ARTICLES

Community-Centered Clinical Practice: Is the Integration of Micro and Macro Social Work Practice Possible?

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ABSTRACT. There has been a longstanding tension between the domains of micro and macro practice in social work practice and academic programs. A set of structural and interpersonal tensions can be identified as interfering with accurate perceptions of the underlying continuity of social work practice that is reflected in the mission of the profession. This analysis addresses this tension by defining the elements needed for the integration of micro and macro practice in the form of community-centered clinical practice. A set of cross-over skills are identified along with recommendations for improved agency operations and pro-

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fessional education related to the integration of micro and macro social work practice. [Article copies available for a fee from The Haworth Document Delivery Service: 1-800-HAWORTH. E-mail address: <docdelivery@haworthpress.com> Website: <http://www.HaworthPress.com> © 2005 by The Haworth Press, Inc. All rights reserved.]

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INTRODUCTION

In her book, What Is Social Casework?, Mary Richmond (1922) advanced the ideal of a form of social work practice that included multiple levels of intervention that are currently termed ‘micro, mezzo, and macro social work,’ today known as “generalist social work practice” (Miley, O’Melia, & DuBoise, 2001; Derezotes, 2000; Kirst-Ashman & Hull, 1999). Based upon Richmond’s description of an emerging continuum of social work practice, one might assume a harmonious and integrated form of social work practice. It will be argued in this analysis that “tension” seems like a more apt description than integration.

This tension has been a long-standing problem within the social profession and has been addressed previously in the literature (Lagay, 1982; Gilbert & Specht, 1974; Schwartz, 1969). The tension has been referred to by the use of other terms such as the clinical and community cultures of social work practice (Lagay, 1982), the duality of social cause and social function, treatment and social action, direct service and indirect service (management), or the polarity of the direct service practitioner and the social welfare specialist (Gilbert & Specht, 1974). In this analysis, the focus is on the inherent tension between clinical practice and community practice in addressing human problems. In an effort to bridge the specializations of clinical and community practice, this analysis focuses renewed attention on the negative impact of the tensions between clinical and community practice on the social work profession.

The tension between the clinical and community domains of social work practice dates from the debates of the 1920’s between the social control function (empowering clients) and the social reform cause (changing the system). To this day, the tension can be found in the misunderstanding and unproductive disconnection between these two major domains of social work practice. The tension in the field can be
difficult to recognize as it runs counter to the commitment of the social work profession to ‘person-in-environment’ and ‘eco-systems’ perspectives for understanding what impedes human functioning at the individual, family, community, agency, and policy levels. At the same time, this ecological perspective can inform collaborative interaction between micro and macro social work practice but requires renewed dialogue across the domains of practice if the tension is to be addressed. The terms “micro” and “macro” practice are used throughout this analysis as synonymous with clinical and community practice respectively. The “mezzo” form of practice is combined in this analysis with micro. Similarly, the “macro” form of practice usually encompasses community, management, and policy practice. However, in this analysis, the focus is primarily on community practice in order to elaborate on the core theme of community-centered clinical practice. This approach does not analyze the definitional debates in the field regarding the centrality of micro, mezzo, and macro perspectives in generalist practice (Bakalinsky, 1982) or the changing terminology regarding family-centered or neighborhood-based practice (Johnson, 1998).

In contrast, this analysis explores the following questions: (1) how are clinical and community practice defined in the literature?, (2) how can the tensions between these domains of practice be described?, (3) what are the implications of these tensions for agency practice and academic curricula?, (4) how does the historical literature inform an understanding of these tensions?, and (5) how might these tensions be addressed in the future? The goal of this analysis is to define community-centered clinical practice and begin the process of identifying a roadmap for integrating the strengths of clinical practice with those of community practice.

