A PORTFOLIO OF STUDY, PRACTICE AND RESEARCH

SUBMITTED FOR DOCTORATE OF PSYCHOLOGY
IN CLINICAL PSYCHOLOGY, (Psych. D)

CONVERSION PROGRAMME

BY

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DECEMBER 1997
UNIVERSITY OF SURREY

Title of Research: The Use of Frames by Clinical Psychologists in Learning Difficulties Services to Aid Clinical Decision Making in Crises.
ACKNOWLEDGEMENTS:

Thanks are due to Lorraine Nanke, Clare Twigger Ross, Glyn Murphy and Diane Grainger for their advice and support. I am also grateful to Debbie Simons, Tony Cox, Keitha Bassett and Jennifer Belvin for helping to prepare the thesis.
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SECTION ONE

PERSONAL STUDY PROGRAMME PROPOSAL
PERSONAL STUDY PLAN

DOCTORATE OF PSYCHOLOGY (PSYCH. D.)

in

CLINICAL PSYCHOLOGY JAN 1995

CONVERSION PROGRAMME

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1.0 INTRODUCTION

The overall aim of this portfolio is to extend and consolidate my knowledge about the management of challenging behaviours in people with learning difficulties. The term "challenging behaviours" shifts emphasis from the person with challenging behaviours to the response of the service to that behaviour. This emphasis is reflected in the choice of topic areas, which focus on clinical and organisational issues associated with the management of challenging behaviours. Understanding of these issues is central to my work as a clinician and manager specialising in challenging behaviours in people with learning disabilities.

2.0 SECTION TWO: ACADEMIC AUDIT.

2.1 Literature Review One: Service Developments in the United Kingdom.

Aim: To provide an overview of the range of services which have been developed for people with learning difficulties and challenging behaviours and review the evidence for their effectiveness.

Rationale: There is no single consensual approach to the management of challenging behaviours, and many different types of service are currently available. Information about the range and effectiveness of different types of service provision is of direct relevance to my work in developing services in this area.
2.2 **Literature Review Two: The Use of Change Management.**

**Aim:** To provide a broad spectrum account of the approaches to change management which have been used to implement the NHS and Community Care Act (1990) (Secretaries of State, 1989).

**Rationale:** The NHS and Community Care Act provided guidelines on required changes in health and social services in this country. It required that services adopt business strategies, e.g. separating into purchasing and providing elements but it did not prescribe how the changes should be managed. This review will provide an account of the range of approaches which have been used to implement the legislation.

2.3 **Literature Review Three: Anger Management for People with Learning Difficulties and Challenging Behaviours.**

**Aim:** To evaluate the range of anger management techniques which have been used to help people with learning difficulties overcome aggressive behaviour. To examine the scope and limitations of cognitive behavioural anger management techniques.

**Rationale:** Anger and aggression are common challenging behaviours that are often referred to clinical psychologists. This review will provide an account of the range of techniques available and evaluate their effectiveness.
3.0 SECTION THREE: CLINICAL AUDIT


Aim: To provide an account of the processes involved in developing a service strategy for the management of challenging behaviours within a particular organisation.

Rationale: The work described culminated in the production of a report recommending that the organisation develop the ability of mainstream services to cope effectively with challenging behaviours, so reducing the need for specialist referral as a means of crisis management. There was also a recommendation to develop specialist services as a resource for staff support and training, and for those individuals whose challenging behaviours could not be managed by mainstream services. The current account describes how the production of this report was informed by a knowledge of organisational change. The report has helped to both consolidate and learn from the experience of developing a strategy to implement change in an organisation.

4.0 SECTION FOUR: RESEARCH AUDIT

4.1 The Effects of Self Advocacy on the Behaviour and Attitudes of People with Mental Handicap

Rationale: A copy of the research conducted for the M. Sc. Clinical Psychology is included as requested by the University of Surrey.
4.2. The Impact of a Strategy Designed to Aid the Organisation of Information in Clinical Crises on Clinical Decision Making by Clinical Psychologists.

**Aim:** To develop a model that offers an explanation of clinical decision making in crises and suggests a strategy (frame) to aid the organisation of information and therefore decision making. To investigate whether the frame aids decision making by clinical psychologists in an artificial experimental situation.

**Rationale:** Clinical decision making is an integral part of the work of clinical psychologists, especially in crisis situations. However, the literature in this area is sparse. The model was developed to offer a theoretical explanation of the process of clinical decision making in crises. The research was conducted to investigate whether the frame developed was effective.

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**Head of Department**  
**Date**

**Course Supervisor**  
**Date**
5.0: NOTE:
The definition of learning difficulties/disabilities used in this thesis is derived from DSM.IIIR (American Psychiatric Association, 1987). Learning disabilities has the following features: significant sub-average general intellectual functioning, significant impairments of adaptive functioning depending on age, culture, etc. and early onset of intellectual impairment. It is assumed, for the purpose of this thesis, that the terms learning disability, learning difficulty, mental retardation and mental handicap refer to the same population.

6.0. REFERENCES


SECTION TWO

ACADEMIC AUDIT
LITERATURE REVIEW ONE

SERVICE DEVELOPMENTS FOR PEOPLE WITH CHALLENGING BEHAVIOURS AND LEARNING DIFFICULTIES IN THE UNITED KINGDOM
1.0 INTRODUCTION

The statutory duty of health and social services is to provide for all people with learning difficulties. Services often adopt the common philosophy of providing an ordinary life in the community for people with learning difficulties. These views are based on the philosophy of normalisation developed by John O’Brien (O’Brien and Lyle, 1987) and Wolfensberger (1972).

Organisations for people with learning difficulties also provide for people with challenging behaviours, for example aggression and self-injury. Figures on prevalence of challenging behaviours are high (73% and lower), hence there is sufficient evidence to indicate that it is a significant problem that has to be managed (Querishi, 1994).

People with challenging behaviours are often forgotten, e.g. they are usually the last to be re-settled. However, there have been attempts to provide services for this group. The aim of this literature review is to look at some of this work. The emphasis is on areas directly relevant to service development in the United Kingdom.

The first section considers the underlying theoretical concepts, as these are crucial to any area, either academic or applied. Secondly, policy and guidance papers are reviewed, as these are designed to be templates for service developments. The third area is that of published papers describing
services for people with challenging behaviours. These are included to enable an evaluation of developments to date, so that one can learn from the experience of others.

2.0 THEORETICAL CONCEPTS

The term "challenging behaviours" is adopted from The Association for Persons with Severe Handicaps (TASH), an American organisation. The decision was taken to adopt the term rather than "problem behaviours" or "severe problem behaviours" since it emphasises that such behaviours represent challenges to services, rather than problems which individuals with learning difficulties in some way carry around with them (Blunden and Allen, 1987, p. 14).

There are no substantial models or concepts underpinning this area. The term has been used in many different ways. It describes a shift in attitude as pointed out by Blunden and Allen above. However, it is not clear whether the use of the term has led to a change in the behaviour of all professionals. There is no significant evidence indicating that there has been an attitude shift, except for anecdotal views. Some service developments seem to reflect the change in attitude, e.g. the creation of individualised services for people with challenging behaviours. However, those who design specialist units that people with challenging behaviours are removed to, still view the behaviour as a problem despite any statement they make.
The term "challenging behaviours" also describes a wide range of behaviours, each of which have different underlying causes. Furthermore, Naylor and Clifton (1993) note that there may be a difference in how professionals, e.g. psychologists and psychiatrists, explain the underlying causes. This confusion can only be resolved by conducting further research, i.e. to try to find similarities and/or differences between all the causes for all the challenging behaviours. For example, Murphy (1994) highlights factors that contribute to the emergence and maintenance of different challenging behaviours. If this work was to be developed, then it may be possible to evolve a unitary model.

Regardless, the term "challenging behaviours" is used widely by professionals and politicians when carrying out research, conducting clinical work and planning and writing policy documents. It is also used in the mental health field. There is a tendency to assume that the term is valid and has a usefulness. Authors, practitioners, and policy makers then assume that it is sufficient to offer a definition of the term. This somehow means they do not have to consider the above mentioned problems, e.g. the Mansell Report (1993) (see next section for details) (Naylor and Clifton, 1993).

The definition offered by Emerson, Barrett, Bell, Cummings, Hughes, McCool, Toogood, and Mansell (1988, p. 17) is the one most frequently used in the United Kingdom:
"Behaviour of such an intensity, frequency, or duration that the physical safety of the person or others is placed in serious jeopardy, or behaviour that is likely to seriously limit or delay access to, and use of ordinary community facilities."

This definition and the one (see below) produced by Zarkowska and Clements (1988, p. 2) are used in major policy documents and elsewhere. Zarkowska and Clements state that a behaviour may be regarded as a problem if it satisfies some or all of the following criteria:

1. "The behaviour itself, or its severity is inappropriate, given a person's age and level of development.

2. The behaviour is dangerous either to the person, to himself or to others.

3. The behaviour constitutes a significant additional handicap for the person, by interfering with the learning of new skills, or by excluding the person from important learning opportunities.

4. The behaviour can cause significant stress to the lives of those who live and work with the person, and impairs the quality of their lives to an unreasonable degree.

5. The behaviour is contrary to social norms."
The definition offered by Emerson et al. (1988) places an emphasis on physical safety, whereas Zarkowska and Clements' explicitly allows the professional to consider other aspects, e.g. social acceptability. Given that a wide range of behaviours is deemed to be challenging, the second definition is more comprehensive in its description. Zarkowska and Clements' definition also encompasses more aspects that are necessary when deciding if someone has challenging behaviours, e.g. stress. Both definitions offer a range of criteria to use to judge whether or not a behaviour is challenging. Both emphasise the behaviour and its impact, but each definition skirts the issue of causality. Furthermore, neither definition considers the possible links between mental illness and challenging behaviours.

There still is a degree of confusion because there is no external criterion against which to judge the definitions. For instance, Naylor and Clifton (1993) note that there is no absolute definition of challenging behaviour. The lack of clarity is also evident in the articles considered for this review. Varying definitions are used by respective authors.

2.1 **Summary**

The term "challenging behaviours" was introduced to shift the focus from the individual towards the relationship between the individual and their environment, though there is currently no agreed definition or theoretical framework associated with the term. There has been no systematic evaluation of the influence of the change in terminology, though anecdotal
evidence and some recent service developments reflect this shift away from an exclusively individual approach.

3.0 POLICY DEVELOPMENTS

The needs of people with learning difficulties who display challenging behaviour is acknowledged in many documents. These are published with the intent of having a national impact. They include:


Needs and Responses, Services for Adults with Mental Handicap who are mentally ill, who have behavioural problems, or who offend, (Department of Health, 1989).

Challenges and Responses: A report on services in support of adults with mental handicaps with exceptionally challenging behaviours, mental illness or who offend, (All Wales Advisory Panel on the Development of Services for People with Mental Handicap, 1991).

Services for People with Learning Disabilities and Challenging Behaviours or Mental Health Needs, (Mansell Report), (Department of Health, 1993).

The first paper considers a wide variety of issues including prevalence rates. The second and third papers view people who are difficult to serve in
community settings as falling into three groups: those presenting with additional mental health problems, those with challenging behaviours, and those who offend against the law. All of the papers advocate the development of community based options. They also acknowledge the need to develop specialist services, if necessary.

The Mansell Report adopts a slightly different approach. It acknowledges that there is a considerable overlap between the three groups identified in the 1989 and 1991 documents. It provides a broad definition of challenging behaviours to include those with mental health problems and those who offend (Allen and Kerr, 1994). Mansell (1994) notes that the report has key themes: that challenging behaviour is a product of individual circumstances and environment, that it is important to obtain management commitment, that service development is an evolving process, and that it is important to address cost constraints. The Mansell Report stresses the need for mainstream services to increase their competencies as well as introducing specialist services.

Other documents are also published with the intention of having a national influence: Facing the Challenge Series (Blunden and Allen, 1987), Forum for People with a Mental Handicap (1991). All advocate the development of services in the community as far as possible. There is also some consideration of the need for specialist services, e.g. for people who require forensic services.
Very few of the papers provide any guidance on implementation of the recommendations. Therefore, the practitioner has to work with the fact that the term is unclear, and try to interpret and translate the recommendations into service developments. The exceptions to this, is the King's Fund Series that has some guidelines for service developers, and the Mansell Report that has an implementation phase.

Thus, as Mansell (1994) points out, the Department of Health has adopted a "laissez-faire" model in its relationship with local authorities, such that most of the guidance is permissive. This means that there is no attempt to shape local action into a national unified strategy. Furthermore, the local service developer is not always aware of the existence of these documents as they are not always well publicised.

The impact of these papers is minimal. There are few instances of good policy development and implementation at the local level. Indeed, Cumella and Sansom (1994) state that none of the English health regions have a comprehensive local service of the kind recommended by Needs and Responses (D.O.H., 1989). This is supported by the findings of a London wide survey of service developments for people with challenging behaviours. It concludes that there is a lack of any locally owned policies or comprehensive services for this group of people (Mencap, 1991).
Furthermore, a survey of six areas providing services for people with learning difficulties found, that in one area, different authorities had not consulted with each other, and so had begun to develop different strategies (D.O.H., 1994). Another reason for the lack of any cohesive strategies in a given area is the fact that services are usually provided by more than one agency. This division may lead to a sense of competitiveness, and sometimes an attempt to pass the buck of responsibility for this group of people.

There have been a plethora of policy papers on community care. The paper that referred specifically to the needs of people with learning difficulties was published in 1994 (Department of Health, 1994). Community Care legislation has led to a large degree of confusion about which statutory authority should be responsible for people with challenging behaviours (Mansell, 1994). Social Services is the lead agency for people with learning difficulties, but some consider that people with challenging behaviours only have health care needs, and are the responsibility of Health. They ignore the fact that people with challenging behaviours also have social care needs. This group of individuals has, again, highlighted the faults in the system, i.e. the artificial split between health and social care.

Despite the above, there are several small scale service developments. These are piecemeal and address only one, or at best, two of the needs of this group including residential, day/occupation and access to specialist supports. If a service is to meet the needs of this group of people, it should
also address the needs of the carers (paid and unpaid). It should also ensure that it has adequate organisational strategies in place, e.g. policies and procedures for dealing with emergencies. As Mansell (1994) notes that the task is to bring mainstream services up to the level of the models that inspire their development as espoused in Blunden and Allen (1987).

3.1 Summary

In conclusion, there are a number of policy papers that have been published. Most of them have a number of useful recommendations. However, it is often up to local service developers to translate and use them. This has led to a diversity of services as will be shown in the next section.

Most of the papers reviewed in this section and the next did not consider in any detail whether there is a need to develop the theoretical aspects of this topic. Some papers do consider some of the issues. For example, Mansell (1993) acknowledges the overlap between mental health problems and challenging behaviours. There should have been a greater effort to address these issues at the same time as writing policy documents and describing service innovations.

Each service development (discussed below) was evaluated by myself using the following criteria: whether the outcome data used to assess the service is adequate; and whether a longitudinal study was conducted. If possible,
service developers should describe the stated aims, service mission/philosophy and method of operation.

4.0 SERVICE DEVELOPMENTS

4.1 Residential Options

4.1.1 Units

Some service responses are to develop and/or access facilities to which the individual with challenging behaviours is removed. These are residential facilities with professional support set up by Health, Social Services or a private provider, e.g. Special Security Hospitals, the Mental Impairment Evaluation and Treatment Service (MIETS), and Kneesworth. The aim of all these is to provide appropriate assessment and intervention, to enable the person to return to the community. The methods used vary from medical, e.g. drugs to behavioural approaches.

Clinical experience indicates that both types of facilities are used frequently by professionals, usually at the point when an individual's service is beyond the point of retrieval. The professionals are likely to be extremely stressed and unlikely to be thinking of suitable alternatives, e.g. setting up another local service. They are seeking short term solutions, e.g. a decrease in responsibility for the person, and in professional and organisational anxiety. They often accept sending the person away as a short term solution. Thus they feel they have not compromised their value base, i.e. that people with challenging behaviours should live in the community.
It is not being argued that these facilities should not be used, as there are instances when it is necessary to offer the person and/or their supporters a measure of respite or access to specialist resources. However, these facilities are often seen as the only solution, when there may be a range of answers, e.g. providing respite in the home while the carers go away for a break. Although private units are used so frequently, very little published data is available to judge their efficacy. This is a significant problem that needs to be addressed.

There is some evidence available about the functioning and efficacy of some units that are not private. The MIETS is a hospital based residential service for adults with learning difficulties, in the South East Thames Health Region, who have mild mental handicap (learning difficulties) with additional psychiatric problems, severe challenging behaviours and who reside in the Region.

Its effectiveness was rigorously evaluated in a series of studies (Murphy and Clare, 1991; Clare and Murphy, 1993). Data on each client’s challenging behaviours and social functioning was collected before admission, at discharge and 8 - 20 months after discharge. The Adaptive Behaviour Scale (Nihira, Foster, Shellhaas, and Leland, 1974) was used to measure the level of challenging behaviours. Skill levels were measured using the Vineland Adaptive Behaviour Scale (Sparrow, Bailla, and Cicchetti, 1984). The measures used, were among the more respectable of those available, in
terms of their reliability and validity (Querishi, 1994). Information was collected by interview.

Results suggest that treatment led to an increase in skill levels while at the unit. At follow up, clients were reported to have made gains in skill levels and social functioning. There was a reduction in key challenging behaviours. There was no reduction in the total level of challenging behaviours.

They should have investigated whether the interventions used in the unit were transferable to the community. Despite this, it seems that a stay at MIETS has some positive effects. However, Clare and Murphy (1993) conclude that it is unclear whether the service provided by the MIETS is the most effective means of achieving such outcomes.

Dockrell, Gaskell, Rehman, and Normand (1993) conducted an investigation of MIETS. Professionals working in referring Health districts were interviewed. They conclude that the specialist services at MIETS are helpful in enabling Districts to move people with mild learning difficulties and challenging behaviours into community facilities. However, they also question whether this is the best way of providing specialist services. They suggest that it may have been more useful to consider more local options.

Dockrell, Gaskell, Normand, and Rehman (1995) conducted an economic analysis of resettlement of clients discharged from MIETS. In general,
clients' placements cost 25% more than pre-MIETS placements. This seems perfectly justifiable, given the likelihood that the clients probably had a high level of need that was previously unrecognised.

There are several facilities similar to MIETS. However, most of these purport to serve people with learning difficulties and mental health/psychiatric problems. They are included in this review, because it is likely they are offering a similar service to that provided by MIETS (Allen and Kerr, 1994).

Hurst, Nadarajah and Cumella (1994) conducted a retrospective survey of all admissions, between May 1983 and February 1991, to the Brunei Unit (14 beds for people with learning difficulties and mental health problems). It is funded by the local Health Authority. Diagnoses were assigned using DSM-111R criteria, and outcome assessed using a four-point scale (one = relief of presenting disorder, etc.). Case notes were used to make the judgements. Sixty-three percent of those admitted were said to have improved. There was, however, a thirty-seven percent re-admission rate during the period studied. It is difficult to draw any conclusions from the above, given that diagnoses were made retrospectively, and the assessment of outcome was subjective. No formal measures were used. No comment can be made about any improvements post discharge, as these were not investigated.

DSM-111R is not designed for retrospective diagnosis. All the axes could not have been used since key individuals, i.e. staff and family members were not
involved. There was no follow up data nor was a control/comparison group included in the design. Using a single criterion for outcome, i.e. relief of presenting disorder, is limiting because there are many other relevant factors that should have been included, e.g. quality of life, activity level, longitudinal follow up.

Similar criticisms are made of Nolan and Lewis' (1992) retrospective study of the University Hospital Wales (UHW) service for people with learning difficulties. The service had access to four beds in an acute mental health facility. Case notes were used to assess the service. There was no consideration of any outcome data. Results were based on information gleaned from case notes. They claim that the unit is, to an extent, effective.

Cumella and Sansom (1994) describe two facilities within a Health Region: a medium secure unit, and another with a lower level of security. The Community Placement Questionnaire (adapted version) (Clifford, Chapman, Web and Best, 1991) was used. This includes ratings of social performance and disturbed behaviour. Clients were also interviewed using an adapted version of the schedule used by Wing (1981).

There is no discussion about the way in which diagnoses were reached, or why people were placed in each unit. There is no in-depth discussion of the reliability and validity of the Community Placement Questionnaire. There is again, no consideration of any outcome data. They merely provide data on
skill levels and future placements of clients. However, they make a valid point, that better services are needed for this group, e.g. local secure units and community teams who are trained to work with people with learning difficulties who offend.

Matthews (1995) describes an NHS facility, a Trust managed crisis intervention unit. It is a community resource based in four large detached houses in a rural setting. Three houses offer residential provision for eighteen people, and the fourth is an administrative base and therapeutic centre. All clients were admitted if they had challenging behaviours and were in crisis. Client records were used to evaluate the service. They concentrated on the amount of medication used, pre-admission and post-discharge. There was a reported decrease in medication. More thorough evaluation of other areas should have been carried out.

4.1.2. Summary

Each study, described above, varies greatly in the way in which a unit is assessed, i.e. the measures used. Most rely on the use of self report or case notes. It would have been more useful to use objective measures such as engagement levels (the amount of interaction that takes place in a given setting) and quality of life pre and post-admission and after discharge.

More thorough research is required before valid conclusions can be reached. For instance, each service seems to only cater for the needs of people with mild learning difficulties. The only study that provides a real sense of
whether such units are effective is the work of Clare and Murphy (1993). However, they question whether the service provided by the MIETS is the most effective way of supporting people with challenging behaviours. The recommendations made by Cumella and Sansom (1994) also support this view.

The lack of valid research in this area makes it difficult to judge whether statutory units or private facilities are appropriate service responses. This is somewhat disconcerting, given the resources (financial and otherwise) tied up in these facilities. These facilities can only begin to address a few of the many needs of people with challenging behaviours, their carers and the organisation, e.g. the need for respite and/or access to specialists.

None of the studies provide a detailed statement of the aims or objectives of the facilities being described. It is therefore not possible to judge whether the facilities achieved their aims. Furthermore, the studies should have considered other outcomes as well, e.g. organisational factors, etc.

4.1.3 Community Housing Options

Some local services remain reluctant to resettle those with challenging behaviours (Emerson, McGill and Mansell, 1994). There are, however, some demonstration projects. These are usually group homes that either cater solely for people with challenging behaviours, or, one or two people with challenging behaviours and other people with learning difficulties.
However, they are often geographically and organisationally isolated. Despite these problems, they, at least, are indications of an organisation's intent to develop good community services.

The Berners Road Scheme (health funded) was developed for four men with challenging behaviours (three of whom were detained under the Mental Health Act) (Banks, Myers and Bush, 1991). The project was informally evaluated, showing that some clients had benefited. Banks et al. note that a formal evaluation was being carried out but this was not published.

Banks et al. discuss problems they encountered: difficulties in recruiting and retaining staff, poor staff support networks, the service was perceived as elitist and there were negative relationships with neighbours. Some of these are avoidable, e.g. poor staff support networks. Others are recurring issues, when trying to provide community options for this group of people, e.g. poor relationships with neighbours. They stem from the wider community's reluctance to accept the person with challenging behaviours, especially if the behaviours are socially unacceptable.

Roy, Abdalla, Smee, Fallon, Blincoe, Hayes, Shaw and Marsh (1994) describe a community service for three men with challenging behaviours, a fourth place was used for respite care for another man. The Quality of Life Questionnaire (Cragg and Harrison, 1986) was used. No reliability or validity data of this measure was discussed. There was a reported increase in
engaged behaviour, a decrease in disturbed behaviour and the reporting of violent incidents.

Roy et al. (1994) state there was also a decrease in the use of psychotropic medication. Relatives were also said to be more satisfied with the new service. This study seems to show that community housing can be a successful option for people with severe learning difficulties and challenging behaviours. It would have benefited from a more thorough evaluation.

They do not justify why the men were grouped together, although this is a common solution. Services sometimes group people with challenging behaviours together for a variety of reasons, e.g. that it is less expensive to intensively staff one house as opposed to three or four houses. However, the benefit of grouping individuals with similar needs together is not one that has been investigated thoroughly.

Harris, Thompson and Russell (1992) describe the lives of four people with learning difficulties and challenging behaviours (mainly aggression), some of whom lived in community facilities, i.e. family home, privately run group homes. Compared to the other studies, Harris et al. (1992) investigated a range of service options for people with challenging behaviours. Qualitative and quantitative methods were used in this study, i.e. observations, checklists and interviews.
The findings suggest that only two of the users were benefiting, e.g. making use of opportunities in the community. There was no overall significant decrease in aggressive behaviour for most of the individuals. Progress was linked to whether good support was offered by staff, and if the staff themselves felt supported. More opportunities were available in the community, e.g. visiting local amenities. Psychotropic medication was less likely to be used in the community. There was mention of different interventions being used simultaneously, suggesting that multi component interventions were more effective.

Harris et al.'s work again indicates that community services can be provided for people with challenging behaviours. There was no major decrease in the level of challenging behaviours shown. This is a common finding (see the report of the work of the Special Development Team).

McDermott (1993) describes a residential facility for four people aged fourteen to nineteen. Individual planning systems were used. It was reported that good systems of communication, supervision and support were established and maintained. McDermott claimed that there was a significant reduction in challenging behaviours and the clients had a more valued role at home and in the community. However, the results were not supported by any formal data. The validity of the report, even if it is accurate, is doubtful.
People with learning difficulties, some of whom were reported to have challenging behaviours, were moved into staffed community houses in the Andover area (Felce, 1989). Evaluations were carried out using measures, including engagement. There were significant improvements in quality of life and skill acquisition (Felce, 1989). Greater opportunities for participation in the house and in the community were also reported. However, participation in the community was measured by the use of facilities, e.g. the supermarket and not the amount of integration achieved.

This study used effective measures to assess the impact of moving people with learning difficulties, some of whom were said to have challenging behaviours. It shows that community residential services are feasible developments.

The NIMROD project was based in Cardiff. The aim was to move people from a variety of settings, i.e. institutions and family homes into supported housing set ups. A range of supports was used, from paid staff to support tenants. An individual planning system was implemented which enabled professionals to assess the strengths and needs of people with learning difficulties, and then derive appropriate goals for each person to achieve over a given period.

Sixty-four percent of the people with learning difficulties were rated as challenging. The Disability Assessment Schedule, (cited in Felce, Lowe and
Paiva, 1994), The Adaptive Behaviour Scale (Nihira et al., 1974) and The Pathways to Independence Scale (Jeffree and Cheseldine, 1982) were used. Of these, The Adaptive Behaviour Scale is the one that is most respectable because it has been more comprehensively tested for validity and reliability than other similar scales (Querishi, 1994). The Pathways to Independence Scale has not been found to be significantly reliable or valid. As with other studies, there was no significant decrease in the level of challenging behaviour but there was an improvement in the level of skill development and in the level of community contacts. Felce et al. (1994) suggest that it may have been necessary to have had programmes that specifically addressed the challenging behaviours.

The Special Development Team, based at the University of Kent had a specific task, to support Districts in the South East Thames Region to resettle people with challenging behaviours from Darenth Park Hospital (McGill, Emerson and Mansell, 1994). Expertise from the Team and capital (via pump-priming) was made available to the Districts.

Thirty-five people were identified. Twenty-two people had services designed for them in nine separate districts. Very detailed evaluations (including follow up) of each service were carried out. The findings are much as reported in earlier studies. Often there was a significant increase in the level of engagement, but there was no significant decrease in the level of challenging behaviour. Fifteen of the twenty-two projects survived by 1992, although
sometimes the individuals were moved to another community facility. Services had not survived for many reasons, e.g. the lack of local professional support.

4.1.4 Summary

Studies describing and/or evaluating community housing for people with challenging behaviours show it is possible to support them in the community. The impression of the effectiveness of a service seems to be dependent on the type of evaluation used. Some evaluations are adequate, whereas others are, at best, based on subjective evidence. This makes it difficult to compare across studies. McGill et al. (1994) note that British studies make less use of measures, e.g. skill acquisition. None of the studies carried out any longitudinal follow up, looked at organisational outcomes or stated in depth what the aims of the services were.

The demonstration projects indicate that providing community services for people with challenging behaviours can be effective. However, there are some outstanding issues. Mansell (1994) notes that the way in which staff engage clients is the crucial factor. This is supported by the work of Harris et al. (1992). Staff could be encouraged to interact more with clients by having an effective individual planning system, efficient schedules and a monitoring system to ensure that clients are actively engaged in meaningful activities.
There is said to be a need to develop clearer organisational direction in this area accompanied by appropriate leadership and participative management (Mansell, 1994). These would enable effective infrastructures to be set up and employees would be able to work more effectively.

It is also necessary to integrate the demonstration projects into a comprehensive local service (McGill and Toogood, 1994). Such a service is said to need four sub-systems of activity: prevention, early detection, crisis management and specialised long term support. These are valuable recommendations. However, a good early detection system for potential problems is part of a crisis management system. Crisis management systems include more than the elements suggested above, e.g. the development of staff to act as crisis leaders or to be part of a crisis management team (Eliatamby and Missen, 1996).

Furthermore, McGill and Mansell (1995) stress the importance of working at three levels to ensure an effective service:

1. The relationship between the individual and their immediate environment (service).
2. The relationship between how this environment is delivered and how the placement is organized.
3. The relationship between the placement and the service system of which it is part.
Community service developments for people with challenging behaviours adopt the most popular model of choice: the group home. It would be worth considering a wider range of options such as those suggested in the literature on supported living (Kinsella, 1994). Supported living options are specifically designed to meet the needs of the individual and to use as many naturally occurring supports as possible, i.e. friends, family, neighbours and support tenants. This does not preclude the use of paid staff when necessary.

4.2 Developments in Occupational Services

Some service options have developed over the last few years in this area: day centres, special day facilities and employment opportunities. The most common option is the day centre for all people with learning difficulties. Most of these developments are demonstration projects, and therefore subject to the comments made when considering similar innovations in residential services.

4.2.1 Day Centres

Developments seen in residential services for people with learning difficulties are not matched by developments in day services. A recent Social Services Inspectorate Report (1990) concludes that many local authorities have no clear policies on day services, and that accepted philosophical principles have not generally been translated into clear operational statements despite the existence of policy documents, e.g. National Development Group Report (1977). Allen (1994) notes that, there is however, a trend towards relocation of day services into community based services.
Some day centres created segregated sub units for people with challenging behaviours. There is little or no published data available to evaluate these facilities. The available evidence suggests that people with challenging behaviours are often refused places. Whelan and Speake (1977) found that the presence of behavioural difficulties was the most common reason for refusing applicants a place. However, this may have been dependent on local attitudes and facilities. Crawford, Taylor and Throboe (1984) found that twenty percent of day centres surveyed (nineteen in total) stated that they served special care users (twenty percent of whom had challenging behaviours).

In general, however, statutory services, e.g. day centres do not address the needs of people with challenging behaviours. The demonstration projects described below suggest that it is possible to develop a range of specialist services. It is difficult to compare these services because of the lack of meaningful data, the use of different definitions of challenging behaviour, and the degree to which the challenging behaviour was treated. Each of these points should be borne in mind when reading about the developments outlined below.

4.2.2 **Specialist Facilities within Sheltered Settings**

These were set up to decrease stress levels within the main body of the organization. The Haytor Unit is a specialist day facility for people with severe challenging behaviours and severe learning difficulties (McBrien, 1987). No outcome data was reported, although it was said that many were
kept out of hospital because they attended Haytor. There was no discussion of discharge rates. McBrien notes that there was a variable staff turnover rate. This probably was an indicator of staff morale.

The Rivermead Employment Project was a specialist facility (work station) developed in Sheffield and based on the work of Bellamy, Horner and Inman (1981). It was evaluated in 1986 by the Special Development Team (Special Development Team, 1986). Users were said to have experienced a higher quality of life than in their previous day facilities. There was a marked decrease in challenging behaviours within the setting. This may have been due to the fact that the clients had one to one staffing and were very limited in the activities they could carry out. The report recommended relocation to a community setting, paying users and improving staff skills (Feinmann, 1988).

Hill-Tout (1988) described an individualised package using one to one staffing within an existing day centre. Reported outcomes included higher rates of participation in individual and group activities and an increased use of community facilities. Flexible funding and a base from which to work were said to be key elements.

Allen, Gillard, Watkins and Norman (1989) describe a flexi care system that developed some individual pilot day services for challenging individuals. Eleven people used the service initially. Forty-five percent of them were reported to have challenging behaviours.
It was formally evaluated by Allen (1990). Information was collected by using diaries over two months. Over seventy percent of activities were conducted in integrated settings. Users had access to a wider range of activities than those available within a specialist facility. Higher engagement levels were also reported.

However, the service was fragile, susceptible to staff sickness and monitoring was difficult. Many activities were leisure based. A competitive element arose between the service and the rest of the organisation.

There was little emphasis in the above projects on enabling people to obtain meaningful employment, i.e. real jobs. The exception to this, was Project Intowork in Sheffield. Training in Systematic Instruction was used. Feinmann (1991) reported that seventy job opportunities had been offered to thirty-five job seekers. The article was brief in its description of the work that was carried out. It is therefore difficult to provide a detailed summary or reach any meaningful conclusions. For instance, it is difficult to know what factors were operating if a person did or did not succeed in keeping a job.

4.2.3 Summary

The evidence indicates that where there is good organisational support, there is an increased use of integrated settings and therefore increased opportunities for valued day activities (Allen, 1994). He also notes that there is recognition that specialist skills are not linked to buildings but to staff. In
settings where there are adequate levels of trained staff, clients seem to improve.

These projects are small scale and seem to have very little impact on the remainder of the organisation, except perhaps to create a sense of competitiveness (Allen et al., 1989). They remain vulnerable in many ways, e.g. funding and isolation. Similarly, the degree to which they are evaluated is extremely variable, and this makes it difficult to judge some of them. There are many factors that have led to this situation with regard to services for people with challenging behaviours, including the absence of national policy.

Again, only clinical outcomes were investigated. There was no mention of longitudinal follow up or other outcomes.

4.3 Non-Residential Options

4.3.1 Community Teams

The development of specialist teams working with people with challenging behaviours is popular, because a common need is seen to be made readily available, e.g. professional expertise in assessment, treatment and training. Teams are usually based on the provider side and consist of a range of professionals, e.g. psychologists, psychiatrists and nurses. Some teams have a short life, sometimes due to problems in obtaining permanent funding. Like most of the areas of development, there are a few formal descriptions of different teams, which are sometimes accompanied by an evaluation.
The Family Support Team, Suffolk, consisted of a co-ordinator and three support workers working with children (under nineteen). Referrals were accepted from any agency. The team offered a variety of support, e.g. clinical advice and intervention. They had access to a flexicare budget (30K). Maughan (1991) said that funding was obtained to carry out a formal evaluation. The literature search did not find any evidence of the findings being published. Key factors in the development of the service were felt to be local commitment, and the fact that the service was funded permanently. Problems encountered included initial distrust from potential referrers.

The Support Team for People with Challenging Behaviours, Southmead, Bristol accepted referrals from local community teams who retained overall responsibility for each case. Staite (1991) reports that the service was evaluated as part of a regional monitoring strategy. However, no data was presented, apart from a brief discussion of the results of a consumer survey. Consumers were said to be satisfied with the service they received. Problems included withdrawal of some funding and the lack of a physical base.

The Intensive Support Team, Kidderminster, accepted referrals from hospitals and the community. Mechanisms were developed to ensure that professionals in each locality were informed of relevant referrals. The work of the team was formally evaluated regularly (Burchess, Walker, Dean and Heath, 1991). An external appraisal, conducted shortly after its
establishment, was favourable. Funding was only made available for three years. It was said to be difficult to recruit staff. McBrien (1994) notes that the Intensive Support Team is an expensive resource as they work with few referrals.

The Behavioural Services Team, Plymouth, provided a service to adults and school leavers with moderate to severe learning difficulties and challenging behaviours. Unlike some of the teams described above, an evaluation of the team was conducted. Areas investigated included: types of work carried out, evidence of termination of case work and referral rates. No outcome data was reported (McBrien, 1994). The service claimed to be "bed free" but it had access to beds in a local facility, of which it made use. Professional jealousies arose locally between the specialist team and the local community team. This is a common finding, as local community teams often feel de-skilled when a client they work with is referred to a specialist team. Problems of recruitment arose because the work was intensive and stressful.

The Intensive Support Team, Clwyd, was established in 1989 to provide additional support for existing services. Follow up data was collected. Good outcomes were reported: there was an increase in skill levels and a decrease in behaviour. Toogood, Bell, Jaques, Lewis, Sinclair and Wright (1993, 1994) suggest that one reason for success was the adherence to their operational policy. They note that the time taken to assess and design an
intervention plan was usually eight to twelve weeks. They were said to be trying to decrease the time taken.

Emerson, Cambridge, Forrest and Mansell (1993) conducted a survey of ordinary community support teams in England. A questionnaire was sent to 211 departments of clinical psychology. It was comprehensive in content but the information obtained is obviously dependent on the response rate. They found that some teams were effective in providing technical advice and practical support. Emerson et al. note that such teams should only be seen as part of a comprehensive strategy. A similar point is made by McGill and Toogood (1994) when discussing residential options. This issue does not seem to have been addressed by any of the service developments discussed above. It will be considered in greater detail in the conclusion.

4.3.2 Summary

Community teams address some problems, e.g. the need for access to professional expertise in assessment and intervention by referrers. However, only some of them have been formally evaluated. All the evaluations concentrate on clinical issues. Only one investigated consumer views.

Some problems arose, e.g. professional jealousy unless conscious efforts were made to set up effective communication systems with the rest of the organisation. Work they carried out was either reactive, e.g. accepting emergency referrals, or proactive, e.g. offering training.
An effective team should be very clear about the types of proactive and reactive work it carries out. It should ensure that it fits in with the work of other local teams and is part of a comprehensive strategy. It should not duplicate the work of, or de-skill, other local teams.

Some of the papers mention problems they had faced. It is useful to know about these so that one can learn from others’ experiences.

4.3.3 Multi-Component Services

Multi-component services usually have several facets: a team and/or respite services and/or day services and/or access to resources (Johnson and Cooper, 1991; Hill-Tout, Doyle and Allen, 1991). These services mostly had built in evaluation and monitoring mechanisms. The service described by Hill-Tout et al. attempted to address what were perceived to be identified needs within an organisation. However, a specialist and not a generic service was designed.

4.4 Summary

Some of the papers in this section refer to the policy documents mentioned previously, but it is obvious that these have been interpreted in individualistic ways, hence the many different types of services. What is evident is that all of them assume that the phrase “challenging behaviours” is valid. The only theoretical topic that is sometimes mentioned is the definition of the term.
It is evident that there have been a very wide range of service developments. These are small in nature and address only one or two of the problems that an organisation should be considering when providing for this group of people. An organisation should try to address the needs of the clients with challenging behaviours, the staff and the carers such as parents. It should find out what is currently provided and build on these competencies. Common areas are support and training, specialist assessment and intervention advice, effective emergency strategies, a mechanism for accessing emergency placements, and good working relationships with relevant agencies, e.g. mental health services, the police.

The methods of evaluation are generally poor and need improvement. For example, they should have considered a range of outcomes; organisational issues, quality of life and level of challenging behaviour. They should have included both qualitative and quantitative methods. Efforts should have been made to include consumer’s views.

Very few of the papers provide a description of how the need for the service was identified or how the service was created or resourced. Factors such as changes in local service provision leading to “windows of opportunity,” and the presence of change agents which have been identified as significant (Allen, Banks and Staite, 1991) were not mentioned in many of the papers.

It is obvious that every innovation (except multi-component services) is an add on development rather than one that fits neatly into the existing
organisation. This may have arisen because no-one assessed the way in which the components of the organisation were already meeting the needs of this group and their supporters. Had this been done, the service developers would have designed a multi-component service that strengthened the whole organisation rather than just one part. None of them address the point made by Mansell (1993) that one of the tasks is to improve mainstream services.

5.0 CONCLUSION

The term "challenging behaviours" has been assumed to exist as a fact. There is very little consideration in the literature of the need to explore its theoretical basis. It has also developed a range of meanings, which vary, depending on the context in which it is being used. Research should be conducted on the types of clients served by different services and whether the definition they use is an adequate description. Further work is also needed on whether the term challenging behaviours is a description of the impact of the behaviour, e.g. its' social undesirability or the behaviour itself.

Regardless of the above, there are a number of policy documents that make recommendations on service developments for people with challenging behaviours. They are of some help to the service developer, because some of them outline a series of recommendations, mainly advocating developments in the community.
They do not provide much help on how to implement the ideas, the exception being the Mansell Report. Some policy developers would argue that the lack of advice on implementation is intentional since it gives local developers a chance to be creative. However, this assumes that service developers have skills in implementation and change management they do not appear to have. What is required is guidance on principles of implementation, change and project management.

The fact that there has been more done on the practical/applied side than on the academic may be because services do have to provide for this group. However, service developers should not ignore the more academic aspects of this work. They should at least acknowledge that their work is not based on solid ground. They should also make better use of other areas, namely audit.

Very few of the evaluations discussed are adequate. The reasons for this are unclear. They tend to concentrate on two issues: activity level and incidence of challenging behaviours. This is quite limiting. It would have been more useful to look at the quality of life for the client and carers. Organisational factors such as responsiveness during crisis, training and support offered and the effectiveness of the communication systems should be investigated.

Service developers should also acknowledge that it is unlikely that improving the environment, e.g. by housing people with challenging behaviours in community settings will automatically lead to a significant reduction in
behaviours. The evidence states that challenging behaviours do not change significantly. They should expect the behaviour to continue, and prepare for the fact that it may be many years before any changes are noted. There is no such thing as a perfect service for people with challenging behaviours that will lead to rapid improvement in all areas of a person's life.

The only option is to try to develop good services in a thoughtful way, while taking into consideration the published literature in this area. Good services are those that cater to the needs of the client, their carer and the organisation. They should also acknowledge that needs will change, and therefore build services that can be flexible. These services should have in-built evaluation mechanisms, e.g. looking at the quality of life, and be supported by an effective infrastructure, e.g. good support systems within the wider organisation.

Efforts should also be made to improve other aspects of the organisation as recommended by Mansell (1993). Before a service developer tries to create a service, they must first learn from services that already exist about what works and what does not, e.g. the problems noted by Banks et al. in providing community housing. An audit of the mainstream service should be conducted to find out what is currently provided for people with challenging behaviours, the professionals working with them and their carers. The areas that ought to be included are: community housing, day services, community teams, training, support mechanisms for staff and emergency/crisis mechanisms.
Once this has been done, a comprehensive strategy can be created. It probably would not specify the development of a single component but would state that a multi-faceted approach is required, i.e. developments in each of the areas mentioned above. The evolution of this should be documented and evaluated, as should the implementation phase. Qualitative techniques such as that of Miles and Huberman (1994) could be used to analyse how such developments occur and whether they achieve their stated aims.


Special Development Team (1986). *A Report by the Special Development Team in Mental Handicap on the Quality of Service Provided by the Rivermead Employment Project.* Canterbury: Tizard Centre.


LITERATURE REVIEW TWO

THE USE OF CHANGE MANAGEMENT APPROACHES

TO IMPLEMENT THE NHS AND COMMUNITY CARE ACT (1990)
1.0 INTRODUCTION

The implementation of the NHS and Community Care Act (1990) (Secretaries of State, 1989) requires a great deal of change in the planning and delivery of health and social services in this country. National and local organisational changes are necessary. The aim of this review is to consider the change management approaches utilised to implement these modifications.

Before outlining the approaches used to implement the changes, a brief description of the NHS and Community Care Act will be provided. The required alterations are then analysed using the conceptual theoretical frameworks developed in relation to organisational change. Finally, a review of the published literature that describes some of the changes made using change management procedures will be outlined.

2.0 THE CHANGES REQUIRED IN THE NHS AND COMMUNITY CARE ACT (1990)

Overall responsibility for Health and Social Services lies with the relevant Secretaries of State and allied government departments. Responsibility for managing services is delegated to the local level. For Health Services, the country is divided into health regions that are then sub-divided into districts. At the district level, there is a District Health Authority which is responsible for assessing and providing community and secondary care and for purchasing care from public and private providers. Primary medical and dental care are the responsibility of the Family Health Services Authority.
Health Services in each area were previously provided by a general hospital, general practitioners (GPs) and other community services. The Act requires that self governing trusts be developed to deliver acute and community services that are overseen by a purchasing body. General Practitioners also become fund holders, i.e. purchasers.

Prior to the Act, Social Services were separated by geographical local council boundaries. Each Social Services Department was responsible to the local social services committee of the local council. They offered social care to the local population, e.g. children and older people.

As well as separating into purchasing and providing sections, Social Services are also expected to develop care management as a major means of purchasing services. It is also expected that eighty percent of social care would be provided by the private sector.

The Act is an attempt to introduce business principles to human services with accompanying cultural and structural changes (see next section for details). These are wide sweeping changes to undertake. The Audit Commission (1992; 1993) (a government body that investigates how changes are being implemented) stresses that a cultural revolution is required to develop a responsive service and to change the role of Social Services. Presumably this point also applies to Health Services.
Roy (1993) points out that the White Papers create a legislative framework for the delivery of services and opportunities for the creation of alternative patterns of health and social care. The purchaser/provider split gives new masters the right to question the internal operation of providers. The NHS is said to show an immaturity, both in the service it offers, and in the application of performance measurement and management.

Some of the changes are needed, such as the attempt to create more efficient organisations and to design better methods of assessing and managing care. However, one of the problems with the changes is the range and speed that is required (Fitzgerald and Sturt, 1992). Regardless, they have to be carried out.

3.0 CHANGE MANAGEMENT

There is a large literature on change management in different types of organisations. The literature provides information on definitions, descriptions of the types of change required of an organisation and techniques for change management. This section therefore uses the available knowledge to analyse the changes required by the NHS and Community Care Act.

3.1 Definitions of organisational change

Despite there being a large literature on the topic of change management, many authors do not define change. They tend to assume that it exists and then proceed to either describe the process or other relevant areas related to
change management. The defining of change is often left to the reader. Some organisational consultants appreciate this because they can develop their own definitions. However, the lack of an accepted definition makes it difficult to consider any of the research. One has to assume that all the research in the different areas refers to the same phenomenon.

Robbins (1996), however, distinguishes two types of planned change, first and second order. First order changes are said to be linear and continuous without any fundamental changes in assumptions. Second order changes are multi dimensional, occur at multiple levels, are discontinuous and lead to a re-framing of the assumptions. This is a useful distinction and is adopted for the purposes of this review. The changes proposed by the NHS and Community Care Act can be seen as second order changes. Robbins (1996) also suggests that organisational change can be subdivided into structural and cultural change.

3.2 Types of Organisational Change

Two types of change are described in this section: structural and cultural. Structural changes are defined by outlining commonly accepted organisational designs and then suggesting that these require alteration as part of the change process (Robbins, 1996). This is an improvement in as much as an attempt is made to define the change process. However, it is vague because there is no attempt to describe how such changes occur.
Common organisational designs include the following: the simple structure, e.g. small businesses, the bureaucracy, e.g. large organisations and matrix structures that combine aspects of the first two (Robbins, 1996). Within these, other structures also exist, such as teams.

Within the NHS and Social Services, personal experience suggests that they are bureaucracies that exist in different structural forms, depending what is required by the current legislation. Many are hierarchical and use teams in different shapes and forms. Decision making is via groups who report (eventually) to one person who is in charge of the whole organisation. These structures are required to undergo large scale changes as a result of the Act, e.g. the introduction of the purchaser/provider split.

Culture is said to perform a number of functions (Wheatley, 1992). It defines boundaries between organisations, conveys a sense of identity to its' members, facilitates the generation of commitment and enhances the stability of social systems within. Culture is created by the founders of an organisation and then maintained by practices within, such as recruitment and orientation to the organisation through induction and training. Culture can also be a barrier to change, especially if it is entrenched.

