Part VII: Toward New Service Concepts

Chapter 16 A New Approach to Decision-Making in Human Management Services

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A NEW APPROACH TO DECISION-MAKING IN HUMAN MANAGEMENT SERVICES

The Problem

For the purposes of this essay, I will use the term "human management" and "human management services" to refer to entry by an individual or agency, acting in a sanctioned capacity, into the life of another person or persons, purportedly in order to benefit either such person(s) or a larger social system surrounding him, such as his family, his community, or society more generally.

Public agencies providing human management services, and to some extent nonpublic agencies rendering such services at public expense, are commonly viewed as representatives, even interpreters, of the social norms and intents of the larger society, particularly as these are expressed by law. Thus, when a person or family approaches an agency, or is referred to it, the agency implicitly or explicitly plays the role of the mediator between society and the prospective client.

Generally, services are provided via a stylized pattern of agency-client interaction. Usually, this interaction involves a specific agency with a specific client or client family. After referral and/or application, the agency processes the client through usually well-developed and relatively routine procedures that are designed to identify whether the client needs any services offered by the agency; whether he meets criteria for eligibility for such services; which services, if any, should be offered or provided; what conditions should surround such services; and whether the client should be referred to other agencies for additional or alternative services. If a client is unhappy with one agency, he generally can go to another and the entire process of assessment and decision-making might be repeated there.

Many societal services, once considered Utopian, are now viewed as rightful. Universal and public education, pension schemes, and certain types of medical care are examples. If several alternative service options exist for a given client, and if all these alternativas can be considered rightful, it is widely accepted that the client has the right to choose which option or even combination of options should be implemented. In its extreme form, this view is exemplied in regard to the residential placement of a presumably retarded child; here, a widely accepted assumption has been that parents have the right to judge whether or not they want to, or are capable of, raising such a child at home.2 Parents are seen as having the right of divesting

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2It should be noted that in our society, a parent generally is not considered entitled to divest himself of a young child unless the parent is an unmarried mother, or unless the child is believed to be retarded (e.g., Dybwad, 1961, 1962).

themselves of such a child not only physically but also emotionally and legally. Thus, court commitments relieving parents or guardianship as well as of custody of the child have been common, accepted, and in many cases even defined as desirable. Once a child was legally committed, the parents were under no obligation to maintain any contact with the child. If they moved out of their state, they apparently could not even be compelled legally to contribute to the child's support, i.e., to pay the fees the state or county usually charges parents for at least partial support of institutionalized children.

The assumption that parents have the rights indicated above are expressed not only in current laws but also in innumerable stereotyped statements in the literature to the effect that "the decision to place is the parents' and not the agency's."

I propose that it is time to reconceptualize certain social policies underlying many human management services. Specifically, I am suggesting that most human management agencies, as we now know them, are not, or at least not any longer, in a position to function effectively as mediators between society and citizens. There are at least three reasons. Firstly, our culture is becoming increasingly complex, and agencies find it impossible or unjustifiably expensive to cope with the complexity of laws, regulations, resources, record and data management, etc. secondly, agencies often fall into the error of, in effect, making social policy decisions that should be made at a higher level of social organization. The setting of certain service priorities and sometimes the failure to set such priorities can both fall into this category. Thirdly, agencies often abdicate responsibility to communicate needs for certain social policy decisions to higher levels of social organization, instead continuing to render human services in a stereotyped fashion long after the original operating rationales are no longer adequate.

In addition to the need of fitting service operation to social policy, there is another problem. Agencies are increasing in number while continuing to function in essentially uncoordinated fashion. The service needs of a client may be broad and continuous, while service provisions may be narrow and fragmented. Specific agencies usually have only a narrow range of services to offer, and therefore they frequently render the service they <u>can</u> offer rather than the one that is needed. They may even offer a long-term and difficult-to-reverse option (e.g., institutionalization) available at a given moment in order to meet a need that is likely to be of short-term duration (e.g., parental illness). Thus, even if rationales were strong, even if social policies were clearly defined and understood, and even if services were amply financed, the client might still not receive adequate or optimal services because of the fragmented nature of our current service structure.

Besides proposing that the agency structure of the past is no longer adequate as an interpreter of societal intent in regard to human management, I also suggest that it is not capable of rendering human services based on a social policy consistent with cost-benefit considerations. Yet such a rationale, I propose, is nothing less than essential if we are to cope effectively with the demand for human management services in the furture.

The Cost-Benefit Rationale

Briefly, a cost-benefit rationale implies that when a problem is to be attacked, those approaches should be employed which, within the limits of certain criteria, are likely to attain the goal at least cost; or which result in the most favorable cost-benefit ratio. Cost can be defined in many terms, e.g., time, space, money, manpower, effort, lives, and others.