**DEFINING COMMUNITY-CENTERED CLINICAL PRACTICE**

**Clinical Practice**

As Swenson (1995) so aptly notes, the struggle over the term ‘clinical social work’ reflects the enduring tension within social work between its social change and its individual-family change dimensions (p. 510). For purposes of this analysis ‘clinical social work’ is defined as direct practice with individuals, families, and small groups addressing social problems at the intra-psychic, interpersonal levels within an environmental context. The term “clinical” is seen by some as no longer relevant in the
context of either generalist or specialist practice. However, for this analy-
sis the term is used to capture the traditional worker-client relationship fo-
cused on some form of intervention. It is also a term used extensively
throughout the country by state licensure boards to describe certification
and licensure. Similarly, other professions make active use of the term
“clinical” as in clinical nursing, clinical psychology, and clinical supervi-
sion in education. It is recognized that the term has little or no use in such
specializations as child welfare, adult and aging services, welfare-to-
work services where case management has more prominence. The limita-
tions of the term can be seen in specialized services like prevention and
in-home support that imply the goal of precluding the need for clinical in-
terventions. Similarly, the term “clinical” in today’s managed care envi-
ronment tends to reflect a very narrow view of service, namely reim-
bursing clinicians primarily for their time in face-to-face contact with cli-
ents and very little else. Nevertheless, the “clinical” perspective is used in
this analysis to capture the array of activity related to working with indi-
viduals, families, and treatment/therapeutic groups.

As Gibelman and Schervish (1993) point out, clinical social workers
make up the largest proportion of social workers with approximately
70% of the masters and 40% of the doctoral level members of NASW.
Obviously these statistics do not include the thousands of social work-
ers in public and non-profit agencies who do not belong to NASW as
well as the many BSWs who may also not belong. For the purpose of
this analysis, the most comprehensive definition of clinical social work
by NASW (Minihan, 1987) is used as a way to frame this discussion:

Clinical social work shares with all social work practice the goal of
ehancement and maintenance of psychosocial functioning of indi-
viduals, families, and small groups. Clinical social work practice
is the professional application of social work theory and methods
to the treatment and prevention of psychosocial dysfunction, dis-
ability, or impairment, including emotional and mental disorders.
It is based on knowledge of one or more theories of human devel-
opment within a psychosocial context.

The perspective of person-in-situation is central to clinical social work
practice. Clinical social work includes interventions directed to interper-
sonal interactions, intra-psychic dynamics, and life-support and manage-
ment issues. Clinical social work services consist of assessment,
diagnosis and treatment, including psychotherapy and counseling, cli-
ent-centered advocacy, consultation, and evaluation. (pp. 965-966)
COMMUNITY PRACTICE

Community social work practice refers to the planning and organizing of neighborhood and community change based on addressing social problems within the social environment. Again, the terminology of community practice has been given a broader perspective known as macro practice that includes working with communities, organizations, and policy-making bodies. Macro practice can include the knowledge and skills related to community organizing, agency/program management, and policy practice. The term “macro practice” appears to have more saliency among macro practitioners than it does in the social work profession as a whole. Therefore, this analysis includes community practice as the more all-encompassing term that is better understood throughout the profession. The major purpose of this analysis is to integrate clinical and community practice into an approach called “community-centered clinical practice.”

The terminology of community practice that is used in this analysis draws upon the extensive work of Weil (2005) who provides a comprehensive definition of this form of practice and notes its importance in the provision of services to individuals, families, and groups. She notes (Weil, 2005, p. 9) that community practice encompasses four central processes: (1) development (e.g., enabling and empowering people to work in united ways to change their lives and environment), (2) organizing (e.g., organizing communities of interest), (3) planning (e.g., designing, coordinating, and changing programs and services that are appropriate for different communities), and (4) action for progressive change (e.g., developing and sustaining groups and coalitions engaged in social, economic, and political action). She also notes (Weil, 2005, p. 20) that the social work practice community increasingly recognizes the need for community-based practice. For example, innovative practices related to serving children and families (Annie E. Casey Foundation, 2004), serving the elderly through long-term care systems, serving the mentally ill and homeless through systems of care or a continuum of care are using community-based service models.

Community-Centered Clinical Practice

Building on the definitions of practice that have emerged over time, community-centered clinical practice is defined as a multi-focused practice method that seeks to strengthen neighborhoods and community institutions while also addressing the personal and interpersonal issues
facing members of the community. The definition builds, in part, upon Smale’s (1995) four-part description of community and family-centered practice; namely, direct intervention (inter-disciplinary case conferencing), indirect intervention (involvement on an inter-agency task force), service delivery assessment (participating in client population research), and change agent activities (educate, negotiate, mediate, scan environment, and empower others to advocate in a culturally sensitive manner).

