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Changing Outlooks and New Directions in Psychotherapeutic Rehabilitation: Organisational Tendencies in the Canton Ticino

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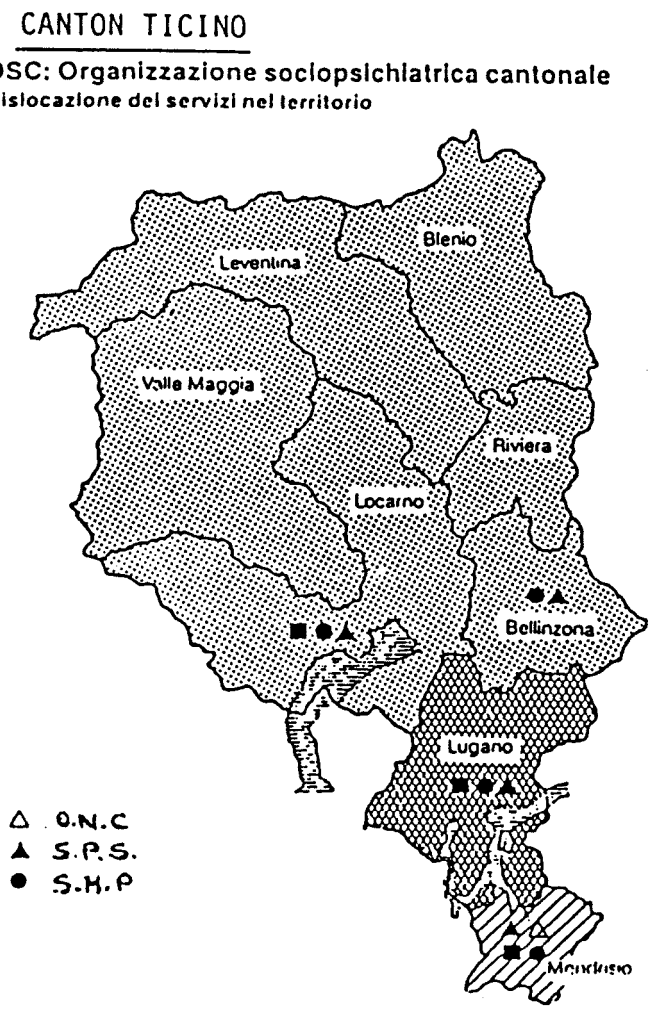
Summary

In the past five years, there has been much interaction between legislative innovations on the Swiss political scene, the emergence of new theories in various scientific fields, and the changes in orientation and intervention in the clinical practice of psychotherapeutic rehabilitation. This has promoted fundamental changes in the organisation and structure of the sociopsychiatric context in the Canton Ticino. These changes are described with particular emphasis on the promotion of a 'semi-private' facility which acts as an intermediary between public and private services, and between psychiatric (medical) and social orientations.

Résumé

Au cours des cinq dernières années, de nombreuses interactions ont eu lieu entre les innovations législatives sur la scène politique suisse, l'émergence de nouvelles théories dans plusieurs disciplines scientifiques et les changements dans l'orientation et l'intervention dans la pratique clinique de la réhabilitation psychothérapeutique. Ce processus a promu des changements fondamentaux dans l'organisation et la structure du contexte sociopsychiatrique du Canton du Tessin. Ces changements sont décrits avec une attention particulière au développement des services 'semi-privés' qui agissent en tant qu'intermédiaires entre les institutions publiques et privées, ainsi qu'entre des orientations psychiatriques (médicales) et sociales.



O.N.C. (Neuropsychiatric Hospital of the Canton)

S.P.S. (Psychosocial Service for Adults)

S.M.P. (Medical -Psychological Service for Minors)

Fig. 1 Sectorial psychosocial organisation of the Canton. Situation of the services - O.N.C. (Neuropsychiatric Hospital of the Canton); S.P.S. (Psychosocial Service for Adults); S.M.P. (Medical -Psychological Service for Minors)

Organisation sociopsychiatrique cantonale par secteurs. Emplacement des services dans le Canton - ONC (Hôpital neuropsychiatrique cantonal); SPS (Service psychosocial pour adultes); SMP (Service médico-psychologique pour mineurs)

