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THE ELEMENTS OF A LOCAL SERVICE PROGRAM

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Design Axioms for Local Services

Discoveries emerging in the context of | expansions of local service activity comprise one of the most active areas in contemporary psychiatry. The hardy rate of such discoveries suggests the time may yet be too early to expect the theory of local service design to become stable. Surprises and reformulations may lie ahead. Several axioms have reached general acceptance with the workers in the field and offer useful pathmarkers for individuals seeking to apply this experience.

1. The characteristic behavior of persons in distress offers a useful basis for planning effective clinical services and supports for such services. Individuals in the midst of crisis cannot easily negotiate complex entrance arrangements. Once admitted to services, they often show an exquisite capacity to be drawn into new conceptions of identity and role. These newly acquired views may yield either helpful expansions of adaptive capacity or undesirable contractions of capacity. Some of the least desirable concomitants of service are movement into prolonged patienthood and recruitment into unnecessary dependence on continuing service. Much of this experience has been drawn together by Caplan and Scheff.

2. The expectable behavior of social networks around persons in

distress! exerts an impact of substantial significance on clinical and supporting activities of local services. This impact can be drawn into constructive outcomes. At the time they present for clinical services, individuals in distress often are being actively extruded from their prior social contacts and relationships. In the context of declining social role performance, frightening behavior, and undependable or unexpected behavior, the surrounding network may demonstrate powerful efforts to extrude the individual from his remaining vital social attachments. Additionally, if an individual is removed for the purpose of contact with services, his attachment opportunities may "close over" without him, a factor that increases with duration of absence. Particularly helpful in achieving increased prospects for life opportunity are services that do not remove an individual from his usual location and that are focused on expanding his competence to manage current life problems in ordinary settings." Reception service practices of a type that usefully involve the social network in the assessment of problems, and the design of a response, seem to soften the extrusive impact of the network. Such practices also may enhance the adaptive capacity of the individual as he operates in conjunction with his usual associates.

3. The clinical linkage of previously separated local program elements, for example, inpatient care, outpatient counseling, and sheltered workshops, frequently has a surprisingly large impact on the effectiveness of such

services. In fact, the service capacity of local programs appears as much related to linkages between elements as to excellent internal design of elements. A noteworthy fraction of persons with psychiatric distress present with a cluster of difficulties. An effective response therefore often requires a cluster of corresponding categories of service. The ability to sum several services, and to arrange them into a meaningful clinical sequence, is an important category of local capacity. The establishment of reliable arrangements for multiagency service activity is a characteristic early objective within local program construction. The bringing together of several existing program elements, for instance, employment counseling, job skill training, and a halfway house (a social setting intermediate between inpatient care and full independence from treatment), frequently has more impact and lower additional cost than originating a new service. The interactive arrangements provided any service element are therefore a critical feature of its design. Persisting practices that routinize options for multiagency service often develop as a side effect of approaching other problems, for instance, plans to receive patients into the correct category of service.

The establishment of a reliable capacity for multiagency activity emerges as a criterion aspect of service design. One path toward achieving such an objective uses formal contracting between two or more agencies each of whom agrees to receive and service all referrals, or all referrals of a particular risk group, sent by the parties to the contract. Such “symmetrical,

non-decline referral agreements" allow an agency to assume client-assessment or service-delivery responsibilities in behalf of all the services assembled by contract rather than in behalf of a narrower, one-agency capacity.

4. As categories and auspices of service become increasingly linked into cooperative clinical and planning activity, a series of basic changes seems to occur in the design of the coalescing services. Procedures to qualify persons for access to service tend to simplify and accelerate. Staffs often decide to work for the establishment of an increased range of types of clinical service. Such increased service variety allows increased design specificity to the types of risk and disability expressed in the local population. Staffs work to provide at least a beginning service approach to each significant type of clinical problem in the settlement, for example, young, old, retarded, addicted, migrant, and delinquent. Agency staffs often work toward the early establishment of a reception service, especially one using a design addressed to the reception of persons presenting with varying grades of distress and a variety of kinds of trouble. A reception service can originate in several ways. Sometimes it begins in an attempt to provide a single front door to the several agencies in a developing network. Sometimes it arises to make possible the arrangement of multiagency staff participation in assessments of individuals presenting for service. In other settings, reception services begin as emergency services, often attached to a general hospital. However they

originate, reception services seem to mature into a more general and continuing role in receiving, assessing, routing, and monitoring patients as they move through a variety of contacts with elements of the local psychiatric service program. Reception services often become a focal point for expanded mental health consultation services and for work to establish other new services. Wide citizen interest often grows from the abundant new service information that accompanies the process of adding a reception service to existing local services.

