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ABSTRACT

Discussed are current delivery problems and current delivery systems for rehabilitation services. The following systems are described: client initiative, consumer appreciation, advertising, referral, client affiliation, family, indigenous worker, developmental, key citizen, legal, community survey, community corporation, catchment area service, and multiple delivery. Also delineated are the attributes of a satisfactory system, human and attitudinal barriers to rehabilitation services delivery, and the philosophical viewpoint of the program. (JM)

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Delivering Rehabilitation Services

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Delivering Rehabilitation Services

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Introduction

The old adage has it that the world will beat a path to the door of the man who makes a better mousetrap. But the grass grows high around the shops of many a creative mousetrap maker—and, for that matter, many a rehabilitator, as well. Despite availability of increasingly effective rehabilitation services,* environmental and attitudinal barriers continue to separate sophisticated and proven services from those who need them the most. By “environmental barriers” we refer to such things as geographical distance, limited funds, personnel shortages, and haphazard distribution of resources. “Attitudinal barriers” refers to the attitudes of a small minority of insecure, frightened, misdirected and immature practitioners and administrators. Presumably engaged in the process of bringing optimum rehabilitation service to the disabled, these professionals sometimes interpose their personal needs between rehabilitation services and rehabilitation clients with apparent impunity.

Although environmental barriers are readily exposed so that they can be examined, and possibly remedied, attitudinal barriers may be more difficult to identify and eliminate since professional courtesy and administrative caution shield many of the perpetrators of service deprivation from responsibility and censure. Yet, both types of barriers, environmental and attitudinal, should be considered in any discussion of the problems of rehabilitation service delivery.

*For the purposes of this paper, rehabilitation services are those services offered by State rehabilitation agencies and their cooperating groups. Although medical and mental health are important components, these large areas of concern are not treated separately but as part of the rehabilitation agency design.

Indeed, if environmental factors alone impeded service delivery, the planning, implementation, and evaluation tools now available to us would suffice to bring most delivery dilemmas under control. Although this paper will discuss environmental restraints in detail, it will also focus upon the neglected attitudinal components that complicate the service delivery problem to an incredible degree and which, because of a "conspiracy of silence" rarely are discussed in the rehabilitation literature. Indeed, the journals are virtually devoid of materials of this type.

Perhaps the best way of introducing the two-sided problem is to suggest that environmental barriers are created by the failure of service delivery systems to respond to the needs of potential clients and the attitudinal barriers are created by the personnel who are assigned to implement such systems. Obviously, the systems themselves are more amenable to study. They are entities that share such common characteristics as a recorded history and a tangible structure. On the other hand, the attitudinal components are far more elusive, and often so subtle that their existence can be denied or explained away. As the least understood and, perhaps, the most vital contributors to service deprivation, attitudinal factors rarely see the light of day. For example, being assigned to one counselor or another, living in one community or another, or being served by one State agency or another, all of them governed by similar legislation and procedures, often spells the difference between dependence and rehabilitation for many disabled persons. The delivery system provides the skeleton; the practitioners provide the tissues that surround this skeleton. Neither the system nor the implementors can function independently.

In recent years, rehabilitation workers have shown increasing concern about service delivery problems. Indeed, no more convincing evidence of this is needed than the fact that the distinguished planners of this Conference assigned this topic to a special Work Group. Other indications of this mounting concern appear in the growing body of literature, scholarly conference papers and State-wide rehabilitation planning reports devoted to the delivery problem. For example, in May, 1968, the National Association of Social Workers conducted a national seminar on the subject in San Francisco as a curtain raiser to the 1968 National Conference of Social Work.

The nature of the service delivery problem is now reasonably well understood. As the Work Group noted in terse and pointed terms in its charge to the authors, the problem concerns obstacles to rehabilitation service including lack of information, agency acceptance, agency personnel, and geographical distance. Although additional detailed delivery problems could be described, it may be more helpful at this time to refer to the Final Report of the Committee on Resources of the New York Statewide Rehabilitation Planning Effort, which cited the following major principles which should guide the delivery of rehabilitation services: (1) all disabled persons eligible under Vocational Rehabilitation legislation should be able to receive appropriate service, (2) service should be provided to clients for whom vocational adjustment is not the primary or even a feasible objective, and (3) the client should receive the services needed when he needs them in the appropriate amount, order, and quality. Growing out of these principles is the Committee's suggestion that new systems of service delivery are needed to carry out current rehabilitation goals. The Committee noted: "It became increasingly clear . . . that our present methods of service delivery are unworkable."

Most of the published materials referred to in this paper concern environmental rather than additudinal variables, reflecting a generalized preoccupation with systems, rather than deliverers. The expectation usually is that improved delivery of services will occur when more efficient mechanisms are found which bring potential clients and waiting services into a more functional relationship. Essentially, these new mechanisms are expected to achieve the following:

1. Expedite the process through which clients get to services and services get to clients.
2. Serve more clients more successfully at a reasonable social and economic cost.
3. Perform the task with the available professional and non-professional manpower resources.
4. Enhance client motivation and self-regard in the course of delivering the service.
5. Provide ample opportunities for client choice and decision making in the delivery process.

Although systems are powerful facilitators, they depend upon human deliverers for their effectiveness. As a matter of fact, not only will the five functions noted above be accomplished more satisfactorily under favorable attitudinal conditions, but two other equally important ones will be achieved as well:

6. Protect potential clients, insofar as possible, from deterrent biases, caprices, and personal ideologies of those who serve them.

7. Eliminate client deprivation resulting from worker apathy, inefficiency, and unprofessionalism.

Most observers agree that some, if not all, of these functions should be performed more efficiently in rehabilitation than they are today. Untold numbers of disabled persons who could benefit substantially from rehabilitation are deterred from doing so by both environmental and attitudinal barriers. Most of these barriers are preventable and remediable by appropriate professional action. Fashioned by a society that manufactures its own cultural lag, these deterrents are part and parcel of a service structure that is not keeping pace with social developments. Furthermore, even the few service delivery systems that are reasonably current can be distorted and weakened by administrators and practitioners who create unnecessary obstacles to successful rehabilitation.

Preliminary to discussing systems, per se, it may be helpful to examine some current rehabilitation service delivery problems that confront the field.

Current Delivery Problems

The service delivery pattern of rehabilitation rests primarily upon premises that were valid a generation ago. The basic assumption was that most employment-motivated, success-oriented disabled individuals who could benefit from rehabilitation would be referred or find their way to a central rehabilitation facility where they would involve themselves in a rehabilitation process which would be consistent with their values, past experiences, and present aspirations. As for the others, they probably were not ready for rehabilitation anyway. In a day when rehabilitation addressed itself primarily to persons who introjected dominant middle-class success values, this assumption came closer to the truth than it does now.

Social conditions have changed materially since rehabilitation saw the first light of legislative day in 1920. More than ever, the field is being charged with the responsibility of working with an increasing proportion of clients who in an earlier day would have been written off in short order as uncooperative, unfeasible, and not ready for service. These clients—alienated, suspicious of organized middle-class controlled community services, and resistant to the usual rehabilitation procedures that worked so well in the past with middle-class clients—are a constant reminder to us that the service delivery machinery constructed so painstakingly over the years does not satisfy present needs. Among the contributing factors which complicate our delivery of service to clients who do not have middle-class values are:

1. They do not respond to the centralized bureaucratic structures that usually deliver rehabilitation services (Aiken and Hage, 1966; Ireland, undated; Riessman, 1962; Webster, 1966).
2. More often than other groups, their rehabilitation is complicated by such factors as prolonged neglect of health conditions,

negative attitudes to organized services, lack of access to proper services, and non-rehabilitative welfare practices. Left alone by society to cope with their disabilities as best they could, many of them have lost hope that the community will intervene on their behalf.

3. They generally suffer the combined losses of the original disability plus the deprivation caused by experiences as a minority group member, a migrant worker, a foreign-born person, or a homebound, neighborhood-bound, or institutionalized individual. Additional handicapping conditions include low educational achievement, indifferent work histories, blunted work motivation, lack of vocational skills and distrust of the establishment.

4. They prefer general informal and personalized treatment situations while rehabilitation professionals gravitate increasingly toward formalization, specialization and "efficiency" (Bernard, 1967; Loeb and Scoles, 1968).

5. They do not necessarily endeavor themselves to counselors, many of whom prefer tractable conforming clients who "fit in". Generally, alienated individuals regard appointments as less sacrosanct, are less accustomed to meet agency requirements promptly and fully, are less responsive in interviews, feel less anxiety about making a good impression, do not give vocational success a high priority, and do not express enthusiasm and gratitude for what is done for them. As a consequence, they are impatient with drawn-out procedures and, if denied early assistance on their own terms, are likely to withdraw from, or participate minimally in the rehabilitation process (Mangum, 1967).