Robbins (1996, p. 681) defines organisational culture as "a system of shared meanings held by members that distinguishes the organisation from other organisations; a set of key characteristics that the organisation values".
Within an organisation, there is a dominant culture and sub-cultures. This is succinct compared to the definition on structural change offered above. Seven primary characteristics capture the essence of organisational culture: innovation and risk taking, attention to detail, outcome orientation, people orientation, team orientation, aggressiveness and stability (Robbins, 1996).

Four cultural types are identified by Robbins (1996). The “academy” is an establishment that recruits young graduates, trains them and steers their career through the system. The “club” highly values loyalty and commitment and seniority. The “baseball team” organisation is entrepreneurial and values risk takers and innovators. The last cultural sub-type is the “fortress” that used to be one of the above, but currently values its survival above all else.

These divisions are useful to understand the different cultural aspects of a business, but are simplistic. It is likely that there is some overlap. For example, while the main business could be seen as a fortress, a sub-division could also be entrepreneurial and therefore a baseball team. Furthermore, organisational cultures presumably reflect societal culture as well as the history of the organisation.

In terms of the Health and Social Service Departments in England, evidently there is a national culture largely determined by the Department of Health, other government bodies and the political stance of the current government. Personal experience indicates that the NHS culture is a combination of a club
and a fortress with some innovation and allowance for young graduates to enter, e.g. through the NHS management training system. Certain aspects of the culture are entrenched, for example, the fact that large scale changes are always introduced from the top. The culture needs to change to a more business like approach as a result of the Act. However, while the Act details what structural change is required, it is not as clear on the cultural changes that are necessary.

3.3 Approaches for Instituting Change

The literature describes many ways in which change could be managed and obtained. The tendency is to describe a process that the authors have developed.

Bruning, Cole and Huffington (1990) state that the necessary steps to achieve successful change are: clear analysis and definition of the change problem, contracting, e.g. obtaining consensus on aims, methods and rules, developing an activity or process plan and developing a commitment plan. They provide clear guidelines on how to achieve these changes but do not justify why these steps and not others should be taken. There is no explicit theoretical framework underlying this model.

Robbins (1996) describes Lewin's Three Step Model (Lewin, 1951) as a framework for change management. Three stages are described: unfreezing, movement and re-freezing. An analysis of the current situation,
of the required change and working out ways of achieving change are outlined. This model has been frequently used and appears to have some effectiveness (Robbins, 1996).

Wysocki, Beck and Crane (1995) describe a stage process for large and small scale project management. They outline a methodology that allows the change agent to define what is required, plan the change, and execute and control the change process. They provide many suggestions on ways of overcoming problems.

Robbins (1996) notes that action research is also useful as a means of managing change. Action research is similar to Bruning et al. (1993), in as much as both adopt a problem solving approach. Action research is a change process based on the systematic collection of data. The stages are: diagnosis, analysis, feedback, action and evaluation. It is said to benefit an organisation in two ways: providing the change agent with an objective and scientific methodology and by lowering resistance to change because employees have to be involved.

All of the approaches discussed above emphasise the need for an analysis of the current situation and then following a clear process for change management. Alternatively others do not provide a clear strategy, as above, but discuss many different aspects that are important to consider. For example, Moss Kanter (1983) discusses teaching appropriate skills to change
leaders, ways of empowering employees, and philosophical issues related to achieving cultural and structural change.

Most of the above approaches do not distinguish between cultural or structural change. Presumably they can be used to achieve either one. Any of the approaches described above could be used to implement the NHS and Community Care Act. The organisation would have to choose a method that fits in with its' needs. Alternatively, the organisation could choose to employ an external change management consultant who would select and use a particular method.

3.4 Summary

The literature has some useful concepts with which to consider the organisational alterations required by the NHS and Community Care Act. A second order, i.e. large scale change is required of both the cultural and structural aspects of the NHS and Social Services. Cultural and structural facets are often intertwined. For example, the political stance of the government will influence the delivery of healthcare. This is especially true of established organisations such as those being considered here. Therefore, it is crucial to choose an approach that enables one to address both aspects. Other aspects to include are an investigation of the history of the system. The ensuing sections describe what approaches are used, firstly by the government and in local health and social services.
4.0 CHANGE APPROACHES USED BY THE GOVERNMENT

The government uses two mechanisms for introducing and implementing change: publication of policy guidance with associated directives and training initiatives. These are considered below.

4.1 Policy Guidance

Policy guidance is, of necessity, general in nature. It is aimed at suggesting what cultural change is required but emphasises structural aspects. The method used to introduce change is left to the discretion of managers at the local level. This led to different methods being used and varying interpretations of the Act. Each of the papers described in this review illustrate this point.

A source of written information that the government provided is embodied in the NHS Research and Development Strategy (Henshall and Drummond, 1994). It emphasises the importance of studying economic appraisal to monitor and inform the health care reforms. Nine bulletins on effective health care are planned. They should enable purchasers and providers to discuss the cost effectiveness of specific interventions. Further publications on epidemiological needs assessments are also planned. The Department of Health has also compiled a register of economic appraisals from the United Kingdom and other countries. However, as Henshall and Drummond (1994) point out, there is a need to ensure that these documents will be used and understood by those they are aimed at. There is no guarantee that this
occurs. In fact, very few of the papers considered in this review refer to any of these publications.

4.2 Training Initiatives

Those chosen to progress as effective managers are required to change the way they do their jobs and to understand the way in which the job is altering (Robinson, 1992). Training initiatives are an attempt to introduce cultural change by re-training key individuals (leaders) and to provide them with the expertise to make necessary structural alterations.

Fletcher (1991) says that the introduction of the reforms brings into sharp focus how fast and how much the nature of the management task is changing. New skills are required: marketing, financial management and information skills. Managers have to be more knowledgeable about needs assessment, health economics and health policy issues. These skills are needed at both the purchasing and providing levels, as well as continuous self improvement.

Roy (1993) also notes that the process of transformation aims to make use of experiences gained in operating efficiency within industry and commerce over the past twenty years. He suggests that managers are having to become accustomed to a changing set of priorities, especially around the establishment of systems for performance management to measure individual performance.
Melling (1993) notes that the Better Management, Better Health Strategy and Action Plan produced by the NHS Training Authority has three aspects to it: the introduction of Individual Performance Review (IPR), the development of an open learning programme for junior and middle managers, and the development of a fast track general management training scheme.

Only the IPR system has been formally evaluated. The Institute of Health Services Management (1991) conducted a study of the extent to which the IPR system is meeting its' stated purpose in practice. The survey results suggest widespread support for the introduction of IPR (53% of respondents felt that it had increased their managerial effectiveness). There were some areas of concern. It was felt that the system was being operated at varying standards of quality and had been slow to extend beyond senior management grades.

It should be noted that the conclusions are based on a survey. Therefore only the views of those who responded can be discussed. Furthermore there was no attempt to collect other evidence.

The other two aspects of the Better Management, Better Health strategy were kept under less formal review, although they seem to have been implemented. This makes it difficult to review the effectiveness of the strategy, and the extent to which its recommendations are met (Melling,
The consensus is said, by Melling, to be that the initial momentum was not sustained and implementation is therefore patchy.

A new strategy was launched by the NHS Management Executive in 1992 (NHSTD, 1992). It is shorter and has two sections: a statement of national policy and an action plan describing different types of support said to be available for those implementing the changes. These two aspects provide a national framework for managers who are creating and sustaining quality in management development. Melling points out that the poor availability of support had an impact on the take up of the strategy, except by those already committed to implementation. He suggests that it is important to make funds available for implementation. However, there was no central allocation of such resources, despite the strategy being enshrined in the Management Executive's objectives for 1993-1994.

There are some local training alternatives linked to the strategies mentioned above. Robinson (1992) describes the Ashorne Hill Management College Programme. It is a course, run in four one week blocks over three months. The focus is to create a learning environment rather than impose a particular teaching model. Individual learning needs are analysed and goals and objectives set. Individual learning programmes are then created. The aim is to develop personal effectiveness in the light of change initiatives and change management. An evaluation of those who attended from a Northern Hospital reported that they experienced improved management performance which
was said to be maintained several years after the programme. The Human Enquiry Research Methodology System that uses interviews as its' method of enquiry was utilised. Participants and their managers were interviewed. Compared to other studies, this is an attempt to ensure that the training provided is effective in the workplace.

There was, however a reliance on self report and no investigation carried out to find out whether training actually had an impact on the effectiveness of the organisation. There are published measures that could have been used. For example, Newman and Milne (1993) describe measures of affective behavioural and cognitive outcomes of training. Rating scales were designed to measure the affective domain, i.e. consumer satisfaction and behavioural change. Management rating scales were also devised. Each one was tested and checked for reliability and validity.

Parkin (1992) described the work done in the Trent Region to develop a fast track (development) initiative to prepare nurses to fulfil new managerial roles. Two self managed action learning programmes were conducted: one for those functioning at the clinical directorate level or equivalent, and another for those at executive board level. The programme was seen as an enabling process. It was said to give participants a language, an understanding of management abilities and confidence to step outside assumed or prescribed roles.
A shift in individuals' perceptions - from an ability to survive change, to seeing it as an opportunity was reported. However, like most of the papers discussed above, the evidence is based on self report. The description of the learning sets lack detail, so it is difficult to criticise them. However, they attempt to address the point made by Knights (1990), that the effective and efficient use of human resources is a priority task at all management tiers. They do not address the needs of junior nurse line managers as recommended by Knights, such as looking at care demands, skill mix and activity workload.

Within Social Services, the government again uses policy guidance and directives as a means to implement change. The guidance often appears late and is often modified by the directives (Lewis, Bernstock and Bovell, 1995). This can only lead to confusion.

Some training initiatives are offered by the government. A set of training days on Joint Commissioning was planned in collaboration with private organisations such as the National Development Team (a group specialising on issues related to people with learning disabilities). These efforts are subject to the same criticisms made earlier.

4.3 Summary

Despite a plethora of policy guidance and directives, there has not been much direction on how to implement these changes for either purchasers or
providers. The change management technique of providing information is only effective if it is used appropriately and arguably not enough has been done to ensure that this is the case.

The management training initiatives, while aimed at obtaining cultural and structural changes make use of only one change management technique, that of targeting leaders (as suggested by Moss Kantor, 1983) with limited success. Training of itself is not sufficient as those who are trained should have support when trying to implement the skills they have been taught. This probably leads to confusion at the local level unless there are professionals present who are expert in change management and can offer advice and support to managers.

Therefore the approaches adopted by the government are limited both in the techniques they utilise and the extent to which they are successful. The evaluation of these approaches could have been much improved.

5.0 CHANGES WITHIN THE NATIONAL HEALTH SERVICE (NHS)

5.1 Purchasing of Health Services including GP Fund Holding

The purchasing/providing split is the most innovative change. It introduces a new way of operating which has not been previously used in human services in this country to any great extent. Services are to be purchased by an organisation that would then oversee them. This introduces structural changes in health (and social) services and different management methods,
i.e. contracts. Cultural changes are also taking place. Services are expected to become more business like, efficient and competitive. These practices have already been adopted in America with some success. For example, services for people with learning difficulties are often provided by not-for-profit private organisations that have contracts with the State or the Federal Government. Purchasers have mechanisms to oversee each contract, e.g. via case managers visiting sites.

The official guidance outlines a variety of purchaser/provider models (Lewis et al., 1995). As is evident below, many different models are used.

In this country, a major structural change that has to take place is the merger of District Health Authorities (DHA) and Family Health Service Authorities (FHSA). However, Huntington (1993) reports that different approaches are adopted. Some FHSA's embrace the development, doing all they can to promote and support it. Others skirt the issue by leaving fund holder development to Regional Health Authorities.

One area where there has been a merger is Dorset (Huntington, 1993). The leadership of the Chief Executive of Commissioning instigated many changes related to the merger. A structural change was brought about such that responsibility for health needs assessment, quality and consumer representation was integrated in directorates containing DHA and FHSA staff. Local General Practitioners were also expected to participate by agreeing
contracts in line with the Dorset Health Investment Plan. Huntington reported that these changes were being implemented successfully. Although, she did not detail what techniques were used to instigate change, it seems that leadership and collaboration were key, as was the use of an external expert in change management. The work would have been improved by the use of methods to rigorously evaluate the impact of the changes.

Other papers describing change at the commissioning level also emphasise structural change. Baird and Sprunt (1990) note that the NHS White Paper re-emphasises the position of finance directors within health authorities, but that it creates tightropes that tests their sense of balance. They suggest that finance directors are more likely to have a larger role in purchasing. Given that the paper was published in 1990, it is hardly surprising they provide no account to support their views. Furthermore, it seems they did not publish any subsequent papers that would also have provided evidence for their suggestions.

GP fund holding implies that GP's, like many other professionals, have to learn a brand new set of skills, e.g. contracting, budgeting, etc. (MacMillan and Pringle, 1992). Many different models are adopted, e.g. multi funds. The models often introduce the role of practice managers who require a range of skills: a knowledge of NHS work, management skills, and an ability to react to change. Their duties often range from dealing with staff issues to financial management. It is essential that all parties share a common ideology and
vision (MacMillan and Pringle, 1992). Macmillan and Pringle (1992) discuss some of the techniques they used to instigate change. These included good leadership, effective communication including starting a newsletter, and collaboration between key individuals. However, the evidence they provided was anecdotal, e.g. quoting examples of proficient leadership. Such evidence provides a sense of the effectiveness of the changes but a more substantial evaluation should have been carried out.

Black (1992) discusses some implications of GP fund holding. He suggests that the present changes aim to bring about an internal market, regulated by a contract between purchasers and providers. He feels this arrangement would impair the coherence of the NHS, add to administrative expenses and complexity, and hinder the role of GP’s as gate keepers. There would be a disincentive to admit because of cost. He implies that there could be undesirable clinical consequences resulting from these changes. The changes are also said to permit experiments in different styles of management. These comments are a personal view made prior to the implementation of the changes, and are therefore not substantiated by evidence.

Contracts are designed to be the structural mechanism that commissioners use to negotiate with providers. They are supposed to ensure implementation and compliance. Melling (1993) suggests that the contracting relationship is in its early stages. The way in which most organisations
introduce contracting is far from sophisticated. They are simply included as structural changes without any real attempt to change the culture of the organisations using them.

For example, Fenn, Rickman and McGuire (1994) outline a formal model of the relationship between a health care purchaser and a provider. They use a range of factors such as capacity and developed mathematical formulae to explain the process. They suggest that the model has practical uses. It is functional in that it highlights some of the factors that need to be considered but gives no guidance on how to address the cultural issues related to introducing contracting mechanisms, e.g. resistance to change.

Other research looks at specific aspects of contracting and uses action research methodology to implement change. For example, Clarke and Gray (1994) described an approach taken in an NHS trust in Northern England. Lead negotiators for the management and consultant side responded to debate in the Trust by offering to research peer attitudes towards a variety of contract options. They defined ten different types of contracts including the current one. They then compared the opinions of consultants, board members and senior managers by questionnaire. They found that consultants preferred no change whereas managers desired it. A time sensitive contract emerged as having the greatest potential for successful negotiation. It is laudable that Clarke and Gray actually carried out some research, but very little detail about the methodology is provided. It would
have been advantageous if they had described other issues they were tackling.

Millar (1995) described a method for contracting for intermediate outcomes based on the advice of an external change management consultant who had surveyed the organisation. The process that was suggested encouraged collaboration between purchasers and providers. Clinical staff were asked to work out intermediate outcomes. The system had yet to be implemented but was based on what was felt to be appropriate for the organisation. However, it was also thought that care was needed to prevent the system becoming very bureaucratic.

Majeed and Pollack (1995) described the work carried out in Wandsworth. Data (including epidemiology and impact of treatment) was collected on one illness, ischaemic heart disease. This information was used to develop a suitable contract for this area. They did note that the existing system was not sophisticated enough and needed to be improved. This comment is probably applicable to other health services in the country. However, they are following one of the government recommendations, that economic appraisal is an important factor that should be considered.

5.2 Summary

There are few papers that describe the process of change management in the area of commissioning, apart from those cited above. The majority of the
papers emphasise structural change and tend to provide anecdotal evidence. The way in which it is implemented in this country within the Health Service depends on local interpretations of the Act. Changes in Social Services are discussed below (see relevant section).

A variety of techniques are used, which is commendable. However, the evidence provided to support the reported success of the changes is not rigorous. They could have investigated whether the changes lead to an improvement in service delivery by seeking consumer views.

None of the papers tackle the thorny issue of cultural change, a vital aspect. This may have been because cultural change is more nebulous and therefore more difficult to achieve and evaluate.

5.3 Provision of Health Services

5.3.1 The Creation of Self Governing Trusts

Dreachslin, Zernott, Fenwick, Wright and Canning (1991) note that self governing trusts need to re-create their own organisational culture in order to succeed. The process of cultural change, development of business acumen, health care professional involvement, and information technology appropriate to self governance were said to be underway at the Freeman Hospital.

Cultural change was said to be achieved by consensus building. They identified sources of resistance in employees and enabled expression of
these and other concerns. They provided communication about the changes through newsletters. New attitudes were encouraged through a system of rewards and recognition. They also changed relevant aspects of the organisational structure.

Dreachslin et al. (1991) did address both the necessary aspects of change: structural and cultural, unlike much of the work described above. They used a variety of approaches to increase the likelihood of success. However, the evidence to support their claims is anecdotal.

Brown and Hayward (1994) describe how changes were implemented in an acute care hospital. They adopted the action research approach. They conducted a clinical role review of the clinical areas and analysed their mission statement. Based on the findings, they continued using a Programme Management Model with some alterations, since it was seen to be effective. Having implemented the changes, they then supported them. For example, they enabled individual programmes to continually address any problems that arose by having retreats and creating working parties. They tended to concentrate on the structural aspects of change but based the alterations on an investigation of the current structures, unlike Dreachslin et al. Once again, their claims for success were not evaluated rigorously.

Battle (1993) adopted a similar approach to Brown and Hayward. He describes the changes implemented at the Royal London NHS Trust.
Managers reviewed the current and future purpose of the organisation, as well as identifying which aspects were effective and which were not. They chose to develop a different organisational structure to those described above. They developed service units and a planning framework, the latter being an essential component that is often omitted. Unit heads had access to experts in relevant areas during the implementation phase.

This approach again concentrated on structural change, but is more thorough in the way in which change was implemented. They also ensured that good support was available during the implementation phase. Unlike Battle (1993), many of the papers in this section did not stress the importance of planning as part of the work of a provider.

Grant and Gale (1990) address the issue of organisational culture and attitude. They say that they adapted key elements of the change management literature. They designed a questionnaire based on categories and stages of the change process deemed to be important. No further details are given. The form was then used to assess attitudes of key figures within an organisation. Content analyses were used. A reliability check was said to have been carried out, but no figures were provided. The results suggest that three aspects are important to the process of successful change: professional characteristics and style, e.g. reliability, type of core activities, and tactical choices made. They make several recommendations, including
the need to make progress in small steps. No evidence is provided of whether the findings were useful.

Fitzgerald and Sturt (1992) suggest that the adoption of a clinical directorate model (often a part of trusts) leads to clinicians assuming imitation general manager roles. They state that there are four important factors that need to be included in managing strategic change in health care, i.e. introducing the directorate model:

1. Developing integrated continua of care
2. Behaving like a system
3. Developing effective manager-physician partnerships
4. Developing strategic leadership

They foresee many difficulties in the range and speed of change required. It is likely to put pressure on key players. Ground work needed to build on collaborative relationships may be ignored or skimped. Fitzgerald and Sturt carried out a literature search of the area. They only found five relevant articles. Evidence from two regions suggests that there are many variants of the clinical directorate model. Only one district had had directorates for some years. However, Fitzgerald and Sturt do not provide enough details to permit further investigation of the articles. The literature search carried out for this review did not locate the articles.
Keen and Malby (1992) studied the Resource Management Initiative adopted in the NHS review for hospital management in the 1990's. It seemed to initially offer nurses a chance to influence decision making directly. They looked at six hospitals that piloted the introduction of resource management. The hospitals were chosen by the (then) Joint DHSS and Joint Consultants Committee. Data was collected between 1988-1990 by: observation of relevant meetings, interviewing key individuals and using a questionnaire with others. They said that experiences were mixed. Nurses did not always grasp the opportunity to enhance their power and practice. There was evidence from the study that the introduction of information technology curbed innovation in practice. It also removed nurses from patient care delivery. They noted that all the sites were moving towards a clinical directorate model which might have caused conflict.

This is one of the few studies that is comparative across sites. However, the data collection and analysis methodology could have been improved. They note that some data was analysed quantitatively by using two benchmarks. No further details are given, e.g. whether reliability or validity checks were carried out. In addition, they do not state why the data was collected over a two year period. There must have been staff turnover and policy changes that affected the data.
5.4 Summary

To summarise, the available literature suggests that the models developed to implement the NHS changes were trusts and clinical directorates. The way in which change is implemented varies greatly. One or two of the papers considered relevant issues such as the need to look at the organisational culture. Most concentrate on the implementation of structural change. Few considered the importance of providing support beyond the initial implementation phase.

None of the papers cited above considered the need to increase skills such as market specialisation, seen as important by Peach (1991). As Melling (1993) notes, the NHS (the largest employer in Western Europe) entered upon a process of fundamental changes affecting structures, systems and mind sets. The changes are said to be proceeding at an uneven pace in various areas. He suggests that it may be some years before we see what kind of service has been created or evolved.

Some of the papers in this section attempted to initiate both cultural and structural changes. This is an improvement to the work described earlier in that both aspects are considered. There is much variance in the way in which the changes have been implemented, which is to be expected, given the general nature of guidance, and there must have been local differences in needs that had to be taken into account.
6.0 CHANGES WITHIN SOCIAL SERVICES

The community care policy is embodied in the 1990 NHS and Community Care Act and the policy guidance that followed. Social Services Directorates have to make substantial changes in three main areas: establishing procedures for assessment and care management that would be needs led; taking steps to become enabling authorities that involve stimulating independent providers, as well as separating the purchaser and provider functions within each organisation; and establishing more effective joint planning such that a seamless service becomes a reality for users.

Lewis et al. (1995), conducted a two year monitoring project from the middle of 1992 to the middle of 1994 in a shire county, one inner and three outer London Boroughs to look at the process of change. The methodology used was described as administrative anthropology, i.e. intensive observation of meetings in each authority, maintaining records of informal contacts and formally interviewing key individuals. There was a reliance on observation and self report without using other methods to validate the findings.

As for care management and assessment, the policy guidance was not prescriptive. Therefore, Lewis et al. (1995) found that there were many models, difficulty in implementation and in linking to other aspects of change.

Design of the forms to assess the need for care management proved difficult. One authority used one form for all client groups. Another tried to do so, but
created such a complex form that it was abandoned in the pilot stage. There was a general fear that assessment would become mechanistic. All experienced difficulty in distinguishing the levels of assessment and ensuring they were needs led. The guidance recommended six possible levels. None of the authorities designed systems that had more than three.

Prioritising and eligibility for service need was often done on the basis of professional judgement. Two had attempted to formalise the process, e.g. developing a risk needs assessment.

There were very unclear definitions of commissioning. All moved towards a high purchaser/provider split, i.e. a separation operating from the second management tier down through the department. In two authorities, purchasers held the budget, in others the providers.

These findings demonstrate that the legislation is being interpreted in many ways, which is one of its aims. However, they also clearly show that much confusion arose as well.

Rachman (1995) presented the findings of a research study that considered the effects of organisational change on the provision of hospital based social work services to adults with health and social care needs in four local authorities (three in London and one in the North of England). Semistructured interviews were used. Only 85 out of 119 social workers and
31 out of 36 managers agreed to participate. This may have skewed the findings. Refusal sometimes occurred because staff were concerned about the possible lack of confidentiality.

The results indicated that the management of change was not being carried out successfully. There was low staff morale. Staff reported feeling confused, alienated, stressed and powerless. The consultation process was poor, despite many memoranda and documents being circulated. There was a lot of variation in the amount and quality of training that was offered. Some staff reported that the training they received was inadequate. Supervision was said to be inadequate.

Many staff reported that their day to day work was changing. More time was being spent on assessment of need, planning of care and negotiating services. This did not leave much time for direct work such as counselling. Different authorities adopted different strategies. Some regarded counselling as essential whereas others focused on assessment. Many were unclear about whether care management was a specialised area that required training.

These results suggest the importance of using effective change management techniques such as those described above. The confusion that arose was due to the lack of clear guidance on how to implement structural change.
Singh (1995) conducted a survey on the practice of care management and assessment for people with learning difficulties. The methodology used included researching past papers, interviews of principal officers, care managers, carers and users in six randomly chosen local authorities. The findings suggest that the necessary changes had not been implemented in a consistent fashion which occasionally was not a significant issue as good standards were adopted. He found that there were large variations in the information strategies being used. The information available did not always meet the needs of the consumers, e.g. using written information for those who cannot read. Similarly, the Manchester Community Care Campaign (1993) found that carers were not receiving information.

Singh found that referral systems were very varied, including the way in which information was analysed. This may have been due to the lack of guidance on this issue. Assessment procedures were extremely different as well. Sometimes, there were no set procedures about who should contribute to the assessment. The quality of training offered to enable care managers to assess depended on the effectiveness of the local training policy. However, some had no set training policy. Feeding service deficits back into the system tended not to be encouraged.

The implementation is not a national success. This is, in part, due to the pace needed to implement change. The failure to use basic change
management strategies, such as an effective training policy, also has an impact.

6.1 Summary
As with the NHS, the guidance in Social Services seems to have been adopted in a variety of ways. This may be due to differences in local need and to the available expertise of local professionals, i.e. those with a knowledge of change management in relation to implementing the guidance. The papers in this section used a wider range of research techniques that enabled them to provide evidence that is more than anecdotal. They demonstrate that the changes are being implemented in many different ways.

The work carried out by Singh also shows that the changes are problematic for consumers as well as the purchasers and providers. Singh's work is one of the few papers that includes consumers' views, a crucial aspect that is often omitted.

7.0 STUDIES INVESTIGATING CHANGE IN HEALTH AND SOCIAL SERVICES IN THE SAME GEOGRAPHICAL AREA
Groves (1993) visited a rural district in Nottinghamshire to look at the community care changes for both health and social services. Information was gathered by informal interviews and site visits. She found that joint planning was difficult because of under funding and boundaries that were not
coterminous. There were different interpretations of care management within social service departments and between health and social services.

GP's were unclear about their role. They stated that they had not had sufficient training. Carers of groups such as the elderly were unsure what the impact of care management would be.

Groves did not indicate which techniques (apart from training) were used to implement change. However, her findings are similar to Singh's and imply that change is not being managed successfully.

A Social Services Inspectorate Report (1994) focused on the way in which the Act had been implemented in services for people with learning difficulties. A project team visited six areas, both Health and Social Services. The methodology adopted was a programme of meetings and visits. All parties, commissioners and providers, were included. They received a questionnaire prior to the visit. The team also received written information from each area, e.g. strategic statements and community care plans.

All areas were undergoing change and transformation from segregated to more individualised services. Change sometimes appeared to be an end in itself. A clear vision where a service should be going was missing in most areas.
There was evidence of joint working between agencies. However, concern was expressed about the lack of expertise and the practice of key aspects of joint working such as commissioning. Effective planning was impeded by a lack of comprehensive information about numbers, needs and cost effectiveness. Users did not always get access to assessment as they needed it. Some assessment systems were still being developed.

Quality assurance systems were embryonic. Contracts were often not sophisticated enough to support quality monitoring. There was concern about a lack of contracting expertise.

There had been mixed success in engaging GP's and health services in the assessment process and service provision. There had been varied opportunities for staff training. More training was needed but there were budget constraints.

7.1 **Summary**

These studies demonstrate that, regardless of the intentions of the creators of the Act, there is much confusion at the local level. There is an indication that not enough thought was given to how the changes should be implemented, e.g. the reported lack of training. There also seems to be a concentration on achieving structural change at the expense of cultural change.
**8.0 CONCLUSION**

There is a plethora of guidance, but very little hard prescriptive information as to implementation. This may be why there is much local variation, both in the way in which the process of change has occurred, and the changes instigated.

The available literature suggests that there is a tendency to rush into the implementation of the guidance. Some concentrate on structural changes whereas only a few attempt to achieve cultural change as well. Both are needed for effective change management, especially in organisations that have established cultures such as those considered here. The "best" example of an attempt to implement both types of change simultaneously is the work described by Battle (1993).

There is a tendency to collect evidence by using interviews, questionnaires and observation. There is therefore a reliance on self report and observation. The methodologies are poor, e.g. the frequent absence of carrying out reliability and validity checks when using observation. Furthermore, very few consider the need to include measures to assess whether the changes being introduced are effective in the long term. They could set goals and outcomes and evaluate the extent to which they are accomplished.
All of the research assumes that change exists and discusses it without attempting to define it. This includes the research that used specific change management techniques, e.g. action research.

The Act does not provide much advice for the professional on guidance on how to achieve change in their organisation. This has led to many different interpretations of aspects of the Act. This is one of the stated aims of the authors of the Act. They could be praised for enabling creativity and individuality at the local level. However, they should provide some formal guidance and support for local organisations in the creation and implementation stages. This support, without being prescriptive, could help local health and social services feel that they are not on a speeding train, and may not lead to the confusion that is often reported.

Guidance on implementation could be obtained from the change management literature. For example, there are certain steps that I find useful to follow. Some of these are clearly stated by Bruning et al. (1993) and others. A crucial aspect is to understand the relationships and cultures that exist within the organisation and to assess the organisation’s experience of change. It is also vital to design the intervention such that there are clear goals and means of assessing the process. The designing of the intervention should be carried out with those within the organisation.


LITERATURE REVIEW THREE

THE USE OF ANGER MANAGEMENT AS A THERAPY FOR PEOPLE

WITH LEARNING DIFFICULTIES
1.0 INTRODUCTION

Aggression by people with learning difficulties is a considerable problem. Institutions are closing. Aggression is likely to be encountered more often in community settings (Querishi and Alborz, 1992). These behaviours have, on occasion, led to the re-institutionalisation of individuals (Emerson, Cummings, Barrett, Hughes, McCool and Toogood, 1988). Similarly, Harris (1993) notes that aggressive behaviour is a major challenge to services for people with learning difficulties.

Whitaker (1993) points out that there is a relatively small amount of literature about the nature of the relationship between anger and aggression, and the treatment of aggression. This review will concentrate on assessing the cognitive behavioural literature on anger management for people with learning difficulties. Definitions, models and clinical interventions will be reviewed.

Other models, for example psycho dynamic, are not considered for the following reasons. Firstly, cognitive behavioural methodology is used most frequently by clinical psychologists for designing interventions for people with learning difficulties. Secondly, the techniques are researched more thoroughly and therefore enable the clinician to operate as a scientist practitioner.
2.0 DEFINITIONS OF ANGER AND AGGRESSION

The available literature distinguishes between aggression and anger. Anger is perceived as the emotion that leads to aggression. Murphy (1997) notes that other terms overlap with aggression: violence and hostility. She points out that each term has a separate and distinct meaning. Few consider this overlap; there is a tendency to only discuss aggression.

When attempts are made to define anger and aggression, the preference is to only define aggression and assume that anger has also been defined. Dollard, Doob, Miller and Sears (1939) define aggression as any sequence of behaviour, the goal response of which is injury of the person towards whom it was directed. As Murphy notes, this definition can be criticised as too narrow. It excludes acts where the person's goal is material gain. Buss, Dansforth and Drabman (1986) state that aggression is the attempt to deliver noxious stimuli (whether or not that attempt is successful). However, this definition is criticised for many reasons (Archer and Browne, 1989).

Archer and Browne (1989) state that there are three common features to aggression: intent, the presence of actions that cause damage and emotional arousal. Harris (1993) points out that a main difference between these factors centres on the issue of intent to inflict harm. He suggests that the practical difficulty with intent definitions is that they often involve value judgements about motives behind actions.
Furthermore, Tedeschi (1983) argues that all concepts of aggression are inadequate. He proposes three general criteria for defining aggression: a definition needs to be specific, free from value judgements and in line with common sense designations of events. This is a plausible statement. It is virtually impossible to obtain, either in clinical work or academic work, as nothing is value free. A definition that meets the other two criteria could be created.

The definition offered by Bandura (1973, p. 5) is described by Murphy (1997) as "the best definition" for professionals working with people with learning difficulties. It does not refer to factors such as intent, expectation and emotional arousal. It simply states, "behaviour that results in personal injury and in destruction of property".

2.1 **Summary**

It would seem that the definition by Bandura (1973) is the most useful as it addresses the comments made by Tedeschi and it can be operationalised with little difficulty. Some of the models discussed later do not try to define anger and/or aggression. In others, there has been an attempt (Novaco, 1977) to develop concepts similar to those above, i.e. those that could be operationalised. Novaco also considers other aspects, such as the functions of anger. Gardner and Cole (1984) also attempt to define anger and aggression.
The emphasis is therefore on defining anger by referring to observable phenomena and aggressive behaviours. The emphasis on behaviour as opposed to the verbal expression of cognitions is common when definitions are created for issues related to people with learning difficulties.

There is an assumption that anger is related to aggression, which is not directly tested. This is not unusual because the cognitive behavioural approach does not permit one to consider concepts, unless they are linked to observable phenomena, e.g. speech. These are the views of those who adhere to this particular paradigm. Others, for example, Freudians, are more willing to consider concepts such as intent and anger without stating that they have to be linked to observable phenomena.

3.0 PREVALENCE

Murphy (1997) notes that studies in this area use one of three methods in establishing prevalence: direct observation of aggressive acts in operant work, criminal statistics and questionnaire methods for the indirect measurement of aggressive behaviour. She points out that each method has disadvantages. For instance, the use of direct observation does not enable one to speculate about overall rates of behaviour. It is difficult to use criminal statistics to estimate overall rates for people with learning difficulties for a variety of reasons: people with learning difficulties are likely to be diverted from prison custody and the increased vulnerability of people with learning difficulties to false confession.
Gardner and Moffat (1990) suggest that estimates of the prevalence of recurring aggressive behaviours among people with learning difficulties vary because of the sampling procedures and diagnostic criteria used. (Figures varied from 8.9% to over 24%) (Borthwick, Meyers and Eyman, 1981; Jacobson, 1982; Hill and Bruninks, 1984; Eyman and Call, 1977). For instance, Eyman and Call include occasional threats, whereas Jacobson only considers physical assaults. These large scale surveys report that aggressive behaviours increase in rate of occurrence as the level of learning difficulties becomes more severe, (from 5.5% among adults with mild learning difficulties to 17.3% for those with profound learning difficulties).

The most accurate prevalence figures are obtained from these surveys, for example Harris (1993). The definition Harris uses includes a wide range of behaviours, e.g. those that result in injury and those that led to management difficulties. The survey was conducted by researchers who had been trained and reliability checks were also done. It was carried out in the Southwest Region of England using the Register for this region (there were 370,000 people listed). An overall prevalence of aggressive behaviour of 17.6% was reported. Physical and verbal aggression were most frequently reported.

It should be noted that Harris relied on the Register and current services to obtain the data. He could not use those who lived in the community and did not access services, or who were not on the Register.
With regard to durability, Eyman, Borthwick and Miller (1981) evaluated the changes in maladaptive behaviour, e.g. threats or physical damage to others over a two year period in groups of people with learning difficulties residing either in residential facilities or community placements. They found that there was no significant change over the time of the study. Similarly, Matson, Gardner, Coe and Sovner (1989) reported aggressive behaviours to be present for a period exceeding twelve months in a sample of adults with severe and profound learning difficulties.

3.1 Summary

The prevalence research demonstrates that there are a sufficient percentage of adults with learning difficulties deemed to be aggressive and therefore needing treatment. The methods used to obtain such estimates vary, and few studies are as thorough as the work carried out by Harris.

The next section considers the different theoretical explanations of anger and aggression. Only those studies addressing issues relevant to people with learning difficulties are included.

4.0 EXPLANATIONS OF ANGER AND AGGRESSION

Several client characteristics are suggested as influential variables in the occurrence of aggression (Gardner and Cole, 1990). These include conditions that instigate or serve as setting events, and thus increase the likelihood of aggressive responding in other specific external events, e.g.
physical sensory factors, drug effects, affective states and cognitive variables.

The models developed to explain anger and aggression are quite selective in the factors they consider. There are few attempts to consider biological influences and environmental factors. More consideration is given to social, cognitive and emotional factors.

4.1 Biological Explanations

Murphy (1997) notes that, in only 60-70% of cases of severe and 10-25% of mild learning difficulties, can genetic causes for the difficulties be identified. She points out that a clear link between genetic abnormality and aggressive behaviour has not been identified, except perhaps in Lesch-Nyhan disease, a rare X-linked disorder (1 in 380,000 births).

There has been no effort to investigate the role of endocrine in aggression in the learning difficulties population. Murphy highlights that, while there is evidence to indicate that some types of challenging behaviours peak in the late teens and early twenties, this does not necessarily imply that the increase is due to hormonal changes.

Similarly, there is little work on neurophysiological influences or the possible roles of neurotransmitters. This means that the possible contribution of such factors in clinical work cannot be considered. None of the models described
below that led to the creation of clinical interventions include any biological factors. Given that a link has been found in people with Lesch-Nyhan, further research is needed in this area. If biological factors have a part to play, then there are implications for the type of treatment to be offered.

4.2 The Role of Environmental Factors

There is evidence to suggest that environmental factors such as the effects of crowding, temperature, noise and the influence of pain all have a part to play in the incidence of aggression in the normal population (see below). Research indicates that some of the above are influential in the lives of people with learning difficulties. For example, Boe (1977) demonstrated a reduction of aggression with increases in physical space. However, the reasons for the reduction may not have been due to the increase in physical space, but to the decrease in potential encounters.

While some models (and clinical interventions) consider environmental manipulations, they did not investigate the role of factors such as room temperature. Rather, they considered large scale manipulations (Gardner and Cole, 1984).

4.3 The Role of Social, Emotional and Cognitive Factors

There is research in this area, both in the normal population and in people with learning difficulties. The factors investigated vary. For instance, Mink and Nihira (1987) found that there is a relationship between family styles and
behaviour. Richardson, Koller and Katz (1985) found that boys with unstable family backgrounds are more likely to show disturbed behaviour in childhood and adulthood than those with more stable backgrounds. Stability was assessed by looking at family discord, changes in caretakers and the presence or absence of abuse or neglect.

There are studies that investigated the relationship between aggression and frustration (Zillman, 1988). The results of these studies suggest that arousal resulting from stress or exercise increases the level of aggression. These findings are explored further in some of the models described below, e.g. Novaco (1976). These models also emphasise the role of cognitions.

Psychosocial influences have differing effects on each individual (Mace, Page, Ivonic and O'Brien, 1986; Carr and Durand, 1985). For example, it was found that conditions such as social disapproval, adult demands and reduced social attention result in varying effects on the aberrant behaviours of some children (Carr and Durand, 1985).

None of the studies consider the possible link between anger problems and mental health. Johnston and Whitman (1990) note that a significant proportion of people with learning difficulties also have mental health problems. Menolascino and McCann (1983) point out that approximately 20-35% of mentally retarded people who live in the community suffer from mental illness, (the incidence of mental illness in the general population is
approximately 16-20%). Biological and psychogenic factors and greater exposure to stress play etiologic roles in the development of mental illness for those with learning difficulties (Parsons, May and Menolascino, 1984).

Some of these factors are also discussed by Murphy and others. Therefore, it is likely that there is a link between mental illness and aggression for people with learning difficulties. However, Gardner and Moffat (1990) note that the precise relationship of aggressive behaviours and specific physical or psychiatric disorders is ill defined. Further research is required. However, any study in this area is made difficult because the majority of assessments for mental illness can only be used with clients who speak. This automatically excludes a large proportion of people with learning difficulties. What is needed is research to find out if factors such as observation of a client's behaviour and a knowledge of their pre-morbid history are as predictive without the use of self report.

Some factors investigated in the non-disabled population are not considered either in the models or in the clinical research reported here. For instance, Rosenman (1986) discusses the relevant evidence that relates the sympathetic nervous system to hypertension and hostility/anger dimensions to the pathogenesis of hypertension. Similarly, Spicer and Hong (1991) look at the relationship between Type A behaviours and psychosocial risk factors for coronary heart disease. It was found that the ability to manage anger was related to the availability of social contact.
4.4 **Summary**

The work described in this section points out there are a number of factors contributing to the occurrence of anger and aggression. Some emphasise factors in childhood, others look at the role of neurology, environment, social, emotional and cognitive factors. In each case, the evidence is not conclusive, so it is difficult to say which one is the most important, or what the interactions between them are. However, what is evident is that only some are included in the models and clinical studies described below. This is not surprising since the review concentrates on cognitive behavioural approaches. However, the work described here should not have excluded factors such as neurology.

5.0 **MODELS OF ANGER AND AGGRESSION**

5.1 **Biaggio's (1987) Model of Anger Arousal**

Biaggio (1987) describes a theoretical model of anger arousal. It is based on Leventhal's (1980) perceptual motor theory of emotion. Three mechanisms or processes are said to act and interact simultaneously in contributing to emotional experience: expressive motor processing system, schematic processing and conceptual processing. Biaggio suggests that the tripartite model can be used to understand anger management. However, the three aspects have yet to be shown to be real, valid and supported by evidence.

Despite this, Biaggio outlines three clinical dimensions of anger: justified versus unjustified anger arousal, normative versus maladaptive levels of
anger arousal and anger suppression. Biaggio then suggests that there are some domains that could be used clinically, for example, assessment of justifiability and adaptiveness.

Mostly she discusses behavioural methods of treatment. She does not attempt to explain any of the treatments in terms of the model outlined earlier. The only link made is that it is necessary to evaluate the anger experience on several dimensions, and then to make appropriate treatment decisions. This is a reasonable suggestion, but needs further elucidation and research. She does not refer to the applicability of any of the work to people with learning difficulties, which is a shame as it could be used with this group. Two of the concepts she describes could be applied to clients with learning difficulties: justifiability and the distinction between normative and maladaptive anger. They would have to be operationalised. It would be necessary to consider if they are applicable to clients who do not speak. The third concept, suppression, would be difficult to utilise. It should be noted that if these concepts are used clinically, then one implicitly accepts Biaggio's adoption of Leventhal's work which has yet to be validated.

5.2 Gardner and Cole's Multi-Component Model

Gardner and Cole (1984), in contrast, describe a multi component model. It is said to be extremely similar to that used by others (LaVigna and Donnellan, 1986) and is applicable to people with learning difficulties (Whitaker, 1993). Gardner and Cole suggest that aggression occurs in an environmental
context, consisting not only of discriminative stimuli, but also of setting events that influence the probability of aggression occurring. Aspects of the individual determine whether or not they deal aggressively with provocation (e.g. the stimuli to which they pay attention). Aggression is reduced by teaching the individual to pay attention to different cues.

Consequences of aggression are also said to affect its future probability. This is the basic behavioural approach. It implies that aggression can be reduced by contingency management methods. Ecological interventions include positive programming. These teach the clients alternative ways of coping with situations that lead to aggression. For example, teaching alternative social skills, or developing greater self control via cognitive change.

The great advantage of this model is that it has direct clinical applications and is linked to a group of clinical techniques found to be reasonably effective with other problems. It has been used to carry out clinical research with people with learning difficulties. However, it is somewhat simplistic because it fails to consider the possible role of factors such as hormones, etc. If such factors have a role, one would have to conduct a medical and psychological assessment, and design an intervention that is psychological and could include medical treatment.
5.3 **Novaco's Model**

Cognitive therapy is best known for its role in the treatment of depression, but it is also used for a variety of psychological phenomena (Reeder, 1990). Novaco's model is described as a model of anger arousal that incorporates elements of cognitive theory (Novaco, 1976).

He proposes that events are perceived as aversive based on the expectations' people have of an event, as well as the appraisal of the event's meaning. When people appraise an event as frustrating, insulting or threatening, or when they expect a certain outcome and receive a different one, the result can be anger. Appraisal of an event as highly provocative is extremely subjective.

Thwarting of expectations are found to influence anger (Novaco, 1979). When expectations are not met, there is an implication of an insult or threat to the ego. The magnitude of the discrepancy between expected and actual outcomes often determines the level of anger arousal and the ensuing behaviour.

Appraisal processes are involved as the person estimates to what extent the unwanted outcome is provocative. The anticipation of an event also affects anger arousal. When one expects an aversive event and when the appraisal of the impending event is anger inducing, it is likely that when the event does occur, the person reacts with anger.
Novaco (1979) also describes phenomena termed “private speech”. This is the self talk that reflects people’s expectations and appraisals. Reeder (1990) notes that private speech is similar to what Beck (1976) defines as automatic thought.

Much of the evidence to support Novaco’s model is based on work he conducted with police forces in America. The techniques he used seem to be effective and reliable (Novaco, 1979; Meichenbaum and Novaco, 1985).

Meichenbaum and Novaco (1985) consider the ways in which stress inoculation is used, and it’s similarity to anger management procedures. Stress inoculation comprises three phases: teaching the client a conceptual framework to understand stress reactions, providing him/her with alternative behavioural and cognitive coping skills and providing opportunities to practice the skills. Novaco simply adapts these procedures for anger management. Novaco’s work has been used with people with learning difficulties.

Both Gardner and Cole and Novaco stress the importance of cues in the anger process and both have been used as the basis for clinical work. Some studies considered in the next section are also explained by Gardner and Cole’s model. (This could potentially lead to a dilemma for the practitioner who is trying to decide which treatment approach should be used.)
5.4 **Murphy's Multi Factorial Model**

Murphy (1997) considers that affective factors, the effect of social learning, environmental and biological factors should also be incorporated in any model. She describes a model that expands Gardner and Cole's work. Following a review of the literature in this area, Murphy suggests factors such as early childhood events and social learning should be included. She expands Gardner and Cole's model to include environmental and biological factors. Murphy notes that the model has not been proven but that it may be useful to use it to further explore theoretical explanations of anger and aggression and for clinical work.

There could be instances when the model would be useful in clinical work as it provides the clinician with a wide range of factors to consider. However, it is difficult to see how all aspects of the model could be tested given the current technology available, e.g. the proposed link between biology and aggression.

5.5 **Summary**

Biaggio's model has some useful concepts that could be applied to people with learning difficulties. However, the clinician would initially need to operationalise the concepts.

Gardner, Cole and Novaco are similar in that they stress the importance of external factors. However, Novaco describes a mechanism for the way in
which these factors affect the individual, i.e. appraisal, whereas Gardner and Cole do not. Neither model considers factors such as the role of hormones. Both models offer a definition of anger, whereas Biaggio does not. A further problem with these models is that they do not consider how the concepts and strategies could be utilised with people with learning difficulties who are not verbal.

The main difference between the models seems to be which factor is chosen to explain anger and aggression. However, if one considers the research in the previous section on explanations of anger and aggression, many factors are found to be significant. What is required is a model that considers all the factors and the interactions between them. Murphy's model includes a wider group of factors, but it has not been investigated.

6.0 ANGER MANAGEMENT TECHNIQUES

6.1 Self Control Techniques

Whitman (1990) suggests a failure to use self control is a fundamental deficit in people with learning difficulties. There is evidence that people with learning difficulties can be trained to use self control procedures (Shapiro, 1986; Whitman, Burgio and Johnston, 1984). However, Whitman (1990) and Carr, Robinson, Taylor and Carlson (1990) suggest that a minimum amount of language is necessary for people to learn and use self control. Training in self control has been effective in reducing anger and aggression in people without learning difficulties (Novaco, 1979).
Other cognitive abilities such as imagery are also important. Shapiro (1986), in a review of self control procedures with people with learning difficulties, divided the methods used into those in which self control is achieved by teaching the client to control the consequences of his/her own behaviour, and those in which self control is developed by cognitive change. The distinction is followed here.