The definition of community-centered clinical practice presents many challenges. First, there is the tendency in the literature to avoid addressing the significant tensions that underlie micro and macro divisions and how this dynamic impedes efforts to bring about a more positive connection between these two bodies of knowledge and practice. Second, part of the problem is that the practice literature continues to reflect a separate articulation of micro, mezzo, and macro practice skills (not fully integrated) as basic to the acquiring of a generalist foundation of social work practice (Adams & Krauth, 1995; Kirst-Ashman & Hull, 1999; Hardcastle, Wenocur, & Powers, 1997). As Smale (1995) has observed, “Even when there is an intellectual acknowledgement of ‘community’ or structural dimensions to people’s problems, many agencies and their workers continue to intervene exclusively at an individual (client) level” (p. 75). Third, there is little available research on the array of community-based activities carried out by clinical social workers (Webster-Stratton, 1997; McDonald, Billingham, & Conrad, 1997; Feikema, Segalavich, & Jeffries, 1997). Fourth, the literature on community-centered practice features more description of community-centered services (Schorr, 1997) than any consensus on the definition of community-centered practice.

Given these challenges, some concrete evidence from the practice community should help frame the issues surrounding the need for community-centered clinical practice.

SOCIAL WORK AND COMMUNITY-CENTERED PRACTICE

In 2000, the national Alliance for Children and Families issued a report entitled Aligning Education and Practice: Challenges and Opportunities in Social Work Education for Community-Centered Practice (Ryan, DeMasi, Heinz, Jacobson, & Ohmer, 2000). In essence, it is a position paper on the need for more ‘community-centered practice’ to be taught to future social work practitioners in order to help them ad-
dress the multi-faceted problems faced by clients and to engage the resources needed to build upon client strengths.

The Report raises concerns about the movement of social work practice away from community-centered interventions and notes that “. . . community-centered social work is at the core of the profession’s mission but at the margins of social work practice” (Ryan et al., 2000, p. 5). The Report also raises questions about how to increase the number of social workers, especially clinicians, who can demonstrate the skills and capabilities needed to carry out community-centered work. While these concerns are noteworthy and deserve major attention, there are a number of serious problems with the assumptions underlying the Report that inadvertently feed the tensions between micro and macro practice. The problems can be seen in the tone and language used throughout the Report as noted in the following statements:

• “They (clinicians) say they think about families, and systems, and communities, but really their eyes glaze over when you talk about community-centered work.” (Ryan et al., 2000, p. 6)
• “Social work is a profession that thrives on ‘treating, even contriving, personal pathologies’ instead of helping communities mobilize their own assets to create natural and informal helping networks.” (Ryan et al., 2000, p. 8)
• “They (clinicians) lack group empowerment skills, building capacity, leading processes, and the desire to work in the neighborhood . . . but the emphasis in (graduate social work) schools appears to have been in building clinical skills for an office setting.” (Ryan et al., 2000, p. 7)
• “The new (social work) profession is more about changing individuals and less about changing both individuals and communities.” (Ryan et al., 2000, p. 8)

The Report appears to reflect a divisive tone that can perpetuate the tensions that underlie the lack of effective collaboration between micro and macro practitioners. It can lead to continued misunderstandings and create barriers to genuine collaboration and respect that could advance community-centered practice. While it is understood that taking language out of the context in which it is used can contribute to stereotypic thinking, the following examples of the consequences that can emerge from the tensions between micro and macro practices that are reflected in the Report:
Interpersonal Tensions

- **Minimizing the other**: Defined as a tendency to under-estimate and even demean the importance of the work of the other domain. An example would be an agency administrator who takes the stance that clients’ problems would be better addressed if the clinicians would get out of their offices and do more community work . . . or a clinician who devalues or under-estimates the importance of community-centered changes and maintains that one-on-one interventions are more important.

- **Feeling the ‘other’ doesn’t see the ‘real problem’**: Defined as the tendency for micro and macro practitioners to focus more strongly on the importance of their domain, such as intra-psychic and interpersonal aspects vs. community and environmental aspects. This can obscure a focus on the actual connections between the person and their environment.

