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ABSTRACT

This report is a summary of the functional analysis of the activities of those engaged in social service occupations in medical settings, which was conducted as part of the UCLA Allied Health Professions Project. A task inventory composed of 192 tasks relating to intake, information and referral, treatment, supportive, community and administrative services was developed and submitted to a representative sample of hospitals in six geographic regions. Responses from 148 persons employed in social services departments revealed that: (1) The community services function was performed least by the social service workers; and (2) Many more similarities than differences were discovered among aides, social work assistants, and social workers with the master's degree (MSW) in both task performance and frequency of task performance. It was recommended that aides be given training to help them perform the higher order treatment functions they are already required to perform and that MSWs receive intensive training in supervision of personnel management, performance evaluation, and task delegation. A copy of the survey questionnaire and other study material are appended. (SB)

THE UCLA ALLIED HEALTH PROFESSIONS PROJECT

OCCUPATIONAL ANALYSIS OF SOCIAL SERVICES IN MEDICAL CARE FACILITIES

USOE RESEARCH AND DEMONSTRATION
GRANT 8-0627
UNIVERSITY OF CALIFORNIA, LOS ANGELES
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ALLIED HEALTH PROFESSIONS PROJECT

AUGUST 1971

UNIVERSITY OF CALIFORNIA, LOS ANGELES
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OCCUPATIONAL ANALYSIS OF SOCIAL SERVICE IN MEDICAL CARE FACILITIES

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FOREWORD

The Division of Vocational Education, University of California, is an administrative unit of the University which is concerned with responsibilities for research, teacher education, and public service in the broad area of vocational and technical education. During 1968 the Division entered into an agreement with the U.S. Office of Education to prepare curricula and instructional materials for a variety of allied health occupations. For the most part, such materials are related to pre-service and in-service instruction for programs ranging from on-the-job training through the Associate degree level.

A National Advisory Committee, drawn from government, education, professional associations in the health care field, and the lay public, provides guidance and help to the over-all activities of the Allied Health Professions Projects. The following individuals and institutions participate in the activities of this nationwide interdisciplinary body:

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SUMMARY

Object of the report

The object of the report was to analyze the activities of those engaged in Social Service occupations in medical settings.

Methodology

The analysis was carried out by means of a questionnaire of 192 tasks, which was submitted to a representative sample of hospitals in six geographical areas. Respondents to the questionnaire were categorized into four levels of employees. All levels were compared and examined on two variables: percentage of task performance, and frequency of task performance. The analysis, which was both numerical and descriptive, dealt with six major social service functions: Intake Services, Information and Referral Services, Treatment Services, Supportive Services, Community Services, and Administrative Services.

Results of the study

1. The community services function was the function least performed and performed with the least frequency. It appeared that social service workers operated very little in the community and when they did, they were mainly engaged in promoting the health services offered by the medical facility. Very little community organization on the part of social service personnel was evident, and preventive health education was minimal.

2. Many more similarities than differences were discovered among the various levels of employees in both task performance and frequency of task performance. There were no clear-cut role differentiations among aides, social work assistants, and social workers with the master's degree (MSW).

Recommendations

1. Educational attainment is an inadequate discriminator of occupational role. More emphasis should be given to allowing work experience as equivalent to academic credit, and to evaluating experience and job competence.

2. Aides should be given training to help them perform higher order treatment functions, since they are indeed required to perform them.

3. Intensive training is recommended for MSWs in supervisory roles of personnel management, performance evaluation, and task delegation.

4. Better definition is needed for occupational roles and patterns of staff utilization. A design for using parallel levels of staff, field staff, and operations staff is proposed.

I. INTRODUCTION

1. Background of the Project

The Allied Health Professions Projects (AHPP) began operations in August 1968, funded under a provision of the Vocational Education Act of 1963. The main goals of AHPP are:

To develop in-service and pre-service curricula for some 20 allied health occupations.

To diagnose training needs for the occupations under study and to develop instructional materials to meet those needs.

To disseminate information and instructional materials developed by AHPP.

The medical social service occupations were chosen as one of the 20 allied health occupations to be surveyed. This report is the result of research into the structure and operation of the medical social services.

2. Purpose of this report

The report is intended to provide a total picture of medical social service operations, as well as to examine the roles of all those who perform social service functions in a medical setting. Thus, the report is concerned with such people as medical social workers, psychiatric social workers, social work assistants, social work aides, mental health workers, health advocates, community workers, and other such persons as registered nurses who perform social service functions in lieu of social service professionals. The report is intended as the first step in outlining a curriculum for the social service occupations, and for identifying training needs for a social service worker who is required to perform functions much different from the skills which he or she is taught. Consequently, discussion about job performance and job roles will be slanted toward curriculum development and training needs.

3. Background to the report

This study has been conducted at a time when the social service profession is going through a period of divisive self-doubt that is rapidly polarizing the profession. The decade of the 1960's, which began in the confidence of building a great society and ended with despair and reappraisal of long-established values and goals, saw a parallel development in the social services. Ivor Kraft, in the 1968 National Association of Social Workers Symposium on

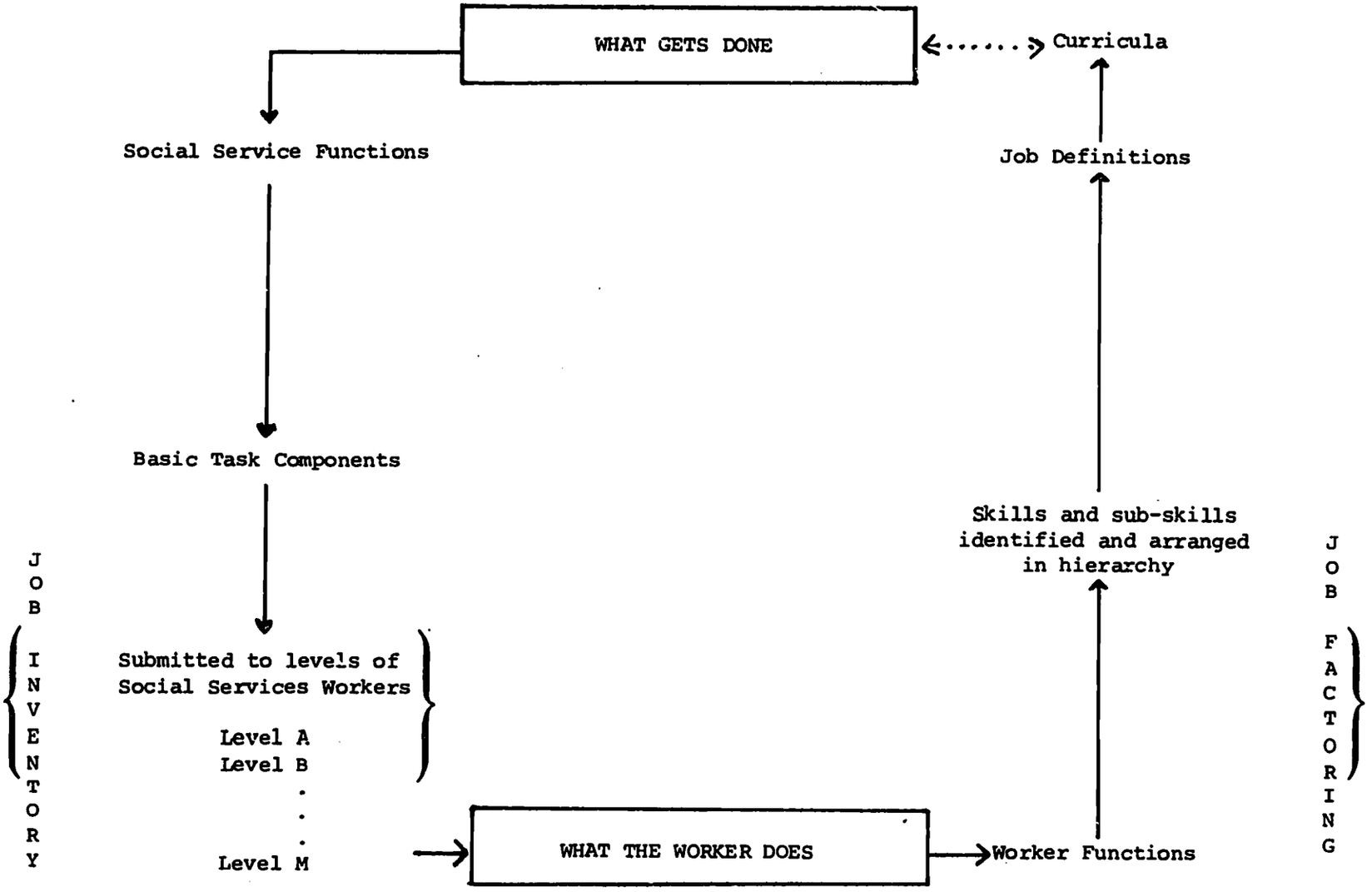
Human Services and Social Responsibility, labeled the NASW Social Work Year Book for 1960 "as optimistic, buoyant, and sprightly a catalog of achievements of American Society and the social work profession as anyone could hope to encounter." (p. 354) This description could by no means be applied to current social work literature. The journals are rife with vigorous exchanges over such issues as the value of the medical model of professional-patient relationship, the roles of professionals and non-professionals, and the need for positive social action in the community. Similar scrutiny of traditional roles and values is taking place in other medical professions, but the social worker, operating in a field which is highly subjective and devoid of a clearly proprietary, demonstrable body of knowledge, is especially vulnerable. Consequently, attacks on delivery of social services tend to be met with retrenchment and raised demands for professionalism, and the spirit of compromise is displaced by emotional charges and countercharges. It is hoped that this study, by focusing on actual job performance rather than role perception, will inject an element of objectivity against which the claims made in the forum can be judged.

4. Methodological approach

The analysis represented a combination of a job factoring approach, as outlined by Fine (1955), and a job inventory, a technique outlined by Christal (1969), shown as Figure 1. Job factoring is a process whereby worker activities are broken down into their simplest task components, and the tasks are clustered on the basis of skill requirements to develop a job performance hierarchy. A job inventory is completed by listing all the tasks performed in a particular occupation and submitting the list to a representative cross-section of workers in that occupation. Each worker checks every task that he performs and thereby defines his job role. The job factoring approach provides for the development of curricula and career ladders, and the job inventory provides information on whether current practice is in line with current curriculum theory and teaching. Both approaches have been used with success in industrial occupations for many years. However, in applying them to the social service occupations a few words of caution are in order.

Teare and McPheeters (1969), in discussing job factoring, make two important points worth recording. The first is that job factoring, by partitioning jobs on the basis of a hierarchy of skills, tends to invest the jobs with built-in status differentiation. Furthermore, they added that " if this condition is made worse by blocked or nonexistent access to the higher levels of occupational functioning, the lower level jobs will be perceived as low status, dead-end positions. In all too many instances this has been the end result of many of the activities designed to modify patterns of utilization of workers in the social services field." (p. 6) Their second point has to do with the danger of focusing too much on worker functions and not enough on client needs. They point out that the job factoring approach, based as it is on tasks currently being undertaken

FIGURE 1: OCCUPATIONAL ANALYSIS FOR SOCIAL SERVICES



by workers in the field, rarely incorporates new tasks in the new job definitions generated. "Consequently, if client needs are not being met by the existing system, the jobs constructed by job factoring give no greater assurance of being relevant to the needs of the public and, in many instances, actually reduce the likelihood that the needs of the client will be served." (p. 5) The issue of task relevance to client need is crucial in social service, and it must be borne in mind as an important qualifier to the job factoring approach.

With respect to developing a social service job inventory, one problem is that a job inventory presupposes that all the tasks performed are observable and recordable. For example, tasks such as "Collect blood specimens from patients," "Wrap instruments for sterilization," and "File index cards alphabetically" are especially suitable to the job inventory approach in that they refer to specific behavior which is observable and reproducible and can be analyzed objectively. However, social service activities are not easily quantifiable. In social service, the product is not things but people, and the activities that count the most are often the least observable. For example, establishing a good relationship with a client is a crucial social service activity but it is not readily observable. One can observe a social service worker smiling, aking questions, nodding and listening, but one cannot in the same way observe the establishment of a good relationship. Good relationships are established by means of a meld of behaviors which are highly specific to the social worker and to the client.

Another point of departure between the social service occupations and other occupations that do not have such a high investment in people is that the job inventory approach depends upon being able to describe a task accurately. The worker should either perform or not perform a task and all those who perform it should perform it in the same way. However, with the social service occupations there are many tasks which can be performed in different degrees. For example, "Explaining the nature of services available" is a task that is done by most social service workers who come into contact with a client, but it can be done at many different levels, from simply giving out information to recognizing and responding to a client's anxieties and hostility.

There are other, more general, limitations to the job factoring and job inventory approach to task analysis which should be mentioned. The two most important are that such an approach gives a picture only of what people are doing now; it gives no indication of what people will be doing in the future. For example, low performance tasks may be obsolescent or emergent: the inventory does not tell us which. This means that curriculum development based wholly on job inventory task analysis would be constantly behind the times, drawing only from present and past practice. The second general limitation is that no evaluative information is transmitted about how well tasks are being performed. Training deficiencies reside in gaps between performance requirements and

actual performance. The job inventory approach supplies only the second part of the equation.

The value of the job inventory approach lies in providing an accurate picture of actual occupational roles, which are often different from the idealized roles on which many curricular decisions are based. The job inventory is a tool by which training practices can be constantly brought into line with real world requirements. It has the added merit of being inexpensive in terms of the returns gained for time and money expended.

However, task analysis cannot exist in a vacuum; it must be conducted with reference to the opinions voiced by leaders and practitioners in the field. Consequently, a National Technical Advisory Committee (NTAC) for Social Services was established. (See Appendix 1.) The Committee represents a cross-section of those engaged in the social service professions. The data in this study will be reported in the light of discussions with the NTAC and interviews with practitioners at all levels of job performance. Reference will also be made to the trends and ideas expressed in the professional literature.

II. DEVELOPMENT OF THE TEST INSTRUMENT

1. Development of the questionnaire

The questionnaire (See Appendix 1) consisted of a list of tasks with provisions for responses to each item on the basis of certain variables.

a) Questionnaire variables

The variables on which the questionnaire was based fell among four dimensions. The first dimension was "Check if Done." If a positive response were registered in this category, responses were requested to the other three variables, which were "Frequency of Performance," "Estimate of Supervision," and "Estimate of Difficulty." Each of these three variables had a range of five values.

b) Development of the task inventory

The task inventory was generated by the National Technical Advisory Committee (NTAC) for the social services. See Preface for a list of Committee members. Full details of the development of the task list are available in the Preliminary Analysis of the Social Service Occupations (Munoz, 1970). In all, 192 tasks were identified, and the questionnaire was built around them. Space was provided at the end of the task list for respondents to add tasks which they performed which were not on the task list.

c) Background data

A Background Data Sheet (Appendix 9) was included with the task list to determine certain characteristics of the sample population. Responses were requested about the respondent's personal characteristics, position title, area of specialty, previous experience, education, certification, and salary.

d) Field testing of questionnaire

The questionnaire was field tested on social service workers in the Los Angeles area. The respondents used in the field testing ranged from a mental health worker to assistant director, medical surgical department.

2. Survey sample

The questionnaire was administered to the National Survey sample developed for AHPP. The National Survey sample was chosen to represent a cross-section of medical facilities in six geographical

areas, each centered in a metropolis and extending approximately 200 miles in radius to include both urban and rural facilities. The six geographical areas were Boston, Chicago, Birmingham, Denver, Los Angeles, and Seattle. Within these areas the main criterion for selection was size. Eight facilities were selected from each of the six areas, each having two hospitals with more than 200 beds, two hospitals with 100-199 beds, two hospitals with less than 100 beds, and two Extended-Care Facilities. An additional requirement imposed on the selection of the sample was that the facilities should meet the requirements for Medicare. All 48 institutions met these requirements and registered their willingness to participate in the survey.

The questionnaires were sent to a member of the administrative office in each facility with instructions to distribute them among the social service departments or personnel. Those completing the questionnaires were asked to return them directly to the project.

Only 57 completed questionnaires were returned to AHPP, from 19 of the 48 institutions. When contacted, 13 of the 29 non-contributing facilities replied that they had no social service departments or personnel. These facilities were distributed fairly evenly according to size of facility, with three in the category of 200 beds or more, five in the category of 100-199 beds, three in the category of less than 100 beds, and two Extended-Care Facilities. It was felt that a total of 57 respondents was not enough for the purposes of the survey. Accordingly, efforts were made to contact facilities other than those in the national survey. With the help of the members of the NTAC, a list was drawn up of six institutions willing to participate. All six institutions were of over 200-bed capacity. Questionnaires were sent to these institutions.

Four facilities were able to distribute questionnaires. The institutions and number of respondents are shown in Table 1.

TABLE 1. ADDITIONAL FACILITIES BY NO. OF RESPONDENTS

Additional Facilities	No. of Respondents
Maimonides Mental Health Center, N.Y.C.	6
Mt. Sinai Hospital, N.Y.C.	69
Fort Logan Mental Health Center, Denver, Colo.	6
Presbyterian St. Luke's Hospital, Chicago,Ill.	9
	N = 90

It was decided that the combined total number of 148 would be enough for a satisfactory analysis of the occupations.

III. ORGANIZATION OF DATA

1. Primary analysis

a) Inspection of modes

Percentages of performance for the total survey population were computed and the modes were plotted for the three variables of frequency of performance, estimation of difficulty, and estimation of supervision. The modes for frequency of performance were found to vary from task to task more or less independently of the other two variables, which tended to follow a fairly fixed pattern. "No Supervision" was the predominant modal value for estimations of supervision, accounting for 82 percent of the tasks surveyed. The modal values for estimates of difficulty were almost exclusively in the "Routine Procedure" or "Select Most Suitable Procedure" categories. In view of these modal patterns, it was decided that the analysis should be concentrated on the percent performance and frequency of performance variables. Estimations of supervision were retained for descriptive purposes; estimations of difficulty were discarded altogether.