Producing self control through cognitive change is based on the work of Novaco (1979) and makes use of such methods as self instruction and problem solving which require a greater cognitive and linguistic ability, than simply teaching a client to control the consequences of his/her behaviour. Nonetheless, authors advocate these methods as appropriate to reduce anger and aggression in people with learning difficulties (Benson, 1985).

Self monitoring procedures have only been used with subjects with moderate or mild learning difficulties. Shapiro, McGonigle and Ollendick (1980) reported that one of their subjects failed to learn to self monitor and another failed to learn to self reinforce. Therefore, there may be variables, besides the degree of learning difficulty, that determine if the client can be trained to manage the consequences of their own behaviour. Shapiro et al. (1980) suggest that further work is needed in this area.

Benson, Johnson Rice and Miranti (1986) carried out a study using adults with learning difficulties who attended vocational training programmes. Fifty-
four individuals were assessed using the Peabody Picture Vocabulary Test (Dunn and Dunn, 1981) and a self report anger inventory (no details of this were provided). All of the subjects acknowledged that they had a problem with anger management. The dependent measures were a self report anger inventory (no details were provided), a Conflict Situation test (no reference given), ratings of a video taped role play test and supervisor ratings. They failed to show that a self control package consisting of relaxation training, learning coping self statements and problem solving was anymore effective than the individual components on their own. However, the results showed a decrease in aggressive responding over time. Since there was no control or comparison group, it is not clear whether the decrease occurred because of the treatment given, or, because the subjects changed simply because they were included.

Harvey, Karen, Bhargava and Morehouse (1978) devised an intervention for a thirty-eight year old female client with a history of aggression. It was implemented at her home and her place of work. It consisted of time out, a token economy based on her self ratings of mood and teaching her positive self statements to replace negative ones. There was a reported decrease in the frequency of aggressive incidents in both settings. However, it is not clear whether some or all of the components of the intervention package contributed to the decrease in aggression.
Golden and Consorte (1982) report work carried out with two male and two female clients. Each one was treated individually with different combinations of stress inoculation, biofeedback, rational emotive therapy and assertiveness training. No rationale was provided for the different interventions. In all cases, they state that there was a significant reduction in aggression but they provide only anecdotal evidence to support their statements.

Further research in this area is needed before any conclusions can be made regarding the efficacy of the techniques mentioned above. For instance, Whitaker (1993) notes that dealing with low frequency target behaviours is problematic and makes it a difficult area to study.

6.2 Other Cognitive Behavioural Anger Management Techniques

Benson (1985) adopted a slightly different approach to those described above. A components analysis of a cognitive behavioural anger management programme was conducted with adults with learning difficulties attending vocational training programmes. Subjects received one of four treatments: relaxation training, self instruction, problem solving or a combined anger management condition.

Fifty-four individuals with mild or moderate learning difficulties (eleven were on medication) took part in the study. Subjects were those who agreed to participate and acknowledged that losing their temper at work was a problem.
Case notes were used to assess intellectual functioning based on the American Association on Mental Deficiency System (Grossman, 1983) and the Peabody Picture Vocabulary test (Dunn and Dunn, 1981). Dependent measures included: an anger inventory (modified version of Children's Inventory of Anger, (Finch, Saylor and Nelson, 1983)), Conflict Situation test (said to be similar to the Situational Self Report Inventory, cited in Benson, 1985), ratings of a video taped role play test and supervisor ratings. These were used at pre-test (one- two weeks before), post test (one - two weeks after), and follow up (four - five weeks after post test).

The results suggested a decrease in aggressive responding over time. However, there were no significant between group differences and the follow up period was short. Therefore, there was no evidence that the treatments were effective in the long term. As there were no significant group differences, simply being part of the study may have produced a decrease in aggressive responding. However, it is difficult to ascertain whether participation was a factor, because there was no control group in the study.

Johnston and Whitman (1990) describe a case study of a client whom they described as a young man with learning difficulties who experienced problems with anger of such proportions that his community placement was at risk. They conducted a thorough assessment: interviews, psychological tests and a psychiatric evaluation using the Vineland Adaptive Behaviour Scales (Sparrow, Bailla and Cicchetti, 1984); the Wechsler Adult Intelligence

A four phase multi faceted treatment programme was designed and implemented. Components included: attending community meetings at the day programme, individual therapy, changes in the way staff worked with the client at the group home, changes in demands made on the client in the home, social skills training and anger management training (stating the rationale, assessment using an anger diary, skills acquisition and skills application). Self statements, role play and a psycho educational workshop were also used.

Johnston and Whitman report significant improvements in the client's life, but there is only anecdotal evidence to support this statement. Furthermore, it could not be said that only one treatment component led to the reported changes, as most of the components were administered simultaneously.

Black and Novaco (1993) adapted the techniques designed by Novaco for use with a male client with learning difficulties. Longer sessions were used than previously. A thorough assessment was carried out using a range of rating scales, ratings of behaviour by ward staff and the use of archival
records. Treatment consisted of self monitoring, providing relevant information, arousal reduction and providing cognitive/behavioural coping skills. The treatment was said to be successful. Ward staff reported an increase in tolerance and a willingness to compromise. This was maintained at follow up (one year later), during which time the client moved into a community facility. It is possible that moving may have contributed to the reported decrease in aggression.

Anderson-Malico (1994) describes using anger management and cognitive group therapy with people without learning difficulties. It is said to offer several pragmatic and therapeutic advantages. Anderson-Malico claims that this approach offers several pragmatic and therapeutic advantages such as combination of practical techniques of cognitive therapy with the curative factors of groups. This provides the client with concrete techniques to manage anger, and a safe environment in which to practice these techniques. This may be an approach worth considering for use with people with learning difficulties. She notes that further research is, however, required.

6.3 Summary

It is difficult to compare studies, despite them using either Gardner and Cole or Novaco's model as a theoretical basis, because they vary in the assessment tools and techniques used. None of the studies provide a clear definition of anger and some use poorly validated measures to assess the
interventions they discuss. Very few include long term follow up which is vital.

A number of them use a combination of intervention strategies, some of which are not cognitive behavioural, e.g. biofeedback. This makes it difficult to state that it is the cognitive elements that were significant in reducing aggression. Furthermore, the distinction between self control techniques and other cognitive behavioural techniques is blurred, e.g. both seem to use similar treatments.

It is likely that the therapist's skills in assessing the situation and then choosing a particular combination subsequently led to an effective intervention. Consistency when implementing the intervention would also be important.

The generalisability of the findings must be questioned, as people with verbal skills were always used. A significant proportion of people with learning difficulties have no speech and some of these require treatment for aggression. Therefore, further work is required to find out whether any of these techniques can be applied to this population.

7.0 CONCLUSION

Obviously, the study of anger and aggression is an area that is important in clinical psychology. Attempts have been made to offer operational definitions
of the terms used. However, there are still unresolved issues that have to be considered, for example, the exact nature of the link between anger and aggression.

Regardless of the above, various cognitive behavioural treatments have been suggested for persons with learning difficulties who present with problems of aggression. Some of them have been considered in this review. Empirical support of treatment efficacy is available for a range of behavioural therapy procedures for use with clinically significant problems of aggression (Gardner and Cole, 1984; Dansforth and Drabman, 1989). The studies are not as conclusive as one would like them to be.

They seem to have investigated only people with verbal skills. Indeed, the techniques have been designed for people who do communicate with words. It would be valuable to find out if any aspect of these approaches could be changed for use with people who do not communicate with words, for example, the relaxation methods.

Effective treatment is dependent on a diagnostic understanding of the specific and unique constellation of factors that occur in an individual client. Such detailed assessment is not carried out in many of the studies mentioned. This is important, as Gardner and Moffat (1990) note that individualised assessment reflects the reality that there is no single effective treatment, psychopharmacological or psychological, for aggression.
Therefore, it would be extremely important to test Murphy's model, as it seems to be the only one that considers all the potential factors. For instance, one could design an assessment tool that ensures the practitioner has to consider a wide range of variables. The tool could also be created so that it can be used with all people with learning difficulties. This would enable the practitioner to consider a wider range of interventions.

There is a need to thoroughly compare and contrast the definitions and models so that an integrated model can be developed which may be more reflective of the complexity of the problem. The only model that attempts to do this is that offered by Murphy (1997). Unfortunately, it has yet to be tested. Any future model, including Murphy's, must be developed so that it is applicable for all people with learning difficulties.

The aim of this literature review was to find out about the research that had been carried out on the definition and explanations of anger and aggression, and to consider clinical studies of cognitive behavioural approaches. The work carried out in each area seems to have been conducted without reference to the other sectors.

The clinician must therefore look at each area and glean what she/he can from them. Clearly some of the factors used to explain anger and aggression should be included when assessing a situation clinically. Some of the models and the clinical studies describe techniques that could be used. Beyond this,
the clinician has to rely on her/his experience and expertise, especially in reference to people with learning difficulties who do not speak. Indeed they may well be advised to look at the feasibility of other therapeutic approaches that do not rely on speech, e.g. art therapy.

However, it should be remembered that research in this area is relatively young. Perhaps it is too soon to expect a definitive set of models, explanations and clinical studies.


Who are the People who Challenge Services? Mental Handicap, 16, pp. 16-19.


SECTION THREE

CLINICAL AUDIT
DEVELOPMENT AND EVALUATION

OF A SERVICE STRATEGY

FOR PEOPLE WITH CHALLENGING BEHAVIOURS

IN A LEARNING DIFFICULTIES ORGANISATION
1.0 INTRODUCTION

1.1 Aim

To outline the development of a proposal for a service strategy for people with challenging behaviours that meets the needs of the organisation, the Joint Division for People with Learning Difficulties (JDPLD).

1.2 Process

Developing service strategies is a difficult task. Unfortunately, there are no tried and trusted recipes to follow. I have been involved in a range of developments including building based initiatives, large scale service developments and training initiatives. Experience indicates that new developments are best seen as organisational interventions. This proposal was therefore developed following the steps outlined in the change management and project management literature (Wysocki, Beck and Crane, 1995; Bruning, Cole and Huffington, 1990). The steps to take include:

1. Identify the problem as presented by the organisation.
2. Assess available theoretical background to this area.
3. Obtain a schema of the organisational structure(s) and attitudes.
4. Identify a method of designing the service strategy.
5. Create the service strategy.
1.3 Definitions

The terms challenging behaviours and challenging needs are used interchangeably because the organisation adopted the term challenging needs, although the official term is challenging behaviours (Mansell, 1993).

The definition of learning difficulties/disabilities utilised in this chapter is the one that was outlined in the note attached to the personal study plan. The service uses the term "learning difficulties".

2.0 THE PROBLEM AS PRESENTED BY THE ORGANISATION

The organisation is the Joint Division for People with Learning Difficulties (JDPLD). It comprises an amalgamation of the relevant departments of the local Social Services and Healthcare Trust. The JDPLD wanted to develop services provided to people with challenging behaviours because it had a closure plan for a small hospital and certain areas (including this one) needed to be developed and/or re-provided. The organisation also had several people with challenging behaviours in out of district placements that were expensive. It therefore wanted to develop suitable services for this group within the district. The health commissioners and the health care trust had also prioritised challenging behaviours as a key area.

The task of developing a service strategy had been allocated to the Challenging Needs Steering Group and the Specialist Health Care Manager (who was given total responsibility) by the Division Management Group.
(DMG) and a decision was taken to employ a specialist clinical psychologist in challenging behaviours to offer clinical advice and to take the lead in coordinating the development and implementation of the strategy. A "B" grade clinical psychology post was created and advertised. I was appointed to the post. I was managed within the psychology department but I was expected to work closely with the Specialist Health Care Manager and the Challenging Needs Steering Group.

3.0 ASSESSMENT OF RELEVANT THEORETICAL BACKGROUND

In a perfect world, the service developer should be able to consider well established models of challenging behaviours and of organisational development. Since such a world does not exist, I had to consider the knowledge that is available (see next paragraph). It is not exhaustive, but provides a glimmer of the issues involved.

Firstly, it is important to consider the available knowledge on definitions and models of service development for people with challenging behaviours. Secondly, models of normalisation and social role valorisation are considered because they have greatly influenced service delivery for all people with learning difficulties. Lastly, relevant aspects of the change management literature are considered as the work described below is essentially organisational development.
3.1 **Defining Challenging Behaviours**

Challenging behaviour(s), e.g. aggression, self injury, destruction of property is the term used to describe those individuals, who are seen as difficult to serve, and often pose problems to services for people with learning difficulties. The term was adopted in this country as an attempt to shift the focus and responsibility for action from the person, to the service system that provided for them (Blunden and Allen, 1987).

The term, challenging behaviours, is used widely by academics, practitioners and politicians alike. However, despite its popular usage, there is no agreed definition (Naylor and Clifton, 1993). Furthermore, there are no models of challenging behaviours that have been developed. Therefore, the first task in the development of the strategy was to define what was meant by the term. This process is outlined in detail in Section 6.0.

3.2. **Policy and Guidance on Service Developments**

Services for people with learning difficulties are provided by Health and Social Services. These departments are influenced by policy and guidance papers from the government and other organisations, e.g. the King's Fund.

The NHS and Community Care Act (1990) (Department of Health, 1989) led to changes that had an impact on the way in which services for people with learning difficulties (including those with challenging behaviours) are organised. First, the separation between commissioning/purchasing and
providing means that services are divided. For instance, service
developments are now usually generated by either a local purchaser or a
provider rather than through a partnership between a purchaser and provider.

The situation is complicated by the role that Social Services has been given,
i.e. as the lead authority for people with learning difficulties (Mansell, 1994).
It is assumed that people with learning difficulties who have social care needs
are the responsibility of Social Services, whereas those with largely health
care needs (this often includes people with challenging behaviours) are the
responsibility of the local Health Authority. Often, however, people with
challenging behaviours have both social and health care needs. Therefore
both Health and Social Services departments should collaborate when
designing services.

Part of the funding for health services for people with learning difficulties has
become the responsibility of General Practitioners. They are another group
who should be consulted when creating a service that includes health care.

There has also been some specific guidance on services for people with
learning difficulties that includes the needs of people with challenging
behaviours (Mansell, 1994). He notes that there were two specific attempts
(Department of Health and Social Security, 1984; Department of Health,
1989). However, he states, "in both cases they had produced reviews of all
possible options without drawing any conclusions". Perhaps, not surprisingly therefore, "these reports had sunk without trace" (Mansell, 1994, p. 300).

Another potential reason for the ineffectiveness of the guidance is that it is not certain if it is circulated to service developers. Guidance is distributed to relevant senior personnel, e.g. Chief Executives of Commissioning but there is no guarantee that it is then disseminated effectively. Another problem with guidance is that the documents merely provide information on concepts. They do not provide advice on methods of implementation (the exception being the Mansell Report).

The Mansell Report (1993) attempts to overcome this criticism. The aim of the report was to analyse how four local services approached the task of providing for people with challenging behaviours, and to synthesise the findings into practical guidance for other services. It recognises that people with learning difficulties and challenging behaviours form an extremely diverse group, and that services therefore need to be individualised.

The report highlights the need to develop the competence and capability of mainstream services to prevent "problems arising in the first place, to manage them when they occur and to implement relatively sophisticated long term arrangements for management, treatment and care". (Mansell, 1994, p. 302). It suggests that specialist services be created to support mainstream
services. A range of options is suggested, e.g. specialist teams, residential homes.

The Mansell Report stresses the importance of having management commitment to any service development and states several reasons why these services should be prioritised: people with challenging behaviours have the greatest needs, providing good quality services achieves results and failing to develop services threatens the policy of community care. It also recognises that while there is a preference for developing community services, some organisations want to create a more institutional model.

The guidance offered by the Mansell Report was influential in the work described in this paper. It highlights the need to improve mainstream services as well as developing specialist services. It is also important to secure management commitment to the project.

3.3. Models of Service Provision

There is a range of service developments in this country (see below). These were discussed in depth in the first literature review. Few of these developments were systematically evaluated in terms of their effectiveness. The standard of evaluation was very poor. An exception is the research conducted by Emerson and others on the housing developments in the South East Thames Region (Emerson, McGill and Mansell, 1994). The findings
indicated that each development was operational but there were some limitations.

**Residential Facilities:**

These are usually units used by provider agencies. They vary in size and the type of professionals employed in them. The advantage of these is that the client has access to a range of professional expertise on one site. Very few of them have been evaluated effectively except the MIETS unit which was investigated by Clare and Murphy (1993) and Dockrell, Gaskell, Normand and Rehman (1995). They demonstrated that the unit was competent.

**Community Housing Options:**

These are either single developments or large scale projects, e.g. the Andover Project (Mansell, 1994). They are different to the units because they are in the community and the client has more opportunities to be integrated. Some were evaluated. The findings show that there was an improvement in the number of activities carried out by clients, but no significant decrease in challenging behaviours (Emerson, McGill and Mansell, 1994).

**Specialist Facilities within Sheltered Settings:**

These were set up to try to decrease stress levels in the rest of the organisation. They are similar in structure to the residential facilities. The Haytor Unit (McBrien, 1994), for example, is a specialist day centre opened to accept clients who could not be placed within ordinary day facilities.
Specialist Community Teams:
These are a popular option and usually consist of specialists, e.g. clinical psychologists and/or nurses and are often separate from other community services. They usually concentrate on working with people with challenging behaviours and their carers by designing interventions, offering training, etc.

Multi Component Services:
They have several elements, e.g. team and/or access to day services. They attempt to meet a small range of local needs.

A vital aspect of any service development is the emergency and crisis mechanism. It is highly likely that each of the developments described above had such systems, e.g. on-call. However these were rarely discussed.

It is evident, except in the multi component services, most of the developments address only one issue within an organisation. Since the Mansell Report recommends that all aspects of a mainstream service should be reviewed, the work described below attempts to develop a multi component service that enhances overall competence at managing challenging behaviours as well as providing a range of specialist facilities.

3.4 Risk Taking
Experience indicates that when professionals work with people who have challenging behaviours, both at the clinical and organisational level, they
often have to consider the risks involved in serving this group. An organisation that encourages positive risk taking is more likely to develop less restrictive and controlling services. Employees are less frightened because of their belief that the organisation will support them. One danger, however, is that if there is insufficient management guidance on implementation, then some employees take unnecessary risks or no risks (Gavilan and Hughes, 1997).

Some organisations for people with learning difficulties have developed a policy on risk taking to encourage staff to take risks (Hughes and Gummer, 1989). The criteria used to decide what is an acceptable risk varies from organisation to organisation. Personal experience indicates that it is vital to find out what the attitude towards risk taking is, e.g. by finding out how the policy is implemented.

3.5 Normalisation/Social Role Valorisation

The philosophies of Wolfensberger (1972) and O'Brien and Lyle (1987) have had an impact in the field of learning difficulties. Their work emphasises the need to consider people with learning difficulties as a group who has been discriminated against, de-valued and segregated and to think of more appropriate alternatives.

The methods used to implement these ideas vary. Wolfensberger and others developed the PASS and PASSING methods of evaluation to enable
professionals to assess the extent to which a service followed the principles of normalisation or social role valorisation (a later version). O'Brien and Lyle created the five accomplishments and the Framework for Accomplishments as ways of developing services. The five accomplishments are community presence, relationships, choice, competence and respect. They represent goals a person with learning difficulties should be supported to attain. Framework is used to assess a service, so that recommendations can be made to enable more inclusion into community life. These influential ideas are a direct contrast to the earlier model that encouraged segregation, i.e. institutionalisation.

These models have had an impact on the way in which services are provided for people with challenging behaviours. Some organisations attempt to enable people with challenging behaviours to achieve the five accomplishments in community settings. This is not the case in all organisations. For instance, experience suggests that this group is usually among the last to be re-settled when a large institution is closed. They are often sent out of district to a segregated setting (unit or private hospital) if it is felt that the service can no longer cope with their behaviours.

In view of the above, it was crucial to ascertain the way in which the service adopted the concepts of normalisation. Failing to do so would have lead to any recommendations not being accepted.
3.6 Change Management

Lessons from experience and the change management literature suggest the need to ascertain the organisational structure and decision making mechanisms and to attempt to find out who the key stakeholders are (Nadler, Shaw and Walton, 1995). They recommend an investigation of three aspects: hardware, i.e. the formal elements and structures of an organisation; software or the informal elements such as the communication channels, and finally the people within the system.

It is important to find out how the organisation (JDPLD) managed change and why it introduced changes. This is crucial, as a service developer should use the change strategies utilised by an organisation. If she/he does not, then they risk failure.

3.7 Summary

There are several influences on service provision for people with challenging behaviours. These are now summarised so that the second step in the process of developing the strategy (as outlined in the introduction) can be achieved. The widespread adoption of the principles of an ordinary life, as suggested by Wolfensberger and O'Brien, has had a direct effect.

Furthermore, the developments in this country are mainly project based and separate from the rest of an organisation. Some are community based, others are not. A key finding is that moving clients with challenging
behaviours into community facilities does not necessarily lead to a decrease in these behaviours. This is to be expected for a variety of reasons. For example, it is unrealistic to expect behaviours to change simply because the environment alters. Developing a community based service seems to be the best option, especially because clients have greater opportunities and many services are being re-provided in the community.

Components seen as necessary for a service strategy seemed to vary and depend on local need. Common elements included training, residential services, and/or specialist advice and support.

The above views were taken into account when developing the strategy described below. They represent the current popular stance that services should be re-provided in community facilities.

In order to implement Mansell's recommendation that mainstream services should be improved as well as specialist facilities, it is important to design a method to assess the organisation that had requested the strategy. The areas to be assessed include the organisational systems and structures, e.g. the decision making mechanism, the crisis (on-call) systems. The Mansell Report also stresses the importance of securing the commitment of key stakeholders. It is also important to identify their attitudes towards risktaking, change management and normalisation of people with learning difficulties and challenging behaviours.
4.0 METHOD USED TO ASCERTAIN THE ORGANISATIONAL SYSTEMS, STRUCTURES AND ATTITUDES

The method chosen was one that attempted to include all the recommendations made by Mansell. A way of assessing the mainstream and specialist services that enabled an investigation of the attitudes of the key players was devised. It was necessary to find out who the key players were (both within and outside the Joint Division), the internal organisational structure, mechanisms for decision making and producing change, as well as the overall attitude of the organisation towards people with learning difficulties and risk taking.

Information about structures, attitudes and practices was obtained through interviews with key professionals within the organisation, and a review of relevant documentation. Interviewing was selected as this approach was familiar to key players within the JDPLD, and therefore more easily accepted. The professionals were selected by consultation with my manager and the Development Manager (overall manager of the Joint Division). Professionals were chosen if they were part of the Division Management Group or had key roles, e.g. Manager of the local Mencap (total number= 14). Each person was invited to a formal interview and there was a hundred percent attendance. Each individual was asked to define and describe their area of responsibility, to discuss the attitude of the organisation towards people with learning difficulties and challenging behaviours, risk taking, normalisation and
to identify any resource constraints. They were also asked to describe the organisational systems and structures.

This was not an exhaustive process but it provided an overview of the systems and structures I was working within. The information obtained is summarised in the next section.

5.0 THE ORGANISATIONAL STRUCTURE AND ATTITUDES OF THE JOINT DIVISION

There is an informal agreement between the Healthcare Trust and the Borough to have a joint division for people with learning difficulties. Professionals are either employed by the Healthcare Trust or the Borough. There are four purchasing authorities.

There are some links with other key stakeholders. At the clinical level, there is a lot of contact with children's services, mental health, the police and general practitioners. There are a number of on-call systems: psychiatric on-call, a nine to five system and an after hours system run by social services. There is also some joint strategic work being carried out with all of the stakeholders, except the general practitioners, eighty percent of whom belong to a multi fund. Voluntary organisations such as Mencap and the Friends of the Hospital are also involved. Local private providers include Mencap and London and Quadrant.
5.1 **The Structure of the Joint Division**

The Development Manager has overall responsibility for the service. He is supported by a range of purchaser and provider managers (as shown in the diagram). Their areas of responsibility reflect the different business domains of the Joint Division. The organisational structure is hierarchical (Diagram One).

The Division Management Group (DMG, Business) meets once a week to discuss all business matters. Once a month, there is a DMG (Policy) meeting at which policy issues are discussed. These meetings are open to Heads of the Health Professionals.

5.2 **Diagram One: The Organisational Structure**

Development Manager

Division Management Group: Purchaser Manager
(Business) Provider Manager-Day Services
Provider Manager-Residential Services
Hospital Manager
Business Manager
Resettlement Project Manager
Personnel Manager
Healthcare Manager
Other significant groups are:

The Care Management Working Group
The Respite Care Working Group
The Resettlement Working Group (which was later replaced by the Project Group)
The Day Services Working Group (defunct)
The Challenging Needs Steering Group
The Register Working Group
The Healthcare Advisory Group
The Community Team Managers Group
The Core Training Group
The Hospital Managers Group

Only the last four and DMG are permanent groups. Some of them do not have an operational policy, e.g. the Community Team Managers Group (CTMG). The other groups were created by the Division Manager, in consultation with DMG. The aim is to progress key areas of work identified as necessary to the organisation, especially in view of the proposed closure of the hospital.

All of the above groups are ultimately responsible to the DMG. Occasionally, they are given specific tasks, e.g. a review of day services. Others are expected to oversee day to day functions, e.g. the CTMG is responsible for the community teams.
A special working group had been convened to address the mental health needs of people with learning difficulties. Representatives from the Learning Difficulties and Mental Health Services attended. The group was disbanded after it had produced a strategy which has yet to be discussed by the Trust Board.

The service consumers are:

- People who live at the hospital. It is anticipated that the hospital would close in December 1996.

- People who live in the community in a variety of facilities; group homes (run either by Social Services or private providers), or living at home with minimal support or with parents.

- People who live in out of borough facilities.

- Children who become the responsibility of the service when they reach the age of eighteen.

People with learning difficulties are not represented in any of the formal groups mentioned above. They are consulted on some matters on an ad hoc basis, e.g. by holding one day workshops to obtain views on day services.
Clinical services are provided either directly into the houses (wards) or through the three community teams. The main focus of the service is the re-provision programme and the day to day maintenance of the organisation.

5.3 **Mechanisms for Decision Making and Achieving Change**

The formal mechanism for decision making and change is through one of the groups or by approaching the Development Manager. All decisions have to be approved by DMG, the Trust Board and Social Services Committee.

In reality, there is an informal process. Decisions agreed by DMG are often reversed after a meeting by certain members who are powerful within the organisation. They then encourage other members of DMG to reconsider.

5.4 **Attitudes of the Organisation**

The prevailing attitude in the organisation is that it publicly follows the philosophies of Wolfensberger (1972). Members of DMG had been on a training course to learn about the principles of normalisation. Any change or action is therefore judged on whether it fits in with this philosophy. The Training Officer (who is accredited in training in Social Role Valorisation/Normalisation) is asked to help DMG make these decisions. This means that the philosophical aspects of different issues are debated at length, sometimes in preference to making a decision. For instance, the service tends not to finish developing key strategies, e.g. the mental health
strategy. It is therefore crucial that the strategy I was asked to develop is in line with the service philosophy.

The JDPLD is also insular in that it does not include General Practitioners or Commissioners (except Social Services Purchasers) in its daily development work. There is a certain amount of dialogue, e.g. when creating annual business plans but very little else.

The JDPLD is in the process of developing a document on risk taking. This means that staff are unclear about whether risks should be taken. This has led to a conservative attitude within the organisation towards risk taking, especially in relation to people with challenging behaviours.

5.5 Summary.
The organisational structure includes a mechanism for decision making which will be utilised. The attitudes towards change and normalisation were noted and taken into account when designing the strategy. The lack of a policy on risktaking indicates that the organisation is reluctant to develop this area. However, it is crucial that a policy is created as part of the mainstream improvements needed to develop a challenging behaviours strategy.

6.0 DESIGNING THE SERVICE STRATEGY
The first step was to agree a local definition of challenging behaviours, since there is no globally accepted one. An attempt was then made to follow
Mansell's recommendations: that the task is to improve mainstream services at the same time as introducing specialisms. An effort was also made to use the organisational structures that exist. All the work described below was channelled through the Challenging Needs Steering Group and the Division Management Group. The Challenging Needs Steering Group has been in existence for a period of years. It consists of representatives from psychology, psychiatry, social services and provider agencies. It is chaired by the Specialist Healthcare Manager.

The steps that were taken were:

- Agreeing a local definition
- Establishing the magnitude of the problem
- Investigating the capability of the mainstream components to identify which aspects need to be improved and what specialisms should be added.

Given the lack of any agreed definitions or models in the area of challenging behaviours, it was vital to obtain a local agreement. Secondly, it was essential to ascertain who the service consumers would be. Thirdly, if Mansell's recommendations are to be implemented, then it was vital to audit the mainstream organisation.
6.1 **Agreeing a Local Definition of the Term Challenging Behaviours**

A definition had been agreed prior to my arrival. It was the one created by Emerson, Barrett, Bell, Cummings, Hughes, McCool and Toogood and Mansell (1988, p17): 'Behaviour of such an intensity, frequency or duration that the physical safety of the person or others is placed in serious jeopardy, or behaviour that is likely to seriously limit or delay access to, and use of ordinary community facilities.'

This definition was subsequently discussed by The Challenging Needs Steering Group and was agreed as the one that should be used throughout the development of the strategy. The Steering Group did not want to change or alter the definition despite being shown alternatives.

The JDPLD also stated, in its Strategic Intentions, that:

People with challenging behaviours should have an equal right to live in their local community and access generic services and facilities.

Services for people with challenging behaviours, therefore need to be comprehensive and flexible recognising that this group of people have the same underlying needs as other people with learning difficulties.
Research evidence now shows that if people with challenging behaviours are supported to live in the community the incidence of challenging behaviours decreases.

The statements made in the Strategic Intentions were also accepted regardless of the fact that the last statement is not wholly supported by published evidence. It was felt they reflected the attitudes of the organisation, i.e. that it adheres to the principles of an ordinary life.

6.2 Establishing the Magnitude of the Problem

It was not necessary to research this area as a member of the psychology department (Charles Parkes) had already carried out a survey of:

a) the numbers of people with challenging behaviours,

b) the types of challenging behaviours that were being demonstrated,

and

c) staff attitudes on working with people with challenging behaviours.

The research had been conducted a few months before my appointment.

The findings were:

a) The number of people living within the boundaries whose behaviour presented a management problem of some kind was approximately 170.
Of these, those living outside the district number approximately 50 and those at the hospital, approximately 30. The remainder live in the community.

The proportion of the total population whose behaviour was deemed to be a management problem was 26%.

b) The behaviours shown to be challenging were:

- Unco-operative: 49%
- Attention Seeking: 45%
- Physical aggression: 35%
- Excessive noise: 31%
- Excessive activity: 25%
- Damage to property: 22%
- Self Injury: 16%
- Wandering Off: 16%

c) A questionnaire survey was carried out of direct care staff (78 in total) and professional staff (13 in total). It assessed the current issues they were facing, e.g. levels of stress and whether they would make use of a specialist service if it existed.

Respondents stated they had to deal with a variety of challenging behaviours from clients. They had experienced high levels of stress. They required
more training and guidance on intervention, but less advice on assessment. Respondents tended to agree with the need for a specialist service for clinical advice and support, extra resources in short term and long term residential care, day care and carer support and training.

These findings were discussed by The Challenging Needs Steering Group. It was considered unnecessary to update the work on prevalence. The group decided to emphasise training as it had been highlighted as well as the other recommendations.

6.3 Establishing the Capability of the Mainstream Organisation and Identifying what Specialisms were Required.

It was important to secure management commitment before choosing a method to establish the capability of the mainstream aspects of the organisation and to identify what specialisms would be required. A request was made to DMG for a discussion of this topic. This ensured that the decision making mechanism in the service was used. A decision was taken by DMG to carry out an informal audit in the service via the mechanism that already existed, i.e. the Challenging Needs Steering Group, as the members were also key stakeholders in the organisation. The group was asked to develop a strategy after each member had reviewed their areas of responsibility.
To assess the current service, the following areas were identified as important: the strengths and weaknesses in purchasing/commissioning and providing in relation to people with learning difficulties and challenging behaviours. Areas that were considered included training needs, specialist advice and support, and mechanisms for dealing with crises. Each group member was asked to report their findings at meetings of the Challenging Needs Steering Group. However, these meetings were poorly attended. This was partly because the Specialist Healthcare Manager left. Overall responsibility was not allocated to another member of DMG for some months. It was therefore not possible to continue either with the audit, or the development of the strategy.

A discussion was again held at DMG, and the decision was taken to adopt a slightly different approach using a variety of methods. These were:

Interviewing (separately) key purchasers and providers.

Developing a training element for the strategy, by consultation with the reconstituted Challenging Needs Steering Group and the Training Officer.

Surveying the systems for dealing with emergencies.
6.4 **Interviewing Key Purchasers and Providers**

The key stakeholders whom I interviewed are listed below. They were identified through discussion between DMG (Business) and myself. Other possible stakeholders, e.g. General Practitioners were not seen as relevant to the work by DMG.

- The Development Manager (who has responsibility for the service)
- The Project Manager (who has responsibility for the re-provision programme)
- The Personnel Manager
- The Purchasing Manager
- The Social Services Provider Manager
- The Manager of the Hospital
- The Heads of Department of Specialist Healthcare, e.g. psychology
- The Training Officer
- Representatives from a number of provider agencies, e.g. MENCAP Homes Foundation

These individuals were identified as they had responsibility for key areas. Those who had responsibility for purchasing were included, e.g. Development Manager. A range of providers was also identified: those who had overall responsibility for day and residential services.
The Project Manager was included because of the implications of the Resettlement Programme. Specialist Healthcare Managers were consulted to identify issues related to specialist advice and support.

The Personnel Manager was involved because she was responsible for ensuring that staff received proper supervision and support. The Training Officer was responsible for the overall training programme. Both these areas had been emphasised in the work carried out by Charles Parkes.

The survey questions were created by discussion with the Challenging Needs Steering Group. Each interview was conducted by myself and lasted approximately one hour. There was a hundred percent attendance. All interviewees were reminded of the agreed definition of challenging behaviours and the statements made in the Strategic Intentions. (See Section 6.1).

The interview questions included:

1. Clearly define your responsibilities. What are the boundaries? Are there any overlaps with other areas?

2. What are the issues/problems relevant to working with people with challenging behaviours with reference to managerial responsibility, carers (paid and unpaid), and clients?

3. What are the features of a good solution?

4. Identify a range of solutions. Include a rationale and recommendations.
5. Prioritise these recommendations. Provide an estimate of the timetable for implementation and resource requirements.

6.4.1 Findings of the Survey

Purchasing managers prioritised the following as issues that should be dealt with to improve the mainstream service:

Purchasers needed to be educated on the needs of people with challenging behaviours. Often, they were asked to make decisions about this group, e.g. to provide funding for an out of district placement, but did not have an awareness of current knowledge.

Mechanisms to ensure that providers adhered to all the policies and procedures of the JDPLD needed to be made more stringent. Provider contracts stated that they should adhere to these standards, but there was no guarantee that they did. It was felt that a thorough monitoring mechanism and default clauses needed to be introduced.

Relevant policies and procedures needed to be created or finalised, for example, Risk Taking, Dealing with Sudden Emergencies and Coping with Violence.
Purchasers and Providers felt that the following areas should be addressed in the provision of services:

- Training of staff in areas related to working with people with challenging behaviours.
- More effective systems of support and supervision ought to be developed.
- Development of a specialist clinical team to support the existing community teams and the re-provision programme.

The re-provision programme needed to be made more flexible to accommodate the needs of people with challenging behaviours. Re-provision should include resources to enable a client to move more than once as needs often alter.

Plans needed to be made to return those clients who were out of district.

Greater collaboration with other agencies should be encouraged. This was essential at all levels. For instance, a memorandum of agreement between all agencies could be negotiated, so that they purchased and provided services collaboratively.

6.5 **Surveying the Systems for Dealing with Emergencies**

Within the service, there are a number of systems for dealing with emergencies/crises. There is an on-call duty system operated by each
community team during the hours of nine to five. Out of hours help is obtained from a generic service run by Social Services and the on-call duty psychiatrist. Only the system that is the sole responsibility of the service, i.e. the nine to five duty system was investigated. It was not possible to survey the other systems.

The duty system was reviewed by holding a series of meetings with team members and their managers, to identify strengths and weaknesses in the system. The problems were identified by asking each group to discuss two crises they had experienced and to highlight the problems they had encountered. The difficulties they reported included not knowing who to seek advice from and the lack of a senior duty on call manager. They reported a number of communication difficulties. Some felt that they lacked expertise in some areas and often had to contact another professional for advice. For instance, if a health professional was on-call, they would have to seek the advice of a care manager about placement concerns.

A survey of the three community teams was also carried out as not all team members attended the meetings. A questionnaire was designed to investigate how clinical crises had been managed by team members. It included the following topics: the number of crises they had experienced, the predictors of a particular crisis, the outcomes of the crisis, the extent to which they felt the service system was effective in resolving the crisis and any suggestions for improvements.
There was a fifty-eight percent response rate. The types of crises that were identified included; abuse allegations, incidents of aggression and withdrawal of medication. Early warning signs included poor staff support/training, breakdown in communication and inadequate monitoring of medication.

More than fifty percent of the respondents felt that the crises they experienced had been resolved unsatisfactorily, e.g. continuing communication difficulties. There were, however some satisfactory outcomes, e.g. reinstatement of medication. The survey suggested that some service improvements were required: (i) an improvement in the senior duty management system and (ii) the need to formulate contingency plans for people with learning difficulties if they are deemed vulnerable.

The findings from the meetings and the survey indicated the need for a senior duty management system (so that junior staff on duty know who to go to for advice on complicated situations), the development of information packs, e.g. about local resources for staff on duty, and the need for the development of relevant policies and procedures such as dealing with sudden deaths, emergency admissions, etc.

6.6 Developing a Training Element of the Strategy

This was developed by inviting purchasers, providers and the training officer to special meetings of the Challenging Needs Steering Group. The areas considered were: identifying training needs, identifying areas that could
already be offered by professionals within the organisation and resource implications for any suggestions. A paper was developed and presented to the Core Training Group and their recommendations were incorporated into a second paper. These were included in the service strategy document. The following issues were identified.

6.6.1 **Groups who Require Training**

It was suggested training be offered to voluntary agencies, users, carers, providers within social services (day and residential services and care managers), providers within the health service (professional staff on the teams and in the houses) and senior managers across the joint service. Each group was seen as having a range of training needs, some of which were similar. It was recognised that efforts should be made to assess their needs in each area.

6.6.2 **Ensuring that Training is Effective**

The group agreed that each course should be continuously evaluated and improved when necessary. There needed to be follow-up strategies to ensure consolidation, e.g. via action learning sets. This would be particularly important for participants who received training on crisis management. Participants would have to convene every three to six months to discuss issues related to crises they may have experienced.
6.6.3 Practical Matters Related to Training

The group felt that agreements to release staff for training should be made. Resources to provide training needed to be identified. Suitable trainers needed to be found, either within or outside the JDPLD.

6.6.4 Subjects that Staff Require Training In

Each of the topics that were identified could be offered separately, or combined to meet the needs of a particular group of staff and/or carers. The topics were:

1. Legal and ethical issues
2. Risk assessment and analysis
3. Values and philosophy underlying the work
4. Factors underlying challenging behaviours, e.g., self injury, mental health or physical health problems
5. Assessment and recording techniques
6. Understanding challenging behaviours
7. Designing action plans to help people with challenging behaviours
8. Techniques/approaches for helping people with challenging behaviours
9. Handling techniques/control and restraint
10. Coping with stress/difficult situations
11. Crisis management
12. Designing individualised services
All of these findings represented the perceived needs of the organisation. Another organisation would have prioritised other areas. They were included in the Strategy.

7.0 THE STRATEGY

A draft strategy was developed (see Appendix One) and presented to DMG. Care was taken to consult with major stakeholders while writing it, e.g. by discussing initial drafts of the paper with the Development Manager. It incorporates the findings mentioned above, e.g. analysis of emergency systems. It has two aims: to develop mainstream service competencies in relation to people with challenging behaviours and to create specialisms where necessary.

The service principles outlined in the Strategic Intentions are used as the wider framework. The areas are separated into purchaser and provider issues. This seems to be a useful distinction, given the current legislation. Resource implications for each area are also discussed. Exact costings are not included.

The areas covered are listed below (see Appendix One for details): the values and aims of the service, purchasing, providing, collaboration with other services and an action plan. The areas of potential development are seen to be:
• Effective mechanisms at the commissioning and purchasing level to ensure good liaison and communication.
• Effective support systems to enable staff to work efficiently.
• Training to enhance the expertise of all professionals in the service.
• Specialist support and advice to add to that already available.
• Crisis management mechanisms to enable the service to develop proactive strategies.
• Support for the re-provision process.
• Bringing people back from out-of-district placements.
• Liaison with other agencies, e.g. police, mental health to ensure good collaboration.

The resources deemed to be necessary to implement the strategy are:
• A challenging needs co-ordinator to oversee the service
• A training officer
• A specialist clinical psychologist in challenging behaviours
• 4 specialist support workers in challenging behaviours
• 2 out-of-district support workers

7.1 The Process of Implementation

As mentioned earlier, any proposal has to be sanctioned by DMG. It is then discussed by Social Services Committee and/or the Trust Board. On occasion, it is discussed with relevant health commissioners. The strategy is usually presented by the Development Manager at these meetings.
The final draft strategy was accepted, in principle, by the Division Management Group. It was felt that the paper would benefit from further in-depth discussion. Two one day meetings of DMG with invited others, e.g. representatives of healthcare professions were held. Several key issues were identified and discussed, e.g. ensuring that the proposed strategy was congruent with national policy and guidance. The strategy was also tested by looking at certain individuals known to the organisation to find out if it met their needs. Individuals who lived in and outside the district were considered. Three further half day meetings were then proposed to finalise the strategy. At the date of submission, these meetings had yet to be held.

Following the meetings, it is hoped that a final document with relevant costings will be developed. It will then be presented to the Trust Board as it is likely that the necessary financing will be provided by Health.

8.0 EVALUATION OF THE METHODS USED AND OF THE SERVICE SYSTEM'S RESPONSE TO THE CREATION OF THE STRATEGY

8.1 Discussion of the Methods Used

The method used to create the strategy tried to take account that organisational change was required. An effort was made to use principles of change management. This enabled key issues in the organisation to be identified as well as potential problems, e.g. the preference for discussion and not action. However, identifying problems such as inaction is not enough, a method for overcoming them should also be designed. It was not
necessary to do so as the Trust Board set a deadline for completion of the strategy. An alternative strategy would have been to set up the three half day meetings and invite members of the Trust Board and Social Services Committee.

Other techniques for ascertaining the change process and for designing change could have been used, e.g. search conferences. However these were not utilised as the techniques used are the ones preferred by the organisation.

The methods used tried to ensure that certain standards were met, e.g. agreeing a local definition. They were based on discussion either in large groups (the Challenging Needs Steering Group), individually or the findings of the survey carried out by Charles Parkes. These techniques would have been improved by trying to incorporate a process to validate statements made by professionals. For example, finding out if there was data to support the creation of a specialist team.

The strategy was created despite the fact that there is no solid theoretical background. It was done because there is a real need to provide for people with challenging behaviours in the community. Efforts were made to adhere to the recommendations made by Mansell that the commitment of managers had to be secured, that mainstream services should be enhanced, and that specialisms ought to be developed.
One of the problems with adopting this approach is that some suggestions are not as concrete as others, e.g. developing effective contracting systems. The 'customer' may therefore experience a certain amount of dissatisfaction and uncertainty. For instance, it is easy to conceive of a specialist team and the work they would do, but it is difficult to think about what a good contracting mechanism would look like. This may have contributed to the reluctance to accept the strategy wholesale. It is possible that the process of implementation identified was an attempt to be educated, e.g. using case studies to discuss the less concrete areas of the strategy.

Thought also needs to be given to the links between this strategy, and the one for meeting the mental health needs of people with learning difficulties. The Mental Health Strategy recommended that emergency beds be purchased. A link is crucial because these services could be providing for the same client group and the Challenging Needs Strategy does not include any provision for clients who require emergency hospitalisation.

Some potential partners/customers, e.g. General Practitioners were not formally included in the creation of the strategy. Their views should be sought before the strategy is finalised. Evaluation mechanisms to measure the effectiveness of the strategy, e.g. monitoring the number of clients sent out of district should be designed. These should include an annual update of the information collected in the survey carried out by Charles Parkes, e.g. number of people with challenging behaviours in the service.
8.2 Fitting in with the Process of Change in the Organisation

Historically, the service is not known for being action oriented. In contrast, it prefers discussion. This means that progress is slow, e.g. the three half day meetings have not been held.

The slowness of the change process is also typical of other human service organisations I have worked in. This is especially true when developing services for people with challenging behaviours. There is sometimes an element of fear present that impedes progress.

What is evident that making attempts to ensure that a strategy fits in with service philosophy, e.g. by including statements about philosophy does not necessarily guarantee its success. The overall service attitude to change is the most important factor. It is a service that implements strategic change but not by using the formal change mechanisms, e.g. DMG. In fact, change is usually achieved via one or two key individuals on DMG adopting one or more of the recommendations within a strategy and implementing them.

This is the way in which the Abuse Strategy has been implemented, i.e. it has not been formally accepted but is being used. This is also the case with this strategy. For instance, the Out of District Care Manager has already been given a deputy to help her with her work in resettling people with challenging behaviours from out of district.
A key factor in this process may have been that I was located within the Psychology Department as opposed to within the Division’s management structure. This decision was taken before my arrival. Given that most of the work is at a systems level, it may have been more advantageous to have linked the post more closely to one of the Managers, e.g. Specialist Healthcare Manager. This would have enabled me to have better access to the formal and informal decision making mechanisms.

8.3 Conclusion

The main lesson is to recognise that a service strategy is a living thing. It is not implemented in discrete steps. The way in which it develops will reflect the way in which the organisation allows growth. These factors should be recognised at an early stage by the service developer. It is also vital to include all stakeholders in its development so that they own it.

It is likely that the Strategy will be finished in the next two months. My role in it will be to facilitate the work that needs to be done and ensure that it is presented well. The Strategy has to be formally accepted, costed and taken to the Trust Board and Social Services Committee. Once this has been done, there will have to be negotiations about where the different posts will be located and how they will link in with other professionals. A system for evaluating the strategy should be built in.
9.0 BIBLIOGRAPHY


Department of Health (1989). Needs and Responses. Services for Adults with Mental Handicap who are Mentally Ill, who have Behavioural Problems, or who Offend. Middlesex: Department of Health.


10.0 APPENDIX ONE: THE DRAFT STRATEGY FOR PEOPLE WITH
CHALLENGING NEEDS IN THE JOINT DIVISION

MEETING THE NEEDS OF PEOPLE WITH LEARNING DIFFICULTIES
WITH CHALLENGING BEHAVIOURS AND THOSE OF THEIR
SUPPORTERS. (1995)
1. Introduction

1.1 A draft strategy for the joint service was produced by the Challenging Needs Steering Group in March 1995. This was discussed by the Division Management Group (Business). It was decided to use the draft as a basis for consultation with key stakeholders so that it could be developed.

1.2 The key stakeholders who were consulted were:

(Names omitted for confidentiality)

1.3 The strategy is now presented in draft form. It is based on the discussions held. There are a number of sections:

Values

The Aims of the Service

Purchasing Services

Providing Services

Collaboration with other services

A Plan of Action

Each section contains a description of what the perceived need is and ways and means of meeting it in each area.
2. VALUES

The value statements made in the Service Review and Strategic Intentions Document (1994-99) more than adequately describe the values a service should aspire to, when trying to provide for people with challenging behaviours. It is important to try to develop services by enhancing the relevant aspects of the generic service and include specialisms where necessary. The value statements are repeated below:

2.1 People with challenging behaviours should have an equal right to live in their local community and access to generic services and facilities. People with learning difficulties who present challenging behaviours form an extremely diverse group. They include individuals with varying levels of learning difficulty, sensory or physical impairments and additional mental health problems.

