14Ibid.

15Ibid.


17For a discussion of how consultation may be differentiated from other methods, including supervision and education, see Gerald Caplan, The Theory and Practice of Mental Health Consultation (New York: Basic Books, 1970), pp. 21-28.


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22 Briar, "Teaching Center Design as a Function of Curriculum Objectives," p. 77.

23 Ibid., p. 74.


26 Ibid., pp. 86-93.

The welfare poor in America are classified into a "subterranean" strata not solely because of economic inequality but entrenched by racial ethnicity, age disadvantages, physical and psychological impairment, and broken family structures. While the misery and plight of the poor are often recognized in basic terms in which the survival necessity of food, clothing, health care, and shelter are real concerns, seemingly other less important cultural considerations are glossed over as trivia. Leisure participation continues to be neglected by researchers and because of this low priority, little or nothing is known of the leisure lifestyle of the poor. Less still is known about how leisure or the absence of it affects the status of the poor. And of even greater interest are questions about lost autonomy, undifferentiation, and social isolation resulting from leisure patterns. Every one of these issues deserves further treatment but this research will be limited to probing the question of whether the poor have either a restrictive or multiple pattern of association in their leisure. The comparison is solely limited to testing the range of association among the poor and no comparisons are made either implicitly or explicitly on how higher status groups associate against the pattern of the poor. Before that task can be accomplished, it is necessary to determine exactly where the poor rank and the examination in some detail of that position in society may help to reveal how they associate in their leisure.

In characterizing the poor strata, explanations have consistently developed among similar lines of inquiry. Although dominant trends prevail, important contributions have been added by differing vantage points. In presenting what might be termed a theory of limited outlook, Curtis et al (1971: 344) concludes "that the position of the poor in our social structure limits their outlook to the local, intimate setting, impedes their hope for meaningful control of their destinies and facilitates the
development to feelings of alienation, isolation, fatalism, and low self-esteem." The inept impression of intimate, warm, informal relations does not describe the poor, rather the "informality," "personal quality of ease," "warm humor," so perceived and stereotyped, only shuts them off from further secondary relations in the community. "Numerous studies have documented the marked degree of social and cultural isolation of lower class persons. Nor is this isolation simply a separation from the mainstream of society; typically lower class persons have minimal interaction with those of their own kind (Roach, 1965: 507)."

Indeed, depersonalization has even been found to pervade consumer interaction (Farberman and Weinstein, 1970). Most pointedly, a persistent pattern of circumspect relationships has been identified as limiting a poor person's range of social interactions and contacts.

By reducing interpersonal relationships, the role structure becomes undifferentiated. When relationships are narrowed, possibilities of exchange, and resulting integration into a community are depressed. What looks informal and relaxed in interpersonal relations is the negative consequences of this action. Reestablishing contacts of exchange in the community, moving from a state of unemployment to work, from abandonment to family, and from sickness to health is more possible than overcoming the social barrier of race (Yancey et al, 1972: 343-4). Contributing further to that narrow sphere of sociability is the reluctance of making "primary social relationships outside the immediate environment (Besner, 1965: 20)." By restricting the social environment, as if it were a closed system, entropy sets in thereby decreasing the chances of adaptation by reducing the interpersonal levels of contact. Substituting a managed welfare system, while providing necessary assistance, may even lead an individual to still greater dependency, since many interactions are then channeled through an agency. Place these individuals in a community environment which exhibits a degree of social disorganization and the problem proportionately increases. Moreover, the poor blacks even have a "rougher" time of it than whites, since their ghetto neighborhoods "exhibit a higher degree of disorganization (Drake, 1965: 785)." Given many of the conditions of age, race, housing and decreased sociability, the typical welfare recipient exists in a rather limiting situation with few options for social interaction.

The poor welfare recipient loses much autonomy and perhaps a measure of leisure which is an expression of freedom and voluntarism. "Their autonomy curtailed and their self-esteem weakened by the operation of the caste-class system are confronted with identity problems. Their social condition is essentially one of powerlessness (Drake, 1965: 772-3)." A movement away from society's institutions occurs because welfare recipients become dependent on bureaucratized agents to manage their external affairs, a movement analogous in many ways to prison inmates whose "external social status distinctions are severely
curtailed and so are contacts with the external world (Katz, 1968: 75)."
While the analogy to prisons as opposed to slums is exaggerated, there
are similarities between roles, and in particular over delimited pat-
terns of social interaction.

SOCIAL CONTACTS AND AFFILIATION

Patterns of interaction and association in the community by poor
welfare recipients are acknowledged to be of limited involvement. The
pattern of most relationships is limited to immediate family or extended
to church attendance. There are open contrasts even among the adjacent
working class, black or white, where friendship and relational patterns
possess a wider circle including some friends and neighbors (Feagin,
1970: 306-7). Declaring the poor as being isolated and unorganized is
more of a declaration for their absence of affiliational ties. Without
social contacts among friends, neighbors, relations, and interest groups,
the sphere of interaction for an individual narrows and with that also
freedom. Leisure is a voluntary act socially carried out with others
who share and reinforce the norms of discretion. No activity is without
its participants, audience, reference group, club, clique, or spectator.
Leisure activities are indeed done alone, but the norm is with others
(Cheek, 1971). Even with respect to solitary activities, one has to
recognize that there is at least some indirect kind of interaction
occurring even when reading, relaxing, or musing.

An obvious standard of a modernized industrial society is multiple
role relationships, the ability to manage many different expectations,
and to carry out diverse performances toward specified goals. The
fewer an individual's role expectations, the weaker are his bonds to
the community. The option of engaging in many differing role perfor-
mances offers the individual a greater range of choices and freedoms.
If an individual's role relations are few, his influence is reduced.
Another important source of independence occurs when an individual
changes roles, for it is during that interchange process that a routine
is terminated and an individual can act in a relaxed voluntary manner.
Leaving the office, shop or factory, going on a work break or pausing
to chat, coming from school or church are times when an individual moves
away or ceases to perform a designated role task. If an individual
possesses a large number of role statuses, the potential for leisure
freedom is greatly increased because of the possibility for more role
interchanges.

Another element of the issue which has to be examined is where and
under what circumstances do individuals normally socialize. The con-
trasts between the status of black and white are striking. The status
variable is unmistakably a decisive factor, because proportionately a
higher percentage of blacks are poor and welfare bound. The withi-
race comparisons between the welfare poor and other classes of blacks
should also be included when considering the issue of socializing. An urban study of blacks and whites which looked at this question found decisive differences (Yancey et al, 1971: 39). Upon examining various socializing situations, they stressed that "differences between the races appear only when we compare those who indicated that their socializing was facilitated by some play activity, as contrasted with those who mentioned some work activity--on car, house, garden. The former pattern is more frequently mentioned by blacks, while the latter is more mentioned by whites." The pattern of focused socializing around some play activity in the home is more likely to be present in middle class black households, while unfocused socializing in the home is more prevalent in lower class black and white households. The absence of direction, norms and rules found in game-like behavior in the lower classes removes an important source of adult socialization for those homes. One source of patterning or learning behavior involves aspects of cooperation and competition which is easily acquired in leisure situations of a game-like nature. Both the black and white middle classes are significantly higher participants than the lower class in subscribing to a formal game of socializing. Unfocused, random, nonpurposive socializing does not give rise to patterns of goal directedness and more rigid disciplined forms of socializing. The consequences of game-like behavior might prove to be quite revealing but are yet to be tested.

Lower class blacks also reveal reduced levels of socializing with friends done in the outside community. "Among blacks, the middle class is more likely to engage in these activities than the working or lower class, but the within-race status comparisons are hardly as significant as those between races (Yancey et al, 1971: 42)." Taking a localized stand toward the community cuts off channels of information and pleasure which are available in an urban environment.

