WAITING LIST PRIORITIES IN THE FAMILY AGENCY*

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"WHAT determines priorities on our waiting lists? Is it the nature of the problem, treatment potentialities, client motivation, or community pressure? What criteria determines case selection for service or for a place on the waiting list?" I was to deal with these questions with the presumption that the problem of overall social planning and of agency definition of services had been dealt with. This paper will, therefore, assume that the services developed in an agency had been arrived at on some basis; that it had been decided to keep intake open, rather than closed; that there should be a waiting list; and, that a decision had been made as to what proportion of staff time should be devoted to "first aid" functions: consultative, informational, and short-term services in keeping with the family agency's traditional "open door" policy, as differentiated from more extended treatment processes. As used in this paper, "waiting list" will refer to clients who have been seen at least once in an initial intake interview and are waiting for further service; "priority" will refer to preferential consideration given a waiting list case that results in assignment on a basis other than chronology of application.

There are many facets to the question of determining priorities and in the consideration of a particular case a number of factors are usually involved in the choices made. Practices will inevitably vary with different agencies and staffs, and in different communities, with varying needs, resources, and client populations. The intent here, therefore, will not be to attempt overly-inclusive generalizations, even if this were possible, but to explore some of the elements involved in defining priorities. Disregarding the larger questions of social planning and agency definition of services, it seems to me that along with the questions raised by the committee, four major elements can be considered in defining priorities: (1) the length of the waiting list; (2) agency structure, as this determines at what point clients are placed on a waiting list, how much service they receive in initial intake, etc.; (3) philosophic concepts regarding the role of the family agency as these bear on the definition of priorities; and, (4) the knowledge and skill of the particular staff involved.

Let us start with a specific question: Is the interest of the community better served by a three year investment in a

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sociopathic family that will result in lowering the probability of three children becoming severely delinquent, or by a one and a half year investment in a less deteriorated family that will result in lowering the probability of two children becoming severely neurotic? This poses no problem when there is no waiting list for service. In due course, both families would be served. However, as the length of the waiting list grows, the import of the question changes. It may not change very much when there is only a two or three month waiting list, but a new element is added when clients have to wait longer. Many clients who wait for more than six months do not return when reached on the waiting list. Experientially, though not backed by formal research, we have found that the failure of these clients to return for service when it is offered seems relatively unrelated to diagnosis, severity of problem, practitioner skill, or any other factor we have thus far been able to isolate other than the sheer passage of time. However, were it not for those who failed to return, our waiting lists would soon attain astronomical lengths and become completely meaningless. As this relates to the question of priorities, it poses a negative question. We must here ask ourselves what situations can we not allow to wait for more than six months lest we seriously compromise the possibility of offering any service beyond intake at all.

The intent in presenting this aspect of the question is also to highlight the reality inherent in all of our discussion of priorities, namely, that the extended treatment services of the family agency are not available to all the clients who are ready to use them, much less to the potential population that could benefit from them. In defining priority, therefore, though we usually approach it with the question: "When shall the particular client be served?" behind this is also always the distasteful question "*Who* shall be served?"

If we consider the situation of the client at the point of application, we find that there are certain clients who just cannot wait at all. For example, a widow, mother of a young adolescent boy is indefinitely hospitalized with a possibly fatal illness. The only relative, with whom the child is living, is having considerable conflict with him and does not want to be "stuck" with him. In this kind of situation I suspect we react first and find the good reasons for immediate assignment afterwards. Questions of diagnosis, motivation, and treatability seem quite irrelevant at the time. This seems to be generally true of emergency assignments. The criteria for their immediate assignment would be much the same as they would be for stopping the clock in a time bomb—to stop an impending explosion. However, what is an emergency, or what can go on a waiting list is dependent on the structure of the initial intake process as well as on the client's situation. There are many more emergencies where we are limited to offering only one or two initial interviews than there are where we can offer a six week service or exploratory process. For a short time, in our beginning experience with a waiting list at JFS, and out of concern for protecting our continued service load, we limited intake to one or two interviews. Very high priority was justifiably given to situations where there was apprehension about possibly psychotic breakdown, or where pathology was recognized but referral could not be affected in such a time-limited intake process. As a consequence, we soon found that our caseload was becoming more and more inappropriately pathological and we were by no means accomplishing what we had hoped for. Of course, we needed to sharpen our

diagnostic skill and our competence in referral processes, but we also learned that it is "penny-wise" to overly constrict the length of initial intake. Though most of our initial contacts with clients, some 80 per cent, remain one to two interviews, we now offer three to seven interviews in selected situations. We offer a more extended service in situations where we can give a complete service that obviates the need for a client to be on our waiting list; where clients need a more extended referral process and should not be on our waiting list at all; where an immediate service in clarifying a situation seems indicated before deciding what will be most helpful for a client; and where a somewhat more extended "first aid" for a family that is appropriate for our waiting list will make it possible for the family to wait. Operating on this basis we have found we are left with relatively few emergencies and that we are providing a relevant short-term service that makes a significant contribution to the well-being of the community.

The skill of the practitioner is the ultimate determinant of whether an agency can do the flexible initial intake described here. He must be able to develop quick tentative psychosocial diagnoses on the basis of brief contact, to evaluate internal and external stresses, to know how much to give, how much to uncover. He must decide whether a brief service is sufficient. He must learn skills in reducing anxiety, in helping clients to wait, in organizing and remembering. He must be able to find different tempos of working with people —sometimes because of a sudden flood of applications—and must carry his role so as to convey the agency's concern to the community. This is a big and challenging job.

