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PROBLEMS INHERENT IN MULTI-SERVICE DELIVERY UNITS

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"When Alice came out of the Duchess' kitchen she saw the Cheshire Cat who was perched on the limb of a tree above her and was smiling a broad smile. 'Cheshire puss' she enquired, 'would you tell me please which way I walk from here?' 'That depends a great deal on where you want to go,' said the cat. 'I don't care much where,' said Alice. 'Then it doesn't matter which way you walk,' said the cat. '-so long as I get somewhere,' Alice added as an explantion. 'Oh you're sure to do that,' said the cat, 'if you walk long enough,'. With that judical summation of the problem the Cheshire Cat slowly vanished from view...."

By Lewis Carroll, Alice in Wonderland

Introduction

Like Alice, the field of social work in general, and the social service delivery system in particular, seems to be going through a confusing state, lacking direction. Just as the Cat suggests to Alice that any direction would get her somewher over time, so the diverse social service delivery systems(1) have, in recent years, moved off in a particular direction (methodologically) only to return to step one and then set off again. Various fads have seemed to provide the needed answers. In time, however, they served only to create a series of new questions with corresponding dilemmas.

In the last few years both the literature and practice have suggested that the integration of the service function would provide the long-sought methodological break-through. The instrument to attain the goal of integration would be multi-service delivery units of one form or another. It is the purpose of this paper to trace these developments and to examine some of the problems inherent in multi-service delivery units as a mode of integration of the service delivery task.

The various approaches are presented here in a quasi historical and linear fashion, with one system following an another. In practice, the movement from one mode to another was neither as direct nor as rational. They are presented in this manner to try to underline the antecedinal relationship inherent in the search for an organization form which constitutes effective service delivery. Further, the models are by necessity generalizations of practice and may not fully describe any one setting. Still it is hoped one

may derive a sense of the difficulties faced in the development of new operational types of service delivery.

CO-ORDINATION:

The realization that there is a need for integration of the service delivery mechanism begins for each worker, no matter what their area of practice, when they become aware of the fact that they are incapable of providing all the services needed by any single client, at any time. Further, this position is validated when the worker looks around and sees fellow workers in their own or different settings facing the same frustrating dilemma.

The most difficult question is what to do about this untenable situation. The intial approach to integration was an attempt to design a co-ordination role both within an agency structure and between agencies. The problem with this concept, both internally and externally, is similar, although the interagency milieu adds the concomitant problem of the co-ordinator always starting from a 'one-down' position.

Looking at the co-ordination approach within agencies, we often find a person in this designated role with no clear mandate to do anything else but to co-ordinate. The question immediately arises, co-ordinate what? or whom? Further, the important question that must be answered is, to co-ordinate to what goal? and as soon as we begin to talk about goals one is immediately faced with an inherent set of operational problems.

On one hand, the view is put forward that the goal is to meet humand needs. Again, a new set of questions is immediately thrust forward. Who defines the need? To what degree will this need be met? What methods will be used? Each of these questions (and a multitude more) could be the subject of its own forest of papers. Answering these questions is not the primary function of this paper and yet the dilemma developed is a crucial one. If one was a co-ordinator and an agency, one would certainly need a clear-cut perspective on exactly the answers to these questions before any so-called co-ordination could be done. There is, however, ample evidence that most of these questions have not been answered in the past and are not being answered currently. Hence, this dooms the intra-agency co-ordinator to failure from the outset.

If the above is a valid description, can you imagine the poor soul who is the incumbent in an inter-agnecy setting where the goals between agencies are general and often conflicting, where a number of units are vying for both power and recognition, and frequently for the same clients. Each of these units is willing to co-ordinate the other, but resisting to the death being co-ordinated themselves. The rallying cry, in the days when co-ordination was major theme was "Autonomy and Professionalism." This allowed the agency to take a stance of not knuckling under to the demands of some external co-ordinator, while still ambitiously forging ahead in one's own right to become 'top dog'.

The banner of co-ordination slowly moved to half mast, for the very important reason that the co-ordinator simply had no real power. Power is the key to the success of co-ordination as a mode of integration (once the important questions suggested above are answered). If one is to help the members of society who indicate their desire for some service in the most efficient and humane manner, some level of co-ordination is necessary and desirable. How to create mechanisms of organizational structure which will accomplish this goal, however, is a true test of integration.