The fact that cosmopolitanism is positively related to innovation and localism is negatively related to innovation works against the lower class black. The opportunity to accept change, new ideas and innovation is part of the growth and development of any class. To be cut off from social relationships is to experience routine monotony without any prospect of excitement and challenge. Briefly then, sociability among lower class blacks reduces their changes for social ties at least as it applies to their leisure needs.

LEISURE LIFE STYLE AMONG THE POOR

Given the six patterns of leisure which Kaplan (1960) identified for American society, the two of association and sociability just reviewed have accounted for very little involvement among the poor. While this pattern does not constitute any great cultural loss since other patterns of leisure are available, the fact that social contacts are generally so minimal among the poor does constitute a loss. The
problem is plainly demonstrated in the findings of a national probability sample on leisure which found that for those who participated, over seventy percent did so with others in all activities (Cheek, 1971: 254). The social process of engaging in leisure is normally done by interacting with social others, and not done as unattached individuals or alone. To say that the poor don't really join clubs or visit as a form of leisure is one thing, but to observe that they do not carry out leisure through any kind of group is quite another. The poor seem to be socially isolated and neutralized. Part of that narrowing process includes leisure caused by segregation in which "so many of the usual recreational forms were denied them (Myrdal, 1964: 40)." The exclusion of blacks did not completely hinge on the basis of race, but was further compounded by low socioeconomic status. If any dominant consensus has emerged for the poor, it is that they are "automatically prevented from enjoying most of the forms of private or commercial recreation which are available to the rest of society (Kraus, 1965: 191)." Largely relegated to unemployed or marginally employed situations, the poor face a kind of "enforced leisure"—not a leisure allowing free voluntary autonomous action with social others, but a form of "nothingness" or "emptiness" which signals the absence of leisure. Because routinized patterns of work and group affiliation are not necessarily part of the daily life experiences, there is little to be "free of" and probably not much discretionary time.

Few studies have ever seriously evaluated the leisure style of the black, let alone the poor black. As early as 1927, attention was called to the plight of the black living in an urban setting. "Probably no greater problem arises in connection with the Negro's adjustment to urban life than that of how to achieve an effective organization and control of his leisure time activities in the face of race prejudice and other barriers which limit his contacts and frustrate his wishes. Those who have studied seriously the social life of Negroes realize something of the significant role which pleasure and relaxation play among them (Jones, 1927: 25)." If our knowledge is weak about the black pattern of leisure, still less information is known about the poor black's leisure. That only a few studies have been done is quite obvious from the literature, and none with any kind of solid basis for making accurate generalizations. To offset that evident lack of information, an urban-centered study was carried out in an attempt to identify the leisure life style of the poor. This study was part of a much larger project which sought to uncover attitudes of the poor toward selected aspects of the welfare system.

SAMPLE AND METHODOLOGY

The respondents in this study comprise a sample of individuals residing in Fulton County (Atlanta, Georgia) who were receiving assistance from the Social and Rehabilitation Services of the Department of
Health, Education and Welfare during the winter of 1973. Originally, 700 names were randomly drawn from a sampling frame consisting of 18,000 individuals who were currently enrolled in either the Aid to Families of Dependent Children, Vocational Rehabilitation (blind or disabled) or programs for the aged by SRS/HEW. Seventy-eight percent or 549 of the target group were ultimately interviewed by professional interviewers who were screened and matched by race with the respondent. The sample consisted of 82 percent black and 18 percent white; a ratio proportional to the welfare population in the Atlanta metropolitan area. Sample bias was minimal and unsystematic with the exception of thirty individuals who were unable to be interviewed due to apparent mental incapacities.

Undoubtedly the reasons for so few studies among the poor are the many difficult problems of enumerating the population, sampling, contacting, and interviewing respondents. Establishing rapport and convincing the respondent that what they reported would not be used against them is a difficult problem, but not insurmountable. This is especially true as concerns their leisure, since shades of the Protestant ethnic, notions of frivolity, and stereotypes of being lazy and listless linger on.

Establishing rapport and convincing the respondents that their comments would be treated with strictest confidentiality was a primary concern in the present situation due to the nature of the subject matter and the understandable suspicion with which welfare recipients would tend to view a stranger seeking to ascertain personal information. Interviewers were trained and alerted to the difficulties of eliciting information from the potential sample. A number of role playing situations which employed current welfare recipients as interviewees were presented, and the first day's work of each interviewer was carefully assessed before they could continue. Additionally, a review session was held at the end of the first week of data collection. Validation checks were made for ten percent of the completed interviews and comments from those subjects contacted were favorable with respect to the interview situation. The researchers are, therefore, confident that the data are believable and were collected under the best of circumstances. Our assumptions concerning the validity of responses has been corroborated by Weiss (1968-1969), who concluded that the responses of black welfare mothers in New York were valid.

FINDINGS

A series of leisure activities was factor analyzed in order to determine whether any peculiar patterns would emerge deviating from that described by Kaplan (1960). The principle components method, with orthogonal rotation, was utilized to extract unidimensional factors of leisure involvement from the Atlanta sample. Five factors emerged and the least squares method was used to assign factor scores to the individual.
subjects in our sample (Rummel, 1970: 437-41). An emergent pattern of activities was identified by three distinctive groupings presented in Table 1.

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Table 1 about here
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The first factor was marked by aspects of social interaction depicted in partying behavior, card games, and movies in the outside community. Factor one might be termed "entertainment" which implies a notion of openness toward others, interaction in a community setting, or a focused kind of interaction. The distinguishing characteristic of social involvement outside the immediate family means more extensive social contact offering a greater chance for autonomy. The second factor extracted plainly represents "arts and crafts," including sewing and other hobbies. The underlying behavior of this second factor is more likely to be distinguished by the level of individual involvement. The expressed purpose of the activity can be very easily accomplished without involving anyone else. While hobbies are personal kinds of experiences, clubs and voluntary associations dealing with a hobby often serve to provide a social function. Autonomy is served when hobbies evidence a social interactional process organized into clubs, annual meetings or the like. The essential behavior of a hobby, however, plainly requires that an individual take steps and exercise initiative toward a purpose whether building models, collecting artifacts, or creatively engaging in an art form. A third factor emanating out of the analysis paradoxically contains a mixed degree of "sociability" of which shopping and visiting are the principle activities. Shopping allows an individual a readily accessible outlet into the community for browsing, window shopping, pricing or buying. Shopping can be done alone or in the company of others, but never without clerks or other consumers. The context need not include interaction but is still done in public, and behavior must at least take into consideration some minimal forms of intercourse. The other activity of visiting relatives inherently focuses attention upon direct interaction. The social bonds of intercourse rely upon kinship ties which unite the larger family unit and mold interaction. Visiting among relatives when viewed in respect to patterns based on employment or residence is more likely to occur among the lower status levels. The mixed strength of the sociability pattern in this factor hinges upon the degree of interaction necessary for either shopping or visiting.

Two remaining factors have also been identified, but their relative importance is limited by the amount of variance explained. Factor four represents "outdoor recreation" containing park and picnicking behavior while factor five is composed of "radio and television." Because the
sample is predominantly composed of blacks, it is not unexpected that park behavior would represent a low value given the past history of park use among blacks. And, mass media, often believed to be a dominant aspect of the lower strata, rather than assuming a more dominant role, functions more as a babysitting service, or relates simply to reduced leisure participation (Meyersohn, 1968-69).