2.2 Services for people with challenging behaviours, therefore, need to be comprehensive and flexible recognising that this group of people has the same underlying needs as other people with learning difficulties. They do require additional services, however, which are designed to meet the extra challenges that their behaviour presents. They do not surrender their needs for growth and development, their own home, for opportunities to enjoy community facilities, to develop personal relationships or indeed for anything else, because of these special needs.
2.3 Research evidence now shows that if people with challenging behaviours are supported to live in small group homes in the community the incidence of challenging behaviour decreases. (See the Mansell Report published in 1993 by the Department of Health). Increasingly, services are developing their ability to support people with challenging behaviours in the local community.

3. **AIMS**

3.1 If a service is to translate the above mentioned values into reality, then it is important that a true commitment is made to provide for this group, even when individuals are being their most challenging. Commitment of this nature will enable the service to develop a greater sense of responsibility for people with challenging behaviours, which is an essential aspect of developing a service strategy. A sense of responsibility and commitment will ensure that the aims set out in the Service Review and Strategy Document (1994-99) (listed below) can be used to underpin the challenging behaviours' strategy.

3.2 **Challenging Needs Services will:**

- Be integrated into ordinary service networks, with a value base that is consistent with the service as a whole. This is applicable to both generic and specialist developments.

- Ensure that staff working with people with challenging behaviours are well trained and well supported and that the service is able to offer staff practical help and training when appropriate.
• Be planned on the basis of accurate information about the individuals concerned.

• Include provision of community residential care, day-care in small scale services providing supported employment and leisure and educational pursuits.

• Include skilled professional advice from a full range of specialists working in a co-ordinated way, and backed up by good access to generic services.

• Aim to reduce reliance on out of borough placements.

4. METHOD

Services for people with learning difficulties are divided into commissioning, purchasing and providing sectors. It was considered that suitable strategies for addressing the needs of people with challenging behaviours are required at each level. A number of the strategies aim to further develop the generic service and others are suggested to develop necessary specialisms.

4.1 Purchasing services

4.2 This process is carried out at a macro and a micro level, i.e. block and spot purchasing. At the macro level, large scale services are purchased via contracts, and at the micro level, individual services purchased by care managers.
4.3 At both levels, commissioners and purchasers have much expertise when addressing the needs of people with challenging behaviours. This expertise is used in crises when emergency resources are usually requested by a provider. This expertise needs to be built on so that purchasers and commissioners can act before a crisis has developed. To do this, it is necessary to have good communication networks between purchasers and providers at the macro and micro level.

4.4 Commissioners at the macro level need to ensure that providers follow the value base, policies and procedures and service standards contained within service specifications, service level agreements and contracts. Commissioners need to ensure that providers are prepared to support people with challenging behaviours. The necessary policies and procedures that should be developed are:

- Crisis management strategies to deal with situations not covered by the abuse policy.
- Coping with Untoward Incidents (including violence)
- Risk taking strategies
- Dealing with abuse

It is also necessary to ensure that there is a process for identifying the needs of people with challenging behaviours.
4.5 To ensure that contracts are adhered to, an effective mechanism for contract compliance and management is needed.

4.6 Resources are needed to ensure that the above needs are met. It is suggested a Challenging Needs Co-Ordinator, with a business background is employed. Her/his tasks would include:

- Oversee the development of the challenging needs service (including suggestions made below).
- Establish effective liaison mechanisms between purchasers and providers.
- Support the development of relevant policies and procedures.
- Support the development of a sophisticated contracting mechanism.
- Support the improvement of the current mechanism for identifying needs.
- Ensure that relevant training is made available to commissioners and purchasers, e.g. around service design.

The post holder could be managed by the Service Manager, Specialist Healthcare. She/he would work closely with relevant others within the service to ensure that each of the above is attained.
4.7 Providing Services

If a service is to meet the needs of people with challenging behaviours, it is important that the needs of their supporters are also addressed. This section outlines the relevant areas.

4.8 Support needs of paid staff and professionals should be met within their own service structure, i.e. line management, peer support. These needs should be met by developing by a culture of being proactive so that senior line managers are alerted to problems before a crisis occurs.

Resources are required to ensure that all line managers are sufficiently trained and that they can develop effective supervision and appraisal mechanisms.

4.9 Training is seen to be an important part of any support mechanism. Three levels of training are required:

1. Basic training to cover general issues related to working with people with challenging behaviours.

2. Training related to supporting specific people with challenging behaviours, e.g. helping staff to implement an intervention. This should be carried out with relevant professionals, e.g. speech therapy, psychology, psychiatry.
3. Learning sets of professionals so that expertise can be shared across professional groups and community teams. External experts could be invited to these.

Training needs of relevant staff groups must be identified.

Any training carried out should be accompanied by effective follow-up mechanisms. Staff could be required to implement aspects of the training under the supervision of their line manager and a member of the training department. Training could also include in-house coaching and modelling. It is essential that the training needs of staff are identified and that resources are allocated so that they can be released from their daily duties.

Parents and carers may also have needs that could be addressed through training. Any training carried out needs to be sanctioned by the Training Officer so that service standards and values are followed.

Training materials have been developed by the Challenging Needs Steering Group and can be used as a basis for a training programme.

Resources are required to ensure that all of the above needs are addressed. This could be done by appointing a staff person to be part of the training department. Their job would include:
• The development and implementation of a rolling programme of training.
• To work with relevant professionals and providers to develop and implement specific training programmes.
• To develop the learning sets for professionals.

5.0 In general, those who support people with challenging behaviours are more than able to work with them effectively. This expertise should be balanced against a need for specialism that is often required. Specialist clinical skills are required at two levels: offering advice and hands-on working with those who support people with challenging behaviours. These skills are required in the community via the community teams and for the resettlement process at the Hospital.

Currently specialist advice is offered through the psychology department. Expertise and advice are also available from other professional groups, e.g. psychiatry, care management, speech therapy. This expertise could be enhanced by creating specialist support worker posts. They would work with relevant professionals, including psychiatry, psychology and occupational therapy to implement any interventions designed to meet the needs of people with challenging behaviours.

The specialist support workers would be responsible for carrying out hands-on work or any training that is necessary. They would liaise with relevant
professionals in provider agencies. They could have a range of qualifications, e.g. PGCE, CQSW, RMNH. They would have to be reasonably experienced.

A total of four posts could be created, one each for two of the teams. Two posts could be allocated to the third team, one to support the team and the second to initially support the resettlement process and then to work in the team. They would be managed and supervised by a specialist psychologist (B Grade) in the first instance, and work with relevant professionals for specific pieces of work. They would be expected to facilitate any relevant training.

5.1 As mentioned earlier there is a need to develop an effective crisis management mechanism. This process needs to involve both purchasers and providers. A survey carried out with the community teams indicated that there was a need to improve the current system by offering training to professionals who work on duty, the development of a senior duty management system.

The current system needs to address those times when there is liaison with general practitioners.

The tasks that need to be carried out (perhaps co-ordinated by the Challenging Needs Co-Ordinator) are:
• The development of training for staff who will be working on duty.
• The development of a senior duty management system.
• Developing effective ways of working with GP's.
• This work would have to be carried out with relevant professionals from the community teams and others.

5.2 The re-provision process is currently under way. It is important to ensure that issues mentioned above are also addressed as part of the process. This could be done by enhancing the re-provision systems and structures in place by:

• Ensuring that there is flexibility within the system to address the fact that a person's needs may change and/or they may require extra support at given times, e.g. when they move.

• Making sure that plans are made for emergencies.

• Ensuring that people listed as requiring individualised services have their needs addressed so that if they want/need to live with others, they are able to. These services could be developed with relevant care managers. Some of these are likely to require extra funding.

• Developing a de-briefing mechanism to assess the re-provision process after each project has opened.
5.3 There are a significant amount of people (some of whom have challenging behaviours) who are currently in out-of-district placements. A care manager has been recently appointed to address their needs and to begin the process of bringing some of them back into district. This is a complicated and time-consuming process that requires a significant amount of personnel resources. There are three strategies:

1. Assessment of need
2. Designing a plan for return
3. Implementing the plan

The out-of-district care manager would require the support of two staff to work under her management and supervision to carry out the work.

6.0 COLLABORATION WITH OTHER AGENCIES

The strategy should ensure that there is good collaboration and joint working with relevant agencies and organisations. These include:

- Children's Services- to ensure that adult services become aware of children with challenging behaviours early enough to plan proactively for them.

- Mental Health and Forensic Services.

- Police and Probation Services.
The Joint Service has already begun work in some of these areas. Training programmes for the police have been developed as part of a collaborative process between the Mental Health, the Learning Difficulties Service and the Police in the Borough. Further training is being discussed. A draft strategy for people with learning difficulties and mental health problems has been designed.

If this strategy is implemented, it would complement the challenging needs strategy. There are areas of overlap that need to be discussed, e.g. the provision of emergency respite.

The Challenging Needs Co-Ordinator could have responsibility to ensure that this work is carried out.

7.0 SUMMARY

The elements of the strategy have been outlined above. The areas that need to be included are:

7.1 Effective mechanisms at the commissioning and purchasing level to ensure good liaison and communication.

7.2 Effective support systems to enable staff to work effectively.

7.3 Training to enhance the expertise of all professionals in the service.
7.4 Specialist support and advice to add to that already available.

7.5 Crisis management mechanisms to enable the service to develop proactive strategies.

7.6 Support for the re-provision process.

7.7 Bringing people back from out-of-district placements.

7.8 Liaison with other agencies to ensure good collaboration.

The resources required to implement the strategy are:

- A challenging needs co-ordinator to oversee the service
- A training officer
- A specialist clinical psychologist in challenging behaviours
- 4 specialist support workers in challenging behaviours
- 2 out-of-district support workers
- Other clinical specialists may be required

Each professional’s management and supervision arrangements would need to be agreed so that they “fitted” into the service as much as possible, e.g. the training officer should be managed by a member of the personnel and training department. A mechanism for co-ordination, development and implementation of the strategy and the posts is needed.
8.0 ACTION PLAN

The service strategy needs to be agreed as the appropriate way forward. A mechanism for securing resources is needed. It is necessary to further develop and implement the strategy outlined above. Outcomes for each aspect of the service should be designed. The outcomes could be used to evaluate the service.
SECTION FOUR

RESEARCH AUDIT
Investigation of the Effects of Self Advocacy
on the Behaviour and Attitudes of People with Mental Handicap

By

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Thesis submitted to the Council for National Academic Awards in part fulfilment of
the requirement for the award of Master of Science in Clinical Psychology from
Plymouth Polytechnic.
I would like to thank everyone at the Adult Training Centres who participated in this study. Thanks are also due to my supervisors, Olive Pyke and Judith McBrien for their advice and help and to Shirley Bryans for typing the manuscript.
ABSTRACT

A study was conducted to investigate the effects that self advocacy training and participation in a trainee committee would have for people with a mental handicap. Three groups were used: experimental group (self advocacy via the formation of a trainee committee), control group and a comparison group (members of a trainee committee already in existence). (A self advocacy course that had been devised for the purposes of the study was administered to the experimental group.)

Possible behavioural and attitudinal changes were measured using the following: The Adaptive Behaviour Scale; Pathways to Independence Checklist; Acceptance of Others Scale; Self-Esteem Inventory.

Behaviour in meetings of the experimental group was also recorded. All measures were given at the following time periods:

(a) One week before committee was formed (but after the committee had been elected).

(b) Twelve and twenty-four weeks after the committee had been in existence.

Results indicated that some behavioural changes had taken place. No attitudinal changes occurred. However, there were some methodological faults which may have affected the results.
1.0 INTRODUCTION

Self advocacy has been defined as the principle and process of mentally handicapped people speaking for themselves (Hersov, 1984). It is usually operationalized by the formation of a group of people with mental handicap in a locality. Attached to each group is an advisor(s) whose task it is to perhaps train the group in self advocacy or in such matters as how to form a committee or to help in the general running of the group.

There are different organisational models for running self advocacy groups: the autonomous group model, the divisional model, the service system model and the coalition model (La Roche, Evans and Donahue, 1985). The autonomous group model is described as being the ideal model. The reason being that because it is autonomous, it retains complete financial and organisational independence from other organisations. A possible disadvantage is the group may be seen as being too separate from the service to promote change - hence La Roche et al. (1985) suggest that it is essential to develop a good rapport with service systems.

The second model involves developing a self advocacy group as a division of an organisation for people with mental handicap that already exists, e.g. a parents' group such as the Association for Retarded Citizens, Protection and Advocacy Systems. A primary advantage of developing a group in this way is the immediate availability of resources, a disadvantage is that conflicts of
interest may arise if disagreements arise between the self advocacy group and the parent organisation.

The third (and perhaps the most frequently used model) is the service system model, i.e. the group is located within a service. Recruitment is usually not necessary as there is a "built-in membership." Members are also able to focus on issues of rights and responsibilities that affect them. There are disadvantages, however: possible conflicts of interest may arise if views seen as unfavourable by those working in the service are adopted. Similarly, members may be chastised for adopting such views: the group may have unrealistic expectations or it could become defined as a token self advocacy group. This model is said to be more workable if the advisor is someone from outside the system. It is suggested that once a group has been formed using the above model, it should strive for autonomy as soon as possible. This is the model that was used in this study. The fourth said to be comprised of a “group of independent organisations that work together to protect the human and legal rights of disabled people.”

The self advocacy movement developed by using one or other of the above models. Its development was facilitated by the following: de-institutionalisation, the articulation and the application of the philosophy of normalisation (normalisation being defined as making available to the mentally handicapped, patterns and conditions of everyday life which are as
close as possible to the norms and patterns of the mainstream of society
(Nirje, 1970; Crawley, 1983).

The movement first began in Sweden in the 1960's following government
recommendations that consultative bodies of people with mental handicap be
set up in institutions, special schools, etc. In America, the self advocacy
movement known as “People First” developed from the First Convention for
the Mental Handicapped in North America in 1973 (and was inspired by
events in Sweden). From this has grown a network of local self advocacy
groups (known as Chapters). These, and other groups, are now part of an
International Movement called, “People First International.”

The task of the movement at present is to cultivate a group identity and
provide support and to organise the local Chapters and hold conferences. In
Britain, the first national conference for people with mental handicap was
organised by the Campaign for Mental Handicap (CMH) in 1972. It was
attended by six carers for people with mental handicap and twenty-two
people with mental handicap. There followed a series of “participation”
weekends in 1973 - 1975. Although there have been publications of the
views of people with mental handicap, e.g. Williams (1974), Crawley (1983)
suggests these meetings were not as successful as similar conferences had
been in America in encouraging the development of individual groups. The
conferences have continued, however, and there has been increasing
interest. As Crawley notes, the foundations for a British self advocacy
movement are being laid through another medium - that of trainee committees in Adult Training Centres. Such committees have been successful in some of their ventures, e.g. the committee at the AURO centre in Essex have joined the NUS and participated in television programmes on self advocacy.

Trainee committees consist of trainees representing the centre and usually advisor(s). Advisors are non-handicapped people (sometimes staff members of the A.T.C.) whose task it is to train the committees in self advocacy and to function effectively as a committee. (Not all trainee committees, however, have formal training). In order to train a committee, it is necessary to consider what skills are necessary for self advocacy and to function as a committee. Crawley (1983) has attempted to separate out these skills. She suggests that they consist of the following: problem solving, decision making, assertiveness, communication and interpersonal skills, knowledge of rights (human, civil and legal), the nature of advocacy and self advocacy; leadership and organisational skills. She also notes that in particular, individuals need to learn about their own personal worth, their right to equality of opportunity, the possibility of taking part in the decision making of society and contributing positively to the community.

It is usually the advisor who attempts to teach the above skills. There are manuals available to help the advisor. Crawley (1983) has, in fact, written one specifically for use in A.T.C.'s. However, although it provides adequate
information on some aspects, e.g. writing the constitution of the committee, it
does not provide information on how to teach other aspects, e.g. assertiveness. Thus, for the purposes of the present study, Crawley's manual was used with others (Crawford and Hart-Furman, 1983; Hart-Furman and Furman, unpublished; Hallgren and Norsman, 1977; La Roche et al, 1985) to construct a course for use with a committee at an A.T.C. A.T.C. manuals being chosen as they seemed to provide the best descriptions on how the above mentioned skills could be taught.

A further aim of the research reported here is to evaluate the effects of self advocacy training and participation in a trainee committee on members of that committee. There have been few attempts to evaluate such efforts.

Browning, Thorin and Rhoades (1984) conducted a national survey of self advocacy groups in America and Canada. They found that when advisors were asked to estimate the percentage of members in their group who showed changes in the following areas: personal, social and informational, approximately half of the advisors reported moderate change in each area, the remaining advisors reported approximately equal amounts of "slight" and "much" change. Over 80% of the advisors also reported group change in the following areas: cohesion, interaction, communication, leadership role and organisational development.
Thus, it could be suggested that membership of a self advocacy group can lead to change. However, it is difficult to ascertain the nature of such change from the above study because Browning et al. do not clarify what is meant by terms such as "personal" and "social". Furthermore, it should be noted that members of the individual groups were not asked to indicate whether they felt they had changed, nor were more objective measures used, e.g. self report questionnaires. Similarly, Siegel and Kantor (1982) note that the group of developmentally disabled people, for whom they were advisors, underwent changes, i.e. became self confident but failed to obtain any objective measures of such changes.

In contrast, Crawley (1983) adopted a more scientific approach. Individual and group assessments were made of the following groups: a committee that had been in existence, a committee that was formed as part of the ongoing research and a control group.

All groups were assessed at the following times: prior to training of the experimental group and on one or two occasions after training. Crawley found that there had been improvement on some committee related skills and in locus of control for the experimental group. Thus it is suggested that self advocacy training can lead to changes. Such changes seem to be limited if one considers the findings of Crawley's study. However, this study can be criticised as both the experimental and control groups were formed by choosing people whose abilities matched those of the members of the
committee that had already been in existence. (The Scale for Assessing Coping Skills was used). Thus one could question whether members of the newly formed committee were motivated to be on the committee.

The study described below attempted to evaluate the effects of self advocacy training and committee membership. A similar design to that used by Crawley was utilised. However, the experimental group was formed by holding elections within an adult training centre in an attempt to overcome the criticism made above as regards motivation. A course for self advocacy training that had been devised was then administered in an attempt to investigate whether self advocacy leads to changes in areas not investigated by Crawley.

Behavioural measures included the following: a diary of activities (to investigate if there would be an increase in activities), the Adaptive Behaviour Scale Part II (Nihira, Foster, Shellhaas and Leland, 1974) to investigate the possibility that self advocacy training may affect the incidence of inappropriate behaviours, the Pathways to Independence Checklist (to investigate whether self advocacy training affected skill levels). Group behaviour was measured by recording three meetings at the aforementioned times. Attitudinal measures included the following: a measure of self acceptance (Frey, 1955). It was expected that there would be an increase in self esteem and self acceptance for the experimental group. It would have also been advisable to include a measure of locus of control as Crawley
(1983) found that there had been changes in locus of control. This was not done unfortunately.

The measures were administered at the following times: just after elections were held, twelve weeks after elections, and twenty-four weeks after elections. The three groups used by Crawley attended three different adult training centres, hence it is possible that changes in policy, staffing, etc., could have affected the results. (Crawley, however, did not investigate this possibility). Hence, an attempt to monitor such changes was also made in this study.

Thus, the following predictions are made:

(a) That there will be behavioural and attitudinal changes in individuals and the group as a result of participating in a committee.

(b) That these changes may be dependent on the length of time a committee has been in existence.

(c) That there may be changes in policy and staffing in each of the centres in which the study was conducted.
2.0 METHOD

2.1 Design

Three groups were used: an experimental group (n = 8), a control group (n = 8) and a comparison group (n = 6). The experimental group and the control group were matched for reading ability (Neale Analysis of Reading Test). All groups were assessed on the measures discussed below at the following time periods: just after elections were held, twelve and twenty-four weeks after elections. The following measures were used: (Appendix Two), Pathways to Independence Checklist; The Adaptive Behaviour Scale (Part II); Self-Esteem Inventory; Acceptance of Others.

Each subject also kept a diary. (See Appendix One) to record all activities that they participated in for a week after each assessment. The first two measures were completed by the experimenter by consulting the subject and the instructor in whose group they worked. All other measures were completed by consulting the subject. A questionnaire was given to the manager of each centre at the beginning and the end of the study to investigate what staffing and organisational changes there may have been (Appendix Three).

Group behaviour of the committee was also measured at the above mentioned times. Behaviour was video recorded and analysed. The following categories were used: relevant comments made to other representative(s), relevant comments made to advisor, irrelevant comments...
made to other representative(s), irrelevant comments made to advisor. Relevance being defined in the following manner; a comment was deemed as being relevant if it was pertinent to the topic being discussed and if the topic was one that was on the agenda.

Reliability of observation was also carried out. A record was also kept of all topics discussed in each meeting.

The self advocacy course was designed to cover the following areas: self advocacy, committee membership, the running of a committee. Appropriate films, reading material and practical exercises were used.

2.2 Subjects

The experimental group consisted of three males and five females (average chronological age = 30 years; average reading age = 8.33 years). Seven of the people were elected onto the committee, the eighth member was co-opted onto the committee to represent those in the special care unit, i.e. people with severe mental handicap. The control group consisted of four males and four females (average chronological age = 32.63 years; average reading age = 8.33 years). The comparison group consisted of three males and three females (average chronological age = 34 years; average reading age = 7.7 years).
2.3 Measures

Copies of the measures are in Appendix Two.

1. The Adaptive Behaviour Scale (ABS), Part II

The Adaptive Behaviour Scale was designed to provide objective descriptions of the behaviour of a person with mental handicap (Nihira et al., 1974). It consists of two parts: Part A enables one to evaluate ten aspects of a person's behaviour which are said to be important to the development of person independence in daily living, e.g. economic activity. Part II provides measures of maladaptive behaviour in the following areas - violent and destructive behaviour, withdrawal, stereotyped behaviour and odd mannerisms, inappropriate or eccentric habits, self-abusive behaviour, hyperactive tendencies, sexually aberrant behaviour, psychological disturbances and use of medication. The mean reliability for Part II was found to be .57. Reliability of the separate domains varies from .37 to .77. Practical validity of the ABS Part II was also investigated. Greenwood and Perry (1968) found that only some of the behaviour domains significantly discriminated between those who had been classified to be at different levels by clinical judgement. The scale is also found to be useful to evaluate outcomes (Foster and Foster, 1967).
2. Pathways to Independence (Checklist of Self Help Personal and Social Skill (Jeffree & Cheseldine, 1971))

This enables one to measure ability to carry out skills that are said to contribute to personal and social independence in different areas: eating and drinking, domestic tasks, cleanliness and health, clothing, giving information, use of information, time, money, freedom of movement, use of amenities and leisure.

3. Self-Esteem Inventory (Coopersmith 1967)

This was designed for use with non-handicapped populations and is said to measure evaluative attitudes towards the self. There have been some studies that have investigated the scale's reliability. Test-re-test reliability varies from .61 (Watkins and Astilla, 1979) to .81 (Spatz and Johnston, 1973). Rubin (1978) also found the scale to be reliable (although Rubin found that it was less reliable if young children (ages 9 - 12) were used). Construct validity of the scale has been confirmed in a series of studies (Kokenes, 1979; Watkins and Astilla, 1979; Johnson, Redfield, Miller and Simpson, 1983). However, it should be noted that Kokenes (1978) found the scale to be factorially complex. Van Tuinen and Ramanaiah (1979) also reported a high level of discriminant validity.
4. Acceptance of Others Scale, (Frey 1955)

This scale is said to enable the measurement of the following: feelings of self acceptance, acceptance of others, and feelings of acceptability to others. This scale, unfortunately, has not been thoroughly investigated as regards reliability and validity. No validity data were reported in the original study. Split half reliability's were reported to be .90.

2.4 Analysis of Results

The data from the questionnaires were analysed and scored. The information obtained from the diaries was also analysed. The total scores from each of the above measures were statistically analysed using one between one within (three levels) analyses of variance i.e. scores from each of the above measures were statistically analysed separately. The scores from the above measures could have been submitted to a multi-variate analysis of variance. However, it was felt that the number of subjects used in this experiment (n = 22) was not large enough to justify using a multi-variate analysis of variance. Data obtained from the content analyses were analysed using one within analyses of variance. It should perhaps be noted that since there are quite a few analyses of variance being carried out, it is likely that some of the effects may be significant by chance.

Data obtained from the questionnaires given to staff in the centre (usually the manager or the deputy) were not submitted to any form of statistical analysis.
Information obtained from the diaries was analysed by recording the total number of activities that a person participated in for a week and whether this activity was carried out independently or not.

3.0 **PROCEDURE**

This is reported under the following sub-sections: a) formation of the experimental group; b) details of the self advocacy course; c) administration of the measures and d) recording of meetings.

3.1 **Formation of the Experimental Group**

Firstly, the experimenter gave a talk to staff at the centre about the study and the formation of a committee. The notion of the centre having a trainee committee was positively received.

Arrangements were then made for the advisor to meet the trainees. Seven of the nine groups were approached by the advisor and were given a brief explanation of self advocacy and were informed that a committee would be formed. Nominations of interested persons were requested. Once these had been obtained, a ballot was held. Secret ballots were held by giving people pieces of paper with all the candidates' names on and by asking people to place a cross against the candidate of their choice. (Candidates were able to vote for themselves if they so wished). For those people who could not read, help was given by either the advisor or an instructor. By this method, seven members of the committee were chosen. The eighth member was co-opted.
onto the committee to represent those people who were in the special care group, i.e. people who were severely handicapped and therefore unable to communicate verbally. She was asked to join the committee as she herself was quite able and also spent a large proportion of her time with those in the special care group and it was felt that she would be able to represent those in the special care group.

Two of the groups in the centre were not initially included: the independent living group, and the special needs group (those people with mental handicap who also demonstrated inappropriate behaviour). The reasons for the exclusion of the first group were that the independent living group was in the process of being disbanded. At the beginning of the study, with the special needs group, it was felt that to include a member of the group would be too disruptive to the committee as a whole. Both groups were later represented as one of the existing members was moved to the newly formed independent group. (Her task was, therefore, to represent both groups). A ninth member was in the process of being co-opted onto the committee some while after the study had ended. Her task was to represent those in the special needs group. She was chosen by the committee as she spent some time working with this group. (Managers were also asked to fill in the questionnaires (see Appendix Three). Therefore, for the purposes of the study, eight committee members were chosen to represent other people in the centre.
3.2 **Details of the Self Advocacy Course**

During the training period, the committee met with the advisor twice a week for an hour. Meetings took place in a room that had been allocated by staff for specific use by the committee. Once the training period had ended, the committee met once a week. Details of the course are now given (see Appendix for details of materials used).

**Session One**

**Being a Representative**

Each person introduced themselves to the rest of the group. A warm up exercise was then carried out - (the Tick Tock game), (see Appendix Four). Each person was asked to draw or write a description of their group and to speak about their group to the rest of the committee. The above was then used by the advisor to explain what the role of a representative was and what the committee’s function in the centre should be. The role of the advisor was also explained by using a diagram (see Appendix Five). Committee members were informed that initially the advisor’s role would be great, especially during the training phase, but that the advisor’s importance would diminish as the committee became functional. Details of the training course were also given. Each representative then wrote or drew a record of what had been said in the meeting so that they could report back to their respective groups.
Session Two

Being Different

In this session, the aim was to discuss the effects of being labelled mentally handicapped and to encourage talking aloud in groups.

Committee members were asked to say something positive about the person next to them. (This is a warm up exercise known as Fuzzies). Each person was then asked to put their hands out in front of them (the advisor also participated). They were then asked to point out one similarity and one difference between their hands and those of the person next to them. Each person then talked about a favourite object that they owned and had brought along to the meeting. The advisor then pointed out similarities and differences between the objects. This was then used as a means of enabling the advisor to say that one difference between herself and the committee was that she had not been labelled mentally handicapped. The committee was then asked to discuss what the effects of being labelled had been for each member. After the discussion, each representative was asked to say one positive thing about themselves and about the person next to them. Each representative then made a record of the meeting so that they could report back to their groups.
Session Three

The group was shown a film on normalisation called "We’re People Too." This was used as a forum for discussion. Representatives then reported back to their groups.

Session Four

Positive Aspects of being Labelled

The aim in this session was to suggest that despite being labelled it was still possible to achieve and to have a choice. Representatives were shown two figures - one labelled "Mr Normal" and the other called "Mr Handicapped". They were then asked to state what foods each of the figures could eat. This was then used as a basis to suggest that regardless of being labelled, both "Mr Normal" and "Mr Handicapped" could choose to eat the same types of food. The notion of choice was widened to include other areas, e.g. being able to choose clothing, where to live. The United Nations Declaration of Rights was discussed.

The committee was also informed of the existence of the People First Group and the achievements of Helen Keller. Parts of her autobiography were read out as an illustration that it was still possible to achieve a great deal despite having a disability. At the end of the meeting the representatives recorded points that had been discussed so that they could report back to their groups.
Session Five

The committee watched a film called "People First" made by People First of Oregon. It was a film about a conference for people with handicaps, organised by people with handicaps. A discussion ensued and again the representatives made a record.

Session Six

A discussion was held about authority in the following spheres:

(a) at the centre itself,
(b) Social Services,
(c) Health Authority,
(d) the Government.

Different ways in which authorities could be approached were also discussed. Representatives again made a record to report back.

Session Seven

Summarisation of Course to Date

Firstly, representatives were invited to discuss the topics covered to date. Once this had taken place, the committee watched a film of the MENCAP Participation Forum (a self advocacy committee). Again this was discussed and the representatives reported back to their groups.
Session Eight

Canvassing Groups for Opinions (Voting)

Representatives were taught how to canvas others in their group for their views on a given topic. They were reminded of the way in which they had been elected. The voting form was then introduced (see Appendix Six). The steps necessary to carry out a vote were also explained using role play. Representatives wrote down their impressions so that they could report back to their groups.

Session Nine

Forms

Two forms: the Agenda form and the Minutes form were introduced (Appendix Seven). The function of an agenda was explained as was the necessity of keeping minutes of each meeting. A record of the meeting was made by each representative.

Session Ten

The Committee and its' Constitution

The notion that there would need to be a chairman, an agenda secretary and a minutes secretary was discussed. These jobs were then discussed. Elections then took place. The committee was then shown constitutions of other committees. These were then used as a basis to write their own constitution (Appendix Eight). The following were included: a description of the jobs (chairman, agenda secretary, minute secretary), being a
representative, a description of how to vote and a description of the way in which to approach the manager. The chairman was then asked to approach the manager’s secretary to ask her to type the constitution. (The chairman and the advisor carried out a role play of how to approach the secretary).

Session Eleven

Summary of Course

The course was summarised and the representatives were asked if there were any aspects that they wanted to be repeated. The committee was then informed that although the advisor would still attend meetings, her role would diminish as the committee became fully functional. In future meetings, the advisor would only actively participate at the request of the chairman or by asking the chairman for permission to speak.

The committee subsequently met once a week. A formal meeting was held every second week. Informal meetings were held in between the formal meeting to discuss possible items for the agenda for the formal meeting. As well as attending the above meetings, the advisor also helped the agenda secretary, the minutes secretary and the chairman to become used to their roles. Three months after the study had begun, the committee was informed that the advisor would be leaving and that her job was being taken by one of the instructors.
3.3 Administration of Measures

These were first administered after the committee had been elected and prior to training taking place and twelve and twenty-four weeks thereafter. Each subject in each group was seen individually by the experimenter. The measures were administered in a random order. The Pathways to Independence Checklist was completed by firstly consulting the subject. If adequate information could not be obtained, instructors (staff members) were consulted. The Adaptive Behaviour Scale was completed by also consulting the instructor in whose group a subject had been placed. The same instructor was always consulted each time a measure was administered. The scores obtained were then analysed.

3.4 Analysis of Group Behaviour

Video recordings were made of meetings of the committee (experimental group at the following times: two weeks, twelve and twenty-four weeks after the study had commenced. Prior permission of the committee had been obtained. These were then subsequently analysed in the manner described in the design. A record was also kept of topics discussed by the committee at each meetings.

4.0 RESULTS

Only the data from the experimental and control groups were analysed statistically. The reason for the above is that three of the members of the comparison group underwent further self advocacy training between the
second and third administration of the measures. This occurred as a result of their joining a newly formed local branch of People First, Great Britain. It was felt that the further training would have made it difficult to interpret the results had the comparison groups' data been included. There was one set of missing data (the chairman of the committee was on holiday when the final administration of measures took place). Data were analysed using the SPSS-X Statistical Package on the Prime System at Plymouth Polytechnic.

INFORMATION OBTAINED ABOUT THE CENTRES

TABLE 1: Information obtained about the centre.

<table>
<thead>
<tr>
<th>Type of Information</th>
<th>Centre A (Experimental Group)</th>
<th>Centre B (Control Group)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>One Month</td>
<td>Six Months</td>
</tr>
<tr>
<td>Total number of trainees attended.</td>
<td>141</td>
<td>141</td>
</tr>
<tr>
<td>Total number of types of activities carried outside the centre, e.g. swimming.</td>
<td>7</td>
<td>6</td>
</tr>
<tr>
<td>Total number of meetings held on a regular basis within each centre.</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Types of professional contact.</td>
<td>Speech Therapy, Social Work, District Nurse, Psychology, Area Health staff.</td>
<td>As for one month.</td>
</tr>
<tr>
<td>Type of organisational changes that took place during study.</td>
<td>1. Review of each client. 2. Attendance money abolished. 3. Students committee.</td>
<td></td>
</tr>
</tbody>
</table>
As can be seen from Table One, there was little change as regards the number of trainees attending each centre (two more trainees in centre B). There were changes in staff at both centres: at centre A, the deputy left to take another position, at centre B (which remained understaffed throughout the study) the manager left temporarily to take up a six month post to be in charge of day services for the county. The most significant changes occurred at centre A - namely the trainee committee and the abolishment of attendance money (trainees used to receive a nominal sum each week). Although both centres carried out similar types of work, trainees at centre A were separated into groups whereas no such formal separation took place at centre B. In most other respects, the centres were similar.
4.1 **Statistical Analysis of Administration of Measures**

1. **Pathways to Independence Checklist**

   The statistical analysis of the data revealed that the only significant effect was that of time ($F = 7.77$, $[2.28]$, $p<002$). That is, for both groups as a whole there was a reported increase in skills measured by the checklist (total score at administration 1 = 298.15, total score at administration 2 = 313.6, total score at administration 3 = 317.625). Comparisons of means indicated that there were the following significant differences between scores at administration 1 and 2 and between scores at administration 1 and 3, ($p<.05$) (Appendix Nine).

2. **Adaptive Behaviour Scale - Part 2 (ABS - 2)**

   There were the following significant effects when total ABS - 2 scores for each group were analysed: Groups ($F = 4.44$, $[1,14]$, $p<054$) (Appendix Ten). That is, there is a significant difference in overall total scores between the experimental group (mean total score = 16.46) and the control group (mean total score = 5.708). There was also an almost significant effect of time of administration ($F = 3.031$, $[2,18]$, $p<.064$) and of an interaction between groups and time of administration ($F = 3.106$, $[2.28]$, $p<.061$) (Figure 1 and Figure 2). As can be seen from Figure 1, there is a non-significant tendency for ABS - 2 total scores to decrease over time for both groups.
Figure 2 indicates that the following effects approach significance: a general decrease in ABS - 2 total scores for the control group, an increase and then a decrease in ABS - 2 scores for the experimental group, and that there seems to be a greater decrease in ABS - 2 total scores for the control group than for the experimental group.

Individual analyses of variance were also carried on the sub-scale scores of ABS - 2 (Table 2). The results of these analyses are now given. No significant effects were found for the following domains: withdrawal, violent and destructive behaviour, anti-social behaviour, rebellious behaviour, untrustworthy behaviour, stereo-typed behaviour, inappropriate / interpersonal manner, unacceptable or eccentric habits, self abusive behaviour, hyperactive tendencies, sexually aberrant behaviour and use of medication. There was a significant interaction between groups and time of administration when the scores for unacceptable vocal habits were analysed - (F = 3.924 [2,28] p<.05) (see Table 2 a) (Summary Table in Appendix Eleven). Given that the main effects were not significant, this finding is difficult to interpret. There was also a significant main effect of groups when the scores on the psychological disturbances sub-test were analysed.
TABLE 2: Total ABS Part 2 scores for each subject at each time of administration.

<table>
<thead>
<tr>
<th>Sub-Number</th>
<th>Time of Administration</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Control Group</td>
</tr>
<tr>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td>2</td>
<td>10</td>
</tr>
<tr>
<td>3</td>
<td>12</td>
</tr>
<tr>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>6</td>
<td>0</td>
</tr>
<tr>
<td>7</td>
<td>35</td>
</tr>
<tr>
<td>8</td>
<td>16</td>
</tr>
</tbody>
</table>

TABLE 2 a: Mean scores for unacceptable vocal habit sub-test (ABS -2) for experimental and control group per time of administration.

<table>
<thead>
<tr>
<th>Group</th>
<th>Time of Administration</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>(0 weeks)</td>
</tr>
<tr>
<td>Experimental Group</td>
<td>.125</td>
</tr>
<tr>
<td>Control Group</td>
<td>.25</td>
</tr>
</tbody>
</table>

(F = 5.2002 [1.14] p<.05). That is, the experimental group had a higher mean overall score for psychological disturbances than the control group.
(Overall mean score for experimental group = 5.208, overall mean score for control group = 1.416) (Appendix Twelve).

3. **Self-Esteem Inventory**
   No significant differences were noted (Table 3).

4. **Acceptance of Others Questionnaire**
   No significant differences were noted (Table 4).

5. **Diary of Activities**
   There was a significant main effect of time (F = 3.458 [2,28] p<.045) (Appendix Thirteen) (Tables 5 and 5 a). As can be seen from the table, there is a decrease in activities over time (post-hoc comparisons of means indicated that there were no significant differences between times of administration).

**Figure 1: Mean total ABS - 2 scores at each time of administration.**
Figure 2: Mean total ABS - 2 scores at each time of administration for each group.

<table>
<thead>
<tr>
<th>Time of Administration</th>
<th>Group</th>
<th>Time of Administration</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 (0 weeks)</td>
<td>Experimental</td>
<td>14.125</td>
</tr>
<tr>
<td></td>
<td>Group</td>
<td>15.25</td>
</tr>
<tr>
<td></td>
<td></td>
<td>21.875</td>
</tr>
<tr>
<td>2 (12 weeks)</td>
<td>Control Group</td>
<td>13.750</td>
</tr>
<tr>
<td>3 (24 weeks)</td>
<td></td>
<td>14.75</td>
</tr>
<tr>
<td></td>
<td></td>
<td>13.250</td>
</tr>
</tbody>
</table>
TABLE 4: Mean scores achieved on Acceptance of Others Scale by experimental and control groups at each administration (maximum score = 100).

<table>
<thead>
<tr>
<th>Group</th>
<th>Time of Administration</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(0 weeks)</td>
</tr>
<tr>
<td>Experimental Group</td>
<td>56.5</td>
</tr>
<tr>
<td>Control Group</td>
<td>60.625</td>
</tr>
</tbody>
</table>

TABLE 5: Total mean number of activities undertaken by experimental and control groups for one week after each administration.

<table>
<thead>
<tr>
<th>Group</th>
<th>Time of Admission</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(0 weeks)</td>
</tr>
<tr>
<td>Experimental Group</td>
<td>21.125</td>
</tr>
<tr>
<td>Control Group</td>
<td>18.25</td>
</tr>
</tbody>
</table>

TABLE 5 a: Total number of activities that subjects participate in for a week after each administration (maximum score = 20).

<table>
<thead>
<tr>
<th>Total Number of Activities</th>
<th>Time (0 weeks)</th>
<th>Time (12 weeks)</th>
<th>Time (24 weeks)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>19.687</td>
<td>16.125</td>
<td>16.062</td>
</tr>
</tbody>
</table>

Data obtained from the diaries was also separated into the total number of activities that an individual carried out independently, i.e. without help. No significant differences were noted (see Table 6).
4.2 Group Behaviour: Content Analysis of Video Recordings of Three Meetings

The verbal behaviour of each subject during each meeting was analysed into the following categories: relevant comments made to advisor(s), irrelevant comments made to other representatives, irrelevant comments made to advisor. The results obtained are depicted in Figure 3. Statistical analysis revealed that the only significant effect was an increase in the number of relevant comments made to other representatives over time (F = 4.225 [2,14] p<.05) (Appendix Fourteen) (see Table 7).

As regards reliability of observation, mean percentage agreement was found to be 87.45% (range 83% to 96%).

TABLE 6: Total number of independent activities undertaken by experimental and control groups for one week after each administration.

<table>
<thead>
<tr>
<th>Group</th>
<th>Time of Administration</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(0 weeks)</td>
</tr>
<tr>
<td>Experimental Group</td>
<td>10.375</td>
</tr>
<tr>
<td>Control Group</td>
<td>7.375</td>
</tr>
</tbody>
</table>
Figure 3: Average number of comments made by committee during meetings.

Average Number of Comments made:

Key
1 = Relevant comments made to representative.
2 = Relevant comments made to advisor.
3 = Irrelevant comments made to representative.
4 = Irrelevant comments made to advisor.
<table>
<thead>
<tr>
<th>Subject Matter</th>
<th>Type of Comment</th>
<th>( \text{Relevant comments to representatives} )</th>
<th>( \text{Relevant comments to advisor} )</th>
<th>( \text{Irrelevant comments to representative} )</th>
<th>( \text{Irrelevant comments to advisor} )</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Meeting: 1</strong></td>
<td>S1</td>
<td>11</td>
<td>9</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>S2</td>
<td>21</td>
<td>42</td>
<td>9</td>
<td>11</td>
</tr>
<tr>
<td></td>
<td>S3</td>
<td>66</td>
<td>44</td>
<td>7</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>S4</td>
<td>9</td>
<td>12</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>S5</td>
<td>56</td>
<td>13</td>
<td>9</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>S6</td>
<td>15</td>
<td>8</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>S7</td>
<td>5</td>
<td>9</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>S8</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Meeting: 2</strong></td>
<td>S1</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>S2</td>
<td>58</td>
<td>19</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>S3</td>
<td>65</td>
<td>45</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>S4</td>
<td>37</td>
<td>3</td>
<td>10</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>S5</td>
<td>12</td>
<td>13</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>S6</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>S7</td>
<td>19</td>
<td>5</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>S8</td>
<td>6</td>
<td>3</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Meeting: 3</strong></td>
<td>S1</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>S2</td>
<td>126</td>
<td>61</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>S3</td>
<td>75</td>
<td>14</td>
<td>11</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>S4</td>
<td>18</td>
<td>2</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>S5</td>
<td>27</td>
<td>4</td>
<td>6</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>S6</td>
<td>38</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>S7</td>
<td>3</td>
<td>4</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>S8</td>
<td>65</td>
<td>12</td>
<td>9</td>
<td>3</td>
</tr>
</tbody>
</table>
5.0 DISCUSSION

It is tentatively suggested that the predictions are upheld to an extent as regards behavioural changes for the reasons stated below.

From the results of the content analysis of the video recordings of the meetings, it can be seen that there seems to have been a change in the verbal behaviour of the experimental committee. That is, there was a significant increase in the number of relevant comments made by members to other committee members. There was no increase in irrelevant comments made either to other members or to the advisor, nor was there any increase in the number of relevant comments made to the advisor. This could be seen as indicating that committee members felt more able to participate in meetings. This is perhaps the case since there was no increase in the number of comments made to the advisor.

However, it should also be noted that there was no decrease in the number of comments made to the advisor. It is difficult to ascertain, however, whether this increase was due specifically to the training that they had undergone or whether it was due to having become used to participating in a particular group over a period of time. The reason for the above statement is that the control group's ability to participate in a meeting was not investigated.
From Appendix Fifteen, it can be seen that not only was there an increase in the verbal behaviour of committee members, but that the committee had begun to deal with everyday issues, such as complaints, and with larger issues such as that of wages.

The changes noted above were not, however, reflected in any of the measures taken to any great extent. The possible exception being scores of the Adaptive Behaviour Scale (Part II). There was a non-significant tendency for members of the experimental group, i.e. committee members, to have higher scores (Figure 2) than the control group. (Higher scores indicating the presence of more inappropriate behaviours).

There was also a non-significant tendency for ABS - Part II scores to increase at administration 2 and then to decrease at administration 3 for the experimental group. It could be tentatively suggested that the experimental group were perceived by instructors as demonstrating more inappropriate behaviours, especially just after the self advocacy course had finished and the committee had begun to function - i.e. at administration 2. If this is the case, then presumably the decrease in ABS - Part II scores between administrations 2 and 3 indicate that the adverse effects of self advocacy training had declined. The above suggestions are tentative at best.

It should also be noted that ABS - Part II scores declined over time for the control group as a whole. This was probably due to the fact that there was a
large decrease in inappropriate behaviour for one subject between administration 1 and 2; his initial score was 35, subsequent scores were 6 and 7 respectively. Both the above could be seen as tentative explanations for the fact that there was a significant decrease in ABS scores for both groups over time.

Closer analysis of ABS Part II scores indicated that there were the following significant effects: a significant interaction between groups and time of administration when the scores for unacceptable vocal habits were analysed, a significant difference between the control groups' scores and the experimental group's scores on the psychological disturbances sub-test. It is difficult to interpret the above results for the following reasons: a) that there were no significant main effects indicating differences between the two groups when the data for unacceptable vocal habits were analysed and, b) given that a large number of analyses were conducted it is likely that these effects may be significant by chance.

It was expected that there may have been an increase in the number of activities participated in by the experimental group over time. The results did not support the above. The only significant effect was that of a decrease in the number of reported activities for both groups over time. The decrease may have been due to the fact that the initial recording of events took place a short time before Christmas when both groups had more opportunity to participate in social activities than during the weeks after administration 2 and
3. In general, neither participation in a committee nor self advocacy training had an effect as regards the activities that subjects took part in nor when these activities, e.g. shopping, were carried out independently.

Similarly, there was no significant difference in skill levels (as measured using the Pathways to Independence Checklist) between the experimental and control groups over time. There was, as above, a general significant increase in skill levels for both groups which cannot be attributed to either self advocacy training or participation in a committee. It probably is the case that the increase is due to training that took place in both centres during the study.

The predictions were not upheld as regards attitudinal changes. Hence, there were no significant attitudinal changes in either self-esteem or acceptance of others. Once could perhaps have expected some change given that there was an indication that behavioural changes had taken place. It may be the case that behavioural changes are not necessarily accompanied by attitudinal changes. However, there are methodological criticisms that can be made of both the above measures that may have affected the results. Firstly, neither measure had been validated for use with people with mental handicap. Secondly, although the Self-Esteem Inventory has been found to be reliable and valid, it is also said to be factorially complex; also, it is not clear exactly what the Acceptance of Others Scale is measuring, as it has not been thoroughly investigated as regards reliability.
and validity. It would probably have been of more use to have administered measures that could not be criticised in the same manner.

Other methodological criticisms can be made of this study. Firstly, it may have been of more use to administer measures on the second occasion directly after training had ended, since one of the aims of the study was to investigate the effect of self advocacy training on individuals. A second criticism is that all the groups were in different environments and, as can be seen from the results, there were changes in each centre during the study (prediction three was therefore upheld). There was a difference between the two centres in terms of the attitude and approach taken towards the people with mental handicap. The centre that the control group attended had a more positive approach. (These observations were noted by the experimenter). It is difficult to ascertain the exact effect of these experimental and control groups in the same environment. This was not seen to be acceptable as it is likely that the existence of a committee may have affected the general behaviour of others in that centre - i.e. those in the control group.