MULTI-DISCIPLINARY TEAMS:

When the formalized co-ordination approach failed, a number of agencies turned in the opposite direction to provide the necessary service to clients. The scenario went something like this, "Well, if I can't get those other SOB's to provide my client with the right services, at the right time, and in a manner I consider appropriate, then I have no choice but to do it myself.

This started the era of the expansive total service super-agency, (often at the State level). Knowing that the degree of influence they had over other agencies' performance was limited, many service providers withdrew from the field of combat. Instead, the goal was to strengthen one's own ability to provide clients with a vast array of combined services. The approach that followed was very much a mirroring of the medical model with a key, dominant, usually status professional being in charge of the case. Then attached in a number of innovative ways were support or ancillary services, which, while seen as necessary, were not primary. Thus, we saw the hopsital-based service, with physican in charge, perhaps social worker and psychologist offering additional support along with the nurse and paramedical professional offering specialized case, if

necessary. At times, family members were seen, and even other actors from the community who had interactional influence on the family were also included. These might include school personnel such as teachers, school social workers, school psychologists, and perhaps a guidance counsellor. Depending on the depth of the multi-problem classification of the family, a court worker (probation officer) and a rehabilitation counsellor might be on the scene.(2)

The focus, however, was the primary multidisciplinary team, and not necessarily the family, although often the intervention was labelled as family oriented. The team approach was an important new wrinkle in service delivery; a key attempt to integrate the service delivery function.

From its early use in the institutional setting, it spread to other organizational forms. The earliest were those which closest resembled the medical setting, such a rehabilitation institutes, centres for the mentally retarded and the physically handicapped. The inherent value of the team approach however, was quickly recognized by other service-providing components. The employment service recognized the efficacy of a team approach, particularly for the complex case. The housing agnecy also recognized that housing was more than physical structures and began using a team approach to cope with the human dimension of providing their unique service. The example was repeated over and over in a variety of settings.

The team approach did have some inherent diffficulties however and the first was size. If all the necessary services that a family needs or requests are to be provided, the team could become immense. This leads to a series of internal administrative problems and a reverting back to the weaknesses of the intra-agency co-ordinator model. In addition, the team could easily grow much larger than the family, with each team member suggesting their time and their input to be both basic and or priority. Pretty soon a battle is raging as to who is truly responsible for the "whole family." Furthermore, the different approaches and treatment methodologies of the various disciplines can often be mutually exclusive or actually counter-productive. Who then decides which service is truly necessary and which is contra-indicated?

With size comes the concomitant problem of cost. As the team size and separate service modules increase, so does the cost, often geometrically. Some service organizations can get away with this for a while but not much longer than the first audit. The cost-

cutting becomes fashionable and compromises are made. How these compromises are accomplished often has nothing to do with the true needs of the family or individuals, but rather with the status and relative strength of the team member in particular settings.

Another problem with this particular approach is the duplication of services. Sometimes it is inherently profitable to all concerned to have a system that, in fact, competes. In the long run this should ensure that the client will generally receive the best service possible. However, when functioning in competition for scarce resources, namely money for services, as well as trained staff, the duplication of the same service by competing delivery entities is both inefficient and costly in all senses of the word.

Still another drawback of the team approach is the nature of the team composition itself. While some teams advertise themselves as being interdisciplinary, most are, in fact, multi-disciplinary at best. This may appear to be a minor point but in fact there is a major difference betwen the two concepts. Inter-disciplinary suggests the team members understand the basic theoretical and methodological approaches of their fellow team members. This is extremely rare. Multi-disciplinary merely suggests that more than one discipline is represented on the team. Some of the problems of the multi-disciplinary approach, such as different status, power, approaches to treatment, and, of course, competition were addressed earlier. The larger the team, the more exacerbated these problems become. If one discipline is dominant, as so often is the case, other members feel misused and ill-treated and morale suffers. In the end, it is the client who is the one to pay.

REFERAL:

For a number of reasons, including those above, a number of agencies did not or could not move to the large multi-disciplinary team approach of solving the integration questions. These were often private or voluntary, highly specialized agencies, or those in settings outside major population centres, where multi-disciplinary professionals are more often available. Instead these agencies used a different strategy. They decided on quality rather than quantity. Here the mode was to provide the best, most intensive service possible within their limits. It was based on good professional practice (e.g. good diagnosis including use of specialists for that phase, good treatment planning, including having consultative services, and consistent follow-up). For those services the agency

couldn't supply themselves, they referred the client to other specialized agencies that could. This may be classified as a serial model, where one good service follows another, versus the all-inclusive model provided by the team approach.