1. The Legislative Context

Switzerland (6500000 inhabitants) is a federation of 26 cantons, each of which has a vast legislative autonomy, insofar as the Confederation deals solely with matters regarding international relations, national defence and a few others. In this respect, the Canton Ticino (280000 inhabitants), differentiates itself from a general Swiss perspective as far as Public Education and Health policies are concerned. With regard to mental health in particular, sociopsychiatric assistance in the Canton Ticino was redefined and reorientated through the passing of the 1983 law on sociopsychiatric assistance (LASP), which came into function in 1985. The priorities dictated by its directives concerned the protection of patients' rights, and in particular the right to adequate treatment (Borghi, 1978, 1985).

Article 6 stated that, for an admission to be acceptable, the service and facilities would have to be proportional to the particular need of the person and, where possible, situated in his or her family and social environment. Specialist services would have to be created and, therefore, the need for ongoing staff training schemes. Therapeutic programmes would have to be tailor-made for the individual and, where possible, created in collaboration with the person. With regard to treatment, admissions, or any intervention which may restrict the person's personal liberty, a judicial commission would be at the disposal of anybody in need of clarifications, or in need of legal representation.

2. Organisational Aspects

The sociopsychiatric organisation of the Canton Ticino divides the territory into three distinct psychiatric sectors which include both intra and extra hospital units for minors, adults and elderly people. These units, known as UTRs (Therapeutic-Rehabilitative Units) include: out-patient services, consultancy services, crisis-intervention teams in the community, day and night hospitals, foyers, half-way houses and supervised apartments, psychiatric wards in general hospitals, single sectors in the Canton's neuropsychiatric hospital and any other service (whether public or private) which has been recognised by the sector's management.

With regard to the neuropsychiatric hospital of the Canton (ONC) situated at Mendrisio, the law dictates as follows:

> "The ONC is a place specialising in intense residential treatment. All patients will be guaranteed continuity of care and treatment designed to avoid the negative implications and consequential dependency characteristic of institutional life" (Rezzonico *et al.*, 1990).

The organisational aspects have been further defined by the directives of the LASP, which promote the creation of a Cantonal Sociopsychiatric Organisation (OSC). The three sectors previously mentioned, into which the territory of the Canton Ticino has been divided (Figure 1), include the area of Mendrisio (47000 inhabitants), the area of Lugano (107000 inhabitants), and the area of Sopraceneri which includes the two areas of Locarno (57000) and Bellinzona (65000 inhabitants). The ONC has been divided into the corresponding three sectors, each of which is autonomous in the management of the geriatric and psychiatric wards. Each sector is directed by a psychiatrist who co-ordinates the various activities of the Psychosocial Service for Adults (SPS) and the Medical-Psychological Service for Minors (SMP) and the staff

teams for psychogeriatric patients in the community, as well as the sector's various wards on the ONC.

In addition to the sector's UTRs, the OSC includes intersector services:

- the Cantonal Management for non-medical, non-therapeutic matters
- the medical director of the ONC responsible for co-ordination and medical training/specialisation
- the Intern services (internist, laboratory, etc.)
- the Nursing Staff Organisation
- the Administrative, Technical and Financial Service
- the Centre for Research, Documentation and Specialisation.

3. Private Services of Psychiatric Interest

In the sociopsychiatric context of the Canton Ticino, the public services function essentially in terms of diagnosis and treatment which is of a fundamentally psychiatric orientation. Psychotherapeutic interventions may be practiced, usually in those cases where private services do not find the activity convenient.

The private practices are fundamentally social and psychotherapeutic in orientation - with the exception of private psychiatric clinics - dealing only with those psychological disorders or handicaps which do not present extremely disturbing or clamorous psychiatric problems. These private psychiatrists, psychologists and psychotherapists operate as consultants and outpatient therapists, utilising the private medical clinics when necessary.

3.1. The Role of a Semi-Private Service: The Pro Malati Foundation

In the sociopsychiatric context as described above, the problem exists of co-ordination and integration of the various services offered. In particular, this occurs between the public and private outpatient services, the private and public institutions, and the single professionals in the field. At an operative level it has proved beneficial to promote a private association - the Pro Malati Foundation (PMF) - which has the unusual characteristic of being the private force of the public services. By statute, the President of the Foundation is also the Director of the OSC, thus guaranteeing maximum collaboration and co-ordination between both public and private services.