- **Mistrust**: Defined as the experience of feeling defensive and/or adversarial, seemingly a natural result of a lack of communication, a shared misunderstanding, and a lack of appreciation of each other’s knowledge and skills.

Structural Tensions

- **Not sharing a common language**: Micro and macro practice draw upon different theories to inform practice, key practice concepts use different words and emphases that create the feeling of disconnection between the two domains.

- **Communication gap**: Defined as the tendency for clinical practitioners and community practitioners to stay separate, to avoid dialogue and collaboration, based upon perceived difference in goals, methods, and underlying tensions.

- **Lack of knowledge about and appreciation for the skills, abilities and contributions of the other**: Defined as the cumulative result of the tendency for the micro and macro domains to operate as dichotomous and separate segments of the profession whereby both domains fail to acquire a more accurate understanding of the skills, knowledge, and methods that could enhance practice with clients in their communities.

- **Gender and power issues**: Micro social workers tend to be women, and macro social workers tend to be men. These differences can
impact salary, status and power issues, which can interfere with mutual collaboration, especially if not addressed.

While these interpersonal and structural tensions between micro and macro practice are common in social work practice, they are rarely addressed (like unstated taboo topics underlying familial conflict). Using a systems theory framework, these tensions create boundaries that can become rigid rather than flexible, leading to cognitive distortions or errors (e.g., polarized thinking, faulty assumptions, over-generalizing, etc.). Rather than integrating micro and macro practice, these tensions can lead to disengagement and misattributions and thereby produce the negative illustrations found in the Alliance Report. The negative illustrations can exacerbate the tensions and prevent the development of integrative connections between the micro and macro levels of social work practice. The implications of ignoring these tensions and the need for community-centered clinical practice can be viewed from two inter-related perspectives; namely, social service agencies and academic institutions with undergraduate and graduate social work programs.

**Agency Perspectives**

Social work practice continues to change and evolve in the responses to welfare reform, managed care, service integration, and neighborhood-based family-focused service delivery. However, it is not always clear that agency management understands what it will take to transform agency processes to enable and support the efforts of clinical staff to incorporate a community practice component into their daily work life. Some of the workplace changes and associated managerial skills require administrative leadership that: (1) legitimizes community outreach activities, (2) modifies agency information systems to document both client contacts and community contacts with respect to assessing service outcomes and job performance, (3) develops creative responses to staff concerns about expanded workloads and adequate training, (4) recognizes and rewards community-centered clinical practice, (5) creates a learning organization that supports community-centered practice with training and mentoring opportunities, and (6) develops new forms of accountability and managerial support to fully engage clinical staff in community-centered practice.

Since community-centered clinical practice is often situation specific (i.e., not all worker-client situations call for community-centered clinical practice), further work is needed to identify the factors in the assessment process that trigger decision-making related to community-
centered clinical practice. How do we help practitioners hold onto two competing ideas at the same time; namely, individual and community assessment? Agency staff need a regular forum, like a case conference, for assessing whether a given case is best served by solely micro practice, a combination of micro and macro interventions (which we are calling community-centered clinical practice) or by a macro orientation alone where the individual problem is best served through community and/or policy interventions.

While the micro-macro continuum exists in most agency settings, finding a forum for on-going dialogue to identify creative ways to address the tensions seems essential for community-centered clinical practice to thrive. How do we help staff at all levels of an agency deal with the emotionality of the tensions; namely, the anxiety of macro practitioners over their concern that micro practitioners will perceive all client problems as needing clinical treatment in contrast to the anxiety of micro practitioners over the lack of affirmation from macro practitioners regarding the importance of treating one person whose life impacts many others?

Even though the economics of service delivery in this era of managed care can have a profound impact on the nature of practice, it is important to find incentives to support the environmental interventions that are central to community-centered clinical practice. How can agencies find the commitment to secure the resources needed to supplement the “fee-for-service case counting” demands of third-party payers with support for the community-centered dimensions of clinical practice? If client problems have multiple sources, how do we fund multiple collaborations to help clients become self-sufficient and empowered?