Again, there are a number of positive aspects to this approach. It solves the size problem, the duplication of service problem, the cost variable, and even to some degree, the question of multi-disciplinary concerns. Carried out on a small scale, with good client follow-up, and perhaps even providing ancillary services such as transportation to the program users, it may even lead to highly qualitative personalized service. Attempted on a larger scale the results tend to be questionable. Often when people are referred to other agencies they don't show up. For whatever reason they simply drop out. When people do appear too often the new agency makes them go through another demeaning eligibility determination or begins by asking the same diagnostically-oriented questions that were asked by the original agency. Records are often not passed on and at best the new agency has only a phone call (sometimes only from the client) or a letter to explain the reason for referral. For the new agency to have some sense about what treatment has transpired is considered an absolute prize. Is it any wonder that the client often becomes angry and frustrated and decides to forego further contact?

NEED FOR REFORM - A NEW APPROACH

Combine all of these problems with the fact that services are often inaccessible, fragmented, have different eligibility rules for different things, and often for different people asking for the same things, and one must become aware that there is a need for yet a better model. In essence, a new service concept is necessary, and this is a need that is shared by every country that has any kind of service delivery mechanism, no matter how primitive or how sophisticated.

It is an attempt to reform the system that new structural mechanisms have been designed and it is out of this need that the multi-service centre concept has emerged. It grew with the apparent concern for providing comprehensive social welfare and a social service delivery system which is both humanized and efficient as well as responsive to the needs of the client. Thomas H. Walz[3] suggests that the multi-service centre is in fact the best way of meeting these goals for the following reasons:-

1. It is a separate agency for the people who most need the service.
2. It uses methods of aggressive outreach and goes beyond the lip service given by many social welfare agencies to case finding. Within this rubric it has a two-fold purpose:
   a) to reach those who are unaware of the service available or lack the will to take the first step;
   b) to demonstrate the inadequacy and inefficiency of the present services as the first step in social change.
3. It has a convenience factor since most multi-service centres operate in the local neighborhood and are therefore more geographically accessible as well as structured within the working hours of those needing the service.
4. The multi-serivce centre tends to be a place that has been de-bureaucratized and, therefore, is more human in its approach.
5. The multi-service centre offers instant service; people walk in, ask for something and generally get it. They are not referred elsewhere.
6. The multi-service centre concept carries with it consumer control. Policy making is generally in the hands of the people who use the agencies themselves.
7. The multi-service centre tends to use militancy and direct action when it needs to. The centres espouse and openly advocate methods which will bring services to their clients.
8. As part of the staffing complement, they use indigenous non-professionals.
9. They are not locked in to old methods but rather will experiment and use any service methodology that is effective.
10. They use the concept of comprehensive care.

From this description it does seem that we have struck the millennium. Yet this is only one, heavily value-laden model among a series of descriptions of multi-service centres. For the final stages of this paper, the concept of multi-service delivery units will be examined, and the pros and cons of different approaches under this rubric will be evaluated.

CENTRALIZATION VERSUS DECENTRALIZATION

Most of the models which have been described above operate under the concept of a centralized delivery system. The first model

uses a key agency of key agent which in turn co-ordinates other service delivery mechanism from a centralized position. The second model uses a team approach with the central figure as team leader. The third approach uses the referral mechanism but again from a centralized perspective. In the Walz description, we see for the first time some discussion of a decentralized approach. Part of the impetus for this change has come about because of the need to re-arrange the service delivery mechanism in a way that would enhance the clients ability to negotiate it. Too often in the past, and in relation to the models described earlier, the clients were expected to integrate the service, and to be able to weave their way through the maze of bureaucracy of each agency in turn, before getting the type of service they desired. Logic will suggest that if it is so difficult for the professionals to accomplish this task it would be next to impossible to expect a person who is in need to manage the very same thing. Hence, the firt debate of policy import is presented; that of centralization versus decentralization of the service delivery mechanism.