5. Professionals working within service operations undergoing substantial changes in clinical design are able to acquire new clinical skills with surprising speed if their leadership engages them with relevant information and resources for retooling. Skills often critical in local service programming are ones associated with the convening of groups, with the facilitation of normal human adaptive work, and with the rapid assessment of clinical status and social attachments. Convening skills are useful in assisting groups of citizens, or professionals, conduct productive meetings, and for bringing families and members of a social network into the treatment process. Skills in convening also allow a treatment staff to take advantage of the fact that an assembled social network offers a greater capacity for adaptive change than does a distributed network. Skills for enhancing adaptive capacity of persons who are passing through stressful intervals of life are a central ingredient in many inpatient and outpatient programs.

Services that increase the likelihood of adaptive success are desirable because they approach the objective of reducing the need for extended intervals of treatment. Skills in the rapid assessment of symptoms, role performance, social attachments, and adaptive capacity are important in making precise use of scarce service resources. Such skills are also necessary when using service settings that do not involve removal from the ordinary circumstances of life. Rapid clinical assessment practices also assist in providing prompt access to services during the flexibility of crisis and in avoiding waiting lists and other complex qualifying routines prior to service.

6. The leadership tasks for constructing local service programs seem to center around gaining an easy familiarity with the current state of affairs and combining it with personal confidence in a service strategy that provides increasing evidence of its value as time proceeds. Citizen, agency, and professional endorsements are necessary components of effective local service systems. Such support can be expected to derive not from strong professional pronouncements but from visibly successful services. The communal patterns of established medical practice and of social casualty management practice! form a background for citizen expectations for service and professional behavior. Evolution of some practices away from existing expectations is often required to approach the design of an improved service network. When such evolution appears as a series of small, cumulative steps it seems to have the best chance of enabling a persisting network. The cluster

and flow properties of a human settlement, its fields of dwelling, work, recreation, and assembly, § offer place and occasion to a service program. Desirable patterns of administrative mechanics for local service programs seem to strike a balance between necessary program precision and protection of the clinical creativity of personnel. Another group of administrative design requirements grows out of the special folk customs and professional attitudes that cluster about an enterprise addressed to the management of a group of human conditions regarded as important but of disputed cause. Local service programs can be buffeted by changing waves of public and professional sentiment. Such waves of sentiment include peculiar mixtures of concern and neglect. Local programs also can become encumbered by ideological fixity, careless thrusts of innovation, and inattention to the simple and obvious.} A reasonable posture seems to be a continuing vigilance for the hazards of ideology and haste.

Clinical Services to Individual Persons

Features That Describe a Service

A useful definition of the term "service" is an experience or event, purposefully provided by others, that occupies a brief portion of a lifetime and results in continuing enhancement of the adaptive capacity of an individual after its completion. Within the context of this definition, the term

"service design" is understood to encompass those features of any service that are thought essential to accomplishing its desired effect. Because there are many kinds of psychiatric distress and disability, there are many categories of service and service designs. For most services the essential design features turn out to be the timing, setting, participants, objectives, type of adaptive enhancement, duration of service, and criteria of exit. Though local services show considerable variation and experimentation, most workers appear to be approaching the following trends in service design:

1. The timing of entrance to service is moving closer to the onset of symptoms or of social network collapse.

2. The sites of reception into service and of main service activities are moving closer to the individual's usual space of life.

3. The persons engaged in the service activities, in assessing the trouble, and in evaluating the treatment plan are growing in number. An attempt is increasingly made to include as many network persons and service personnel as can make an efficient, productive contribution. Much hum an adaptive work seems to require a corporate participation or component, provision for which emerges as an element of service design.

4. The objectives of service are becoming more explicit. There is earnest endeavor to specify the nature of the pending adaptive work or disability undertaken for service. Changes in these same specifics are increasingly regarded as the

product of service and as the standard within which effectiveness of service is most precisely reckoned.

5. The behavior and operations of the service personnel, which comprise their service activities, are being more explicitly described. Special effort is given to determining which activities are necessary or essential for the intended service design. What do the service agents do to enhance the client's adaptive work? As such "active principles" become known, the service agents can refine their service designs.

6. The duration of service encounters is shortening as service designs become more precise. Local service personnel show a keen interest in unencumbering their service activity from unnecessary amounts of continuing contact and from other recruitatory practices.

7. Criteria defining the proper occasion of exit from service are growing more prominent in definitions of service design. Frequently, behaviors or events signaling that the objectives of service have been attained are defined early in service so their appearance can be promptly recognized.