6. Not infrequently, they bring social problems with them that are less familiar to rehabilitation workers, and apparently, less responsive to orthodox rehabilitation treatment. Among these social problems are: narcotics addiction, unstable and problem families, ethnocentric attitudes, functional retardation, chronic unemployment through choice, overdependence upon welfare, high levels of geographical mobility, and covert, if not open rebellion against established society (Communities in Action, 1966; Glazer, 1965; Goldfarb, 1964; Hatcher, 1966; Howells, 1966; Kemp, 1966; Kruger, 1966; Leshner and Snyderman, 1965; McCabe, 1966; Rosenbaum and Hasson, 1968; Siegel, 1964; Whitman, 1966; Weinandy, 1964; Wirtz, 1966; and Young, 1966).

7. They are less inclined to take the initiative in seeking out rehabilitation services. Gellman, in the Report of the Third Rehabilitation Workshop of the New York City Regional Interdepartmental Rehabilitation Committee (1967), noted the ramifications of waiting for such clients to apply for rehabilitation assistance: "Rehabilitation will recognize that its services must be sold to clients as well as to the ultimate consumer, society. . . active case-finding will become a major service component."

8. Present-day delivery systems which rely upon client conformance to an established structure are likely to prove ineffective with this group. Indeed, as things stand now, a disproportionately small number of the socially disadvantaged and severely multi-handicapped, including welfare clients, are active in most State rehabilitation agency caseloads. An even smaller proportion eventually have their cases closed as "rehabilitated".

In addition to the disabled who are poor and deprived, large segments of disabled persons with favorable employment motivation and sound vocational strengths also fail to enter and remain in the rehabilitation process. This is because the provisions made for "average" clients fail to meet the needs of such groups as the homebound, the institutionalized, those with unclear vocational goals, the migrant, the severely multi-handicapped, and the aged. Even if such clients find their way across the threshold of a State rehabilitation agency office, the odds are against their being perceived as promising candidates for rehabilitation. The problem is complicated further by the fact that even favorable State agency attitudes may not suffice if supporting voluntary and public agency programs expressly designed for these groups are not accessible to them. Not infrequently, employer and labor union attitudes can constitute still another restriction on rehabilitation and need to be taken into consideration in developing an effective service delivery system.

Additional Deterrents

The service delivery problem is complicated by other deterrent elements as well. Many services are geographically maldistributed so that the accident of residence impairs the quality of as-

sistance offered in some States and regions. Furthermore, as some rehabilitation workers discovered this spring, the flow of Federal and State funds into rehabilitation programs can no longer be regarded as inevitable. Thus, the date on which a client applies for service could well determine the quality of rehabilitation he receives. Still another deterrent is the centralized nature of rehabilitation delivery which requires some clients to reach out over time and distance to make contact with rehabilitation workers. The more centralized the system, the greater will be the number of disabled persons who have to inconvenience themselves substantially to establish communication with the helping source.

In addition, service delivery frequently is impeded by stereotyped rehabilitation procedures. In some states and communities, service to clients is systematized to such a degree that rehabilitation workers are compelled to "work by the book". For almost every situation there is a paragraph in the service manual which dictates the appropriate action. Despite differences in people, situations, and communities, a client with impaired sight may be compelled to see an ophthalmologist for low-vision aids even though an optometrist might serve him better; a client may have to go through a standardized evaluation procedure even though such a procedure has dubious value for him as an individual; and a homebound person may be denied an extensive extended tryout during which he can overcome the overlay of years of neglect because of a policy that arbitrarily stipulates that a counseling interview coupled with a medical examination and a psychological evaluation suffices in such cases.

Finally, service delivery may be restricted by the professional perceptions of rehabilitation as an adjusting mechanism. Virtually unchanged from the 1920's is the belief that rehabilitation has the mission of assisting clients to fit into existing society rather than changing society to make it more adaptable to the needs of disabled persons. Moved by political conservatism and expediency, rehabilitation has sought to change the client and not the world. Yet, society is not altogether a desirable place for the disabled under the best of circumstances. We have failed to deliver what is perhaps the most needed service of all—social action to provide a better world for the deprived. Most rehabilitation workers do not perceive themselves as bearers of this responsibility. Consequently, they readily become apologists for a society

which, in some respects, makes excessive demands upon the disabled and provides all too few benefits for them.

The Pace of Progress

With growing public and professional concern about rehabilitation's performance in meeting the needs of the severely disabled, the alienated and the deprived, piecemeal efforts have been made to study and remedy the situation. However, the pace has been slow. For example, a number of innovative service delivery mechanisms have been established in other educational, health and welfare programs and have grown old even before they were given widespread field trials in rehabilitation. Among these mechanisms have been comprehensive community service centers (Black, 1967; Terris, 1963), community social planning (Cohen, 1966), agency partnerships and coalitions on a formal contractual basis (Corwin, Bramberg and Rice, 1967; Warren, 1965), traveling clinics (Koch, Schild, Ragsdale and Fishler, 1965); automatic data-processing case-finding methods and comprehensive health screenings (Beckman, 1966; Harris, 1968; Lind, 1968), outreach programs (Epilepsy Foundation of America, 1967); central information and referral systems (Lester, 1968); comprehensive general hospital programs, (Russell, 1965); citizen and client boards



(Welfare Administration, 1967); and union-management projects (Weiner, 1967).

In the face of all the challenges noted above, the response of rehabilitation has been relatively leisurely. As a result, chronic barriers to effective rehabilitation service delivery remain in relation to alienated and disadvantaged individuals, welfare clients, the severely disabled, the multi-handicapped, the geographically and culturally remote person, the migrant worker, the offender, and the addict. Essentially, the central problem is that the people who need rehabilitation the most are the least likely to receive it, and, concurrently, when they receive it, are the least likely to benefit from it. Yet, there are available to rehabilitation agencies in all sections of the United States well-defined choices. They need not cling to established ways of doing things. Alternatives do exist. Some of these are described in the next section.

Current Delivery Systems

The Client Initiative System

This classical model requires the Agency to inform the community about its services after which it relies upon potential clients or those associated with them to take the initiative to request assistance. In this "come-and-get-it" approach, it is assumed that the client who really needs and wants the service will learn about it and take the necessary steps to obtain it. Since mass educational techniques do not always result in a universal community awareness of existing services, even among middle-class residents, this approach may by-pass large numbers of potential clients (Bradley and Frank, 1967; Dilley, 1967). Furthermore, as Halpert (1963) observed in a review of studies relating to public opinion and attitudes toward mental health, we cannot assume that giving people the facts about a service necessarily alters their readiness to accept that service in a positive way. Indeed, even after positive community attitudes have been demonstrated, there is no certainty that those who need a service automatically reach out to organized service deliverers to obtain it.



The Consumer Appreciation System

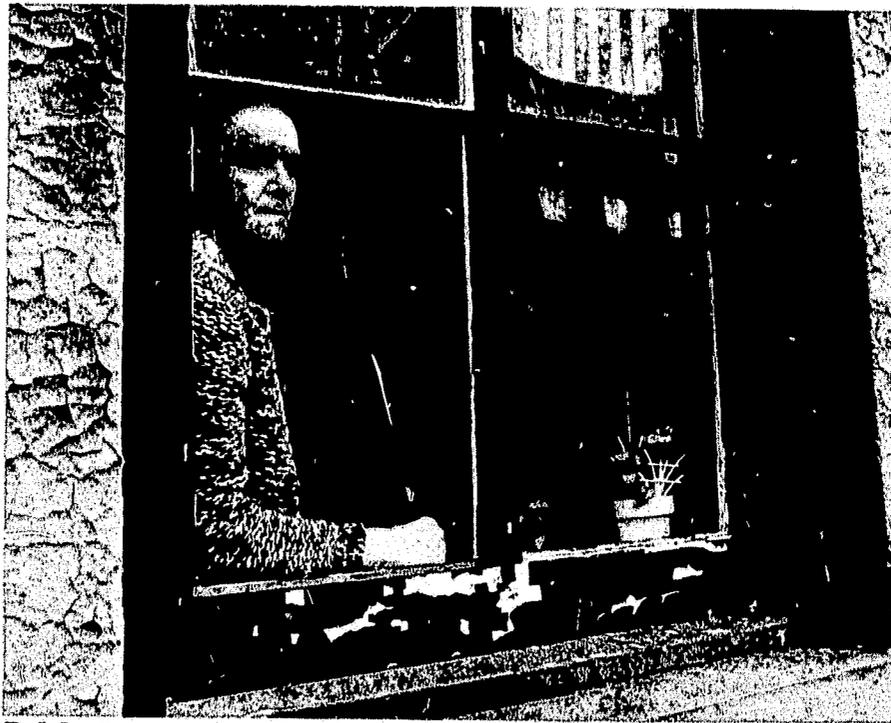
This system depends upon an informal social network through which satisfied rehabilitation clients influence disabled associates to seek similar services from the same source. It is assumed in this approach that an agency that performs well in rehabilitation will develop a supportive constituency which will communicate its satisfaction to potential clients in the community through word-of-mouth advertising. However true this may be for other client groups, it has dubious relevance for the migrant, the alienated, the aged, the isolated, the homebound, the socially disadvantaged and members of minority groups. Testimonials concerning rehabilitation service are less likely to reach them, and even if communication is established, they are less likely to act upon the information. Thus, hopes for a spontaneous interaction with successful former clients, and a subsequent search for service, are not always realized. Indeed, in some communities, the probability of such interactions occurring at all may be discouragingly small.