Rein,(4) in quoting the work of Tiebout points out three types of decentralization:-

1. Political Decentralization:
   This involves the efforts of local officials to re-distribute political power and policy-making authority through the creation of new sub-units of government often with power to tax as in the case of school districts.

2. Territorial Decentralization:
   This range from a dispersal of local facilities to ease access by bringing programs physically closer to people, to efforts to facilitate by proximity the expression of residents wishes and preferences.

3. Administrative Decentralization:
   This calls for the delegation of decision-making authority to subordinate officials who operate public services in neighborhood areas. They are decentralized outposts of more centralized public bureaucracy.

It should be noted that the form of decentralization cannot be mechanically equated with its purposes. Administrative decentralization for instance may be inspired by the ideals of uncovering preferences

of individuals, as in the case of neighborhood service centres or by the aims of imposing standards for those in economic need as in the example of the detached gang worker. In other words, the function of bureaucracy, rather than its territorial or administrative decentralization pattern moreoften shapes its objectives.

There are important arguments both pro and con on the issue of centralization versus decentralization.(5)

DECENTRALIZATION	CENTRALIZATION
'PROS'	
1. Local governments are more knowledgeable about problems in their areas.	1. Commands greater resources to attract and support administrative expertise.
2. More responsible to needs of a particular community.	2. Superioroty of a central system to interpret and co-ordinate information.
3. Increase accountability of social service suppliers.	3. Deployes resources more economically by optimizing on a global basis.
4. Reinforces access.	4. Defined minority interests.
5. Adaptable	5. Freedom to act in a corrective way if evaluation and feedback mechanisms are built.
6. Resident participation	
'CONS'	
1. Local administrators often tend to develop political alliances that may work to restrict or contaminate the flow of information to central offices.	1. Increases problems of access access.
2. "A local authority may tend to interpret distributive justice in too narrow a framework; thus, its decisions while appearing to be equitable within the locality may actually	2. Inaccountability.
	3. Increases problems of discountinuity.
	4. Lacks responsiveness to clients needs.
	5. Maintains rigid boundaries.

'PROS'

aggravate inequities that are manifested in a wider scale."

3. In small decentralized units the majority may disregard the interests of other groups.
4. Under political decentralization, political jurisdictions may be subject to being paralyzed by a persistent minority, and is more reliant on consensus decision making.
5. Decentralization reduces the system's ability to gather and process information in consistent and useful forms and co-ordinate its various local actions.
6. Political decentralization without administrative decentralization would leave local units in conflict over scarce resource allocation.
7. Central government is reluctant to give up power over resources.
8. Some problems are beyond the scope of local initiative.

It appears that the decentralization argument can carry some weight. The fact remains that the opposite also suggests some important considerations that need to be taken seriously. It is also obvious that these positions alone do not solve the dilemma of whether it is centralization or decentralization that holds the key to reform. Kahn helps shed some light on this problem. He states "It has been apparent that effective social policy must to some degree seek consciously and planfully to be re-distributive. One can acheive re-

distribution by arrangements that facilitate the established rights, benefits, services and entitlement and that assure the actual delivery and use of the intended services.(6)

MULTI-SERVICE CENTRE CONCEPT

When examining the multi-service centre concept, we find increased possibility for redistribution inherent in this model and it carries with it the necessity for decentralized approach.

This approach is conceived as the one-step shopping centre for social services, as the social brokerage firm in the social service market. A number of models have been conceived and tested in the field. Some suggested approachers currently in operation are:

MODEL 1 - Detached Worker:

Here, one major agency is operating in a decentralized mode. Workers from other agencies are given physical space to bring their skills and programs into the centre. A centralized intake is used, often manned by indigenous non-professionals. The office manager, and hence, the person in charge, is from the original orgainzing agency. Program thrust comes, in each case, from the parent agency to the detached worker.

The administration procedure in this type of setting generally functions as follows: A person comes in the door, often drawn in by a search for those services offered by the host agency. This is an important issue because if the host agency's program offers no appeal to the potential client then no-one will come in. In addition, if that particular program is seen as bureaucratised, stigmatising or is mistrusted by the local people they will not use any of the services being offered by that centre. This latter point will naturally be true for any model.

In one form as the clients enter, they are greeted by a local resident functioning as intake worker and then directed to a host agency worker. Services are offered and the transaction may end there. Or the worker may recognise the need for additional services and suggest that while the person is there they talk with a representative from one of the tenant agencies. If the client agrees, the worker may take the person directly to the other worker (if they are available) or send them back to the intake worker who then shunts them to the appropraite service worker. If the tenant agency worker is not available,

the client may be given an appointment for the following day or just asked to come back again.