Highly productive work toward the improvement of local psychiatric services can derive from a more explicit specification of the risk groups in need of service. Also useful are clearer allocations of responsibility, among the several agencies in a settlement, for delivery of the desired elements of service. Precise understanding of the interagency allocation of responsibility

also can allow for reliable sequencing of several kinds of service contact as well as for simultaneous, complex service contacts. Several questions recur at each effort to attain such understandings. What risk group is the service intended to benefit? What profile of disability is expressed by the risk group? What are the active ingredients in a service intending to reduce such a profile of disability? What is the value of the effect or desired outcome? How will an observer detect that the desired effect has occurred? What special problems can be expected in making links for this service with other elements of the local service program?

Ordinarily the local service elements needed within any settlement will include the following kinds of service to individual persons: Reception service, which provides access; inpatient service, which provides controlled environment for residence; day care and night care service, which provides a treatment-oriented social system for a part of each day but expects the patient to spend another part of each day in an independent social system; outpatient service, which provides intermittent services to enhance adaptive capacity; home care service, which provides service set in a person's place of residence and usually involves his family; shelter care service, such as a halfway house or sheltered workshop, in which the individual moves freely about the community some portions of the day or week, perhaps holding employment, but in which the setting of his work or residence is specifically modified so as to reduce a disability state; and after care and communal

reentry service, which provides packages of service for persons who have been institutionalized for a long time, or repeatingly, and are now preparing to resume movement about the general community. Table 42-1 reviews several differences among these service types. Note for instance that the duration of service, or transit time, is characteristic for each category of service. Note also that the assets and liabilities of the several services are complementary, a fact that suggests why a large increment in productivity regularly occurs when a set of previously unlinked services become linked.

Reception Service

Tasks accomplished in a reception service are reception of persons for entry into appropriate elements of the treatment system, assessment of the disability and resources of the individual, and arrangement of commencement of clinical services. A large amount of planning and several complex decisions occur during the relatively short period encompassed by reception service. It is therefore useful to design the service in such a manner as to acquire adequate information from brief clinical contacts. The establishment of capacities for multiagency participation in reception work, for convening the family unit or other members of the social network, and for ombudsman activity are useful steps toward making maximum use of the reception phase. Some assessments made during reception service and at passage from ordinary social networks into contacts with special, treatment

networks seem to carry a capacity to label, forecast, and recruit persons into continuing casualty status. It is therefore advantageous to develop a strategy of assessment that is maximally informative to service planning and minimally recruitatory. A series of assessments that explore a person, network, and situation is helpful. What is the current disability in role performance? What is the degree of clarity of identity and life objectives? What is the general health status, with special attention to aspects that interfere with usual roles or with the adaptive work, including schizophrenia, brain damage, or drug use? What is the status of the affectional attachments and network relatedness? From such information reception workers can develop a treatment plan. The report of such information also originates the clinical service record and establishes baseline descriptions and formal objectives later used to assess the impact of the service delivered. Other important issues in the design of reception services are linkage with a general hospital facility, telephone service, walk in (or unscheduled) reception capacity, and mobile capacity for reception and assessment. Assessments at entry to service are often made in the setting where an individual is lodged when psychiatric intervention is being considered, particularly when persons are in hospital emergency rooms, prisons, old persons' homes, and nursing homes. Assessment designs that do not require removal to a cloistered setting seem to preserve more opportunity for a plan of management that minimizes the use of institutionalization. Assessments in situ can provide opportunity to

assess and involve the network and may offer pertinent skill-enhancing experiences for staff.

Table 42-1. Differences among Principle Categories of Service within a Non-exporting Local Program of Services

COMPARISON FEATURE	RECEPTION	OUTPATIENT	INPATIENT		SHELTER CARE	
				Day Care	*Halfway House*	*Shel Wor*
Usual reason individual presents for service in such setting	Nonresponsive to adaptive challenge	Role decline (Network intact)	Fixed, non-adaptive behavior	Precarious network attachments		
			Addiction		Plus atrophy of role or job skills	
			Physiologic decline			Plus expa of rc skill
Objective within service	Entry	Start adaptive work	Alter behavior or physiology	Enhance attachments, roles, skill		
Asset of setting	Precise linkage to service(s)	Nonrecruitatory service	Control	Built-in network and resources f skill enhancement; setting modif reduce impact of disability		
Liability of setting	Awkward with repeating users awkward with addicts, isolates	Recruitatory, Expensive		Risk of encounter becoming prolonged into life location rathe than service		
Usual transit	Hours	Weeks	Days	Months		