The Advertising System

This is a variant of the client initiative system in which dissemination of information about the service is systematic, professional, and persuasive, with emphasis on the use of the newer educational and advertising media, such as television and radio, to stimulate client action (Communities in Action, 1966). One model

that has received wide attention is the Dallas program (Carmack, 1965) of preparing the community for school desegregation by attempting to shape group attitudes. This program involved the use in mass media of highly credible information sources, the participation of opinion leaders from a variety of social strata, person-to-person communication among peers, and meticulous preparation of the message to be delivered. Convincing data are still lacking as to whether the Dallas experience actually reshaped attitudes or merely reinforced prevailing beliefs. Furthermore, the application of this program to the much less incendiary issue of delivering health and welfare services is still in doubt. Although mass media advertising approaches merit further study, their value for engineering substantial changes in emotionalized attitudes or counteracting the disinclination of disadvantaged individuals to reach out to organized rehabilitation services is still to be established. To be considered successful, Spitzer (1966) feels that a program of this type must reach out to the large mass of uninvolved, more passive individuals who form the backbone of any community.



**Pride, fear, and confusion
are stopping 5 million disabled from
getting the help they need.**

Five million disabled people are in need of our help. And we can't find them. Either they don't know where to go for help or they won't go.

Some are disabled physically. Others mentally. Some are living in

the past. Others, disabled from birth, have no past.

But most, with proper guidance and medical aid, could be living instead of existing. They could be learning to take care of themselves. They could be taught interesting

jobs. They could be getting more out of life than they're getting.

So if you're disabled (or concerned about someone who is), write to us for help.

You've got nothing to lose but your disability.



What's stopping you!

The Referral System

The referral delivery system rests upon the belief that organized groups and agencies in the community will make suitable referrals to rehabilitation agencies to the extent that most of those who need the service will have access to it. Although positive results have been reported, and although referral has become a rehabilitation staple, its effectiveness may be lessened by inter-agency rivalries, interpersonal tensions among workers for different organizations, rapid turnover in agency personnel, and the disinclination of some professionals to "share" their clients with other workers.

The information and referral service, a more sophisticated version of this approach, is an autonomous operation that informs people in the community about available services, invites them to seek out these services via the central data source, and makes appropriate referrals to the community agency that is qualified to work with the particular problem, (Greene, 1966). Although a centralized referral approach often neutralizes the biases and predilections of workers in the individual agencies in making referrals, its value with unaffiliated and alienated clients is still to be demonstrated. Indeed, in setting up still another layer of organization between the client and the help he needs, it may actually constitute a deterrent to the individual whose need is for a straight, direct, and informal line to services.



The referral system model varies in its effectiveness depending upon the care and precision with which a referral is made. Casual referrals in which the name, address, and functions of an agency are communicated to the client without concern for his perceptions of, and feeling about, this information can readily undermine the system. Much more success can be expected from a counseling process that not only interprets the reasons for the referral and describes the nature and means of obtaining service from the agency to which the client is being referred, but also provides opportunities for clients to express feelings and make choices.

Even today, however, time limitations, heavy caseloads, and worker insensitivity sometimes preclude painstaking referrals. The consequence is that many clients get "lost" en route to the service. Aware of this danger, some agencies attempt to strengthen this means of delivering services by assigning liaison workers to "accompany" the client as he makes the transition from one agency to the next (Finegan, 1964). Other agencies, particularly those in poverty areas, advocate teaching a referred client how to obtain, through individual or group action, the services he needs from that agency with a minimum of red tape and delay. Workers who assume this "advocate" role abandon traditional neutrality and undertake to assist clients to assert their rights. One justification for this approach is that, through acquiring a feeling of personal or group competency in dealing with the organized community, the client will be less reluctant to use community resources and will be more competent to cope with the bureaucratic structures that serve him, (Grosser, 1965). Under these circumstances, careless, indifferent, and inefficient workers will become subject to censure by service consumers and will be less likely to function in an arbitrary and authoritarian manner.

The Client Affiliation System

Many potential rehabilitation clients affiliate with an organized community service some time in the course of the disability experience. Points of contact exist in welfare and housing agencies, physicians' offices, clinics, hospitals, mental health centers, anti-poverty programs, employment services, labor unions, employer-sponsored organizations and other groups. These points of con-



tact, plugged into the rehabilitation enterprise through formal and informal agreements with rehabilitation agencies, are more than simple referral sources. As used extensively by the Federal-State rehabilitation programs, these affiliates become active participants in the process, often through the medium of stationing rehabilitation workers on their premises or by some other means of program integration. The critical attribute of the client affiliation delivery system is that it is not merely a matter of case-finding. Instead, personnel participate on service teams representing multiple agencies in an ongoing program that dovetails resources for maximum benefit to clients.

Many rehabilitation case-finding and service delivery accomplishments have been reported in connection with this approach. Currently, interagency affiliation programs are being conducted in mental health and mental retardation centers and institutions, day and residential schools for disabled young people, prisons, detention homes, general and specialized hospitals, homes for the aged, and long-term illness institutions, among others. Within this system, many different arrangements have proven successful in promoting rehabilitation objectives. A few of the cooperative patterns include institutional work programs, institutional sheltered workshops, member-patient work schemes, half-way houses and other transitional living plans, self-help programs in long-term care facilities, and community-based evaluation, training, and placement programs, (Anderson and Irving, 1965; Rogatz, 1965; Rosenberg and Cotloff, 1967). Some exciting projects have been established in public housing (Epstein, 1964; Fasteau and Martz, 1964). Although the client affiliation delivery system re-

portedly has been productive of favorable results, its principal weakness has been in finding the unaffiliated individual and in serving those whose affiliations with community services are brief and tenuous. Most affiliations of low-income people are limited in scope and duration, and as in the case of general hospitals, the potential client may be in and out of the affiliated service before the affiliation mechanism really "takes hold". Even if rehabilitation begins, discontinuance of the original short-term service that brought the client into rehabilitation in the first place may be accompanied by disaffiliation with the rehabilitation service as well. There is also a problem when clients make a transition from the centralized, compact, comprehensive, all-under-one-roof service found in many institutions to scattered and loosely organized community programs. In moving from the shelter of institutional structure into a more amorphous community, some clients get lost in a maze of agencies and individuals that may seem rational to the professional but appear chaotic and bureaucratic to the consumer.

The Family System

This delivery system, a special variation of the client affiliation approach, focuses on family as well as individual affiliations. Thus, in this model, disabled persons often develop links with rehabilitation through their families which, accordingly, become a major affiliation unit. In view of recent legislation, tying family members more closely into the rehabilitation process, this is a timely approach in which it is recognized that successful rehabilitation rarely begins, functions and terminates without the active participation and, perhaps, treatment of the family unit. Increasingly, rehabilitation agencies are accepting clients for service with the understanding that family members simultaneously will take part in such activities as group and individual counseling, family orientation programs, rehabilitation planning, and post-care arrangements. Others have moved even further in this direction by involving everyone in the disabled person's household in a family-centered treatment process in which services are offered to all family members, not only in accordance with the needs of the



individuals concerned, but also with reference to interventions that will strengthen the family as a unit.

The potential of the family as a focus for service delivery has been explored most thoroughly in social work settings where family-centered approaches commonly are used in the treatment of children and adolescents, (Janowicz, 1967; Lewis and Stark, 1966; Markowitz and Gordis, 1966; Meyer, Schiff, and Becker, 1967) and marital partners. For many years, rehabilitation workers have drawn family members into client service, understanding that the disability experience of an individual can influence and be influenced, in turn, by family relationships. Some clients never reach rehabilitation because they are sheltered or isolated by their families, and some of those who do enter rehabilitation make minimal use of the service because of family deter-

rents. In the case-finding area, focus on the family increases the number of potential contact points between clients and agencies. In the service area, family involvement creates a more favorable rehabilitation climate and ensures coordination of agency and family efforts on behalf of the disabled person. Much less developed is that aspect of a family delivery system in which the initial point of contact is between a non-disabled family member and a non-rehabilitation agency. The degree to which such relationships can be used as a rehabilitation springboard is still unknown. Indeed, despite its evident logic and its bright promise, the organized family delivery system in rehabilitation is still so new that its full effectiveness has not been tested as yet.

The Indigenous Worker System

Negative attitudes toward the "establishment" and those representing it make some client groups, such as narcotics addicts, alcoholics, the poor and dispossessed, the socially disadvantaged, and the offender, varyingly inaccessible to organized community services. Even when professional workers function in the framework of so-called "out-reach" programs, important communication and cultural barriers persist. On the other hand, properly selected and trained non-professionals who share some of the life experiences and social values of the alienated clients they serve can become points of contact not only in case-finding, but also in expediting services, delivering some forms of assistance, and following service consumers in the community.