Within a cost-benefit- scheme, the distinction between effectiveness and efficiency must be made. An effective approach is one that reaches a goal; however, not all effective approaches are efficient: an efficient approach attains a goal at low cost.

The question may be raised whether human services really should be based on cost-benefit considerations, and there is much sentiment that they should not, Indeed, personnel in our current human management agency structure, having been trained in a clinical tradition, often react emotionally and reflexively against anything resembling a cost-benefit approach. However, two overwhelming realities are emerging that are bringing more and more people to accept cost-benefit rationales.

One such reality is the shortage of human service manpower vis-a-vis the rising and acknowledged need for such services. Professional manpower projections in many large human service areas do not foresee an adequate manpower supply for the service demands of the immediate or intermediate future. In fact, in some areas, a widening gap is predicted. Thus, one cannot escape the question as to who is to be served when not all can be served, and how to distribute what limited service there is and will be.

The second reality alluded to is the growing realization that not even the richest country in the world has unlimited natural and financial resources.- One can already hear questions raised whether millions of dollars spent in one area of human service would not have accomplished what billions spent in other areas failed to do. Also, the public is beginning to be told that it will cost billions in the near future merely to keep our water drinkable and the air breathable, i.e., to maintain our most basic life support systems. An example a bit closer

to our topic was given by Dybwad (1962), who pointed out that the cost of inappropriate institutionalization of mongoloid infants could finance extensive maternal and child health services crucial in the prevention of large numbers of cases of retardation.

While decision-making dilemmas of human management have been with us so long that they should have been faced well before now, they have been sharpened by recent events, such as organ transplants and renal (kidney) dialysis (e.g., Haviland, 1966; Murray, Tu, Albers, Burnell & Scribner, 1962). Let us assume that a heart surgery team could perform one heart transplant for every 50 eligible applicants at any time, Who, then, is to select the surgery client, and by what criteria? And is this not a decision reaching so far into social and ethical areas as to require a social rather than merely medical judgement, and a legally defined rather than merely informally established decision-making mechanism? One step in that direction has been taken in some settings in regard to the allocation of renal dialysis resources, where such allocation decisions are made by groups which include community leaders such as lawyers and clergymen in addition to physicians.

While sentimentality and perhaps ill-rationalized 19th century humanism might have it otherwise, cold reality will increasingly demand that human management decisions of the future, like other national practices, be based upon a cost-benefit policy if our society, perhaps even mankind, is to survive.

A New Policy and a New Mechanism

The New Policy

I am proposing that as a matter of social policy, cost-benefit considerations should be made the basis of human management services; concomitantly, I am suggesting that in order to carry out such a social policy, we will need a new human management mechanism.

In order to develop the new policy, certain rights and duties involved in the interaction between citizen-client and societal services as rendered by publicly supported human management agencies must be clarified. Specifically, I suggest that in regard to publicly funded human services, society should take a more direct role in setting eligibility rules, and in defining what service options it will offer to a client. Clients would retain rights to refuse those options offered by society, but would not be perceived as having the right to utilize all options that society has at its disposal and that may meet the client's service needs. In other words, the new policy would not only establish eligibility; it would offer options on the basis of cost-effectiveness criteria, where cost and effectiveness would be judged

in terms of social, moral, emotional, financial, and other interests of child, family, community, and society.

An example from the mental retardation field will illustrate the principle. A problem-ridden family with a severely retarded child may come to a societal representative (e.g., an agency) for service. The only options that are relevant and that exist at that point in time and space may be institutionalization, visiting homemaker services, day-care services, and income subsidy. Let us assume that a cost-benefit policy were in operation, and that the parents requested institutionalization of the child. The societal representative might then establish that the family, being under extraordinary stress, is eligible for services, but that services other than institutionalization can provide adequate relief and will be more consistent with the interests and service needs of all involved. Thus, visiting homemaker services and day-care services are offered. At this point, the parents could elect to reject these two offers, but in that case they would be denied the right to place their child into an institution at public expense, while retaining the privilege of pursuing services at their own expense.

In the past, the family in the foregoing case typically would have been handled one option at a time. It could conceivably apply to one or more of a number of uncoordinated agencies offering only one or a few options each, and be processed without true regard to the option optimal to anyone; the option maximizing the benefits of child, family, and society simultaneously; or the option that would accomplish the latter at least "cost." Instead, the family had to be merely "eligible" to be served or placed on the waiting list for service, and in the latter case, they might have been served whan their turn came up, regardless of the constellation of circumstances that differentiate one case from another.