Thus the FPM becomes the intermediary between private and public services. Above all, it is able to cover those areas and fulfil those functions which are not dealt with by either public or strictly private services. With regard to the private services, such areas would include those cases which are too clamorous psychiatrically, and which require a more intense level of supervision and support, where continuity of care must be guaranteed. With regard to the public services, such areas would include similar cases which, in addition to strictly psychiatric treatment, may require a more specialist orientation. Such social, rehabilitative and psychotherapeutic programmes of an intensive and specialist nature may be incompatible with more medically orientated interventions for which the public organisation caters.

To cater for such cases and to provide the most adequate and 'proportional' treatment, as specified by the LASP, the FPM should necessarily create new specialist services, provide the necessary training for staff, in line with the specific service, and

should be experimental in nature. In addition to the necessary flexibility of such services, consequent to their being experimental, the FPM has an administrative flexibility (as a private foundation), which renders an eventual re-organisation of a service much easier than in a state-run public service.

In this respect, the FPM becomes an instrument for progress, for experimentation of new models of intervention, and above all, for avoiding chronicity and immobility within the sociopsychiatric field. Furthermore, any programme or structure which proves to be functional and valid may then be incorporated into the OSC. Similarly, a programme or service considered worthy but of a fundamentally social nature, may become autonomous of the FPM or become incorporated into other private foundations.

3.1.1. The Activities of the Foundation Pro Malati

The FPM was founded in 1967 on the basis of a donation and its activities consisted mainly in funding recreational activities for residents of the neuropsychiatric hospital (ONC). In the last few years, the FPM has extended its activity to include rehabilitation, sheltered work and protected apartments, and aims to promote any worthy new initiative in 'the community'.

At present the FPM is responsible for:

- sheltered workshops (two within the ONC)
- protected apartments (six dispersed in three sectors and accommodating 25 ex-residents of the ONC)
- the Therapeutic-Rehabilitative Centre for young people with psychotic disorders and other clamorous psychiatric cases
- The Recreation Centres in 'the community' for ex-residents of the ONC
- staff training programmes in psychotherapeutic rehabilitation.

The systematic organisation of the various services commenced in 1984, with the introduction of a rehabilitative programme within the ONC for long-term residents, in particular people with chronic psychotic problems (Rezzonico & Meier, 1987). Based on a cognitive-behavioural model, the aim was to de-institutionalise and reintegrate these people socially by offering them gradual steps towards 'the community'. A 'school' was attended regularly with the gradual introduction of a working schedule (attendance at the two sheltered workshops within the ONC). Group homes and protected apartments were organised, (the group home within the ONC and the six protected apartments in 'the community'). A specialised staff team, (which included both hospital and non-hospital staff) participated in the programme, thus guaranteeing continuity and congruity of care, and above all, familiarity with future caretakers in 'the community' by the group prior to discharge.

Where necessary, collaboration and therapy with family and relatives was encouraged, but above all, emphasis was placed on the reciprocal and non-professional support afforded by the group and on the importance of the 'working role' as a substitute for the sick-role. Once in 'the community', the various group members (living together in protected apartments) were supervised by the Psychosocial Service for adults. In addition to attending sheltered workshops, they were able to frequent the community Recreation Centre for ex-residents of the ONC.

After this experience with over 40 long-term chronic residents, the FPM took an interest in a more preventive orientation, creating the Therapeutic-Rehabilitative Centre for highly disturbed cases, in particular young people with psychotic problems. Rather than de-institutionalise people with chronic problems, the idea was to offer an alternative to hospital admissions, by creating the necessary service in 'the community', specialised to deal with the initial (rather than more chronic) phases of psychotic disturbance.