2. The survey sample

a) Classification of respondents

In order to make comparisons within the sample population, the sample was divided into subgroups. Initially, the criterion used for classification was position-title, as stated on the Background Data Sheet. However, when cross-tabulations were made between position-title and other variables, such as education prior to entering the profession, certification, and salary, wide ranges were discovered for each position-title category. It became apparent that position-title was not sufficiently discriminatory to be used as a basis for analysis. It was therefore decided to group the respondents on the basis of employment patterns within the social services where the predominant criterion appeared to be education before entering the profession. Four levels of employees were identified and used for the survey analysis:*

* See Appendix 10 for Dictionary of Occupation Titles and Survey Levels

Level I	Aides	those social service workers who do not have a college degree
Level II	Social Work Assistant	those social service workers who have a college degree but not a master's degree in social work
Level III	Professional Social Worker	those social service workers who have a master's degree in social work
Level IV	Miscellaneous	those who responded to the survey as performing social service functions but did not fit easily into Level I, Level II, or III - i.e. RN's

A word of explanation is in order with respect to Level II. Level II employees are those who have a college degree but not a master's degree in social work. This classification does not recognize the baccalaureates in social work personnel, who are becoming a whole new resource in social welfare. This has been the result of a reverse in the trend in the 1950's and early 1960's when organizations such as the Council on Social Work Education actively discouraged undergraduate social work programs to be discontinued. However, the numbers of this new breed of professionals are as yet too few for them to have been included in this analysis. They will almost certainly be an important part of the organization of the social services within a few years, but as yet their general impact is slight.

b) Comparison of National Survey Sample with additional sample

Chi-square distributions were made in order to check for compatibility between the National Survey Sample and the additional facilities used to supplement the sample. It was found that on task percent performance the Mt. Sinai Sample was significantly different from the National Sample and from the rest of the supplementary sample. It was therefore decided to separate the Mt. Sinai sample from the rest of the supplementary sample, which was combined with the National Sample to produce a total number of 78. However, the Mt. Sinai Sample was not discarded from the survey but was kept for comparison purposes. With its 69 members, the Mt. Sinai Sample clearly represented a large department with presumably well-defined spheres of responsibilities. The National Sample, on the other hand, with its 78 members drawn from 22 different facilities, presumably represented the small social service department, and it was felt that a comparison between the two samples would provide useful insight into the way jobs

and responsibilities are partitioned and structured. For a description of the Mt. Sinai Department, see Siegel (1971).

c) Subgroup background characteristics

1. Sex

Table 2 presents the respondents by sex. It is interesting to note that while the males represent only 13 percent of the sample, they are somewhat disproportionately represented in Level III, the MSW category.

2. Age

Table 3 presents the respondents by age. Level I and Level II employees both have their modes in the 20-29-year age group, with Levels III and IV having their modes in the 50-year plus age group. Only eight of the Level III employees, the MSW's, were below thirty.

3. Position title

The majority of Level I employees had the title "Social Health Advocate," eleven of the Level II category had the title "Social Work Assistant," while in Level III the majority of the employees were split evenly between the titles "Medical Social Worker" and "Director (or Chief) of Social Work." Nine of the Level IV employees were RN's. It was interesting to note that position title overlapped between the levels. For example, one respondent in Level III, the MSW category, identified herself as a "Mental Health Worker," and two other respondents in this category called themselves "Social Worker Assistants."

4. Years in present position

Five of the Level I employees had spent one year or less in that position. The longest experience in this category was 12 years. In Level II, 12 (60 percent) of the employees had spent one year or less in their position. Level III had almost an equal number of newcomers, with 17 (55 percent) of the employees with experience of one year or less, and with only one person having over nine years' experience. In Level IV, the years of experience were distributed fairly evenly, ranging from less than one year to 20 years.

3. Secondary analysis

Because of the limitations of the job factoring approach which were referred to on Page 4, it was felt that discussion of specific tasks would be unprofitable. Many social service tasks

TABLE 2: SEX OF RESPONDENTS

Level of Employee	MALE		FEMALE		TOTAL
	No.	%	No.	%	
I	1	8	11	92	12
II	2	10	18	90	20
III	6	18	26	82	32
IV	1	8	13	92	14
TOTAL	10	13	68	87	78

TABLE 3: AGE OF RESPONDENTS

Level of Employee	20-29	30-39	40-49	50+	TOTAL
I	5	0	2	5	12
II	8	6	4	2	20
III	8	8	6	9	31*
IV	3	2	3	6	14
TOTAL	24	16	15	22	77

* One respondent failed to provide data on this variable

taken individually are meaningless: it is only when the tasks are placed together that a clear picture emerges. Tasks were therefore grouped on the basis of the six functions identified by the NTAC. These six functions--Intake Services, Information and Referral Services, Treatment Services, Community Services, Supportive Services, and Administrative Services--follow traditional social service departmental organization. An effort was then made to focus on each function by separating simpler tasks from more complex tasks. Two sub-divisions were organized:

1. Lower order tasks--those tasks such as recording and processing information, following routine procedures or performing simple activities.

2. Higher order tasks--those tasks which are more complex and of a non-routine nature, involving such activities as making decisions, persuading, diagnosing, and counseling.

It was recognized that the grouping of tasks in this way would necessarily result in some tasks being classified on a somewhat arbitrary basis, but it was felt that in general the groupings had enough validity to justify comparisons between them.

a) Numerical values used

In describing the functions, two main numerical values were used:

1. Percent performing task for each level of employee.

2. Mean frequency of performance for each level of employee.

The mean estimate of supervision for each level of employee was used as a supplementary indicator.

4. Supplementary analysis

Two extra data interpretations were made:

a) Level I task identification

Special attention was paid to the Level I employee category--the social service aide--as it was felt that this was the most fruitful area for developing instructional materials. Forty-six tasks were identified by the NTAC as being suitable for Level I employees, and the data on these tasks were inspected to see if these tasks were indeed performed highly and predominately by Level I employees.

IV. RESULTS OF SURVEY

A. FUNCTION: INTAKE SERVICES

1. Introduction

The tasks in this function relate to the initial contact between the agency and the client, from the client's request for help from the social service department to the intake interview.

The intake interview is the vehicle for explaining to the client the nature of the agency's services, and for gauging the nature and extent of the client's problem. Consequently, intake services are viewed by social service departments as of considerable importance, for it is from the intake report that the assessment of the client is made and the disposition of his case determined. The role of intake interviewer has traditionally been the domain of the case-worker, the social worker with a bachelor's degree (Level II employees in the context of this report).

2. Survey data

a) Performance and frequency of performance

Chart I shows the percent performance and mean frequency of performance for intake services tasks for the four levels of employees. The National Survey data show that the traditional model still predominates, with the Level II employees performing these tasks the most. However, the percentages for Levels III and I are not far behind those for Level II, which seems to indicate that intake services are shared by all three levels rather than being the domain of one level in particular. This is borne out by the mean frequencies of performance. Here the Level I employees, the aides, scored highest, and this would seem to suggest that in those places where aides are permitted to handle intake services, they perform them very frequently. Looking at the Mt. Sinai data, there is a clear differentiation between levels of staff, as one would expect from a large organization, but this is strikingly in favor of the aide, in both performance and frequency of performance.

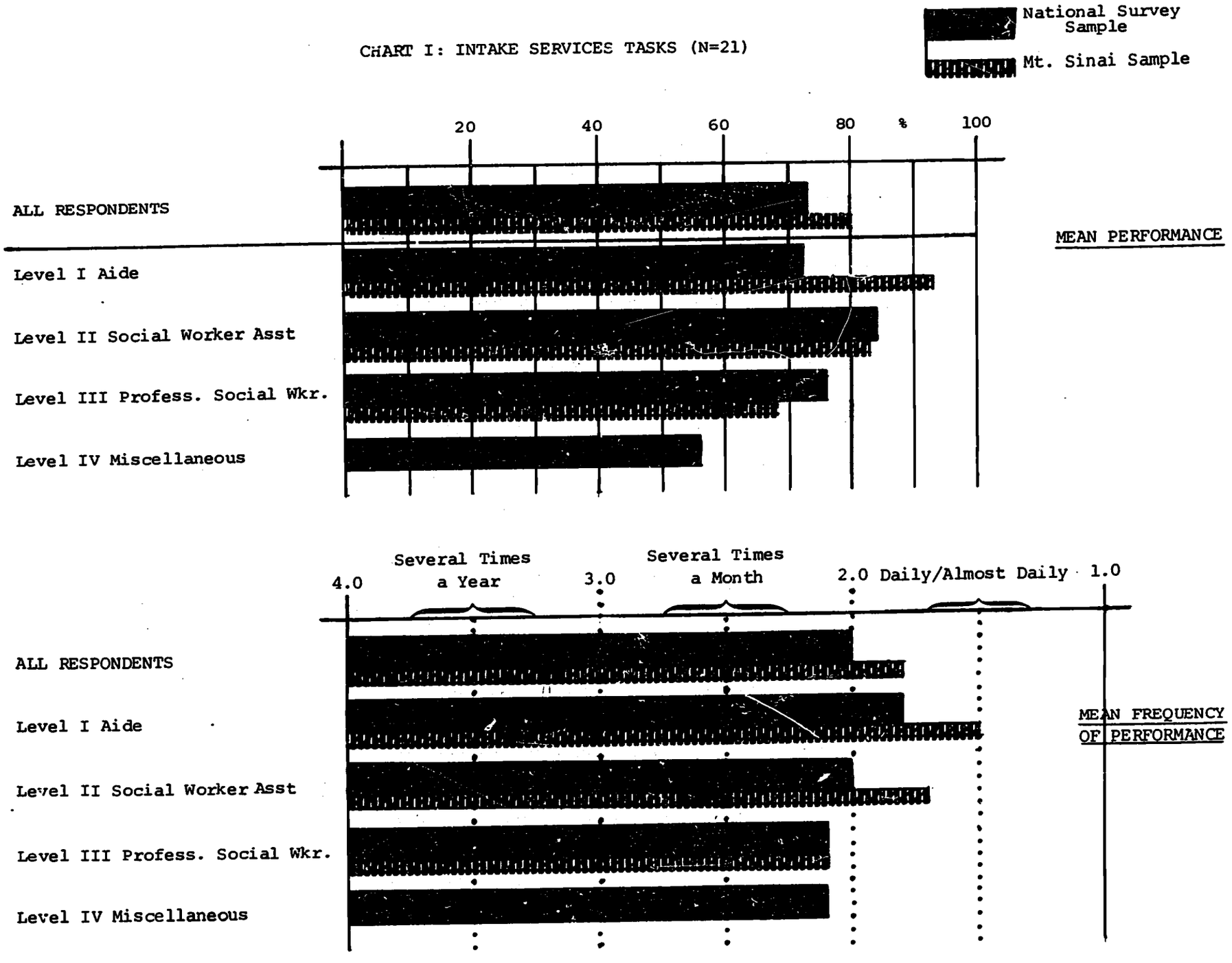


CHART I: INTAKE SERVICES TASKS (N=21)
National Survey Sample
Mt. Sinai Sample
20
40
60
80
%
100
ALL RESPONDENTS
Level I Aide
Level II Social Worker Asst
Level III Profess. Social Wkr.
Level IV Miscellaneous
MEAN PERFORMANCE
4.0
Several Times a Year
3.0
Several Times a Month
2.0 Daily/Almost Daily
1.0
ALL RESPONDENTS
Level I Aide
Level II Social Worker Asst
Level III Profess. Social Wkr.
Level IV Miscellaneous
MEAN FREQUENCY OF PERFORMANCE

b) Lower order and higher order tasks

(See Appendix 2 for the task list.) Table 4 shows that there is a difference between "lower order tasks" and "higher order tasks." With the former, for both sample, Level III employees are less active than the other two levels. With "higher order tasks", however, Level III employees carry about the same load as Level II employees. The difference between aides is pronounced--92 percent for the Mt. Sinai population and 67 percent for the national survey. However, the frequency of performance figures are identical, again showing that in the facilities where aides are used for intake interviewing they are used extensively.

TABLE 4: PERCENT PERFORMANCE AND FREQUENCY OF PERFORMANCE OF INTAKE SERVICES TASKS

Level of Employees	Lower Order Tasks (n=7)				Higher Order Tasks (n=14)			
	% Performance		Frequency of Performance		% Performance		Frequency of Performance	
	National Surveys	Mt. Sinai	National Survey	Mt. Sinai	National Surveys	Mt. Sinai	National Survey	Mt. Sinai
ALL	71	79	2.3	1.9	77	85	1.7	1.7
I	78	93	2.0	1.6	67	92	1.5	1.5
II	83	84	2.1	1.7	87	83	1.8	1.7
III	71	62	2.7	2.4	88	81	1.7	1.9
IV	53	--	2.4	--	64	--	1.8	--

c) Supervision

Table 5 shows that in all cases, the Mt. Sinai sample employees received more supervision at all levels than did the National Sample. One explanation for this is that Level I employees in the National Sample perform these tasks as an expedient rather than by design, and that the departments simply do not have the manpower available to supervise them. However, the relatively high supervision figures for the Mt. Sinai sample, together with the staff differentiation noted on Page 9 would seem to indicate that aides could be used extensively in the intake process where there is enough supervisory manpower available.

TABLE 5: ESTIMATE OF SUPERVISION OF INTAKE SERVICES TASKS				
Level of Employee	Lower Order Tasks		Higher Order Tasks	
	National Survey	Mt. Sinai	National Survey	Mt. Sinai
ALL	3.1	2.7	2.8	2.0
I	2.9	2.1	2.4	1.7
II	2.9	2.6	2.6	1.8
III	3.4	3.3	3.1	2.5
IV	3.1	---	3.1	---

KEY: 1.0 - 1.9 = All or most of the time
2.0 - 2.9 = Occasionally
3.0 - 3.9 = Rarely
4.0 = No supervision

d) Level I tasks

Looking at the actual tasks (Appendix 3), five Level I tasks can be identified as "lower order tasks" and one "higher order task." All the tasks are performed with greater than 75 percent performance by Level I employees, and four of the six are performed with less than 75 percent performance by Level III employees. It would seem, therefore, that the NTAC perceptions of those tasks which can be classified as Level I tasks are accurately reflected by those hospitals where staff differentiation is carried out.

However, it would also seem that the NTAC estimates tend to be conservative. All the "lower order tasks" and nine out of the 14 "higher order tasks" are performed by two thirds or over of the Level I employees, and most of these tasks are performed on a daily basis.

3. Interpretation

The data seem to suggest that although Level II employees, the social workers with the baccalaureate degree, have the predominant role in this area, it is shared by the social

service aides. This would seem to be an embarrassment to those who argue for increased professionalization of the social services. For example, Task 2.4, "Identify and evaluate the existence of resistance," is a task calling for considerable knowledge about human behavior, both verbal and non-verbal, and for considerable judgmental abilities. Nevertheless, this task is performed by 58 percent of the aides, who have had at best a high school education and have had no formal training in this area. Moreover, those who perform these tasks do so daily, with greater frequency than the Level II employees. It would seem from the data in general, and from the Mt. Sinai data in particular that social service aides are performing this function quite extensively. In order to make sure that it is being performed properly, it would seem important to give aides training in the techniques of interviewing and to maintain close supervision of their operations. With many MSW's this might necessitate their being trained in the techniques of management and supervision.

B. FUNCTION: INFORMATION AND REFERRAL SERVICES

1. Introduction

The tasks in this function represent the traditional referral activities of social service departments. Information is given and referrals are made in response to specific requests and circumstances. The information given generally concerns types of medical services the facility has to offer and types of community services open to the client. Referrals are made to other agencies outside the medical setting, such as the welfare department and the department of public health, and these are mostly of a routine nature.

2. Survey data

a) Performance and frequency of performance

Chart II shows the mean percent performance and mean frequency of performance for the four levels of employees. For both sample groups performance of the tasks is quite high--70 percent of the tasks are performed by the National Sample and 72 percent by the Mt. Sinai Sample. However, differences emerge in the performance patterns of the various levels of employees and in the frequency of performance. With the National Sample it is the social work assistant who performs these tasks most often, with aides and MSW's performing about 20 percent fewer tasks. The situation is quite different with the Mt. Sinai distribution. Here the aides perform 85 percent of the tasks, 13 percent more than the social worker assistants, who themselves perform 12 percent more tasks than the MSW's. The patterns for frequency of performance mirror those for performance. The most notable difference is that these tasks are performed considerably more frequently in the Mt. Sinai Sample than in the National Sample.

b) Higher order and lower order tasks

Because of the basically routine nature of this function, all the tasks can be considered as lower order tasks. Appendix 4 lists the tasks together with the mean percent performance and mean frequency of performance for each task.

c) Supervision

Table 6 suggests that relatively little supervision is available in this function, and this is consistent with the more or less routine nature of the tasks. As would be expected, Level I employees receive slightly more supervision than the other employees, and the Mt. Sinai sample receives slightly more supervision than the

National Sample. This, again, is to be expected because of the relatively small administrative units represented by the National Sample where supervisory personnel are limited.

TABLE 6: MEAN ESTIMATE OF SUPERVISION FOR INFORMATION AND REFERRAL SERVICES TASKS

Level of Employee	Lower Order Tasks (n=16)	
	National Sample	Mt. Sinai Sample
ALL	3.2	2.7
I	2.8	2.1
II	3.1	2.6
III	3.5	3.3
IV	3.4	---

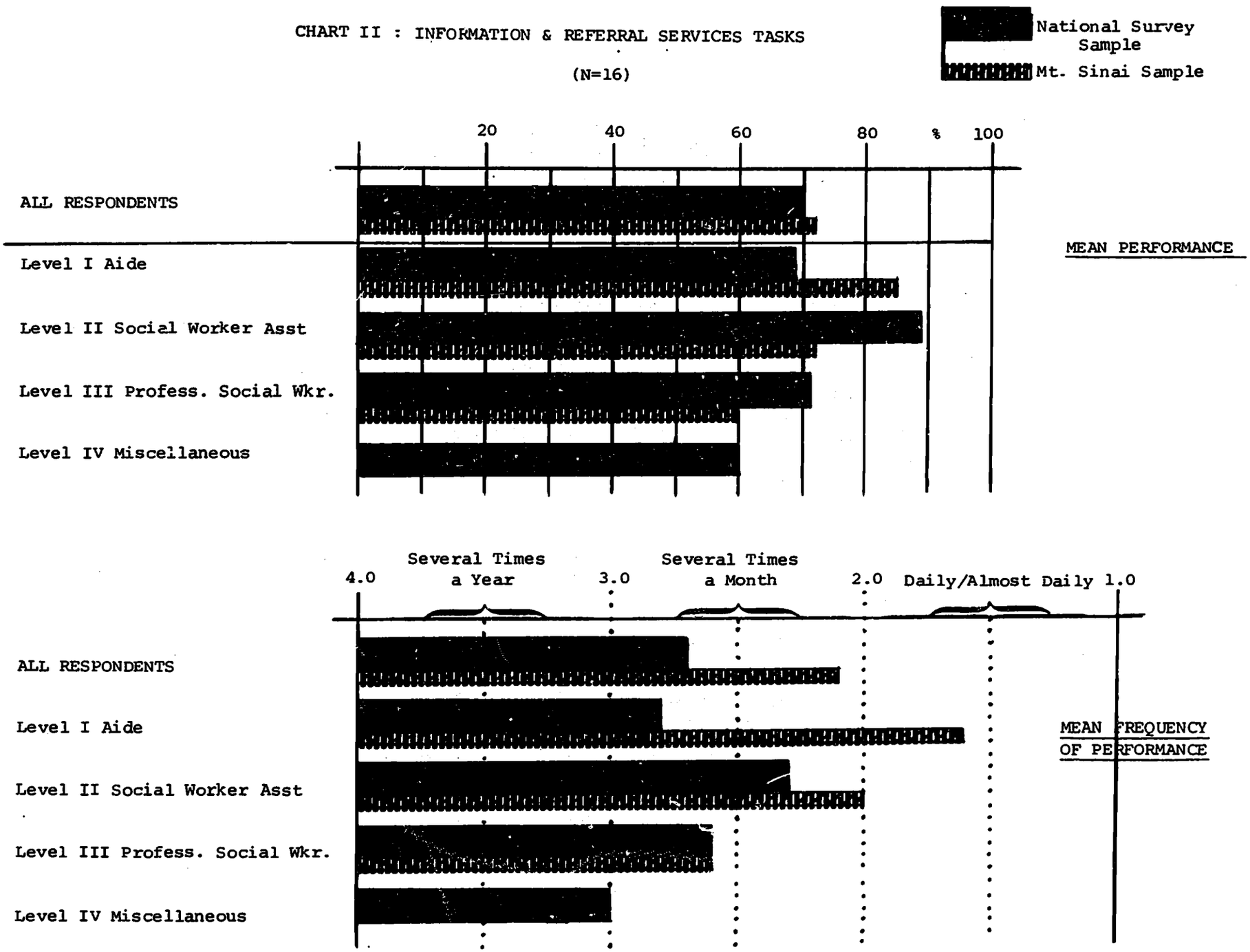
KEY: 1.0 - 1.9 = All or most of the time
2.0 - 2.9 = occasionally
3.0 - 3.9 = rarely
4.0 = no supervision

d) Level I tasks

Appendix 2 shows that six of the tasks have been chosen as Level I tasks by the NTAC. Interestingly, only two of these tasks are performed with greater than 75 percent performance by Level I employees, whereas all but one of these tasks are performed with greater than 75 percent performance by Levels II and III. The four low-performance tasks all have to do with resources outside the facility and it would appear that the aides do not devote as much time to getting to know the community as Level II and III. This, together with the similarity between performance figures for Level I and Level IV, the latter being employees who are strictly in-house personnel and would not be expected to get out into the community very often, suggests that Level I employees in this function are largely confined to the facility. Four of the tasks not recommended for Level I workers by the NTAC are in

CHART II : INFORMATION & REFERRAL SERVICES TASKS

(N=16)



fact performed with 75 percent or higher performance by Level I employees. Taking this in conjunction with the greater performance by Level I employees in the Mt. Sinai Sample noted above, it is probable that the NTAC has been conservative in its estimate, and that aides could perform all tasks in this function.