Confidence in the original factors is definitely enhanced by a validation procedure but even without that, they are sound theoretically when compared to Kaplan's model which classifies activities in roughly the same manner. In an effort to test influences on the leisure factors a series of independent variables was measured which assessed socioeconomic influences, personality and associational determinants. Variables were chosen for their possible effect on the leisure factors. Socioeconomic data including education and income were gathered along with aggregate data measuring age and number of family dependents. Personality information was obtained from the anomie scale (Srole, 1956) and an attitude scale toward welfare (Kallen and Miller, 1971). Both these sets of variables played very little part as predictors of leisure factors. The variables were tested by applying a multiple stepwise regression model to the data. Practically no variance in any of the five leisure factors was accounted for by these variables. That finding is not surprising and coincides with data on the Srole index. The sample data was so consistent of poor welfare types that very little could be determined from some of the information because of the skewed distributions. The results obviously confirmed that the poor lacked education, income and were highly alienated. Nobody should be surprised to find that aggregate data, socioeconomic indices, and even some personality variables would not predict any outcome for the leisure factors because of the lack of differentiation among such a strata. More importantly, the variables tend to overlook patterns of social relationships which structure group life.

To at least begin an approach in determining patterned social relationships among the poor on leisure, three sociability indexes were tested by obtaining scores on who participated with another individual in an activity. The aloneness index measured the times an individual did an activity without social interaction as a ratio over their total pattern of activity. A primary group leisure involvement index was also employed to measure the number of times an individual did an activity with members of the immediate family expressed as a ratio over their total pattern of activity. Finally, a secondary group leisure involvement index was measured that took into consideration patterns of association with friends and neighbors also expressed as a ratio over total activity patterns. Tables 2 and 3 contain an intercorrelation matrix among the predictor...
and dependent variables along with the results of the multiple regression analysis for the first three leisure factors. The contribution to the total explained variance by factors four and five was minimal and could not be expected to reach any meaningful level of explanation.

Tables 2 and 3 about here

The bulk of the explained variance for the entertainment factor was accounted for by three variables. Secondary group associations accounted for most of the variance, since parties and game behavior are carried out in the company of others. Rather than occurring solely among family members, the pattern is more autonomous and reaches out to friends and neighbors in the community. The isolation generally expected among the welfare poor did not hold for this factor, perhaps because age enters into the explanation. The younger are more active in entertainment, more mobile, sexually aggressive and less likely to be trapped without friends. Yet, this factor still turns upon the alone variable. Although the explained variance is minor, having the variable even appear is telling of some degree of isolation. The norms regulating participation in leisure activity are partially influenced by how the activity itself is structured. Some activities by their very rules require more than one individual in order to complete the act, but the precise nature of the social relationships are not that clearly specified. Mates, friends and organizations are but a few possibilities. To have a single party seeking entertainment alone is not typical. Arts and crafts, on the other hand, are more adaptable to singularity. Evidence is found of the alone situation operating to predict a major amount of the variance for this factor. There was also a positive relationship with more immediate members of the family or primary group. The older tended to be more involved and there was evidence of a weak negative relationship with secondary groups. The pattern of predictors for the second factor is quite consistent with what might be expected given the kind of activities. The fact of the activities being more adaptable to engaging in leisure by oneself or in primary relations is more in keeping with the social isolation explanation. A third sociability factor including a combination of visiting and shopping was undertaken alone or in more primary group relationships. The limitations on social relationships takes over this third factor revealing a model that reinforces the isolation theme.

The second and third factors strongly suggest that the poor possess a somewhat restrictive leisure. The first factor clearly establishes an extended sphere of socializing. But the data unfortunately do not get at an in-depth view of friendship among the poor. The number of different associates, basis of association, or degree of association are questions
which need to be asked before a clearly defined view can be presented. Even without this information, the weight of the evidence suggests that the poor engage in a narrow band of activities, and for the most part are either accompanied by family or are simply alone. A cross-tabulation of activities by persons engaging in them clearly reveals that there is a restrictive pattern of socializing among the poor. Of the twenty-one different leisure activities that were selected by the poor with varying degrees of participation, the highest ranked category was consistently that of being alone, followed next by that of participating with children. The lowest ranked category of participation was found among one's friends. Clearly the pattern emerging from the data strongly points to a rather limited circumspect pattern of association.

CONCLUSIONS

The opportunity to exercise discretionary time is controlled not only by access to employment but also by one's pattern of association. The experience of autonomy is lacking among the lower classes because of such barriers. Reduced autonomy results from a limited range of responses to possible leisure activities. Couple this narrow response set with highly circumspect patterns of association and the consequences become more disastrous for the poor. The leisure life style of the poor can best be characterized by their response to an open-ended question probing what they do in their free time. Many responded by saying they did "nothing" or just "sat and relaxed." The response is symptomatic of deeper ills that reflect a general subsistence level of existence.

Living within the context of an urban industrial society is both rewarding and punishing. Like any paradox, the solution eludes reconciliation because the ambivalence is reality. But certain segments of society are set off from the pleasures and pressures of meaningful cultural activity; they fall far beyond the expected pattern of normal social interaction. Some are poor and share less in wealth and the pleasures that it can bring. The disjunction between the material displacement among the poor and middle income groups is obvious for the displacement of the poor from social roles. The fact that they do not usually have a job career or strong family ties removes much from their lives. Not just the subjective experiences but also many normative consequences both positive and negative are never realized within a narrow band of role expectations. The freedom of exercising role choice in leisure is greater than in other behaviors. That freedom expressed by participating with other people is more important than some range of activity. The function of sociability is therefore essential for providing an individual with interactional relationships which unite them with the larger community. The welfare poor are simply denied relational autonomy within the associational framework of leisure.
FOOTNOTES

1 In both instances, the Eigen values were well below 1.00, so they were not included in Table 1.

2 Since an orthogonally rotated factor analysis forces the factors to be statistically independent, the resulting patterns may simply be a function of the technique. As a check against just such a possibility an oblique rotated factor matrix was generated and none of the resulting factors which emerged were different from those found in the original rotated matrix.

3 Kendall's coefficient of concordance was sig. at .05, W=.563.

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TABLE 1

THREE ORTHOGONALLY ROTATED FACTORS FOR SELECTED LEISURE ACTIVITIES*

<table>
<thead>
<tr>
<th>Variable</th>
<th>Factor 1</th>
<th>Factor 2</th>
<th>Factor 3</th>
<th>h²</th>
</tr>
</thead>
<tbody>
<tr>
<td>Partying</td>
<td>.711</td>
<td></td>
<td></td>
<td>.57</td>
</tr>
<tr>
<td>Attend movies</td>
<td>.656</td>
<td>.57</td>
<td></td>
<td>.51</td>
</tr>
<tr>
<td>Play cards</td>
<td>.594</td>
<td>.42</td>
<td></td>
<td>.42</td>
</tr>
<tr>
<td>Play a sport</td>
<td>.393</td>
<td></td>
<td>.20</td>
<td>.20</td>
</tr>
<tr>
<td>Attend sports</td>
<td>.383</td>
<td>.31</td>
<td></td>
<td>.31</td>
</tr>
<tr>
<td>Visit friends</td>
<td>.353</td>
<td></td>
<td>.31</td>
<td>.31</td>
</tr>
<tr>
<td>Go driving or riding</td>
<td>.337</td>
<td>.34</td>
<td></td>
<td>.34</td>
</tr>
<tr>
<td>Do sewing</td>
<td></td>
<td>.590</td>
<td>.45</td>
<td></td>
</tr>
<tr>
<td>Work on hobby</td>
<td></td>
<td>.584</td>
<td>.42</td>
<td></td>
</tr>
<tr>
<td>Do gardening</td>
<td></td>
<td>.396</td>
<td>.25</td>
<td></td>
</tr>
<tr>
<td>Work on house or apartment</td>
<td></td>
<td>.324</td>
<td>.26</td>
<td></td>
</tr>
<tr>
<td>Go shopping</td>
<td></td>
<td>.646</td>
<td>.42</td>
<td></td>
</tr>
<tr>
<td>Visit relatives out of home</td>
<td></td>
<td>.555</td>
<td>.44</td>
<td></td>
</tr>
<tr>
<td>Reading</td>
<td></td>
<td>.490</td>
<td>.34</td>
<td></td>
</tr>
</tbody>
</table>