The pros of this model are that it does achieve territorial decentralization and brings the service effort closer to the consumer. The unit size, generally, is smaller and more negotiable for the client. The services are in one place, and hence the loss from referal is not usual. Local people are often employed in the agencies particularly in intake, so communication at the first instance tends to be positive. If the array of services is broad enough, one would expect clients to do well in this structure in relation to the models developed above.

The cons of this model are obvious. The administrative structure carries with it all of the drawbacks of both the co-ordination and team models. One agency is the host, the others mere tenants and have little or no input into the policies and procedures of the centre. Since they generally have no overall administrative responsibility there is a hierarchial structure established with host agency carrying all of the supervisory tasks. The host agency also sets the tone of the operation and detached workers have little influence over this aspect, even if it violates their own professional orientation. Therefore, if the host agency is overly bureaucratice, stigmatising, or repressive, the detached worker can do very little about it. In the long run, this could erode any impact of the tennant agency's program.

By the same token the detached worker displays no allegiance to the host agency or to the administration of the centre. Their allegiance is to their home agencies which still control the workers' rewards or promotions. The detached workers continue to take directions from their parent agencies and continue to work within the framework and philosophy of that structure. Needless to say, the opportunities for conflict are immense in this system and reminiscent of the description of the multi-disciplinary team, only worse. In the team setting, the leader does have some inherent authority. In this model, the authority of the centre administrator is limited and circumscribed by the external demands of the other member agencies. The use of an indigenous worker at intake must also be examined closely. They must be well oriented to the services available in order to direct clients to the proper service. The question is, who does this orientation? Generally it is the centre administrator who naturally would make sure the intake worker is sufficiently aware of the host agency's program and to a lesser degree tenant agency's program. There is a real

danger in the use of the local resident worker in this role. An untrained worker is being asked to accomplish tasks - namely, to be knowledgeable of all the services available, the eligibility requirements and how they function - something which many highly trained workers are incapable of doing.

Model 2 - The Central Authority Model:

In this model, some major authority such as the central government decides that there is a need for a unifying structure such as a multi-service authority, and such a mechanism is established. Locations are chosen and planned centrally and then put in place. An administrator is transferred to the site from somewhere within the governmental structure, or hired from outside, and then various government organizations are instructed to assign personnel to the centre to carry out certain specific program responsibilities. In some cases voluntary agencies are also invited to participate. Generally, the staff reports to the centre administrator on a seconded basis. Program responsibility and design, however, generally continue to flow from the nominally designated agencies, although it may be modified to fit the particular locality or population to be served. A centralized intake worker will be used with maximum use of local residents in this role similar to Model 1. Some attempts would be made to let people know the service that are available through the use of the established communication links (e.g. newspapers, churches, schools, visiting nurses, etc.).

Within the centre, workers would not be grouped by agency but either randomly or by teams. An effort would be made to have workers learn more than their own program. This could be done formally by use of a program back-up system one worker functions as a back-up for another worker - or less formally through the mechanism of staff meetings where workers inform their working colleagues of what they do and how they do it.

The service delivery task will then be carried out in the fashion of the worker available and knowledgeable supplying the service. When appropriate, the local residents would also contribute the delivery effort. Where possible one worker would deliver more than one service using either a method of checking back with a responsible agency member or having a previous agreement covering this aspect. For instance, a mother may come into the centre asking for birth control information. She is seen by a health workers and during

the discussion it is apparent that the youngest child in the family is in need of day care. The health worker then determines the eligibility for subsidised day care and issues a voucher covering this expenditure. A copy of this action is then sent to the day care worker. In answer to a question, the health worker may also inform the mother of the availability of employment at a local industrial plant, information gleened from the manpower representative during a meeting earlier in the day.

The pro of this approach is that it incorporates some level of territorial and administrative decentralization. Planning of services are more often completed on site, even if guidelines are issued by central authorities. There is a greater integration of staff into a holistic approach to service delivery and hopefully the client needs are better served.