Although the indigenous system can produce its quota of unfavorable experiences, especially when it is planned and implemented with improper role definitions and safeguards, it has functioned as a useful supplement to systems dominated by professional workers. Along with using non-professionals as volunteers and lay leaders, (Brager, 1965; Eisenstein, 1964; and Jackson, 1964), agencies have experimented with employing non-professionals as deliverers of service in school, social agency, rehabilitation facility and institutional settings. It has been suggested that it is unreal to expect that these indigenous workers can or should convert clients to middle-class mores and values or serve

as substitutes for professional workers (Coggs and Robinson, 1967). Major areas of reported indigenous worker usefulness include interpreting the community culture to the professionals (Brager, 1965b), increasing the level of participation of community members in the rehabilitation program (Brager and Specht, 1965), mediating between middle-class professional workers and lower-class clients (Grosser, 1966), and providing security and understanding to their peers (Levinson and Schiller, 1966).

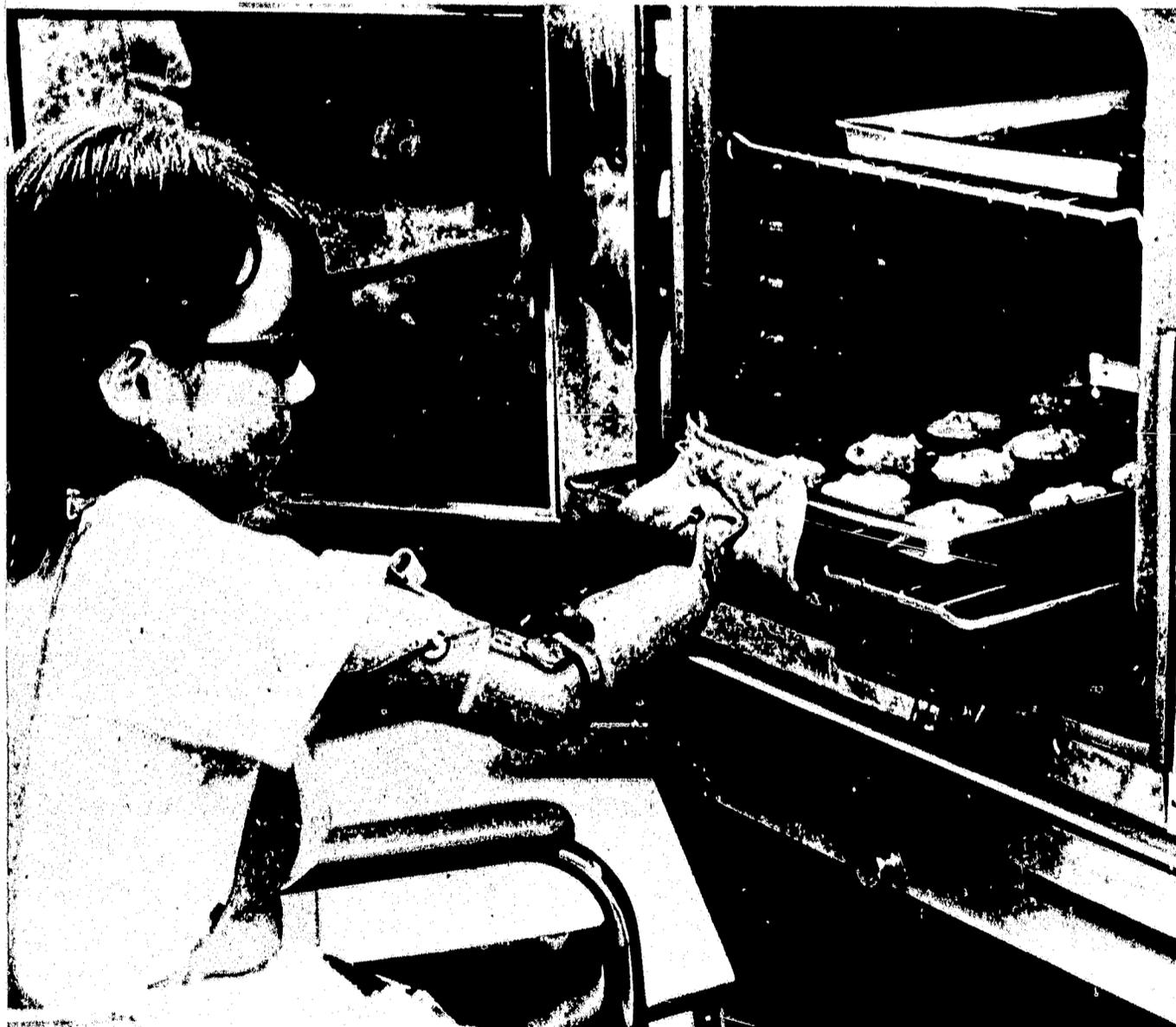
The indigenous worker concept has been adopted more widely by social work-oriented programs than by rehabilitation services. Without the benefit of further experience and research, it will be difficult to specify the indigenous worker component in rehabilitation delivery systems. Unsolved problems include determining the means to be used to organize the three-way relationship (client, professional and non-professional) without vitiating or compromising the contributions of each participant, the boundaries of non-professional worker influence in shaping agency policies and procedures, and the ways of avoiding non-professional worker "over-identification" with either clients or professionals. Some reports attribute special gifts of communication, relationship, and understanding to non-professional workers. These conclusions have yet to be verified by organized research but the service delivery implications of these statements are attractive enough to justify a substantial investment in early research in this area. If, in fact, non-professional workers do effectively narrow the gap between available rehabilitation services and the potential consumers of those services, this approach could become a vital element in the rehabilitation service delivery system of the future.

The Developmental System

This approach generally is applied to rehabilitation services offered to children and adolescents. The underlying belief is that early rehabilitation or habilitation intervention in the life of a child, even on a preventive basis, contributes materially to his overall development. This principle has been widely recognized by rehabilitation agencies for many years and incorporated into

ongoing practice. For the most part, however, the pre-adolescent child and, in some instances, the teen-ager, as well, have been perceived primarily as the responsibility of the family and the school. Thus, rehabilitation agencies may not begin to provide effective service until the child is age 14 to 16, a point relatively late in the developmental history of the individual.

This relatively tardy entry of rehabilitation into the life of the child may impede subsequent service delivery. By age 14 or 16, many attitudes and behaviors concerning rehabilitation and the use of organized community resources for self-improvement have crystallized and, to some extent, already determine how constructively the individual will respond to offers of service. If, at time of case-finding or intake, negative attitudes already condition the child's response to the helping situation, they can constitute long-standing barriers to client progress in rehabilitation. Earlier rehabilitation interventions merit consideration since they can play a part in fashioning attitudes during the formative stage.



Working with disabled children and their families on a developmental basis can pave the way for improved rehabilitation performance later on. Although no one can be quite sure about how far down the age and development scale rehabilitation should go, intervention during the pre-school years is not inconceivable. Experiments at United Cerebral Palsy of Queens suggest that service to a child and his family when the former is 18 months of age makes the family unit more accessible to rehabilitation later on. Since participation on a developmental level is relatively new for rehabilitation, the results of early service should be studied with some care. Premature intervention, in its way, can be as hazardous as delayed service.



The Key Citizen System

This system relies upon the intervention in the rehabilitation process by exceptional individuals in the community (Freeman, 1963). Considered superior by their fellow citizens in some important attribute, respected for their wisdom, or recognized as knowledgeable, disinterested, or skillful and perceived as having no personal axe to grind, key citizens often provide an endorsement of rehabilitation that is so influential that it motivates some disabled persons who might not otherwise seek service. Thus, many rehabilitation workers routinely enlist the visible approval of rehabilitation by clergymen, attorneys, educators, businessmen,

and other recognized community leaders. For example, in view of their unique role in the lives of their patients, physicians can be highly influential in referring patients to rehabilitation agencies and in encouraging them throughout the rehabilitation process. Indeed, finding improved means of sensitizing physicians to the values of rehabilitation constitutes a persistent service delivery problem in this field.

Although the key citizen delivery system already is well-established, new directions in its use are being taken. A promising variant is the local citizens' advisory board which not only provides invaluable expertise to a rehabilitation program, but endows it with prestige and endorsements that shape the behavior of prospective clients (O'Neal, 1961; Schaller, 1964). Other applications of the key citizen approach include the enlistment on behalf of rehabilitation of distinguished or successfully rehabilitated disabled persons (Dilley, 1967) and of indigenous urban agents who have access to informal lower-class communication networks and opinion-molding social interactions. Such agents include barbers, bartenders, taxicab drivers, certain types of store-keepers (Kelly, 1964), and teen-age community leaders (Davison and Ripeto, 1964). Although favorable reports concerning the use of this service delivery system appear with great frequency, unsolved problems remain. For example, new techniques are needed to commit to rehabilitation objectives physicians and attorneys who participate in workmen's compensation cases and to develop a corps of professional neighborhood "intervenors," who, in the course of their daily practice of dentistry, optometry, teaching, and other professions, can make gross judgments about need for rehabilitation and use their special relationship with a disabled person to usher him into service. With the manifest encouragement of key citizens, many more potential clients than at present will become accessible to service.