Percent common variance 55.3 15.7 11.9
Eigen Values 4.30 1.22 1.02

*The activities were originally coded in terms of frequency (1. Never; 2. In last month; 3. In last week). Several other leisure activities (fishing, picnicking, visiting a park, watching TV, listening to the radio, listening to music, and home doing nothing) loaded moderately on three additional factors which were discarded due to noninterpretability and because each had Eigen Values of less than 1.00.
TABLE 2

ZERO-ORDER CORRELATION MATRIX OF FOUR PREDICTOR
VARIABLES AND THREE DEPENDENT VARIABLES*

<table>
<thead>
<tr>
<th>Variable</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
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<tbody>
<tr>
<td>Age</td>
<td>1.000</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aloneness index</td>
<td>-.055</td>
<td>1.000</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary group leisure involvement</td>
<td>-.325</td>
<td>.016</td>
<td>1.000</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Secondary group leisure involvement</td>
<td>-.362</td>
<td>.280</td>
<td>.211</td>
<td>1.000</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Factor Scale 1 (Entertainment)</td>
<td>-.415</td>
<td>.215</td>
<td>.164</td>
<td>.560</td>
<td>1.000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Factor Scale 2 (Arts and Crafts)</td>
<td>.064</td>
<td>.444</td>
<td>.217</td>
<td>.041</td>
<td>-.034</td>
<td>1.000</td>
<td></td>
</tr>
<tr>
<td>Factor Scale 3 (Sociability)</td>
<td>-.180</td>
<td>.470</td>
<td>.408</td>
<td>.343</td>
<td>.170</td>
<td>.211</td>
<td>1.000</td>
</tr>
</tbody>
</table>

*In some instances, the correlations are based on slightly less than 570 cases.


| TABLE 3 |

REGRESSION ANALYSIS OF THE DEPENDENT VARIABLES

<table>
<thead>
<tr>
<th>Dependent Variable: Factor Scale 1 (Entertainment)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Independent Variable</td>
</tr>
<tr>
<td>----------------------</td>
</tr>
<tr>
<td>Secondary Group Leisure Involvement</td>
</tr>
<tr>
<td>Age</td>
</tr>
<tr>
<td>Aloneness Index</td>
</tr>
</tbody>
</table>

\[ R^2 = 37.1\% \]

<table>
<thead>
<tr>
<th>Dependent Variable: Factor Scale 2 (Arts and Crafts)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Independent Variable</td>
</tr>
<tr>
<td>----------------------</td>
</tr>
<tr>
<td>Aloneness Index</td>
</tr>
<tr>
<td>Primary Group Leisure Involvement</td>
</tr>
<tr>
<td>Age</td>
</tr>
<tr>
<td>Secondary Group Leisure Involvement</td>
</tr>
</tbody>
</table>

\[ R^2 = 27.6\% \]
TABLE 3 (Cont'd.)

<table>
<thead>
<tr>
<th>Independent Variable</th>
<th>Zero-Order Correlation</th>
<th>Unstandardized Regression Coefficient</th>
<th>Standard Error</th>
<th>Standardized Beta Weight</th>
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</thead>
<tbody>
<tr>
<td>Aloneness Index</td>
<td>.470</td>
<td>.227</td>
<td>.020</td>
<td>.400</td>
</tr>
<tr>
<td>Primary Group Leisure</td>
<td>.408</td>
<td>.160</td>
<td>.016</td>
<td>.351</td>
</tr>
<tr>
<td>Involvement</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Secondary Group Leisure</td>
<td>.343</td>
<td>.123</td>
<td>.032</td>
<td>.144</td>
</tr>
<tr>
<td>Involvement</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

$R^2 = 40.2\%$
ABSTRACT

A recent research study suggests that persons living together outside of marriage do not view social work services as a potential source of help for problems brought into the living together arrangement, those common to all intimate long-range dyadic relationships or those directly related to choice of lifestyle. A multi-faceted approach is suggested which would aim at reaching this potential client group in a climate which will neither stigmatize or judge the alternate lifestyle or the persons who practice it.

Social work has established specialized agencies and/or practice areas to help with specialized problems. Illness related problems can be brought to the medical social worker, school related problems find their way to school social workers, psychiatric social workers work with many areas of emotional illness and social dysfunctioning. Logically, family problems should be addressed by family agencies and "marital" problems by counseling agencies.

Many family and marital problems never come to the attention of social workers and other counseling professionals. They occur in an almost infinite variety of living arrangements. The very fact that two or more adults live in close proximity, share possessions and intimacy and confront mutual problems preordains them to certain areas of stress and interpersonal difficulty as well as to other prob-
blems inherent in the interface between their family system and other social systems. Many of these families do not possess the ticket to general social acceptance, a marriage license. Because of this they either are or perceive themselves to be (it makes little difference to the person in need of help) separated from sources of counseling and assistance which they may require. Who are these potential clients and what are the obstacles to their acquiring help?

The Living Together Arrangement

There exists a sizeable proportion of persons in America today for whom the institution of marriage is unacceptable as a lifestyle. They have chosen an alternative which affords a complex and paradoxical composite of freedoms and restrictions, sanctions and stigmata, superficiality and intensity. The living together (outside of marriage) arrangement may have arisen as a lifestyle as an indirect result of increased technology and demand for women's rights as suggested by Bernard, the rising employment of women cited by Otto, or from a number of other causes reflecting a reaction to the failure of contemporary monogamy. It is probably accurate to say that the reasons for its growth are as varied as the contracts which exist within the arrangement.

There are, in all cross-sections of our society, persons who have built a reasonably stable heterosexual relationship outside the legal sanctions of marriage. They do not attempt to deceive others by pretending to be married nor do they openly flaunt their lifestyle in a show of defiance. The relationship is characterized, not by the hedonism or promiscuity portrayed in popular media, but by variations on the themes which we have come to know and expect among married couples.

Reflection on Recent Research Findings

One recent research study sought to identify and categorize the problems of an alternate lifestyle and to attempt to learn what is necessary for social work to begin to relate effectively to this potential client group. The living together arrangement (LTA), was operationally defined as "a relationship of at least six months' duration consisting of an unmarried heterosexual couple who occupy the same household in a conjugal relationship. They adhere to an essentially monogamous lifestyle, but do not consider themselves to have a common law marriage." A case study design was employed. Four LTA couples were studied over an extended period of time. While generalizations from a case study must necessarily be limited, a number of the research findings have serious implications for social work practice.

The couples reflected wide diversity in some areas and surprising agreement in others. Rationale for the choice of the LTA included some combination of economic considerations, a desire for sexual intimacy and companionship, a reaction to perceptions of traditional marriages, and a desire for a deepening of intimacy as a prelude to a more permanent commitment.

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Generally the male assumed a traditional "head of household role," although in one family responsibilities were divided with mathematical precision. While individual freedom varied, most couples adhered to a contract of sexual exclusivity and described little conflict in this area.

All the couples perceived considerable advantage to the LTA. They viewed it as being without constraints of traditional role structure and conducive to personal and interpersonal growth.

While they did not feel particularly alienated or discriminated against because of their lifestyle, the couples revealed a certain guardedness about open discussion of their arrangement with such people as employers, landlords and business associates. They believed that the intensity of their relationship and its potential for societal sanction limited their outside involvement with others. They regarded this as predictable result of a choice of their own making.