**Academic Perspectives**

There are multiple implications of community-centered clinical practice for the academic community and they can be framed as questions. For example, to what extent do the generalist practice foundation courses taught in many undergraduate and graduate programs (as reflected in the textbooks and articles on the educational continuum) pay attention to the tensions between micro and macro practice? Content analysis of a representative set of course outlines and frequently used textbooks would be needed to answer this question. If the answer is “very little,” then it may be necessary to rethink the social work curriculum in order to fully integrate the micro and macro practice perspectives inherent in community-centered clinical practice. For example, the cur-
curriculum content on Human Behavior and the Social Environment (HB&SE) has implications for community-centered clinical practice whereby the social environment of the client (community) and the social environment of the worker (organization) are taught as essential elements of community-centered clinical practice. In addition, in order to teach this form of practice there is a need for case studies of “promising practices” reflecting the work of skillful community-centered clinicians as well as supportive/enabling agency administrators. Similarly, there is a need for more rigorous assessment of the impact and outcomes of community-centered clinical practice.

Since the inception of social work as a profession, the segregation of social work practice methods into micro and macro practice activities has had a profound impact on the development of integrated practice methods. In essence, there are competing mental models for micro and macro practice when moving beyond the rhetoric of the tensions noted in the Alliance Report (Ryan et al., 2000). A major source of the tensions can be found in the social work literature and the curricular structures. For example, tensions can emerge in the human behavior and the social environment courses when they focus more on human behavior than the social environment (Taylor, Austin, & Mulroy, 2005). Similarly, the curricular offering of micro and macro practice courses suggests that two different people or agency employees need to become proficient in these separate domains of practice when they are required in one specialization but not another.

As we search the social work practice literature, it is difficult to find many examples of how these curricular issues have been effectively addressed.

**BUILDING ON PREVIOUS LITERATURE**

The integration of micro and macro practice has been discussed in the literature for the past several decades under the following categories: community-based practice (Johnson, 1998); generalist practice (Parsons, Hernandez, & Jorgensen, 1988; Landon, 1995; Vecchiolla, Roy, Lesser, Wronka, Walsh-Burke, Gianesin et al., 2001); empowerment-based practice (Dodd, 1990; Gutiérrez, DeLois, & GlenMaye, 1995; Lee, 1994); policy practice (Rocha & Johnson, 1997); family-centered practice (Sviridoff & Ryan, 1997; Adams & Nelson, 1995); strength-based practice (Saleebey, 1996); person-environment practice (Kemp, Whitaker, & Tracy, 1997); and the ecological life course model
While each approach seeks to encourage the integration of social work methods that address the person, their environment, and the interaction between person and environment, it is important to identify the strengths and limitations of these approaches as reflected in textbooks and articles as well as historical analysis (Leighninger, 1980). For example, Landon (1995) notes that there is no agreed-upon definition of generalist practice and advanced generalist practice other than the centrality of common values, systems concepts, and planned change, and a skill focus on specific client systems (individual, family, small group, organizations, and communities) (Landon, 1995, p. 1106).

The evolution of the advanced generalist ideas (built on the cross-systems generalist foundation) also lacks a common conceptual framework but appears to seek some level of specialization by social problem area (family violence, criminal justice), field of practice (aging, child welfare, health, mental health), or leadership at the level of small systems or large systems. Other curriculum organizing themes include gender, cultural competence, or public sector challenges (Landon, 1995, pp. 1101-1108).

While the debates about the nature of micro and macro practice continue on campus, the practice community has been pursuing a parallel agenda. For example, the combining of clinical services with community interventions to impact neighborhood or community problems has been gaining adherents over the past decade among large foundations and national organizations; such as the Family to Family and the Making Connections models promoted by the Annie E. Casey Foundation and the HIV prevention efforts in communities of color and with gay/bisexual men (c.f., Casey Foundation, 2000; Casey Foundation, 2004; Kegeles, Hays, Pollack & Coates, 1999; Sikkema, Kelly, Winett, Solomon, Cargill, Roffman et al., 2000). Many of these initiatives are moving forward without clear definitions of what constitutes community-based practice and the theories that guide such practice (Johnson, 1998; Weil, 1996).