The Legal System

Much useful legislation encourages client participation in rehabilitation. Some laws on workmen's compensation, social security, public welfare, education, and narcotics addiction recommend,

require, or set the stage for client participation in rehabilitation. Ranging widely in the degree of "compulsion" they impose upon affected individuals, these laws and their concomitant operational procedures are responsible for much service delivery. Philosophically and practically there are real limits to the amount of legal pressure and compulsion that can be used in an open society to induce an individual to accept rehabilitation. Consequently, mandatory legislation of this type usually is viewed with distrust. On the other hand, legislation that rewards, reinforces, endorses, and facilitates rehabilitation can be the starting point for exceedingly effective service delivery systems. In the latter regard, some vital legislation, e.g., recent changes in welfare enactments, have not yet been fully exploited in rehabilitation terms.

The Community Survey System

Some agencies have used community surveys as one means of finding potential clients and engaging them in the rehabilitation process. In this system, trained interviewers call on local residents, informing them about rehabilitation and inquiring about disabled individuals in the home or neighborhood who, apparently, could benefit from a rehabilitation evaluation. Upon learning about a potential client, the interviewer attempts to interest him or his family in an appropriate service. Although some success might be achieved in case-finding through this means, the current climate in American cities limits its effectiveness. For example, Federation Employment and Guidance Service in a community survey in the Bronx, New York, found that strangers at the door tend to arouse anxiety. This resulted in a high frequency of "no responses" and guarded communications. Other doubts were raised by Weiss (1966) who, in reporting on urban survey experiences, indicated that respondents in poverty areas are hard to locate, tend to be evasive, noncommittal, and opportunistic in their reports, are not motivated to provide accurate information, and lack the language (and perhaps the thought processes) needed to express themselves about abstract matters. In general, the community survey approach has yet to prove itself as a viable service delivery mechanism.

The Community Corporation System

Many corporations, councils, and other associations of local residents have been organized under anti-poverty program auspices to assume active direction of community action programs designed to solve critical neighborhood problems. Based upon the self-help principle, these agencies reputedly have the advantage of physical and psychological proximity to the community and, through providing constructive action outlets to the poor, are thought to enhance local acceptance of, and participation in, organized services (Katz, 1967). Characteristic of this delivery system is a reduced emphasis upon uncoordinated "absentee" agencies in favor of a concerted community-led attack upon local problems by a newly-created master agency. New York City's Mobilization for Youth is an example of such an agency. In its broad form, the community corporation becomes involved in health, housing, education, careers, political action, community betterment, recreation, and crime prevention (Moguloff, 1965; Scobie, 1966). If existing agencies are considered to be sensitive and responsive to local needs and issues, they may be included in the comprehensive service. Otherwise, the community may decide to by-pass them partially or entirely, and establish new locally-directed services of this type under the corporation's umbrella.



It is still too early to assess the values and limitations of the community corporation approach but already it is becoming important for rehabilitation in modified form through the Model Cities program. In the present early stages of this program few successes are evident. Beset by organizational problems, involved in neighborhood group rivalries, often in conflict with the establishment, lacking conceptual and administrative leadership, staffed by many workers who are inadequately trained for their jobs, and riddled with political and internecine struggles, these community programs have yet to prove themselves to be effective deliverers of rehabilitation services. Perhaps as more stable organizational structures, personnel, and procedures emerge, more promising results will be forthcoming. As of now, the poor and their "professional" advocates have shown themselves no more competent to deliver rehabilitation services than members of the rehabilitation "establishment". Despite the difficulty of devising assessment procedures, the long-term service delivery role of this approach will depend upon how favorably they are evaluated by dispassionate observers.

The Catchment Area Service System

This delivery system is built on the belief that all of the people in a defined geographical area who have rehabilitation needs should have appropriate opportunities to satisfy these needs. Consequently professional services should be coordinated and organically related within that area, reflecting local needs, concerns and conditions, and providing for a measure of local lay and professional participation. The mental health movement has used this approach to some extent. It has identified geographical areas, both in terms of population and location, which serve as defined organic units in conducting comprehensive services.

Cooperating in varying degrees with existing community services, catchment areas constitute a manageable focus for specified community services. This concept is applicable to medical, educational, rehabilitation, housing, recreational and other services, as well as to mental health. A wide variety of types of sponsorship,

administration, program, and community involvement is possible so that the structures developed in any catchment area can be adapted to the demographic and cultural factors prevailing in that region. If necessary, by reason of limited resources or agency intransigence, new services may have to be introduced into the area.

The catchment area concept is still too early in its history to be evaluated in terms of its service delivery potential, especially in regard to rehabilitation. Currently few, if any, rehabilitation programs offer locally based comprehensive services within a specified neighborhood or catchment area. However, a proposal for at least one catchment area demonstration project is under consideration in New York State. Others soon may be getting under way. As these projects are launched and as they undergo evaluation, it will become increasingly possible to determine, in actuality, if the catchment area approach does indeed deliver a wide spectrum of rehabilitation services more effectively to a larger proportion of its potential clientele than other systems currently in use.

The best mechanisms for encouraging local participation and integrating existing programs into the catchment area rehabilitation service have not yet been determined, but advocates of the concept believe that impersonality toward service consumers will be minimized, lay involvement will be enhanced, professionalism will be strengthened under local review, and services will be increasingly responsive to expressed local needs. Some of the other types of delivery systems that have been described can be incorporated into the total design of the catchment area but on a decentralized basis. If this is done, the catchment area system becomes an intermediate administrative device intended to bring other delivery systems closer to the rehabilitation constituency. Professional control and responsibility for the services offered remains with the other systems.

Multiple Delivery Systems

Probably no single delivery system can perform the enormous task of delivering rehabilitation services to the American people without the support of one or more other systems. However, even

when such systems appear in combination, one system or concept tends to stand out in the multiple structure. Thus, complex delivery systems can be identified by the dominant themes that characterize them rather than by their exclusive adherence to a single approach. In actual practice, most service delivery systems are amalgams of several systems, hopefully unified by a consistent philosophy and an organized plan built around any of the service delivery approaches discussed in this section :

1. The Client Initiative Delivery System
2. The Consumer Appreciation Delivery System
3. The Advertising Delivery System
4. The Referral Delivery System
5. The Client Affiliation Delivery System
6. The Family Delivery System
7. The Indigenous Worker Delivery System
8. The Developmental Delivery System
9. The Key Citizen Delivery System
10. The Legal Delivery System
11. The Community Survey Delivery System
12. The Community Corporation Delivery System
13. The Catchment Area Service Delivery System
14. Multiple Delivery Systems

As indicated, each of these approaches, individually and in combination, has its own values and limitations which should be ascertained in the framework of the attributes of a satisfactory rehabilitation service delivery system.

Attributes of a Satisfactory System

From a pragmatic viewpoint, the one critical characteristic of a satisfactory rehabilitation service delivery system is that it gets adequate service readily delivered to disabled persons under conditions which enable them to make optimum use of it. Unfortunately, criteria and techniques for measuring the degree to which any delivery system accomplishes this goal in relation to other delivery systems are not available. However, some recent attempts have been made to move in this direction. For example, the Department of Health, Education, and Welfare Task Force on Organization of Social Services (1968) noted that: (1) even the most effective service delivery system should not be regarded as a substitute for a healthy economy and national policies that promote full employment and satisfactory income levels, (2) effective delivery of services presents the client with a choice of alternative delivery systems, (3) clients should play a role in planning and offering services, (4) quality services should reach all citizens without distinction and with due regard for the dignity and self-respect of the the consumer, and (5) although wealth is rising and increasing commitments to social services may be expected, resources will be limited, necessitating the establishment of service priorities.

Additional principles could well be added to this list. Without exception, a service delivery system should have rationality; it should be planned and implemented on a logical step-by-step basis (Joint Committee of the American Hospital Association and the United States Public Health Service, 1961). From the very beginning, an overarching philosophy and a theory of service delivery should be adopted which relates the program to larger social

movements and provides consistency and order to the total design. Once the underlying concepts have been established, the service delivery system should be made responsive to those whom it will serve in the target area, an objective that can be achieved with the help of data derived from organized studies of both the communities and the individuals involved in the delivery system. In conjunction with these studies, every effort should be made to acquire an intimate knowledge of the social, economic, cultural, and psychological factors which shape life in that community, and which, in the long run, will determine the nature of the services to be delivered.

Lay and Professional Participation

After the facts concerning the target area and population have been considered, a service structure should be developed which provides for appropriate lay and professional participation and which protects the service consumer from unreasonable and detrimental behaviors of both professional workers and community residents. The administrative structure adopted should offer security for all participants while fostering desirable change, creativity, innovation, demonstration, and research. With this framework as a basis and with continuing lay and professional involvement, procedures, techniques, records and relationships can be introduced which implement the organized plan and which bring the planners' philosophy, theory and ideas to full and practical realization. Long before the first client enters the service delivery system, provisions should be made for a systematic and objective evaluation of the program by technically competent individuals. Thus, under a sound delivery system, the service remains open to alteration and revision in accordance with evaluative recommendations. Finally, a sound delivery system should eliminate, insofar as possible, the human and attitudinal factors that pervert an otherwise effective plan. This aspect of the service delivery problem will be discussed later.