3.2. Centre Al Dragonato

The Centre Al Dragonato is a non-residential day centre with an interdisciplinary staff team, who in addition to their particular training (psychiatry, psychology, social work, etc.), are specialised in various psychotherapeutic orientations (psychotherapeutic rehabilitation, systemic family therapy, cognitive-behavioural methods). The members of the staff team work either in Administration and Research, the Therapeutic Centre, the Work Centre, the Recreational Centre or the Agricultural Co-operative. All staff are involved in research activity, regardless of their role. At present the staff team includes:

- Administrative director
- Therapeutic director (Psychologist/Psychotherapist)
- Consultant Psychiatrist and Research Supervisor
- Psychologist/Psychotherapists (2)
- Educators (2)
- Socioprofessional teacher
- Animator
- Auticulturist specialist in organic agriculture
- Secretary

The on-going staff training programmes include research activity as a prerequisite to a flexible and evaluative approach. Furthermore, much emphasis is placed on intensive training, due to a conviction that it is the attitude and approach of the staff (and, therefore, their hypotheses as observers and not the structures available) that render the Centre's activities therapeutic (Rezzonico & Meier, 1989). The staff includes non-specialists, and functions in a non-hierarchical fashion, with decisions made by the whole team.

The Therapeutic Centre is equipped for family, group and individual therapy (video-recording equipment, one-way mirror) and works in strict collaboration with the other centres which are considered to be just as 'therapeutic'. It has proved therapeutically functional to differentiate between the different aspects of the Centre.

3.2.1. Work Centre

The Work Centre offers employment (bar-restaurant, a shop for the creation, rent and sale of carnival costumes, gardening teams, computer and secretarial jobs and a co-operative for organic agriculture) and, unlike a sheltered workshop, pays realistic wages. On a part-time basis, the Work Centre has employed various professionals (tailor, gardener) to supervise the various lucrative activities.

3.2.2. Recreation Centre

The Recreation Centre is open to the young public at large, thus creating a 'normal' social environment through the organisation of various courses and activities and through its various facilities (billiard room, bar-restaurant, ping-pong, music room equipped with instruments, video club).

3.2.3. Accommodation Centre

In addition to these facilities, there is a two-bedroomed apartment which may be used for clients in need of a temporary housing solution. Furthermore, the Centre is in the pocess of creating a series of accommodation possibilities ranging from the more sheltered to the less supervised according to the level of autonomy of the individual.

3.2.4. Research

The centre is equipped for the necessary research (computers, video cameras) which is carried out continuously and parallel to all the centre's activities. With the necessary expertise and equipment, the centre is able to assume an experimental approach and hence, continuously evaluate the adequacy and validity of services offered. In addition to new methods of intervention in the field of therapeutic rehabilitation, the centre is interested in developing new ideas in the field of sheltered work, which go beyond the traditional sheltered workshop. The Agricultural Co-operative is one step in this direction.

The Centre Al Dragonato is situated in the area of Bellinzona in the sector of Sopraceneri (in a population of 65000 inhabitants it caters for 30 to 50 clients) and is in a trial phase. If the centre is successful it may be incorporated as a service into the OSC and become a model for other sectors in the Canton Ticino.

3.2.5. Conceptual Base

With any attempt at re-organisation, or elaboration of new projects within the sociopsychiatric field, the underlying concepts which orientate changes are central. In addition to the need for testing these new hypotheses and methodologies, however, there is a risk that any theory or model, once applied, may lose its initial force and function, and that in time models may be retained when no longer functional or applicable.

Knowledge of complex systems theory and the importance of dynamic interaction in the evolution of systems has inreased our awareness of how the political and economic context (the various scientific fields and specific theoretical and practical experiences in the clinical field of psychotherapeutic rehabilitation) contribute to the co-creation of the sociopsychiatric context of the Canton Ticino. In turn, this sociopsychiatric reality propagates new ideas and new experiences which produce modification and further evolution.

As observers, the centre's staff are also participants in this evolution and, therefore, their hypotheses should take into account not only the influence of larger social and political systems and general scientific theories in the sociopsychiatric field, but also their own influence. In this sense concepts and ideas and their communication

become important in determining the possibilities and the limits for any person, whether client or caretaker.

The importance of flexibility and experimentation of new ideas which may be evaluated for their viability becomes evident when considering what influence ideas and underlying hypotheses may have in determining the practical outcome of those same ideas. The dangers of self-fulfilling prophecies and the risk of clinging rigidly to the same hypothesis, regardless of the effects of subsequent intervention, are apparent in this field. For example, a diagnosis which describes a serious and irreversible deterioration as the only possible prognosis may also contribute in creating those same conditions and convictions which bring about the serious irreversible deterioration. Similarly, a negative outcome of a treatment or therapy may be attributed to the gravity of the illness, rather than to the inefficacy of the treatment or of the therapist.