Inpatient and Day Care Service

An inpatient psychiatric service is a key service element of a local program. It may also provide a home base for professionals who work in reception, outpatient, and consulting settings. The special characteristic of inpatient service, when conducted as an aspect of a larger local service program, is rich linkage with other types of local service. Such links allow movement of the objectives of inpatient service away from shelter and asylum toward operations that enhance adaptive capacity for life in ordinary locations. As inpatient service is more fully linked with other categories of service, average inpatient stays are shortening, now averaging fewer than twenty days. Inpatient service can be conducted using practices that productively involve the family and network. An inpatient setting can be a constructive place for commencement of coping work and for testing new life skills. When hospital care is conducted in a manner that does not separate an individual from his usual life pattern and from his social network, it can provide an advantageous setting for the titration of psychotherapeutic drugs, for withdrawal from an addicting material, for assembling clinical planning information, and for drawing together the patient's fragmenting social network. Key professional activities in inpatient care, when conducted as an element of a network of services, are provision of a temporary social system

that can help a person return to usual function and arrangement of circumstances for the work of reconstructing a more permanent social network. If an inpatient service is distant from other local services, or included within a larger, regional hospital facility, for example, a state mental hospital, it seems important that the service be reaching toward increasing linkage with a network of extramural services rather than operating primarily as a component of the regional hospital plant. Administrative movement to accomplish these objectives is sometimes called “unitizing” a mental hospital.

Inpatient service can offer hazards to a local service program. It is usually the most expensive element of local service. Unless used precisely, inpatient service can encumber so large a fraction of the program resources as to constrain their overall productivity. If offices, administrative activities, and clinical records for many parts of the local program are located at the inpatient service space, inpatient operations can divert attention from important events in the more distributed program elements. Also, inpatient service appears to carry more recruitatory effect than nonresidential services: It tends to separate an individual more completely from his network and from ordinary environments and draw him into a life pattern embracing extended contact with service networks and environments. In some locations, the courts and the legal code governing movement to and through some forms of treatment status join in viewing the service network as if it were constituted principally of inpatient activity. Such a view can jeopardize

development toward a network of more varied service elements. When the interested court is brought into service planning work, particularly around efforts for the court and service agents to relate as collaborators in planning an effective reception service, the court can be a force of consequence in developing a varied service network.

Day care and night care, perhaps because they do not separate a person from the ordinary setting of his life throughout the whole of a twenty-four-hour period, appear to convey distinctly less recruitatory effect. They are relatively inexpensive and offer efficient extensions of the staff and other resources that comprise an inpatient psychiatric service unit. Hertz et al. demonstrated that day hospitalization frequently offers a shorter, less expensive, and more valuable clinical product than inpatient care, in studies that seem to control for severity of illness and other important variables. In order to use day care, a patient must be able to travel back and forth between the service point and a residence or job and must not be addicted to a narcotic material. The productivity of day care service seems to be related to its special capacity to provide intense, precise service during one portion of a day, while allowing the individual to operate in ordinary locations for the balance of the day.

Outpatient Service

The volume and variety of outpatient service is in a phase of rapid expansion in the United States and is likely to be the major element of local services in most areas. In this discussion we use the term “outpatient service” to designate service in which the patient moves with free social excursion about the community, is not located in a specially designed, residential facility, and comes intermittently to a place of service for contacts lasting minutes to several hours. The principal components of service provided in a psychiatric outpatient facility are psychotherapy, decision counseling, application and monitoring of psychopharmacological agents, services that monitor the behavior of individuals who have experienced a significant episode of disability, and services that enlarge an individual’s operating social network. The demonstration that expanded outpatient care tends to prevent, shorten, or reduce the frequency of return to inpatient care has been made for many risk groups and for many parts of the United States.® It has also been demonstrated for many communities that risk groups underrepresented in outpatient care, for instance, children, retarded persons, old persons, and delinquents, will tend to be overrepresented in inpatient care. From these findings emerges the precept that outpatient services for any territory can have the greatest impact on reducing the use of institutional modes of care if such outpatient services are designed for, and focused onto, persons and groups known to be likely to be institutionalized from that community.

Within the overall group of persons at risk of institutionalization, those

who often can use outpatient care most effectively are persons whose role performance and network linkages are substantially intact. Persons whose adaptive efforts and skills for maintaining their social attachments are discovered to be even partially operative usually can be serviced in outpatient settings.