3. Interpretation

The National Survey data suggest that social worker assistants perform this function more than aides or MSW's. However, with the Mt. Sinai Sample, it is the aides who have the highest performance figures. The discrepancy might be explained by the possibility that aides are used more for clerical functions in the National Survey Sample, and that they handle initial inquiries but do not get out into the community. This possibility is borne out by the similarity of figures for performance and mean frequency of performance between aides and miscellaneous workers. The latter are facility employees who fulfill social service functions in lieu of bona fide social service employees. They are definitely in-house personnel and would not be expected to have functions outside the facility. It should also be noted that the miscellaneous employees are not much below the other levels in terms of frequency of performance for information and referral tasks. The general picture that seems to emerge is therefore one of social service employees operating largely within the facility, and giving information and making referrals on demand rather than going out of the facility.

C. FUNCTION: TREATMENT SERVICES

1. Introduction

The tasks in this function are essentially those that contribute to the emotional support of the clients and help them to adjust to the problems confronting them. (See Appendix 4) Support ranges from counseling on home management, child rearing, and problems of employment to individual and group therapy. Casework represents a large part of this function. A client is assigned to a social service worker, and from then on the worker handles that client's case. The disposition of the case may require only a single interview, or it may be effected through a number of sessions, generally on a weekly basis, until the client is able to function independently of the therapy, or has been referred elsewhere.

Casework is one of the central points of controversy in the social services. At issue are the extent and value of casework, and the therapeutic techniques it embodies. The general object of casework therapy is to help the client accept and adjust to certain realities of life, and the general objection to casework therapy is that this is treating the symptoms rather than the disease. It is argued that many of the people the social worker deals with are "normal" people reacting to the stress of oppressive conditions. Peissachowitz and Sarcka (1969) support this contention when they state that a "community mental health program meets its most severe challenges in a transient, low-income, inner-city area. In such a neighborhood, the relationship between individual pathology, the rigidity and inadequacy of social institutions, and the illness that pervades society as a whole become inextricably interwoven." (p. 75)

Instead of operating on a piece-meal individual basis in an often futile attempt to help the client adjust to his problems, it is argued that social service workers should devote more time to preventing people "from being vulnerable by eliminating the conditions to which they are vulnerable." (Barker and Briggs, 1968, p. 189.) Treatment, whatever its virtues, is being carried on at the expense of social action, which many see as the only feasible way of substantially helping the public by reducing such stresses as shorter life expectancy, unemployment, poor housing, and economic and social deprivation in general (Turner and Cumming, 1967, p. 57). Kraft (1969) characterized the feeling that therapy could be an effective approach towards the victims of poverty as "the peculiar albatross of contemporary social work." (p. 350)

Casework therapy is attacked from another quarter not merely as an activity used at the expense of more fruitful social action but as to whether it is a valid technique at all. Turner and Cumming observed that "among a number of mental health professionals there is a feeling of strong dissatisfaction

and disappointment with current psychiatric practices... Frustrated by failure, clinicians have turned away from the hospitalized patient and the seriously disturbed ex-patient and focussed most of their attention on the mildly impaired upper-class individual." (p. 40) They go on to make the point that therapy copies the medical model of the one-to-one physician-patient relationship. "This is the relationship of an authoritative agent acting with a receptive patient who, as with organic disease, takes the traditional sick role. Evidence suggests, however, that this role may be the most inappropriate or even damaging of all possible roles for a person having psychological difficulties." (p. 42)

Nevertheless, despite the double-fronted attack made on it in recent years, therapeutic casework remains a cornerstone of graduate school curricula and social work practice. French (1957) reported that more time was devoted to the subject of human growth and development in the curriculum of schools of social work than to the history of social work reforms and the structure of welfare services, and that most students for the master's degree in social work chose casework as their specialty. Zimbalist (1970), in a study of social services in the Chicago area, reported that 80 percent of the MSW's were involved in "case-serving" fields.

Many of those involved with social service agree that disturbed clients must receive emotional support when they are in need and that some type of crisis-intervention therapy must be conducted. Turner and Cumming (1970), arguing from the standpoint of Erikson's (1950, 1959) concept of personality growth, claim that during a personal crisis there is an openness in the individual which is especially conducive to positive suggestion, generating a release of energy in the individual which can be used to help him to cope with the crisis and to function even better than before. What is at issue is not the giving of emotional support to the client, but the balance between treating the distressed and removing the causes of stress.

However, it is the contention of many social service workers operating in a medical setting that their proper function is to stay within the facility. They argue that caseloads are such that they cannot help their clients enough as it is, and that by engaging in community activities they would be short-changing their clients. There is undoubtedly much validity in this point of view. However, in the light of recent trends towards community medicine and preventive medicine, it is appropriate to raise the issue of whether social workers in medical settings should not also engage in preventive activities. For further expansion on this point, see the introduction to "Community Services" on Page 35.

2. Survey data

a) Performance and frequency of performance

Chart III shows that for the National Sample 58 percent of all respondents performed this function, with Level II employees performing it the most and Level IV employees the least. Performance is similar for the Mt. Sinai Sample, but the performance patterns for the employee levels are different, with Level I employees performing this function the most. Looking at the graph of frequency of performance there is a marked difference between the two. Mt. Sinai employees perform this function almost daily whereas in general the National Sample performs this function about once or twice a week.

The data show, rather surprisingly, that this function is not the special domain of the MSW. With the National Sample, both performance and frequency of performance are more or less the same for Levels I, II, and III, and with the Mt. Sinai Sample, Level I employees predominate on both measures.

b) Lower order and higher order tasks

An initial word of explanation is due here. Considerable difficulty was experienced in dichotomizing the tasks into lower order and higher order tasks. For example, giving counseling on budget and money management or finding a home could be conceived as fairly straightforward tasks not requiring any special sensitivity. However, performing these tasks effectively presupposes that certain other factors have been taken care of. Fundamentally, they involve the establishment of an open relationship between worker and client, and this often involves recognizing and overcoming resistance and hostility and winning the client's trust. Consequently, all tasks that depend on a relationship of trust between worker and client have been classified as higher order tasks.

Table 7 shows that for both groups, there is little difference between the performance and the frequency of performance for lower and higher order tasks. Slight differences emerge in the performance figures for the National Sample for the individual levels. Lower order tasks are performed by each level to more or less the same degree, but with the higher order tasks, Level II employees predominate. With the Mt. Sinai Sample, Level I employees predominate in both types of tasks. Surprisingly, in the Mt. Sinai Sample only 45 percent of the MSW's perform the lower order tasks in this function and only 49 percent perform the higher order tasks. This is considerably different from the role of the MSW as traditionally conceived.

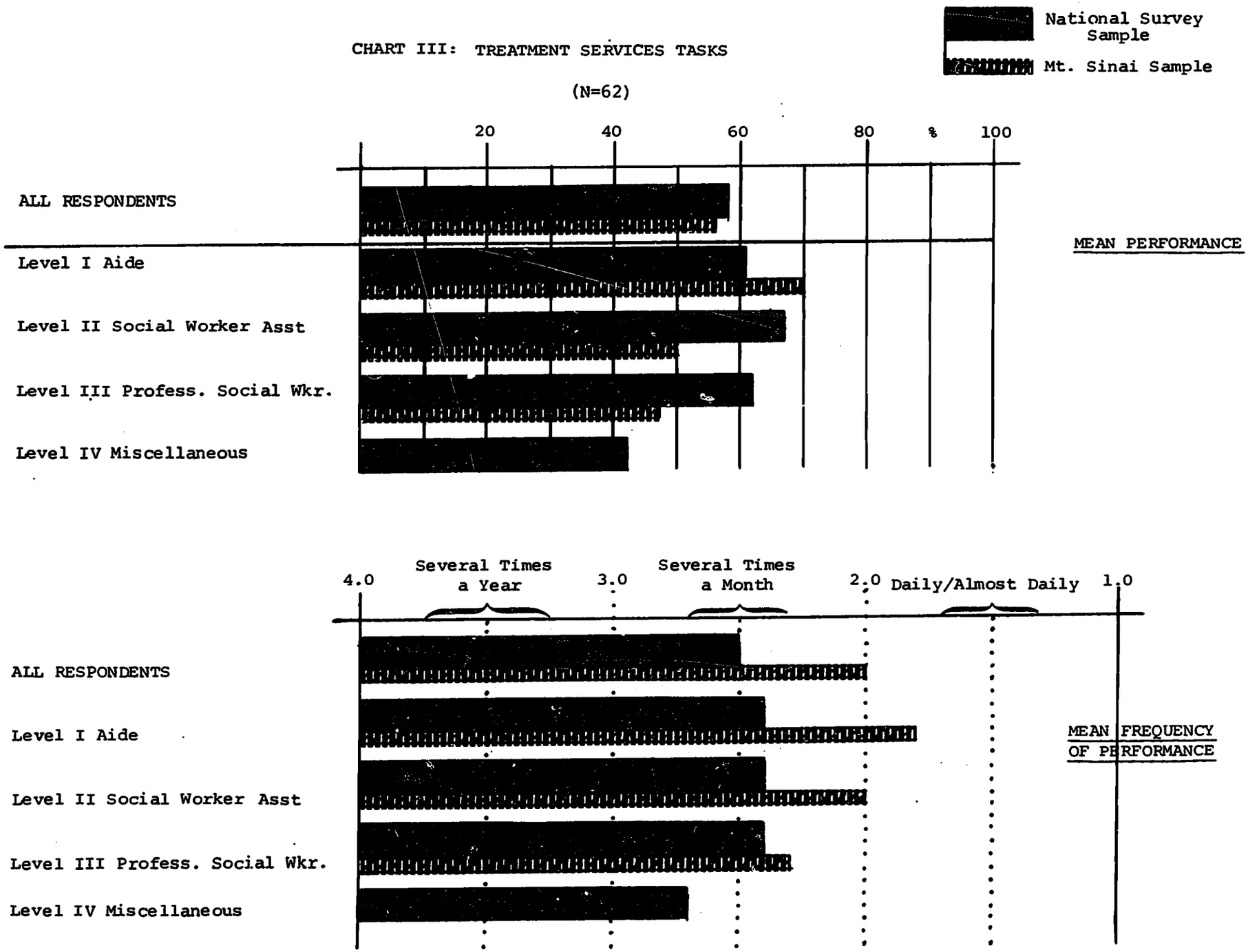

National Survey Sample
Mt. Sinai Sample
CHART III: TREATMENT SERVICES TASKS
(N=62)
20
40
60
80
%
100
ALL RESPONDENTS
Level I Aide
Level II Social Worker Asst
Level III Profess. Social Wkr.
Level IV Miscellaneous
MEAN PERFORMANCE
4.0
Several Times a Year
3.0
Several Times a Month
2.0
Daily/Almost Daily
1.0
ALL RESPONDENTS
Level I Aide
Level II Social Worker Asst
Level III Profess. Social Wkr.
Level IV Miscellaneous
MEAN FREQUENCY OF PERFORMANCE

TABLE 7: PERCENT PERFORMANCE AND FREQUENCY OF PERFORMANCE FOR TREATMENT SERVICES TASKS

Level of Employee	Lower Order Tasks n=23				Higher Order Tasks n=39			
	% Performance		Frequency of Performance		% Performance		Frequency of Performance	
	National Survey	Mt. Sinai	National Survey	Mt. Sinai	National Survey	Mt. Sinai	National Survey	Mt. Sinai
ALL	58	57	2.5	2.1	58	56	2.5	2.0
I	63	71	2.5	1.7	59	70	2.3	1.9
II	65	53	2.4	2.2	70	48	2.5	1.9
III	61	45	2.4	2.5	63	49	2.5	2.1
IV	42		2.7		42		2.8	

c) Supervision

The noticeable differences here are that the National Sample receives considerably less supervision than the Mt. Sinai Sample. With the latter, Level I employees are supervised all or most of the time in performing both types of tasks. This might explain the discrepancy noted above whereby the Level I performance figures are considerably higher than Level III performance figures for both types of tasks. It would appear that the MSW delegates many of these tasks to the aides and to some extent to the social worker assistants, who perform them in close contact with the MSW supervisor.

d) Level I tasks

The NTAC identified 15 tasks as suitable for Level I employees, eight lower order tasks and seven higher order tasks. (See Appendix 4.) With the lower order tasks, there were only two tasks where the Level I employees' performance was considerably less than that for Level II and Level III employees. Of the tasks not recommended for Level I employees, six were in fact highly performed by them.

TABLE 8: MEAN ESTIMATE OF SUPERVISION FOR TREATMENT SERVICES TASKS

Level of Employee	Lower Order Tasks n=23		Higher Order Tasks n=39	
	National Sample	Mt. Sinai	National Sample	Mt. Sinai
ALL	3.2	2.4	3.2	2.3
I	2.9	1.9	2.8	1.9
II	3.1	2.6	3.0	2.4
III	3.5	2.8	3.3	2.7
IV	3.4		3.5	

KEY: 1.0 - 1.9 = all or most of the time
2.0 - 2.9 = occasionally
3.0 - 3.9 = rarely
4.0 = no supervision

In two of the tasks, Task 43, "Arrange patient transfer from hospital to Extended-Care facility, etc.," and Task 64.4, "Complete necessary papers for placement," Level I employees' performance was greater than that for all the other levels. Looking at the higher order tasks, in all the seven Level I tasks recommended by NTAC, Level I employees performed highly in comparison with the other levels.

3. Interpretation

The numerical analysis would seem to indicate that the treatment function is not performed predominantly by the MSW but that it is more or less shared among the first three levels of employees. However, it should be pointed out that there are many tasks in this function, even higher order tasks, which would not be considered as treatment in a therapeutic sense. Looking at tasks which can be taken as real discriminators of therapeutic activity such as Task 13, "Provide support/help to patient to adjust to reality situation," Task 58, "Participate in therapy by observing/interacting with patients," and Task 57, "Participate in group therapy, family interviews and case conferences," the MSW's in the National Sample perform highly in all three tasks, with the aide performing least highly. However, in frequency of performance, the aide has the highest frequency in all three tasks. The interpretation would therefore seem to be that even in therapeutic treatment, although the MSW predominates in performance, aides do perform these functions and those that do, perform them often.

It is, of course, impossible to determine whether aides are performing therapeutic functions by design or by default. It is possible that both factors are operating. Some experts such as Gordon (1965) and Rioch (1965) suggest that non-professionals can be competent therapists if given training restricted to limited and specific techniques. Some aides interviewed in connection with this study said that they handled cases by themselves, conducting individual and group therapy with little supervision and no training. By contrast, most MSW's interviewed felt that aides were not able to handle cases alone, although some felt that they could with enough direction be delegated the most straightforward cases. Truax (1970) on the other hand has found, in a study comparing the effectiveness of untrained aides acting as therapists and of master's level therapists over a 14-month period, that greater client improvement, measured on eight scales, occurred with the aides than the trained therapists. "The findings here are consistent with a growing body of research (Truax and Carkhuff 1967) which indicates that the effectiveness of counseling and psychotherapy as measured by constructive change in client functioning, is largely independent of the

counselor's level of training and theoretical orientation." (p. 333-334) Truax goes on to suggest that traditional graduate training programs might in fact be dysfunctional and have reduced their students' effectiveness. The study also showed that when aides were used as assistants of therapists then client-improvement was worse than for the other two conditions (untrained aides alone and trained therapists alone). This is interesting in view of the fact that this is the only acceptable condition for many MSW's of using aides in therapy.

As one would expect, the aides received the most supervision in all three tasks. The rather high performance of aides in these tasks could be accounted for by the possibility that the MSW's delegate their easier therapeutic tasks to aides who work under their supervision. Unfortunately, with this type of quantitative analysis there is no way to distinguish the intensity of therapeutic work. In informal discussions with aides, it was found that in some instances cases were referred to the MSW or psychiatrist who delegated them according to their merit, whereas in other instances, cases were assigned on the basis of the person who was available regardless of professional status.

Another interesting inference can be drawn from Task 35, "Handle children with primary disorders." This task is generally thought to be a task needing a high degree of training. However, the data suggest that aides, social worker assistants, and MSW's perform this task to more or less the same extent, with the aide receiving slightly more supervision. The data for Tasks 52 and 53, "Make home visit to gather routine information," and "Make home visit to observe home environment or family situation," seem to support inferences made with reference to "Information and Referral Services" to the effect that National Survey social service workers operate largely in-house. Performance figures were 47 percent and 57 percent respectively, with a frequency of several times a year for the MSW, several times a month for the social worker assistants and almost daily for the aide. It appears that the social service workers in medical facilities operate largely within the facility, but when they do make home visits, it is the aides who do so most frequently.