Weaknesses In Present Systems

When measured against these criteria, current rehabilitation delivery systems reveal weaknesses in several dimensions:

1. Having developed by an additive rather than a planful process, they do not spring from nor operate under a carefully thought through conceptual, theoretical, or philosophical system. Winthrop (1964) suggested that community services should grow out of a consideration of the philosophy of communities and community planning, social and psychological pathology, ecology, economics, sociology, political science, law, the psychology of change, and modern technology. Few, if any, rehabilitation service delivery systems were designed to be congruent with theoretical formulations in one or more of these disciplines.

2. As a differentiated function in agency administration, rehabilitation service delivery is awarded scanty allocations of rehabilitation personnel, time, and funds. Although Statewide rehabilitation planning has stimulated some movement in this direction, there are few evidences on the operational level of a commitment to give delivery systems parity with other rehabilitation agency functions. Consequently, fundamental changes have been few in number and the installation of up-dated systems has been more a matter of expediency than planfulness. An essential first step toward improving this situation will be taken when rehabilitation agencies routinely assign technically competent personnel to study and re-design the approaches used to deliver effective services to all clients who need them.

3. The distribution of rehabilitation service throughout all strata of the community is improving, but it still has a long way to go. If the national goal of giving all disabled persons in the United States access to the rehabilitation services they need is to be achieved by 1975, fragmented and patchwork repairs in delivery systems will have to be replaced by thorough-going and systematic efforts. Too many of the Statewide rehabilitation planning recommendations consist of requests for more of the same. Apparently, these massive efforts have produced more stereotyped than creative service delivery ideas. In the long run, committees consisting of interchangeable human units with homogenized views will not generate the overarching changes called for by present conditions. If the Statewide rehabilitation planning reports the authors have read are any criterion of the productivity of these bodies, they argue for placing the task in the hands of a few highly creative individuals.

4. In many rehabilitation agencies, consideration of service delivery problems is still spasmodic. Overburdened counselors, deeply involved in serving heavy caseloads, often constitute an agency's case-finding shock troops. In view of current priorities and currently accepted criteria of counselor success, most counselors are likely to be more concerned with helping their already swollen caseloads than with seeking new candidates for places on a waiting list. Orthodox agency staffing patterns tend to define counselors' jobs so broadly that they are asked to undertake an astonishing variety of technical and specialized rehabilitation functions, some of which demand other competencies and considerable released time. As in the case of other service delivery components, some or all case-finding functions should be made the responsibility of technically competent individuals who are equipped both with the personal attributes and the resources to commit themselves fully to studying and remedying current inequities in the delivery of rehabilitation services.

5. Despite some hopeful signs, rehabilitation is still on the threshold of reaching the large mass of unaffiliated and alienated disabled persons who constitute what Zolik and Marches (1966) call the "zone of invisibility". The members of this group who do actually receive service at present usually enter agency programs through special projects, seasonal recruitment efforts and special enrollment drives. An improved permanent, organized, and ongoing case-finding plan with the disadvantaged as its target is needed in many communities to dovetail with a service pattern that makes provision for the value systems, expectations, and bureaucratic tolerance of this group.

6. With all the changes that have taken place in recent years, the rehabilitation enterprise in the United States essentially remains a centralized service delivery system. Although occasional attempts are made to bring the service closer to the consumer, remoteness and disassociation from clients still are more common than localization and community contiguity. For the most part, rehabilitation retains its extensive network of State, county, and city service sites, many of which constitute physical manifestations of a State authority visiting rather than springing from the tap roots of a community. The aura of absentee management still permeates much of the daily practice of rehabilitation workers.

7. Despite sharing common Federal legislation and operating under comparable State laws, state rehabilitation agencies vary in the quality of service they offer, and, even within the same State, numerous clients in certain groups or geographical areas suffer significant degrees of service deprivation. Among other groups, these under-served client strata often contain disproportionately large numbers of the poor, members of minority groups, residents of rural areas, migrant workers, the aged, the homebound, the institutionalized, and persons with criminal records. In some cases, persons with some disabilities have an advantage over persons with other disabilities. Depending upon seasonal availabilities of funds, personnel, and caseload pressures, clients may fare better in one season than another. Ideally, accidents of residence, timing, and personnel have no place in a service delivery system. Hopefully, the growing pressure for national welfare standards will eventuate in the elimination of chance, residence, and other extraneous variables from influencing the quality of rehabilitation services available to any disabled American. Unfortunately, national parity has not been achieved under current delivery systems.

8. Rehabilitation today is more adequately financed in some locations than in others. Affluent suburbs and certain urban centers tend to be richer in resources than other areas. This is especially true of the number and quality of cooperating voluntary agencies, many of them competing for State rehabilitation agency fees which have become for them a major source of program support. Uncoordinated and unplanned in many communities, these voluntary agencies can present as many problems in their multiplicity as in their absence. Attempts to organize them into a cohesive rehabilitation structure have not been successful in most communities. As a consequence, their special foci of interest may ensure adequate facilities for some client groups, while others remain under-served. In fact, in some places, these agencies compete for the same clients, while other people who need service have no place to go. On the other hand, down the road a piece, small towns and rural districts not only have no competition but to all intents and purposes, have no voluntary agencies. Since voluntary agencies often spring up and sustain themselves without a logical regional or national design, they deliver rehabilitation services

without regard for established priorities or overall planning. Yet, without them or comparable State-oriented facilities, communities tend to have poorer rehabilitation resources. Not the least of the unsolved rehabilitation service delivery problems posed by these voluntary groups is their relationship with public agencies. All too often, excessive dependence upon income from State agency fees has rendered them toothless and incapable of exercising independent judgment (Allan, 1963; Solender, 1964; Whitten, 1964).

Despite tactful public utterances, all is not well between many public and voluntary rehabilitation agencies. Although relationships between the two have not been subjected to extensive dispassionate study, even casual observation indicates considerable strain. The mutual complaints of rigidity, ineffectiveness, and power hunger are usually expressed privately rather than in the public forum. Locked into their interdependence and relying upon each other in a partially satisfying relationship, they have not yet engaged in a major re-appraisal of their complementary roles nor worked out a re-definition of their common and differentiated responsibilities and procedures. Many private and public agencies work together very smoothly. Yet, some private agencies are viewed with some justification by their State agency counterparts as purveyors of second-rate services whose major interest appears to be that of collecting fees from the State agency for service of dubious value. On the other hand, some public agencies are perceived with some justification by their voluntary counterparts as inflexible, narrow, and authoritarian wielders of power who unreasonably constrict innovative programming and unorthodox, but possibly useful, approaches. In either case, the partial correctness of the protagonists' positions indicates that neither house is sufficiently in order to enable them to work together optimally toward improved service delivery. In fact, State rehabilitation agencies and their employees may sometimes have used fees to coerce community agencies. In turn, community agencies sometimes use the threat of adverse public opinion and political influence to attain their own ends. Still to be achieved is free and equal bargaining between public and voluntary interests which protects the autonomy and freedom of each but requires both to maintain client interest as the framework for the negotiations and the subsequent service delivery relationship (Hanlan, 1967; Litwak and Meyer, 1966).

9. Practitioners rarely need to refer to the literature on interdisciplinary teamwork to be aware of the influence of this variable on the quality of service delivery (Mueller and Murphy, 1965; Rusalem and Acciavatti, 1964; Sister Jean de la Charite, 1962; Sloane, 1965). Their daily experience is sufficient to confirm the existence of serious interdisciplinary problems in communication, status and interpersonal interactions that characterize some teamwork relationships. In actual fact, unresolved interdisciplinary frictions and rivalries still constitute important deterrents to effective service delivery. Thus rehabilitation has before it the unfinished business of devising techniques for bringing together the contributing professions in a democratic fellowship that maximizes the contributions of each to disabled clients. Although medicine is generally regarded as the worst offender, other professions are not free of behaviors that impede inter-professional harmony and the smooth flow of service to as many clients as possible.

10. One of the major barriers to improved rehabilitation continues to be the human implementation of existing delivery systems, whatever their nature may be. This aspect of the total delivery system problem is so important that it will be discussed in detail in the next section.

In summary, then, although rehabilitation throughout the United States is making strong, even dramatic progress toward improved service delivery systems, many unresolved problems remain. It is apparent that the field does not yet measure up to all of the criteria of a sound service delivery system.

Human and Attitudinal Barriers

Some professional workers charged with the delivery of rehabilitation services are outstanding facilitators of the rehabilitation process. Some function as prime deterrents. The latter group comprises one of the least publicized segments of the rehabilitation community. Professional courtesy, poorly defined standards of performance, and inadequate means for evaluating these deliverers of service often protect them from the scrutiny that they merit. Not infrequently, they function under a cloak of tacit agency protection, shielded from public view despite their disservice to the disabled.