Several design features of outpatient care seem to expand its potential contribution to the overall service capacity for a settlement. If closely linked with a reception service, it can interrupt and control the routes to and from institutional care. If linked with other categories of service, especially job training and general health services, it can provide the setting for groupings of service that benefit particular individuals. The arrangements for groupings of interlocking services, often provided under several agencies' auspices, are most expeditious if they include service exchange agreements of the reciprocal, non-decline type. Other important characteristics of effective local outpatient services are staff competence in the provision of temporary, task-directed relationships, provision for convening the family unit or other portions of a patient's network, funding arrangements to provide service access for migrant persons and poor persons, and apparatus for participation by the service consumers in the design and assessment of services.

Home Care Service

Judging from the best results reported, home care may be advantageous and currently underutilized in local service programs. Perhaps it is not more prominent because of the cultural and organizational supports it requires. When the necessary professional skill, administrative support, and family interest are present, the use of the home as the setting for all, or a portion of, a program of care appears to offer advantages in cost and social outcome. The use of the home as a principal location, and the family as central providers of care activity, can result in prevention of hospital admissions, significant expansions of staff skill, expansion of the management options available to reception service workers, reduction in extrusive activity by the social network and a lower likelihood of future hospitalization. Used with children, it bypasses a very difficult design requirement of residential services for children, the need to provide a special school and a substitute family unit during treatment. With elderly persons it bypasses the hazards attendant separating an individual from a nurturing family unit and familiar environments. With schizophrenic persons it can result in increased effectiveness of the family unit as a problem-solving entity during crisis periods.

In order to deliver effective assessment and treatment work within the home, it is necessary for the family unit to have a suitable dwelling place and willingness to participate. The home care staff group needs appropriate experience, mobility, and rapid response capacity. The capacity of the family

to attempt care of a member in the home can be assessed in ordinary reception service settings or in the home. Professional ideological beliefs suggesting that home care cannot be expected to be successful may contribute to the existence of styles of practice that omit home assessments or treatment arrangements. Home care is seldom useful as the setting for withdrawal from drug addiction or abuse or when the family cannot be diverted from a fixed pattern of extrusive sentiment, as assessed during reception service or during an exploratory home care visit.

Shelter Care Service

Included under the term “shelter care” are halfway houses, sheltered workshops, and expatient clubs. They are grouped together because of an identifying similarity: They couple the provision of a specially altered local environment, or group, with an absence of limitations on free movement about the community. Such programs attempt to enhance individual adaptive capacity by offering a special environment or group for a part of the time only. They envision competent engagement with ordinary life settings as the primary objective of service. Halfway house service usually follows inpatient service, a response to the fact that much of the adaptive work formerly done in inpatient settings can be accomplished more easily in other settings. Halfway houses embody a small social unit and a sharp focus on skill-enhancing objectives. Other features of shelter care environments may

include an organized schedule of daily social activity, an associated work setting for wages or for the acquisition of job skills, sleeping and domiciliary provisions, often somewhat like a boarding house, participation in a regularly convened social network comprised of persons with similarly precarious attachments, decision counseling, behavior monitoring and direct critique by professionals and by members, and other outpatient services, including phenothiazine monitoring. In all the variations of shelter care, the central objectives remain the expansion of role and job skills and the expansion of skills for maintaining a social network. The risk groups effectively serviced in shelter care settings cover the full range of diagnostic and symptom groups but have in common the atrophy of social attachments and job skills, sometimes derived from experiencing prolonged, or repeated, institutionalization.

Shelter care services have a capacity to flourish under a variety of auspices and organizational arrangements, including families and expatient groups, whether local or affiliated with a larger grouping, such as Recovery, Incorporated or Alcoholics Anonymous, and with or without continuing professional participation. Most shelter care organizations work toward autonomous financing and policy development and to involve all their members in the tasks and governing of the group. Most tend to emphasize an intense, but transitional, membership in the group, leading toward a goal of movement beyond the group into a social network comprised largely of

persons without residential institutional experience. Shelter care organizations usually have a pipeline view of themselves and maintain ordinary expectations for conventional conduct. They tend to dissociate themselves from attitudes linked with careers of permanent residence in a sanctuary, or asylum, and from special expectations not compatible with general social excursion throughout the settlement. Sometimes a few permanent figures maintain the philosophy and structure of the group, while most members pass through with an average residence or active membership time of several months. Changes often destructive to the rehabilitative capacity of shelter care occur when it is conceived as a continuing method of care or when the average time in residence goes beyond about a year. Key features of an environment organized to maintain a continuing flow of intense but transitional opportunities are a psychological set that emphasizes performance achievement as a personal identity element, a daily organization around accomplishable tasks or role elements, and a local culture that can detect competent, attractive performance by a person who presented to the service with an offensive reputation. Linkage and ombudsman services of a character similar to those that are part of ordinary reception services can make a substantial impact on the productivity of shelter care service.