The general conclusion from these findings must be that, at least on a quantitative analysis, there is relatively little difference in performance patterns among the different employee levels identified. As has been mentioned earlier, there is no indication from the data about the quality of services rendered. It is impossible to determine if aides are performing these high level functions effectively or not. Judging from the research alluded to above, by Truax and Gordon and Rioch it would seem that aides can

be effective in performing higher order tasks. Whether this is true or not, the data in this report strongly suggest that aides are practising therapy and treating children with primary disorders, and, if this is the case, it would seem appropriate to give serious thought to training them for this role. The aides interviewed in connection with this study who were practising therapy had received no training in therapeutic techniques. They had taken courses in sociology and human development and behavior but they had not taken part in any practicums in individual and group dynamics along the lines Truax, for instance, specifies. As aides continue to be used in social service it would seem important that the training given them should approximate the reality of the performance world, and that they should be trained for responsible, independent roles in social service rather than the more subservient adjunctive roles for which they are currently being trained. As for the MSW's, it would seem important that they should receive relevant training in therapeutic techniques. It would seem important in connection with the relatively high level of supervision of aides and social worker assistants found in the study, especially in the Mt. Sinai Sample, that MSW's receive training in supervisory and performance evaluation roles.

D. FUNCTION: SUPPORTIVE SERVICES

1. Introduction

The tasks in this function are largely the "enabling" tasks--escort, transportation, baby-sitting, appointment-making--in short, all the tasks which help the client to receive service and specific treatment from the facility or agency. (See Appendix 5 for a list of the tasks.)

2. Survey data

a) Performance and frequency of performance

Chart IV shows that only 49 percent of the National Sample and 37 percent of the Mt. Sinai Sample performed this function. Level I employees had the highest performance in both samples as one would expect. Perhaps the greatest surprise lies in the high frequency of Level IV employees in relation to that of Levels I, II, and III. Level IV employees are those who perform social service functions in lieu of social service personnel. It would be reasonable to expect that these people would perform these services almost as often as the others, but it is somewhat surprising to see that they perform them by far the most frequently. The frequency of performance chart shows that with the Mt. Sinai Sample, although they may not as a whole perform these tasks very much, those that do perform them do so often, especially at the Level I level.

b) Lower order and higher order tasks

All the tasks were identified as lower order tasks, with the exception of Task 66, "Observe and assess patient's behavior outside the context of treatment." Consequently, there is no point in drawing any comparisons between the two orders.

c) Supervision

It can be seen from Table 9 that aides receive slightly more supervision than the rest of the employees, but that the level of supervision is generally very low. This is not unexpected in view of the lower-order nature of the tasks.

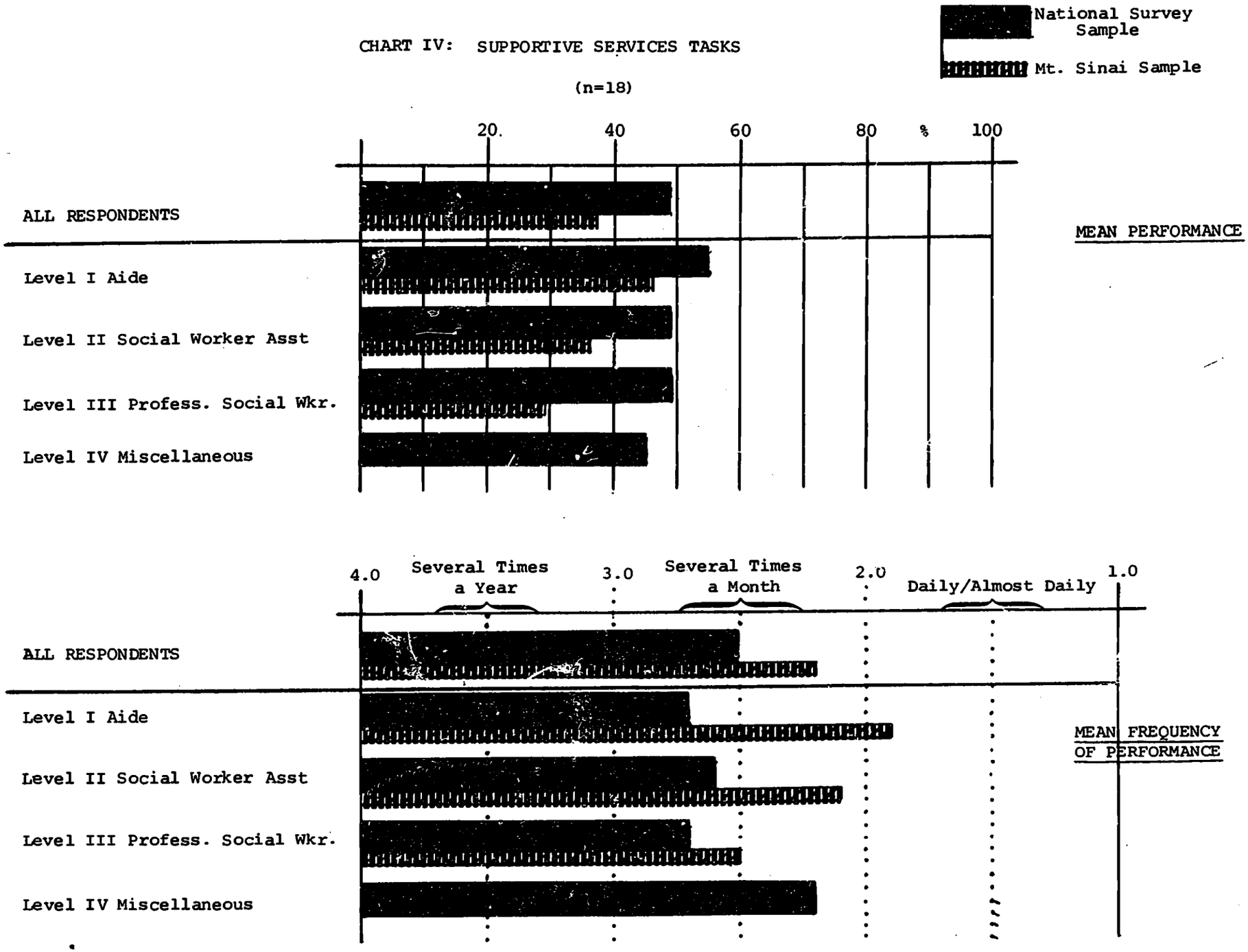

National Survey Sample
Mt. Sinai Sample
CHART IV: SUPPORTIVE SERVICES TASKS
(n=18)
20
40
60
80
%
100
ALL RESPONDENTS
Level I Aide
Level II Social Worker Asst
Level III Profess. Social Wkr.
Level IV Miscellaneous
MEAN PERFORMANCE
4.0
Several Times a Year
3.0
Several Times a Month
2.0
Daily/Almost Daily
1.0
ALL RESPONDENTS
Level I Aide
Level II Social Worker Asst
Level III Profess. Social Wkr.
Level IV Miscellaneous
MEAN FREQUENCY OF PERFORMANCE

TABLE 9: MEAN ESTIMATE OF SUPERVISION FOR SUPPORTIVE SERVICES TASKS

Level of Employee	Lower Order Tasks (n=18)	
	National Sample	Mt. Sinai
All	3.5	3.0
I	3.3	2.2
II	3.2	3.2
III	3.7	3.6
IV	3.6	

KEY: 1.0 - 1.9 = all or most of the time
2.0 - 2.9 = occasionally
3.0 - 3.9 = rarely
4.0 = no supervision

d) Level I tasks

Fifteen of the tasks were designated by the NTAC as suitable for Level I employees. Performance for Level I employees was higher than that of the other levels of employees for nine out of the 15 tasks, and in only two tasks was performance for Level I employees the lowest of all the other levels. In Task No. 78, "Secure corrective appliances for patients," Level II and Level IV employees showed considerably higher performance than did Level I employees. Of the three tasks not designated as Level I tasks, Task 68, "Locate nursing home vacancies, foster homes, etc," is in fact highly performed by Level I employees.

3. Interpretation

The tasks in this function are fairly basic social service tasks and as one might expect, aides perform this function more than the other levels of employees. It is, however, somewhat surprising to see that the tasks are performed by only about half of the social service workers and with a low frequency of performance. Two tasks in particular, Task 65, "Provide social-recreational activities to patients and children in the waiting room," and Task 80, "Provide baby-sitting and other child care services for patients," are performed by only 30 percent and 29 percent respectively of the National Sample, and each of them only a few times

a year. Similarly Task 139, "Transport patients when necessary," is performed by only 42 percent and only several times a year. The low performance and frequency of performance figures for this function would seem to indicate that the other social service functions are being carried out at the expense of this one, and that this is seen as a fairly low priority function. However, when such activities as escorting and transporting patients and making arrangements for child care are considered from a client's viewpoint a very different picture emerges. Interviews with aides in the Los Angeles area revealed that transportation--often involving a two-hour bus-ride--was, indeed, one of the major obstacles to their clients' keeping hospital appointments. If the client were a mother the problem was made worse by her having to look after small children of all ages for long periods in the waiting room. The situation was often compounded by her need to return home before her other children returned from school, thus forcing her to forego the appointment. It is hard not to conclude that for an indigent mother in a metropolitan area the tasks in this function must represent highly needed services and that judging from the figures in this survey these needs are being given relatively little consideration.

E. FUNCTION: COMMUNITY SERVICES

1. Introduction

This function is very broad in scope. (See Appendix 6 for a list of the tasks.) The activities range from promoting facility services among the inhabitants of the community and discovering and responding to community needs for health care, to working to improve living conditions in the community. The latter activity is itself broad in scope, ranging from such activities as setting up programs for senior citizens or for drug addicts and alcoholics to organizing members of the community into political action to improve their social and material conditions. The extent of the Community Services function is a key issue in social service ideology.

This report is restricted to social service workers in a medical setting and it is probably fair to say that many social service workers in a medical setting see their role in the community as limited strictly to health-related activities. Although they are aware of the need for social reform, they feel that their main responsibility is to their individual clients, and that their effectiveness in this respect would be jeopardized if they spread their activities into community affairs. This point of view is understandable especially in the context of the understaffed, under-budgeted, hospital social service department, but it is in conflict with emergent theories of health care delivery. The traditional social service model in a medical setting has followed the medical model of fragmentary, episodic care. Toomey (1971) in an article entitled "Health care delivery: 'Community' vs. specialized medicine," makes the point that medical schools have switched their emphasis from the patient to the course of disease, and medical facilities have ignored health care needs in patients with conditions of a non-complex nature in preference for care of the acutely ill, "the glamour market in the industry." (p. 44) Similarly, some observers claim that hospital social service departments have been too eager to focus on their "glamour industry," psychotherapy, and have ignored altogether the concept of preventive medicine. In this context, Rehr and Goodrich (1970), in an article entitled "Problems of Innovation in a Hospital Setting," put forward the concept of "social health," which they define as "incorporating those known somatic and multisocial, environmental, and emotional factors that comprise the social health of an individual in his family constellation." (p. 305) They go on to state that the social health concept was promulgated in the belief that sound medical care "cannot be administered separately from an awareness of the socio-emotional environment in which the individual lives." (p. 306) At Mt. Sinai School of

Medicine, Dr. Rehr's philosophy has been incorporated into a Social Health Advocate Program, which was designed to employ "local community members to service patients and families by helping them to deal with environmental problems which emanate from conditions of poverty and which impair their social and health status." (Siegel, 1970) In action terms this meant "helping patients to follow medical advice; assisting to negotiate with Welfare and Housing; interpreting rights; helping to report building and sanitation violations; visiting homes to help with home management, child care, recreational planning, vocational direction; providing escort service or baby-sitting to enable keeping necessary appointments." (Siegel) Fulfilling this type of a role is, it is claimed, a legitimate function of social service workers in a medical setting, and a necessary function if the hospital is in a large urban community. This is the social action that social workers used to be involved with until the 1930's when they switched to therapeutic practices. One problem with this type of community organization is that the social service worker may be acting in conflict with other bureaucracies, notably the Welfare Department. This may indeed be the price of gaining the client's confidence. In his article, "Social Work in a Black Community Hospital: Its Implications for the Profession," Russell (1970) acknowledges this in discussing the perceptions of his staff. "It is their conviction that they cannot work with patients effectively if they are not truly identified with improvement of patient care on every possible level, particularly where community resources are concerned." (p. 710) As Grosser (1965) observes, the worker is in fact "a partisan in a social conflict and his expertise is available exclusively to serve client interests. The impartiality of the enabler and the functionalism of the broker are absent here." (p. 18)

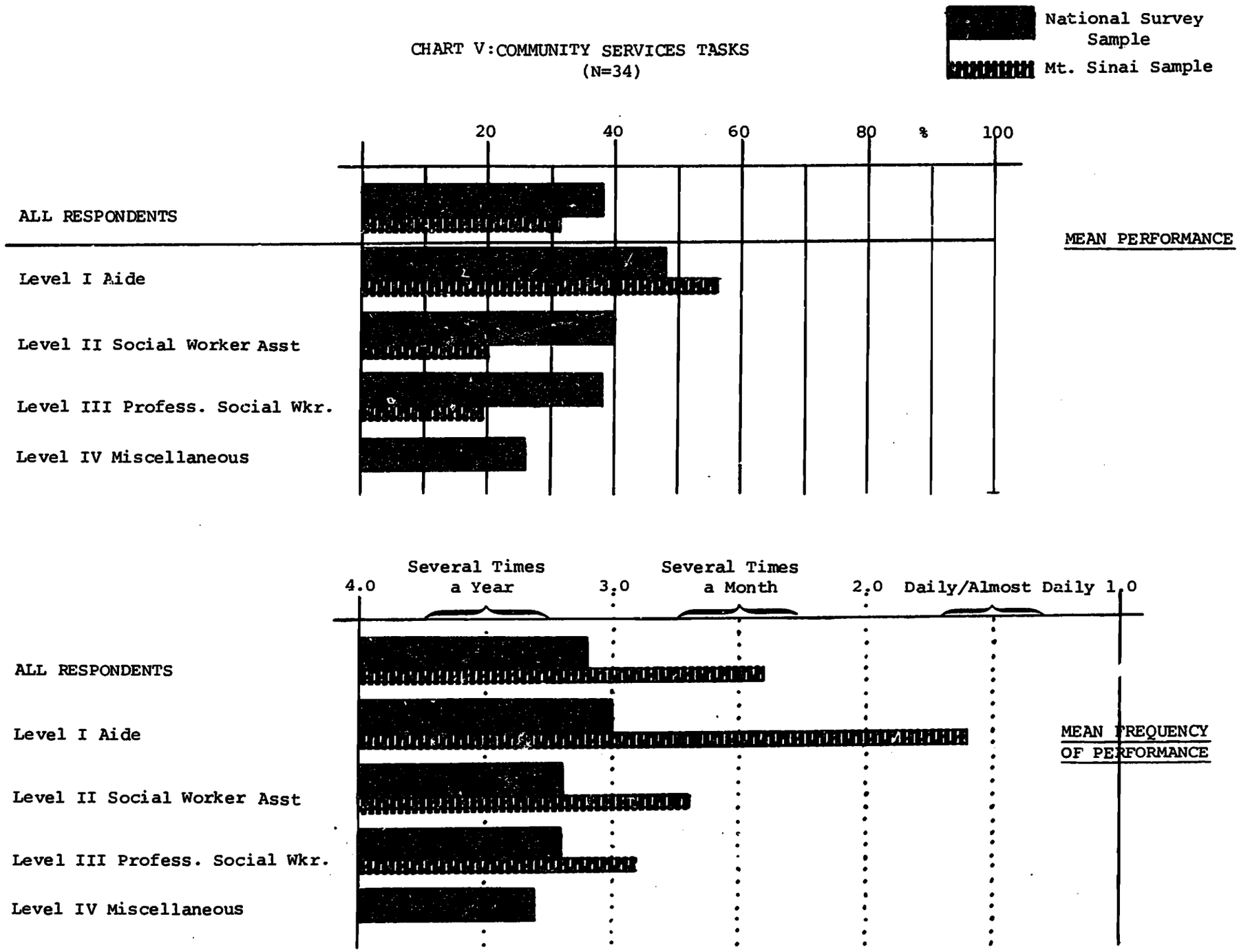
It can be readily appreciated that the Community Services function is an important indicator of social service orientation. However, any analysis of the Community Services function must be tempered by the realization that it represents, at best, a still picture of a dynamic scene constantly distorted by the pull of opposing philosophical currents.

2. Survey data

a) Performance and frequency of performance

Chart V shows the performance and frequency of performance figures for the 34 tasks in this function. The chart shows that 38 percent of the National Sample respondents and 31 percent of the Mt. Sinai respondents perform this function. When performance is broken down among the various levels of employees, Level I employees in both samples perform this function the most. The

CHART V: COMMUNITY SERVICES TASKS
(N=34)



performance patterns for both samples are fairly similar, except that Level II and Level III employees in the Mt. Sinai Sample have a considerably lower performance than anyone else. However, inspection of the frequency of performance chart reveals a marked difference in frequency between the two samples. The frequency for the National Sample is that of several times a year, considerably below even the lowest Mt. Sinai frequency. The Mt. Sinai Level I employees who are involved in community affairs appear to operate in or with the community on a daily basis, with Level II employees acting about twice-weekly.

b) Higher order and lower order tasks

The four lower order tasks represent more or less straightforward information-giving activities, whereas the higher order tasks involve organizing and persuading.

With both samples the higher order tasks are less performed than the lower order tasks. Indeed, Levels II and III employees show very low performance for higher order tasks with the National Sample, with the overall frequency of performance being on the order of a few times a year. The figure of 3.4 for frequency of performance for aides and social worker assistants

(Level I and Level II employees) is very low indeed, and shows that these higher order functions are performed only about once or twice a year. This is in marked contrast to the frequency of performance for the Mt. Sinai Sample, where aides operate in the community on a daily basis. Although an average of only 49 percent of the aides perform these tasks, they perform them daily.

TABLE 10: PERCENT PERFORMANCE AND FREQUENCY OF PERFORMANCE FOR COMMUNITY SERVICES TASKS

Level of Employee	Lower Order Tasks n=4				Higher Order Tasks n=30			
	Percent Performing		Freq. of Performance		Percent Performing		Freq. of Performance	
	Nat'l Sample	Mt. Sinai	Nat'l Sample	Mt. Sinai	Nat'l Sample	Mt. Sinai	Nat'l Sample	Mt. Sinai
ALL	43	37	3.0	2.5	33	26	3.4	2.2
I	58	64	2.6	1.7	38	49	3.4	1.5
II	47	26	3.1	2.9	33	15	3.4	2.4
III	44	23	3.1	3.0	33	15	3.4	2.8
IV	24		3.4		28		3.3	

c) Supervision

Supervision of these tasks is very low, ranging from almost none (3.8) to very occasionally (2.7).

TABLE 11: MEAN ESTIMATE OF SUPERVISION FOR COMMUNITY SERVICES TASKS				
Level of Employee	Lower Order Tasks		Higher Order Tasks	
	Nat'l Sample	Mt. Sinai	Nat'l Sample	Mt. Sinai
ALL	3.3	3.3	3.5	2.9
I	2.6	3.6	2.9	2.7
II	3.3	3.1	3.7	2.9
III	3.4	3.3	3.6	3.2
IV	3.8		3.7	

KEY: 1.0 - 1.9 = all or most of the time

2.0 - 2.9 = occasionally

3.0 - 3.9 = rarely

4.0 = no supervision

d) Level I tasks

None of these tasks was designated as Level I tasks by the NTAC. However, in view of the superiority of the aides of both samples, both in performance and frequency of performance, it would seem that it is impossible to exclude aides from this function.