Community practice includes a wide range of practice related to increasing civic involvement, assisting groups and communities in advocating for their needs, and organizing for social justice to improve the responsiveness of human service systems (Weil & Gamble, 1995; Cox, 2001; Pilisuk, McAllister, & Rothman, 1996). Johnson (1998) notes that the term "community-based" implies the integration of micro and macro level interventions. It is a term that is often used to describe the combining of client-involved grassroots organizing with direct services in com-
munity settings. Other terms for community-centered practice include community-based services and family-centered community services. Johnson (1998) advocates for the use of the term “community-based practice” to represent an integrated model of practice that incorporates both micro and macro skills by integrating direct service skills with the skills traditionally associated with community organization and community development.

Beyond the focus in the literature on micro and macro practice, there is other research relevant to this discussion. For example, Ezell’s (1994) study of clinical social workers in Washington State found that the majority of direct practice social workers engage in macro-level activities on their own time; either by lobbying for a specific client group, sitting on a board of directors, or working on a community issue. Similarly, Walz and Groze (1991) propose the clinician-activist approach in which clinical practice is the essential foundation for the process of advocating for the most oppressed and needy clients. And finally, Bakalinsky (1982) noted that a good deal of generalist education is segmented into the traditional triad of methods (micro, mezzo, and macro) with most attention still being paid to the smaller systems (micro and mezzo). Without additional research related to both practice and curriculum, it is difficult to describe the multiple ways by which clinicians currently engage in or are prepared for community-centered practice.

A FRAMEWORK FOR COMMUNITY-CENTERED CLINICAL PRACTICE

Given the definitions and implications of community-centered clinical practice, it seems useful to envision a continuum of practice by combining “clinical practice” (based inside or outside the community) with the term “community-centered” (using the skill sets of community work). One of the goals of this analysis is to define an integrated practice model of community-centered clinical practice through the development of a continuum of practice activities and knowledge areas. It is designed to infuse a community-focus into micro practice as well as an interpersonal focus into community practice in the form of community-centered clinical practice. The framework integrates skills and activities that promote change simultaneously through the use of micro and macro practice. The continuum of practice builds upon Johnson’s (1998) definition of community-based practice by combining direct services with community development activities.
Since our definition of community-centered clinical practice is built upon a clear understanding of the core skills, it is important to briefly identify examples of these skill areas: (1) core clinical practice skills, (2) core community practice skills, and (3) skills common to both domains of practice. These skill sets are then illustrated with the use of a case vignette.

**Core Micro Practice Skills**

Expert micro practice and its underlying clinical mindset are based on the dynamic quality and central role of human intra-psychic and interpersonal life as it affects human growth and functioning. Human suffering is seen as a cyclic interactive process between an individual’s personality and the ongoing daily experience and interactions with one’s interpersonal, environmental, and cultural context. The knowledge base of clinical social work practice includes: theories of human personality development and functioning, concepts related to empowerment, self determination and systems perspectives, basic psychological processes (both conscious, and out of awareness), multiple psychotherapeutic theories of helping and change, understanding of the impact of cultural differences and the need for culturally sensitive practice. Core clinical skills for working with individuals, families, and groups include: the ability to establish empathic, strength-based helping relationships with a diversity of clients; the ability to engage clients in the process of clarifying their needs and goals; collaboratively helping clients to acquire new understandings and formulate potential solutions; supporting the capacity of clients to stay motivated and connected with the process of change, including navigating set-backs and barriers to change, and monitoring and evaluating the helping process. It also includes the skillful use of change interventions from various helping modalities, matching client need with effective interventions.

**Core Macro Practice Skills**

A core value of macro practice is to assess and intervene to promote change in the larger system within which individuals, families, and groups are embedded. The macro practice mind-set is focused on systems change at the community, organizational, and policy levels in order to empower, not blame, client and worker populations. A community-focused practice includes the core skills needed to work with systems of small groups, neighborhoods, and communities
such as the ability to create relationships with individuals who create policy or affect community attitudes. The essential community practice skills include the ability to engage/align with community members, assess group and community needs and goals, determine pathways for helping with problems, intervene to help groups/communities create change or intervene to promote prevention of problems, and evaluate effectiveness of interventions. These core macro skills include the ability to establish trust and cooperation of community members. Skillful practice includes the ability to work with a diversity of clients including difficult to engage clients. The processes of managing conflict, mapping and re-framing issues, generating options, and continuously monitoring and evaluating are central to community practice.