If the aim is to introduce alternative services and types of treatment, which correspond to the specific needs of a particular person, this implies individual evaluation, rather than generalised preconceptions and hypotheses regarding mental disorder. No longer should the individual be forced into a pre-established framework, created by hypotheses and convictions and consolidated by long-standing institutions which need people to justify their existence. It should be the outcome of the treatment that justifies its acceptance and not an initial hypothesis which justifies the treatment, regardless of the results. If the hypothesis of an observer of an individual client involves the diagnosis of 'catatonic schizophrenia' *(sic)* and this leads to a particular treatment such as ECT which happens to cause this particular person brain damage, clearly, the treatment and the initial hypothesis should be re-evaluated. Similarly, if after years of long-term admissions and neuroleptic medication, the result is chronicity and irreversible neurological side-effects, the continuation of such treatment cannot be justified simply by resorting to an initial hypothesis which claims low probability of cure, regardless of the type of treatment received.

The efficacy of a treatment may be considered in terms of an individual's biological, social and psychological restraints and functioning. If a treatment exceeds the individual's limits, by causing biological damage, or if a treatment leads to social isolation and separation or loss of job (or if a treatment causes psychological stress through not taking into account the individual's internal coherence or family relationships), the treatment must be considered non-viable.

For these reasons, the underlying concepts and hypotheses should be clearly defined, consequent interventions evaluated for their efficacy and viability at the three levels previously mentioned, and flexibility towards change when necessary should be maintained through continuous staff training programmes, which include research activity (De Isabella & Rezzonico, 1989; Rezzonico & Meier, 1989; Rezzonico, 1990).

4. Conclusions

In view of these considerations, the advantages of the FPM organisational model within the socio-psychiatric context of the Canton Ticino may be summarised as follows:

4.1. The Possibility of Experimentation

In line with the law (LASP) that dictates the necessity for adequate treatment which is in proportion to the specific needs of the client, the need for the evaluation of new ideas and methods is evident.

On a practical level, the bureaucratic facilitations and characteristic flexibility of a private foundation with regard to decision-making and the introduction of innovations, enables a progressive experimental approach. The structural and organisational flexibility is in line with the operative flexibility required in order to create and evaluate new specialist services. In turn, these new services need to have the flexibility necessary in order to try out new programmes which are yet to be validated, and which therefore may have to be modified or abandoned altogether.

In this sense, the practice of research as an integral part of staff training has proved effective in involving staff in a flexible approach of continuous re-evaluation, according to the feedback received. The integration of research activity with theory and practice in the field of psychotherapeutic rehabilitation tends to increase the awareness of the hitherto unrecognised relationship between the observer and the observed. This promotes a self-critical outlook which underlines the influence of initial hypothesis and the participation in the outcome.

Finally, the experimental nature of the various services of the FPM (in particular the Centre Al Dragonato) tends to improve and encourage public relations, insofar as the constitution of a new service with preconceived ideas may be threatening to established institutions. A centre working on the basis of trial-and-error is open to new ideas and contributions from all sources in the field, especially those with a long experience, regardless of the results of those experiences.

4.2. Co-ordination and Collaboration between Public and Private Services

The collaboration between the FPM and both private and public services is guaranteed, because the President of the FPM is by statute the Director of the OSC. Furthermore, the FPM is a private foundation which enables it to fulfil certain functions which may be of convenience to both public and private organisations. Finally, the private nature of the FPM on the one hand, and its adherence to 'public' legislation on the other, favours integration and the possibility for a more efficient co-ordination of activities.

5. Overview

With reference to Baldwin (1987), the difference between the concept of neighbourhood services and traditional 'care in the community' seems to lie in the particular work modalities which have been suggested to promote and facilitate the transition from 'traditional services' to 'client-orientated services'. According to Baldwin, to provide services which offer specific solutions to specific problems, a data-based approach with systematic record-keeping is a prerequisite in the organisation of new and more adequate services and for the evaluation of the same, according to the feedback received. The organisation and the planning of such services should include 'specialists' who nevertheless collaborate with the local residents. In particular, these would include key people and where possible the clients themselves, to ensure the

provision of services which correspond to the actual needs of clients, and not to the needs of the paid workers.