Actual problems of social stigma were generally not perceived, except in relationships with parents. While conflict over the LTA varied from virtual ostracism from the family of origin to a climate of "subtle hints," all the couples described an increased social distance from parents.

Problems of the LTA Couples

There are apparently three major categories of stress which are likely to occur within the living together relationships. It is important to remember, as in formal marriages, that health and adaptability are probably far more characteristic of the relationships than are pathology or narrow rigidity. Yet certain "problem patterns" can be observed to occur with some degree of regularity; it is these problems which must be addressed by those who seek to offer help through counseling and other assistance:

1. Problems brought to the LTA. The decision to enter into the LTA cannot and should not be viewed as an evidence of pathology. Like all persons, couples in the LTA may, however, have intraphysic problems of varying severity. These may not be more prevalent than those found among married persons; they are probably more potentially debilitating than actually obstructive to social functioning.

Among persons in the LTA, there seems to be a rather excessive (relative to traditional relationships) concern with capacity to establish relationships of intimacy, honesty and trust. (Whether the LTA is in fact, a superior alternative to marriage in its potential for meeting this individual need is not at issue here.) Persons who choose the LTA may take great pains to impress others with what they view as the advantages of their lifestyle in areas of intrapersonal need gratification. They seek an attitude or feeling of freedom, allowing for a continued love relationship based on choice. The search for this ideal while, perhaps, differing somewhat in degree of intensity is similar to that sought by most couples who elect marriage. The frustration resulting from the inability to attain it is but one area of potential intrapsychic stress which may require assistance.
2. Problems common to all intimate long-range dyadic relationships. Nearly any interpersonal problem inherent in the traditional marriage agreement can be seen in the LTA. Irritability, sexual problems, jealousies, "in-law" stress, financial tension, conflict over alleged impingements on individual growth, child-rearing disagreements and even boredom can be seen. (Role conflicts are generally less apparent, perhaps because some couples characteristically seem to have engaged in considerable role negotiation early in the agreement.) Any intimate relationship can and often does require outside professional intervention; the LTA shares many of the areas of stress seen in marriage and is in no less need of assistance with "normal" interpersonal conflicts.

3. Problems directly related to the LTA. A specific syndrome of tension with families of origin (relating to stigmatization and alienation) is a major difficulty inherent in the LTA. Another potential area of stress, perceived alternately as a strength or a weakness by persons within the LTA, is the absence of definable structure in the relationship. While on some occasions it may be described as creating a latitude conducive to interpersonal growth, some of the same individuals may, on other occasions, speak of their anxiety about future security and uncertainty. A characteristic turning inward and away from community interaction and involvement, whether voluntary or of necessity, represents another potential problem area. One can easily project long range difficulties for persons so heavily invested in a relatively closed system with minimal input from other social systems. Assistance in "bridging" system boundaries may be indicated.

The LTA and Social Services

The overall emotional health of LTA couples does not, in itself, suggest cause for alarm. It is reassuring to note that they have relatively few problems unique to the LTA or exacerbated by it. Unfortunately, however, persons in the recent LTA study did not view social services as a potential source of help for any problems which they may have individually, as a couple, or as a family. While social agencies are beginning to move away from viewing a marriage license as a prerequisite for family counseling, persons in the LTA continue to view social agencies as so judgmental and stigmatizing as to be unable to help them should problems arise. Agencies are often viewed as traditional, untrustworthy, and unreceptive to persons practicing alternate lifestyles.

These perceptions are not incompatible with the description of Cogswell and Sussman:

In performing their functions, human service systems make certain assumptions about the family. They gear their services toward an ideal of what the family ought to be, namely, a nuclear traditional one...Because agencies idealize the traditional family, their programs are aimed at restoring this form, and thus, are ill-equipped to provide relevant supportive services to variant family forms.5

In the recent case study, descriptions of social workers as "welfare workers" or "voyeuristic" were common. Respondents assumed that their lifestyle would be
viewed as a form of defiance. Even "normal problems" were not viewed as appropriate for social work intervention. All four couples saw dissolution of the relationship as the only viable alternative (despite the presence of children) should interpersonal conflicts become severe. One participant observed that, "No social agency would probably want to try to help until we could show them a marriage license. Even if they agreed to see us, probably their main goal would be to get us married. We would either work things out ourselves or split up."

Similarly, persons who choose the LTA do not view social work as a potential resource for problems relating to broader social systems. While they perceive legal and social policies as prejudicial in areas such as taxation, evictions, policies, and termination of employment, they rarely perceive social work as a source of potential advocacy, support or even referral to other resources of potential redress. The only known alternatives seem to be to brood in silence or to seek commiseration with another LTA couple.

Implications for Outreach and Services

Existing literature and the recent case study suggest that persons in the LTA are neither significantly healthier or less healthy than other persons in other long-range dyadic relationships. They do, however, represent a sizeable number of persons for whom problems will periodically occur which require skilled professional assistance. At present they feel cut off from services which could be of help. A three-faceted solution to this situation is suggested:

1. A loosening of "family" definitions and liberalization of attitudes among individual practitioners and agencies. The nonjudgmental stance of social work remains partially a myth in relation to this potential client group. While progress has been made (most notably in areas of birth control and abortion counseling) there remains a gap between verbalized values and those operationalized in attitudes of individual professional personnel and in some cases, even agency policies. Persons in the LTA are extremely sensitive to criticism of their lifestyle. An innuendo, an assumption about the maturity level of the couple or a hint of proselytizing can abort an attempt at seeking help before benefits can be achieved. A process of soul searching with particular emphasis on values related to marriage is indicated for all who seek to serve those who choose the LTA.

2. An active program of outreach employing mass media and other publication techniques. Persons in the LTA need to recognize that professionals in social agencies understand both the unique and the common nature of their problems. They need to know that social workers do not regard these problems as their "comeuppance" but rather as a normal byproduct of a long term, intimate relationship. The role of the social worker as a resource coordinator and source of referral available to facilitate access to all other human services, should be stressed. Persons in the LTA need to know that there are medical, legal and financial resources available to assist in those areas where social work services are not sufficient.

3. Intensive research into the LTA. Sociology and social work, with highly developed interviewing techniques and sensitivity to subtle communication, are
logical choices for the task of gathering extensive data on the strengths and areas of vulnerability of the LTA as an alternate lifestyle. If services to couples in the LTA are to be relevant and effective they cannot be based on mythology or stereotypes. At the present, additional case studies offer a beginning to help illuminate the variations which comprise the LTA. As fact begins to replace fiction, other "tighter" research designs will need to be employed, especially if a program of outreach based on scientific knowledge is to be undertaken.

In Summation

A recent case study of LTA couples revealed more similarities to marriage than differences. It also spotlighted a sizeable percentage of our population, (and, on that basis alone, a large potential client group) that feels cut off from traditional sources of help for marriage-type problems as well as those unique to the LTA.

The LTA is a lifestyle which may be growing and is definitely becoming increasingly visible. Persons who elect this alternative possess human needs and problems which must be addressed by the helping professions. At this time there are few services perceived by these persons to be readily accessible. Social workers have traditionally served as advocates in the area of marriage and the family. Now they can contribute a vital and needed service by emphasizing traditional social work practice roles and by finding new ways to meet the changing needs of a society in transition. If the social work profession does not move to fill a gap in human services, who will?

FOOTNOTES


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UPWARD MOBILITY POTENTIAL
ATTITUDES TOWARD MENTAL ILLNESS
AND WORKING-CLASS YOUTH

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Honey A. Mendelson, A. B.
Department of Social Work Services
Hillside Division
Long Island Jewish-Hillside Medical Center

ABSTRACT

The investigators were interested in assessing the relationship between upward mobility potential and attitudes toward mental illness. For the 147 male adolescents studied, it was hypothesized that those working-class youth who demonstrated a high predictability of future upward social mobility would score more liberally on the five factors of the Opinions about Mental Illness Scale than those working-class youth who demonstrated a low predictability of future upward social mobility. Through the use of the aforementioned scale, the Otis Quick Scoring Mental Ability Test and Zero Order Correlations, the hypothesized relationship was confirmed; i.e., the upwardly mobile group was significantly more liberal than the non-mobile group.