The committee was formed by electing one person to represent each group in the centre. However, during the course of the study some of the representatives were moved to other groups. This, in effect, meant that they represented people with whom they no longer had regular daily contact. This problem could have been overcome by choosing eight people from all the
trainees, i.e. holding an election throughout the centre, and then allocating a
group to each person.

As regards the training course that the committee underwent, it could
probably have been improved. Firstly, the course initially covered self
advocacy training and then details on how to run a committee. It may have
been more interesting if the first and second halves of the course had been
more intermingled. A final point is that it was beneficial to the training phase
that the advisor was not someone who was employed in the centre as
committee members were more able to discuss openly grievances and
complaints. This was not initially the case when the advisor was replaced by
one of the staff members of the centre.

6.0 CONCLUSION

In conclusion, it is suggested that self advocacy training and participation in a
committee led to changes in verbal behaviour. There was a non-significant
tendency for there to be an initial increase in inappropriate behaviour of
members of the committee. Few other changes in skill levels or attitudes
were noted. However, it should be remembered that methodological faults
may have affected the results. These faults could easily be rectified in further
research by either choosing or devising measures that were more reliable
and valid. It may be of use to also devise a measure that looks at attitudes
towards being labelled mentally handicapped. The reason for the above
suggestion is that it is perhaps one of the aims of self advocacy training to
alter a person's attitude towards being labelled and hence it would be worthwhile investigating whether any changes did, in fact, take place.
7.0 **BIBLIOGRAPHY**


8.0 **APPENDICES: List of Contents**

One: Proforma used by subjects to keep a record of activities

Two: Copies of Measures used in study

Three: Copy of Questionnaire given to the Adult Training Centre

Four: Details of the Tick Tock Game

Five: Diagram used to explain the role of the advisor

Six: Example of voting form used by the committee

Seven: Copies of the Agenda form and the Minutes form used by the committee

Eight: A copy of the constitution of the committee

Nine: Summary Table of Analysis of Variance using data obtained from the administration of the Pathways to Independence Checklist

Ten: Summary Table of Analysis of Variance for total ABS - 2 scores for experimental and control groups
Eleven: Summary Table of Analysis of Variance of scores on unacceptable vocal habits sub-test (ABS - 2) for experimental and control groups

Twelve: Summary Table of Analysis of Variance of Scores on the psychological disturbances sub-test of the Adaptive Behaviour Scale, Part III

Thirteen: Summary table of Analysis of Variance of Activities that control and experimental groups participated in for a week after each administration.

Fourteen: Summary Table of Analysis of Variance of average number of relevant comments made by committee members to each other during each meeting.

Fifteen: Topics discussed during meetings

Sixteen: Index of materials used in self advocacy course
APPENDIX ONE:

Proforma used by subjects to keep a record of activities.

RECORD OF ACTIVITIES

Name:_____________________________________________________________

Age:__________________

Own Home/Parental Home:______________________________

Place of Work:____________________________________________________

Type of Work:_____________________________________________________

Record Kept By:__________________________________________________

Key:

Please tick ( ) if amenity used:

Please also state if amenity used independently (I) or if person was accompanied.
<table>
<thead>
<tr>
<th>Type of Amenity</th>
<th>Mon</th>
<th>Tues</th>
<th>Wed</th>
<th>Thur</th>
<th>Fri</th>
<th>Sat</th>
<th>Sun</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Shops</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Leisure (Clubs, etc.)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public Transportation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Government Amenities</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health, e.g. G.P.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social Services, e.g. Welfare</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Repairs, e.g. calling plumber</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Domestic, T.V.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hobbies (please specify)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social Outings</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OTHER</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX TWO:

Measures used in the study.

SELF-ESTEEM INVENTORY

NAME: ............................................................................................

DATE OF ADMINISTRATION: ................................................................

1. I often wish I were someone else.
   LIKE ME UNLIKE ME

2. I find it very hard to talk in front of a group.
   LIKE ME UNLIKE ME

3. There are lots of things about myself I'd change if I could.
   LIKE ME UNLIKE ME

4. I can make up my mind without too much trouble.
   LIKE ME UNLIKE ME

5. I'm a lot of fun to be with.
   LIKE ME UNLIKE ME
6. I get upset easily at home.
   LIKE ME   UNLIKE ME

7. It takes me a long time to get used to anything new.
   LIKE ME   UNLIKE ME

8. I'm popular with people my own age.
   LIKE ME   UNLIKE ME

9. My family expects too much of me.
   LIKE ME   UNLIKE ME

10. My family usually considers my feelings.
    LIKE ME   UNLIKE ME

11. I give in very easily.
    LIKE ME   UNLIKE ME

12. It's pretty tough to be me.
    LIKE ME   UNLIKE ME

13. Things are all mixed up in my life.
    LIKE ME   UNLIKE ME
14. Other people usually follow my ideas.
   LIKE ME   UNLIKE ME

15. I have a low opinion of myself.
   LIKE ME   UNLIKE ME

16. There are many times when I'd like to leave home.
   LIKE ME   UNLIKE ME

17. I often feel upset about the work that I do.
   LIKE ME   UNLIKE ME

18. I'm not as nice looking as most people.
   LIKE ME   UNLIKE ME

19. If I have something to say, I usually say it.
   LIKE ME   UNLIKE ME

20. My family understands me.
   LIKE ME   UNLIKE ME

21. Most people are better liked than I am.
   LIKE ME   UNLIKE ME
22. I usually feel as if my family is pushing me.
   LIKE ME   UNLIKE ME

23. I often get discouraged at what I am doing.
   LIKE ME   UNLIKE ME

24. Things usually don’t bother me.
   LIKE ME   UNLIKE ME
ACCEPTANCE OF OTHERS

NAME: ................................... DATE: ................................

1. People are too easily led.
   ALMOST ALWAYS 1  2  3  SOMETIME 4  VERY RARELY 5

2. I like people to get to know.
   ALMOST ALWAYS 1  2  3  SOMETIME 4  VERY RARELY 5

3. People these days have pretty low moral standards.
   ALMOST ALWAYS 1  2  3  SOMETIME 4  VERY RARELY 5

4. Most people are pretty smug about themselves, never really facing their bad points.
   ALMOST ALWAYS 1  2  3  SOMETIME 4  VERY RARELY 5
5. I can be comfortable with nearly all kinds of people

ALMOST ALWAYS 1 2 3  SOMEWHAT 4  VERY RARELY 5

6. All people can talk about these days, is films, TV, and foolishness like that.

ALMOST ALWAYS 1 2 3  SOMEWHAT 4  VERY RARELY 5

7. People get ahead by using “pull” and not because of what they know.

ALMOST ALWAYS 1 2 3  SOMEWHAT 4  VERY RARELY 5

8. If you once start doing favours for people, they’ll just walk all over you.

ALMOST ALWAYS 1 2 3  SOMEWHAT 4  VERY RARELY 5

9. People are too self centered.

ALMOST ALWAYS 1 2 3  SOMEWHAT 4  VERY RARELY 5

10. People are always dissatisfied and hunting for something new.

ALMOST ALWAYS 1 2 3  SOMEWHAT 4  VERY RARELY 5
11. With many people you don’t know how you stand.

ALMOST ALWAYS 1 2 3  SOMETIMES 4  VERY RARELY 5

12. You’ve probably got to hurt someone if you’re going to make something out of yourself.

ALMOST ALWAYS 1 2 3  SOMETIMES 4  VERY RARELY 5

13. People really need a strong smart leader.

ALMOST ALWAYS 1 2 3  SOMETIMES 4  VERY RARELY 5

14. I enjoy myself most when I am alone, away from people.

ALMOST ALWAYS 1 2 3  SOMETIMES 4  VERY RARELY 5

15. I wish people would be more honest with you.

ALMOST ALWAYS 1 2 3  SOMETIMES 4  VERY RARELY 5

16. I enjoy going with a crowd.

ALMOST ALWAYS 1 2 3  SOMETIMES 4  VERY RARELY 5
17. In my experience, people are pretty stubborn and unreasonable.

ALMOST ALWAYS 1 2 3  SOMETIMES 4  VERY RARELY 5

18. I enjoy being with people whose values are very different than mine.

ALMOST ALWAYS 1 2 3  SOMETIMES 4  VERY RARELY 5

19. Everybody tries to be nice.

ALMOST ALWAYS 1 2 3  SOMETIMES 4  VERY RARELY 5

20. The average person is not very well satisfied with himself.

ALMOST ALWAYS 1 2 3  SOMETIMES 4  VERY RARELY 5

21. People are quite critical of me.

ALMOST ALWAYS 1 2 3  SOMETIMES 4  VERY RARELY 5

22. I felt “left out” as if people don’t want me around.

ALMOST ALWAYS 1 2 3  SOMETIMES 4  VERY RARELY 5
23. People seem to respect my opinion about things.
   ALMOST ALWAYS 1 2 3  SOMETIMES 4  VERY RARELY 5

24. People seem to like me.
   ALMOST ALWAYS 1 2 3  SOMETIMES 4  VERY RARELY 5

25. Most people seem to understand how I feel about things.
   ALMOST ALWAYS 1 2 3  SOMETIMES  VERY RARELY 5
A A M D
ADAPTIVE BEHAVIOR SCALE
For Children and Adults
1974 Revision

Name ____________________________________________________
(last) (first)
Date _____________________________   Sex: M F
(mo) (day) (year)
Name of person filling out Scale ______________________________________
Source of information and relationship to person being evaluated (such as "John Doe - Parent," or "Self - Physician") _____________________________________________________________________________________________
Additional Information: ______________________________________

Special Identification ________________________________

Date of Birth ____________________
(mo) (day) (year)

This Scale consists of a number of statements which describe some of the ways people act in different situations. There are several ways of administering the Scale; these, and detailed scoring instructions, appear in the accompanying Manual.

Instructions for the second part of the Scale immediately precede the second half of this booklet.

INSTRUCTIONS FOR PART ONE

There are two kinds of items in the first part of the Scale. The first requires that you select only ONE of the several possible responses. For example:

[2] Eating in Public (Circle only ONE)

Orders complete meals in restaurants 3
Orders simple meals like hamburgers or hot dogs 2
Orders soft drinks at soda fountain or canteen 1
Does not order at public eating places 0

Notice that the statements are arranged in order of difficulty: 3,2,1,0. Circle the one statement which best describes the most difficult task the person can usually manage. In this example, the individual being observed can order simple meals like hamburgers or hot dogs (2), but cannot order a complete dinner (3). Therefore, (2) is circled in the example above. In scoring, 2 is entered in the circle to the right.

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INSTRUCTIONS FOR PART TWO

Part Two contains only one type of item. The following is an example.

<table>
<thead>
<tr>
<th>[2] Damages Personal Property</th>
<th>Occasionally</th>
<th>Frequently</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rips, tears, or chews own clothing</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Soils own property</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Tears up own magazines, books, or other possessions</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Other (specify ____________________________)</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>None of the above</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Select those of the statements which are true of the individual being evaluated, and circle (1) if the behavior occurs occasionally, or (2) if it occurs frequently. Check "None of the Above" where appropriate. In scoring, total each column on the bottom (Total) line, and enter the sum of these totals in the circle to the right. When "None of the above" is checked, enter 0 in the circle to the right. In the above example, the first statement is true occasionally, and the last two statements are true frequently; therefore, a score of 5 has been entered.

"Occasionally" signifies that the behavior occurs once in a while, or now and then, and "Frequently" signifies that the behavior occurs quite often, or habitually.

Use the space for "Other" when:

1. The person has related behavior problems in addition to those circled
2. The person has behavior problems that are not covered by any of the examples listed.

The behavior listed under "Other" must be a specific example of the behavior problem stated in the item.

Some of the items in Part Two describe behaviors which need not be considered maladaptive for very young children (for example, pushing others). The question of whether a given behavior is adaptive or maladaptive depends on the way that particular behavior is viewed by people in our society. Nonetheless, in completing this Scale you are asked to record a person's behavior as accurately as possible, ignoring, for the moment, your personal biases; then, when you later interpret the impact of the reported behaviors, you should take into consideration societal attitudes.
### I. VIOLENT AND DESTRUCTIVE BEHAVIOR

#### [1] Threatens or Does Physical Violence

<table>
<thead>
<tr>
<th>Occasionally</th>
<th>Frequently</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uses threatening gestures</td>
<td>1</td>
</tr>
<tr>
<td>Indirectly causes injury to others</td>
<td>1</td>
</tr>
<tr>
<td>Spits on others</td>
<td>1</td>
</tr>
<tr>
<td>Pushes, scratches or punches others</td>
<td>1</td>
</tr>
<tr>
<td>Pulls others' hair, ears, etc.</td>
<td>1</td>
</tr>
<tr>
<td>Bits others</td>
<td>1</td>
</tr>
<tr>
<td>Kicks, strikes or slaps others</td>
<td>1</td>
</tr>
<tr>
<td>Throws objects at others</td>
<td>1</td>
</tr>
<tr>
<td>Chokes others</td>
<td>1</td>
</tr>
<tr>
<td>Uses objects as weapons against others</td>
<td>1</td>
</tr>
<tr>
<td>Hurts animals</td>
<td>1</td>
</tr>
<tr>
<td>Other (specify)</td>
<td>1</td>
</tr>
<tr>
<td>None of the above</td>
<td>Total</td>
</tr>
</tbody>
</table>

#### [2] Damages Personal Property

<table>
<thead>
<tr>
<th>Occasionally</th>
<th>Frequently</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rips, tears or chews own clothing</td>
<td>1</td>
</tr>
<tr>
<td>Soils own property</td>
<td>1</td>
</tr>
<tr>
<td>Tears up own magazines, books, or other possessions</td>
<td>1</td>
</tr>
<tr>
<td>Other (specify)</td>
<td>1</td>
</tr>
<tr>
<td>None of the above</td>
<td>Total</td>
</tr>
</tbody>
</table>

#### [3] Damages Others' Property

<table>
<thead>
<tr>
<th>Occasionally</th>
<th>Frequently</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rips, tears, or chews others' clothing</td>
<td>1</td>
</tr>
<tr>
<td>Soils others' property</td>
<td>1</td>
</tr>
<tr>
<td>Tears up others' magazines, books, or personal possessions</td>
<td>1</td>
</tr>
<tr>
<td>Other (specify)</td>
<td>1</td>
</tr>
<tr>
<td>None of the above</td>
<td>Total</td>
</tr>
</tbody>
</table>

#### [4] Damages Public Property

<table>
<thead>
<tr>
<th>Occasionally</th>
<th>Frequently</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tears up magazines, books or other public property</td>
<td>1</td>
</tr>
<tr>
<td>Is overly rough with furniture (kicks, mutilates, knocks it down)</td>
<td>1</td>
</tr>
<tr>
<td>Breaks windows</td>
<td>1</td>
</tr>
<tr>
<td>Stuff toilet with paper, towels or other solid objects that cause an overflow</td>
<td>1</td>
</tr>
<tr>
<td>Attempts to set fires</td>
<td>1</td>
</tr>
<tr>
<td>Other (specify)</td>
<td>1</td>
</tr>
<tr>
<td>None of the above</td>
<td>Total</td>
</tr>
</tbody>
</table>

#### [5] Has Violent Temper, or Temper Tantrums

<table>
<thead>
<tr>
<th>Occasionally</th>
<th>Frequently</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cries and screams</td>
<td>1</td>
</tr>
<tr>
<td>Stamps feet while banging objects or slamming doors, etc.</td>
<td>1</td>
</tr>
<tr>
<td>Stamps feet, screaming and yelling</td>
<td>1</td>
</tr>
<tr>
<td>Throws self on floor, screaming and yelling</td>
<td>1</td>
</tr>
<tr>
<td>Other (specify)</td>
<td>1</td>
</tr>
<tr>
<td>None of the above</td>
<td>Total</td>
</tr>
</tbody>
</table>

### II. ANTISOCIAL BEHAVIOR

#### [6] Teases or Gossips About Others

<table>
<thead>
<tr>
<th>Occasionally</th>
<th>Frequently</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gossips about others</td>
<td>1</td>
</tr>
<tr>
<td>Tells untrue or exaggerated stories about others</td>
<td>1</td>
</tr>
<tr>
<td>Teases others</td>
<td>1</td>
</tr>
<tr>
<td>Picks on others</td>
<td>1</td>
</tr>
<tr>
<td>Makes fun of others</td>
<td>1</td>
</tr>
<tr>
<td>Other (specify)</td>
<td>1</td>
</tr>
<tr>
<td>None of the above</td>
<td>Total</td>
</tr>
</tbody>
</table>

#### [7] Bosses and Manipulates Others

<table>
<thead>
<tr>
<th>Occasionally</th>
<th>Frequently</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tries to tell others what to do</td>
<td>1</td>
</tr>
<tr>
<td>Demands services from others</td>
<td>1</td>
</tr>
<tr>
<td>Pushes others around</td>
<td>1</td>
</tr>
<tr>
<td>Causes fights among other people</td>
<td>1</td>
</tr>
<tr>
<td>Manipulates others to get them in trouble</td>
<td>1</td>
</tr>
<tr>
<td>Other (specify)</td>
<td>1</td>
</tr>
<tr>
<td>None of the above</td>
<td>Total</td>
</tr>
</tbody>
</table>

#### [8] Disrupts Others' Activities

<table>
<thead>
<tr>
<th>Occasionally</th>
<th>Frequently</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is always in the way</td>
<td>1</td>
</tr>
<tr>
<td>Interferes with others' activities, e.g., by blocking passage, upsetting wheelchairs, etc.</td>
<td>1</td>
</tr>
<tr>
<td>Upsets others' work</td>
<td>1</td>
</tr>
<tr>
<td>Knocks around articles that others are working with, e.g., puzzles, card games, etc.</td>
<td>1</td>
</tr>
<tr>
<td>Snatches things out of others' hands</td>
<td>1</td>
</tr>
<tr>
<td>Other (specify)</td>
<td>1</td>
</tr>
<tr>
<td>None of the above</td>
<td>Total</td>
</tr>
<tr>
<td><strong>Occasionally</strong></td>
<td><strong>Frequently</strong></td>
</tr>
<tr>
<td>------------------</td>
<td>---------------</td>
</tr>
<tr>
<td><strong>[9]</strong> Is Inconsiderate of Others</td>
<td></td>
</tr>
<tr>
<td>Keeps temperature in public areas, uncomfortable for others, e.g., opens or closes window, changes thermostat</td>
<td>1</td>
</tr>
<tr>
<td>Turns TV, radio or phonograph on too loudly</td>
<td>1</td>
</tr>
<tr>
<td>Makes loud noises while others are reading</td>
<td>1</td>
</tr>
<tr>
<td>Talks too loudly</td>
<td>1</td>
</tr>
<tr>
<td>Sprawls over furniture or space needed by others</td>
<td>1</td>
</tr>
<tr>
<td>Other (specify)</td>
<td>1</td>
</tr>
<tr>
<td><strong>None of the above</strong></td>
<td>Total</td>
</tr>
<tr>
<td><strong>[10]</strong> Shows Disrespect for Others' Property</td>
<td></td>
</tr>
<tr>
<td>Does not return things that were borrowed</td>
<td>1</td>
</tr>
<tr>
<td>Uses others' property without permission</td>
<td>1</td>
</tr>
<tr>
<td>Loses others' belongings</td>
<td>1</td>
</tr>
<tr>
<td>Damages others' property</td>
<td>1</td>
</tr>
<tr>
<td>Does not recognize the difference between own and others' property</td>
<td>1</td>
</tr>
<tr>
<td>Other (specify)</td>
<td>1</td>
</tr>
<tr>
<td><strong>None of the above</strong></td>
<td>Total</td>
</tr>
<tr>
<td><strong>[11]</strong> Uses Angry Language</td>
<td></td>
</tr>
<tr>
<td>Uses hostile language, e.g., &quot;stupid jerk,&quot; &quot;dirty pig,&quot; etc</td>
<td>1</td>
</tr>
<tr>
<td>Swears, curses, or uses obscene language</td>
<td>1</td>
</tr>
<tr>
<td>Yells or screams threats of violence</td>
<td>1</td>
</tr>
<tr>
<td>Verbally threatens others, suggesting physical violence</td>
<td>1</td>
</tr>
<tr>
<td>Other (specify)</td>
<td>1</td>
</tr>
<tr>
<td><strong>None of the above</strong></td>
<td>Total</td>
</tr>
</tbody>
</table>

**III. REBELLIOUS BEHAVIOR**

<table>
<thead>
<tr>
<th><strong>Occasionally</strong></th>
<th><strong>Frequently</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>[12]</strong> Ignores Regulations or Regular Routines</td>
<td></td>
</tr>
<tr>
<td>Has negative attitude toward rules but usually conforms</td>
<td>1</td>
</tr>
<tr>
<td>Has to be forced to go through waiting lines, e.g., lunch lines, ticket lines, etc</td>
<td>1</td>
</tr>
<tr>
<td>Violates rules or regulations, e.g., eats in restricted areas, disobeys traffic signals, etc</td>
<td>1</td>
</tr>
<tr>
<td>Refuses to participate in required activities, e.g., work, school, etc</td>
<td>1</td>
</tr>
<tr>
<td>Other (specify)</td>
<td>1</td>
</tr>
<tr>
<td><strong>None of the above</strong></td>
<td>Total</td>
</tr>
<tr>
<td><strong>[13]</strong> Resists Following Instructions, Requests or Orders</td>
<td></td>
</tr>
<tr>
<td>Gets upset if given a direct order</td>
<td>1</td>
</tr>
<tr>
<td>Plays dead and does not follow instructions</td>
<td>1</td>
</tr>
<tr>
<td>Does not pay attention to instructions</td>
<td>1</td>
</tr>
<tr>
<td>Refuses to work on assigned subject</td>
<td>1</td>
</tr>
<tr>
<td>Hesitates for long periods before doing assigned tasks</td>
<td>1</td>
</tr>
<tr>
<td>Does the opposite of what was requested</td>
<td>1</td>
</tr>
<tr>
<td>Other (specify)</td>
<td>1</td>
</tr>
<tr>
<td><strong>None of the above</strong></td>
<td>Total</td>
</tr>
<tr>
<td><strong>[14]</strong> Has Impudent or Rebellious Attitude Toward Authority</td>
<td></td>
</tr>
<tr>
<td>Resents persons in authority, e.g., teachers, group leaders, ward personnel, etc</td>
<td>1</td>
</tr>
<tr>
<td>Is hostile toward people in authority</td>
<td>1</td>
</tr>
<tr>
<td>Mocks people in authority</td>
<td>1</td>
</tr>
<tr>
<td>Says that he can fire people in authority</td>
<td>1</td>
</tr>
<tr>
<td>Says relative will come to kill or harm persons in authority</td>
<td>1</td>
</tr>
<tr>
<td>Other (specify)</td>
<td>1</td>
</tr>
<tr>
<td><strong>None of the above</strong></td>
<td>Total</td>
</tr>
<tr>
<td><strong>[15]</strong> Is Absent From, or Late For, the Proper Assignments or Places</td>
<td></td>
</tr>
<tr>
<td>Is late to required places or activities</td>
<td>1</td>
</tr>
<tr>
<td>Fails to return to places where he is supposed to be after leaving, e.g., going to toilet, running an errand, etc</td>
<td>1</td>
</tr>
<tr>
<td>Leaves place of required activity without permission, e.g., work, class, etc</td>
<td>1</td>
</tr>
<tr>
<td>Is absent from routine activities, e.g., work, class, etc</td>
<td>1</td>
</tr>
<tr>
<td>Stays out late at night from home, hospital ward, dormitory, etc</td>
<td>1</td>
</tr>
<tr>
<td>Other (specify)</td>
<td>1</td>
</tr>
<tr>
<td><strong>None of the above</strong></td>
<td>Total</td>
</tr>
</tbody>
</table>

283
**V. WITHDRAWAL**

<table>
<thead>
<tr>
<th>Occasionally</th>
<th>Frequently</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sits or stands in one position for a long period of time</td>
<td>1 2</td>
</tr>
<tr>
<td>Does nothing but sit and watch others</td>
<td>1 2</td>
</tr>
<tr>
<td>Falls asleep in a chair</td>
<td>1 2</td>
</tr>
<tr>
<td>Lies on the floor all day</td>
<td>1 2</td>
</tr>
<tr>
<td>Does not seem to react to anything</td>
<td>1 2</td>
</tr>
<tr>
<td>Other (specify ___)</td>
<td>1 2</td>
</tr>
<tr>
<td>None of the above</td>
<td>Total</td>
</tr>
</tbody>
</table>

**VI. STEREOTYPED BEHAVIOR AND ODD MANNERISMS**

**[23] Has Stereotyped Behaviors**

- Drums fingers | 1 2 |
- Taps feet continually | 1 2 |
- Has hands constantly in motion | 1 2 |
- Slaps, scratches, or rubs self continually | 1 2 |
- Waves or shakes parts of the body repeatedly | 1 2 |
- Moves or rolls head back and forth | 1 2 |
- Rocks body back and forth | 1 2 |
- Paces the floor | 1 2 |
| Other (specify ___) | 1 2 |
| None of the above | Total |

---

**III. REBELLIOUS BEHAVIOR**

**[17] Misbehaves in Group Settings**

<table>
<thead>
<tr>
<th>Occasionally</th>
<th>Frequently</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interrupts group discussion by talking about unrelated topics</td>
<td>1 2</td>
</tr>
<tr>
<td>Disrupts games by refusing to follow rules</td>
<td>1 2</td>
</tr>
<tr>
<td>Disrupts group activities by making loud noises or by acting up</td>
<td>1 2</td>
</tr>
<tr>
<td>Does not stay in seat during lesson period, lunch period, or other group sessions</td>
<td>1 2</td>
</tr>
<tr>
<td>Other (specify ___)</td>
<td>1 2</td>
</tr>
<tr>
<td>None of the above</td>
<td>Total</td>
</tr>
</tbody>
</table>

---

**IV. UNTRUSTWORTHY BEHAVIOR**

**[18] Takes Others’ Property Without Permission**

<table>
<thead>
<tr>
<th>Occasionally</th>
<th>Frequently</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has been suspected of stealing</td>
<td>1 2</td>
</tr>
<tr>
<td>Takes others’ belongings if not kept in place or locked</td>
<td>1 2</td>
</tr>
<tr>
<td>Takes others’ belongings from pockets, purses, drawers, etc.</td>
<td>1 2</td>
</tr>
<tr>
<td>Takes others’ belongings by opening or breaking locks</td>
<td>1 2</td>
</tr>
<tr>
<td>Other (specify ___)</td>
<td>1 2</td>
</tr>
<tr>
<td>None of the above</td>
<td>Total</td>
</tr>
</tbody>
</table>

---

**[19] Lies or Cheats**

<table>
<thead>
<tr>
<th>Occasionally</th>
<th>Frequently</th>
</tr>
</thead>
<tbody>
<tr>
<td>Twists the truth to own advantage</td>
<td>1 2</td>
</tr>
<tr>
<td>Cheats in games, tests, assignments, etc.</td>
<td>1 2</td>
</tr>
<tr>
<td>Lies about situations</td>
<td>1 2</td>
</tr>
<tr>
<td>Lies about self</td>
<td>1 2</td>
</tr>
<tr>
<td>Lies about others</td>
<td>1 2</td>
</tr>
<tr>
<td>Other (specify ___)</td>
<td>1 2</td>
</tr>
<tr>
<td>None of the above</td>
<td>Total</td>
</tr>
</tbody>
</table>

---

**[20] Is Inactive**

<table>
<thead>
<tr>
<th>Occasionally</th>
<th>Frequently</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sits or stands in one position for a long period of time</td>
<td>1 2</td>
</tr>
<tr>
<td>Does nothing but sit and watch others</td>
<td>1 2</td>
</tr>
<tr>
<td>Falls asleep in a chair</td>
<td>1 2</td>
</tr>
<tr>
<td>Lies on the floor all day</td>
<td>1 2</td>
</tr>
<tr>
<td>Does not seem to react to anything</td>
<td>1 2</td>
</tr>
<tr>
<td>Other (specify ___)</td>
<td>1 2</td>
</tr>
<tr>
<td>None of the above</td>
<td>Total</td>
</tr>
</tbody>
</table>

---

**[21] Is Withdrawn**

<table>
<thead>
<tr>
<th>Occasionally</th>
<th>Frequently</th>
</tr>
</thead>
<tbody>
<tr>
<td>Seems unaware of surroundings</td>
<td>1 2</td>
</tr>
<tr>
<td>Is difficult to reach or contact</td>
<td>1 2</td>
</tr>
<tr>
<td>Is apathetic and unresponsive in feeling</td>
<td>1 2</td>
</tr>
<tr>
<td>Has a blank stare</td>
<td>1 2</td>
</tr>
<tr>
<td>Has a fixed expression</td>
<td>1 2</td>
</tr>
<tr>
<td>Other (specify ___)</td>
<td>1 2</td>
</tr>
<tr>
<td>None of the above</td>
<td>Total</td>
</tr>
</tbody>
</table>

---

**[22] Is Shy**

<table>
<thead>
<tr>
<th>Occasionally</th>
<th>Frequently</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is timid and shy in social situations</td>
<td>1 2</td>
</tr>
<tr>
<td>Hides face in group situations, e.g., parties, informal gatherings, etc.</td>
<td>1 2</td>
</tr>
<tr>
<td>Does not mix well with others</td>
<td>1 2</td>
</tr>
<tr>
<td>Prefers to be alone</td>
<td>1 2</td>
</tr>
<tr>
<td>Other (specify ___)</td>
<td>1 2</td>
</tr>
<tr>
<td>None of the above</td>
<td>Total</td>
</tr>
</tbody>
</table>

---

**[23] Has Stereotyped Behaviors**

- Drums fingers | 1 2 |
- Taps feet continually | 1 2 |
- Has hands constantly in motion | 1 2 |
- Slaps, scratches, or rubs self continually | 1 2 |
- Waves or shakes parts of the body repeatedly | 1 2 |
- Moves or rolls head back and forth | 1 2 |
- Rocks body back and forth | 1 2 |
- Paces the floor | 1 2 |
| Other (specify ___) | 1 2 |
| None of the above | Total |

---

**[16] Runs Away or Attempts to Run Away**

<table>
<thead>
<tr>
<th>Occasionally</th>
<th>Frequently</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attempts to run away from hospital, home, or school ground</td>
<td>1 2</td>
</tr>
<tr>
<td>Runs away from group activities, e.g., picnics, school buses, etc.</td>
<td>1 2</td>
</tr>
<tr>
<td>Runs away from hospital, home, or school ground</td>
<td>1 2</td>
</tr>
<tr>
<td>Other (specify ___)</td>
<td>1 2</td>
</tr>
<tr>
<td>None of the above</td>
<td>Total</td>
</tr>
</tbody>
</table>

---

**[24] Is Inactive**

<table>
<thead>
<tr>
<th>Occasionally</th>
<th>Frequently</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sits or stands in one position for a long period of time</td>
<td>1 2</td>
</tr>
<tr>
<td>Does nothing but sit and watch others</td>
<td>1 2</td>
</tr>
<tr>
<td>Falls asleep in a chair</td>
<td>1 2</td>
</tr>
<tr>
<td>Lies on the floor all day</td>
<td>1 2</td>
</tr>
<tr>
<td>Does not seem to react to anything</td>
<td>1 2</td>
</tr>
<tr>
<td>Other (specify ___)</td>
<td>1 2</td>
</tr>
<tr>
<td>None of the above</td>
<td>Total</td>
</tr>
</tbody>
</table>

---

**[25] Is Withdrawn**

<table>
<thead>
<tr>
<th>Occasionally</th>
<th>Frequently</th>
</tr>
</thead>
<tbody>
<tr>
<td>Seems unaware of surroundings</td>
<td>1 2</td>
</tr>
<tr>
<td>Is difficult to reach or contact</td>
<td>1 2</td>
</tr>
<tr>
<td>Is apathetic and unresponsive in feeling</td>
<td>1 2</td>
</tr>
<tr>
<td>Has a blank stare</td>
<td>1 2</td>
</tr>
<tr>
<td>Has a fixed expression</td>
<td>1 2</td>
</tr>
<tr>
<td>Other (specify ___)</td>
<td>1 2</td>
</tr>
<tr>
<td>None of the above</td>
<td>Total</td>
</tr>
</tbody>
</table>

---

**[26] Is Shy**

<table>
<thead>
<tr>
<th>Occasionally</th>
<th>Frequently</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is timid and shy in social situations</td>
<td>1 2</td>
</tr>
<tr>
<td>Hides face in group situations, e.g., parties, informal gatherings, etc.</td>
<td>1 2</td>
</tr>
<tr>
<td>Does not mix well with others</td>
<td>1 2</td>
</tr>
<tr>
<td>Prefers to be alone</td>
<td>1 2</td>
</tr>
<tr>
<td>Other (specify ___)</td>
<td>1 2</td>
</tr>
<tr>
<td>None of the above</td>
<td>Total</td>
</tr>
</tbody>
</table>

---

**[27] Has Stereotyped Behaviors**

- Drums fingers | 1 2 |
- Taps feet continually | 1 2 |
- Has hands constantly in motion | 1 2 |
- Slaps, scratches, or rubs self continually | 1 2 |
- Waves or shakes parts of the body repeatedly | 1 2 |
- Moves or rolls head back and forth | 1 2 |
- Rocks body back and forth | 1 2 |
- Paces the floor | 1 2 |
| Other (specify ___) | 1 2 |
| None of the above | Total |
### IX. UNACCEPTABLE OR ECCENTRIC HABITS

<table>
<thead>
<tr>
<th>Occasionally</th>
<th>Frequently</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smells everything</td>
<td>1 2</td>
</tr>
<tr>
<td>Inappropriately stuffs things in pockets, shirts, dresses, or shoes</td>
<td>1 2</td>
</tr>
<tr>
<td>Pulls threads out of own clothing</td>
<td>1 2</td>
</tr>
<tr>
<td>Plays with things he is wearing, e.g., shoe string, buttons, etc.</td>
<td>1 2</td>
</tr>
<tr>
<td>Saves and wears unusual articles, e.g., safety pins, bottle caps, etc.</td>
<td>1 2</td>
</tr>
<tr>
<td>Hoards things, including foods</td>
<td>1 2</td>
</tr>
<tr>
<td>Plays with spit</td>
<td>1 2</td>
</tr>
<tr>
<td>Plays with feces or urine</td>
<td>1 2</td>
</tr>
<tr>
<td>Other (specify)</td>
<td>1 2</td>
</tr>
<tr>
<td>None of the above</td>
<td>Total</td>
</tr>
</tbody>
</table>

### VIII. UNACCEPTABLE VOCAL HABITS

<table>
<thead>
<tr>
<th>Occasionally</th>
<th>Frequently</th>
</tr>
</thead>
<tbody>
<tr>
<td>Giggles hysterically</td>
<td>1 2</td>
</tr>
<tr>
<td>Talks loudly or yells at others</td>
<td>1 2</td>
</tr>
<tr>
<td>Talks to self loudly</td>
<td>1 2</td>
</tr>
<tr>
<td>Laughs inappropriately</td>
<td>1 2</td>
</tr>
<tr>
<td>Makes growling, humming, or other unpleasant noises</td>
<td>1 2</td>
</tr>
<tr>
<td>Repeats a word or phrase over and over</td>
<td>1 2</td>
</tr>
<tr>
<td>Mimics others' speech</td>
<td>1 2</td>
</tr>
<tr>
<td>Other (specify)</td>
<td>1 2</td>
</tr>
<tr>
<td>None of the above</td>
<td>Total</td>
</tr>
</tbody>
</table>

### VII. INAPPROPRIATE INTERPERSONAL MANNERS

<table>
<thead>
<tr>
<th>Occasionally</th>
<th>Frequently</th>
</tr>
</thead>
<tbody>
<tr>
<td>Talks too close to others' faces</td>
<td>1 2</td>
</tr>
<tr>
<td>Bluets on others' faces</td>
<td>1 2</td>
</tr>
<tr>
<td>Harps at others</td>
<td>1 2</td>
</tr>
<tr>
<td>Kisses or licks others</td>
<td>1 2</td>
</tr>
<tr>
<td>Hugs or squeezes others</td>
<td>1 2</td>
</tr>
<tr>
<td>Touches others inappropriately</td>
<td>1 2</td>
</tr>
<tr>
<td>Hangs on to others and does not let go</td>
<td>1 2</td>
</tr>
<tr>
<td>Other (specify)</td>
<td>1 2</td>
</tr>
<tr>
<td>None of the above</td>
<td>Total</td>
</tr>
</tbody>
</table>

### VII. INAPPROPRIATE INTERPERSONAL MANNERS

<table>
<thead>
<tr>
<th>Occasionally</th>
<th>Frequently</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rolls things in pockets, shirts, dresses, or shoes</td>
<td>1 2</td>
</tr>
<tr>
<td>Pulls threads out of own clothing</td>
<td>1 2</td>
</tr>
<tr>
<td>Plays with things he is wearing, e.g., shoe string, buttons, etc.</td>
<td>1 2</td>
</tr>
<tr>
<td>Saves and wears unusual articles, e.g., safety pins, bottle caps, etc.</td>
<td>1 2</td>
</tr>
<tr>
<td>Hoards things, including foods</td>
<td>1 2</td>
</tr>
<tr>
<td>Plays with spit</td>
<td>1 2</td>
</tr>
<tr>
<td>Plays with feces or urine</td>
<td>1 2</td>
</tr>
<tr>
<td>Other (specify)</td>
<td>1 2</td>
</tr>
<tr>
<td>None of the above</td>
<td>Total</td>
</tr>
</tbody>
</table>

### IX. UNACCEPTABLE OR ECCENTRIC HABITS

<table>
<thead>
<tr>
<th>Occasionally</th>
<th>Frequently</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tears off buttons or zippers</td>
<td>1 2</td>
</tr>
<tr>
<td>Inappropriately removes shoes or socks</td>
<td>1 2</td>
</tr>
<tr>
<td>Underdresses at the wrong times</td>
<td>1 2</td>
</tr>
<tr>
<td>Takes off all clothing while on the toilet</td>
<td>1 2</td>
</tr>
<tr>
<td>Tears off own clothing</td>
<td>1 2</td>
</tr>
<tr>
<td>Refuses to wear clothing</td>
<td>1 2</td>
</tr>
<tr>
<td>Other (specify)</td>
<td>1 2</td>
</tr>
<tr>
<td>None of the above</td>
<td>Total</td>
</tr>
</tbody>
</table>

### VIII. UNACCEPTABLE VOCAL HABITS

<table>
<thead>
<tr>
<th>Occasionally</th>
<th>Frequently</th>
</tr>
</thead>
<tbody>
<tr>
<td>Giggles hysterically</td>
<td>1 2</td>
</tr>
<tr>
<td>Talks loudly or yells at others</td>
<td>1 2</td>
</tr>
<tr>
<td>Talks to self loudly</td>
<td>1 2</td>
</tr>
<tr>
<td>Laughs inappropriately</td>
<td>1 2</td>
</tr>
<tr>
<td>Makes growling, humming, or other unpleasant noises</td>
<td>1 2</td>
</tr>
<tr>
<td>Repeats a word or phrase over and over</td>
<td>1 2</td>
</tr>
<tr>
<td>Mimics others' speech</td>
<td>1 2</td>
</tr>
<tr>
<td>Other (specify)</td>
<td>1 2</td>
</tr>
<tr>
<td>None of the above</td>
<td>Total</td>
</tr>
</tbody>
</table>

### VII. INAPPROPRIATE INTERPERSONAL MANNERS

<table>
<thead>
<tr>
<th>Occasionally</th>
<th>Frequently</th>
</tr>
</thead>
<tbody>
<tr>
<td>Talks too close to others' faces</td>
<td>1 2</td>
</tr>
<tr>
<td>Bluets on others' faces</td>
<td>1 2</td>
</tr>
<tr>
<td>Harps at others</td>
<td>1 2</td>
</tr>
<tr>
<td>Kisses or licks others</td>
<td>1 2</td>
</tr>
<tr>
<td>Hugs or squeezes others</td>
<td>1 2</td>
</tr>
<tr>
<td>Touches others inappropriately</td>
<td>1 2</td>
</tr>
<tr>
<td>Hangs on to others and does not let go</td>
<td>1 2</td>
</tr>
<tr>
<td>Other (specify)</td>
<td>1 2</td>
</tr>
<tr>
<td>None of the above</td>
<td>Total</td>
</tr>
</tbody>
</table>
### XII. SEXUALLY ABERRANT BEHAVIOR

<table>
<thead>
<tr>
<th>Occasionally</th>
<th>Frequently</th>
</tr>
</thead>
<tbody>
<tr>
<td>[33] Engages in Inappropriate Masturbation</td>
<td></td>
</tr>
<tr>
<td>Has attempted to masturbate openly</td>
<td></td>
</tr>
<tr>
<td>Masturbates in front of others</td>
<td></td>
</tr>
<tr>
<td>Masturbates in group</td>
<td></td>
</tr>
<tr>
<td>Other (specify )</td>
<td></td>
</tr>
<tr>
<td>None of the above</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Occasionally</th>
<th>Frequently</th>
</tr>
</thead>
<tbody>
<tr>
<td>[34] Exposes Body Improperly</td>
<td></td>
</tr>
<tr>
<td>Exposes body unnecessarily after using toilet</td>
<td></td>
</tr>
<tr>
<td>Stands in public places with pants down or with dress up</td>
<td></td>
</tr>
<tr>
<td>Exposes body excessively during activities, e.g., playing, dancing, sitting, etc.</td>
<td></td>
</tr>
<tr>
<td>Undresses in public places, or in front of lighted windows</td>
<td></td>
</tr>
<tr>
<td>Other (specify )</td>
<td></td>
</tr>
<tr>
<td>None of the above</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Occasionally</th>
<th>Frequently</th>
</tr>
</thead>
<tbody>
<tr>
<td>[35] Has Homosexual Tendencies</td>
<td></td>
</tr>
<tr>
<td>Is sexually attracted to members of the same sex</td>
<td></td>
</tr>
<tr>
<td>Has approached others and attempted homosexual acts</td>
<td></td>
</tr>
<tr>
<td>Has engaged in homosexual activity</td>
<td></td>
</tr>
<tr>
<td>Other (specify )</td>
<td></td>
</tr>
<tr>
<td>None of the above</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Occasionally</th>
<th>Frequently</th>
</tr>
</thead>
<tbody>
<tr>
<td>[36] Sexual Behavior That Is Socially Unacceptable</td>
<td></td>
</tr>
<tr>
<td>Is overly seductive in appearance or actions</td>
<td></td>
</tr>
<tr>
<td>Hugs or caresses too intensively in public</td>
<td></td>
</tr>
<tr>
<td>Needs watching with regard to sexual behavior</td>
<td></td>
</tr>
<tr>
<td>Lifts or unbuttons others’ clothing to touch intimately</td>
<td></td>
</tr>
<tr>
<td>Has sexual relations in public places</td>
<td></td>
</tr>
<tr>
<td>Is overly aggressive sexually</td>
<td></td>
</tr>
<tr>
<td>Has raped others</td>
<td></td>
</tr>
<tr>
<td>Is easily taken advantage of sexually</td>
<td></td>
</tr>
<tr>
<td>Other (specify )</td>
<td></td>
</tr>
<tr>
<td>None of the above</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
</tr>
</tbody>
</table>
### XIII. PSYCHOLOGICAL DISTURBANCES

#### [37] Tends to Overestimate Own Abilities

<table>
<thead>
<tr>
<th>Occasionally</th>
<th>Frequently</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>None of the above</td>
<td>None of the above</td>
<td>None of the above</td>
</tr>
</tbody>
</table>

#### [42] Has Hypochondriacal tendencies

<table>
<thead>
<tr>
<th>Occasionally</th>
<th>Frequently</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>None of the above</td>
<td>None of the above</td>
<td>None of the above</td>
</tr>
</tbody>
</table>

#### [43] Has Other Signs of Emotional Instabilities

<table>
<thead>
<tr>
<th>Occasionally</th>
<th>Frequently</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>None of the above</td>
<td>None of the above</td>
<td>None of the above</td>
</tr>
</tbody>
</table>

### XIV. USE OF MEDICATIONS

#### [44] Use of Prescribed Medication

<table>
<thead>
<tr>
<th>Occasionally</th>
<th>Frequently</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>None of the above</td>
<td>None of the above</td>
<td>None of the above</td>
</tr>
</tbody>
</table>

#### [44] Use of Prescribed Medication

<table>
<thead>
<tr>
<th>Occasionally</th>
<th>Frequently</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>None of the above</td>
<td>None of the above</td>
<td>None of the above</td>
</tr>
</tbody>
</table>

### XIV. USE OF MEDICATIONS

#### [44] Use of Prescribed Medication

<table>
<thead>
<tr>
<th>Occasionally</th>
<th>Frequently</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>None of the above</td>
<td>None of the above</td>
<td>None of the above</td>
</tr>
</tbody>
</table>
PATHWAYS TO INDEPENDENCE

Checklists of Self-Help Personal and Social Skills

Compiled by Dorothy Jeffree and Sally Cheseldine
These charts arose out of the PATH Project directed by the authors and financed by the Department of Health and Social Security. Many of the items contained in this checklist were derived from a Checklist of ‘Self-Help Activities’ by C. C. Cunningham and D. Jeffree (published in Cunningham, C. C., and Jeffree, D., Working with Parents: Report of a Workshop Course for Parents of Young Mentally Handicapped Children, National Society for Mentally Handicapped Children (North West Region) and the Hester Adrian Research Centre, University of Manchester, 1971). We would like to acknowledge our debt to this previous work.
Completing the checklists

Below the target items, which begin each section, the task is broken down into a sequence of developmentally logical steps leading to the target. The first step in each section is at the bottom. The very first steps towards the development of independence are included, and many people may already have mastered some of them.

When completing the checklist tick every item, or colour the box, which the person is at present able to do. Try to complete all sections. Use one colour of ink throughout the first time and date the top entry in the same colour. Subsequently record any new achievement in another coloured ink and again include the date. The corresponding box on the profile at the back of the booklet can be filled in at the same time, providing an overall view of progress.