Baldwin proposes that the staff team should be organised in a non-hierarchical fashion and should be interdisciplinary, to avoid top-down decisions. Common training schemes for all staff involved are suggested to ensure an "explicit commitment to specific goals within an agreed constitution" and "where uncertainty exists, the needs of the immediate client group generally take precedence". Where motives may be suspect, ("it is often difficult to detect the true value transmission of human services"), advocacy systems are proposed to ensure that decisions are made for the benefit of clients and not for the convenience of the staff. Finally, smaller geographical limits are suggested (even under a square mile) with suggestions as to qualifying and quantifying the area through the compilation of a Neighbourhood Directory and a list of Neighbourhood Workers.

A comparison of the work modalities within the neighbourhood concept and the work modalities of the Centre Al Dragonato described previously reveals some accordance. In particular, the experimental nature of the centre which is data-based and individual orientated; the directives of the sociopsychiatric law which give priority to clients' rights and therefore to the provision of services which correspond to the needs of the clients and not vice versa; the use of advocacy systems by clients; the creation of an interdisciplinary staff team which operates in a non-hierarchical fashion and which includes 'non-specialists'; the common training schemes for all staff which ensures a congruity and unity of intervention; and the strict collaboration and co-creation of programmes with clients and their "significant others". Collaboration with existing structures and entities is also considered fundamental, so much so that emphasis is put on the 'positive connotation' of existing methodologies and structures. This attempt at finding new answers to old problems is seen as an evolution of past attempts, and not as a distinct alternative.

The attitude expressed in Baldwin's article may be interpreted as provocative by sustainers of the community concept, in so far as it distinguishes neighbourhood and community as rival concepts where

> "other people may have vested interests in existing structures and be highly resistant to change ... In addition, attempts to reduce or eliminate funding for neighbourhood work may occur, with projects liable to sabotage".

Perhaps an important aim of the paper should be to reduce tensions, by avoiding totally negative criticism of the one, and by avoiding too much self-assuredness regarding the success of the other. Workers in the community concept also have had to fight against the rigidity of 'institution believers'; they too had to face economical difficulties resulting in "care by women". Baldwin refers to the disasters which occurred "following closure or rationalisation of statutory services without necessary and sufficient local support services". How far is the neighbourhood concept totally and sufficiently prepared to substitute the community concept? As Baldwin himself admits,

> "no formal theory exists upon which to test assumptions ... much of the written work is speculative and not based on empiricism or experimental methods" (Baldwin, 1987).

For these reasons, in the Ticino experience of deinstitutionalisation, the neuropsychiatric institution was never totally abandoned, but was required to evolve with the times and according to the new directives of the sociopsychiatric law. The introduction of the Foundation Pro Malati as intermediary between public and private, intra and extra hospital services, was a further precaution taken during the transition phase, to facilitate the co-ordination of new services. It is not sufficient, however, to prescribe the provision of alternative services or to criticise the "absence of inter-agency teamwork" as the cause of inefficiency. "Sabotage", "planned ambiguity" and "exploitation and abuse" are not the result of "community care" or the "failure to achieve specifity and clarity about what constitutes so-called community care". Instead, sabotage and lack of unity may be the result of dynamics at a totally different level, for example, when rivalry between ideologies becomes a power game, rather than a contribution to progress.

A new concept may be welcome, if introduced as a means by which to perfect an already good job, especially in the initial experimental phase based on trial-and-error. Perhaps the future of the neighbourhood concept is already speculative. The needs of clients and of a given society change continuously and in the near future, even the neighbourhood concept will be open to similar criticism and should, therefore, be the first to emphasise the willingness to give way to new ideas. In this sense, the advantage of geographical limits and smaller units may be seen, not only as facilitating analysis but also as facilitating change, if not total abandonment of the service and thus of the new concept itself. Putting the concept on the line may be setting a good example in flexibility.