If we turn now to the waiting list, there are a number of philosophic concepts that have usually been mentioned as guides to practitioners in selecting priorities. Granted that we cannot meet the total need of the community, it is said that we should offer priority to situations where we can have the greatest possible impact on community welfare. This concept may clearly be used in giving priority to a teacher who may be destructively imposing his problem on a class of 35 or 40 children. But in other cases it might be difficult to decide, e.g., the illustration given previously that weighs the prevention of delinquency as against the prevention of neurosis.

Another concept is that the probable duration of a case should be a consideration in priority lest we compromise our ability to be available to the community in any significant way. On the whole I agree with this, even though it may often be difficult to assess this accurately in a brief initial contact. General agreement does not exist in this area. Some social workers believe that the length of service should be related to the client's ability to continue to use help, that we are too concerned, as a field, with repairing and preventing social breakdown at the expense of the equally important contribution we can make to society in helping people to use themselves to their fullest creative potential. Though the point is well taken, this seems overly idealistic in the face of our long waiting lists and leaves the definition of social goals too unspecific for use by family agencies.

Another frequently encountered concept is that of prevention. It is said that since the family agency cannot meet all needs, highest priority should be given where we can accomplish a preventive purpose. Practical translation of this concept offers some obstacles to the practitioner since it is hard to find a case in a family agency in which some

preventive aspect could not be found. Other things being equal, however, it is not difficult to distinguish between a marital problem that has gone on for twenty years and a problem affecting newlyweds. At JFS we also have a preventive interest in situations that affect children under five years of age. This stems from our acceptance of a psychology that defines these early years as most important in personality formation, and from the fact that these situations, if family related treatment of parents is diagnostically indicated, have particular functional appropriateness for the family agency. It is also an area of our greatest skill. Our preventive interest is also frequently directed at client anxiety. We would not want a client's excessive anxiety to be translated into less accessible defenses or destructive behavior.

The question of staff skill, mentioned above, is basic when we come to the question of specific case assignment, and has general relevance for a staff as a whole. Of course it cannot be the sole determinant of whom we serve. However, a review of any caseload would support the contention that, in general, we give the best help, when we give the help we best know how to give.

"Treatment potentialities" and "motivation" give us no firmer base for definition, in and of themselves, than the other factors we have mentioned, though they are obviously important in considering any case and enter into the weighing of priority. The delineation of treatment potential is a variable of professional knowledge, practitioner skill, social and environmental factors, and goal definition, as well as personality factors. We have by now developed considerable knowledge of ego psychology and have become quite skilled in helping clients with weak ego structures achieve limited, but important, social goals. Do we now see these clients as having a high treatment potential? If we take the factor of client personality *per se*, this has little necessary bearing on the question of length of service or on most of the other factors thus far mentioned. As a matter of fact, the very responsive clients are often the ones with whom we tend to find it hardest to end. We can say much the same for "motivation" as we said for "treatability."

"Community pressure" is, of course, a factor in defining priorities, but it is somehow very different from the kind of pressure we used to resent when we administered financial assistance for basic maintenance—or at least it feels very different, and we do not get as much of it. This may, at JFS, be the result of our being quickly available at intake, or because we have been able to give some help to families before placing them on our waiting list, or because we are available to clients who become very upset while they are on our waiting list. However, should we get a phone call from a principal, telling us he is on the verge of expelling a child from school unless we do something, we may be ready to consider his request. Or, if the two grown daughters of an aged mother on our waiting list continue to phone because they cannot stand what mother is doing to them, as recently happened, we may end up with both the daughters on our waiting list and a higher priority for the mother. We would also be particularly responsive to pressure from a segment of the community in which we are interested in making a special investment. Also, as members of a federation, we are ready to try to lend ourselves to that which protects the services of federation or our sister agencies.

There are some "type" situations, usually where a number of the factors already mentioned are involved, that we will often give priority consideration.

These are the situations where a family's relatively adequate functioning has been disrupted by birth, death, illness, etc., and help is needed in establishing a new functioning balance in the family, or where, perhaps, a second marriage with two sets of children is foundering. In such situations we frequently find a lot of anxiety, good motivation, rapid deterioration, and other preventive considerations. We also usually have a high level of staff skill and knowledge to meet such situations. In a sense, therefore, we can say that "the nature of the problem" is also a consideration.

All of the factors discussed in this brief presentation have, I think, some bearing on the question of priority. And in general, priority is given where a number of these are operative in a case. It would be difficult to justify any single one of them as a sufficient basis for priority in and of itself, yet it is possible to weigh situations on a case by case basis and arrive at valid recommendations. However, it should also be apparent that defining relative priorities is not easy. It is impressive to find that an intake staff can take on this job in a professionally responsible way.

In conclusion, I believe that the whole question of priority and of family agency services needs reevaluation at this point. As a field, we seem to have come full circle since the 1930's, and are again in a situation where the demand for our services is far beyond our ability to meet it. The years since governmental bodies assumed responsibility for basic maintenance have been exciting and fruitful for the family agency. We have grown in knowledge and skill. We have gone far in educating the community to value, and to apply for, family counseling. This certainly has its positive meaning. However, it is again necessary for us to face up to the gap between need and resources as we did in the thirties. I believe it is time for us to again affirm that the private family agency can only provide a demonstration of what professional family casework can accomplish, and that the basic responsibility for providing counseling services should rest with governmental bodies. Such an affirmation of our role would have important ramifications for the definition of our services in general and of priorities in particular.