Credit an item only if it is done without help and is an established skill shown on a number of occasions.
## Eating and Drinking

### Section 1: Utensils (Eating)

<table>
<thead>
<tr>
<th>1.11</th>
<th>Feeds self competently, with no assistance or supervision</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.10</td>
<td>Uses knife and fork easily</td>
</tr>
<tr>
<td>1.9</td>
<td>Uses knife to cut foods</td>
</tr>
<tr>
<td>1.8</td>
<td>Uses knife and fork; knife used to hold or push food</td>
</tr>
<tr>
<td>1.7</td>
<td>Uses knife to spread jam, butter, etc.</td>
</tr>
<tr>
<td>1.6</td>
<td>Uses spoon and fork together consistently</td>
</tr>
<tr>
<td>1.5</td>
<td>Feeds self with fork</td>
</tr>
<tr>
<td>1.4</td>
<td>Feeds self with spoon</td>
</tr>
<tr>
<td>1.3</td>
<td>Feeds self with fingers</td>
</tr>
<tr>
<td>1.2</td>
<td>Cooperates when being fed (e.g. opens mouth, chews, etc.)</td>
</tr>
<tr>
<td>1.1</td>
<td>Only eats pureed foods (e.g. baby food)</td>
</tr>
</tbody>
</table>

### Section 2: Utensils (Drinking)

<table>
<thead>
<tr>
<th>2.7</th>
<th>Drinks in a normal fashion (without spilling), using glass, or cup and saucer and teaspoon as appropriate</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.6</td>
<td>Drinks in normal fashion from mug or glass without spilling</td>
</tr>
<tr>
<td>2.5</td>
<td>Picks up cup with two hands and drinks</td>
</tr>
<tr>
<td>2.4</td>
<td>Drinks from non-spill cup, held by self</td>
</tr>
<tr>
<td>2.2</td>
<td>Puts hand round cup when given drink by other</td>
</tr>
<tr>
<td>2.1</td>
<td>Drinks from ordinary cup or glass, held by other person</td>
</tr>
</tbody>
</table>

### Section 3: At the Table

<table>
<thead>
<tr>
<th>3.10</th>
<th>Has very good table manners and needs no special help at the table</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.9</td>
<td>Helps self to salt, sauce, sugar, etc., without overdoing it</td>
</tr>
<tr>
<td>3.8</td>
<td>Pours out drinks without spilling</td>
</tr>
<tr>
<td>3.7</td>
<td>Helps self to vegetables, gravy, etc.</td>
</tr>
<tr>
<td>3.6</td>
<td>Waits to be served without fuss</td>
</tr>
<tr>
<td>3.5</td>
<td>Gets on with own meal, while others are eating</td>
</tr>
<tr>
<td>3.4</td>
<td>Sits at table with others</td>
</tr>
<tr>
<td>3.3</td>
<td>Sits at table until finished eating</td>
</tr>
<tr>
<td>3.2</td>
<td>Has reasonable manners but plays with food</td>
</tr>
<tr>
<td>3.1</td>
<td>Will eat at table but tends to be disruptive, (e.g. takes food off other's plates)</td>
</tr>
</tbody>
</table>
### Section 4: Eating out

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
<th>Tick or colour in box</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.12</td>
<td>Goes out unsupervised for meal on own or with friend</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.11</td>
<td>Pays for meal, works out cost and checks change, unsupervised</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.10</td>
<td>Pays for meal, simply hands over money and receives change, unsupervised</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.9</td>
<td>Orders full meal appropriately, unsupervised</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.8</td>
<td>Knows the way from home to at least one cafe or restaurant</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.7</td>
<td>Helps self to meal on tray at self-service cafeteria, unsupervised</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.6</td>
<td>Orders meal supervised (several times)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.5</td>
<td>Hands over money for meal when given correct amount</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.4</td>
<td>Goes alone to counter to ask for drink, ice-cream, etc.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.3</td>
<td>Will say or show what he wants (to waitress, etc.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.2</td>
<td>Will say or show what he wants (to you)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.1</td>
<td>Eats in unfamiliar places without fuss</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Domestic Tasks

### Section 5: Setting a table

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
<th>Tick or colour in box</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.5</td>
<td>Sets table, including salt and pepper, for small number of people</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.4</td>
<td>Sets a simple place (e.g. knife, fork, spoon, glass, etc.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.3</td>
<td>Puts plates, etc., round table, more or less correctly</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.2</td>
<td>Knows what to put on table (e.g. cutlery, mats)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.1</td>
<td>Carries items and puts them on table</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Section 6: Clearing a table

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
<th>Tick or colour in box</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.7</td>
<td>Clears table unsupervised after meal, putting all items in appropriate  places (crockery, cloth, mats, etc.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.6</td>
<td>Removes, folds and puts away tablecloth or mats</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.5</td>
<td>Puts items in appropriate places (e.g. sink or cupboard)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.4</td>
<td>Wipes down table</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.3</td>
<td>Clears breakable items — without breaking them!</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.2</td>
<td>Clears unbreakable items (e.g. cutlery, mats)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.1</td>
<td>Removes one or two items from table</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Section 7: Washing dishes

| 7.9 | Washes, dries and puts away dishes and pans when necessary, without supervision (i.e. right amount of washing up liquid, right temperature of water, scraping pans, clearing up sink afterwards) |
| 7.8 | Washes, dries and puts away dishes, but not pans, without supervision (i.e. right amount of washing up liquid, right temperature of water, clearing up sink area afterwards) |
| 7.7 | Fills bowl with water, adds right amount of washing up liquid and washes simple items |
| 7.6 | Washes simple items (e.g. plastic plates) with water prepared by adult |
| 7.5 | Helps with drying |
| 7.4 | Puts items away (e.g. cups on hooks, plates in cupboard) |
| 7.3 | Passes items to help others to wash |
| 7.2 | Copies others washing up in game, but not any real help |
| 7.1 | Enjoys playing with water |

### Section 8: Preparing food

| 8.17 | Prepares an adequate variety of meals without supervision |
| 8.16 | Will prepare complete meal, unsupervised |
| 8.15 | Makes complete meal under supervision |
| 8.14 | Prepares simple hot food, unsupervised |
| 8.13 | Prepares simple hot food, supervised |
| 8.12 | Uses gas or electric cooker, unsupervised |
| 8.11 | Uses gas or electric cooker supervised for toast or boiling a kettle |
| 8.10 | Makes toast using toaster |
| 8.9 | Makes hot drinks |
| 8.8 | Makes up food not requiring cooking (e.g. jellies, soup mixtures) |
| 8.7 | Makes sandwiches |
| 8.6 | Prepares cereals |
| 8.5 | Makes up cold drink from squash, etc. |
| 8.4 | Adds water to squash from tap or pours own cup of water |
| 8.3 | Rolls out small piece of pastry when adult is preparing food |
| 8.2 | Helps to stir cake mixture, etc., in preparation |
| 8.1 | Copies adult in pretend play but does not help in real household tasks |
### Section 9: Care of kitchen

<table>
<thead>
<tr>
<th>9.12</th>
<th>Looks after kitchen equipment, is aware of potential dangers, keeps fridge, cooker, floor, etc., clean without supervision</th>
</tr>
</thead>
<tbody>
<tr>
<td>9.11</td>
<td>Cleans cooker and/or defrosts and cleans fridge, turns off power, selects settings unsupervised</td>
</tr>
<tr>
<td>9.10</td>
<td>Cleans cooker and/or defrosts and cleans fridge with help</td>
</tr>
<tr>
<td>9.9</td>
<td>Mops or scrubs floor</td>
</tr>
<tr>
<td>9.8</td>
<td>Tidies and cleans work surfaces and cupboards</td>
</tr>
<tr>
<td>9.7</td>
<td>Wipes up anything split without reminder</td>
</tr>
<tr>
<td>9.6</td>
<td>Disposes of waste — uses dustbin, wraps perishable waste, or uses sink disposal unit appropriately</td>
</tr>
<tr>
<td>9.5</td>
<td>Puts rubbish in dustbin</td>
</tr>
<tr>
<td>9.4</td>
<td>Places rubbish in pedal bin on request</td>
</tr>
<tr>
<td>9.3</td>
<td>Helps to mop or brush floor when told</td>
</tr>
<tr>
<td>9.2</td>
<td>Mops up spilled food or drink reasonably if reminded</td>
</tr>
<tr>
<td>9.1</td>
<td>Copies adults in sweeping, mopping or cleaning, or copies such housekeeping actions in play but cannot be left to cope with real situations</td>
</tr>
</tbody>
</table>

### Section 10: Making the Bed

<table>
<thead>
<tr>
<th>10.11</th>
<th>Makes bed and changes bedclothes regularly</th>
</tr>
</thead>
<tbody>
<tr>
<td>10.10</td>
<td>Regularly makes bed without help (except for changing bedclothing)</td>
</tr>
<tr>
<td>10.9</td>
<td>Changes duvet (continental quilt) cover</td>
</tr>
<tr>
<td>10.8</td>
<td>Makes bed with help</td>
</tr>
<tr>
<td>10.7</td>
<td>Puts pillow in case</td>
</tr>
<tr>
<td>10.6</td>
<td>Tucks in bedclothes, once on bed</td>
</tr>
<tr>
<td>10.5</td>
<td>Knows the order of putting on bedclothes</td>
</tr>
<tr>
<td>10.4</td>
<td>Helps to make bed (e.g. holds one side of sheet)</td>
</tr>
<tr>
<td>10.3</td>
<td>Helps in stripping bed</td>
</tr>
<tr>
<td>10.2</td>
<td>Straightens bedclothes</td>
</tr>
<tr>
<td>10.1</td>
<td>Puts nightclothes away</td>
</tr>
</tbody>
</table>
### Section 11: Cleaning and tidying room

<table>
<thead>
<tr>
<th>11.8</th>
<th>Takes complete charge of keeping own room tidy and clean, including polishing and vacuuming</th>
</tr>
</thead>
<tbody>
<tr>
<td>11.7</td>
<td>Cleans room reasonably well by self, when reminded</td>
</tr>
<tr>
<td>11.6</td>
<td>Does dusting and tidying own room</td>
</tr>
<tr>
<td>11.5</td>
<td>Puts possessions away in correct place without supervision</td>
</tr>
<tr>
<td>11.4</td>
<td>Attempts to dust and tidy up, but adult has to finish it</td>
</tr>
<tr>
<td>11.3</td>
<td>Helps to tidy up</td>
</tr>
<tr>
<td>11.2</td>
<td>Sometimes puts games, etc., back into boxes when urged, but does not sort them</td>
</tr>
<tr>
<td>11.1</td>
<td>Makes no attempt to clear up games, etc.</td>
</tr>
</tbody>
</table>

### Section 12: Cleaning equipment and tools

<table>
<thead>
<tr>
<th>12.11</th>
<th>Takes initiative in household repairs and maintenance appropriately</th>
</tr>
</thead>
<tbody>
<tr>
<td>12.10</td>
<td>Changes fuse (e.g. in plug)</td>
</tr>
<tr>
<td>12.9</td>
<td>Changes electric light bulbs</td>
</tr>
<tr>
<td>12.8</td>
<td>Empties vacuum cleaner or carpet sweeper and reassembles</td>
</tr>
<tr>
<td>12.7</td>
<td>Uses hammer for simple tasks</td>
</tr>
<tr>
<td>12.6</td>
<td>Uses can opener</td>
</tr>
<tr>
<td>12.5</td>
<td>Uses bottle opener</td>
</tr>
<tr>
<td>12.4</td>
<td>Uses vacuum cleaner or carpet sweeper</td>
</tr>
<tr>
<td>12.3</td>
<td>Uses scissors</td>
</tr>
<tr>
<td>12.2</td>
<td>Screws/fastens bottle tops, etc.</td>
</tr>
<tr>
<td>12.1</td>
<td>Unscrews bottle tops, etc.</td>
</tr>
</tbody>
</table>
## Cleanliness and Health

### Section 13: Hands and face

<table>
<thead>
<tr>
<th>13.5</th>
<th>Washes without being told, i.e. regularly and when necessary</th>
</tr>
</thead>
<tbody>
<tr>
<td>13.4</td>
<td>When told, washes hands, face, etc., and does not need to be checked</td>
</tr>
<tr>
<td>13.3</td>
<td>Washes when told, but sometimes needs to be checked</td>
</tr>
<tr>
<td>13.2</td>
<td>Washes, but needs help in finishing</td>
</tr>
<tr>
<td>13.1</td>
<td>Cooperates when washed by other</td>
</tr>
</tbody>
</table>

### Section 14: Bathing

<table>
<thead>
<tr>
<th>14.10</th>
<th>Baths or showers regularly and when necessary without supervision, cleaning bath afterwards</th>
</tr>
</thead>
<tbody>
<tr>
<td>14.9</td>
<td>Prepares bath or shower, adjusts water to right temperature, gets towel and soap when told</td>
</tr>
<tr>
<td>14.8</td>
<td>Undresses, bathes and dries self when told, when bath has been prepared by other</td>
</tr>
<tr>
<td>14.7</td>
<td>Dries self adequately</td>
</tr>
<tr>
<td>14.6</td>
<td>Soaps and washes self in bath</td>
</tr>
<tr>
<td>14.5</td>
<td>Dries self but needs checking</td>
</tr>
<tr>
<td>14.4</td>
<td>Helps to dry self when dried by other</td>
</tr>
<tr>
<td>14.3</td>
<td>Helps to wash self when bathed by other</td>
</tr>
<tr>
<td>14.2</td>
<td>Cooperates when bathed by other</td>
</tr>
<tr>
<td>14.1</td>
<td>Enjoys water-play</td>
</tr>
</tbody>
</table>

### Section 15: Teeth

<table>
<thead>
<tr>
<th>15.5</th>
<th>Brushes teeth adequately and regularly without being told</th>
</tr>
</thead>
<tbody>
<tr>
<td>15.4</td>
<td>Applies toothpaste; brushes teeth when reminded</td>
</tr>
<tr>
<td>15.3</td>
<td>Brushes teeth without help, but can't put paste on</td>
</tr>
<tr>
<td>15.2</td>
<td>Attempts to brush teeth but needs help</td>
</tr>
<tr>
<td>15.1</td>
<td>Cooperates when teeth cleaned by other</td>
</tr>
</tbody>
</table>
### Section 16: Hair

<table>
<thead>
<tr>
<th>16.11</th>
<th>Is completely responsible for care of own hair including having it cut when necessary</th>
</tr>
</thead>
<tbody>
<tr>
<td>16.10</td>
<td>Cares for hair (including washing) unsupervised</td>
</tr>
<tr>
<td>16.9</td>
<td>Goes for haircut unsupervised when told</td>
</tr>
<tr>
<td>16.8</td>
<td>Goes to get hair cut with adult</td>
</tr>
<tr>
<td>16.7</td>
<td>With help, washes and dries hair</td>
</tr>
<tr>
<td>16.6</td>
<td>Combs/brushes hair regularly and when necessary</td>
</tr>
<tr>
<td>16.5</td>
<td>Combs/brushes hair when told</td>
</tr>
<tr>
<td>16.4</td>
<td>Cooperates when hair is cut</td>
</tr>
<tr>
<td>16.3</td>
<td>Cooperates when hair washed by other</td>
</tr>
<tr>
<td>16.2</td>
<td>Combs/brushes hair with help</td>
</tr>
<tr>
<td>16.1</td>
<td>Cooperates when hair brushed by other</td>
</tr>
</tbody>
</table>

### Section 17: Nails

<table>
<thead>
<tr>
<th>17.5</th>
<th>Takes complete care of toenails and fingernails, cutting them when necessary</th>
</tr>
</thead>
<tbody>
<tr>
<td>17.4</td>
<td>Cuts own nails when reminded</td>
</tr>
<tr>
<td>17.3</td>
<td>Cuts nails with help</td>
</tr>
<tr>
<td>17.2</td>
<td>Keeps nails clean</td>
</tr>
<tr>
<td>17.1</td>
<td>Cooperates when nails cleaned or cut by other</td>
</tr>
</tbody>
</table>

### Section 18: Nose

<table>
<thead>
<tr>
<th>18.5</th>
<th>Remembers to carry clean handkerchief or tissue, blows and wipes nose when necessary, even copes with heavy cold</th>
</tr>
</thead>
<tbody>
<tr>
<td>18.4</td>
<td>Usually remembers to blow and wipe nose when necessary</td>
</tr>
<tr>
<td>18.3</td>
<td>Wipes own nose with tissue/handkerchief when told</td>
</tr>
<tr>
<td>18.2</td>
<td>Blows on request when handkerchief held by other</td>
</tr>
<tr>
<td>18.1</td>
<td>Cooperates when nose wiped by other</td>
</tr>
</tbody>
</table>
### Section 19: Use of toilet

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>19.15</td>
<td>Goes to toilet when necessary, asking for toilet in strange surroundings, and using public conveniences when necessary</td>
<td></td>
</tr>
<tr>
<td>19.14</td>
<td>Uses familiar toilet appropriately when necessary, flushes toilet and washes hands after use — no help needed</td>
<td></td>
</tr>
<tr>
<td>19.13</td>
<td>Washes hands and remembers to flush toilet after use</td>
<td></td>
</tr>
<tr>
<td>19.12</td>
<td>Uses toilet tissue appropriately</td>
<td></td>
</tr>
<tr>
<td>19.11</td>
<td>Goes to toilet by self but needs help with wiping</td>
<td></td>
</tr>
<tr>
<td>19.10</td>
<td>Takes pants down and goes by self (bladder only)</td>
<td></td>
</tr>
<tr>
<td>19.9</td>
<td>Asks for toilet in strange surroundings</td>
<td></td>
</tr>
<tr>
<td>19.8</td>
<td>Asks to be taken when necessary at home</td>
<td></td>
</tr>
<tr>
<td>19.7</td>
<td>Performs when taken to toilet</td>
<td></td>
</tr>
<tr>
<td>19.6</td>
<td>Keeps dry and clean for up to two hours during day (with some accidents)</td>
<td></td>
</tr>
<tr>
<td>19.5</td>
<td>Sits on toilet willingly for a few minutes</td>
<td></td>
</tr>
<tr>
<td>19.4</td>
<td>Indicates when about to perform</td>
<td></td>
</tr>
<tr>
<td>19.3</td>
<td>Indicates when has performed</td>
<td></td>
</tr>
<tr>
<td>19.2</td>
<td>Shows some regularity in bladder and bowel movements</td>
<td></td>
</tr>
<tr>
<td>19.1</td>
<td>Shows signs of discomfort when wet or soiled</td>
<td></td>
</tr>
</tbody>
</table>

### Section 20(a): Menstruation

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>20a.7</td>
<td>Cares for self completely during menstruation without assistance or reminder, using vending machines for pads, and incinerators where appropriate</td>
<td></td>
</tr>
<tr>
<td>20a.6</td>
<td>Cares reasonably well for self during menstruation</td>
<td></td>
</tr>
<tr>
<td>20a.5</td>
<td>Helps in changing pads</td>
<td></td>
</tr>
<tr>
<td>20a.4</td>
<td>Indicates that pads needs changing</td>
<td></td>
</tr>
<tr>
<td>20a.3</td>
<td>Indicates that menstruation has begun</td>
<td></td>
</tr>
<tr>
<td>20a.2</td>
<td>Cooperates when being cared for during menstruation</td>
<td></td>
</tr>
<tr>
<td>20a.1</td>
<td>No menstruation</td>
<td></td>
</tr>
</tbody>
</table>
### Section 20(b): Shaving

<table>
<thead>
<tr>
<th>20b.5</th>
<th>Shaves adequately when necessary without being told</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>20b.4</td>
<td>Shaves with ordinary razor when told</td>
<td></td>
</tr>
<tr>
<td>20b.3</td>
<td>Shaves with electric razor when told</td>
<td></td>
</tr>
<tr>
<td>20b.2</td>
<td>Cooperates when shaved by other</td>
<td></td>
</tr>
<tr>
<td>20b.1</td>
<td>Does not need to shave</td>
<td></td>
</tr>
</tbody>
</table>

### Section 21: Health

<table>
<thead>
<tr>
<th>21.10</th>
<th>Looks after minor health problems (headaches, indigestion, etc.) without help, and seeks advice appropriately when necessary</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>21.9</td>
<td>Goes to dentist regularly, unsupervised</td>
<td></td>
</tr>
<tr>
<td>21.8</td>
<td>Knows how to obtain help in an emergency (e.g. ring doctor or summon neighbour)</td>
<td></td>
</tr>
<tr>
<td>21.7</td>
<td>Can deal with simple injuries independently (e.g. put plaster on cut, run small burn under cold water)</td>
<td></td>
</tr>
<tr>
<td>21.6</td>
<td>Seeks help for minor health problems and injuries (e.g. cuts, indigestion, upset stomach)</td>
<td></td>
</tr>
<tr>
<td>21.5</td>
<td>Accepts prescribed medication (e.g. tablets and medicines)</td>
<td></td>
</tr>
<tr>
<td>21.4</td>
<td>Accepts and wears prescribed aids (e.g. glasses, hearing aids, calipers, toothbrace)</td>
<td></td>
</tr>
<tr>
<td>21.3</td>
<td>Looks after personal health (e.g. changes wet clothing — shoes, pants, coat)</td>
<td></td>
</tr>
<tr>
<td>21.2</td>
<td>Goes to dentist, supervised</td>
<td></td>
</tr>
<tr>
<td>21.1</td>
<td>Indicates when in pain or unwell</td>
<td></td>
</tr>
</tbody>
</table>
### Clothing

#### Section 22: Dressing and undressing

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>22.12</strong></td>
<td>Dresses and undresses self without help, including difficult fastenings (e.g. buckles, ties, laces)</td>
</tr>
<tr>
<td><strong>22.11</strong></td>
<td>Dresses and fastens straightforward fastenings (e.g. buttons, press-studs)</td>
</tr>
<tr>
<td><strong>22.10</strong></td>
<td>Puts on coats, shirts, jumpers, etc., without buttons</td>
</tr>
<tr>
<td><strong>22.9</strong></td>
<td>Undoes belts, buckles, bows, ties, shoes</td>
</tr>
<tr>
<td><strong>22.8</strong></td>
<td>Puts shoes on correct feet</td>
</tr>
<tr>
<td><strong>22.7</strong></td>
<td>Puts on simple articles of clothing (e.g. pants, mitts, slippers)</td>
</tr>
<tr>
<td><strong>22.6</strong></td>
<td>Unbuttons/unzips and takes off garments</td>
</tr>
<tr>
<td><strong>22.5</strong></td>
<td>Undresses completely when undone by other</td>
</tr>
<tr>
<td><strong>22.4</strong></td>
<td>Takes off simple garments (e.g. vest, pants)</td>
</tr>
<tr>
<td><strong>22.3</strong></td>
<td>Slips off shoes</td>
</tr>
<tr>
<td><strong>22.2</strong></td>
<td>Tries to help in dressing and undressing — holds arms out, lifts feet</td>
</tr>
<tr>
<td><strong>22.1</strong></td>
<td>Cooperates when being dressed</td>
</tr>
</tbody>
</table>

#### Section 23: Selection and care of clothing

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>23.15</strong></td>
<td>Completely responsible for own wardrobe, including laundering and repairing clothes and choosing appropriate items to wear</td>
</tr>
<tr>
<td><strong>23.14</strong></td>
<td>Washes by hand, uses self-service laundry or operates washing machine at home</td>
</tr>
<tr>
<td><strong>23.13</strong></td>
<td>Selects appropriate clothes for short holiday</td>
</tr>
<tr>
<td><strong>23.12</strong></td>
<td>Does simple repairs</td>
</tr>
<tr>
<td><strong>23.11</strong></td>
<td>Chooses what to wear independently and appropriately</td>
</tr>
<tr>
<td><strong>23.10</strong></td>
<td>Cleans own shoes</td>
</tr>
<tr>
<td><strong>23.9</strong></td>
<td>Irons simple articles</td>
</tr>
<tr>
<td><strong>23.8</strong></td>
<td>Indicates when clothes need cleaning or repairing</td>
</tr>
<tr>
<td><strong>23.7</strong></td>
<td>Changes clothes regularly and appropriately</td>
</tr>
<tr>
<td><strong>23.6</strong></td>
<td>Has a good idea what to wear for specific occasions</td>
</tr>
<tr>
<td><strong>23.5</strong></td>
<td>Puts on appropriate garments when it is raining or cold</td>
</tr>
<tr>
<td><strong>23.4</strong></td>
<td>Places dirty clothes in laundry basket or washing machine</td>
</tr>
<tr>
<td><strong>23.3</strong></td>
<td>Shows interest in own clothes</td>
</tr>
<tr>
<td><strong>23.2</strong></td>
<td>Selects matching socks or shoes</td>
</tr>
<tr>
<td><strong>23.1</strong></td>
<td>Wears clothes without protest</td>
</tr>
</tbody>
</table>
**Living Information**

**ction 24: Spoken information**

<table>
<thead>
<tr>
<th>24.9</th>
<th>Can be clearly understood by others and uses appropriate language in all day to day situations both at home and in unfamiliar surroundings. Able to give and receive information and remember it</th>
</tr>
</thead>
<tbody>
<tr>
<td>24.8</td>
<td>Uses appropriate language in day to day situations and responds to others both at home and in unfamiliar surroundings. Cannot always be clearly understood (i.e. articulation difficulty)</td>
</tr>
<tr>
<td>24.7</td>
<td>Expressive language good but not always appropriate. Response to others and to the situation limited</td>
</tr>
<tr>
<td>24.6</td>
<td>Can give specific information on request (e.g. name and address)</td>
</tr>
<tr>
<td>24.5</td>
<td>Good understanding and expressive language at a simple level — i.e. single words or short sentences. Will respond both at home and in unfamiliar surroundings</td>
</tr>
<tr>
<td>24.4</td>
<td>Good understanding at simple level. Expressive language at single word or short sentence level. Can be understood by family and friends — not always by strangers</td>
</tr>
<tr>
<td>24.3</td>
<td>Uses mainly gestures to make wants known, both at home and in unfamiliar surroundings. A few words. Quite good at being understood and understanding at simple level</td>
</tr>
<tr>
<td>24.2</td>
<td>Uses a few gestures and some idiosyncratic articulations to make wants known. Can only be understood by family and friends</td>
</tr>
<tr>
<td>24.1</td>
<td>Responds to cuddling and attention</td>
</tr>
</tbody>
</table>

**tion 25: Written information**

<table>
<thead>
<tr>
<th>25.12</th>
<th>Writes and addresses letters (business or personal), keeps diary</th>
</tr>
</thead>
<tbody>
<tr>
<td>25.11</td>
<td>Can write short personal letter</td>
</tr>
<tr>
<td>25.10</td>
<td>Can write short notes (shopping list, reminders)</td>
</tr>
<tr>
<td>25.9</td>
<td>Can write own name and address</td>
</tr>
<tr>
<td>25.8</td>
<td>Can write own telephone number without help</td>
</tr>
<tr>
<td>25.7</td>
<td>Writes first and second names without help</td>
</tr>
<tr>
<td>25.6</td>
<td>Writes first name without help</td>
</tr>
<tr>
<td>25.5</td>
<td>Writes own first name from copy</td>
</tr>
<tr>
<td>25.4</td>
<td>Can copy single letters and numbers</td>
</tr>
<tr>
<td>25.3</td>
<td>Can copy a circle</td>
</tr>
<tr>
<td>25.2</td>
<td>Scribbles purposefully with pencil or crayon</td>
</tr>
<tr>
<td>25.1</td>
<td>Holds pencil or crayon; attempts to scribble</td>
</tr>
</tbody>
</table>
## Use of Information

### Section 26: Spoken instructions

<table>
<thead>
<tr>
<th>26.9</th>
<th>Can remember and carry out a sequence of instructions like a simple recipe or directions to a place</th>
</tr>
</thead>
<tbody>
<tr>
<td>26.8</td>
<td>Remembers to pass on messages (e.g. from school or work)</td>
</tr>
<tr>
<td>26.7</td>
<td>Follows two part instructions (e.g. &quot;Go downstairs and look for the post&quot;, &quot;Go to the shop and buy a loaf&quot;, &quot;Pick up your cardigan and put it on a hanger&quot;)</td>
</tr>
<tr>
<td>26.6</td>
<td>Will get two objects from another room without forgetting (e.g. &quot;Get my spectacles and pen&quot;)</td>
</tr>
<tr>
<td>26.5</td>
<td>Follows simple instructions (&quot;Switch on light&quot;, &quot;Open the window&quot;, etc.) which involve carrying out action on object</td>
</tr>
<tr>
<td>26.4</td>
<td>Responds to simple and familiar requests (e.g. &quot;Sit down&quot;, &quot;Wash hands&quot;, &quot;Coat off&quot;)</td>
</tr>
<tr>
<td>26.3</td>
<td>Responds appropriately to &quot;No&quot;</td>
</tr>
<tr>
<td>26.2</td>
<td>Responds to own name</td>
</tr>
<tr>
<td>26.1</td>
<td>Turns towards sound (e.g. spoon rattling in cup)</td>
</tr>
</tbody>
</table>

### Section 27: Written instructions

<table>
<thead>
<tr>
<th>27.12</th>
<th>Can read and follow a sequence of instructions (e.g. recipe or directions on packet)</th>
</tr>
</thead>
<tbody>
<tr>
<td>27.11</td>
<td>Can read and follow a line of instructions (e.g. on packet or in book, &quot;cut along dotted line&quot;)</td>
</tr>
<tr>
<td>27.10</td>
<td>Can read and act appropriately to signs, giving directions (e.g. in shop or in street)</td>
</tr>
<tr>
<td>27.9</td>
<td>Recognises and acts appropriately to signals such as 'Danger', 'Bus Stop', 'Exit', 'Entrance', 'On', 'Off', (estimate how many)</td>
</tr>
<tr>
<td>27.8</td>
<td>Recognises and acts appropriately to common signs such as 'Ladies' and 'Gents'</td>
</tr>
<tr>
<td>27.7</td>
<td>Recognises other familiar written names (e.g. Mummy, pet's names, names of class or work mates)</td>
</tr>
<tr>
<td>27.6</td>
<td>Recognises and picks out trade names in supermarket (e.g. brand names for soft drinks, margarine, washing powder, chocolate bars)</td>
</tr>
<tr>
<td>27.5</td>
<td>Recognises the labels in the kitchen (e.g. Rice, Sugar, Lentils, etc.) (estimate how many)</td>
</tr>
<tr>
<td>27.4</td>
<td>Recognises own name written down</td>
</tr>
<tr>
<td>27.3</td>
<td>Identifies pictures of common objects</td>
</tr>
<tr>
<td>27.2</td>
<td>Sorts out shapes (e.g. circles from squares) and/or colours (e.g. red from green)</td>
</tr>
<tr>
<td>27.1</td>
<td>Sorts out objects</td>
</tr>
<tr>
<td>28.19</td>
<td>Good understanding of time concept, i.e. to the extent of organising self during the day and in relation to past and future events (e.g. uses watch, timetable, calendar, TV programme guide)</td>
</tr>
<tr>
<td>28.18</td>
<td>Uses simple timetable or programme (e.g. of school activities)</td>
</tr>
<tr>
<td>28.17</td>
<td>Regularly uses watch or clock to check timing of activities (e.g. when bus is due)</td>
</tr>
<tr>
<td>28.16</td>
<td>Tells time from a digital clock or watch</td>
</tr>
<tr>
<td>28.15</td>
<td>Tells time from clock without figures, i.e. with lines or Roman numerals</td>
</tr>
<tr>
<td>28.14</td>
<td>Associates printed time with correct time on clock</td>
</tr>
<tr>
<td>28.13</td>
<td>Tells time in hours and minutes</td>
</tr>
<tr>
<td>28.12</td>
<td>Appreciates relative length of time (e.g. appreciates how long it takes to arrive at a destination, or how long he/she has to wait)</td>
</tr>
<tr>
<td>28.11</td>
<td>Recognises quarter past and quarter to on clock</td>
</tr>
<tr>
<td>28.10</td>
<td>Recognises half past</td>
</tr>
<tr>
<td>28.9</td>
<td>Knows what hour it is on clock</td>
</tr>
<tr>
<td>28.8</td>
<td>Knows the names of the months and associates particular events with them (e.g. birthdays, holidays, etc.)</td>
</tr>
<tr>
<td>28.7</td>
<td>Reads the numbers of a standard clock face</td>
</tr>
<tr>
<td>28.6</td>
<td>Counts up to 12</td>
</tr>
<tr>
<td>28.5</td>
<td>Distinguishes large and small hand</td>
</tr>
<tr>
<td>28.4</td>
<td>Understands the difference between today, tomorrow and yesterday</td>
</tr>
<tr>
<td>28.3</td>
<td>Appreciates the difference between weekdays and the weekend, as shown in different behaviour in rising and dressing, etc.</td>
</tr>
<tr>
<td>28.2</td>
<td>Shows by behaviour that he/she can anticipate some events of the day (e.g. start of TV programme, mealtimes)</td>
</tr>
<tr>
<td>28.1</td>
<td>Shows regularity in sleep/waking patterns</td>
</tr>
</tbody>
</table>
### Money

#### Section 29: Money handling

<table>
<thead>
<tr>
<th>29.11</th>
<th>Responsible use of money, i.e. no difficulty in coping with everyday money transactions, giving right amount and checking change</th>
</tr>
</thead>
<tbody>
<tr>
<td>29.10</td>
<td>Gives change in a transaction</td>
</tr>
<tr>
<td>29.9</td>
<td>Combines coins and notes to give specified sum of money</td>
</tr>
<tr>
<td>29.8</td>
<td>Proffers amount of money reasonably appropriate to stated price of article</td>
</tr>
<tr>
<td>29.7</td>
<td>Knows equivalent value of coins and notes (e.g. that ten coins are worth as much as one higher denomination coin or note)</td>
</tr>
<tr>
<td>29.6</td>
<td>Estimates roughly what different amounts might buy (e.g. if given a coin has some idea of what to buy)</td>
</tr>
<tr>
<td>29.5</td>
<td>Waits for change when given money to buy goods</td>
</tr>
<tr>
<td>29.4</td>
<td>Picks out coins by name</td>
</tr>
<tr>
<td>29.3</td>
<td>Uses coins to buy goods if given the exact price of the purchase</td>
</tr>
<tr>
<td>29.2</td>
<td>Matches coins by colour, shape and size</td>
</tr>
<tr>
<td>29.1</td>
<td>Knows what money is for</td>
</tr>
</tbody>
</table>

#### Section 30: Saving

<table>
<thead>
<tr>
<th>30.6</th>
<th>Is completely responsible for own money and depositing or withdrawing from bank or post office</th>
</tr>
</thead>
<tbody>
<tr>
<td>30.5</td>
<td>Deposits and withdraws money from savings account or bank with supervision</td>
</tr>
<tr>
<td>30.4</td>
<td>Understands and uses a simple savings scheme with help (e.g. savings stamps, cash contributions)</td>
</tr>
<tr>
<td>30.3</td>
<td>Understands function of bank/post office as place to keep money safely and to save, and where others can deposit and withdraw money on his/her behalf</td>
</tr>
<tr>
<td>30.2</td>
<td>Uses piggy bank for saving towards some special occasion</td>
</tr>
<tr>
<td>30.1</td>
<td>Is only given small amounts of money at one time</td>
</tr>
</tbody>
</table>
### Section 31: Budgeting

| 31.7 | Assumes responsibility for major part of living essentials (e.g. whole wardrobe) and contributes realistically towards housekeeping every week |
| 31.6 | Has a pay packet and is expected to buy larger necessities (e.g. shoes, T-shirts, jeans, etc.) |
| 31.5 | Plans spending over a given period of time (e.g. till next instalment of pocket money or next pay packet) |
| 31.4 | Has weekly allowance to spend as she/he pleases but is responsible for small essentials (e.g. bus fares, toothpaste) |
| 31.3 | Has weekly pocket money to spend as she/he pleases |
| 31.2 | Parents control money and only hand it over for specific purposes |
| 31.1 | Parents control spending completely |

### Freedom of Movement

### Section 32: Out and about

| 32.16 | Uses public transport and amenities independently and confidently, in familiar and unfamiliar settings |
| 32.15 | Changes bus or trains, recognising numbers and choosing the appropriate stop |
| 32.14 | Takes familiar direct bus or train journey independently, i.e. no changing involved |
| 32.13 | Travels on public transport alone when put on and met |
| 32.12 | Goes to self-service shops or cafe independently |
| 32.11 | Is sent on errands for small number of items, without note |
| 32.10 | Is sent on errands, without note, for single items |
| 32.9 | Is sent into strange shop for simple purchases if adult stays outside |
| 32.8 | Knows which are the most appropriate shops, where the postbox is, uses pedestrian crossings |
| 32.7 | Knows way around immediate neighbourhood and does not get lost |
| 32.6 | Crosses quiet roads to visit neighbour or shop |
| 32.5 | Is sent with written message to neighbour or nearby shop |
| 32.4 | Plays alone safely in quiet road outside own house and does not stray |
| 32.3 | Plays alone safely in house or garden |
| 32.2 | Plays alone safely in separate room |
| 32.1 | Needs constant supervision even in own house |
### Use of Amenities

**Section 33: Telephone**

<table>
<thead>
<tr>
<th>33.14</th>
<th>Makes and receives telephone calls independently, including for information, using directory and public phones where necessary</th>
</tr>
</thead>
</table>

| 33.13 | Makes use of a telephone directory with some success |
| 33.12 | Uses personal telephone book |
| 33.11 | Uses phone to call new numbers (written down) and speak to strangers for information, advice, etc. |
| 33.10 | Uses a pay phone for well-known numbers |
| 33.9 | Uses a private phone and dials well-known numbers |
| 33.8 | Answers phone and can take and remember a simple message |
| 33.7 | Answers phone and calls appropriate person |
| 33.6 | Answers phone and carries on a simple conversation |
| 33.5 | Talks to familiar person if number dialled |
| 33.4 | Answers telephone but is unable to take a message or call appropriate person |
| 33.3 | Turns dial if finger put in correct hole |
| 33.2 | Counts up to 10 |
| 33.1 | Uses toy or real phone more or less appropriately in play, i.e. pretends to dial and speak into mouth-piece and listen into ear-piece |

**Section 34: Public amenities**

<table>
<thead>
<tr>
<th>34.13</th>
<th>Copes independently in the community, using public amenities such as library, swimming pool, vending machines, etc.</th>
</tr>
</thead>
</table>

| 34.12 | Uses lift independently, i.e. summons it by pressing button for UP or DOWN, can hold doors open if necessary, selects required floor |
| 34.11 | Uses vending machine independently |
| 34.10 | Uses libraries with help |
| 34.9 | Uses electricity and gas meters, inserting appropriate coins and turning knob to register power paid for |
| 34.8 | Uses vending machines with help |
| 34.7 | Uses lifts with help |
| 34.6 | Uses turnstile (e.g. in sports ground, supermarkets) |
| 34.5 | Uses escalator confidently |
| 34.4 | Uses escalator with help |
| 34.3 | Opens and closes doors and climbs stairs in unfamiliar settings |
| 34.2 | Opens and closes doors and climbs stairs at home but not confident outside |
| 34.1 | Finds own way from one room to another (no stairs) |

---

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### Section 35: Leisure time activities

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>35.13</td>
<td>Has regular involvement with one or more community-based leisure-time activities (e.g. swimming, horse riding, dancing class, pottery class, yoga)</td>
</tr>
<tr>
<td>35.12</td>
<td>Attends an open youth club or organisation (e.g. Scouts, Guides, Red Cross)</td>
</tr>
<tr>
<td>35.11</td>
<td>Takes part in unsupervised activity with friends from school, institution or hostel (e.g. visits, shopping, swimming, park)</td>
</tr>
<tr>
<td>35.10</td>
<td>Takes part in a long-term skilled activity or hobby (e.g. playing musical instrument, knitting, photography, model making, pottery, reading for pleasure, gardening)</td>
</tr>
<tr>
<td>35.9</td>
<td>Goes regularly to 'special' Youth Club or leisure-time facility and is actively involved</td>
</tr>
<tr>
<td>35.8</td>
<td>Goes occasionally to events (e.g. barbecues, outings, discos) arranged by 'special' Youth club or organisation</td>
</tr>
<tr>
<td>35.7</td>
<td>Takes part in games with rules (e.g. board games, card games, football, darts, snooker, table tennis)</td>
</tr>
<tr>
<td>35.6</td>
<td>Takes part in semi-skilled leisure activities without rules (e.g. jigsaws, construction sets, skittles, sorting games)</td>
</tr>
<tr>
<td>35.5</td>
<td>Takes part in simple leisure activities mainly with members of the family (e.g. playing ball, looking at picture books, helping to take dog for walk)</td>
</tr>
<tr>
<td>35.4</td>
<td>Is taken on family trips and outings (e.g. shopping, visits to friends and relatives, car trips)</td>
</tr>
<tr>
<td>35.3</td>
<td>Engages mainly in fairly passive, unskilled occupations either alone or with others present (e.g. watching TV, listening to radio, tapes or records, chatting)</td>
</tr>
<tr>
<td>35.2</td>
<td>Is usually over-active when not being directed (e.g. tearing around, picking objects up, throwing things around)</td>
</tr>
<tr>
<td>35.1</td>
<td>When left to own devices is almost entirely passive (e.g. staring into space, playing with fingers, tearing paper, rocking)</td>
</tr>
</tbody>
</table>

* Run exclusively for the handicapped or rehabilitation groups
Checklist Profile

Each square in the column represents an item in the checklist. By filling in the profile you will get an overall picture of the person's strengths and weaknesses in the different areas of independence. Colour in the box corresponding to the questions you ticked, i.e. those things the person can do. By using a different colour each time you fill in the checklist, you will be able to see how much progress has been made, and which areas you should perhaps work on next. Remember to fill in the date each time.

<table>
<thead>
<tr>
<th>Eating and Drinking</th>
<th>Colour Key</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. 1 2 3 4 5 6 7 8 9 10 11</td>
<td>1. Utensils (eating)</td>
<td>..........</td>
</tr>
<tr>
<td>2. 1 2 3 4 5 6 7</td>
<td>2. Utensils (drinking)</td>
<td>..........</td>
</tr>
<tr>
<td>3. 1 2 3 4 5 6 7 8 9 10</td>
<td>3. At the table</td>
<td>..........</td>
</tr>
<tr>
<td>4. 1 2 3 4 5 6 7 8 9 10 11 12</td>
<td>4. Eating out</td>
<td>..........</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Domestic Tasks</th>
</tr>
</thead>
<tbody>
<tr>
<td>5. 1 2 3 4 5</td>
</tr>
<tr>
<td>6. 1 2 3 4 5 6 7</td>
</tr>
<tr>
<td>7. 1 2 3 4 5 6 7 8 9</td>
</tr>
<tr>
<td>8. 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17</td>
</tr>
<tr>
<td>9. 1 2 3 4 5 6 7 8 9 10 11 12</td>
</tr>
<tr>
<td>10. 1 2 3 4 5 6 7 8 9 10 11</td>
</tr>
<tr>
<td>11. 1 2 3 4 5 6 7 8</td>
</tr>
<tr>
<td>12. 1 2 3 4 5 6 7 8 9 10 11</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cleanliness and Health</th>
<th>Colour Key</th>
</tr>
</thead>
<tbody>
<tr>
<td>13. 1 2 3 4 5</td>
<td>13. Hands and face</td>
</tr>
<tr>
<td>14. 1 2 3 4 5 6 7 8 9 10</td>
<td>14. Bathing</td>
</tr>
<tr>
<td>15. 1 2 3 4 5</td>
<td>15. Teeth</td>
</tr>
<tr>
<td>16. 1 2 3 4 5 6 7 8 9 10 11</td>
<td>16. Hair</td>
</tr>
<tr>
<td>17. 1 2 3 4 5</td>
<td>17. Nails</td>
</tr>
<tr>
<td>18. 1 2 3 4 5</td>
<td>18. Nose</td>
</tr>
<tr>
<td>19. 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15</td>
<td>19. Use of toilet</td>
</tr>
<tr>
<td>20. 1 2 3 4 5 6 7</td>
<td>20. a. Menstruation</td>
</tr>
<tr>
<td>20. 1 2 3 4 5</td>
<td>20. b. Shaving</td>
</tr>
<tr>
<td>21. 1 2 3 4 5 6 7 8 9 10</td>
<td>21. Health</td>
</tr>
</tbody>
</table>
Clothing
22. Dressing and undressing
23. Selection and care of clothing

Giving Information
24. Spoken information
25. Written information

Use of Information
26. Spoken instructions
27. Written instructions and signs

Time
28. Time concept

Money
29. Money handling
30. Saving
31. Budgeting

Freedom of Movement
2. Out and about

Use of Amenities
3. Telephone
4. Public amenities

Leisure
5. Leisure time activities
APPENDIX THREE: COPY OF QUESTIONNAIRE GIVEN TO THE ADULT TRAINING CENTRE.

NAME AND ADDRESS OF ADULT TRAINING CENTRE

NAME:

POSITION HELD:

DATE OF COMPLETION:

1. How many people attend the centre?

2. Who has the authority to admit new trainees? (Please tick)
   I do ____
   I am always consulted ____
   I am sometimes consulted ____
   I am rarely or never consulted ____

3. In the last six months how many new trainees have been admitted?
4. In the last six months how many trainees have left?

5. Please list below reasons why trainees left.

6. Please describe briefly the types of work carried out in your centre.
   e.g. woodwork, education.

7. Please list below any other activities outside the centre that the trainees go to and how often?

<table>
<thead>
<tr>
<th>Activity</th>
<th>Once a week?</th>
<th>How often?</th>
<th>Once a year?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Once a month?</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

8. Could you list below the main committees or other regular meetings which occur at the centre.

<table>
<thead>
<tr>
<th>Committee/Meeting</th>
<th>How often?</th>
<th>Once a month?</th>
<th>Once a year?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Once a week?</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
9. Do staff eat with trainees? (Please tick)
   Yes ____
   No ____

10. Do staff have coffee breaks with trainees?
    Yes ____
    No ____

11. Please list below the professionals that you have contact with.
    e.g. Occupational Therapist, Social Worker?

<table>
<thead>
<tr>
<th>Type of Profession</th>
<th>Amount of contact (hours / week)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
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<td></td>
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<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
12. Please state briefly the types of organisational and policy changes that have occurred in the last six months.

13. Please state below the staff changes that have occurred in the last six months.

14. Who has the authority to decide:

   a) the number of staff allocated to the Centre?

      Answer .................................................................

   b) who is hired to fill a position in your centre?

      Answer .................................................................

   c) whether a person in your centre is to be fired?

      Answer .................................................................

15. Do you have written procedures governing the day to day work which your subordinates do?

   a) yes for all aspects of your work _____

   b) for some aspects of your work _____
c) for few or no aspects of work ____

16. Are staff formally assigned to workshops?

Yes ____

No ____

Thank you for completing this questionnaire.
APPENDIX FOUR: Details of the Tick Tock Game.

The Tick Tock Game

Steps Necessary

1. Participants sit in a circle.

2. An object is passed around from left to right. As it is passed around, each person has to say, “This is a tock”.

3. A second object is passed around from right to left. As this happens, each person has to say, “This is a tick”.

4. Steps 2 and 3 are carried out twice.
APPENDIX FIVE:

Diagram used to explain the role of the advisor

KEY

R = Representative
A = Advisor
Diagram used to explain the role of the advisor

The arrow being used to indicate the diminishing role of the supervisor as training ended.
APPENDIX SIX: An example of the voting form that was used by the committee.

What would you like to drink in the afternoon tea break?

<table>
<thead>
<tr>
<th>NAME</th>
<th>TEA</th>
<th>COFFEE</th>
<th>SQUASH</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
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<td></td>
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</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX SEVEN: Copies of the Agenda form and the Minutes
Form used by the Committee.

ADULT TRAINING CENTRE

TRAINING COMMITTEE AGENDA

DATE:

1. Open the meeting (Simon).

2. Write down who is here (Brenda).

3. Old Business.

4. Make notes on old business (Brenda).

5.

6. Make notes on (Brenda).

7.

8. Make notes on (Brenda).
10. Make Notes on (Brenda).

12. Make notes on (Brenda).

13. Next Meeting (Simon).

ADULT TRAINING CENTRE

TRAINEE COMMITTEE MINUTES FORM

DATE:

REPRESENTATIVES PRESENT:

MATTERS ARISING FROM LAST MEETING:
APPENDIX EIGHT: A copy of the constitution of the committee

THE RULES OF THE TRAINEE COMMITTEE

Written by:

ADULT TRAINING CENTRE:

TRAINEE COMMITTEE 1985 - 1986

CHAIRMAN:

RECORDING SECRETARY:

AGENDA SECRETARY:

LIST OF REPRESENTATIVES:

(R's Group and P's Group)

(G's Group)

(M's Group)

(Special Care)

(R's Group)

(M's Group)

(P's Group)

We believe in helping people.
We want to make sure people are treated fairly.

We make sure we are people's first, and labelled second.

Be nice to each other.

**RULES FOR REPRESENTATIVES:**

1. Talk to your group.

2. Speak for yourself.

3. Try and help the Centre change.

4. Come to meetings on time.

5. Help staff.

6. Do the job for a year.

7. Get voted onto the committee.

8. Take matters very seriously.
9. Tell the groups what we spoke about in meetings.

10. Ask the group what they want to talk about before each meeting.

RULES FOR THE AGENDA SECRETARY:
1. Ask what is to be put on the agenda.