This study emerged from the confluence of two streams of interest: attitudes toward mental illness and the concept of anticipatory socialization.

There are a number of studies which have been concerned with attitudes toward mental illness. They agree that, in general, the public does not hold favorable attitudes toward mental illness. In those studies in which social class was a factor there were clear class distinctions between lower and middle class attitudes, with the lower classes less favorable in their recognition of mental illness and less liberal in their outlook about mental illness, even though the lower class has a higher prevalence of mental illness. When occupational groups and groups of students were studied the same findings held: those in lower class occupations were more conservative in their attitudes than those in middle or upper class occupations.

The process of social mobility and its effects on atti-
tudes toward mental illness has not been studied explicitly. The investigators were interested in determining if upward mobility potential is related to attitudes toward mental illness and whether working-class adolescents with upward mobility potential would bear a greater resemblance to the middle class in their attitudes toward mental illness or to the outlook of their class origin. The literature on social mobility reports two conflicting trends regarding the liberalism-conservatism continuum. Curtis,4 Lenski,5 O'Kane6 and Tumin7 identify upward mobility with greater liberalism. Lipset and Zetterberg8 identify upward mobility with conservatism. Would those with upward mobility potential be liberal or conservative in their attitudes toward mental illness?

In attempting to answer this question the investigators utilized Merton's concept of anticipatory socialization which states that those in society with realistic upward mobility potential socialize themselves to the values and attitudes of the class to which they aspire to join.9 Thus, those with realistic upward mobility potential from the working class should be more like the middle class in their attitudes toward mental illness and the attitude formation should occur prior to attainment of middle-class status. O'Kane, in studying attitudes toward liberalism, offers some support for Merton's concept.10 He discovered that working-class youth with a high predictability of upward mobility potential reflected more liberal attitudes toward non-economic issues (characteristic of the middle class) than working-class youth with a low predictability of upward mobility potential.

Thus the problem emerges: What is the relationship between upward mobility potential and attitudes toward mental illness?

Hypothesis

To evaluate this question the following hypothesis was proposed:

Working-class youth demonstrating a high predictability of future upward social mobility will score more liberally on the five factors of The Opinions about Mental Illness Scale than those working-class youth who demonstrate a low predictability of future upward social mobility.

METHOD

The sample for the study was drawn from the senior class.
of a high school in a major Eastern city. This high school was selected because of its location as the school mostly serving children from working-class families. While the total class of 406 was tested, the investigators only utilized males for the sample to be analyzed. This was done in order to eliminate sex as a variable because the literature reports that there is a difference between social mobility patterns in male and female adolescents.11

Of the 406 members of the senior class, 220 were female and 186 were males. Thus, the potential sample number was 186. In order to exclude all non-working-class adolescents, the investigators utilized the Duncan Index of Socio-economic Status. Each respondent was asked to indicate the usual occupation of the head of household.

Previous use of the Duncan Index established a cutting point of 35 between low and middle status occupations.13 Twenty-nine respondents were eliminated because they were not considered to be of working-class origin when the head of the household’s occupation was compared with the Duncan Index. Of the remaining 157 respondents, 10 were eliminated because of incomplete questionnaires, leaving a final sample of 147 working-class adolescent males.

The investigators divided this sample into two groups - a potentially mobile group and a potentially non-mobile group.

The mobile group was composed of those subjects who had a high predictability of future upward social mobility. Two procedures were utilized to indicate future upward social mobility. (1) Occupational choice: Each respondent was asked to indicate three future occupational choices. These three choices were then ranked by comparison with the Duncan Scale; the mean score was compared with the score of the occupation of the head of household. If the mean score was above 35 and therefore above the score of the occupation of the head of household, this was used as one of the necessary criteria for indicating upward mobility potential. (2) Realistic college aspirations: The respondent was asked to indicate his desire for a college education and the steps he had taken to apply to a college or university. The respondent was considered to have upward mobility if he met the following criteria:
a. had manifested a desire to go to college after being graduated from high school.

b. had taken the Scholastic Aptitude Tests.

c. had actually applied for admission to college or university as stated on the face sheet data and verified by school guidance records.

d. had been accepted by at least one college or university. This was verified by school guidance records.

Those respondents who met all the above criteria were placed in the group considered to have upward mobility potential.

The investigators, through the above procedures, divided the sample into a group with upward mobility potential consisting of 77 members and a group with little or no upward mobility potential (non-mobile), consisting of 70 members.

To assess the effect of upward mobility potential on attitudes toward mental illness, prediction of upward social mobility was established as the independent variable, attitudes toward mental illness was established as the dependent variable and I.Q. scores was introduced and held constant as a test variable in additional treatment of the data. Prediction of mobility was based on the two indicators discussed earlier: future occupational choice and realistic college aspirations. Measurement of the respondents' attitudes toward mental illness was accomplished through the utilization of a five-factor scale developed by J. Cohen and E. Struening, called the Opinions about Mental Illness Scale. Finally, assessment of the respondents' intellectual activity was established through the Otis Quick Scoring Mental Ability test.

Due to the fact that the results must be considered in the light of the individual factors of the Opinions about Mental Illness Scale a brief description of each factor is in order.

Factor A, Authoritarianism, reveals a view of the mentally ill as an inferior class requiring coercive handling. A lower score on this factor would be considered a reflection of a liberal attitude toward mental illness.

Factor B, Benevolence, reflects a kindly paternalism whose origins lie in religion and humanism. A higher score on this factor indicates a liberal attitude toward mental illness.
Factor C, Mental Health Ideology, may be partially summarized by the view that mental illness is an illness like any other. Scoring higher on this factor reflects a liberal attitude toward mental illness.

Factor D, Social Restrictiveness, incorporates the idea that the mental patient constitutes a threat to society and must be restricted in his functioning during and after hospitalization. A lower score on this factor would indicate a liberal attitude toward mental illness.

Finally, Factor E, Interpersonal Etiology, reflects the belief that mental illness arises from interpersonal experience, especially deprivation of parental love during childhood. Scoring higher on this factor is indicative of a liberal attitude toward mental illness.

In sum, a generally liberal attitude toward mental illness as determined by the OMNI Scale would consist of a lower score on Factor A (Authoritarianism); a higher score on Factor B (Benevolence); a higher score on Factor C (Mental Health Ideology Dimension); a lower score on Factor D (Social Restrictiveness) and a higher score on Factor E (Interpersonal Etiology).

Statistical Procedures

In determining the relationship among specific variables the investigators used zero order correlations and a correlation matrix - the Pearson r was used to measure the degree of relationship. The criterion of .05 level of significance was used. Additional statistical treatment of the data included a partial correlation to partial for the effect of I.Q.

This analysis is limited to theoretical analyses and not causal factors. It is hoped that the analyses will shed light on the relationship between upward mobility potential and attitudes toward mental illness.