In order to implement the new policy, there must be extensive revision in the basic mechanisms by which human service decisions currently are made, and by which such services are rendered. Most essentially, agencies must surrender decision-making functions as to both client eligibility and option offering to a higher level body, thus permitting societal intent to be expressed more directly in the service process. One mechanism proposed here that would accomplish this is a supra-agency regional human management decision-making center.

The New Mechanism: A Decision Center Model

To facilitate the discussion, I will speak in terms of state-level action, although the concepts advanced here could be applied at higher and lower levels of geopolitical organization.

A state law would establish the legal framework by which expenditure of public funds through human service agencies would be regulated. Among other things, this law would establish a workable coordinating mechanism for such agency services, and would vest regulating powers in an existing or new state-level department or office, or in a special commission appointed by the governor for that purpose.

The coordinating mechanism would consist of a new type of agency interposed between society on the one hand, and the more traditional agency structure on the other. It would ascertain that human management options are administered in a fashion more consistent with a cost-benefit rationale, I will, for the purposes of this paper, call this agency a human management decision center.

The coordinating mechanism would apply to all agencies funded fully or in part by the state and to all clients served by such agencies, as well as to clients served at public expense by agencies not funded by the state. In other words, generally no state funds would be expended for human management purposes not subsumed under the scope of the coordinating mechanism. It is quite conceivable that many agencies not supported by state funds, and some service systems such as the Red Feather conglomerates, may voluntarily place themselves within the coordinating mechanism.

It is obvious that in larger geopolitical systems such as states, the coordinating mechanism will have to be established in the form of a number of decision centers, perhaps with one central administration. These centers may have to be established on a regional basis, and/or on the basis of broad service areas classified essentially by human conditions such as mental retardation, mental "illness," physical and sensory disorders. While socio-historical antecedants may require such a classification at first, a preferrable system that may become more feasible in the extended future would merge the functions of "special condition " centers into primarily geographic centers dispersed so as to be conveniently accessible to the population.

The function of a decision center would be threefold:

1. It would serve as a depository and clearing house regarding service agencies and operations within its problem and/or geographic area. Agencies would apprise each other, the center, and the public of their plans and operations.

2. It would become the screening point for clients for all service agencies within its scope. In other words, clients would no longer apply to an agency for a specific service, but they would go, or be referred to, the appropriate center to state their problem.

Center personnel (to be discussed later) would conduct diagnostic and evaluative procedures, but only to the extent necessary to determine eligibilities and to provide a basis for the next, crucial step: option offering.

3. The key to the entire mechanism lies in the option offering concept. The center, having conducted its evaluation, will select from the eligible options those that are believed to have optimal cost: benefit ratios. Here it should be recalled that a decision center would have at its disposal all options offered by all the agencies within its scope; thus, the center would have more options available, and a better opportunity to optimize management, than any traditional agency functioning in the tradition way.

In most cases, it should be possible to offer clients more than one option believed to carry desirable cost:benefit ratios. Thus, a client could choose the one option most congenial to him; however, from none of the agencies within the scope of a center, or of parallel centers in a region, would the client be able to obtain options not offered to him by a center.

Once he has chosen his options, the client is referred to the agency or agencies that will implement them. By keeping an up-to-date (automated) record system, the center will avoid errors in offering options already pre-empted, or in assigning clients to agencies whose service load is full. One of the many advantages of the center system is that with crowded service loads, options that are less than optimal but immediately available can be identified and offered, at least on a short-term basis, thus saving the client agency shopping, endless waiting lists, etc. In a geopolitical area where options are few and service supply short, centers are in a much better condition to allocate services on a cost-benefit basis than on some other inefficient basis, such as one heavily influenced by mere time, as under the sequential waiting list system in which priority on the waiting list rather than priority of need determines service allocations.

The new scheme would also permit the constructive employment of a number of variations. For example, of a number of effective service options, a client would ordinarily be offered only those that are judged to have favorable cost:benefit ratios. However, the client may prefer an option which, though judged effective, had also been judged inefficient. In such a case, it may be justifiable to give the client his option if he is willing to pay its full cost (or cost differential) out of private means.

An important point in conceptualizing the new policy and mechanism is that clients would no longer be perceived as applicants for a specific service, but as individuals who state a problem. True, clients may see themselves as applicants for a specific service, but this would change as the rationale for the new scheme becomes better understood.

Specifically in human problem areas where parents are perceived, in affect, as possessing the right to "give their child away," a cost-benefit management policy with a practical implementing mechanism would be likely to open options rarely utilized today. For example, parents with a child that is severely impaired mentally would no longer be perceived as coming to a center with a specific service request such as institutionalization, although the parents may verbalize such a request. Instead, such parents would be perceived as having a problem requiring relief, and it may be found that a number of options may be equally effective, appropriate, and eventually acceptable to the family.