On the contrary, it would seem that aides drawn from the community would be especially fitted for roles within the community. Their experience and knowledge of the people and leaders must surely be an important advantage in winning the trust of the community and in organizing its members effectively.

Interpretation

The overwhelming conclusion from the data would seem to be that the community services function is performed neither much nor often by social service personnel in medical settings. This finding is perhaps slightly more encouraging than that of Barker and Briggs (1968)

who reported in their study of social work manpower that working in the community took up 1.11 percent of MSW time and 0.72 percent of non-MSW time (p. 108), but the impression still remains that for the National Sample there is very little priority given to community activity. The more highly performed tasks are those which have to do with strictly health-related tasks such as informing the community of the services available (Tasks 93 and 96) and "Motivating families to seek health care." (Task 130) Tasks which are perhaps indicators of the extent of true social action are Task 83.3, "Encourage groups/individuals to bring change or improvements in conditions contributing to problems of health, mental health, or social adjustment," and Task 83.4, "Develop resources and leadership in the community." These tasks are performed by only 41 percent and 29 percent respectively of the sample and with a frequency of performance of 3.3 and 3.8, perhaps once or twice a year. Moreover, even in health-related matters very little preventive health work is done. Tasks relating to providing educational services on health-related matters, Tasks 91.1 to 91.8, have an average performance of 23 percent with an average frequency of 3.7, or once or twice a year. The performance and frequency of performance figures for Task 93, "Develop/ organize community groups for the prevention of drug use, and venereal disease," are 24 percent and 3.7, or only once or twice a year. It would appear that the National Sample social service workers rarely engage in community activities, and when they do so, it is generally in those activities which relate to the health services of the facility. Activities such as preventive health education, social reform, and community action to improve material conditions are seldom performed by social service personnel. However, those that do perform these tasks the most are in the aide category.

The picture is considerably different for the Mt. Sinai Sample. The aides involved in community services operate there on a daily basis. The impression of heavy community involvement by the aides is reinforced by looking at the tasks performed by the highest percentages of the aides. (See Appendix 7 for the Mt. Sinai figures.) One-hundred percent of the aides perform Task 87, "Help individuals/ groups obtain needs through organized community efforts," and 85 percent of the aides perform the two related tasks, Task 82 and Task 83.3, which concern encouraging community residents to recognize problem-causing conditions and to bring about changes in these conditions. Preventive health education tasks are performed by a low percentage, but those who perform them do so very frequently.

The contrast provided by the Mt. Sinai Sample, where a large medical social service department in a total health facility is heavily committed to community involvement and action, and the National Sample, where small medical social service departments appear to operate very little in the community is perhaps illustrative of the social service dilemma with respect to community services. The problem is not so much of manpower which Barker and Briggs (1968) call "the principal scapegoat to which failures in achieving social work goals have been consigned" (p. 21), but of orientation. Given the commitment to community services, it would seem that the necessary manpower could be recruited and trained. It is possible that as the political shift towards community and preventive medicine--embodied, for example, in the proposals for Health Maintenance Organizations--becomes more pronounced, medical social service departments will be drawn into a more active role in the community. This will presumably involve relying heavily on the use of aides and following the type of program typified by Mt. Sinai.

F. FUNCTIONS: ADMINISTRATIVE SERVICES

1. Introduction

These tasks include in-house activities of any department--improving communication, making reports, evaluating program effectiveness, consulting with other staff--as well as those specific to a social service-organization (See Appendix B for a list of the tasks.) Such activities as compiling inventories of physicians and resources in the community, keeping records of families contacted, and maintaining liaison with the community fit into this category. It is arguable that some of the tasks in this function might rightfully belong to some of the other functions such as "Information and Referral Services" or "Community Services." By organizing the tasks this way, however, it is possible to gauge the extent of all desk-related activities.

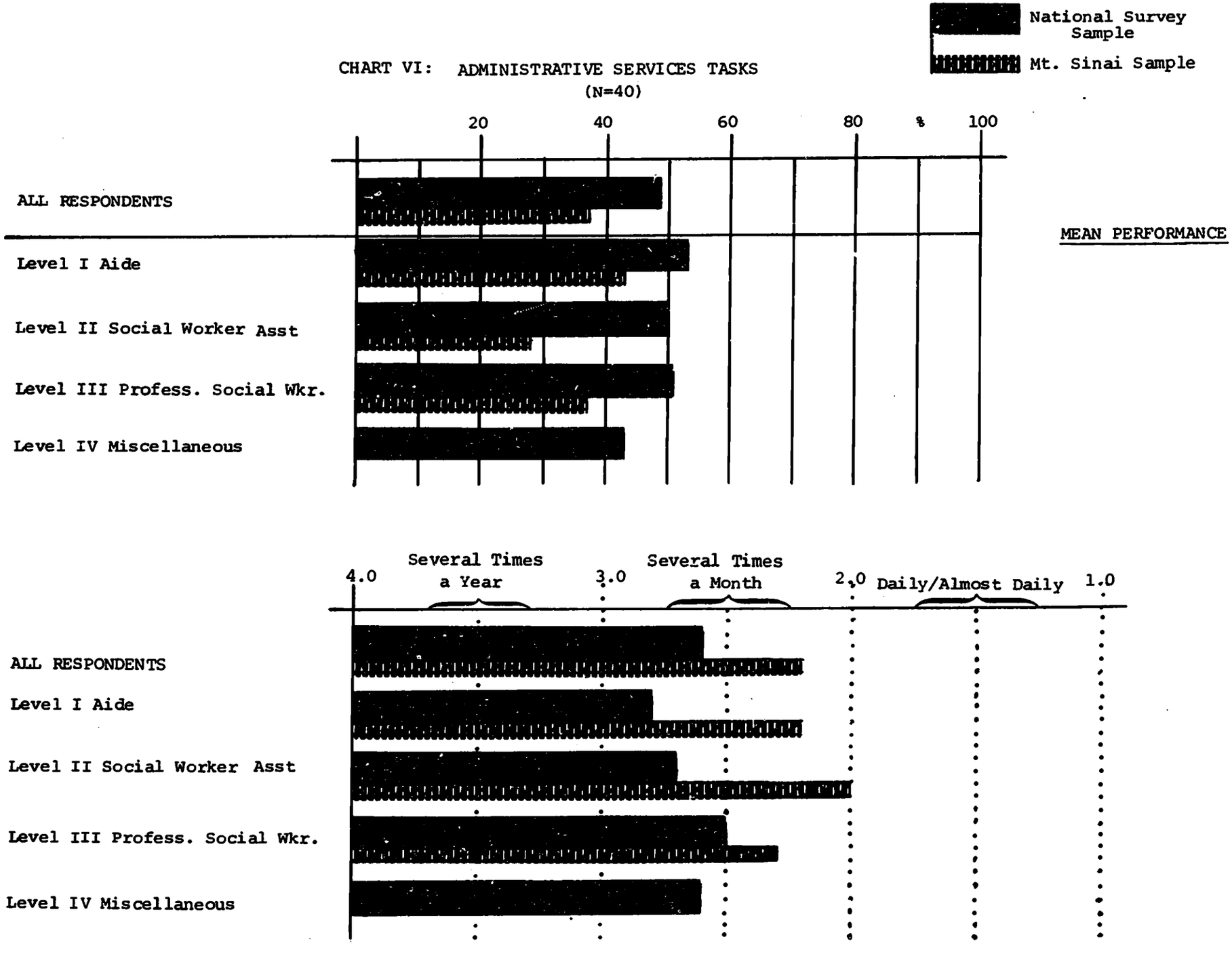
2. Survey data

a) Performance and frequency of performance

Chart VI shows the performance and frequency of performance data for each function. Administrative services tasks were performed by 49 percent of the National Sample and by 37 percent of the Mt. Sinai Sample. For the National Sample the performance by Levels I, II, and III employees was more or less even, whereas for the Mt. Sinai Sample the performance for Level II employees was considerably less than that for employees from the other two levels. For frequency of performance, the chart shows a difference in favor of the Mt. Sinai Sample, who perform these tasks on an almost daily basis, whereas the National Sample performs them on more or less a weekly basis. Differences also emerge in the frequency of performance patterns for the employee levels. With the National Sample, Level III employees perform these functions the most frequently, whereas with the Mt. Sinai Sample, they perform them the least frequently. It is interesting to note that Level IV employees show a frequency of performance equal to the average for the whole National Sample group. These are workers who are not strictly social service workers and who would therefore not be expected to perform at much above the minimum level necessary. Nevertheless, they appear to spend more time on administrative tasks than do aides or social service assistants.

b) Lower order and higher order tasks

Table 12 shows that when the administrative tasks are divided into lower order and higher order tasks, the lower order tasks show a greater percentage and frequency of performance by both sample groups. However, this does


National Survey Sample
Mt. Sinai Sample
CHART VI: ADMINISTRATIVE SERVICES TASKS
(N=40)
20
40
60
80
%
100
ALL RESPONDENTS
Level I Aide
Level II Social Worker Asst
Level III Profess. Social Wkr.
Level IV Miscellaneous
MEAN PERFORMANCE
4.0
Several Times a Year
3.0
Several Times a Month
2.0
Daily/Almost Daily
1.0
ALL RESPONDENTS
Level I Aide
Level II Social Worker Asst
Level III Profess. Social Wkr.
Level IV Miscellaneous

not apply to the MSW's, the Level III employees. The MSW's perform lower order tasks less than do aides or social worker assistants, but when it comes to higher order tasks, their performance is higher than that for the other two levels. This is to be expected, as one would suppose that MSW's would perform more higher order tasks than any of the other social service workers.

TABLE 12: PERCENT PERFORMANCE AND FREQUENCY OF PERFORMANCE FOR ADMINISTRATIVE SERVICES TASKS

	Lower Order Tasks n=12				Higher Order Tasks n=28			
Level of Employees	Percent Performing		Freq. of Performance		Percent Performing		Freq. of Performance	
	Nat'l Sample	Mt. Sinai	Nat'l Sample	Mt. Sinai	Nat'l Sample	Mt. Sinai	Nat'l Sample	Mt. Sinai
ALL	53	47	2.4	2.0	45	27	2.9	2.3
I	60	57	2.4	2.1	47	32	3.2	2.2
II	57	43	2.5	1.7	43	14	3.0	2.3
III	52	41	2.4	2.2	50	34	2.7	2.5
IV	46		2.4		40		2.8	

c) Supervision

General estimates of supervision appear to be relatively low, except for higher order tasks for the Mt. Sinai Sample. Another exception worth noting is the generally higher estimate of supervision for the aide category.

TABLE 13: MEAN ESTIMATE OF SUPERVISION FOR ADMINISTRATIVE TASKS

Level of Employee	Lower Order Tasks		Higher Order Tasks	
	Nat'l. Sample	Mt. Sinai	Nat'l Sample	Mt. Sinai
ALL	3.1	3.0	3.2	2.4
I	1.8	2.2	2.7	2.0
II	3.3	3.5	3.5	2.3
III	3.6	3.3	3.2	2.9
IV	3.6		3.2	

KEY: 1.0 - 1.9 = all or most of the time
2.0 - 2.9 = occasionally
3.0 - 3.9 = rarely
4.0 = no supervision

d) Level I tasks

The NTAC identified three lower tasks as being suitable for Level I employees. However, in view of the high performance of aides in this function (shown in Chart VI) it would seem that current practice is different from NTAC predictions.

e) Interpretation

Administrative services appear to be performed by all levels of employees to about the same extent. Non-social service workers (Level IV employees) appear to perform this function as much as social service workers, suggesting that in general performance approximates the minimum necessary. Another point worth noting is the high performance of aides in this function. Part of the rationale for using aides in social service, as Hardcastle (1971) points out, is that they will "add

something to the service delivery in their own right, not just as adjuncts to professional manpower or to create new employment opportunities for the poor." (p. 57) Whatever the indigenous characteristics of the aide may be, they are hardly likely to be clerical. Nevertheless, the data show that aides are being used fairly extensively for clerical duties. Although a certain amount of clerical work is undoubtedly necessary, there is a danger that the clerical load allotted to aides may grow to an extent that precludes them from serving the clients in ways for which they may be well equipped.

Turning to the MSW's, it can be seen that they by no means predominate in this area, as one might have expected, but perform slightly more higher order tasks than the other social service workers. Of these tasks, their highest performance occurs in Task 109, "Confer with personnel to interpret social service function re: specific cases," where 90 percent of MSW's perform this task on an "almost daily" basis. It is interesting to note that social worker assistants show an even higher percent performance and comparable frequency of performance on this task. Task 102, "Plan, assign, and supervise the work of subordinate workers," is performed by only 50 percent of the MSW's, but of those who do, their frequency of performance is daily and is higher than that for any other task in this function. Similarly, Task 113, "Supervise, consult with social work staff re: casework practice, etc.," is more highly performed by the MSW, with an almost daily frequency of performance. These three tasks appear to give a fairly good indication of the extent of supervisory work carried out by MSW's. The data seem to suggest that only 50 percent of them have workers directly subordinate to them, but those that do have them keep close supervision over their activities. The point made with reference to "Treatment Services" earlier is also relevant here: that is, that MSW's often have to perform quite heavily in a supervisory capacity, though their training for the role is generally inadequate.

Looking at educational matters within the department, little time seem to be available for any group for Task 97, "Organize, handle administrative details of educational projects at the clinic," where performance is 24 percent with an "almost never" frequency, nor for Task 118, "Develop program of staff education and development," From these figures it would seem that little emphasis is given to updating training and in-service educational opportunities.

V. CONCLUSIONS AND RECOMMENDATIONS

A. Medical social services staff give very little priority to community services. The most performed community tasks are those which promote facility services. Preventive health education is minimal.

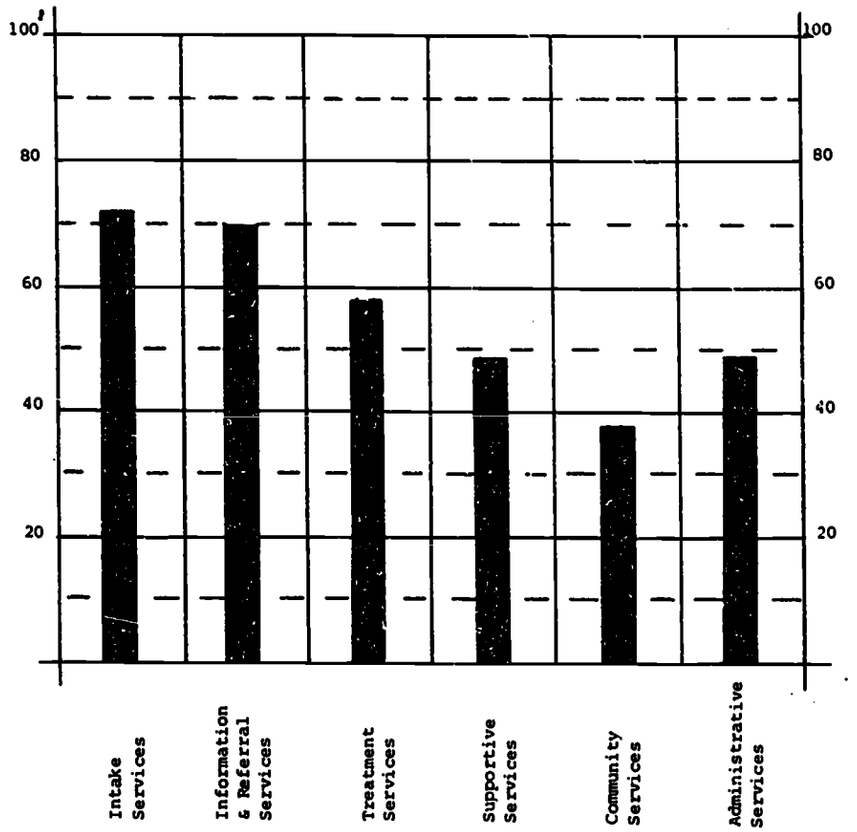
Discussion

Chart VII shows the relative differences in performance and frequency of performance between the six social service functions. Four of the six functions--Intake Services, Information and Referral Services, Supportive Services, and Administrative Services--represent fairly basic social service activities, and one would not expect to gather much about departmental orientation from them. For example, it comes as no surprise that Intake Services should be the priority function in both performance and frequency of performance scales. It may be slightly surprising for many observers to find "Administrative Services" ranking fourth in performance and fourth in frequency of performance. However, this scale is in all probability artificially depressed in that there are tasks in the other functions which could easily be classified as administrative. For example, Task 33, "Facilitate discharge plan," is classified under "Treatment Services," although it is largely an administrative activity. These functions are interesting more from the standpoint of role differentiation within the function than from that of total performance.