FINDINGS

Table I below provides the matrix of the zero order intercorrelations of the specific variables for the 147 cases. For those correlations which were hypothesized a one tail probability test was used. For those which were not, a two tail probability test is reported.
<table>
<thead>
<tr>
<th>Variable</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mobility</td>
<td>1.00</td>
<td>.200</td>
<td>-.439</td>
<td>.439</td>
<td>.225</td>
<td>-.384</td>
<td>.217</td>
<td>.589</td>
</tr>
<tr>
<td>I. Q. Score</td>
<td>1.00</td>
<td>.158</td>
<td>-.154</td>
<td>-.242</td>
<td>-.242</td>
<td>-.259</td>
<td>.612</td>
<td></td>
</tr>
<tr>
<td>Factor A - OMI</td>
<td>1.00</td>
<td>.422</td>
<td>-.143</td>
<td>.476</td>
<td>.343</td>
<td>-.357</td>
<td>.014</td>
<td>.697</td>
</tr>
<tr>
<td>Factor B - OMI</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Factor C - OMI</td>
<td>1.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Factor D - OMI</td>
<td>1.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Factor E - OMI</td>
<td>1.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sum Score of Factors ABCDE</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1.00</td>
</tr>
</tbody>
</table>

A) Statistically significant beyond the .05 level of probability (.164 or greater for 100 D.F.)
1 tail test
B) Statistically significant beyond the .01 level of probability (.230 or greater for 100 D.F.)
1 tail test
C) Statistically significant beyond the .001 level of probability (.312 or greater for 100 D.F.)
1 tail test
D) Statistically significant beyond the .05 level of probability (.174 or greater for 125 D.F.)
2 tail test
E) Statistically significant beyond the .01 level of probability (.228 or greater for 125 D.F.)
2 tail test
F) Statistically significant beyond the .001 level of probability (.288 or greater for 125 D.F.)
2 tail test
Based on the information provided in this table the following results are reported:

The correlation between Factor A of the OMI Scale and Upward Mobility Potential is -.439, which is significant at the .001 level of probability. Thus, there is a significant relation between Authoritarianism and Upward Mobility Potential.

A correlation of +.430 between Factor B of the OMI Scale and Upward Mobility Potential which is significant at the .001 level of probability verifies that a significant relation exists between Benevolence and Upward Mobility Potential.

The significant correlation (+.225, p < .05) between Factor C of the OMI Scale and Upward Mobility Potential confirms the significance of the relationship between Mental Health Ideology and Upward Mobility Potential.

The correlation between Factor D of the OMI Scale and Upward Mobility Potential of -.384 (p < .001) verifies that a significant relationship exists between Social Restrictiveness and Upward Mobility Potential.

Finally, the reader will note that the obtained correlation coefficient between Factor E of the OMI Scale and Upward Mobility Potential is +.217 (p < .05), a correlation confirming the significance of the relationship between Interpersonal Etiology and Upward Mobility Potential.

In sum, the investigators have confirmed the hypothesis that working-class youth demonstrating a high predictability of future upward social mobility will score more liberally on the five factors of the OMI Scale than working-class youth who demonstrate a low predictability of future upward social mobility. By establishing the following statistically significant relationships: Working-class youth with realistic Upward Mobility Potential score significantly lower on Authoritarianism, higher on Benevolence, higher on Mental Health Ideology, lower on Social Restrictiveness and higher on Interpersonal Etiology than non-mobile, working-class youth. Table 2 summarizes the findings relevant to each factor.

-607-
<table>
<thead>
<tr>
<th>Variables Involved</th>
<th>Correlation Coefficient</th>
<th>Level of Probability</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Factor A and mobility</td>
<td>-0.439</td>
<td>0.001</td>
</tr>
<tr>
<td>2) Factor B and mobility</td>
<td>-0.250</td>
<td>0.001</td>
</tr>
<tr>
<td>3) Factor C and mobility</td>
<td>-0.280</td>
<td>0.001</td>
</tr>
<tr>
<td>4) Factor D and mobility</td>
<td>-0.217</td>
<td>0.001</td>
</tr>
<tr>
<td>5) Sum Score of Factors</td>
<td>-0.589</td>
<td>0.001</td>
</tr>
</tbody>
</table>
Additional Statistical Treatment of Data

In this section of the research analysis, the investigators present an additional statistical procedure to investigate the relationship between mobility potential and attitudes toward mental illness. The statistical procedure utilized was: partial correlations.

Partial Correlations

The relationship between two variables may often be influenced by a third variable. Questions can be raised regarding the relationship between the stated variables if there was possible influence by a third variable. Since it was possible that I.Q. could be influencing attitudes toward mental illness, the investigators, through the use of the partial correlation coefficient, controlled or partialed-out the effects of I.Q.-the third variable.

TABLE 3
Partial Correlation Coefficients
Derived by Controlling for I. Q. Scores

<table>
<thead>
<tr>
<th>Variables Involved</th>
<th>Original Level of Correlation</th>
<th>Original Level of Probability</th>
<th>Partial Level of Correlation Coefficient</th>
<th>Partial Level of Probability</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Factor A and Mobility</td>
<td>-.439</td>
<td>.001</td>
<td>-.421</td>
<td>.001</td>
</tr>
<tr>
<td>2) Factor B and Mobility</td>
<td>.430</td>
<td>.001</td>
<td>.412</td>
<td>.001</td>
</tr>
<tr>
<td>3) Factor C and Mobility</td>
<td>.225</td>
<td>.05</td>
<td>.224</td>
<td>.05</td>
</tr>
<tr>
<td>4) Factor D and Mobility</td>
<td>-.384</td>
<td>.001</td>
<td>-.404</td>
<td>.001</td>
</tr>
<tr>
<td>5) Factor E and Mobility</td>
<td>.217</td>
<td>.05</td>
<td>.225</td>
<td>.05</td>
</tr>
</tbody>
</table>

When I.Q. is partialed-out the changes in the correlations are small as compared to the original correlation coefficients. All of the partial correlations remain significant at the same level of probability in the original matrix before I.Q. has been controlled.

The correlations are slightly decreased on Factors A, B and C; the correlations are slightly increased on Factors D and E. Therefore, I.Q. as a variable does not significantly affect the responses of the two groups on the OMI Scale.
DISCUSSION

This study has been concerned with the theoretical relationship between upward mobility potential and attitudes toward mental illness in working-class adolescents. From a sample of 147 working-class adolescents who attended a high school in a major Eastern city, this relationship was investigated. The size of the sample and its special characteristics make the applicability of these findings to a larger universe tenuous.

The most important finding in this study is that a definite relationship does exist between upward mobility potential and attitudes toward mental illness. Those subjects with mobility potential were significantly more liberal in their attitudes toward mental illness than those subjects without mobility potential. Exactly what this conclusion means in relation to the OMI Scale is deserving of explanation in further detail.

Each of the five factors of the OMI Scale was significantly related to upward mobility potential. The combined scores of the five factors of the OMI Scale was more significantly related to upward mobility potential than was any other variable used in this study.

The relationship between Factor A, Authoritarianism, and upward mobility potential offers significant evidence that upwardly mobile working-class youth are, to a significant degree, less authoritarian in their attitudes toward the mentally ill than their non-mobile peers. Not only was this relationship statistically significant but, of the five factors comprising the OMI Scale, Factor A was the most strongly associated with upward mobility potential on the correlation matrix (Table 1). This finding supports the research of O'Kane, who found that upwardly mobile working-class adolescents are less authoritarian than those with little or no mobility potential. The findings concerning Authoritarianism also offer support to the work of Lieberman, Cohen and Struening who found those people engaged in working-class occupations to be more authoritarian in their attitudes toward mental illness. The work of Lipset and Janowitz and Marvick offer contradictory findings in that they found generalized authoritarianism in the working class. Since they did not look at the question of upward mobility potential, it is possible that the findings are not contradictory, but exist because they did not define their sample in a similar way.

The significance of the relationship between Factor B,
ranking second in its degree of association, and upward mobility potential offers verification that upwardly mobile working-class youth are more often benevolent in their view of mental illness than non-mobile working-class youth (Table 2). In addition, there was a high degree of relationship between Factors A and B (Authoritarianism and Benevolence), indicating that those who scored low on authoritarianism also scored high on benevolence (Table 1).