Services for Repeating and Prolonged Users

Services termed “after care” are composed of elements not unlike other

outpatient services but drawn into a focus on experiences benefiting persons who have been in inpatient care, especially prolonged inpatient care. Such persons often need service after the inpatient phase. Services termed “re-entry” or “rehabilitative” use inpatient, outpatient, home care, and shelter care elements organized to achieve non-institutional life for individuals who have been institutionalized repeatedly or for prolonged periods. Services designed to lower the likelihood of rehospitalization are often termed “after care.” Services designed to assist a person to be able to move from a period of prolonged or repeated institutional care to continuing non-institutional life are termed “re-entry” services. Although only a small percentage of a territorial population becomes hospitalized even once during a lifetime for mental or social disability, a fraction of the group who do become institutionalized become multiple occasion and multiple type service users. Previously institutionalized persons are therefore a population of more than usual risk justifying a category of services of special focus in design and administration. The aftercare and re-entry categories of service can be expected to comprise major sectors of the steady service activity in most territories, approximating, perhaps, 20 percent of the reception work, 30 percent of the outpatient and linking work, and 40 percent of the inpatient work. 101-103,207 whereas services for other risk groups may be omitted or ineffective and the service network will not be resultingly incapacitated, services for the group at high risk of continuing, or repeating,

institutionalization must be effective or the troubles of this risk group will encumber the major part of the capacity of the service network. The characteristic persons who present for multiple or prolonged service include social isolates, migrants, and persons with clearly defined, familial schizophrenia. In addition to expanding the service capacity of the treatment system, effective aftercare and re-entry services can be expected to free significant amounts of resources previously committed to prolong institutional care for other use. The successful introduction of such services to a local area can cause expansions in public understanding of the assets and liabilities of institutions as components of a strategy of casualty management.

Phenothiazine medication can be expected to be helpful in many but not all situations in which a diagnosis of schizophrenia is made. This fact is sufficiently important to suggest the value of precise service design for this group. The appropriate clinical contacts used to be reliable over a period of years. Prolonged phenothiazine administration and monitoring can be done in group settings. Patients can make effective use of telephone and postcard methods for keeping in touch without unnecessary inconvenience and disruption to their employment and pattern of life.

Aftercare and re-entry services use substantial components of decision counseling, employment training, linkage and ombudsman service, and services to enhance group skills and affiliative capacity. Many persons at risk

of prolonged, or repeating, hospitalization have no social network available for the daily maintenance of life patterns and personality.! Successful services to this group often provide direct assistance in identifying, linking, and maintaining a social network. An example of a method for providing service, which apparently enhances affiliative capacity, is the spin-off group. The spin-off group method employs a highly structured routine for several months. There are meetings and a set of roles, conventions, and group exercises. The therapist group assistant works to spin off a competent, autonomous, continuing group after eight to ten get-ready meetings. The method is conserving of professional time and appears to be a precise response to the predicament of isolated persons. It appears that isolated persons, given assistance in formation of new, small groups, show significant improvements in general social performance and surprising release from psychiatric distress.

Many service areas contain a substantial number of hospitalized persons who have experienced years, even decades, of hospitalization. About half of those in state and county mental hospitals have been there more than a year, and one quarter for more than ten years. Perhaps half of the persistingly resident group have a physiological status compatible with life outside an institution. But the atrophy of social and employment skills is often profound. Many local service programs are attempting service for this group. Several investigators have reported surprising results if the service program

is suited to the presenting difficulties. Re-entry service programs for this group have been carried out in inpatient, outpatient, and shelter care settings. Common elements in several designs to service this group include a social system that expresses vigorous expectations for competent performance, combined with a finely structured daily routine and a focus on a closely organized, small cohort of persons in a similar performance status. Movement toward full, independent excursion in the community proceeds in a series of graded steps, often augmented with ombudsman and linking services. Services for this group often last a year or more. The longer a service is expected to extend, the greater is the indication to define an observable feature of behavior that will signal an end point to service and the proper occasion of exit from service. Such a provision operates to reduce the risk of recurring recruitment into the social system of treatment on the part of individuals with precarious social networks.