Even where a family situation is such that no service options are considered adequate for retaining a (problem) child in the family, such a situation need no longer be considered as implying institutionalization; it may only imply removal of the child from the home, for adoption or foster placement.3 As the literature has amply documented, many institutionalizations are totally unjustified., A Cost-benefit scheme would prevent most such child removals; where such removal takes place, the new scheme would facilitate possibilities other than institutional placements in many instances.

The system, of course, requires that agencies relinquish certain of their traditional prerogatives, primarily those associated with intake practices. Because of the agency-centeredness and inertia of most social agencies, this must be accomplished by law, at least in regard to publicly supported operations. Such law would also transfer to the coordinating mechanism many decision-making practices now held by couts and tribunallike bodies, e.g., those bodies that currently make institutionalization decisions in many states regarding the mentally retarded or mentally "ill." However, preserving much of the current agency structure within the new system would have the advantage of making the transition from a clinical to a cost-benefit base more feasible, while preserving the strength of the clinical method in the individual encounter between professional and client <u>after</u> option decisions have been made.

The single regulating body for a state, mentioned earlier, would develop and periodically review guidelines which would underlie the evaluation and service option offering process of all the human management coordinating centers in a state. Such guidelines would standardize the human management process to a good degree, and remove many inequities,

A more extensive discussion of rationales for removal and institutionalization of a retarded family member is presented elsewhere (Wolf-ens berger, 1967).

Decision Centers and Traditional Assessment Functions

The argument may be advanced that a decision center is merely a version of the traditional multidiciplinary assessment center or clinic where the nature of a client's problems are determined ("diagnosed") and where appropriate referrals to services, mostly to be rendered by other agencies, are made. However, there are some crucial differences between the two models:

1. Decision centers, unlike traditional assessment clinics, would make binding decisions as to which agency may or may not accept a client for service at public expense. This implies a degree of administrative control not possessed by the traditional assessment services.

2. Decision centers would not necessarily engage in the exten sive, even exhaustive, assessment process that has been traditional in diagnostically oriented clinics. One reason for such extensive studies has been the location of many assessment centers in universities where extensiveness of study was believed to serve in the teaching and train ing of professionals. A center would carry assessment only far enough to be able to reach a decision as to which service options -to offer. Indeed, it is conceivable that after preliminary review, a client may be referred for a traditional and exhaustive assessment study to an agency such as a clinic, and further case processing may even be made contingent upon such a study. A critical point here is that under the new policy, the agency to which the client is referred for the tradi tional assessment would not make any further decisions or referrals at the end of its study, but would return its findings and suggestions to the center for evaluation and utilization.

3. Decision center staff would not be involved in any services other than evaluation and option offering. Thus, they would not have affiliation with, or responsibilities for or to, any specific service or service agency. In a sense, they would exercise a judicial-like function. In contrast, most traditional agencies not only conduct eligibility and other evaluations but also offer services themselves. By being divorced from the service process, a decision center should find it easier to maintain perspective on larger issues and to make option decisions consistent with broad social policy and on the basis of cost-benefit criteria, as most traditional agencies did not, could not, and would not do.

Decision Center Staffing

The staff of a decision center, aside from clerical and supportive personnel, would have the following characteristics:

1. If the center coordinates a specialty area (e.g., mental retardation), most staff members will have to have special experience in this area.

2. The staff will have (or, because of lack of such training at present, must acquire) skills in evolving option decisions based on cost-benefit considerations discussed above. Universities would have to introduce appropriate training in these concepts and skills into their programs.

3. So far, we are speaking of specialty skills practiced by otherwise traditional staff. However, a center, in order to mediate societal values, should also utilize personnel from atraditional sources and in atraditional ways. I am suggesting the inclusion of attorneys and intelligent laymen on center staffs. Indeed, I would urge the in clusion of representatives of the typical consumer of services in a particular specialty area. For example, in a mental retardation center, I would suggest the inclusion of a parent of a retarded child as a staff member.

Unusual Opportunities and Options Under the New Policy

It is possible that the new policy and mechanism proposed could facilitate certain opportunities seldom exercised at present, and that the advantages of these would be so massive as to alone justify the new scheme. The opportunities are the prospects to develop family subsidy and foster care as major options, and of basing service operations on an empirical foundation.