The discovered relationship between Factor C, Mental Health Ideology, and upward mobility potential offers statistical evidence that working-class adolescents possessing realistic mobility potential view mental illness as an illness like any other significantly more often than their non-mobile counterparts (Table 2). This finding also offers support for a similar conclusion reached by Cohen and Struening.21

Upwardly mobile working-class youth saw the mental patient as a threat to society requiring restrictions in functioning significantly less often than their non-mobile peers, as established by the statistically significant relationship between Factor D, Social Restrictiveness, and upward mobility potential (Table 2). Additionally, Factor D, ranking fourth on the correlation matrix, was highly correlated with Factor C, Mental Health Ideology, and Factor B, Benevolence (Table 1). Hence, those scoring low on Social Restrictiveness also scored high on Mental Health Ideology and high on Benevolence.

Finally, the relationship between Factor E, Interpersonal Etiology, and upward mobility potential offers statistical evidence that upwardly mobile working-class youth view mental illness as arising from interpersonal experience significantly more often than working-class adolescents with no such mobility potential (Table 2). This finding offers additional support to a similar discovery made by Cohen and Struening.22

Based on the results provided in the correlation matrix the investigators were able to conclude that a relationship exists between upward mobility potential and attitudes toward mental illness and, furthermore, that upwardly mobile working-class adolescents possess more liberal attitudes toward mental illness than non-mobile working-class adolescents. Taking verification of this relationship one step further, a partial correlation was done to assess whether intelligence, as measured by I.Q., had any effect on the stated relations between the independent and dependent variables. As is evident, the effects of I.Q. as a variable are negligible (Table 3).
It not only did not affect the level of significance between the major factors in the study, the only variable it significantly correlated with in the correlation matrix was mobility potential \((p < .05, \text{Table 1})\). Hence, this finding further validates the confirmation that the results give to the hypothesis stated in the beginning of this paper. In addition, this finding offers support for the O'Kane finding of a weak association between I.Q. and mobility potential.\(^{23}\)

There is literature in the social sciences which is concerned with attitudes of each social class toward mental illness and with the effects of social mobility on rates of mental illness. There are studies which suggest a more conservative trend in attitudes during the process of upward mobility. However, to the authors' knowledge, there are no research studies which deal directly with mobility potential and attitudes toward mental illness. The results of this study therefore cast light on past and future theoretical issues, providing evidence for the former and questions for the latter. It is to this we now turn.

Firstly, this study offers further confirmation of Merton's concept of anticipatory socialization.\(^{23}\) In past research O'Kane has offered some support for this concept by recognizing that attitude change occurs before the attainment of social mobility.\(^{25}\) The present study has verified this observation by demonstrating that working-class adolescents with realistic mobility potential take on the more liberal attitudes toward mental illness characteristic of the middle class prior to attaining this higher social class.

While there have been contradictory reports on the literature with respect to the type of change in attitudes that occurs during the process of upward mobility, this study offers support for that group identifying upward mobility with a greater degree of liberalism. Hence, while the working class view mental illness more conservatively than the middle class, those adolescent members possessing upward mobility potential view mental illness in a liberal light significantly more often when compared with their non-mobile peers.

In addition, the results of this study complement the works of Cohen and Struening\(^{26}\) and Lieberman\(^{27}\) regarding occupational and class differences in attitudes toward mental illness. We discovered that working-class youth planning for working-class occupations regarded mental illness less favorably, as well as more conservatively, than working-class youth with upward mobility potential, hence confirming the difference that would be predicted by past research.
The conclusions reached in this study suggest evidence for a previously inexplicable phenomenon within the working class. Past research confirms the fact that the working class view mental illness and subsequently psychotherapy in an unfavorable light. However, there are those factions within the working-class realm that do not conform to this view; rather, they see mental illness and psychotherapy more favorably. This study has cast light on this apparent contradiction by providing a reasonable explanation. It is entirely likely that these past studies did not consider the variable of upward mobility potential within their samples. If they had, as our study suggests, perhaps they would have discovered that those members of the working class who regard both mental illness and psychotherapy more favorably would also be upwardly mobile, thereby explaining the more liberal attitudes.

Thus, this study supports the notion that upward mobility potential leads to a more liberal outlook with respect to attitudes toward mental illness. It may explain what Nunnally has reported as a liberalizing of attitudes in adolescents in mental health courses. The explanation he offered seemed more general than warranted by his data. It is possible that if he re-examined the sample utilized in his study, upward mobility potential might be a significant factor in explaining the liberalizing of attitudes toward mental illness.

Finally, this analysis has raised other theoretical questions for further research: Will the attitudes of adolescents toward mental illness remain the same over time? Would subjects of different ages, sexes and racial backgrounds alter the findings of this study? What roles do psychological variables play in assessing mobility potential? What factors other than anticipatory socialization might explain the attitude change in upwardly mobile working-class adolescents? Does the liberalism of the potentially upwardly mobile adolescent apply to other areas such as religion, punishment of offenders, other areas of deviance, etc.? Do value shifts among the classes occur over time in regard to social issues? What is the relationship between attitudes toward mental illness and the continuum of liberalism with economic liberalism at one end and non-economic liberalism at the other?

SUMMARY AND CONCLUSIONS

In this study of 147 working-class adolescent males, the relationship between upward mobility potential and attitudes toward mental illness has been analyzed. The concept of anticipatory socialization has been utilized in suggesting that work-
ing-class adolescents who aspire to, and have realistic potential for middle-class status, would resemble in their attitudes toward mental illness the liberalism of the middle class, rather than the more conservative beliefs of their class of origin—the working class.

Through the use of the Opinions about Mental Illness Scale, the Otis-Quick Scoring Mental Ability Test and Zero Order Correlations, it was discovered that the group with upward mobility potential was, with respect to attitudes toward mental illness, significantly less authoritarian, more benevolent, had a significantly greater degree of mental health ideology, significantly less social restrictiveness and held an inapernonal etiology regarding mental illness significantly more often than the non-mobile group. Hence, the results of this study confirmed the hypothesized relationship in this sample between upward mobility potential and more liberal attitudes toward mental illness.

The potential upwardly mobile adolescent may be of crucial assistance in mental health planning and in the delivery of services to the working class. Since this group closely resembles the mental health professionals in outlook, but are still members of the working class, they offer the possibility of becoming a significant community referral and education resource, if they could be identified and assisted in such tasks. At the very least, they represent a more liberal group regarding the mentally ill and some of the problems inherent in that social status.

REFERENCES


22. Ibid.


25. J. M. O'Kane, "Upward Mobility Potential, Political Attitudes and Catholic Working-Class Adolescents.";


27. L. Lieberman, "Attitudes toward the Mentally Ill, Knowledge of Mental Illness and Personal Adjustment," p. 47.

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The scenario of social policy formulations may be summarized in two contradictions—"Do Something!" and "Do Something Good!" (Edward Banfield, The Unheavenly City). The decisions to develop and put into operation plethora of social programs have largely been guided by 'need' to do 'something' rather than clearly stated goals and objectives. In instances, ideological demands have been the harbinger of social needs. The commitment to "post-industrial society" to the contrary involves professional demands in the equalization of social conditions. This Special issue—"Perspectives on Social Policy" will be directed to examining the above stated formulation. Critical articles (no more than fifteen double-spaced pages) stating basis structural assumptions in examining the professional consequences of the varieties of social programs (welfare, crime, mental health, drug, education, and others) may be submitted to Professor Asoke Basu, Editor, Department of Sociology, California State University, Hayward, California 94542, and Associate Editor, Professor Martin Lowenthal, Social Welfare Regional Research Institute, Boston College, Chestnut Hill, Massachusetts, 02167.
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