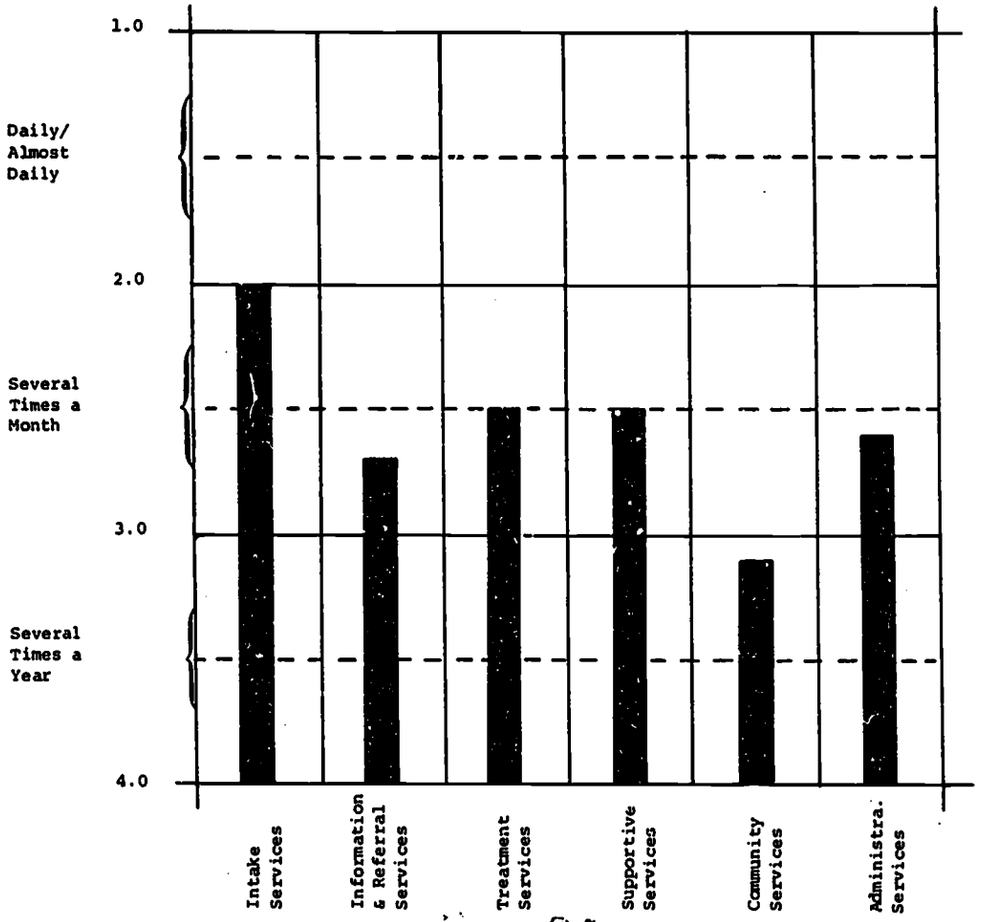
However, the other two functions, Treatment Services and Community Services, are important in the context of total performance. As was pointed out earlier (page 35), these functions represent a key issue in current social service controversy. The issue has to do with the balance between treating a patient to help in adjustment to stress and working in the community to help remove the stresses themselves. The medical analogy is the balance between crisis-care and preventive medicine. Both should be practised, but as Toomey has forcefully pointed out, they are out of balance, with crisis-care "the glamour industry of medicine." Similarly, Rehr and Russell have argued strongly that the social services are out of balance in their orientation, which they claim leans heavily toward the therapeutic approach. This is also true of the schools of social service work where according to Kraft (1969) "there are not 25 graduate centers of social work where teams of social planners are being trained to reconstruct social welfare theory and practice in America; instead...social planners must shout to be heard over the babble of derivative Freudian theory and tired cliches' about 'community organization.'" (p. 346) Chart VII would certainly seem to show that in practice the balance is strongly tipped against community involvement. The Community Services is performed by only 38 percent of the total social service staff and only on the average of several times a year. Furthermore, the most heavily performed tasks in the Community

CHART VII

PERCENT PERFORMING SIX SOCIAL SERVICES FUNCTIONS



MEAN FREQUENCY OF PERFORMANCE FOR SIX SOCIAL SERVICES FUNCTIONS



Services Function were those that had to do with strictly health-related matters. By contrast, Treatment Services are performed by 58 percent of the staff and on a weekly basis. The imbalance no doubt is attributable in part to manpower problems. The immediate needs of clients cannot be ignored or by-passed for activities which can bring relief only at some undetermined date in the future. However, a more pertinent cause for the imbalance might lie in the fact that medical social service staffs are confronted by clients and are not confronted by the community, nor do social service staffs put themselves in a position where they confront the community. Nevertheless, there are external signs that the imbalance may soon be righted. The developing political trend is towards community and preventive medicine. Walk-in storefronts, such as the Neighborhood Service Centers described by Peissachowitz and Sarcka (1970), are beginning to open up in large urban areas, and Rehr's concept of "social health," whereby sound medical care depends on an awareness of the socio-economic environment of the client, is beginning to gain currency. In consequence of these developments, the social service departments may also find themselves caught in the tide and encouraged to operate more and more outside the facility.

This, of course, is not to recommend that crisis-reduction techniques should be discontinued. There is an obvious need for such service, and it must continue to be met. However, as long as therapy is the predominant function the social work profession is open to the charge of treating the symptoms of a disease rather than its causes. The relationship between mental health and environmental factors has been well documented by James (1967) and Peissachowitz and Sarcka (1970), and there is much validity to the argument that the responsibility of medical social services is in treating the one to work towards improving the other.

B. No distinguishing patterns of performance or of frequency of performance emerged between the levels of employees identified.

C. Aides and social worker assistants perform higher order social service tasks such as conducting individual therapy and treating children with primary disorders. With the aides, although their total performance is not as great as that of the MSW's, those who do perform these tasks tend to perform them more frequently than the MSW's.

Discussion

Looking at the data for any of the six functions identified in this survey, it is hard to escape the conclusion that from the standpoint of both performance and frequency of performance there are many more similarities among the various levels of employees than there are differences. Even activities such as practising individual and group therapy, long considered the province of the MSW, or treating children with primary disorders, are being carried out not only by social worker assistants but by aides.

The differentiation among levels of employees, as explained earlier (p. 8) was made on the basis of educational attainment, as this is the prime discriminator currently used in social work employment practices. Advancement up the career ladder in the social services depends mainly on education. An aide can progress in his or her career only to a certain point, after which it is necessary to receive an A.A., B.A., and eventually an M.S.W. to continue to advance and receive appropriate salary increases. However, on the basis of this survey it would seem that formal education is a poor discriminator of task performance. The survey shows that most tasks are being performed regardless of previous education. It is of course important to realize that this survey does not supply an evaluative data as to how well the various levels of personnel are accomplishing their tasks. It is possible that aides who perform higher order tasks may be performing them inadequately. However, among the NTAC for the Social Services there was "the general feeling that the completion of academic credentials may not have anything whatever to do with how well an individual performs his task function."*

It is consequently hard to escape the conclusion that education is often an irrelevant requirement and an unnecessary obstacle to the progress of many social service personnel. The other conclusion that seems to follow from the above is that social service staffs at all levels are performing roles for which they have not been trained. Whether it is desirable or not, aides are performing higher order treatment tasks, and as long as this remains a distinct possibility it would seem important that they be given training in this regard. However, very little training is given to aides to help them perform such tasks. Similarly, the earlier discussion of Survey Results revealed that MSW's perform a high degree of supervisory roles. However, to resort once more to Kraft's eloquence, "social work is the only profession that trains its would-be practitioners in one misnamed 'method' (dynamic counseling and psychotherapy) and then sends many, if not most, of them off to practise something quite different (low or middle-level supervision and administration of individuals who have not been schooled in social work)." (p.350) Accordingly, all aspects of staff management--planning, control, evaluation, and delegation--must become a large part of MSW training, if they are to perform effectively.

It would therefore seem essential that training approximate actual job performance rather than professional prejudice. Further, it would seem important that some form of recognition be granted for experience so that it can be used to overcome current educational obstacles. In this context, it must be recognized that although experience may well be a necessary condition of social work competence, it is by no means a sufficient one. Hand-in-hand with recognizing experience must go the evaluation of experience, whereby experience that is cumulative can be distinguished from

*Letter from Harold Light, October 1970.

that which is merely repetitive.

It is relevant at this point to focus on the use of aides in the social service profession, as they constitute the most recent addition to the work force and are having a considerable impact upon staff utilization. The NTAC identified 45 tasks as being Level I tasks, that is, tasks which were suitable for aides to carry out. However, it is only fair to point out that there was a considerable range among the experts as to what tasks could be done by individuals with various levels of training (Munoz, 1970, p. 6). It was generally agreed that a causative factor of this wide range was that people were influenced more by their own experience with aides rather than by theoretical academic qualifications. This perception was borne out in interviews conducted in connection with this study. Those who used aides in higher order tasks felt that they were performing them well, whereas those who did not allow aides individual responsibility felt that aides were not capable of assuming it. It is probably fair to say that aides are capable of doing more than most of them are allowed to do.

There has been much written in the literature on the subject of the use of non-professional personnel, and much of it appears to be highly critical. MSW's are accused of protecting their professional status at the expense of the needs of their clients, and of using aides as a dumping ground for all the tedious and unrewarding tasks that they were previously forced to fulfill. The charge is made that MSW's are too comfortable in the security of their desk and office to bother to work in the community. (Grinker, 1961) There is certainly some truth in these accusations. However, it is a little too glib to attribute the inefficient use of aides to MSW unwillingness to use them properly. There are other factors which may be operating and which are rarely mentioned. One of these is that MSW's rarely receive training in the management of aides. Another is that aides are often hired not in response to the MSW's requests, but for political reasons. The aides are imposed on the MSW, who must then make up job descriptions for them. It is no wonder that in these circumstances the aides are often given the meanest tasks to perform. Furthermore, allowing aides to work in the community raises enormous supervisory problems. Many MSW's to prevent aides operating outside their control, will devise obstacles to prevent their operating effectively in the community. It would seem that inefficient use of aides is attributable as much to the inadequate training of MSW's as to their unwillingness to use aides.

Model for Staff Utilization

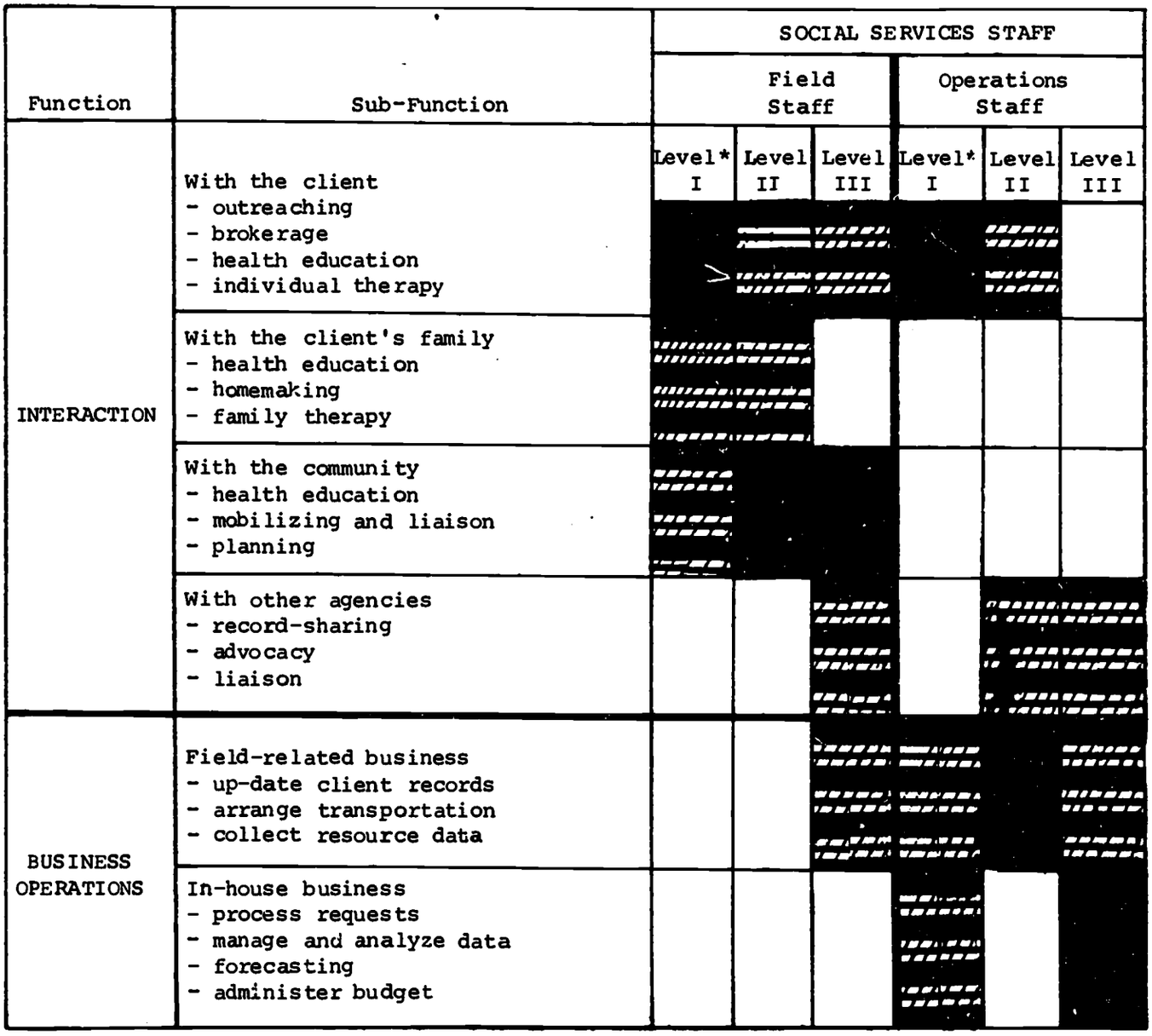
It is possible that the two issues of under-investment in community activities and under-utilization of aides are symptomatic of a basic confusion within social service departments as they are currently operated. Aides, for instance, are hired because of their indigenous characteristics, but often, as Hardcastle (1971) points out, the

effect of department screening and training is to discriminate against the very attributes for which the aides are hired. Many aides are hired to work with people in the community, but they are judged by their ability to conform to agency bureaucratic practices rather than by their competence in the field. Similarly, the MSW who by training and inclination often is best equipped to treat categorical disorders and to arrange the delivery of specific services is under pressure to leave his office and to work in a community he does not know and in which he does not feel comfortable.

The basic confusion may reside in the failure to distinguish between two main functions which are essential to meeting the client's needs. One of the functions is that of interaction: the client needs to talk to someone he can trust, the client community needs people who can act as intermediaries, as advocates and planners. The other function is that of matching client need with agency service, of processing and expediting the client's business, of keeping and up-dating records-in short, the function of business operations. Both functions are vital to the client's needs. It would seem that the social work profession needs people who are competent in either of these activities, whereas currently the profession is requiring that people be competent in both. If client care delivery can be looked at from this standpoint, then the problem of professionalization will diminish. Certainly, there will be levels or gradations of personnel, but there would be no need for someone who is competently performing the interaction function to excel in business operations as well. With this organization, professionalization could be gained through a combination of experience, training, and job competence. There could be parallel staff to perform the parallel functions, as outlined in Figure 2. The ratio of field staff to business operations staff would complement their activities and maintain the day-by-day running of the department. Level III, in both staffs, would be a professional position. The professionals would have to supervise the lower ranks, and make high-level administrative decisions about their particular operations.

What is interesting about this model, and what makes it particularly illustrative, is that the MSW, as he or she is presently trained, would be hard put to qualify as a professional on either staff. As Teare and McPheeters (1970) point out, graduate schools have tended to restrict the training of MSW's to "clinical work with individuals or groups of clients as if no other functions lay in the immediate future of their graduates." (p. 60) In the model, clinical work is but a part of field staff functioning: the field staff professional would also need to be an expert in the community, knowing its members well and being capable of mobilizing support within the community and acting as liaison with community grass-roots organizations. As for business operations, the MSW does not have enough training in top-level data managing and forecasting techniques to qualify as a professional on that staff.

FIGURE 2: ORGANIZATION OF SOCIAL SERVICE DEPARTMENT BY FUNCTION



To train these two types of staff, two distinct curricula would be needed, the one leaning heavily towards the client community, the other towards data management and business practices. Under such an arrangement, each staff would need a clear understanding of the functioning of the other so that both could work effectively in the client's interests. Furthermore, the dual system would call for both staffs to receive intensive training in record-keeping, which would take on a new significance. If the two staffs are to communicate effectively with each other, some short-hand notation system for exchanging information about the clients would certainly be necessary. Indeed, effective communication is the key to the workability of the suggested system of dual responsibility. Without it, social service departments may still be open to the charge of fragmented, episodic delivery of service. What is certain, however, is that judging from the data in this survey there is little coherence in job roles in the social services as they are currently organized, and there is an urgent need to fashion a system whereby the basic organizational structure is directly geared to the emotional and material well-being of the client population.

05 041

SOCIAL SERVICE

	Check if Done	FREQUENCY: How often do you do this task? Daily / Almost Daily	Several times a Week	Several times a Month	Several times a Year	Almost never	SUPERVISION: How much supervision do you get for this task? All the time	Most of the Time	Occasionally	Rarely	No Supervision	DIFFICULTY: How difficult is this task? Routine procedure- No decisions	Several procedures- Minor decisions	Select most Suitable procedure	Establish and/or Modify procedure	Make complex decisions Little precedent
1. Intake interviewing (clarification of services to prospective patients and determining if services are consonant with the needs of the patients.		1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
1.1 Help client define problems and needs for service.		1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
1.2 Assess client's request or need for service.		1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
1.3 Decide whether client's request or need is appropriate for services rendered.		1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
1.4 Explain the nature of services available.		1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
1.5 Explain and interpret eligibility requirements (e.g., age, citizenship, financial, certain groups or status).		1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
1.6 Take initial application for service.		1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
1.7 Assist clients in application procedures.		1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
1.8 Help clients fill out forms.		1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
1.9 Help clients obtain necessary records, documents required (e.g., birth certificate, financial statement).		1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
2. Preparation of patients for treatment, dealing with resistance to treatment and establishing the proper motivation for treatment.																
2.1 Observe patients' reactions and discuss observation with the patient by explaining to patient confusion, anxiety about the treatment.		1	2	3	4	5	1	2	3	4	5	1	2	3	4	5

APPENDIX 2

INTAKE SERVICES - LOWER ORDER TASKS (n=6)

Task no. in survey	Task	% Performing task					Mean frequency of performance				
			LEVEL					LEVEL			
		Tot* n=78	I n=12	II n=20	III n=32	IV n=14	Tot* n=78	I n=12	II n=20	III n=32	IV n=14
** 1.6	Take initial application for service.	60	83	75	59	35	1.9	1.5	1.7	1.9	2.6
** 1.7	Assist clients in application procedures.	69	83	85	65	42	2.2	1.6	2.3	2.5	2.5
** 1.8	Help clients fill out forms.	71	91	85	59	50	2.7	2.0	2.7	2.9	3.0
** 1.9	Help clients obtain necessary records, documents, etc.	61	75	75	53	42	3.1	2.9	3.0	3.4	3.2
4.	Communicate findings to agency through conference or written report.	66	66	70	87	42	2.5	3.0	2.6	2.5	2.0
5.	Consult with physician/others involved in care of patient.	85	66	100	90	78	1.6	1.8	1.5	1.5	1.5

*Total Sample ** Level I Tasks

APPENDIX 2 (CONTINUED) INTAKE SERVICES - HIGHER ORDER TASKS (n=15)

Task no. in survey	Task	% Performing task					Mean frequency of performance				
			LEVEL					LEVEL			
		Tot* n=78	I n=12	II n=20	III n=32	IV n=14	Tot* n=78	I n=12	II n=20	III n=32	IV n=14
1.1	Help client define problems and needs for service.	79	75	95	87	57	1.2	1.4	1.4	2.1	1.5
1.2	Assess client's req. or need for service.	77	75	95	87	57	1.4	1.4	1.5	2.0	1.6
1.3	Decide whether client's req./need is appropriate for services.	82	83	95	87	64	1.1	1.4	1.5	2.0	1.5
**1.4	Explain the nature of services available.	88	83	95	87	85	1.1	1.4	1.6	1.9	1.5
**1.5	Explain/interpret eligibility requirements, e.g., age, citizenship.	75	75	85	81	57	1.6	1.6	2.0	2.4	1.9
2.1	Observe patient's reactions to treatment and discuss same with patient.	76	58	85	90	71	1.1	1.7	1.5	2.2	1.6
2.2	Define goals for treatment and explain process.	76	58	80	87	78	1.6	1.8	1.6	1.5	1.6
2.3	Discuss limits and requirements of treatment.	77	58	80	90	78	1.3	1.7	1.9	1.5	1.6
2.4	Identify and evaluate the existence of resistance.	75	58	85	93	64	1.3	1.8	1.7	1.4	1.6
2.5	Resolve/modify resistance of client.	74	66	80	93	57	1.6	2.0	1.8	1.5	1.7
2.6	Discuss alternatives to treatment and interpret consequences.	74	66	85	87	57	1.6	1.8	2.0	1.6	1.8
3	Identify/assess resistance in agency which may constrain clients.	66	66	70	87	42	2.3	2.6	2.3	1.5	2.2
6.	Provide consultation to staff re: problems in pts. re: finance, health, etc.	87	75	95	93	85	2.2	1.9	1.5	1.3	1.7
7.	Act as liaison between pt. and others when necessary to give reassurance.	85	75	95	93	78	1.7	1.8	1.6	1.6	1.7
9.	Manage parents, mate, etc. who require counseling as aid to pt. treatment.	69	58	90	71	57	1.6	2.2	1.7	2.4	2.0