Perhaps the large majority of rehabilitation workers are creative, motivated, and skillful practitioners who place client needs and community values before all else and who not only fulfill their service delivery mission in accordance with accepted procedures, but in many instances, extend themselves for their clients beyond their procedural requirements. Long before it became popular to do so, certain rehabilitation workers found ways to help the socially deprived, the multi-handicapped, and the homebound. In days when poverty programs were not yet a gleam in the eyes of the bureaucrats, indigenous community leaders and sociologists, there were some rehabilitation workers who were already taking creative steps to reach greater number of clients on the poverty level and offer them appropriate rehabilitation services. Simultaneously, however, we have had with us some narrow rehabilitation workers who have committed both sins of omission in the delivery of service and acts that have damaged clients chances for an improved quality of living.

The existence of workers of this type is no secret to many agency administrators and supervisors. Unfortunately, many of

these officials are unable to correct the situation fully. Whenever possible, a knowledgeable and sensitive administrator will assign members of the deterrent group to functions which neutralize or restrict the damage they do, but suitable tasks of this type in any agency may not be numerous enough to accommodate all those who merit transfer. Included in this minority counselor group are those who fail to use certain community resources because of personal antipathy to an agency's staff or program, those who deny some types of service to a client because they have personal feelings about this service, and those who inhibit service because of a client's race, religion, or personal characteristics. Others are unconsciously repelled by one or more disabling conditions, lack the capacity to develop warm relationships with clients, are guided primarily by political considerations or personal gain, ignore certain legal services with which they do not agree (e.g., the use of extended evaluations), despair of rehabilitating certain clients who actually have good potential, or establish unilaterally their own personal service priorities.

Controls Needed

Unless suitable controls are instituted, rehabilitation workers can be almost a law unto themselves in relation to their clients. Directives from the central office can be circumvented by postponing case activity so long that some clients relinquish hope, or by adopting behavior that transmits negative perceptions or expectations to the applicant. If he wishes, the rehabilitation worker can project his negative feelings on to the client, attributing to him characteristics that presumably render him uncooperative or his rehabilitation unfeasible. From time to time, counselors offer minimal assistance to socially disadvantaged and other "problem" clients, arguing that such clients are unmotivated, lack rehabilitation readiness, and are unwilling to accept rehabilitation values. Often this attitude takes the form of assigning low priorities to such clients, thereby delaying service to them. Yet, when client discouragement sets in and they move to disengage themselves from the program, the counselor may accuse them of being unreliable. Simultaneously, favored clients in the same caseload may receive prompt and efficient service calculated to retain them in the program until they have been successfully rehabilitated.

The human breakdown in service delivery is difficult to document, but is altogether real. Many of us are aware of colleagues who are less interested in their clients and less dedicated to delivering the most effective assistance to them than they should be. With few exceptions, these non-deliverers of service maintain long-standing careers in rehabilitation without serious challenge. Under these circumstances, they can frustrate even the most sophisticated of delivery systems through their inadequate performance. For example, the programmatic research project for the Rehabilitation of the Homebound (sponsored by the Federation of the Handicapped with support from a grant from the Social and Rehabilitation Service) has found that, throughout the United States, the major professional barriers to the delivery of service to the homebound is the recalcitrance of rehabilitation workers. Neither costs nor rehabilitation techniques, neither transportation nor the severity of the disability was found to be as critical as the attitudes of key professional workers in the community. When positive attitude changes occur among agency administrators and supervisors and adequate leadership controls are provided to staff, the homebound persons begin to receive service despite the persistence of all the other barriers that commonly confront the members of this group.

Similarly, during ten years of innovative effort in developing programs for the older disabled worker, the Federation Employment and Guidance Service has discovered that the hopelessness, despair and defeat often felt by professional workers in a neighborhood can constitute the major deterrent to the delivery of vocational services to this client group. Even after a viable and economical vocational rehabilitation program for the aged had been demonstrated by FECS and supported by extensive independent research, some rehabilitation workers failed to use this program for eligible and feasible clients for thoroughly irrelevant and personal reasons. Unequivocal evidence of the value of this program, support of it by national, State, and local leaders, and extensive educational efforts all failed to change the referral behavior of some of these professional workers, and consequently, the older disabled clients in their caseloads received little service.

Causes of Failure

Certain aspects of professional worker resistance are related to such problems as large caseloads, inadequate and inefficient secretarial staffs, excessive paperwork, poor program planning, or weak administrative structures. Nevertheless under these same burdensome conditions, some compassionate, motivated, and skillful rehabilitation workers sustain their morale and deliver services imaginatively to even the most disabled clients.

Workers who once were conscientious and creative employees have, over a period of time, become defeated by an inflexible bureaucracy, inept supervisors, and lack of adequate supportive resources to do the job. Some have failed to keep pace with change and still function as rehabilitation workers did a generation ago. Others have not been able to adapt to their changing clientele and, despite in-service training, perceive rehabilitation as a service reserved for the well-motivated younger client group who have relatively clear-cut goals and aspirations. Some counselors still believe that a brief interview can reveal all that needs to be known about a severely disabled client. Some cannot accept such concepts as training services, extended evaluation, demonstration projects, or rehabilitation workshops. In some cases, each exciting step forward is viewed as a "gimmick" which lacks real value and which frivolously consumes public funds. Consequently, workers with these outmoded views persist in their well-rutted track, failing to deliver to their clients the newer and more powerful rehabilitation services that have been added to the rehabilitation armamentarium in recent years.

In effect, then, the planners propose and some of the practitioners dispose. The end-product in many instances is flawed service delivered by some professional workers and effective service delivered by other workers in the same office or the same community. For the client and his family, rehabilitation becomes a form of Russian roulette.

Thus, it is important to focus upon the deliverers of a service as well as the system under which they operate. Even though delivery systems may become increasingly sophisticated, nothing really changes unless the service deliverers implement the systems properly. Consequently, the challenge of the future lies in what we do about both the deliverers of service and the system under which delivery takes place.

A Philosophical Substructure

An assumption of the authors is that a service delivery system is a man-made institution that follows the laws that apply to such institutions as they function in a modern technological society. A relevant discussion of the manner in which human institutions fall behind social conditions, and thereby prevent man from fulfilling himself, was presented by John W. Gardner during the Godkin Lectures at Harvard University (quoted in *Time*, April 11, 1969). Gardner takes the position that, as it presently operates, our society is not an adequate problem-solving mechanism. Merely repairing institutions in an attempt to maintain pace with social change can well lead to a confrontation between those who resist change and those who would destroy our institutions completely. Thus, our task is to "design a society (and institutions) capable of continuous change, renewal, and responsiveness."

Gardner holds that government, courts, unions, corporations, universities and other institutions are "waxworks of stiffly preserved anachronisms . . . with their own impenetrable web of vested interests." All human institutions require periodic redesign. Such redesign would provide for continuous renewal so that the institution in question continues over the long run to develop human resources to the fullest, remove obstacles to human fulfillment, and emphasize lifelong learning and self-discovery. It is not that our values are weak, it is that we have not been able to make our values live in our institutions. The breakdown in modern living seems to stem largely from a deterioration in the relationship between the individual and society.

Gardner finds an analogue for this breakdown in a beehive model. In this model, society perfects itself while the individual becomes increasingly dwarfed in the process. Whatever the political system, man is moving toward an ever greater dominance by

the system over the individual. Even the keepers of the system are imprisoned by it, just as the queen bee is a prisoner in her beehive. They build, protect, and lovingly sustain the system, making it an increasingly effective inhibitor of individuality and creativity that eventually destroys them as well. Of all the losses that occur in a beehive structure the most serious is the loss of one's sense of being part of a community and its replacement by formula controls that require little or no participation by the individual. Since all large-scale present-day organizations smother man, new ways must be found to restore his role as a participating community member. Thus, we need to design a structure which expands man's choices and enriches his life with procedures that will strengthen, not diminish, him. Rather than anarchy, planned and orderly change is needed to move our institutions in the direction of individual freedom and responsibility. "We have plenty of debaters, blamers, provocateurs," Gardner said, "We don't have plenty of problem-solvers. A relevant call to action would address itself to that complacent lump of Americans who fatten on the yield of this society but never bestir themselves to solve its problems . . ."

The libraries of America are full of books, reports, pamphlets, conference papers, and journal articles that suggest problems in rehabilitation service delivery. Despite these reminders of a cultural lag in rehabilitation, corrective action has been slow in coming. We have backed and filled, proposed and amended, patched and repaired until the rehabilitation structure now is largely a composite of disparate enactments superimposed on each other haphazardly. In some instances, procedures date back to 1920, and some personnel have a concept of society that is based upon a view of man that was outdated at the turn of the twentieth century. If all that the Conference on Rehabilitation of the Disabled and Disadvantaged accomplishes is still another patch on a tottering service delivery mechanism, it may merely help the current archaic structure to survive until, as Gardner sees it, the system either breaks down of its own weight or smothers both those who tend it and those who should be served by it.