**Common Practice Skills**

While it is interesting to note the differences between micro and macro practice, it is increasingly evident that more attention is needed in explicating the commonalities across both domains of social work practice. These are referred to as *common* skills utilized by both micro and macro practitioners. They include: (a) relationship building (e.g., engagement, trust-building, collaboration), (b) assessment (e.g., interaction between person and environment), (c) promoting helping processes and engaging in change strategies (e.g., contracting and monitoring the change process), (d) effective use of self in fostering client empowerment (Gutiérrez et al., 1995), and use of empathy and cultural sensitivity. These *common* skills are of equal importance to the education of clinicians and community practitioners.

**APPLYING THE SKILL SETS TO A CASE VIGNETTE**

Beyond defining these examples of skill sets, it is important to demonstrate their application through the use of a case vignette. The following scenario involves a neighborhood-based non-profit Family Service agency under contract to assist parents, teachers and administrators in an urban neighborhood elementary school in addressing student behavioral problems in the classroom and on the playground. The ongoing disruptive and aggressive student behavior was lowering the morale and academic standards of the whole school. Since the parents saw the teachers and principal as ineffectual and perpetuating a culture of fail-
ure with their children, they no longer attended parent/teacher meetings, or responded to teachers’ messages about their children’s disruptive behavior and poor performance.

A closer look at the problem by the community-centered clinical practitioners employed by the Family Service agency (using focus groups of teachers, children, and parents) revealed that approximately 5% of the most difficult students were causing problems for 85% of the student body. Although the student body was 30% African American, 50% Latino, 10% Asian-American and 10% Caucasian, the children identified as “trouble makers” were primarily Latino. The teachers and administrators in the school were predominantly Caucasians. The usual school protocol would be to handle the 5% of the difficult students on a case by case basis, using disciplinary action, and possible referral for psychological or social work services. Instead, the community-centered clinical practice model of the Family Service agency was used to support the children in succeeding in school to their fullest potential. Based on the involvement of parents, teachers and administrators, multiple interventions were designed to include the following activities with the skill sets noted for each intervention:

1. a Latino-American parent/teacher club in the community which helped to address long-standing and pervasive racial tensions in the school including the process of rebuilding trust and shared goals between the school and parents;

   core micro skill = collaborative helping process
   core macro skill = engaging key community members
   common skill = relationship-building with use of empathy and cultural sensitivity

2. support groups for teachers around their stressful work, including coaching teachers in therapeutic techniques such as re-framing to more successfully approach parents in order to help their children;

   core micro skill = support, empathy, re-framing
   core macro skill = organizing teachers-home connection
   common skill = reframing empathy, organizing teacher/family/engagement

3. group work with disruptive students (focusing on emotional development, anger management, and social skills such as empathy training);
core micro skill = intra-psychic and interpersonal focus on emotion, self regulation, self reflection, modeling empathy  
core macro skill = managing group conflict and generating options  
common skill = individual and interpersonal change in group change context

4. in-home family therapy that included the teacher (based on case conferencing with all relevant parties) to help address problematic family dynamics and build alliances between the child, parent, and teacher to help the children succeed in school (teachers were reimbursed for their extra time);

core micro skill = family therapy with extended system addressing child/family/school dynamics  
core macro skill = promote mechanism for prevention and raise dollars to support teacher participation  
common skill = promoting client/family/teacher empowerment through collaborative effort, therapeutic skills in group intervention

5. case management that included crisis intervention counseling, parent training workshops, classroom presentations about mental health issues, and consultation services to teachers;

core micro skill = crisis intervention, case management, individual/family therapy  
core macro skill = organizing parent training group and community consultation and education services  
common skill = intervening with clients and their environmental context helping with needs at the individual, family, and community levels

6. focus groups to evaluate how the interventions were working by carrying out research and evaluation of the specified goals of the interventions (reduction in number of aggressive incidents in classes and on the play ground; reductions in number of detentions and expulsions, raising of grade levels of students, improving the abilities of students to manage their anger and empathize more with each other, increasing the participation of parents, improving study skills of students, and increasing support of par-
ents in helping students improve their school performance) and making changes where needed.

