The Journal of Sociology & Social Welfare

Volume 6
Issue 3 *May*

Article 10

May 1979

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INTEGRATING CHILD CARE SERVICES: OVERCOMING STRUCTURAL OBSTACLES TO COLLABORATION OF INSTITUTIONAL AND COMMUNITY AGENCY STAFFS

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ABSTRACT

Social Work practice settings are so diversified that different perspectives inevitably develop among practitioners. These may undermine collaborative efforts between agencies. Child care services afford an example of a field requiring diversified agency settings and therefore vulnerable to development of contrasting perspectives. Some of the sources of an "institutional perspective" and of a "community perspective" are identified, as well as problems originating in lack of a shared perspective. Proposals for overcoming these problems and promoting integration of services comprises the final section of the paper.

Within a profession as wide-ranging as social work differences of perspective inevitably emerge among practitioners. Unifying influences such as a common core of norms and values, a generic knowledge base, and shared interventive skills promote a common viewpoint. However, these unifying influences may be at least partially nullified by attributes of the various settings in which social workers pursue their careers.

For certain clients effective service necessitates integration of institutional and community facilities. Substance abusers, the mentally ill, adult offenders, and some classes of dependent children exemplify the need for deployment of dual (institutional and community) resource systems. This paper seeks to identify obstacles to effective service generated by varied "definitions of the situation" developed by institutional and community agency staffs. There follow some suggestions which may promote more unified service delivery.

SOME ELEMENTS IN DEVELOPMENT OF THE "INSTITUTIONAL PERSPECTIVE"

When an individual is hospitalized, imprisoned, or otherwise "placed" for sustained care in an institution alterations occur in the person's social status, i.e., the relative prestige and authority accorded him by others; self-definition also changes, usually in a negative direction. To be institutionalized is to be less in control of one's destiny, more helpless, more in need of being "looked after." Goffman (1961), among others, has pointed out how the fact of being institutionalized, in itself, entails a reworking of perceptions of the self based upon definitions pertinent to the new environment. Self-labeling appropriate to this new identity reciprocates staff definitions of the identity and status of the institutionalized person.

These redefinitions of status and identity are abetted by physical removal from anchoring contexts. Not only is the individual separated from his usual social milieu, the sources of his customary self-affirmation, (family, school or work, etc.), he is also removed from his accustomed physical environment. Efforts in recent years to make the person's new surroundings more "home-like" and to locate institutional facilities closer to the communities they serve have been only partially successful. In most urban areas institutions are still regarded as less than desirable neighbors. Thus, imposed isolation readily leads to an acquired feeling of "apartness."

Other factors have contributed to the defensive posture into which many institutional workers have been maneuvered. Emphasis on institutional care of the indigent, the disabled, the disturbed, the "rule breaker", the immature has a history in this country dating to colonial times (Trattner, 1974). But this social arrangement for control of deviance has been under more or less sustained assault in this country for many years. It goes back at least as far as Clifford Beer's (1948) compelling autobiographical memoir of his ordeal as a mental hospital patient, first published in 1906. It produced strong reformist sentiment for modifying institutional practices and for finding alternatives to mental hospitalization (and culminated in the founding of what is now the National Association for Mental Health).

Another significant force for change came from the field of psychology. A more sophisticated understanding of the emotional needs of children emerged following the penetration of psychoanalysis into the American marketplace of ideas. Thus it appeared, in the aftermath of World War II, that institutions for children were doomed. Family environments were seen as the indispensable contexts for meeting basic intellectual, social and emotional needs of children. The traditional

institution seemed passé. Its constricting effects on personality caused by the emphasis on regimentation, conformity and isolation from community life, and its inability to individualize children because of inordinately large staff to children ratios, seemed a logical target for attack. A family environment (it was believed) should be found for every child in need of substitute care.