Family Subsidy

At present, clients with problems are often rendered services of low efficacy and/or efficiency, merely because such services may be the only ones available. Effective and efficient alternatives may be

denied because they may be unorthodox or inadequately sanctioned. Family subsidy appears to be such an unorthodox and inadequately sanctioned alternative to many service options. For example, at present, a family may apply for, and be granted, institutionalization for their retarded child. The average yearly cost of exercising this option in the United States in 1966 was $2,610 (United States Department of Health, Education, and Welfare, 1967), most of it in public funds. With increasing institutional cost, and increasing life spans, it is variously estimated that an admission today may cost the public $100,000-$350,000 over the lifetime of the child. However, what the family may really have needed was temporary emotional, physical, or financial relief; and institutionalization may only have been requested, and granted, because of lack of alternative options. Adequate relief could have been obtained if the mother could have bought herself a washer, a dryer, and a dishwasher; if she could have hired a baby sitter or homemaker for a half-day a week; or if she could have gone on vacation once a year. Any of these could have been accomplished for perhaps $500 a year, i.e., a fifth of the first-year cost of institutionalization.

At present, financial family subsidies of the type just described, and outside of ordinary "welfare" channels, are virtually nonexistant. One likely reason they are nonexistant is that such schemes appear to have been ideologically unacceptable to the public. In other words, a highly cost-beneficient and quite ethical option has been unavailable because it has been inconsistent with socio-political ideology; and one probable reason why this option has been socio-politically unacceptable is lack of a clearly defined social policy resting on cost-effectiveness concepts and supported by a workable mechanism.

Foster Services

Foster care, especially of handicapped children, has been dogmatically held to be unfeasible. However, experience in California, England (see. Norris in this volume), and elsewhere indicates that the dogma may have been one of the agency myths that permeate the human management field. We are now beginning to find that foster care of large numbers of handicapped children may be feasible, particularly if backed realistically by more money and fewer preconceived and stereotyped demands for love. It is indeed ironic that many children have ended up in the high-cost and low-love setting of an institution because the medium-love of relatively low-cost foster parents was judged as being insufficient by an agency.

Under the cost-benefit scheme, children appropriately (or even inappropriately) removed from their families could be fostered, and the foster program could be supported financially to the degree necessary to make this option available, effective, and yet also efficient.

An Empirical Base for Services

Another advantage of a cost-benefit policy would be that research, especially evaluative research, would by necessity become an integral part of service operations. To date, research has been considered a luxury or a nuisance rather than a necessity in human management practice. Services have rarely been built upon a research base, and they are rarely evaluated empirically. Some human management practices that have been employed for decades and that have cost hundreds of millions of dollars, and untold other resources, lack either empirical validation or comparative cost accounting, or both. Indeed, in some cases the evidence is stacked against practices which are very expensive and widely followed. It is ironic that a low-cost drug with relatively minor effects and a small market may undergo more evaluative research in a year or two than is conducted on major social action programs in a decade. Obviously, acceptance of a cost-benefit policy would call for a way of thinking consistent with the full integration of service and research, and the coordinating mechanism would make it possible to conduct research more efficiently and on a larger scale than heretofore.

The Challenge of the Unusual Opportunities and Options

I propose that the family subsidy option may constitute a cornerstone to any human management policy built on cost-benefit concepts, and that an aggressive foster program could become a major rather than minor option in mental retardation specifically. Virtually all human services need better cost-accounting and validation such as can be provided by research. Therefore, a mechanism which will make the meeting of these challenges more feasible, acceptable, and workable should be pursued with vigor, and we should be prepared to sacrifice some of our convenient traditionalisms in order to obtain such a system.

A Review Process

A cost-benefit policy is likely to result in great improvements in service continuity and efficiency. However, it does reduce client control over services, at least in localities where a range of services would be available. Thus, *an* error by a center in regard to problem assessment and option offering could have more deleterious consequences than it would in a system that makes "agency shopping" by a client easy. For this reason, it appears desirable to structure a review mechanism to which citizens can take recourse if they feel that a center has committed wrongs or errors in option offering.

To minimize expensive and time-consuming court involvements, a review and appeal board could be established, Possibilities are to have a single board for a state; a board for each geopolitical service

area; or a board for each group of specialty (e.g., mental retardation) centers within a geopolitical service area or state. Such boards could function as advisory bodies to the state agency that regulates the center system; however, the specifics of board structure and function are less important at this point than the basic concept of a fair review process, short of (but not exclusive of) court action, available to a citizen.

Conclusion

So far, I have mentioned residential services and retardation only tangentially and as examples of broader issues. The reason for this should now be obvious: within a cost-benefit system of human services, consideration of residential service problems can only take place in the context of considering the continuum of service options; and problems related to mental retardation can only be considered in relation to other human problems generally.

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