Services to Agencies and Groups

Consultation and Prevention

Services to agencies, collectivities, and, indirectly, to classes of persons at special risk are a characteristic feature of local service programs. Such services are required in federally funded programs and comprise an area of rapid technical development, often under the terms “consultation” and

"prevention." As is the case with services to individuals, each example of such services is intended to benefit a particular risk group, focused on characteristic disabilities in the target group and organized around design features of setting, timing, participants, objectives, and end point. Activities in which the action responsibility remains with another professional, and in which the recipient has the option to decline the use of the information or observations comprising the service, are usually termed "consultation." Services altering an environment or social aggregate, intended to reduce the occurrence or severity of disability in a group, and often provided in a manner not requiring individuals to enter formally into patienthood status, are termed "preventive." Most local services to agencies and collectivities involve elements of both consultation and prevention. Services to groups derive their main design characteristics from relevant properties of the persons for which benefit is intended and from the specifics of an environment or experience thought beneficial.

The action ingredients in service endeavors to agencies and collectivities seem to be similar to those in services to individuals. They include components such as counseling, convening, facilitating adaptive work, teaching role skills, and advising regarding assessments for service and routing of persons in distress. These components appear to comprise the delivered service even though a wide range of rhetoric is used to describe such endeavor, employing such concepts as "facilitating normal growth and

development" and "developing new institutions to enhance communal adaptation of migrants." In such a rapidly developing field, efforts to provide service are generally enhanced if the desired change is simply identified. Frequently discussed categories of preventive endeavor include the increased use of personal crisis as a period of flexible growth rather than as an occasion for labeling an individual for removal, the alteration of hazardous social roles in structured organizations, and the development of closer linkages between individual aspirations and group allocations of status, sometimes termed "the Hawthorne effect."

The process of selecting groups likely to benefit from indirect services is often aided by using epidemiological data, particularly data from reception service settings. Data originating in reception services can give information on risk groups that are not successfully managed in their current setting or services and, therefore, are presenting for transfer to the mental health system. Data from inpatient and residential services can provide information on risk groups that have been presented to the mental health system but currently are not managed within its non-institutional settings. Other considerations can suggest the value of an indirect route in approaching the problems of a particular risk group. A concern to avoid risks accompanying psychiatric labels, such as patienthood roles and reputations, combined with anticipation of higher leverage in approaches to larger numbers of persons with imminent but unexpressed trouble frequently suggest indirect service

designs. Indirect approaches sometimes excel in avoiding or reducing disability status but can present complex problems in program design, administration, and evaluation.

Services to agencies and collectivities in many local programs are designed to benefit school-age children, persons in nursing and old persons' homes, aged isolates, unwed mothers, persons abusing drugs and chemicals, widows, unemployed persons, and persons in welfare programs. Promising experience has accrued with respect to the design characteristics of programs associated with prepartal care, battered children, lead poisoning, children separated from families during hospitalization, and operations in institutions that operate as family and home to dependent children. Because poor persons are overrepresented in many categories of institutional and disability status, local service programs sometimes attempt to enhance by service the capacity of individuals or groups to extricate themselves from continuing poverty status. For example, some local programs attempt to facilitate capacity for decision and action within organizations of relatively powerless persons. Some risk groups are included indirectly in service efforts through service to an agency or category of professionals with whom they are in direct relationships. The variety of such indirect services is large, and includes efforts through schools, courts, police, and juvenile officers, home visiting nurses, clergy, undertakers, physicians, and welfare workers. Throughout many indirect services is the common element of influence on a critical

turning point in life or on an event of role passage. For example, indirect services to recent widows can be designed around direct services to groups that convene widows to help one another, or by consulting with clergy or undertakers or physicians. Efforts to increase the likelihood of successful accomplishment of the tasks of student-hood can be focused around consulting with teachers, counselors, truant officers, or school administrators, or by convening groups of parents or groups of parents and school personnel.

Children's Services

The volume and precision of children s services seem to lag in development in many territories, perhaps because additional design features beyond those usual for adult services are often necessary. The recent report of the Joint Commission on Mental Health of Children reviewed the situation and termed it a "dire crisis." It recommended, even so, that expanded services for children are not likely to be effective in nurturing healthy growth, and preventing disability, unless such new capacity embodies a service model that emphasizes the maintenance of the child within a family unit, within a school, and within an ordinary communal environment. Therefore, they recommended enhancing local services for children via expanded reception, home care, and school consultation services, including psychiatric participation in interdisciplinary assessments of a child's performance in the student-hood role. They also recommended a heavy emphasis, in local