The infatuation with abolition of children's institutions ran its course, only to find a rewakened echo in the mental health movement and, more recently, in the field of corrections. Indictments of the shortcomings of prisons which fail to rehabilitate led some critics to an abolitionist position: close the prisons. Of equal concern to those still endeavoring to make prisons work was the position adopted by other critics: abandon (allegedly) futile rehabilitation efforts and use prisons strictly for containment and punishment. When the director of the Federal Bureau of Prisons pronounced rehabilitation a failure (as reported in the press) it became more difficult for institutional workers to avoid defensive, if not cynical, reactions.[1]

A third significant element affecting the institutional perspective stems from the institution's inherent complexity as a multi-disciplinary setting. The modern child care residential facility includes staff members who may dichotomize themselves as "professional and non-professional", or "treatment and custodial", or "service and administrative"; also, the staff may be organized as treatment teams which embrace various disciplines, or it may be organized by professional departments which guard their individual identities as social workers, psychologists, health workers, etc. Status problems vis a' vis other disciplines, issues involving maintenance of professional identity and autonomy in the face of pressures which tend to blur professional roles, competing loyalties - to the organization or to one's perceived professional values when the two seem to be in conflict - may produce unremitting psychic strains.

These psychic strains are resolved in various ways. Many "solutions" bode ill for high quality service to clients. One such resolution is to find a less personally fragmenting job, and many institutions are plagued by high staff turnover. Another is to "sleepwalk" one's way through the job, becoming the very model of a modern bureaucrat whose primary concern is to obey the rules and thereby avoid making decisions, or exercising choices, or having to individualize clients. Still another solution is the "paranoid" response, i.e., to see the world of the institution in "black and white", "we and they" terms. This leads to alliance-making; shifting coalitions of staff members, or sometimes of staff and clients, line up vs. "the administration", or "the medical staff", or "the cottage parents." The institution is perceived as under seige from an actively hostile or uncaring community without and as beset by civil war within.

This description seems rather graphic; actually, the issues in most cases exist in covert or "sub-clinical" form. Participants may not be overtly aware of, or willing to acknowledge the existence of issues concerning internal relationships. Their existence might be validated by collecting certain data from staff members, e.g., asking them to identify institutional goals, priorities or purposes, or asking them to identify those on the staff they consider most important to the fulfillment of institutional objectives. Responses may indicate the presence of coalitions, covert norms, goal conflict and other signs of institutional stress.

SOME ELEMENTS IN DEVELOPMENT OF THE "COMMUNITY PERSPECTIVE"

Community social workers are obliged to negotiate placements of children while simultaneously mediating demands for service from several constituencies. These constituencies include the family in distress (and in some instances the child as a separate entity), the community demanding "action", and the institution which is supposed to serve as a resource for both family and agency. Problems arise when the various constituencies perceive their needs as disjunctive, or when they cannot agree on priorities. Indeed, whom is the agency under primary obligation to serve? Can the agency hold at bay an irate community, while it explores alternative courses of action with parents and child and seeks their participation in planning? Can it risk estrangement from its community financial base in order to satsify not always well defined criteria of good service to clients?

The community, acting through one of its agencies, may use the institution as a "dumping ground" for certain children. The institution is perceived as a repository for "undesirables", however this term may be defined in a specific community.

The persistent "problem child" sometimes falls into the category of community reject. The institution's function is perceived as holding the child indefinitely or diverting him elsewhere at time of discharge. If this perception of institutional function persists, the community agency staff lets go with dispatch, severs its ties with child and family and displays a thorough reluctance to engage in further dialogue with institutional staff.

If community agency staff, reacting to community or family pressures, sees placement of the child as of overriding importance, it can truncate planning or even abort it. This is seen, for example, when the community social worker presents the child (and family) a glossed-over picture of what institution life will be like. The community agency staff, anxious

to overcome any resistance the child or his parents may feel about the placement, neglect to mention what it presumes may be discouraging information concerning some of the constraints of institutional life. This mismanagement is compounded when, at the same time, nothing of the family stresses and community pressures relevant to the child's requiring institutional placement is shared with the staff of the receiving institution. These data, of course, are indispensable to comprehensive and effective long range planning.