After all, what guarantees the neighbourhood concept protection from the same pitfalls experienced by the community concept? Baldwin seems to imply that the dangers are inherent in the system based on the community concept, rather than in the relationships and situations which develop in time between human beings. It is not sufficient to prescribe that "scapegoating should be avoided", or to presume that advocacy systems will ensure that services are planned exclusively for the benefit of clients and not for the paid worker. Such dangers will always exist, regardless of the concept adopted, and more so with a policy of "the more the merrier". As he states, "given the range of persons involved, preferences sometimes will be in conflict" above all considering that, "no single value system exists in neighbourhoods". Common training programmes may help in guaranteeing a certain unity of thought, and in particular, may facilitate integration of neighbourhood services for the general public, as well as favouring the co-responsibility for decisions made by all involved.

Ulterior motives are common to humankind, however, and not to a particular concept. For example, advocacy systems may themselves have vested interests or may simply not know what is best for a client. The question arises, who knows best for a client: his/her lawyer who is protecting them from the ulterior motives of an inter-disciplinary staff team; the inter-disciplinary staff team who is protecting them from a pathological family environment; the family who knows and loves them best; or the client who suspects that the advocacy system is in cahoots with the inter-disciplinary staff team and trusts in mum regardless of her provocative effects? Whose point of view or hypothesis has the right to predominate?

The idea of services which include specialists, residents and clients may prove interesting insofar as resulting discussions, due to such diverse points of view, may be fruitful in breaking down deep-rooted convictions which are held as 'truth' regardless

of their viability, and in promoting a more flexible approach to decision-making. Certainly, once a decision has been made which satisfies all the people involved, it has a much higher probability of efficacy. The experience of complexity and relativity of points of view may enrich the quality of decision-making, however, this may also result in never-ending discussions on existential notes of uncertainty, confusion and breakdown in problem-solving capacity. Such a situation has great potential for manipulation and for the realisation of hidden interests.

Even the proposal for common training schemes to favour a more unified and coherent approach to planning is not evident. Here again the question arises as to which type of approach or training scheme should be promoted, considering the risk of falling again into a particular attitude, which in time may be consolidated although no longer functional. Who is responsible for the creation of the training scheme? The key person or local resident, (who may offer a far more 'normalising' approach), the specialist who is an expert, or a research fellow completely separate from the physical reality lived by others but who would be able to continuously evaluate the efficacy of the programme and modify it when indicated? Would there be a risk of de-valuing the role of the specialist, whose status as 'expert' in the social field may be put into doubt, thus creating further tensions and the need for defence tactics?

According to Baldwin, one of the most important characteristics required of a neighbourhood worker, is that of "flexibility". Other requirements include a self-critical approach and a corresponding altruism with regard to differentiating self-needs from client needs and giving priority to the client. What type of training scheme can teach flexibility and altruism? Are training schemes enough to avoid the dangers inherent in any research activity? The risks involved in systematic record-keeping as a means to evaluate services are well-documented (Rosenhan, 1962) where experimental bias and self-fulfilling prophecies may occur, and where the mere choice of which data is to be collected may already be a bias.

Finally, history seems to repeat itself. The tendency towards the 'small village' scene where all people are involved and all have a say in the organisation and planning of services is not new. In time, for expediency, the participants are limited to a few key figures who may become the experts or specialists. The emphasis on limiting the area geographically is not necessarily the solution to the problem. Often, small neighbourhoods are potential coves for pathological dynamics which in no way take the client's needs into consideration but may favour nepotism and power games. The 'specialists' must not be scapegoated because their replacements may have similar techniques (i.e., residents, family members and clients).

The most fundamental difference of the neighbourhood concept is that of the emphasis on continuous research and data-based services. The practice of research as part of training schemes, the promotion of self-criticism and the awareness of the part played by the observer in that which is observed, are possibly means to contain the type of dynamics which exist, between all people, regardless of the concept adopted. The sustainers of the neighbourhood concept propose experimental feedback as the only indicator of efficacy (as opposed to reliance on the whims of the head of a hierarchy). This will encourage a willingness to be observed and analysed by outsiders and suggest the limitation of areas to be served, to favour the detailed analysis of these services, and emphasise openness towards non-experts. Through such means of continuous evaluation in the process of perfecting an organisation, they may succeed in

overcoming some of the pitfalls experienced by practitioners of the community concept, the institution concept or any other concept, upheld in the past.

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