Need for Continual Change

A repair approach is much in the tradition of rehabilitation. Is not the legislation on rehabilitation primarily a series of amend-

ments to an act that has remained relatively intact for almost fifty years? And is not the typical state-centered official rehabilitation agency essentially what it was two generations ago? But lack of change is not the only danger. Equally serious conditions would be created by the Utopians who would design the "perfect" service delivery instrument, one that sweeps away the past with one stroke of the pen and creates a service delivery heaven on earth. Unfortunately, without provision for continual change, that system too soon would become obsolete and archaic as society continues to change even as the system is built. A more relevant approach for us is to redesign service delivery mechanisms so that, imperfect as they may be, they contain a built-in responsiveness to change. As we see it, the core of Gardner's message for rehabilitation is not the pursuit of momentary excellence, but the creation of institutions that enable the forces of change to manifest themselves, that reinforce human activities promoting change, and that bring about needed change promptly and effectively. Divorced from bureaucracy and hardened lines of authority, an improved service delivery system must be one that changes because it depends upon the people who will benefit from, or suffer by it and, therefore, who will not be content to be swallowed up in the maw of a self-destructive, rigid attempt to perpetuate procedures that have long since become obsolete.

Proposals for Improvement

Just as Gardner views society's salvation in terms of a renewal of the relationship between man and his community, so the authors of this paper consider a restoration of man's participant role in his community as the key to an improved rehabilitation service delivery system. We do not believe that any single system is ideal in every respect. Perhaps, the pursuit of a system, per se, is a fool's errand. Consequently, adopting Gardner's concept of self-renewal, we can suggest some of the attributes of a rehabilitation service delivery system which will make the system more responsive to change and more sensitive to human individuality.

Decentralization

To achieve these ends, we suggest a movement away from exclusively centralized State *administration* toward representative,

decentralized, community control, in the tradition of the New England town meeting.

In accordance with the vast differences that prevail among American communities, we recommend the abandonment of centralized *procedures and regulations* that mandate homogenized approaches to rehabilitation. Local diversity is an established fact of American life. Gardner calls this diversity pluralism and views it as variety, alternatives, choices, and multiple focuses of power and initiative. This implies that while basic principles remain intact, the details of implementation rest with professional leadership and lay participation.

A Realistic View of Coordination

We further recommend abandoning what the authors consider to be an unrealistic hope that existing institutions and agencies in a community necessarily will perform more effectively in a rehabilitation service delivery system if they are coordinated in some manner (Messner, 1967). It is well to remember that each constituent agency in such a coordinated effort is mired in its own cultural lag and trapped in its own unyielding power structure. To expect that all, or even most, of these agencies will respond in a self-renewing fashion to our call for coordination is to deny the realities of organizational life. The anti-poverty program, if it has proved nothing else, has underscored the lack of readiness of many community agencies to react swiftly and flexibly to the challenge of change. Attempts to coordinate community agencies, which are in varying stages of self-renewal, into a cohesive and organic whole are almost inconceivable to us. Although we recognize that many other people believe it to be feasible, we consider them visionaries who suffer from their own cultural lag.

We cannot rely upon our presumed capacity to restructure a multiplicity of independent and self-perpetuating agencies, each of which has its own more or less successful strategies for resisting change. By and large, an up-to-the minute rehabilitation establishment operating on a decentralized level will have to go it alone until other self-contained service components in a community give evidence of a greater capacity for recognizing, accepting, and responding to social change. However, this does not contradict an existing vital dynamic agency assuming the major responsibility for conducting the catchment area program.

Delivery Systems of the Future

Envisioning the trend which rehabilitation delivery systems should take, the authors foresee the following developments:

A rehabilitation service delivery system built on decentralized lines will seek total community participation within limits that ensure equitable representation of technical and professional rehabilitation personnel. Its board, committees, membership, and staff will contain a suitable representation of community residents, service consumers, professional and non-professional workers, labor, management, and public officials. At frequent intervals, it will throw open its doors and invite the community to examine its operations and participate in its continuing renewal. Periodic "stockholder" reports will be issued in terms which are meaningful to the community and which can be subjected to review at "town meetings" conducted for this purpose. Routinely, consumers affiliated with the service will participate in agency evaluations leading to organizational and service alterations, as required. Although staff members will have freedom to practice their professions without harassment under the protection of the law and with community respect, the manner in which they discharge their duties will be open to free discussion. Furthermore, they will operate under a remuneration system that rewards quality of performance on behalf of the community as well as seniority and paper qualifications. No longer a law unto themselves, rehabilitation practitioners will become active participants in the community process and will be subject to community interest and concern. Under these circumstances, the coolness, detachment, superordination, and social remoteness that characterize some rehabilitation workers will become less valued indicators of performance and the more valued indicators will be such attributes as zeal, involvement, concern, and sensitivity. Final judgments on policy and performance matters will be made by an agency board that represents all lay and professional strata concerned with the rehabilitation enterprise.

On the community level, office-based service delivery approaches that have held sway in rehabilitation for many years will give way to mechanisms which bring services close to the places where community residents work, play, and interact. For the most part, office appointments will be supplanted by more convenient means of contact: mobile teams, neighborhood store-

fronts, indigenous case-finders, block leaders, one-stop multi-service centers, walk-in services, local information and referral systems, and round-the-clock availability (National Citizens Advisory Committee on Vocational Rehabilitation, 1968).

More extensive use will be made of locally-initiated demonstration projects embodying innovative approaches to community rehabilitation problems. Up to the present, local ideas for improved rehabilitation have received scant attention because community residents and their rehabilitation workers are not altogether able to conceptualize their ideas properly or couch them in the niceties of research language. To achieve this, the requirement of elegant proposals will have to be foregone or specialized assistance in program development and grant-writing and management will have to be made available at no cost to communities who request such help.

Since most community-based rehabilitation delivery systems will be financed by State and national funds, criteria will have to be established for the distribution of such funds. Although population and need factors will continue to be important determinants of level of support, the distribution of funds should also take into account sensitivity to client needs and adaptation to social change. Thus, perhaps, bonus funds will be made available to community rehabilitation efforts that retain their flexibility, respond to local need, enhance individual freedom of choice, innovate approaches that make rehabilitation more effective, and maintain a high level of representativeness and fairness to both the lay and the professional participants in the rehabilitation process. One condition for the granting of any funds might be a requirement that every community, should re-evaluate its rehabilitation program at regular intervals with the aid of consultants and representativeness of the funding agencies. Here too, the evaluation emphasis will be not upon conformity to a preconceived pattern, but upon the community's degree of responsivity to the needs of its disabled residents.

Implementation of the Philosophical Substructure

Every community should be granted freedom to find its own way toward an improved rehabilitation service delivery system that is consistent with the philosophical principles discussed

above. However, the community should not be left entirely on its own to achieve this difficult task. Funding agencies should provide technical assistance which meets the approval of the community. Such technical assistance could well start with a specialist in community organization to help local groups to study the need, mobilize resources, and develop a general design for an appropriate community-based rehabilitation delivery system. Other special consultants dispatched to help local groups would include representatives of the participating professions on the rehabilitation team, administration experts, business consultants, specialists in group dynamics, and developers of creative and innovative demonstrations.

Although almost any local approach that implements Gardner's philosophy would be acceptable, some communities need a starting point in the form of a model system that has special promise for locally-controlled rehabilitation services. In this instance, the authors recommend full consideration of a catchment area approach that enables local communities to band together, if necessary, to establish population units large enough to support a substantial rehabilitation enterprise and yet preserve the ideal of local control and participation. Under the catchment area system, combined professional and lay direction could incorporate the attributes noted in the previous section, safeguard the rights of consumers, deliverers, and the lay public, and mandate improved performance by all concerned. On a local basis, the disabled individual could be served with due regard for his individuality, freed from the necessity of adhering to inappropriate bureaucratic procedures, released from possible dominance by administrators and practitioners who have allegiance to the rigid institutions, and encouraged to make his own decisions in accordance with the conditions that prevail in his community.

No one has the "right" prescription for all the ills of society and its institutions. However, it is evident that rehabilitation service delivery as presently constituted is in a critical stage in which either breakdown or renewal could occur. Breakdown will be hastened by delay in doing something or in focusing more upon the mechanics of a system than upon the attitudinal factors. The precise devices used in the restructuring process are less important than their long-range responsiveness to the forces of change. If responsiveness to change can be incorporated into a service deliv-

ery system, not only will current defects be remedied in time by the built-in change process, but safeguards will be established to enable the system to maintain a receptivity to new ideas and changing conditions. Thus, the construction of a rehabilitation service delivery system is not a task for the systems analyst, the slide-rule engineer, or the bureaucrat bent on preserving the system. On the contrary, sociologists, anthropologists, and social psychologists will feel more comfortable with this problem, especially if they are assisted by the handful of creative rehabilitation thinkers who, today, are responsible for so many of our recent advances in rehabilitation effectiveness.

In brief, the time has come to take rehabilitation service delivery out of the hands of centralized protectors of the bureaucratic faith and return it to the people through means which guarantee lay and professional freedom and the widest possible participation of all concerned. The catchment area concept may be one step in this direction. At least, it constitutes a beginning toward a practical application of Gardner's philosophy.



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