SOME PROBLEMS ORIGINATING IN LACK OF A SHARED PERSPECTIVE

Mutually inappropriate expectations of what agency and institution can accomplish in their respective roles have contributed to relationship problems. Community agencies may have magical anticipations of what institutional treatment staffs will achieve in modifying chronically maladaptive behavior problems of some children. On the other hand, an institutional staff may assume that a child's failure subsequent to discharge is due to the "unrealistic" demands the community agency has made on the child and his family. And both may be so preoccupied with symptomatology, that is, the specific behaviors which brought the child to the community's attention, that they sometimes participate with the child and his family in avoiding what is of greater relevance: the family-centered nature of the problem.

Information concerning family interplay, shared between institution and community agency staffs, provides the knowledge base upon which ongoing planning must be based. Family interviews may be an important means of resolving parent-to-parent and parents-to-child issues, thus leading to family re-integration. This assumption, however, requires drastic modification at times. In some instances so much has happened in the relationship between parents and child that further contacts, at least during the current interval, would simply reinforce difficulties and heighten tensions. The best course of action may be a suspension of the mutually corrupting interactions between family members. The institution thus can provide a "breathing spell" for all concerned. Only a thorough and shared knowledge of the family situation can provide the basis for this difficult decision to suspend or terminate further child-family contacts.

An inventory of potential sources of inter-agency discord would disclose additional factors. One such item would be referrals from the institutional staff to the community agency requesting that the latter continue some highly specific treatment measure begun in the institution. This is essentially an effort to promote institutional goals, post-release, and without regard to the agency's own definition of its areas of competence. A community agency may be asked to provide "intensive

therapy" to its prospective client, soon to be discharged from the institution. The agency may justifiably reject this referral as inappropriate if its treatment armamentarium does not include such a capability. No doubt it belabors the obvious to point out that knowing what the agency receiving the request for service can and cannot provide is a sine qua non of thoughtful referrals.

Sometimes it is the institutions which receive a less than appropriate response to their referrals. Child and parent may not appear strongly motivated to seek agency help at the time they appear for their initial post-release community agency contact. (Some agency files of the past are replete with records bearing the notation: "Case closed . . . client uncooperative.") If the response of agency staff to less than enthusiastic clients is half-hearted in return, the referring institution may reasonably object to this lack of affirmative effort on the part of the community agency.

Many families who have so-called problem children come to the agency encounter reluctantly or only at the instigation of external pressures; perhaps some type of legal coercion may be involved. Some of these clients appear impervious to engagement except when a crisis is at hand. They may keep appointments only when in need of concrete services such as child placement or financial aid. Beyond these needs, they may seem indifferent to agency efforts to plan on any long-term basis. With such clients, the frustrations are many. When staff efforts to help finally bog down in feelings of failure, the temptations to find a scapegoat are compelling. Other than the clients themselves, the handiest ojbects for displacement of these feelings of failure are likely to be the institution staff or the community agency staff. The choice depends upon the particular vantage point from which the problem is viewed.

PROMOTING EFFECTIVE INTEGRATION OF SERVICES

One set of rules to follow which may promote understanding would stipulate: avoid professional jargon; never say in a complicated way what can be said simply; written communication should be as much like conversation in language and style as possible; make maximum use of a vocabulary common to both parties; question immediately what is not clear in another's message. The quicker ambiguity is identified, the easier it is to dispel it. These rules do not guarantee effective interagency planning. They do, however, encourage a pattern of candid interaction, awareness of where each participant stands, and respect by each for the integrity and straightforwardness of the other half of the planning equation.

One removable impediment to productive inter-agency planning has been lack of knowledge of each other's program, and limited experience of each other. To overcome this, agency budgets should include as a standard item funds to enable staff members to visit each other's facilities regularly. Such support would, for example, allow community agency staffs to visit an institution prior to a child's discharge. The visit would enable participation in pre-discharge case planning with institution staff and child, and enable the latter to meet the person who will be following through with him. This is especially important if the community agency worker is new to the child. Such visits also afford the opportunity for the respective staffs to get acquainted (or reacquainted) and to see "how the other half lives": to verify that each staff operates under certain constraints which the other may not fully appreciate.

For example, community agency workers may not keep in mind that an institutional climate of stability is essential to effective carrying out of its program. Every institution has limits to the behavior it can (or should) tolerate. In placing a child because of "acting-out" behavior dangerous to himself or others, community agency staff may assume the institution, as a "closed system," has a virtually limitless capacity for containing any degree of behavioral deviance. However, this is hardly the case.