2. Write the agenda before each meeting.

3. Give out the agenda before each meeting.

RULES FOR THE RECORDING SECRETARY:
1. The Recording Secretary writes the minutes and gives them out.

RULES FOR THE CHAIRMAN:
1. Bring the meeting to order.

2. Let each representative speak - one person to talk at a time.

3. Do the agenda in the meeting.

4. Close the meeting.

5. If a vote is split, the Chairman can vote again.
HOW TO VOTE:

Voting is a way of choosing.

How you vote:

1. Make a list of things to choose.

2. Write them out on a piece of paper.

3. Give the paper to people to make one tick.

4. People count how many ticks for each thing.

5. The thing with the most ticks wins.

RULES OF THE JOB OF THE CHAIRMAN

1. Open each meeting.

2. Ask Brenda to make sure that everyone is here.

3. Say what the first item on the agenda is.

4. Talk about the first item on the agenda. Have a vote.
5. Ask Brenda to make notes about the first item on the agenda.

6. Go on to the second item on the agenda.

7. Say when the next meeting is going to be.

8. Close the meeting.

RULES OF THE JOB OF THE AGENDA SECRETARY:

1. Before each meeting, ask each representative if there is anything that they want to put on the agenda.

2. Write out the agenda.

3. Give each representative a copy of the agenda before each meeting.

RULES OF THE JOB OF RECORDING SECRETARY:

1. Write down who is at the meeting.

2. Write down what is talked about for each item on the agenda.

3. Copy it out onto the Minutes Form.
4. Give a copy of the form to everyone.

RULES ON HOW TO SEE TONY:

1. Make a list of things for the group to see Tony.

2. Make a time with Anne to see Tony.

3. See Tony to tell him about the list.

4. Tell the group what Tony said at the next meeting.
### APPENDIX NINE: Summary table of 1 between 1 within analysis of variance of data obtained from administration of Pathways to Independence Checklist.

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>Sum of Squares</th>
<th>Degrees of Freedom</th>
<th>Mean Square</th>
<th>F</th>
<th>Significance Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Within Cells</td>
<td>34863.833</td>
<td>14</td>
<td>2490.274</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Constant</td>
<td>4606602.08</td>
<td>1</td>
<td>4606602.08</td>
<td>1849.83</td>
<td>.00</td>
</tr>
<tr>
<td>Condition</td>
<td>252.083</td>
<td>1</td>
<td>252.083</td>
<td>.101</td>
<td>.755</td>
</tr>
<tr>
<td>Within Cells</td>
<td>6116.167</td>
<td>28</td>
<td>218.433</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time</td>
<td>3394.667</td>
<td>2</td>
<td>1697.333</td>
<td>7.770</td>
<td>.002</td>
</tr>
<tr>
<td>Condition by Time</td>
<td>393.167</td>
<td>2</td>
<td>196.583</td>
<td>.900</td>
<td>.418</td>
</tr>
</tbody>
</table>
APPENDIX TEN: Summary table of 1 between 1 within analysis of variance for total ABS - 2 scores for experimental and control groups.

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>Sum of Squares</th>
<th>Degrees of Freedom</th>
<th>Mean Square</th>
<th>F</th>
<th>Significance Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Within Cells</td>
<td>4372.917</td>
<td>14</td>
<td>312.351</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Constant</td>
<td>5986.333</td>
<td>1</td>
<td>5896.33</td>
<td>18.877</td>
<td>.001</td>
</tr>
<tr>
<td>Condition</td>
<td>1386.750</td>
<td>1</td>
<td>1386.750</td>
<td>4.44</td>
<td>.054</td>
</tr>
<tr>
<td>Within Cells</td>
<td>1643.583</td>
<td>28</td>
<td>58.699</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time</td>
<td>355.792</td>
<td>2</td>
<td>177.896</td>
<td>3.031</td>
<td>.064</td>
</tr>
<tr>
<td>Condition by Time</td>
<td>364.625</td>
<td>2</td>
<td>182.312</td>
<td>3.106</td>
<td>.061</td>
</tr>
</tbody>
</table>
APPENDIX ELEVEN: Summary table of analysis of variance of scores on unacceptable vocal habits sub-test (ABA-2) for experimental and control groups.

<table>
<thead>
<tr>
<th>Source</th>
<th>Sum of Squares</th>
<th>Degree of Freedom</th>
<th>Mean Square</th>
<th>F</th>
<th>Significance Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>9.9167</td>
<td>47</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Between subjects</td>
<td>2.5833</td>
<td>15</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Groups</td>
<td>.3333</td>
<td>1</td>
<td>.3333</td>
<td>2.074</td>
<td></td>
</tr>
<tr>
<td>Error (S.W. Groups)</td>
<td>2.25</td>
<td>14</td>
<td>.1607</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Within Subjects</td>
<td>7.3334</td>
<td>32</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time</td>
<td>.2917</td>
<td>2</td>
<td>.1458</td>
<td>.742</td>
<td></td>
</tr>
<tr>
<td>Time x Group</td>
<td>1.5414</td>
<td>2</td>
<td>.7707</td>
<td>3.924</td>
<td></td>
</tr>
<tr>
<td>Error (B.S.W Groups)</td>
<td>5.5</td>
<td>28</td>
<td>.1964</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX TWELVE: Summary table of analysis of variance of scores on the psychological disturbance sub-test of the Adaptive Behaviour Scale. Part II.

<table>
<thead>
<tr>
<th>Source</th>
<th>Sum of Squares</th>
<th>Degree of Freedom</th>
<th>Mean Square</th>
<th>F</th>
<th>Significance Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total.</td>
<td>1182.3125</td>
<td>47</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Between subjects.</td>
<td>636.9791</td>
<td>15</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Groups</td>
<td>172.52083</td>
<td>1</td>
<td>172.52083</td>
<td>5.2</td>
<td>.05</td>
</tr>
<tr>
<td>Error (S.W. Groups)</td>
<td>464.4583</td>
<td>14</td>
<td>33.1756</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Within subjects</td>
<td>545.3334</td>
<td>32</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time</td>
<td>104.625</td>
<td>32</td>
<td>52.3125</td>
<td>2.1</td>
<td></td>
</tr>
<tr>
<td>GroupxTime</td>
<td>94.04167</td>
<td>2</td>
<td>47.0208</td>
<td>1.9</td>
<td></td>
</tr>
<tr>
<td>Error Times w Groups</td>
<td>706.5</td>
<td>28</td>
<td>25.232</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX THIRTEEN: Summary table of analysis of variance of activities that control and experimental groups participated in for a week after each administration.

<table>
<thead>
<tr>
<th>Source</th>
<th>Sum of Squares</th>
<th>Degree of Freedom</th>
<th>Mean Square</th>
<th>F</th>
<th>Significance Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Within Cells</td>
<td>858.917</td>
<td>14</td>
<td>61.351</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Constant</td>
<td>14352.083</td>
<td>1</td>
<td>14532.083</td>
<td>234</td>
<td></td>
</tr>
<tr>
<td>Condition</td>
<td>56.333</td>
<td>1</td>
<td>56.333</td>
<td>.92</td>
<td>.354</td>
</tr>
<tr>
<td>Within Cells</td>
<td>557.833</td>
<td>28</td>
<td>19.923</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time</td>
<td>137.792</td>
<td>2</td>
<td>68.896</td>
<td>3.4</td>
<td>.045</td>
</tr>
<tr>
<td>Condition x Time</td>
<td>37.042</td>
<td>2</td>
<td>18.521</td>
<td>.93</td>
<td>.407</td>
</tr>
</tbody>
</table>
APPENDIX FOURTEEN: Summary table of analysis of variance of average number of relevant comments made by committee members to each other during each meeting.

<table>
<thead>
<tr>
<th>Source</th>
<th>Sum of Squares</th>
<th>Degree of Freedom</th>
<th>Mean Square</th>
<th>F</th>
<th>Significance Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>28096.959</td>
<td>23</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Subjects</td>
<td>12152.292</td>
<td>7</td>
<td>1736.0417</td>
<td>2.44</td>
<td>p&lt;.05</td>
</tr>
<tr>
<td>Conditions</td>
<td>6001.334</td>
<td>2</td>
<td>3000.667</td>
<td>4.22</td>
<td></td>
</tr>
<tr>
<td>Residual</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Error</td>
<td>9943.333</td>
<td>14</td>
<td>710.23807</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX FIFTEEN:

TOPICS DISCUSSED DURING MEETINGS:

There follows a list of the topics discussed during committee meetings which took place during the study.

Table: List of Topics discussed by the committee.

<table>
<thead>
<tr>
<th>TOPICS</th>
<th>FURTHER DETAILS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Noticeboard</td>
<td>The suggestion that the committee have a noticeboard in the Centre was made by the advisor. The committee accepted the suggestion and the chairman was asked to approach the manager. He did so, and the manager agreed to let the committee have a noticeboard.</td>
</tr>
<tr>
<td>Drinks</td>
<td>It was felt by one of the committee members that it was inappropriate that trainees were given cold drinks during the afternoon tea break. He felt that a choice of hot or cold drinks should be offered. The rest of the committee agreed and the opinions of all trainees in the Centre were sought. A vote was taken and the result indicated that most of the trainees would also prefer a choice of drinks. The chairman approached the manager who suggested that a meeting be held between the chairman and the person in charge of the Centre’s kitchen. The</td>
</tr>
</tbody>
</table>
meeting was arranged. Unfortunately this failed to take place and another meeting was arranged.

**Constitution**

The committee felt that a tape recording of the constitution should be made for those people in the Centre who could not read. A tape was made and was to be looked after by the chairman.

**Complaints**

Members of the committee received a number of complaints about the following: the domestic science room being left unclean after use; disruptive behaviour during the lunch break. Each item was discussed by the committee who then approached the person concerned.

**Wages**

It had been the policy of Social Services to "pay" trainees a nominal sum each week. This had been abolished on a trial basis without consulting the trainees. The committee noted that trainees in the Centre were dissatisfied. The committee members were going to approach their groups in order to canvas opinion. If the majority were dissatisfied, then the chairman was going to approach the manager of the Centre.
Co-option of a member

The committee decided to co-opt a member to represent those in the Special Needs Unit.
APPENDIX SIXTEEN:

INDEX OF MATERIALS USED IN SELF-ADVOCACY COURSE.

1. "People First" (1975)
   Available from Concord Films Council,
   201 Felixstowe Road, Ipswich, Suffolk, IP3 9BJ

2. "Doing the Lambeth Talk" Mental Handicap Participation Forum
   Available from Hersov., J.
   23 Willoughby Road, NW3 1RJ

3. "We Are People Too" Normalisation
   Available from B I M H,
   Wolverhampton Road, Kidderminster, Worcestershire

THE USE OF FRAMES

BY CLINICAL PSYCHOLOGISTS

IN LEARNING DIFFICULTIES SERVICES

TO AID DECISION MAKING IN CRISES
ABSTRACT

Decision making in clinical situations is facilitated by the use of a guide/frame (Nezu and Nezu, 1994). A model and a frame were devised for use in a crisis situation by clinical psychologists working in learning difficulties services. The model outlines the decision making processes that are used in crises. The frame was designed to help clinical psychologists analyse a crisis situation. It provides cues in two areas, i.e. naming a person as responsible for an action and specifying the stage of a crisis at which that action should occur. These were aimed at helping participants make more detailed decisions in a crisis than they would ordinarily have. The effectiveness of the frame was tested in an artificial experimental decision making situation.

It was hypothesised that clinical psychologists would be aided to make decisions by being provided with a frame. Subjects had to decide what actions they would take in a clinical situation (presented as a case study). Half the participants were given a structured case study and answer sheet based on the frame. Others were given the same information in an unstructured form and an unstructured answer sheet.

Participants who were provided with the frame produced more answers. Only the cue prompting participants to name a person as responsible for an action was useful. Results indicated that there was a quantitative difference between the groups, as hypothesised. There were also some qualitative differences between the groups. Suggestions are made for future research.
1.0 INTRODUCTION

Clinical psychologists who work in learning difficulties services have various responsibilities. These include carrying out clinical work. They are usually trained to carry out a functional analysis to assess the situation and to design and use a variety of interventions to help the client. These skills enable them to perform day to day clinical work.

Clinical psychologists are not formally trained to operate in crisis situations, except to use the skills mentioned above. It is unlikely that they will be aware of the knowledge about clinical decision making and crisis unless they have made an effort to find out. These areas are not often covered during or after training.

The aim of this study is to test a method devised to help clinical psychologists make decisions in clinical crises within an organisational framework. The method (frame) is based on a model abstracted from the available literature. There is no substantial literature on clinical decision making in crises. Therefore, the model is developed by looking at relevant areas: decision making, clinical decision making and crisis management. Each area should provide suitable definitions. The available models in each section are also reviewed. The frames/guides developed to aid clinical decision making are also discussed.
One of the problems of looking at a variety of fields is that they have different standards. They vary in how rigorously terms are defined. Some use research from other areas to support arguments with little justification for doing so. In some, the data used as evidence is anecdotal or not substantiated. Each of these issues is highlighted below.

In order to develop the model, the following elements are required: suitable definitions of clinical decision making and of crisis situations; explanations of the process of clinical decision making in crises, including factors that affect the process and finally methods to aid clinical decision making. It is necessary to provide definitions so that one is clear about the concepts under discussion. The concepts are ones that are assumed to be essential to the model.

2.0 DEFINITIONS OF RELEVANT TERMS

2.1 Definitions of Decision Making and Clinical Decision Making

There are no universally accepted definitions used consistently throughout the literature on decision making and clinical decision making (Plaud, Vogeltanz and Ackley, 1993) despite there being many models and research in these areas (Jennings and Wattam, 1994). Decision making is defined either in very practical terms to aid the professional or by reference to a process. Most of the papers considered here and later on do not even attempt to define clinical decision making. It is beyond the scope of this research to attempt to resolve this matter.
The definition of decision making used in this study is by reference to the process of clinical decision making carried out by clinical psychologists as described by Nezu and Nezu (1994). They suggest that clinical decision making is a problem solving process and is made up of five stages: problem orientation, problem definition and formulation, generation of alternative solutions, decision making, and solution implementation and verification. It is an accurate description of the process (see section on clinical decision making) and it outlines the necessary stages often taught in training. This decision is based on personal clinical experience and by discussion with other psychologists.

2.2 Definitions of Crisis

There is research on crises (see below) in two areas relevant to this study. They are: guidance on how to deal with personal crises that happen to clients in mental health settings, and organisational crises in businesses (not human services).

The term crisis is used loosely. In the first type of literature, it is often confused with the term emergency or a stressful event. Duffy and Iscoe (1990, p. 304) describe it as the "subjective" experience of loss of control, helplessness and perceived inability to cope. This is similar to definitions of stress. Others differentiate between crises and emergencies in terms of duration (Callahan, 1994). Crises occur in a client's life for 4-6 weeks in length whereas an emergency is immediate and requires a faster response.
from professionals. These definitions highlight the need to include stress reactions and to differentiate between an emergency and a crisis.

A similar confusion arises when one looks at the organisational literature on crisis. There is no real consensus on the "best" definition of the term. Some take a historical overview (Lagadec, 1993). Others look for lists of common characteristics of crisis (Wiener and Kahn, 1962). Some however, skirt the issue by not even considering it (Silva and McGann, 1995).

Lagadec (1993) attempts to clarify the situation. He studied the way in which the term was used historically and notes that there are five possible definitions:

- Crisis is seen as a time for examining, deciding, judging and discerning. It is the moment at which decisions are made.
- Crisis is seen as a turning point.
- Crisis is viewed as pathology.
- Crisis situations are key points in the change process.
- Crisis is an opportunity.

Some adopt a slightly different stance by proposing many categories or frameworks. Kahn (1965) identifies forty-four levels in political military escalation. Meyers and Holusha (1986) suggest that there are nine types of business crisis, e.g. public perception, sudden market shift and product
Mitroff, Pauchant and Shrivastava (1988) describe a two dimensional grid. One of the axes measures the internal or external degree of various crisis factors, and the other, the extent to which the factors involve technical or human aspects.

Wiener and Kahn (1962, p. 21) adopt yet another all encompassing approach by identifying twelve general crisis attributes. These emphasise the emotional reactions experienced by participants of a crisis and the stages of crisis, e.g.

1. A crisis is often a turning point in an unfolding sequence of events.
3. A crisis is a threat to the goals and objectives of those involved.

The various lists seem to have been based on the writer's experiences and knowledge base. At best, they are descriptive of the different characteristics and/or types of crisis.

Given the many ways in which this term is used, it is not surprising that, as Bejin and Morin (1976, p. 1) note, the term is an "empty shell" and a "ready to use catch phrase." Others however, state a case for a more disciplined use of the term (Eberwien, 1978). It is clear there is a lack of consensus on the use of the term.
2.3 **Summary**

The definitions discussed above each seem to highlight a number of factors that distinguish clinical decision making and crisis from any other phenomena. As it is essential that a decision is made about choosing definitions, the following are accepted.

The aim of the research described below is to investigate how professionals react in organisational crises. Therefore the definition of crisis accepted is that offered by Wiener and Kahn (1962), regardless of the criticisms made above. The reasons for accepting the definition are that it is the most comprehensive and includes many aspects of a crisis, e.g. the emotions involved in these situations.

The definitions developed in the literature dealing mainly with personal crises are not directly relevant to this study. They do not discuss organisational issues and are mainly concerned with how the clinician can help a client who has mental health problems and who then goes into crisis. Furthermore, the work carried out in learning difficulties services involves clinical and organisational issues, e.g. staffing levels.

Clinical decision making is defined by the process described by Nezu and Nezu (1994). Clinical experience indicates that it includes many relevant aspects that are useful clinically.
MODELS AND RESEARCH RELEVANT TO DECISION MAKING AND CLINICAL DECISION MAKING IN CRISSES

The model developed in this chapter is based on accepting the definitions of crisis and clinical decision making outlined above. The aim of this section is to consider all the relevant literature to abstract what is known about the process of clinical decision making and associated phenomena.

3.1 Models of Decision Making

There are a number of models to explain the general process of decision making. There are three main approaches: normative, descriptive and prescriptive. Normative approaches are said to be formal, mathematical and to assume rationality in the decision maker (Bell, Raiffa and Tversky, 1988) (Chase, Crow and Lamond, (personal communication)). Descriptive approaches explore how people make decisions. They do not assume rationality in decision making. This section describes a range of normative and descriptive approaches. The next section considers prescriptive approaches which are based on normative and descriptive models and provide strategies, e.g. frames to improve decision making.

The Optimising Decision Making Model outlines how individuals should behave to maximise an outcome (Harrison, 1981). There are six steps that an individual should follow, either implicitly or explicitly. The steps contain several assumptions (Robbins, 1996). The model assumes that the process is completely rational, there is no conflict over the goal, and that all options
are known. However, this does not seem to be a reflection of reality. Indeed, Robbins notes that the situation is usually more complex.

The Satisficing Model adopts a slightly different view (Forester, 1984). When faced with complex problems, decision makers respond by reducing the problems to a level at which they are readily understood. The information processing capability of human beings makes it impossible to assimilate and understand all the information necessary. Individuals operate within the confines of bounded rationality (Forester, 1984).

People construct simplified models that extract the essential features from problems without capturing their complexity. The satisficer settles for the first solution that is good enough, rather than continuing to search for the optimum. Other factors in the situation, e.g. the desire or need to act quickly (such as in a crisis) also influence the process.

The Implicit Favourite Model also argues that individuals solve complex problems by simplifying the process (Soelberg, 1967). However, the decision maker is not seen as a rational or objective being. She/he is said to make an implicit choice early in the process. Recent research provides strong support for several tenets of this model (Robbins, 1996). Evidence suggests that individuals make an early commitment to one alternative, and do not evaluate the strengths and weaknesses of other alternatives, until the final choice is made (Langer and Schank, 1994).
The Intuitive Model is a recent innovation in this area (Agor, 1989). Using intuition to make decisions is no longer perceived as irrational or ineffective (Johnson, 1993). Intuition is conceptualised in a variety of ways, e.g. as a sixth sense or as a personality trait. Robbins (1996) defines it as an unconscious process created out of distilled experience. It is said to complement rational analysis. Some evidence for this is found in research on chess playing (Robbins, 1996). Intuitive decision making is most likely to be used when certain conditions prevail. For example, when a high level of uncertainty exists, or when facts are limited. Intuition is said to be used at either the start or the end of the decision making process (Agor, 1989).

Jennings and Wattam (1994) note that chaos theory suggests the need to adopt a radically new perspective on decision making. The rational model of decision making (as used in some of the models described above) is based on a set of beliefs about the clockwork nature of the decision making process and the general environment in which it takes place. Chaos theory emphasises the need to acknowledge the dimensions of uncertainty and unpredictability, e.g. the way in which a small decision has a large effect in an organisation.

### 3.2 Summary

As noted earlier, these approaches are examples of normative and descriptive models. However this distinction is based on two main issues: whether formal and mathematical concepts are used and whether the authors
of the model assume rationality. However, this distinction is criticised here for a number of reasons. It is possible that formal and mathematical concepts can be used to describe irrationality. Secondly, the definition of rationality varies from model to model. For instance, the Satisficing model discusses bounded rationality, whereas the Intuitive model notes that intuition complements rationality.

Furthermore, none of the models are mutually exclusive. The intuitive, satisficing, and optimising models have some similarities, e.g. that decision makers simplify situations. They each highlight several factors that could operate consecutively in a given situation. Each describes a process or processes that the decision maker uses. They highlight several processes that are susceptible to a range of influences, e.g. subjectivity. They all imply that decision making occurs in stages.

There should also have been a description of the circumstances (personal and environmental) which lead to different types of decisions. There should have been a model that synthesised relevant aspects of the above models to describe and explain the process of decision making and considers any interactions between the processes outlined above, e.g. satisficing and choosing an implicit favourite.

There are no attempts to synthesise the models. They are tested using experimental methods accepted within psychology (Robbins, 1996). On the
whole, they are not explicitly referred to in the literature on clinical decision making. Studies of clinical decision making would greatly benefit from doing so. However, Chase et al. (personal communication) attempt to use some of the concepts to make suggestions to aid healthcare professionals in their decision making (see below for further details).

3.3 Models of Clinical Decision Making

Chase et al. (personal communication) distinguish between the different types of decisions that healthcare professionals make: diagnosis/clinical practice, management of care and resourcing. There is some overlap between them, e.g. decisions about clinical practice often involve resourcing issues. Furthermore, since diagnosis is a part of clinical practice, it may be useful to just have a category of clinical practice.

However, their distinctions are used here. The work that is discussed here only considers the process of clinical decision making, an example of diagnosis/clinical practice.

The literature which is considered below describes models of how decisions are made, as well as outlining factors that affect decision making. Only research that includes clinical psychologists is reported.

Dawes, Faust and Meehl (1989) state that professionals use one of two contrasting methods: the clinical and actuarial method. If the clinical method
is utilised, the decision maker combines processes or information in her/his head. An example of a clinical model is that developed by Corliss (1995). It is described as a hypothetico-deductive model. Clinical decision making is seen as "a dynamic system composed of interdependent elements." (Corliss, 1995, p. 363). There are four major components to the model: the clinician's knowledge base and three processes (taking a case history, clinical testing and treating and managing the patient). The last three being similar to those suggested by Nezu and Nezu (1994).

In the actuarial or statistical method, the human judge is eliminated and conclusions rest solely on empirically established relations between data and the condition or event of interest (Goldberg, 1970). Chase et al. discuss some of the aspects of decision theory that could be applied to decision making in health care. As noted earlier, they distinguish the different types of decisions made in health care. They also consider defining and structuring decisions, temporality, taxonomies and individualistic slants to decision analysis and process in decision making. They separate some important factors that are part of decision making in health care. Further research is required to investigate each one and whether there are any interactions between them.

### 3.4 Summary

There is a basic assumption that there is an abundance of data that could be applied when making decisions using the actuarial method. It is further
assumed that the clinical and actuarial methods are mutually exclusive - they are not, especially to those who trained to be scientist practitioners who are taught to use available knowledge to make clinical decisions. It would have been worth looking at the process of decision making to investigate whether clinical methods are used at certain points and actuarial techniques at others. Chase et al.'s work contains some useful suggestions that need to be taken into account. The majority of the studies described below tend to concentrate on clinical approaches.

3.5 Research on Clinical Decision Making

The work carried out in this area is not extensive. For example, only the decision making behaviour of American clinical psychologists in mental health settings seems to have been investigated.

Plaud et al. (1993) investigate clinical decision making by professionals in two inpatient mental health settings in America. Eighteen of the eighty-three participants tested were clinical psychologists. All completed a treatment decision questionnaire designed by the authors. It addressed areas relating to the types of assessment procedures, treatment goals and treatment methods. Participants also had to provide reasons for choosing a given method.

Results showed that mental health professionals usually rely on past success as well as logistical-practical factors, for example inductive thinking, in the
determination and justification of assessment and treatment methods. There was a low response rate in both settings (27% and 31%), therefore these results are treated with caution, because it is not certain to what extent the results can be generalised.

Millard and Evans (1983) investigated the behaviour of twelve qualified clinical psychologists and twelve graduate clinical psychologists. They were asked to perform an analogue task to investigate decision processes with respect to the judged salience of criteria for social validity. Participants considered six child cases by looking at cards containing information about dangerous behaviour. Dangerousness had previously been found to be the most compelling reason for intervention (Voeltz, Evans, Freedland and Donnelon, 1982). Participants consistently evaluated information about dangerous behaviour as being more serious than any other concern. Dangerousness was ranked first ninety-four percent of the time. There were no differences between graduate students and qualified psychologists.

Clavelle and Turner (1980) examined the clinical decision making process of para-professionals, social workers and clinical psychologists. All worked in mental health services. Each participant conducted two simulated intake interviews. It was hypothesised that qualified professionals would be more consistent in their information gathering, show greater consensus in their decisions, be more certain of their final decisions and reach their decisions more quickly. The experienced para-professionals were expected to behave
like the qualified professionals. The qualified professionals displayed no
greater consensus in their decisions than did the para-professionals. The
professionals, especially the psychologists, were more confident of their
decisions. Psychologists were more consistent in information gathering.
They tended to look at the chief complaint first and then obtain background
information.

Christensen, Heckerling, Mackesey-Amriti, Bernstein and Elstein (1995) point
out that a decision maker's willingness to take risks depends on how
outcomes are presented. Individuals are said to be more willing to accept
risk when they perceive something as a potential loss and tended to avoid
risk when they have something to gain. This is the framing effect as noted by

3.6 Summary

The literature described above is sparse. None of the studies define clinical
decision making. Each study uses a different experimental technique. With
these cautions in mind, the studies indicate that the decision making
processes employed by clinical psychologists are affected by a number of
factors: confidence, salience of cues and past experience.

No work investigating the decision making of clinical psychologists in learning
difficulties services in the United Kingdom was found. Therefore, for the
purposes of this study, it is argued that the findings described above could be
generalised to clinical psychologists in England and to those working in learning difficulty services. The author has noted that there are similarities between clinical psychologists in England and America in terms of their training and the organisations in which they work.

3.7 Models of Decision Making of Clinical Psychologists in Learning Difficulty Services

Nezu and Nezu (1994) describe a model for clinical decision making to aid the clinician. Firstly, they review the available literature for outpatient psychotherapy for clients with learning difficulties: psycho-dynamic, behavioural and group psychotherapy and they conclude that there is not a rich database that the clinician could use. They then advocate applying five problem solving operations: problem orientation, problem definition and formulation, generation of alternatives, decision making, solution implementation and verification. This model is based on their earlier work (Nezu and Nezu, 1989, Nezu, Nezu and Gill Weiss, 1992). They use clinical cases to explain the model. There was no substantial testing of whether the model is valid.

Sturmey (1995) also designed a model, based on a review of available literature, to guide clinical decision making for assessing and treating behaviour disorders (challenging behaviours). There are three stages to follow, to assess and then choose an intervention. However, the model was not tested.
3.8 Summary

Both these models seem appropriate for use in clinical situations. They can be seen as guides to carrying out functional analyses and designing interventions. Nezu and Nezu's rationale is comprehensive and can be applied to any clinical setting. Sturmey's is specifically designed for use in learning difficulty services to deal with a specific set of clinical problems. However, as noted earlier, neither was rigorously examined. Both the approaches described above can be depicted as frames that the clinician could use to aid her/his decision making. Since Nezu and Nezu's model can be applied to most clinical situations, it was adopted for this study.

Unlike the models on decision making, the models outlined in this section do not consider what factors affect the process, e.g. intuition. They simply describe it in an abstract manner. These issues need to be included (see below).

3.9 Research on Clinical Decision Making in Crisis Situations

There is no substantial literature to demonstrate that there have been attempts to study clinical decision making in crises by psychologists in learning difficulties organisations. However, Eliatamby and Byles (1995) looked at how community teams (including psychologists) for people with learning difficulties dealt with crises. They hypothesised that some of the factors identified by Eliatamby and Missen (1996) such as the path of crises and warning signs would be present in real life crises. Professionals in
community teams were asked to analyse a crisis they had experienced. A questionnaire was designed and distributed. Participants were asked to identify the path of the crisis, the presence or absence of any warning signs, and any actions taken. The response rate was fifty-eight percent. A common warning sign that was reported was poor communication. However, this study did not look at the clinical decision making processes of any of the team members.

3.10 Summary

The lack of definitions and models in this area is evident. The researcher has to draw from other areas or her/his personal experience to develop a suitable model and concepts. This point is developed below.

3.11 Models of Crisis Management

There are two types of literature in this area: those that simply describe past crises and analyse them, and more academic sources that attempt to explain crises by developing models of crisis management. None of the models are specifically designed to describe the process of decision making in crisis situations. However, they often refer to decision making and factors affecting it.

As support for their arguments, the authors (cited below) often refer to other areas. For example, risk management and analysis, work carried out by sociologists on group and organisational behaviour in post catastrophe
situations, psychological studies of stress and psycho-sociological studies of group behaviour. There is a tendency to synthesise relevant knowledge into the overall discussion without reference to its source or its validity.

Of the models available in the literature, three are the most suitable for the purposes of this study. They are explicit in their explanation and refer to psychological concepts that may be relevant; e.g. the importance of emotions, cognitive rigidity.

Lagadec (1993) states that although crises often look as if they are being "caused" by one individual, each crisis is in part an organisational one. He suggests that organisations operate in one of three states: normal conditions, disturbed and crisis dynamics.

Pearson and Mitroff (1993) suggest that instead of crises being linear, they are cyclical. They again outline crises in stages: normal, warning signs, preparation, containment, recovery state/prevention and damage limitation. Organisations are said to move through the stages cyclically and could learn at each point.

Meyers and Holusha (1986) distinguish between two types of crisis: unmanaged and managed. A managed crisis is one that, to some extent, has been anticipated by an organisation. There are, therefore, plans to deal with it. Their model describes an unmanaged crisis as having three phases: pre-
crisis, the crisis and post crisis/collapse. It is this latter stage that distinguishes this model from that of Lagadec above.

The evidence for each model is mainly provided by referring to past international crises that are documented or personal experience. Some, e.g. Lagadec conducted interviews of those who had experienced crises. This type of evidence is largely anecdotal. However, it is difficult to consider what else could be done to provide evidence.

3.12 **Summary**

Each model emphasises the fact that crises occur in stages; this is a useful distinction. Each stresses the importance of different factors, e.g. the role of warning signs, the process of learning that could take place. It is difficult to compare and contrast them as there did not appear to be any research on this topic. The model offered by Meyers and Holusha contains a degree of simplicity in the way in which it describes stages. It will be incorporated into the model being developed here because it can be utilised, and uses concepts that are easily understandable.

4.0 **FACTORS INFLUENCING DECISION MAKING IN CRISES**

Two literature sources are used in this section. Firstly, research on decision making and secondly literature on the effects of crises.
4.1 **Factors Influencing Decision Making**

Information is the basis of decision making. Whether it is being used to identify and develop solutions or to monitor the effectiveness of a decision, information requires collection, processing and evaluation (Robbins, 1996). Decision makers face serious limitations in attention, memory, comprehension and communication.

The above mentioned factors have an effect on the information used in decision making, e.g. previously learned lessons may not have been reliably retrieved when needed. There are also said to be limited capacities for communication of information and for sharing complex and specialised information (Robbins, 1996).

Most of the evidence for these assertions is obtained from other areas of psychology, e.g. memory research and is then used by those working in the field of decision making. The literature seems to have been selectively chosen to fit the argument being proposed. In a few instances, however, direct research was conducted. For example, the notion of decision styles was applied to ways in which career choices are made (Holland, 1985; Schein, 1978).

Because of the above factors, decision makers use various information and decision strategies to cope with limitations in information and information handling capabilities, especially at times of crisis. Psychological studies of
individual decision making identified many ways in which decision makers react to cognitive constraints (March and Heath, 1994).

Decision makers use stereotypes to infer unobservables from observables. They form typologies of attitudes (liberal, conservative) and traits (dependent, extroverted, friendly) and categorise people in terms of the typologies. They attribute intent from observing the consequences of behaviour. They abstract central parts of a problem and ignore other parts (this point was highlighted in some of the models on decision making discussed earlier). They adopt an understanding in the form of socially developed theories, scripts, schemas that fill in missing information and suppress discrepancies in their understanding. The method of understanding adopted tends to stabilise interpretations of the world (March and Heath, 1994).

There is a tendency to simplify the situation using the following:

- **Editing** - the tendency to edit and simplify problems before entering the choice process.
- **Decomposition** - the tendency to decompose large problems into their component parts.
- **Heuristics** - the tendency to recognise patterns in the situation and apply rules of appropriate behaviour to that situation.
• Framing - the tendency to use a given frame to define the problem to be addressed, the collection of relevant information and evaluation of the same.

Decision makers tend to frame problems narrowly. The frames used are a result of a variety of factors including individual and professional experience (Robbins, 1996). Recently used frames tend to persist over time. Frames are "obtained" from a variety of sources: other professionals, training, consultancy experts and the organisation itself. This point is supported by the findings of some of the research on clinical decision making by clinical psychologists mentioned earlier.

The decision maker is also affected by the rules or procedures they see as appropriate to the situation they find themselves in (March and Heath, 1994). The organisation they are employed by also has explicit and implicit rules about structure and process that they adhere to.

Decisions should be the result of a logical analysis of available information. The analysis should enable the evaluation of alternatives against their expected value by the decision maker. However, certain problems arise at problem definition and solution development. Individuals may develop a distorted reality as a means of reducing or avoiding anxiety. Jennings and Wattam (1994) use psycho-dynamic theories to make this assertion. They also suggest that personal construct theory implies that there are limits on
rational information processing. This is yet another example of knowledge from another area being used to support an argument with little justification.

Individual differences and experiences also lead to variations in what is perceived as the best solution. Robbins (1996) discusses a variety of psychological phenomena shown to influence decision making: selective perception, the halo effect, contrast effects, projection and stereotyping.

4.2 **Personal Reactions to Crises**

A crucial aspect of crisis noted in each model and the literature is that of personal reactions to crisis. Crises invade every aspect of the lives of the players whatever their status. They lead to shock, stress, ineffective problem solving and feelings of panic. Avoidance mechanisms come into play. Thinking becomes rigid. People rely on experience and become very anxious (Meyers and Holusha, 1986).

These factors affect judgement - there is a tendency to lend credence to ideas that would normally be dismissed (Lagadec, 1993). It is also reported that stress has many effects, some of which were mentioned earlier. Others include the fact that individuals are likely to become tense, less flexible and their ability to focus is narrowed. Their conceptual frameworks become very rigid (Parry, 1990).
Individuals who are involved in a crisis are unlikely to be thinking in a coherent manner. They are unlikely to be seeking accurate and objective information. Indeed, their information gathering/collating and decision making skills are likely to be affected by the plethora of emotions they will be experiencing.

4.3 Summary

While it is important to consider these factors, the evidence for them is largely anecdotal. For instance, Lagadec supports his views by referring to past crises in the business world and to conversations he had with key participants of a crisis. What is evident is that it is likely that there is a degree of emotionality present during a crisis. Some of this is likely to affect the decision making that occurs at such times.

It is possible that decision making is differentially affected by factors such as emotionality at different stages of a crisis. This aspect was not discussed in any of the literature considered here or in any other section.

There are also other factors that affect decision making, e.g. limitations on memory. None of these findings seem to have been investigated thoroughly with regard to crisis situations or decision making in clinical crises.
Decision making is also influenced by the frames that an individual possesses. These are based on past training and organisational constraints. They can be helpful or be a hindrance.

5.0 TECHNIQUES TO AID CLINICAL DECISION MAKING IN CRICES

Eliatamby and Missen (1996) describe a three stage process for analysing crises in learning difficulties services. They develop a frame by including the characteristics of a crisis and distinguishing between the different professionals within an organisation who could participate in a crisis. They then recommend an investigation of the way in which the personnel, systems and structures within an organisation functioned in a crisis using the frame. They use some of the work on crisis management, especially that of Meyers and Holusha. They consider that professionals would more easily understand a model with three stages and one that uses comprehensible words and phrases because it is important to try to achieve a degree of simplicity and clarity as the literature indicates that communication systems (including the written form) are fallible, especially during a crisis. Information is often inaccurate, subjective and highly coloured with emotion (Lagadec, 1993). However, the model that Eliatamby and Missen devised has not been tested.

Other work in this area is written for the clinician/practitioner to help increase clinical skills. For instance, Mallans (1993) composed a manual for nurses. Moulds and Martin (1993) describe ways of dealing with emergencies in

There are some attempts to look at emergency strategies within the Health Service. These include investigations of the provision of emergency services in acute and general hospitals (Royal College of Surgeons, 1988; Department of Health, 1991; National Audit Office, 1992). These studies concentrate on organisational issues, e.g. how resources are used as opposed to offering a method for use by the clinician.

5.1 **Summary**

Regardless of the lack of definitions and models in this area, there are some attempts to develop some techniques, e.g. case management that the practitioner could use. The techniques may answer a need but should be accompanied by acceptable definitions and models.

Similarly the work by Eliatamby and Missen (1996) is criticised. They discuss definitions of crisis and described a process for analysing crises. They did not develop a model for decision making in clinical crisis.
6.0 A MODEL FOR CLINICAL DECISION MAKING IN CRISSES

The aim of this section is to review the literature relevant to clinical decision making in crisis by clinical psychologists in learning difficulties services in order to develop a model. Literature on decision making, clinical decision making, crisis management and clinical decision making in crisis was considered as there is no substantial literature on clinical decision making in crisis, as noted earlier. Each area seems to have been researched independently of the others. There were very few attempts to provide adequate definitions of relevant terms. Different research techniques were used. Regardless of the above deficits, an attempt is now made to develop a model to describe the process of clinical decision making in crises.

6.1 Definitions

The literature review should have enabled one to derive definitions of clinical decision making in crisis situations. However, this is not possible, for reasons stated earlier. Therefore, separate definitions of a crisis and of clinical decision making are adopted. The processes described by Lagadec and others are assumed to operate in clinical crises because they are also organisational crises, in part, as indicated by clinical experience. Therefore the definition of a crisis that is used here is that offered by Wiener and Kahn (1962).

The definition of clinical decision making that is utilised here is the process described by Nezu and Nezu (1994). It offers a comprehensive description.
6.2 **A Description of Clinical Decision Making in Crises**

As no models of clinical decision making in crises seem to be available, Nezu and Nezu's model is accepted, despite the lack of validation. It is assumed that the process described by Nezu and Nezu also operates in crisis situations. The evidence from the crisis literature indicates that the thinking processes in crises are the same as in non-crisis situations but are severely affected by factors such as stress and previous experience (Lagadec, 1993).

The literature on decision making describes a number of aspects that are assumed to apply in these situations. Most of the models emphasise the tendency for decision makers to try to simplify complex situations, e.g. the satisficing approach. Decision making (including information gathering and processing) is influenced by the frame used and the rules that a person abides by (March and Heath, 1994). Thinking is affected by a number of factors, e.g. salience of certain cues.

There are some techniques, e.g. frames developed to help the decision maker in her/his work. For clinical psychologists working in learning difficulties services, three frame/guides were published. Two are designed for use in ordinary clinical situations (Nezu and Nezu, 1994; Sturmey, 1995). The third one is developed specifically for use in crisis situations (Eliatamby and Missen, 1996) and seems to be the most appropriate one to adopt.
The model outlined here emphasises that clinical decision making occurs in stages, that crises occur in stages, that decision making is affected by factors such as stress and cognitive rigidity, and that frames can be useful aids. It does not consider whether other techniques would be helpful. It does not specify what interactions there could be between crises, decision making, and factors such as stress. These are shortcomings of this model. Furthermore, Nezu and Nezu's work has been adopted to define, and describe the process of clinical decision making despite the lack of experimental support.

7.0 BACKGROUND TO THE CURRENT STUDY

The aim of the study was to test a frame for clinical decision making in crisis situations. The work carried out by Eliatamby and Missen was used to design the frame. They describe a three stage process for analysing and dealing with past crises and current crises.

The first two stages were devised using a frame that identified the stages of a crisis (using Meyers and Holusha's framework) and the potential actors/professionals in such situations, i.e. managers, professionals, carers and clients.

The steps are:

1. Gathering information: The aim is to collect as much information as possible about the person with learning difficulties, carers (paid and
unpaid), professionals, managers using the three stages of a crisis: pre-crisis, crisis, post-crisis. A set of questions based on the business literature was devised to help participants collate relevant information.

2. Analysis of the situation: The structured information is then further analysed for the presence of positive and negative elements and preferred solutions for each group. Participants are also expected to identify warning signs that may have been missed (examples of warning signs were provided).

3. Analysis of the service systems/methods for dealing with crises: A variety of techniques are suggested, e.g. the use of questionnaires.

The frame contained within the first step was utilised in this study. The categories were: stages of a crisis and personnel who could be involved in the crisis. It seems to provide all the relevant cues necessary to enable the decision maker to think more clearly and less rigidly during a crisis situation.

8.0 THE CURRENT STUDY

The aim of the study was to investigate whether health professionals were aided by having information presented (in a case study) in a structured way and by having to use a structured answer sheet to write down their responses. That is, was a frame at the point of information presentation and problem solving useful? The composition of the frame was designed by using
the same section that Eliatamby and Missen suggested for gathering of information. Other frames had been devised and used in training workshops. However, participants often reported that the one used in this study was the easiest and most effective to use.

9.0 RESEARCH HYPOTHESES

It was expected that, if participants are presented with information (in a case study) separated into sections (using the frame described) and are then given a structured answer sheet, this would have a significant effect on the decisions that they make. By following the procedure, participants should have been encouraged to become more creative and less rigid in their thinking. Half the participants were given a case study and answer sheet that were designed using the frame and the other half were not.

9.1 Hypothesis One

It is hypothesised that being provided with a frame will lead to participants thinking of more solutions (to the situation presented in the case study) than participants who are not.

9.2 Hypothesis Two

It is hypothesised that participants using the frame will produce more responses within the categories than those participants who do not use the frame. The categories are:

(a) a named person for each action,
(b) the separation into pre-crisis, crisis, post-crisis, and
(c) the combination of the two

10.0 RESEARCH STRATEGY

This section outlines the strategy adopted to test the hypothesis. First, there is a discussion of the different methodologies for data collection and analysis that could be used, and reasons given for choosing one. A description of the frame designed is then provided. Reasons for choosing the participants are also outlined.

10.1 Choosing an Appropriate Methodology for the Study

This study could have been conducted in several different ways:

- Providing participants with the frame, observing their use of it in their daily work and investigating whether it had been useful.

- Providing participants with the frame and observing their use of it in an artificial situation, i.e. a comparative study.

The results obtained in a real life situation may have reflected the emotions of the participants as they dealt with it. The impact of the frame may therefore have been contaminated. It would have been difficult to separate the effects of emotions from that of the frame.
This methodology would not have enabled any control of a number of factors. Participants may have had differing interpretations of what was a crisis. They may not have experienced a crisis during the course of the study. They may have had a personal investment in the crisis that affected their performance in the experiment.

Some of these issues were evident in a study that asked participants to describe a crisis they had experienced in the previous year. Some participants had not experienced a crisis. The types of crisis identified varied, from a client becoming angry in a meeting to someone being made homeless (Eliatamby and Byles, 1995). Visual analysis of the data also suggested that the level of emotional involvement in the crisis seemed to affect the recommendations made about future service developments.

A comparative study between groups was chosen as this seemed to allow the most objective test of the hypothesis. Using an artificial situation decreased the likelihood of factors such as emotions having an effect.

10.2 Choosing an Appropriate Methodology to Analyse the Data

One of the aims of this study was to look for possible differences in the responses provided by participants. This could have been done by using a design that produced quantitative data. In psychological research, the most popular paradigm is the quantitative one (Miles and Huberman, 1994).
However, using this may have led to the loss of rich qualitative differences in responses.

Qualitative techniques provide data that is rich and holistic, with a strong potential for revealing complexity. Such data is said to provide descriptions that are "vivid, nested in a real context and have a ring of truth" (Miles and Huberman, 1994, p. 10). These techniques are also extremely useful to explore new areas and to build, confirm or test a theory.

Miles and Huberman (1994) suggest that qualitative and quantitative data could be used in the same study for three reasons:

1. to enable configuration or corroboration of each other via triangulation
2. to elaborate or develop analysis, providing richer detail
3. to initiate new lines of thinking through attention to surprises or paradoxes, turning ideas around, providing fresh insight

Using a combination of approaches aids the conceptual development of a study during the design and implementation stages. During analysis, qualitative data help by validating, interpreting, clarifying and illustrating quantitative findings as well as strengthening and revising theory.
The methodology advocated by Miles and Huberman is prescriptive. It views qualitative data analysis as an iterative and integrated process with three components:

1. data collection and reduction (sampling can be seen as a form of pre-analysis)
2. data display (in organised assemblies of information)
3. drawing and verifying findings (using various strategies)

The approach also allows the researcher to manipulate the experimental setting as part of the design of the study. It was used in this study as it enabled the collection of both qualitative and quantitative data. Therefore qualitative analysis was carried out within an experimental framework.

10.2.1 Reliability

The chosen procedure should have enabled one to reliably assess the influence of the structure of the frame on decision making. Participants were all given the same instructions once. They did not have sight of, or any prior knowledge of the case study or the frame. If they had, this may have affected the degree of reliability as there may have been a practice effect.

Reliability during the analysis phase was obtained by cross checking with a colleague during the creation of the coding system (used to analyse participants’ response) and by asking another colleague to code the
responses. The degree of reliability was calculated using Cohen's Kappa (Miles and Huberman, 1994, p. 64).

10.2.2 Validity
A degree of validity was achieved in the study by the design used and by the inclusion of quantitative data. However, since participants were providing written responses to a hypothetical situation, there was no guarantee that their responses were reflective of what they would actually do in a real situation.

10.3 Creating a Suitable Frame
The frame used was described earlier (Section 7). It appeared to encapsulate the most important features of the literature. Care was taken to ensure that the elements identified by Eliatamby and Missen (1996) were included in the frame and the structured answer sheet. The case study was based on a real life situation that depicted a crisis as discussed by Eliatamby and Missen, e.g. the presence of positive and negative elements for managers.

10.4 Choosing Participants for the Study
The study was carried out using clinical psychologists for several reasons. They are often involved in dealing with crises in learning difficulties services, therefore they are likely to have had some experience of crises. They have some analytical skills, e.g. those gained from being trained in functional
analysis, which may enable them to use a frame for analysis and decision making.

11.0 METHOD

11.1 Design

The method chosen was a combination of qualitative and quantitative approaches. A comparative study using a between groups design was used: two groups of clinical psychologists were given two different sets of information with different answer sheets.

One group was provided with a structured case study and answer sheet developed using the frame. The other group was provided with the same information in the case study in an unstructured form and a blank answer sheet.