services for children, on counseling and convening services. For children who are institutionalized for service, they stressed the importance of smaller institutions, with a family-like social unit, and with opportunity for full participation in the standard program of the local school district. Because of the catastrophic risks attending separation of a child from a family unit, school, and community, most children's services in local service programs stress designs based around a non-institutional location for the child, and on types of service to a social network that are supplemental rather than eclipsing to the existing family unit. The school is the dominant setting for children's services whether or not such services are conducted under strictly educational auspices. Apparently promising are designs that aim to increase the capacity of the school to help more children achieve a successful student-hood experience. Designs that appear effective include services that convene parents for an exchange of experience, especially parents who have children in distress, in trouble in school, or before a court. Whatever the active ingredient in a service is thought to be—educative, task learning, role learning, counseling, or social attachment or relationship—the trend in children's services emphasizes offering such service to children's established social networks rather than through special systems that label children for unique handling or removal from the settlement. Few see much productivity in extended inpatient care, of any design, because of its powerful capacity to recruit children into permanent casualty status and to separate them from

families. In spite of these facts, perhaps because reception service as well as outpatient and consulting services are in short supply in many territories, children are currently entering inpatient facilities in larger numbers and beyond their increased representation in the population. Consulting programs to juvenile courts, to police officers with juvenile surveillance responsibilities, and to foster homes, foster parents, and well-baby clinics are usually productive. The underlying strategic decision in many developing designs for children's services is one to offer intense, continuing service to the parents, schools, and institutions that provide environments for children. The focus on inputs to the environments of children is made in order to make effective interventions in the lives of troubled children without recruiting such children into special institutions and constrictive roles.

Services for Old Persons

Between 10 and 15 percent of the populations of most settlements can be expected to be persons sixty-five years of age or older. Perhaps 10 to 20 percent of this group can be expected to appear in reception, outpatient, or institutional service during an average year. Older persons are highly overrepresented in inpatient care admission rates and, once admitted, tend to remain until death. For most territories, between two-thirds and three-quarters of the institutionalized older persons are in nursing homes rather than public mental hospitals, a trend that is increasing. Older persons are

underrepresented in reception, outpatient, and shelter care service as compared with their representation in residential service. Yet when such services are developed within a settlement, the use of institutional care declines substantially. Of those older persons who become institutionalized in a mental hospital, more than two-thirds are social isolates, having either lost a spouse or never having been married. A major fraction experienced a physical health crisis in the interval just prior to admission. The health decline was followed by a decline in role and network performance, culminating in a performance crisis leading to institutionalization. Services for the elderly attempt to engage with declines and crises in physical health, deficits in adaptational and psychological capacity, poverty and its restriction of options, and general social isolation. Service efforts can focus on efforts to enhance adaptive work to manage events of loss by death, illness, and dignity disruptions coming in the later years, years that often seem oriented to the special experiences of the young-adult portion of the life cycle. Local service designs for elderly persons can be based on the premises that relatively small inputs of health service, and of convening, linking, and counseling service, will make significant improvements in the quality of life and that institutional service, when required, should work to maintain or renew an older person's social roles and network attachments. The setting for much of this service is in residences and in nursing and old persons' institutional homes. Reception services are helpful to older persons if they offer precise assessment, service

planning, and service linkages. Reception service of a type that can develop access to a variety of local services, within the context of a presentation for institutionalization, can often avoid or postpone entrance to institutional life. Home visiting and home care services, together with brief day care and shelter care services, can help many older persons avoid institutionalization in the context of a health or loss crisis. Counseling and brief outpatient services can help many older persons handle the loss of a spouse without moving to restricted life styles, depression, or suicide. It is well known that brain changes in older persons can lead to a wide range of troublesome behavior and positive findings on the mental status exam. But apparently it is not so well known that losses in the richness of a person's social attachments can produce similar findings. Services that facilitate development of new networks, of friends and task groupings, are a promising category of service for older persons. Such service is useful before, during, or instead of movement into institutional care.

Services for Persons Abusing or Addicted to Drugs and Chemicals

From the standpoint of local services, persons who are addicted to or abusing chemicals offer special planning programs. Such persons often present with a biological (tissue) dependence on a chemical, a situation best managed in a controlled, hospital setting. The withdrawal phase of the care of addicts is strictly institutional, whereas much of the rest of local

programming aims for non-institutional designs. Addicts frequently present for service as a result of illegal behavior, for example, the possession or marketing of a chemical. Their service, under such circumstances, is framed within legal boundaries. In addition, the principal social network of many addicts, and alcoholics, is comprised of persons who are also addicts or who collaborate in the destructive use of the chemical. Management in ordinary social networks and settings is, therefore, neither legal nor usually effective. Local programming for persons abusing alcohol or addicted to a narcotic chemical is based around health service and chemical withdrawal, or methadone maintenance, followed by extensive, intensive efforts to develop a new life style within a new social network. Often a group of ex-alcoholic or ex-addict persons combine efforts in a corporate attempt at revamping their whole life patterns.

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