*Total Sample ** Level I Tasks

APPENDIX 3

INFORMATION AND REFERRAL SERVICES - LOWER ORDER TASKS (n=16)

Task no. in survey	Task	% Performing task					Mean frequency of performance				
			LEVEL					LEVEL			
		Tot* n=78	I n=12	II n=20	III n=32	IV n=14	Tot* n=78	I n=12	II n=20	III n=32	IV n=14
** 8.	Locate neighborhood social, recreational, or educational resources.	72	58	100	84	57	2.4	2.1	2.4	2.6	2.4
** 10.	Acquaint pts. with available community resources.	79	66	100	87	64	1.8	1.7	1.6	2.0	1.8
** 11.	Answer inquiries from individuals/agencies re: available medical services.	85	91	95	84	71	2.0	1.7	2.3	1.9	2.0
** 12.	Provide info. to individuals/groups re: existing community resources.	78	83	95	78	57	1.9	1.7	1.8	2.6	2.0
** 13.	Answer letters of inquiry re: pts. from other medical or social agencies.	81	91	80	81	71	3.0	2.6	2.8	3.1	2.9
14.	Write letters of referrals on pts. about to be discharged.	61	66	70	78	50	2.6	2.4	2.6	3.1	2.7
15.	Write referral letters/public agencies on hosp. pts. for financial help.	51	58	55	62	28	3.4	2.6	3.1	3.5	3.2
16.	Make referral for financial assistance, i.e. public assistance.	74	83	90	75	42	3.1	2.2	2.6	3.3	2.8
17.	Make referral for medical care assistance program, i.e. MediCal or Medicare.	72	75	90	71	50	3.4	2.2	2.5	3.3	2.9
18.	Refer pt. to legal resources in critical family or interpersonal situations.	67	75	90	75	28	3.6	3.1	3.5	3.8	3.5
** 19.	Refer pt. to sources for correction of defects in dress, grooming, etc.	42	58	45	25	42	3.3	3.1	3.9	3.2	3.4
20.	Refer pt. to resources for correction of remediable physical disabilities.	70	75	80	68	57	3.2	2.6	2.9	3.0	2.9
** 21.	Refer pt. to appropriate recreational, social, and hobby resources.	74	66	90	81	57	2.9	2.8	3.0	2.8	2.9
136.	Interpret eligibility requirements of various health facilities.	59	50	80	62	42	3.0	2.4	2.6	3.2	2.8
137.	Refer pts. to the appropriate health agency.	62	50	90	68	42	2.8	2.1	2.4	3.0	2.6
138.	Follow up referrals to determine if pt. obtained appropriate service.	58	58	75	59	42	3.0	2.1	2.3	3.4	2.7

*Total Sample **Level I Tasks

APPENDIX 4 TREATMENT SERVICES - LOWER ORDER TASKS (n=23)

Task no. in survey	Task	% Performing task					Mean frequency of performance				
			LEVEL					LEVEL			
		Tot* n=78	I n=12	II n=20	III n=32	IV n=14	Tot* n=78	I n=12	II n=20	III n=32	IV n=14
** 25.4	Information/referral to community resources.	71	66	90	78	50	2.1	2.3	2.6	3.0	2.5
27.	Help in selection of appropriate school for pts.' children.	40	41	35	50	35	3.6	3.1	3.3	3.6	3.4
32.1	Give pt. various resource information on nursing homes, special schools, etc.	81	75	100	90	57	2.0	1.8	2.0	2.8	2.2
32.2	Help decide whose need would best be met re: nursing homes, etc.	74	75	90	87	42	1.8	1.7	1.9	2.7	2.0
33.	Facilitate discharge plan.	74	83	85	84	42	2.1	2.1	1.9	2.0	4.0
** 34.	Make requests for car fare.	55	66	70	56	28	2.9	2.9	3.1	3.8	3.2
43.	Arrange pt. transfer from hospital to extended care facility, etc.	68	83	80	65	42	2.5	2.0	2.0	1.5	2.0
** 50.	Provide social/recreational experiences to pts. through group activities.	30	50	15	28	28	2.5	2.7	2.9	3.8	3.0
** 51.	Provide social/recreational experiences to pts. through individual activities.	37	58	25	37	28	2.6	2.6	1.9	3.5	2.7
** 52.	Make home visit to gather routine information.	47	58	40	56	35	1.4	2.5	3.2	3.0	2.5
** 58.1	Clarify agency programs to individuals.	75	66	90	87	57	2.0	1.9	1.9	2.1	2.0
** 58.2	Convey community cultural patterns/attitudes to agency professional staff.	55	58	60	65	35	3.0	2.5	2.2	2.8	2.6
** 59.	Act as an interpreter where language is a barrier.	29	33	25	37	21	2.5	3.5	3.1	1.7	2.7
60.	Contact individuals/schools for info. and assistance re: case planning.	71	75	90	78	42	2.0	1.8	2.1	2.8	2.2
61.	Provide supervision of teenagers and other groups.	27	41	20	25	21	3.2	3.8	3.8	4.0	3.7
63.3	Contact employers when indicated.	62	66	65	75	42	3.1	3.4	3.4	3.3	3.3
64.2	Determine patient's financial situation.	70	66	95	68	50	2.5	1.9	1.7	2.7	2.2
64.4	Complete necessary papers for placement.	62	83	75	53	35	2.4	2.2	2.2	2.6	2.4
64.6	Keep staff informed during this period.	71	75	95	71	42	2.3	2.0	1.8	2.7	2.2
64.7	Provide or maintain necessary follow-up care.	56	50	70	62	42	3.2	2.2	2.5	3.2	2.8
140.	Report to prof. staff significant findings re: health and social matters.	79	66	90	81	78	2.6	1.7	2.1	2.2	2.2
141.	Upon req., reinforce instructions given by the professional.	69	66	80	71	57	2.6	1.8	1.9	1.3	1.9
144.	Administer first aid measures when necessary.	34	41	15	15	64	3.8	4.0	4.0	2.7	3.6

*Total Sample **Level I tasks

APPENDIX 4 (CONTINUED) TREATMENT SERVICES - HIGHER ORDER TASKS (n=39)

Task no. in survey	Task	% Performing task					Mean frequency of performance				
			LEVEL					LEVEL			
		Tot* n=78	I n=12	II n=20	III n=32	IV n=14	Tot* n=78	I n=12	II n=20	III n=32	IV n=14
22.	Explain health problems to pt. or relative.	81	66	95	33	71	2.6	1.8	1.8	1.6	2.0
23.	Provide support/help to pt. to adjust to reality situations.	85	66	95	93	85	1.3	1.7	1.3	1.8	1.5
24.	Help families/pts. by clarifying illness.	87	66	95	93	92	1.6	1.6	1.4	1.4	1.5
25.1	Budget, money management--counseling.	57	58	70	47	53	2.9	2.9	3.3	3.4	3.1
25.2	Housekeeping problems--counseling.	56	50	70	62	42	2.5	3.0	3.0	3.0	2.9
25.3	Child care management--counseling.	52	58	50	65	35	2.6	2.9	2.7	3.0	2.8
** 25.5	Babysitting services--counseling .	43	50	50	37	35	3.3	2.4	3.3	2.8	3.0
** 25.6	Finding a home--counseling.	55	50	65	68	35	3.5	3.2	3.0	3.8	3.4
25.7	Employment problems--counseling.	62	66	70	75	35	2.5	2.6	2.8	3.2	2.8
26.	Provide education--e.g. sexual relations, child rearing.	46	50	45	59	28	3.0	3.3	2.5	3.3	3.0
** 28.	Assist pt. in adjusting to new or present housing situation.	58	55	75	65	35	2.7	3.1	2.6	3.2	2.9
** 29.	Help pt./family plan and prepare moving to a new neighborhood.	41	50	50	37	28	4.0	3.6	3.6	3.8	3.8
** 30.	Help pt. or family adjust to present neighborhood.	45	50	50	50	28	3.3	3.2	3.3	3.3	3.3
31.	Handle children with primary disorders.	39	41	35	43	35	3.2	3.6	3.0	3.0	3.2
35.	Review pt.'s charts and prepare social service report.	70	75	90	87	28	2.2	1.5	1.6	2.5	2.0
36.	Interview families and collaterals to obtain social information.	71	66	90	93	35	2.1	1.6	1.5	2.2	1.9
37.	Interview pts. for prospective foster home placement.	40	58	40	34	28	3.1	3.4	3.4	3.0	3.2
38.	Review claims folder to compile abstracts of pt. information.	34	25	40	34	35	3.7	3.0	3.5	3.4	3.4
39.	Write letters to pt.'s family re: pt.'s progress or adjustment.	50	50	55	53	42	3.7	3.3	3.5	3.8	3.6
40.	Discuss trial visits, financial arrangements, etc. w/family of hospitalized patient.	56	66	75	53	28	2.3	2.7	2.4	3.0	2.6
41.	Help families prepare for discharge of pt.	80	75	85	81	78	1.9	2.1	1.6	1.6	1.8
42.	Enable clients to develop or use personal resources.	73	66	90	78	57	1.4	1.8	1.8	2.4	1.9
44.	Interpret to pt.'s family/group meaning of cultural patternsn.	52	50	70	59	28	2.3	2.6	2.8	3.0	2.7

*Total Sample ** Level I Tasks

APPENDIX 4 (CONTINUED) TREATMENT SERVICES - HIGHER ORDER TASKS (n=39)

Task no. in survey	Task	% Performing task					Mean frequency of performance				
			LEVEL					LEVEL			
		Tot* n=78	I n=12	II n=20	III n=32	IV n=14	Tot* n=78	I n=12	II n=20	III n=32	IV n=14
45.	Observe gaps in values/standards between client and the community.	59	58	70	78	28	1.7	2.2	2.6	2.5	2.3
46.	Discuss w/client gaps/differences in values/life style between client/community.	58	66	65	71	28	1.8	2.8	2.9	3.8	2.8
47.	Help client resolve conflict of differences by accepting/adopting to same.	58	66	75	68	21	1.9	2.4	2.7	3.7	2.8
48.	Clarify personal standards of pt./family that do not conform with community standards.	57	66	75	65	21	2.1	2.7	2.9	3.7	2.9
49.	Clarify to pts./families legality of certain actions, e.g., voluntary admissions.	54	66	60	56	35	2.1	2.2	2.9	3.2	2.6
53.	Make home visit to observe home environment or family situation.	57	58	65	62	42	1.6	2.9	3.0	3.5	2.8
54.	Observe behavior and appearance of clients.	71	58	80	75	71	1.3	1.9	1.5	1.6	1.6
55.	Make home visit to observe/evaluate in relation to a specific problem.	57	58	60	58	51	1.6	2.7	3.2	3.7	2.8
56.	Participate in therapy by observing/interacting with patients.	62	58	45	75	71	1.4	2.1	2.0	1.2	1.7
57.	Participate in group therapy, family interviews or case conference.	68	66	65	84	57	1.5	2.3	1.8	3.3	2.3
62.	Counsel pts. in relation to their financial and living arrangements.	63	58	80	78	35	2.7	1.9	2.0	3.4	2.5
** 63.1	Encourage relatives to communicate pt.'s adjustment during/after home visits.	53	58	50	62	42	2.1	2.4	2.6	3.5	2.7
** 63.2	Encourage pts. to communicate problems while on leave from hospital.	48	66	40	50	35	2.4	2.8	2.5	3.4	2.8
64.1	Explore pt.'s interest in placement.	70	66	100	71	42	2.1	2.2	2.0	3.0	2.3
64.3	Discuss placement plans with guardian.	62	75	85	53	35	2.9	2.4	2.5	3.2	2.8
64.5	Help pts./relatives handle their anxiety while waiting placement.	77	75	100	68	64	2.3	2.0	2.0	2.6	2.2

*Total Sample **Level I Tasks

APPENDIX 5

SUPPORTIVE SERVICES - LOWER ORDER TASKS (n=17)

Task no. in survey	Task	% Performing task					Mean frequency of performance				
			LEVEL					LEVEL			
		Tot* n=78	I n=12	II n=20	III n=32	IV n=14	Tot* n=78	I n=12	II n=20	III n=32	IV n=14
** 65.	Provide social-recreational activities to pts./children in waiting room.	30	33	25	25	35	3.8	3.8	3.9	2.6	3.5
** 67.	Report pt.'s behavior outside treatment to therapist/supervisor.	46	58	45	46	35	2.6	2.6	2.3	1.4	2.2
68.	Locate nursing home vacancies/foster homes, etc.	69	75	90	68	42	2.6	2.1	2.3	3.2	2.6
** 69.	Arrange transportation and travel for patients.	72	83	75	71	57	2.6	2.1	2.6	3.0	2.6
** 70.	Provide transportation for pts. to clinics, hospitals, etc.	55	66	60	50	42	2.8	2.8	3.2	3.3	3.0
** 71.	Secure necessary documents for pts.'passports, visas, etc.	33	33	45	34	21	4.0	3.2	4.0	3.0	3.6
** 72.	Arrange clinic and other appointments for patients.	52	66	45	62	35	2.9	2.4	2.7	2.6	2.7
** 73.	Escort patients to clinic, hospital, etc.	39	58	40	37	21	3.4	3.3	3.7	3.7	3.5
** 74.	Provide escort service to pts. such as the use of volunteers.	41	41	40	40	42	3.8	3.1	3.2	2.7	3.2
** 75.	Make phone calls or home calls to check a failed appointment.	60	66	55	56	64	2.9	2.5	2.9	2.9	2.8
** 76.	Read/write letters for pts. unable to read or write.	47	41	70	43	35	3.8	3.1	3.3	3.0	3.3
** 77.	Send notice/form letters re: failied appointments and give new appointments.	37	41	35	31	42	3.6	2.8	3.3	2.8	3.1
** 78.	Secure corrective appliances for pts.	50	41	60	43	57	3.4	3.3	3.1	2.5	3.1
** 79.	Obtain specific info. from pts.'charts as req. by social worker, nurse, etc.	59	75	55	50	57	1.9	1.6	2.4	2.0	2.0
** 80.	Provide babysitting and other child care services for patients.	29	25	35	28	28	3.7	3.4	3.2	3.5	3.5
** 81.	Provide hospitality service for visitors and conduct tours of agency.	43	50	30	40	50	3.5	3.4	3.8	2.9	3.4
139.	Transport pts. when necessary.	42	50	40	43	35	3.3	3.1	3.6	3.4	3.4

*Total sample **Level I Tasks

APPENDIX 5 (CONTINUED)

SUPPORTIVE SERVICES - HIGHER ORDER TASKS (n=1)

Task no. in survey	Task	% Performing task					Mean frequency of performance				
			LEVEL					LEVEL			
		Tot* n=78	I n=12	II n=20	III n=32	IV n=14	Tot* n=78	I n=12	II n=20	III n=32	IV n=14
66.	Observe and assess pts. behavior outside context of treatment.	53	58	50	53	50	2.3	2.3	2.3	1.6	2.1

*Total Sample

APPENDIX 6

COMMUNITY SERVICES - LOWER ORDER TASKS (n=4)

Task no. in survey	Task	% Performing task					Mean frequency of performance				
			LEVEL					LEVEL			
		Tot* n=78	I n=12	II n=20	III n=32	IV n=14	Tot* n=78	I n=12	II n=20	III n=32	IV n=14
84.	Develop social-recreational activities for pts. in clinic or hospital wards.	30	50	20	28	21	2.7	3.0	2.9	3.3	3.0
88.	Locate resources to meet clients' needs for clothing, furniture, etc.	39	50	50	43	14	3.0	3.2	3.2	4.0	3.4
93.	Visit community agencies/groups to inform them of department services.	56	66	65	65	28	2.3	3.6	3.2	3.3	3.1
96.	Disseminate info. re: community resources to individuals/groups in commun.	49	66	55	40	35	2.6	2.9	3.1	3.2	3.0

*Total Sample

APPENDIX 6 (CONTINUED) COMMUNITY SERVICES - HIGHER ORDER TASKS (n=30)

Task no. in survey	Task	% Performing task					Mean frequency of performance				
			LEVEL					LEVEL			
		Tot* n=78	I n=12	II n=20	III n=32	IV n=14	Tot* n=78	I n=12	II n=20	III n=32	IV n=14
82.	Assist individuals/groups in community to recognize conditions contributing to problems of health, mental health or social adjustment.	56	66	60	56	42	3.1	2.9	2.8	2.8	2.9
83.1	Bring such problems to attention of responsible community leaders.	45	58	45	50	28	3.7	3.1	3.1	3.5	3.4
83.2	(Re: above 82) Develop awareness in individuals/groups about such problems.	41	50	40	46	28	2.7	3.5	3.3	3.5	3.3
83.3	Encourage groups/individuals to bring change or improvements in such problems.	41	50	35	50	28	3.0	3.6	2.9	3.5	3.5
83.4	Develop resources and leadership in the community.	29	41	20	34	21	3.6	4.0	3.1	3.7	3.6
85.	Develop/organize community volunteer groups: babysitting, escorting, etc.	24	25	20	21	28	4.0	4.0	4.0	3.5	3.9
86.	Assist individuals/groups in identifying needs or gaps in service.	42	50	40	43	35	3.5	3.1	3.2	3.4	3.3
87.	Help individuals/groups obtain needs through organized community efforts.	47	58	40	53	35	3.3	3.3	3.2	3.4	3.3
89.1	Organize after-school/weekend programs for young children and teenagers.	20	25	20	21	14	4.0	4.0	4.0	4.0	4.0
89.2	Organize programs for older citizens in the community.	22	16	25	31	14	4.0	3.6	3.8	4.0	3.9
89.3	Organize programs for young adults.	23	33	25	21	14	3.5	4.0	4.0	4.0	3.9
89.4	Organize programs for parents.	23	25	25	21	21	3.3	3.4	4.0	3.7	3.6
90.	Organize/work/w/small neighborhood groups to solve indiv./commun. problems.	28	41	20	21	28	3.6	4.0	3.7	3.0	3.6
91.1	Provide educational service for dental health.	21	16	20	21	28	4.0	4.0	4.0	3.3	3.8
91.2	Provide educational service for accident prevention.	23	16	25	21	28	4.0	4.0	3.9	4.0	4.0
91.3	Provide educational service for food buying and preparation.	23	25	25	21	21	3.7	3.8	3.9	4.0	3.9
91.4	Provide educational service for household management.	25	25	30	25	21	3.7	3.7	3.8	4.0	3.8
91.5	Provide educational service for consumer buying and credit.	21	25	20	18	21	4.0	4.0	4.0	4.0	4.0
91.6	Provide educational service for sanitation and housing problems.	24	25	25	18	28	4.0	3.4	4.0	3.3	3.7
91.7	Provide educational service for child care.	24	25	25	25	21	4.0	3.4	3.6	3.0	3.5
91.8	Provide educational service for good grooming and personal health care.	26	33	25	21	28	3.8	3.6	3.7	1.8	3.2
92.	Develop/organize commun. groups for prevention of drug use, venereal disease.	24	20	21	21	21	3.5	4.0	3.9	3.3	3.7