*core micro skill* = monitoring and evaluating helping process  
*core macro skill* = engaging a network of community support  
*common skill* = continuous assessment that fosters client involvement and empowerment at the individual, group and community level

7. In addition to these direct service interventions, community-building efforts included: (a) forming a parent’s advisory council to empower them to identify and promote issues needing attention and change, (b) forming a business advisory council to involve local businesses in school improvement projects, and (c) collaboration with the teacher’s union to address teacher issues.

*Postscript on outcomes of case vignette.* In a follow-up discussion with the project director (October, 2004) it was learned that this project was funded for two years and abruptly terminated by a newly-hired principal, preventing the completion of a formal outcome evaluation. However, the project director was able to informally identify the most important aspects of the project; namely, the work undertaken with the teachers. The teachers elected to attend training sessions with clinical staff from the agency in order to learn intervention skills to improve communications with the parents that would ultimately help their children as well as foster a collaborative partnership with the school. The clinical intervention included “positive reframing” to help the parents understand how the teachers were trying to meet the needs of the children. This process was given extra legitimacy by using grant funds to pay teachers for the time spent in the training sessions and fostered a strong incentive for teachers to attend the training sessions. The teachers provided a steady stream of positive feedback to the staff regarding their learning of collaborative family engagement skills.

This case vignette captures the community-centered aspects of clinical practice by recognizing the community as the focal point for addressing the behavior problems of the children (i.e., it takes a whole village to raise a child). The interventions included shared problem identification and problem-solving, group interventions for both assessment and intervention, and on-going evaluation that included all parties. It does not ignore the reality that some children needed individual attention but also recognized that all segments of this school community need to be empowered to engage the issues together and find shared so-
lutions. In essence, the smallest group that can successfully engage in community-centered clinical practice is a team of staff and clients who share an understanding that social problems require a focus on both the community and individuals. This focus builds upon the strengths of all community members who are related in some way to neighborhood challenges/problems emerging in the local school.

CONCLUSIONS

The core inspiration of the social work profession, dating back to its historical roots in the settlement house movement, is its person-environment perspective. This is social work’s central stance for understanding and attending to what impedes human functioning at the individual, family, community, agency and policy level. Clinical and community work ideally should be conjoint practices born of the same vision. Each attends to different levels of problem identification and resolution, thereby providing inherently complementary perspectives. Instead, as pointed out in this paper, there has been a longstanding tension between the domains of micro and macro practice, often perpetuated in agencies and academia. A set of structural and interpersonal tensions, inherent in this schism, interferes with accurate perceptions of the underlying continuity of practice that is reflected in the social work mission. In this paper we have searched for a working definition of community-centered clinical practice and an accompanying continuum of community-centered clinical practice skills. Building on the importance of specialization in micro and macro social work practice, we have identified the areas of common skills as well as identified some of the implications for improving agency operations and professional preparation in academia. Our goal has been to promote a more integrated continuum of micro and macro social work practice, while at the same time keeping in tact the depth of specialization in each of the practice domains. The promoting of an ongoing dialogue to foster understanding between micro and macro practitioners should go a long way towards reducing or eliminating the tension between these two domains of social work practice.

NOTE

1. The Alliance for Children and Families was launched in 1998 when Family Service of America and the National Association of Homes and Services for Children merged. The Alliance represents one of the oldest and largest networks of community based human service organizations in North America, with a membership of 350 fam-
ily service and child welfare organizations. The Report was compiled by a group of consultants and staff from the Alliance based on 50 interviews and three focus groups of agency executives, social work educators, and students along with 60 interviews of executives in Alliance-involved agencies. Based on a literature review, the following questions led to the findings in this Report: (1) Is there a mismatch between the needs of community-centered employers and social work education? (2) If so, what is the nature of the mismatch? and (3) What can be done to close the gap?

REFERENCES