The institution would indeed seem better equipped than the community-at-large to contain deviant behavior. It has well-defined physical boundaries and a control of the total environment and living experiences of its residents which gives it considerable power to resocialize them (Goffman, 1961). However, the institution itself is a society with its own norms and behavioral codes. Some of these are handed down by fiat, some are traditional in origin and some are evolved out of the inter-actions between the two major institutional sub-systems: the caretakers (staff) and those being cared for (clients). (Thus staff behaviors are both contingency-shaped and rule-governed.) Because it is a relatively closed system the possibility of infectious institutional unrest, generated by even one or two charismatic individuals committed to deviant behavior, can be a threat to the orderly care of all others. This is not meant to condone an institution's refusal to engage in the treatment of "difficult" children, but to recognize that a resident's effect on other residents is one important variable among the several which determine the limits of institutional tolerance of exceptional behavior.

To have seen the institution as it actually looks and "feels" and to have seen it actually in the process of carrying out its tasks can

be most enlightening. It also prepares the community social worker for a forthright answer to a child and his parents who may ask, "What is this place like, to which I am going?" Of course, the reciprocal is true. Institutional workers should visit agencies to which their clients will be discharged, for the same reasons.

The necessity of ready access to each other makes highly desirable an additional budgetary commitment: child welfare workers engaged in interagency planning in which the collaborating staff is in another city or state should have access to a WATS line or some other arrangement for "unlimited" telephone communication. To be able to talk long distance whenever desirable is essential to clarify points at issue, clear up ambiguities, and confront emergencies. It also provides one of the necessary tools for coping with "wedging" or "triangulation." This is the maneuver by which the hard-pressed child or parent seeks to pit one agency against the other, in order to divert from themselves the pressures for needed change to which they are being subjected.

Virtually all staff members on the direct service level, whether on the institutional or community agency staff, get caught in wedging at some time(s) in their careers. Their genuine concern for the child's welfare makes this development almost inevitable. Such concern occasionally leads to over-identification with the child against his "detractors," real or presumed. (Usually these "detractors" are identified as parents or the other agency.) To be "taken in," however, is better than to be so armored against involvement that the worker maintains an unblemished record of never being fooled, because he or she never got close to people in need. It is essential these problems of wedging be dealt with quickly and forthrightly. Budgeting for travel and for long distance telephone service helps everyone to do this.

Though each agency may focus on different aspects of the case situation and emphasize work with different individuals, institution and community agency must agree on the identity of the client. In the writer's view the most satisfactory generalization would be that the client is the family. There are several reasons:

This view is consistent with what research and clinical experience have demonstrated in a variety of problem areas, including the treatment of mental illness (Jackson, 1961), "character disorders" (Reiner and Kaufman, 1961), and in family therapy (Ackerman et al, 1961). The defined patient, the identified client, the symptomatic member both experiences and expresses the family conflict and it is the family as an entity which may require workers' attentions.

Since in most cases the child will, or should return to his family it is the better part of wisdom to reard him as a temporarily absent member and it is family reintegration on a more mutually satisfying and productive level that must be sought.

If the child's return to his family is a generalized goal then to protect the integrity of the plan the social worker must secure active engagement of family members in ongoing planning. This forestalls family members prematurely closing ranks, sans child, in an understandable effort to reestablish the family system equilibrium which had been disrupted by the child's departure.

Much remains to be learned and tested concerning the forces impelling change in personal and family functioning. Much remains to be learned and tested concerning effective application of helping techniques with troubled people. Nevertheless, if we can overcome some of the obstacles to integration of services described in this paper, we can create helping environments which will improve our prospects of success.

FOOTNOTE

1. Without doubt these criticisms of facilities and programs had some validity, and they have helped produce needed changes. Institutions have developed more permeable boundaries, allowing a greater flow of in and out traffic: relatives and representatives of community organizations in, and residents out - to schools, to part-time jobs, and to participate in community-based functions. Alternatives to prolonged institutional care have been developed, for example, foster homes for mental patients, expanded probation and parole services and community treatment centers for offenders. These developments should be acknowledged in order to balance the picture.

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