*Total Sample ** Level I Tasks

APPENDIX 6 (CONTINUED) COMMUNITY SERVICES - HIGHER ORDER TASKS (n=30)

Task no. in survey	Task	% Performing task					Mean frequency of performance				
			LEVEL					LEVEL			
		Tot* n=78	I n=12	II n=20	III n=32	IV n=14	Tot* n=78	I n=12	II n=20	III n=32	IV n=14
94.	Assist/organize community self-help projects, e.g., legal aid resources.	28	41	25	31	14	3.8	3.8	3.7	4.0	3.8
95.	Coordinate, develop community resources for solutions of problem employment.	25	41	20	25	14	3.6	4.0	3.6	4.0	3.8
130.	Motivate pts./families to seek health care.	77	75	90	71	71	1.8	1.4	1.7	2.2	1.8
131.	Counsel pt. about seeking preventive care and early treatment.	63	66	70	59	57	3.0	2.2	2.6	2.4	2.6
132.	Counsel indiv. and groups re: primary prevention of sickness and disease.	34	33	25	34	42	3.5	3.6	3.3	3.2	3.4
133.	Evaluate health needs of family under supervision of professional staff.	31	33	35	28	28	3.8	3.1	3.3	3.0	3.3
134.	Determine health need priorities under supervision of a professional.	33	33	30	40	28	2.8	3.3	2.8	2.8	2.9
135.	Counsel family re: available health resources for specific health needs.	62	58	85	62	42	2.6	2.7	2.6	3.0	2.7

*Total Sample **Level I Tasks

APPENDIX 7

COMMUNITY SERVICES - LOWER ORDER TASKS
(MT. SINAI SAMPLE) n=4

Task no. in survey	Task	% Performing task					Mean frequency of performance				
			LEVEL					LEVEL			
		Tot* n=69	I n=7	II n=17	III n=45	IV n=0	Tot* n=69	I n=7	II n=17	III n=45	IV n=0
84	Develop social-recreational activities for pts. in clinic or hospital wards.	11	14	11	8		2.6	1.0	3.5	3.3	
88	Locate resources to meet clients' needs for clothing, furniture, etc.	50	100	29	22		2.7	2.2	2.8	3.2	
93	Visit community agencies/groups to inform them of department services.	48	85	23	37		2.8	2.0	3.0	3.3	
96	Disseminate info. re: community resources to individuals/groups in commun.	41	57	41	26		2.2	1.7	2.3	2.5	

*Total Sample

APPENDIX 7 (CONTINUED)

COMMUNITY SERVICES - HIGHER ORDER TASKS
(MT. SINAI SAMPLE) n=30

Task no. in survey	Task	% Performing task					Mean frequency of performance				
			LEVEL					LEVEL			
		Tot* n=69	I n=7	II n=17	III n=45	IV n=0	Tot* n=69	I n=7	II n=17	III n=45	IV n=0
82.	Assist individuals/groups in community to recognize conditions contributing to problems of health, mental health or social adjustment.	52	85	35	35		2.3	2.2	1.8	2.8	
83.1	Bring such problems to attention of responsible community leaders.	43	71	23	33		2.7	1.8	2.3	3.2	
83.2	Develop awareness in individuals/ groups about such problems.	42	71	23	31		2.2	2.0	2.2	2.4	
83.3	Encourage groups/individuals to bring change or improvements in such problems.	45	85	29	20		2.2	2.0	2.2	2.4	
83.4	Develop resources and leadership in the community.	20	42	11	8		2.6	2.0	3.0	2.8	
85.	Develop/organize community volunteer groups: babysitting, escorting, etc.	12	28	0	6		2.8	2.5	0	3.0	
86.	Assist individuals/groups in identifying needs or gaps in service.	34	57	23	22		2.8	2.0	3.3	2.9	
87.	Help individuals/groups obtain needs through organized community efforts.	47	100	23	17		2.7	2.0	3.0	3.0	
89.1	Organize after-school/weekend program for young children and teenagers.	10	14	11	4		2.4	1.0	2.5	3.5	
89.2	Organize programs for older citizens in the community.	9	14	11	2		2.5	1.0	2.5	4.0	
89.3	Organize programs for young adults.	13	28	5	4		2.7	1.5	3.0	3.5	
89.4	Organize programs for parents.	14	28	11	2		3.2	2.0	3.5	4.0	
90.	Organize/work with small neighborhood groups to solve indiv./commun. problems.	57	57	11	11		2.3	1.8	2.0	3.0	
91.1	Provide educational service for dental health.	17	28	0	4		2.0	1.0	0	3.0	
91.2	Provide educational service for accident prevention.	10	38	0	2		2.0	1.0	0	3.0	
91.3	Provide educational service for food buying and preparation.	7	14	0	6		2.0	1.0	0	3.0	
91.4	Provide educational service for household management.	17	42	0	8		2.3	2.0	0	2.5	
91.5	Provide educational service for consumer buying and credit.	8	14	0	8		2.2	1.0	0	3.3	
91.6	Provide educational service for sanitation and housing problems.	14	28	5	8		2.6	1.5	4.0	2.3	
91.7	Provide educational service for child care.	20	42	5	11		1.5	1.5	1.0	2.0	
91.8	Provide educational service for good grooming and personal health care.	7	14	0	6		2.0	1.0	0	3.0	
92.	Develop/organize community groups for prevention of drug use, venereal disease.	11	28	0	6		2.0	1.0	0	3.0	

*Total Sample

COMMUNITY SERVICES - HIGHER ORDER TASKS

APPENDIX 7 (CONTINUED)

(MT. SINAI SAMPLE) n=30

Task no. in survey	Task	% Performing task					Mean frequency of performance				
			LEVEL					LEVEL			
		Tot* n=69	I n=7	II n=17	III n=45	IV n=0	Tot* n=69	I n=7	II n=17	III n=45	IV n=0
94	Assist/organize community self-help projects, e.g., legal aid resources.	17	42	5	4		2.4	1.7	2.0	3.5	
95	Coordinate develop. commun. resources for solutions of problem employment.	14	28	0	13		2.7	2.5	0	2.8	
130	Motivate patient/families, e.g., giving support, to seek health care.	85	100	82	73		1.6	1.3	1.6	1.8	
131	Counsel patient about seeking preventive care and early treatment of disease.	52	85	29	40		1.6	1.3	1.6	1.8	
132	Counsel indiv. and groups re: primary prevention of sickness and disease.	34	85	5	11		2.3	2.2	2.0	2.6	
133	Evaluate health needs of family under supervision of professional staff.	37	71	29	11		2.4	1.8	2.8	2.4	
134	Determine health need priorities under supervision of a professional.	37	57	23	8		2.5	1.7	2.5	3.3	
135	Counsel family re: available health resources for specific health needs.	65	85	58	51		2.2	1.7	2.4	2.3	

*Total Sample

APPENDIX 8

ADMINISTRATIVE SERVICE - LOWER ORDER TASKS (n=12)

Task no. in survey	Task	% Performing task					Mean frequency of performance				
			LEVEL					LEVEL			
		Tot* n=78	I n=12	II n=20	III n=32	IV n=14	Tot* n=78	I n=12	II n=20	III n=32	IV n=14
99.	Act as liaison between clinic and community organizations re: health, etc.	43	66	30	46	28	3.0	3.3	2.9	3.5	3.2
104.	Note strengths, lags, and gaps in service.	54	66	55	65	28	2.5	2.3	2.0	1.0	2.0
115.	Schedule regular and emergency conferences with workers.	43	41	35	46	50	2.6	2.9	1.6	1.4	2.1
126.	Gather/compile/ethnic/demographic data for use in program development.	29	41	20	28	28	3.4	4.0	3.6	3.3	3.6
127.1	Selected information gathering on pts. to determine planning for service.	48	50	45	46	50	3.2	3.2	3.1	2.7	3.1
127.2	Gathering and compiling lists of community resources.	56	66	70	59	28	2.5	2.6	3.1	3.8	3.0
127.3	Gathering/compiling physician lists--will take pts. on MediCal, etc.	22	16	25	25	21	4.0	3.6	3.8	4.0	3.9
**128.1	Filling out forms.	74	100	75	56	64	1.3	1.7	1.8	1.7	1.6
**128.2	Routine phone calls.	79	100	90	62	64	1.4	1.6	1.4	1.7	1.5
**128.3	Securing patients' charts	68	75	80	53	64	1.7	1.7	1.6	1.6	1.7
129.	Prepare monthly department statistics.	63	41	70	71	71	2.8	2.8	2.9	2.8	2.8
142.	Keep accurate record of contacts with families and services rendered.	72	66	90	75	57	1.5	1.5	1.3	1.3	1.9

*Total Sample ** Level I Tasks

APPENDIX B (CONTINUED)

ADMINISTRATIVE SERVICES - HIGHER ORDER TASKS (n=78)

Task no. in survey	Task	% Performing task					Mean frequency of performance				
			LEVEL					LEVEL			
		Tot* n=78	I n=12	II n=20	III n=32	IV n=14	Tot* n=78	I n=12	II n=20	III n=32	IV n=14
97.	Organize/handle administrative details of educational projects at the clinic.	27	25	20	31	21	4.0	4.0	3.0	3.7	3.6
98.	Interpret work of clinic to community and secure cooperation of community.	38	58	25	40	28	3.0	3.4	3.1	3.5	3.3
100.	Initiate/maintain liaison with executive level of community agencies.	32	33	30	43	21	4.0	3.8	3.1	3.7	3.7
101.	Participate community professional activities for improvement of social services.	44	41	55	59	21	3.6	3.4	2.8	3.7	3.4
102.	Plan, assign, and supervise the work of subordinate workers.	52	58	35	50	64	3.0	2.9	1.4	1.3	2.2
103.	Plan/organize social services to pt. groups in clinic or hospital.	33	33	25	46	28	3.5	3.2	2.7	3.3	3.2
105.	Review social service participation in programs--determine if meeting pt. need.	56	50	70	68	35	3.2	2.4	2.4	2.8	2.7
106.	Consult w/program staff re: methods for improving services where needed.	66	66	75	65	57	3.0	2.7	2.6	2.0	2.6
107.	Define areas needing additional personnel and describe level of personnel.	42	41	35	43	50	3.4	3.3	3.1	1.9	2.9
108.	Outline objectives of facility and relate policy of social service department.	54	58	75	56	28	3.1	2.5	2.9	3.3	3.0
109.	Confer w/personnel to interpret social service func. re: specif. cases.	71	70	100	90	42	2.8	1.7	1.6	2.7	2.2
110.	Provide services to individuals/groups re: decision affecting policy.	58	50	70	75	35	3.0	1.9	1.8	2.8	2.4
111.	Direct admission staff in case screening.	33	41	30	34	28	3.2	2.7	3.3	3.0	3.0
112.	Make decision on difficult borderline cases.	50	58	40	59	42	2.9	2.4	2.7	3.0	2.8
113.	Supervise/consult with social work staff re:casework practice, etc.	50	58	40	65	35	3.1	3.0	1.8	2.8	2.7
114.	Review case records for accuracy, completeness, etc.	49	66	45	43	42	2.8	2.7	2.1	2.5	2.5
116.	Conduct periodic evaluation conferences with workers and write reports.	42	41	30	40	57	3.6	3.2	2.8	2.0	3.6
117.	Participate in planning curriculum, orientation,and training of new staff.	48	66	30	46	50	3.4	3.2	3.2	1.7	2.9
118.	Develop program of staff education and development.	42	50	25	37	57	3.5	3.2	2.2	2.5	3.1
119.	Orient new workers in casework practice in a medical setting.	47	50	50	53	35	3.7	3.5	3.1	3.8	3.5
120.	Recruit, hire, and fire social service personnel.	29	25	30	34	28	3.7	3.7	3.5	4.0	3.7
121.	Evaluate performance and recommend salary increments in written reports.	31	25	30	34	35	4.0	3.5	3.4	3.3	3.6
122.	Participate in intra-hospital committee activities.	53	66	40	50	57	3.0	3.1	2.6	2.8	2.9

*Total Sample **Level I Tasks

APPENDIX 8 (CONTINUED)

ADMINISTRATIVE SERVICES - HIGHER ORDER TASKS (n=28)

Task no. in survey	Task	% Performing task					Mean frequency of performance				
			LEVEL					LEVEL			
		Tot* n=78	I n=12	II n=20	III n=32	IV n=14	Tot* n=78	I n=12	II n=20	III n=32	IV n=14
124.	Attend professional conferences and present papers.	46	41	35	59	50	3.8	3.3	3.2	2.5	3.2
125.	Participate in necessary research and apply data obtained.	36	41	30	37	35	2.8	3.7	3.5	2.8	3.2
143.	Initiate, org. group classes under supervision of the professional.	21	16	20	28	21	3.5	4.0	3.6	3.3	3.6
147.	Participate team conference w/professional staff re: individual families.	64	50	75	68	64	1.5	2.3	1.8	3.1	2.2
123.	Support efforts toward improvement of intra-departmental programming.	60	75	45	56	64	2.8	3.3	2.7	2.5	2.8

*Total Sample

APPENDIX 9

University of California, Los Angeles
Division of Vocational Education
Allied Health Professions Projects

TASK ANALYSIS SURVEY
BACKGROUND INFORMATION SHEET

I.D Number 05 031

Please complete this information sheet now and return it to the survey administrator. The answers to these questions are of importance as we try to evaluate responses from a large number of people across the United States where educational and licensure requirements for specific tasks may be very different.

Remember, this is a confidential document, it is identified by number only, and will not be attached to your name.

1. RESPONDENT:

   1.1 Position Title_____

   1.2 Area of Patient Care or Hospital Services, i.e. Medical-Surgical, Psychiatric, Medical Records, etc. Please specify:

   _____

   1.3 Length of Time in Position_____

   1.4 Age_____

   1.5 Sex (circle one) M F

   1.6 Marital Status (circle oneO

   Married Single Widowed Divorced Separated

2. PREVIOUS EXPERIENCE:

	Type		Years
2.1	_____	2.2	_____
	_____		_____
	_____		_____

3. Highest Grade Completed Before Entering Educational or Training Program: (circle one)

   1 - 8, 9, 10, 11, 12, Some College Baccalaureate

   Post-Baccalaureate

APPENDIX 10

Dictionary of Occupational Titles for

Social Services

Director, Social Service	195.118	Level III
Social Work Assistant	195.208	Level II
Social Worker, Medical	195.108	Level III
Social Worker, Psychiatric	195.108	- Level III

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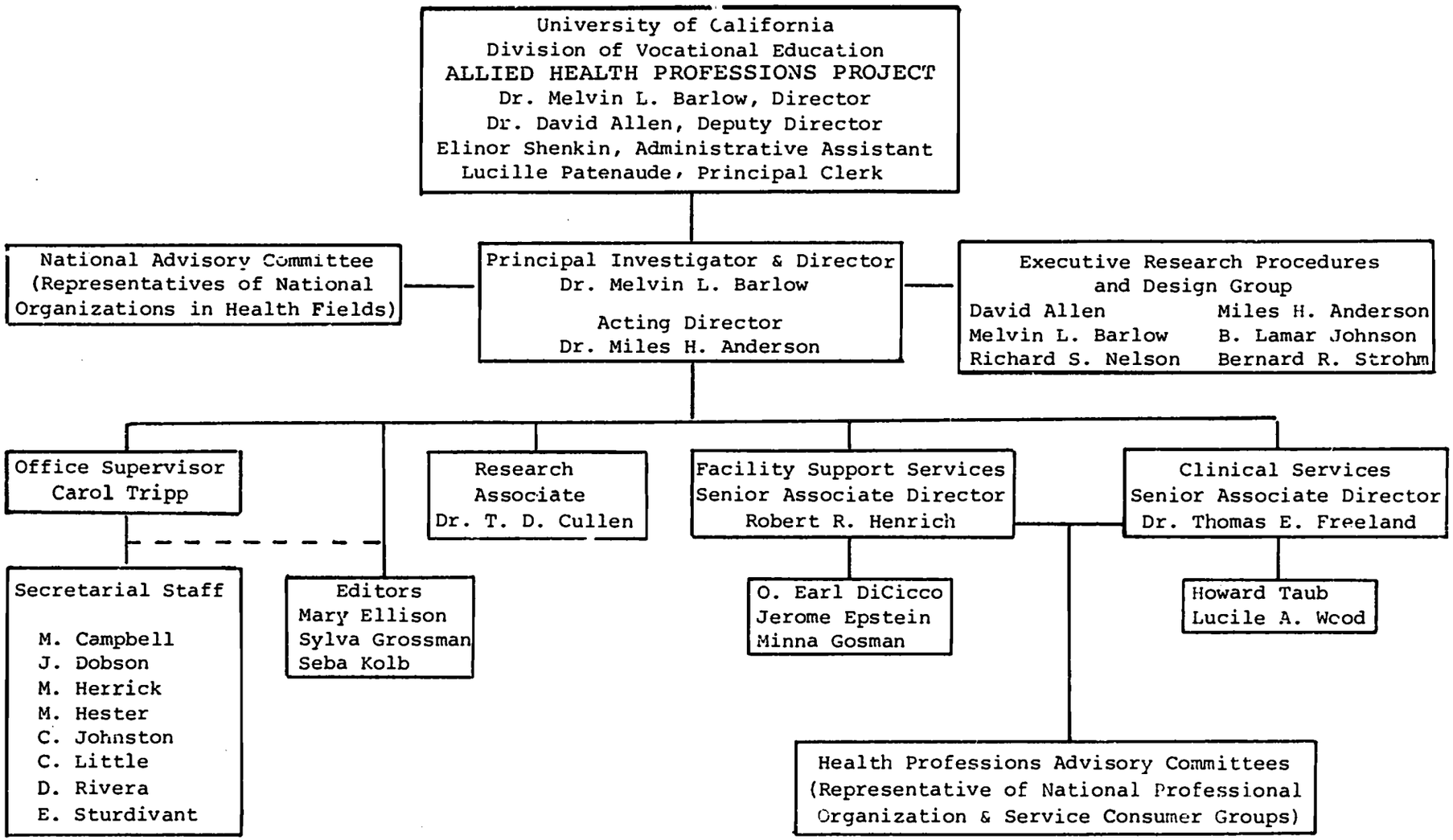
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