The drawbacks of this model are similar to Model 1. In fact, this model is only an incremental departure from the earlier model, when realistically a radical departure is needed. While staff are more strongly integrated into this service model, it remains that they still have to be sensitive to the philosophy and wishes of their parent agency for, in the long run, the workers must still answer to their nominal department.(7) In addition, the administrative function is still highly centralized and external to the centre per se. Hence, by its very nature it is not atuned to local needs but rather reflects a generalised collectivistic thinking generally directed upward. That is, the program managers have a greater tendency to find their direction from the wishes of their superiors rather than from the needs of the clients.

The accountability is to the political system and not to the client system. It is not suggested that the former be denied only that the latter also be recognized. This model does not enhance any effort to accomplish this goal. As a practical example the community service centres currently operating in Canada, particularly in Quebec, more nearly reflect this model than any other.

Model 3 - Client Centred Decentralized Model:

This model more directly reflects the Walz description of the multi-service centre described above. The centre is set up as a seperate entity and while it may be funded directly by the government, the funds go directly to the local neighborhood, represented by an elected board of directors. Therefore, the centre as a whole

reflects the needs, wishes and philosophies of a particular neighborhood rather than a centralized planning body.

The staff of the centre may either be hired directly by the board, or at the request of the board, be placed there by various established agencies. The philosophy and programs are established by the board, and any tenant agencies, as well as hired staff must conform to those particular guidelines rather than those established externally to the service centre.

Amongst the various techniques that are used by the centre, one is the aggressive outreach. Workers are hired to do active case findings; to go beyond just opening the door but rather to go out and find people who are in the need of the service being offered. Often the services are designed to meet social problems that are rampant in the community and hence more closely related to actual needs rather than the perceived needs of the external centralized planning authority. When the identified problem extends beyond the scope of the service centre, a system of militancy and direct action surfacing from the service centre is used as a technique. Advocacy is a tool often used to either support the needs of the neighborhood clientele or to bring about change in the broader community but which are reflected as specific social problems within the neighborhood.

A greater number of local residents are involved in the service delivery function, as well as in the direct administration of the centre.

The positive aspect of this model, is that if it truly reflects the nature and wishes of the community then its acceptance will come naturally from that process. The programs will be geared to meeting individual needs on an individual basis. Accountability will be toward the client system and not only toward the central government structure. There will be a greater decentralization within this type of centre.

The drawbacks of this type of centre are that given the nature of the work as we currently know it, it would not be realistic to expect any governmental structure to fund this model for very long. It is obvious that this would be seen as a threat by the established government agencies and in some respects to the government itself. It decentralizes power and puts it in the hands of the people who are in the first instance powerless. While those in the human service

professions may hold this value to be an important one, the fact remains there are many who would not share this position.

Here too we have a question of accountability upward; is that accountability only to be financial? The government sees its role as being a broker between many conflicting requests for service. It is felt that the government entity is in the position to best mediate between unrealistic demands for service. Here we have a model which directly reflects the needs of a small number of people or a neighborhood but does it in fact reflect the totality of the community and its expectations, or, in fact, should it?

If the model is successful, then the demands for service will be dynamic and ever-changing. While this is a positive outcome, the fact remains that the entity itself, given its need for funding from a centralized authority may not be felxible enough to reflect these changes. That is, in the beginning a service such as employment training may be a necessity. But once people have begun to work the employment training function may no longer be necessary. What do you do with the employment trainers or other specialized workers who have delivered specialized services. The very ability to be flexible and dynamic often creates a whole new set of unexpected consequences. Too often this has led to the substance part of the centre disappearing, while the advocacy part remains.

CONCLUSION:

In this paper, the author has tried to reflect on the various concepts of delivering multi-modal services to people in the most efficient and comprehensive manner. Every model presented has its drawbacks and yet every model has its strengths. The best service delivery model needs to have aspects of co-ordination in it, needs to incorporate a team approach, at times needs to use referral; needs some degree of centralization as well as decentralization, and needs the client to be involved.

The key points to remember, however, are that the multi-service centres in order to best deliver services need to reflect a philosophy that is geared to solving problems not just to bringing pre-packaged programs into neighborhoods and expecting to solve major difficulties in this fashion.

Furthermore, as long as a residual rather than an institutional approach to service delivery is taken and as long as only a social problem approach, rather than a social growth approach is the operating mode then any mechanism, multi-service or otherwise will not accomplish a total integration nor solve the service delivery dilemma.

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