Cross case and within case analyses (as recommended by Miles and Huberman, 1994) were used. The cross case analysis investigated between group differences. The two within case analyses allowed one to look at the responses of each group separately. In both analyses, the same coding categories were used to examine the data to ensure uniformity. If appropriate, matrices of responses were created using guidelines in Miles and Huberman (1994). Matrices were used to investigate response complexity. Multi-dimensional scalogram analyses (MSA) were used to examine the data for both groups across all categories. MSA's are scaling
techniques used to examine the structure of qualitative data. They allow the relationship between variables and the items themselves to be represented visually (Wilson, 1995). Mann Whitney U tests were also carried out.

11.2 Participants

Members of four different clinical psychology departments in the Thames Region agreed to take part. The total number of participants was 20. The potential sample size was 25 - 30. Their consent had previously been obtained. Two groups were used and participants were randomly assigned to either one. The only constraint on group membership was that they had to be members of a clinical psychology department in a learning difficulties service, including assistant psychologists and Chartered A and B Grade psychologists.

11.3 Information Provided to Participants

A case study (see Appendices One and Two) describing a crisis involving a person with learning difficulties was constructed. The case study was based on a real life clinical situation. An attempt was made to ensure that it included key features of such situations. Care was taken to ensure that the information provided was only a description of actions and not emotions as this was not felt to be appropriate.

Both case studies contained the same sentences. The sentences in the structured case study (Form B) were presented using the following headings:
pre-crisis, crisis and post-crisis. In each sub section, the actions of each actor (the client, professionals, managers and carers) were described. The sentences in the unstructured case study (Form A) were presented in a coherent manner but were ordered differently.

Two answer sheets were designed. Answer sheet A simply asked participants to list the actions they felt had to be taken. The instructions were: "Please list the actions that you feel need to be taken." Answer sheet A was used with Form A. Answer sheet B contained the same instructions, but participants were provided with a grid which used the same headings they had been provided with in the case study (Form B) (Diagram One).

**DIAGRAM ONE: GRID USED IN ANSWER SHEET B**

<table>
<thead>
<tr>
<th></th>
<th>Pre-Crisis</th>
<th>Crisis</th>
<th>Post-Crisis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Managers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Carers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Professionals</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Charles</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Group A was given Form A and Answer sheet A and Group B given Form B and Answer sheet B. Other possible combinations were not used as an informal pilot study (see Appendix Three) found that what was useful was the above combination. When participants were provided with an unstructured case study and a structured answer sheet, they tended to ignore the instructions and analyse the case study using the frame provided. The group
who was given the structured case study and structured answer sheet did not do this. Furthermore, being provided with the frame in the case study alone did not lead to participants making use of the cues provided, e.g. naming a person for an action.

All participants in the present study were given the same instructions and were tested in their place of work. Care was taken to ensure that they were unable to see the forms that other participants were given.

11.4 Procedure

Arrangements were made to visit each department at a convenient time. All departments were informed they would be taking part in research on crisis management. Participants were asked to sit in the same room, thus they were unable to view anybody else's work. They were given the following instructions:

"Thank you for participating in the study. Please read the case study and complete the answer sheet overleaf. When you have finished, please give the sheet back to us. Thank you."

The case studies and appropriate answer sheets were given out. Participants read the case study and completed the answer sheet. They were allowed to complete the sheet in their own time.
Once all the answer sheets had been returned, participants were informed of
the purpose of the study. They were given a full explanation and a two page
summary of relevant information, e.g. the path of a crisis and useful
strategies to adopt.

11.5 Method of Analysis

A coding system was devised. It was generated by the researcher in
discussion with a professional colleague. The categories were created by
using answer sheet B (structured form) and considering what types of actions
were likely. Responses were separated out into action phrases/sentences
before coding. The final coding system used is outlined below.

<table>
<thead>
<tr>
<th>Types of Action</th>
<th>Description of Action (including stage of crisis)</th>
<th>Was a person identified as responsible for the action? (Y/N)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Systems Change</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Training</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Support</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Monitoring</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventative Action</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Communication</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Care Plan</td>
<td></td>
<td></td>
</tr>
<tr>
<td>General</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assessment</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
TABLE ONE: CODING CATEGORIES USED IN ANALYSIS OF DATA.  
(Contd.)

<table>
<thead>
<tr>
<th>Intervention</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Structural Changes</td>
<td></td>
</tr>
<tr>
<td>Changes in Personnel</td>
<td></td>
</tr>
<tr>
<td>Changes in Whole Service</td>
<td></td>
</tr>
<tr>
<td>Client (Self Advocacy)</td>
<td></td>
</tr>
<tr>
<td>Neighbours/Police</td>
<td></td>
</tr>
<tr>
<td>Other, e.g. family contact</td>
<td></td>
</tr>
</tbody>
</table>

The definitions for each category were:

*Systems Change:*

Any action that involved a change within the framework of the system (described in the case study) related to staff/professional issues.

*Training:*

Any action that suggested the need for training.

*Support:*

Any statement that recommended support mechanisms, e.g. staff support groups were established/reinstated.
*Monitoring:
Any statement mentioning the introduction or reinstatement of monitoring systems.

*Communication:
Any recommendations that led to an improvement in communication, e.g. regular meetings re-instated.

*Preventative Action:
Any suggestion that there needed to be an analysis of the current situation so that preventative measures could be taken and/or the suggested implementation of crisis management strategies.

*Care Plan:
Any statement related to the use of a care plan or individual planning system.

*General:
Any recommendation that suggested the need to introduce/reinstate a care plan system.

*Assessment:
Any action that implied the need for assessment of the individual, e.g. psychological skills, mental health.
*Intervention:
Any action that suggested the need for continuing, re-commencing or starting a clinical intervention.

*Structural Intervention:
Any action that suggested that there needed to be a significant alteration to the organisational structure described.

*Changes in Personnel:
Any recommendation made to suggest changes in personnel, e.g. new staff.

*Changes in Service:
Recommendations leading to a large scale alteration in the environment, e.g. moving house.

*Client Self Advocacy:
Actions that led to the client advocating for himself.

*Neighbours/Police:
Actions that led to involvement with neighbours and/or police.

*Others:
Any other actions, e.g. a recommendation that the client's family was contacted.
The initial categories did not include a section for monitoring or for the client. However, during data analysis, it became clear these categories had to be included. A third column (Were desired outcomes noted?) was removed as very few responses mentioned this issue.

The categories were used to initially sort the data, both within and across cases. The responses for both groups were initially separated into action phrases or sentences. The coding system was then used to analyse each response per participant. For each response, a record was kept if a stage of a crisis was mentioned or a person was named as responsible for a given action.

Within each category (both within and cross case), partial conceptual matrices were developed. These were constructed using the frame in the structured answer sheet as this was the most suitable method. It was only possible to build up complex conceptual matrices for all responses from Group B (structured form and answer sheet) and a few from Group A. As recommended by Miles and Huberman (1994), attention was paid to any outliers in each group.

To find out whether there was a statistically significant difference between the groups across all coding categories and for each major coding category, the data was submitted to Mann-Whitney U Tests where appropriate.
A multi dimensional scalogram analysis (MSA) was carried out to look at both groups across all coding categories. MSA is a technique that is used to examine the structure of qualitative data. It enables the relationship between variables to be represented in visual summaries. Relationships between variables and items can also be represented (Wilson, 1995). MSA permits the researcher to look at the association between the variables she/he is investigating.

Data for both groups was transformed by marking whether or not a subject had responded in a given category. The scalograms produced were analysed to find out if there were any patterns that distinguished responses between groups across and within categories.

Reliability checks were carried out by cross checking with a professional colleague during the creation of the categories and then asking another chartered clinical psychologist to categorise the data. A reliability check was then carried out using Cohen’s Kappa (Miles and Huberman, 1994).

12.0 RESULTS

These are reported in the following order. First, it is vital to discuss whether the results are reliable before the data is considered. Secondly, it is necessary to investigate whether there were any significant differences between the groups (Hypothesis One). This was done by investigating whether, (a) there was an overall difference between the groups, (b) a
difference between the groups per coding category. Thirdly, there was an
analysis to find out if the categories of the frame had an effect on the
responses provided (Hypothesis Two). Fourthly, there is a discussion of one
participant's responses as the data indicated that she was an outlier.

12.1 Reliability

The completed answer sheets were scored by the researcher and another
chartered clinical psychologist. Cohen's Kappa was used to estimate the
degree of reliability.

A 78.35% degree of concordance was calculated. This is not as high as
expected. Miles and Huberman (1994) suggest that a figure of 90% should
be anticipated. The figure obtained may have been due to the fact it was
difficult to use some categories exclusively of others.

The greatest difficulty occurred with the communication and support
categories. Some answers seemed to fit into the communication (71.26%
degree of concordance) and support categories (66.13% degree of
concordance), whereas others seemed to fit into only one, e.g.
communication. This issue could have been resolved by collapsing these
categories. This was not done as it was felt that communication and support
were two distinct issues, although with some overlap, e.g. communication
was often used for providing support. This decision was reached by
discussion with the other rater. The original categories were used without alteration.

12.2 Hypothesis One

It is hypothesised that being provided with a frame will lead to participants thinking of more solutions (to the situation presented in the case study) than participants who are not.

12.2.1 Between Group Differences

Table Two (see below) lists the total number of responses per category for Group A and Group B. There was a significant overall difference between the groups ($U = 38$, $Na = 12$, $Nb = 13$, $p. <05$) (Mann-Whitney U Test). For Group B, the total number of responses/category varied from 13 - 72, for Group A, the range was 0 - 23. When the data was analysed by coding category, no significant differences were found. In general, Group B tended to provide more answers per category than Group A.

<table>
<thead>
<tr>
<th>TABLE TWO: TOTAL NUMBER OF RESPONSES/CATEGORY FOR GROUP A AND GROUP B.</th>
</tr>
</thead>
<tbody>
<tr>
<td>SYSTEM</td>
</tr>
<tr>
<td>------------</td>
</tr>
<tr>
<td>Training</td>
</tr>
<tr>
<td>Support</td>
</tr>
<tr>
<td>Monitor</td>
</tr>
<tr>
<td>Preventative Action</td>
</tr>
<tr>
<td>Communication</td>
</tr>
</tbody>
</table>

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A multi dimensional scalogram analysis was conducted on the data. It was carried out to examine the structure of the data and the relationship between the variables. As expected, a difference between the groups was found (Figure One). Responses for Group B (participants 1-10) were in a separate sector of the plot than responses from Group A (participants 11-20).
The multi dimensional scalogram analysis indicated that there were some differences between the categories, but these did not match the groupings of participants. The following categories tended to show the same pattern across the groups: Systems (Support), Systems (Monitor), Systems (Communication), Care Plan (Intervention), Structural (Service). The only category that separated the groups was Care Plan (Assessment). Both groups provided responses in most categories (except care plan/general).

Table Three presents responses of both groups in rank order. The largest number of responses were in the systems category and in the care plan/intervention category for both groups.
### TABLE THREE: TOTAL NUMBER OF RESPONSES OF EACH GROUP/PER CATEGORY IN RANK ORDER.

<table>
<thead>
<tr>
<th>RANK ORDER (1 = Highest Score)</th>
<th>FORM B (Proforma)</th>
<th>FORM A (Blank Answer Sheet)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>72</td>
<td>23</td>
</tr>
<tr>
<td></td>
<td>(Care Plan, Intervention)</td>
<td>(System, Support)</td>
</tr>
<tr>
<td>2</td>
<td>64</td>
<td>22</td>
</tr>
<tr>
<td></td>
<td>(System, Communication)</td>
<td>(Care Plan, Intervention)</td>
</tr>
<tr>
<td>3</td>
<td>58</td>
<td>19</td>
</tr>
<tr>
<td></td>
<td>(System, Support)</td>
<td>(System, Training)</td>
</tr>
<tr>
<td>4</td>
<td>54</td>
<td>17</td>
</tr>
<tr>
<td></td>
<td>(System, Training)</td>
<td>(System, Communication)</td>
</tr>
<tr>
<td>5</td>
<td>47</td>
<td>17</td>
</tr>
<tr>
<td></td>
<td>(System, Monitor)</td>
<td>(Structural Changes, Personnel)</td>
</tr>
<tr>
<td>6</td>
<td>28</td>
<td>13</td>
</tr>
<tr>
<td></td>
<td>(Care Plan, General)</td>
<td>(System, Monitor)</td>
</tr>
<tr>
<td>7</td>
<td>24</td>
<td>11</td>
</tr>
<tr>
<td></td>
<td>(System, Preventative)</td>
<td>(Care Plan, Assessment)</td>
</tr>
<tr>
<td>8</td>
<td>23</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>(Structural Change, Personnel)</td>
<td>(System, Preventative Action)</td>
</tr>
<tr>
<td>9</td>
<td>19</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>(Client)</td>
<td>(Structural Changes, Service)</td>
</tr>
<tr>
<td>10</td>
<td>16</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>(Care Plan, Assessment)</td>
<td>(Client)</td>
</tr>
<tr>
<td>11</td>
<td>13</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>(Structural Change/Service)</td>
<td>(Neighbours/Police)</td>
</tr>
<tr>
<td>12</td>
<td>13</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>(Neighbours/Police)</td>
<td>(Others)</td>
</tr>
<tr>
<td>13</td>
<td>11</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>(Others)</td>
<td>(Care Plan, General)</td>
</tr>
</tbody>
</table>
Being provided with a structure/frame did have an effect on the responses/decisions made as predicted, i.e. the group who was provided with a structured frame produced more responses. None of the participants in Group B used sentences, whereas most of the participants in Group A (94%) used sentences for most of their answers and tended to provide much detail about one aspect in particular. For instance, in the Systems Change/Support category, an example of a response from Group B was, “have supervision/appraisal,” whereas a Group A response was, “offer staff support within working environment on a regular basis.”

The coding system may have also inadvertently favoured Group B as a phrase constituted one answer and the structured answer sheet encouraged participants to use phrases to complete the grid. Therefore, the difference in the style of responses, i.e. using sentences (Group A) or phrases (Group B) may have been exaggerated by the coding system. This was quite likely, given the different structures of the answer sheets.

All of the responses were congruent with clinical experience, the exception being one participant who said that Charles (client) should enjoy himself! This was the decision made by both raters. Each answer was very similar to decisions that both raters had either made or had seen made in such situations.
12.3 **Hypothesis Two**

It is hypothesised that participants using the frame will produce more responses within the categories than those participants who do not use the frame. The categories are:

(a) a named person for each action,
(b) the separation into pre-crisis, crisis, post-crisis, and
(c) the combination of the two

12.3.1 **Suggesting a Named Person for an Action**

All the participants in Group B nominated a responsible person for every action. This may have been because the grid required them to do so. Table Four in Appendix Four provides detailed information on the responses provided by Group B per coding category.

Very few participants in Group A tended to nominate a responsible person for an action. Table Five outlines those participants who did do so. Since participants from the same department were randomly allocated to groups, differences between the groups could not be attributed to place of employment or other individual differences, e.g. level of experience.

In both groups, the named personnel were those that would be expected in the situation described. A few participants also suggested that there be contact with outside organisations, e.g. police.
TABLE FIVE: RESPONSES PER CATEGORY FOR GROUP (A) WITH RESPECT TO NAMED PERSONS RESPONSIBLE FOR ACTION.

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>NAMED PERSON RESPONSIBLE FOR ACTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>SYSTEMS CHANGE</td>
<td></td>
</tr>
<tr>
<td>Training</td>
<td>One person stated manager responsible for training.</td>
</tr>
<tr>
<td>Support</td>
<td>One person said that the psychologist should be responsible.</td>
</tr>
<tr>
<td></td>
<td>Three stated that the manager should provide ongoing support.</td>
</tr>
<tr>
<td>Monitor</td>
<td>No suggestions made.</td>
</tr>
<tr>
<td>Preventative Action</td>
<td>Multidisciplinary team seen as responsible for risk assessment by one person.</td>
</tr>
<tr>
<td>Communication</td>
<td>No suggestions made.</td>
</tr>
<tr>
<td>CARE PLAN</td>
<td></td>
</tr>
<tr>
<td>General</td>
<td>No suggestions made.</td>
</tr>
<tr>
<td>Assessment</td>
<td>General comments only, e.g. “develop a psychological formulation.”</td>
</tr>
<tr>
<td>Intervention</td>
<td>No suggestions made.</td>
</tr>
<tr>
<td>STRUCTURAL CHANGES</td>
<td></td>
</tr>
<tr>
<td>Personnel</td>
<td>Key worker named by two participants.</td>
</tr>
<tr>
<td></td>
<td>One person suggested that an experienced psychologist and social worker be employed.</td>
</tr>
<tr>
<td></td>
<td>One person suggested that a psychiatrist become involved, but did not say who should contact the psychiatrist.</td>
</tr>
<tr>
<td>Service</td>
<td>No suggestions made.</td>
</tr>
</tbody>
</table>
TABLE FIVE: RESPONSES PER CATEGORY FOR GROUP (A) WITH RESPECT TO NAMED PERSONS RESPONSIBLE FOR ACTION. (Contd.)

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>CLIENT</th>
<th>NEIGHBOURS/POLICE</th>
<th>OTHERS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No suggestions made.</td>
<td>No suggestions made.</td>
<td>No suggestions made.</td>
</tr>
</tbody>
</table>

12.3.2 A Discussion of Differences in Named Person Responsible For An Action/Category for Group B (Structured)

Table Six indicates that there were some differences within this group. These are discussed below.

TABLE SIX: DIFFERENCES IN NAMED PERSON RESPONSIBLE FOR ACTION/CATEGORY FOR GROUP B (STRUCTURED).

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>NAMED</th>
<th>PROFESSIONAL</th>
<th>Carer</th>
<th>Client</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Manager</td>
<td>Professional</td>
<td>Carer</td>
<td>Client</td>
</tr>
<tr>
<td>SYSTEMS CHANGE</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Training</td>
<td>18</td>
<td>17</td>
<td>10</td>
<td>9</td>
</tr>
<tr>
<td>Support</td>
<td>19</td>
<td>18</td>
<td>18</td>
<td>3</td>
</tr>
<tr>
<td>Monitor</td>
<td>17</td>
<td>14</td>
<td>13</td>
<td>3</td>
</tr>
<tr>
<td>Preventative Action</td>
<td>7</td>
<td>8</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>Communication</td>
<td>18</td>
<td>18</td>
<td>17</td>
<td>11</td>
</tr>
<tr>
<td>CARE PLAN</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>General</td>
<td>12</td>
<td>4</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Assessment</td>
<td>0</td>
<td>16</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Intervention</td>
<td>14</td>
<td>23</td>
<td>22</td>
<td>13</td>
</tr>
</tbody>
</table>
TABLE SIX: DIFFERENCES IN NAMED PERSON RESPONSIBLE FOR ACTION/CATEGORY FOR GROUP B (STRUCTURED).
(Contd.)

<table>
<thead>
<tr>
<th>STRUCTURAL CHANGES</th>
<th>Pre-Crisis</th>
<th>Crisis</th>
<th>Post-Crisis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personnel</td>
<td>11</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Service</td>
<td>13</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>CLIENT</td>
<td>0</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>NEIGHBOURS/ POLICE</td>
<td>7</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>OTHERS</td>
<td>6</td>
<td>5</td>
<td>0</td>
</tr>
</tbody>
</table>

Visual inspection of the data indicated that, in each category, there was a wide range of possible responses. There was also a wide range of individual differences in this area but this fact was obscured by collating the data. Therefore, an attempt was made to look at individual responses to investigate whether collating data had concealed individual differences (Table Seven).

TABLE SEVEN: INDIVIDUAL RESPONSES PER CATEGORY FOR GROUP B.

TABLE SEVEN A: Individual responses about systems change made by participants.

TRAINING SUB-CATEGORY.

<table>
<thead>
<tr>
<th>Named Person</th>
<th>Pre-Crisis</th>
<th>Crisis</th>
<th>Post-Crisis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manager</td>
<td>Organise training for care staff.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Professional</td>
<td>Do on-site training.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
TABLE SEVEN A: Individual responses about systems change made by participants. (Contd.)

<table>
<thead>
<tr>
<th>Role</th>
<th>Pre-Crisis</th>
<th>Crisis</th>
<th>Post-Crisis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carer</td>
<td>Attend training workshops, e.g.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>normalisation, independence.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Client</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Attend training workshops</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>organised by management.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

TABLE SEVEN B: Responses that did not fit into any of the above categories.

SYSTEMS CATEGORY.

<table>
<thead>
<tr>
<th>Named Person</th>
<th>Pre-Crisis</th>
<th>Crisis</th>
<th>Post-Crisis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manager</td>
<td>Train staff prior to opening.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Professional</td>
<td>Request support and training.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Carer</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Client</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

OTHERS CATEGORY.

<table>
<thead>
<tr>
<th>Named Person</th>
<th>Pre-Crisis</th>
<th>Crisis</th>
<th>Post-Crisis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manager</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Professional</td>
<td>Contact family</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Client</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
OTHERS CATEGORY. (Contd.)

<table>
<thead>
<tr>
<th>Carer</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Client</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table Seven shows matrices of individual responses made by two participants in the systems category (most responses provided by the group) and the others category (least responses provided by the group). Matrices for the other categories are provided in Appendix Five. An attempt was made to use responses that reflected the diversity found. The tendency to be very individualistic is obvious. The exception was the Systems Change category that itemised small scale systems changes. All the actions were seen as the responsibility of the manager.

Actions either lacked detail, e.g. "to find a more suitable location for Charles, listening to why he is unhappy" or were very descriptive as shown in Table Seven A. The exceptions were categories that described actions related to Charles, neighbours, police and others. Here, answers tended to be brief.

There was some variation in terms of who was given certain responsibilities, e.g. constructing recording sheets, and at which point in the crisis a certain action was recommended. For instance, one person suggested that monitoring took place at the pre and post-crisis stage, whereas others said that it should have occurred at either the pre or crisis stage. This point is elaborated in the next section.
In the Care Plan/Assessment category, it was always a professional who was given the responsibility for the action (Table Seven (C) in Appendix Five). However, a range of professionals was named. These included psychologists (not surprisingly), psychiatrists and mental health specialists. This was not so for the Care Plan/Intervention sub-category. This is indicative of the fact that while an intervention may be designed by professionals, it is often carried out by others, e.g. carers.

Therefore, being provided with a cue for naming responsible people for actions was effective. Despite a large variation in the types of responses, participants in Group B always named a person for each action. This was probably due to the frame on the answer sheet. Some participants in Group A also named persons as responsible for some actions.

12.3.3 The Influence of the Crisis Category on Participants' Responses

It was not possible to compare both groups across the categories as very few of the participants in Group A considered issues relating to crises. The exceptions to this were responses that could be said to be directly related to crisis management strategies, i.e. preventative actions (eight responses in total from Group A). There was no direct reference to the word crisis. In contrast, the participants in Group B did separate out the stages (Appendix Four). This was because their responses were cued by the frame of the answer sheet, as anticipated.
However, there was a great variety in the way in which the category of crisis was used by itself, and with the named person category. The only sub-categories where participants showed a preference for one category of crisis over another are depicted in Table Eight.

TABLE EIGHT: RESPONSES BY GROUP B (STRUCTURED) WHERE THERE WAS A DIFFERENCE IN TERMS OF WHICH ASPECT OF THE CRISIS CATEGORY WAS IDENTIFIED.

<table>
<thead>
<tr>
<th>Category</th>
<th>Pre-Crisis</th>
<th>Crisis</th>
<th>Post-Crisis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Systems Change (Preventative Action)</td>
<td>0</td>
<td>0</td>
<td>24</td>
</tr>
<tr>
<td>Care Plan (General)</td>
<td>23</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>Structural Changes (Service)</td>
<td>0</td>
<td>7</td>
<td>6</td>
</tr>
<tr>
<td>Client</td>
<td>8</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Others</td>
<td>11</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Collating responses may have obscured the fact that individuals were making use of the category, as expected. Closer inspection of the data did not support this. For example, there was a tendency for subjects to use each category in a very individualistic way. The exception to this, was that all responses were listed in the post-crisis section for the Systems Change/Preventative Action. This may have been expected as managers tend to be seen as responsible for actions that are often carried out in the post-crisis stage.
Alternatively, as the instructions did not include a definition of the stages of a crisis, some participants may have decided to answer as though they had to deal with a "live" crisis, whereas others may have behaved as though they had to respond with actions to prevent such a situation arising. Visual inspection of the data did not support either option. There were very few responses that did not deal with the situation as described in the case study, e.g. "train staff prior to opening." "Re-settlement should have included familiar staff."

The requirement that actions be separated into stages of a crisis was not helpful. Participants may not have had enough knowledge about crises to enable them to use the category meaningfully.

12.3.4 The Usefulness of the Whole Frame (Answer Sheet) for Participants in Group B

The results did not suggest many patterns in responses that implied that participants found the combination of the named person and the crisis category helpful. The exception to this was the Care Plan/Assessment category, where all actions were deemed to be the responsibility of the professional, and the Systems Change/Preventative Action category as noted above.
12.4 **Outliers**

One participant in Group A constructed her own frame for recording her answers. Her answers were written under the following headings (categories):

- Individual work with Charles (client)
- Management of his behaviour
- Staff support and supervision
- Staff training
- Management of the home
- Multidisciplinary team

These categories enabled her to produce more detailed answers than other participants in Group A. Her responses were similar to those of Group B (see below for examples).

**SYSTEMS CHANGE CATEGORY**

**Training Sub-Category**

"Staff training specifically related to understanding Chs difficulties (do staff have a basic understanding about nature or psychiatric problems?) Staff training in managing Chs problem behr - understanding and guidelines. Training in dealing with their own responses to aggressive behaviour. Training in dealing with crisis situations."
Support Sub-Category

“Set up weekly staff meetings.”

“Set up a staff support group to allow staff to express their feelings and concerns in a safe environment (run by an experienced person not in a managerial position.)

“Increase support given to Charles in all he does and support to the staff that work with him.”

The cues within the frame guided the participant when thinking of answers. For instance, the cues she provided herself with seem to have influenced the actions she suggested. For example, she did not include a cue for crisis, and therefore none of her answers mentioned this issue.

13.0 DISCUSSION

13.1 General Issues

The aim of the study was to find out if being provided with a frame during the information gathering and decision making stages would enable participants to generate more and varied answers. Participants who were given a structured case study and answer sheet produced more answers.

Both groups provided answers in most of the categories. The results of the scalogram analysis indicated that, while there was an overall difference between the groups, there were some categories where both groups’ answers lay in the same sector, e.g. support, monitor, communication, intervention,
service categories. This indicated that these categories were being used in
the same way by both groups. This lent support to the notion that there was
a quantitative difference between the groups.

Closer inspection of responses suggests that there was also a qualitative
difference, i.e. style that may have augmented the quantitative difference.
Participants who were not given a frame tended to use sentences and to
describe one action in much detail, whereas those who had access to the
frame tended to use phrases and sometimes suggest several actions. The
structured answer sheet could have encouraged subjects to use short
phrases because there was less space per category. The unstructured
answer sheet may have encouraged participants to use sentences as it
provided more space for each answer. These differences were then
exaggerated by the coding and scoring systems which favoured those who
responded using short phrases.

Visual inspection indicated that participants in Group B suggested a named
person for each action, whereas very few participants in Group A did so. The
frame appears to have cued participants in Group B to include a named
person for an action. This suggests that even if participants knew they
should name people, they may not have done so unless they were provided
with a cue. However, some participants in Group A also named persons
responsible for some actions. These participants may have been using their
own frame.
The crisis category did not seem to help in any significant way. Participants may have been unfamiliar with the notion that a crisis could be separated into stages. This was compounded by the fact that they were not given any explanation of the answer sheet.

The cues provided by the frame were not as helpful to the participants as expected. As noted above, the crisis category was not used as effectively as it could have been. The implication of this is that it is important to choose cues that participants will understand.

All but one of the responses were typical of the solutions for crisis situations. Participants in both groups may therefore have already had a frame for actions to take in crises that they were using. They may have been utilising a combination of professional expertise, knowledge and intuition as suggested by March and Heath (1994). Those who were provided with a visual frame were given extra cues to guide their decision making. The provision of a frame influenced participants to widen their options. Providing professionals with a frame (strategy for analysis), may also have helped them to decrease the negative effects of factors affecting decision making, e.g. stress, personal decision making, style, age, prior experience, awareness of organisational rules and available frames for use in the situation (Robbins, 1996).

The research carried out also indicated that the type of clinical decision making that clinical psychologists carry out in a crisis situation is typical of
clinical decision making as explained by Nezu and Nezu (1994). The reason being that all but one of the answers provided by the participants were deemed to be typical of clinical decision making in such situations. However, it should be remembered, that the situation that the psychologists were in was an artificial one.

The work reported here was an attempt to test the frame that was devised to aid clinical decision making in crisis situations. Therefore, unlike the frames proposed by Nezu and Nezu (1994) and Sturmey (1995), there was an attempt to investigate whether the frame was effective. The results, however indicate that further work is required.

13.2 Methodological Issues

The design used in this study has some limitations. The degree of reliability reported was not as great as expected. The coding system needs to be refined. This could be done by asking a group of professionals to generate a set of categories and agree a process for resolving disagreements. The system devised could then be compared with the one used in this study.

There was an implication in the design that the unstructured answer sheet was not a frame. It may well have been seen as a frame by some of the participants. The results did not allow one to reach any conclusions about this. It was a possibility that should have been considered.
All of the participants were colleagues. This may have affected the way they responded. For example, they may have produced responses that were socially desirable. It would have been difficult to control for this as clinical psychologists often know each other.

There did not seem to be a major difference in the time taken to read the case studies and complete the answer sheets. The time taken varied from twenty minutes to approximately thirty-five minutes across both groups. Within each group, some subjects responded quickly whereas others tended to adopt a more measured approach. One participant in Group B only partially completed the form. Her response was included as she was aware that there was no time limit and she was not the last person to hand in her form.

Despite attempts to ensure that participants could not see each other's work, one person who was in Group A had sight of Form B. Her answer sheet was not used. The brevity of the instructions may have affected the results. There was no attempt to explain the structured answer sheet. This was done deliberately to try to ensure that both groups were given the same test conditions. In retrospect, this may have lead to some confusion for those who had the structured answer sheet. They may have been unclear about certain aspects, e.g. the difference between the stages of a crisis. The results therefore indicated that those who are going to use a frame need to be taught how to utilise it.
One person in Group A wrote her answers down using categories she had devised herself (as noted earlier). These were: individual work with client, staff support and supervision, management of the home and multidisciplinary team. Her answers were coded as it did not seem that she had had sight of the structured answer sheet.

The data was not analysed for individual differences such as sex of the participants for a number of reasons, for example small sample size (only two of the twenty participants were male). Data on length of clinical experience was not collected and therefore an analysis of this factor was not carried out.

13.3 Future Research

The experimental situation that participants were in was artificial. The responses they provided may not be the ones that they would think of in a real life situation. It may be useful to try to find a way of investigating this. For example, it may be possible to train professionals in the use of frames and then ask them to describe (in detail) how they used them.

Another possibility may be to develop a set of general guidelines for analysing crises that participants are trained to use. They could then be given the opportunity to develop their own frames. This would be congruent with the suggestion made by March and Heath (1994) that training is a way of teaching people about frames and rules of organisations.
The frame chosen may not have been the most suitable, i.e. created using Meyers and Holusha's (1986) model. This needs to be investigated further by designing other frames and comparing and contrasting their usefulness. For instance, it may be worth investigating whether the coding system is a useful frame. It is explicit in outlining the range of possible actions needed and may be helpful in reminding professionals of the many types of actions they could take. It would also be interesting to investigate whether other techniques such as thinking aloud could also be helpful. Qualitative methods could be used as they seem to be extremely useful.

Another limitation of the work is that participants' level of experience varied greatly. An attempt was made to control for this through randomisation. It would be interesting to investigate whether experience does have an effect. Equally, it is possible that factors such as professional background, type of employing organisation, and type of post-qualification training will also have an effect. It would be interesting to conduct further research in this area, e.g. by comparing psychologists with psychiatrists.

The research described above was carried out despite the fact that the model of clinical decision making in crises developed in the introduction was not directly tested. In hindsight, it may have been more useful to study this before testing to see if a frame was helpful, especially since the model relied heavily on Nezu and Nezu's work. That is, it is important to explore the frames and decision making processes that professionals (in learning
difficulties services) use in crisis situations, e.g. as used by the outlier. One way of doing so would be to use the grounded theory approach (Henwood and Pidgeon, 1992, 1994) and observe decision making during crises. Using this and other approaches would also enable one to test some of the assumptions of the model. For example, whether the clinical decision making process is affected by some of the factors that operate in crises, e.g. stress, cognitive rigidity and whether there is an interaction between these factors and the stage of a crisis at which clinical decisions are made.

The models described by Sturmey (1995) and Nezu and Nezu (1994) as well as the one developed here, all can be criticised because they have not been created by first investigating how clinical psychologists make decisions. Therefore, it is important that the research outlined in the preceding paragraph is conducted.
14.0 BIBLIOGRAPHY


Nezu, A. M. and Nezu, C. M. (1994). *Outpatient Psychotherapy for Adults with Mental Retardation and Concomitant Psychopathology: Research and


15.0 APPENDICES

15.1 Appendix One

CASE STUDY A AND ANSWER SHEET A

Name: Charles Smith

Age: 32 years

Address: Resident in flat

The situation became markedly worse as the neighbours began to complain about the noise that Charles made at night. Staff had to cope with people shouting and ringing the doorbell late at night. Each staff member had a different way of dealing with the situation; some would shout back, others would apologise. Charles became the centre of attention in the neighbourhood, he was covertly encouraged by some staff members to swear at locals and to become violent. Neighbours began calling the police on a regular basis.

He had recently moved to a flat where he had some staff support but did not have a job or means of occupying himself during the day. He does not have any social networks and very little control in his own life. He only used the community for shopping, etc. Senior managers called an emergency meeting at which the decision was taken to remove Charles. After the main crisis, Charles was moved to another flat two months later.
Charles is a man in his early thirties who has spent a significant part of his life in a long stay institution for people with learning difficulties outside London. He had a history of being the focus for crisis in the services he lived in. His mother and sister lived in the area but neither party were aware of each other’s existence. He has recently moved back to his original district. He acquired a reputation within the service and rumours spread about his behaviour, e.g. climbing out of windows and attempting to throw himself out. Some of the crises were precipitated by services finding it difficult to cope with his behaviours: obsessions with touching people's necks and threatening them, when under pressure he began to self injure, e.g. putting his hand through glass and biting his arms. The management of the staff team was changed and they were asked if they wanted to work with him (they did). The psychologist received and got support from a more senior colleague.

Charles continued to express his unhappiness. Regular staff meetings were reinstated. Staff became more increasingly wary of him and resorted to locking themselves into rooms that he could not get into. Senior managers were aware of his problems but had employed an inexperienced house manager to deal with the setting up of the service including recruitment of staff. Staff also requested that they were not on duty on their own with him. The frequency of emergency meetings and phone calls to professionals increased. Professionals did not visit the house as much as they were ridiculed by the locals and staff. Psychology, psychiatry and community nurses were involved. No care manager had been assigned, the case had
been allocated to the duty system. There were no regular meetings apart from emergency meetings. The psychologist was trying to set up staff training but managers were finding it difficult to release the team.

The psychologist was someone who was relatively inexperienced. Different professionals were given conflicting information about the same incident. As a result of the lack of managerial support, staff began to form their own alliances within the team spending time together outside of working hours. This resulted in conflicts within the team.

He had enjoyed buying furniture and moving into his own flat. Initially he got on well with some of the staff. His behaviour became increasingly worse as time went on. The house manager had no training in management and supervisory skills. The responsibility for monitoring the effectiveness of the service was delegated to a relatively low level. Staff were not offered any training in dealing with crisis and emergencies. Professional back up was requested but not used to good effect.

**ANSWER SHEET A**

Please list the actions you feel need to be taken.

PLEASE NOTE THAT THIS ANSWER SHEET WAS EXPANDED TO A WHOLE PAGE IN THE STUDY
15.2 **Appendix Two**

**CASE STUDY B AND ANSWER SHEET B**

Name: Charles Smith  
Age: 32 years  
Address: Resident in flat

**Client Background**

Charles is a man in his early thirties who has spent a significant part of his life in a long stay institution for people with learning difficulties outside London. He has recently moved back to his original district. His mother and sister lived in the area but neither party were aware of each other's existence. He had a history of being the focus for crisis in the services he lived in. Some of the crises were precipitated by services finding it difficult to cope with his behaviours: obsessions with touching people's necks and threatening them, when under pressure he began to self injure, e.g. putting his hand through glass and biting his arms. He acquired a reputation within the service and rumours spread about his behaviour, e.g. climbing out of windows and attempting to throw himself out.

**Pre-Crisis**

He had recently moved to a flat where he had some staff support but did not have a job or means of occupying himself during the day. He does not have any social networks and very little control in his own life. He had enjoyed buying furniture and moving into his own flat. Initially he got on well with
some of the staff. He only used the community for shopping, etc. His behaviour became increasingly worse as time went on.

**Manager**

Senior managers were aware of his problems but had employed an inexperienced house manager to deal with the setting up of the service including recruitment of staff. The house manager had no training in management and supervisory skills. The responsibility for monitoring the effectiveness of the service was delegated to a relatively low level. Staff were not offered any training in dealing with crisis and emergencies. Professional back up was requested but not used to good effect.

**Carers**

Staff became more increasingly wary of him and resorted to locking themselves into rooms that he could not get into. Staff also requested that they were not on duty on their own with him. The frequency of emergency meetings and phone calls to professionals increased.

Different professionals were given conflicting information about the same incident. As a result of the lack of managerial support, staff began to form their own alliances within the team spending time together outside of working hours. This resulted in conflicts within the team.
Professionals

Psychology, psychiatry and community nurses were involved. No care manager had been assigned, the case had been allocated to the duty system. There were no regular meetings apart from emergency meetings. The psychologist was trying to set up staff training but managers were finding it difficult to release the team. The psychologist was someone who was relatively inexperienced.

The Crisis

Charles.

The situation became markedly worse as the neighbours began to complain about the noise that Charles made at night. Staff had to cope with people shouting and ringing the doorbell late at night.

Carers

Each staff member had a different way of dealing with the situation; some would shout back; others would apologise. Charles became the centre of attention in the neighbourhood, he was covertly encouraged by some staff members to swear at locals and to become violent.

Professionals

The frequency of emergency meetings and phone calls to professionals increased. Professionals did not visit the house as much as they were
ridiculed by the locals and staff. Neighbours began calling the police on a regular basis.

Managers

Senior managers called an emergency meeting at which the decision was taken to remove Charles.

Post-Crisis

After the main crisis, Charles was moved to another flat two months later. The management of the staff team was changed and the team were asked if they wanted to work with him (they did). The psychologist received and got support from a more senior colleague. Charles continued to express his unhappiness. Regular staff meetings were reinstated.

**ANSWER SHEET B**

Please list the actions you feel need to be taken.

<table>
<thead>
<tr>
<th></th>
<th>Pre-Crisis</th>
<th>Crisis</th>
<th>Post-Crisis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Managers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Carers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Professionals</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Charles</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

PLEASE NOTE THAT THIS ANSWER SHEET WAS EXPANDED TO A WHOLE PAGE IN THE STUDY.
PILOT STUDY

The aim of the pilot study was to find the most effective way of conducting the study. Case Study A and Answer Sheet A (unstructured) and Case Study B and Answer Sheet B were used in the following combinations:

- Case Study A with Answer Sheet A
- Case Study A with Answer Sheet B
- Case Study B with Answer Sheet B
- Case Study B with Answer Sheet A

They were given to different groups of professionals working on community teams in a learning difficulties service. Participants were asked to complete the answer sheets and to comment on how easy/difficult they found it to complete the forms. Combinations of the structured (either case study or answer sheet) and unstructured (case study or answer sheet) format led to a degree of confusion among participants that affected their responses.

Those who received the structured case study and unstructured answer sheet tended not to use the cues mentioned in the case study, e.g. named person for action. Those who received the unstructured case study and structured answer sheet tended to simply analyse the case study.
TABLE FOUR: NUMBER OF NAMED PERSONS PER ACTION PER STAGE OF CRISIS IN EACH CODING CATEGORY (GROUP B).

### TABLE FOUR A: SYSTEM CHANGE CATEGORY.

**TRAINING SUB-CATEGORY.**

<table>
<thead>
<tr>
<th>Named Person</th>
<th>Pre-Crisis</th>
<th>Crisis</th>
<th>Post-Crisis</th>
</tr>
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<tbody>
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<td>Professional</td>
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<td>3</td>
<td>5</td>
</tr>
<tr>
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<td>7</td>
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</tr>
<tr>
<td>Client</td>
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<td>4</td>
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**SUPPORT SUB-CATEGORY.**

<table>
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<th>Post-Crisis</th>
</tr>
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<tbody>
<tr>
<td>Manager</td>
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<td>Professional</td>
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<td>7</td>
<td>4</td>
</tr>
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</tr>
<tr>
<td>Client</td>
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**MONITOR SUB-CATEGORY.**

<table>
<thead>
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<th>Post-Crisis</th>
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<tr>
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<tr>
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**PREVENTATIVE ACTIONS SUB-CATEGORY.**

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<tbody>
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<td>Carer</td>
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**COMMUNICATIONS SUB-CATEGORY.**

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**TABLE FOUR B: CARE PLAN CATEGORY. GENERAL SUB-CATEGORY.**

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**ASSESSMENT SUB-CATEGORY.**

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### INTERVENTION SUB-CATEGORY.

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<tr>
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### TABLE FOUR C: STRUCTURAL CHANGES CATEGORY. PERSONNEL SUB-CATEGORY.

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<tr>
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### SERVICE SUB-CATEGORY.

<table>
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<th>Post-Crisis</th>
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<td>6</td>
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<tr>
<td>Professional</td>
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<tr>
<td>Client</td>
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### TABLE FOUR D: CLIENT CATEGORY.

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<th>Post-Crisis</th>
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<tr>
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<td>Carer</td>
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<tr>
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### TABLE FOUR E: NEIGHBOURS/POLICE CATEGORY.

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<td>Professional</td>
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</tr>
<tr>
<td>Carer</td>
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<td>Client</td>
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### TABLE FOUR F: OTHERS CATEGORY.

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<th>Post-Crisis</th>
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<tr>
<td>Professional</td>
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</tbody>
</table>
TABLE SEVEN: INDIVIDUAL RESPONSES PER CATEGORY FOR GROUP B.

TABLE SEVEN A: Individual responses about systems change made by participants.

**TRAINING SUB-CATEGORY.**

<table>
<thead>
<tr>
<th>Named Person</th>
<th>Pre-Crisis</th>
<th>Crisis</th>
<th>Post-Crisis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manager</td>
<td>Organise training for care staff</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Professional</td>
<td>Do on-site training</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Carer</td>
<td>Attend training workshops, e.g. normalisation, independence</td>
<td></td>
<td>Attend training workshops organised by management.</td>
</tr>
<tr>
<td>Client</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Named Person</th>
<th>Pre-Crisis</th>
<th>Crisis</th>
<th>Post-Crisis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manager</td>
<td>Train staff prior to opening</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Professional</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Carer</td>
<td>Request support and training</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Client</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### MONITOR SUB-CATEGORY.

<table>
<thead>
<tr>
<th>Named Person</th>
<th>Pre-Crisis</th>
<th>Crisis</th>
<th>Post-Crisis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manager</td>
<td>Set up consistent and higher level monitoring. Monitor services.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Professional</td>
<td>Visit house, gain respect of house staff and locals. Hold regular meetings of all staff for communication and action.</td>
<td></td>
<td>Continue monitoring Charles (client).</td>
</tr>
<tr>
<td>Carer</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Client</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### PREVENTATIVE ACTIONS SUB-CATEGORY.

<table>
<thead>
<tr>
<th>Named Person</th>
<th>Pre-Crisis</th>
<th>Crisis</th>
<th>Post-Crisis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manager</td>
<td></td>
<td></td>
<td>Learn from errors in post analysis of crisis. Identify shortfalls of service.</td>
</tr>
<tr>
<td>Professional</td>
<td></td>
<td></td>
<td>Carry out post analysis to learn from situation.</td>
</tr>
<tr>
<td>Carer</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Client</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### COMMUNICATIONS SUB-CATEGORY.

<table>
<thead>
<tr>
<th>Named Person</th>
<th>Pre-Crisis</th>
<th>Crisis</th>
<th>Post-Crisis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manager</td>
<td>Ensure adequate system for top-down communication</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Professional</td>
<td>Improve family contact</td>
<td></td>
<td>Provide written report identifying shortfalls and problems.</td>
</tr>
<tr>
<td>Carer</td>
<td>Call meetings of professionals. Alert social worker to situation.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Client</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### TABLE SEVEN B: Responses that did not fit into any of the above categories.

### OTHERS CATEGORY.

<table>
<thead>
<tr>
<th>Named Person</th>
<th>Pre-Crisis</th>
<th>Crisis</th>
<th>Post-Crisis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manager</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Professional</td>
<td>Contact family. Find out support networks (family).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Carer</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Client</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### TABLE SEVEN C: Responses made in Care Plan/Assessment Category.

**CARE PLAN/ASSESSMENT SUB-CATEGORY.**

<table>
<thead>
<tr>
<th>Named Person</th>
<th>Pre-Crisis</th>
<th>Crisis</th>
<th>Post-Crisis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manager</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Carer</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Client</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### TABLE SEVEN D: Responses related to care planning, assessment and intervention.

<table>
<thead>
<tr>
<th>Named Person</th>
<th>Pre-Crisis</th>
<th>Crisis</th>
<th>Post-Crisis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manager</td>
<td>Ensure complete care plan including work, leisure and self help. Meeting with multidisciplinary team to set up care plan, risk assessment and emergency situations.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Professional</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Carer</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Client</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### ASSESSMENT SUB-CATEGORY.

<table>
<thead>
<tr>
<th>Named Person</th>
<th>Pre-Crisis</th>
<th>Crisis</th>
<th>Post-Crisis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manager</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Carer</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Client</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### INTERVENTION SUB-CATEGORY.

<table>
<thead>
<tr>
<th>Named Person</th>
<th>Pre-Crisis</th>
<th>Crisis</th>
<th>Post-Crisis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manager</td>
<td>Guidelines for dealing with difficult behaviour. Set up structured timetable. Help carer to avoid having unfilled time. Psychologist to set up new guidelines.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Professional</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Carer</td>
<td>Consistency of approach, call for aid sooner</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Client</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### STRUCTURAL CHANGES: Changes in Personnel.

<table>
<thead>
<tr>
<th>Named Person</th>
<th>Pre-Crisis</th>
<th>Crisis</th>
<th>Post-Crisis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manager</td>
<td>Employ experienced manager</td>
<td>Move in more experienced staff to manage crisis</td>
<td></td>
</tr>
<tr>
<td>Professional</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Carer</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Client</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### SERVICE SUB-CATEGORY.

<table>
<thead>
<tr>
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<th>Pre-Crisis</th>
<th>Crisis</th>
<th>Post-Crisis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manager</td>
<td></td>
<td>Plan to cope with Charles; remove him.</td>
<td>Re-organise management and staff team. To find a more suitable location for Charles.</td>
</tr>
<tr>
<td>Professional</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Carer</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Client</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### CLIENT CATEGORY.

<table>
<thead>
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<th>Crisis</th>
<th>Post-Crisis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manager</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Professional</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Carer</td>
<td>Talk to Charles. Someone to work with him.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Client</td>
<td>Accept staff support in increasing social networks</td>
<td>Try to make others aware of feelings, either staff or professionals (psychologists, psychiatrists).</td>
<td></td>
</tr>
</tbody>
</table>
### ACTIONS RELATED TO NEIGHBOURS/POLICE.

<table>
<thead>
<tr>
<th>Named Person</th>
<th>Pre-Crisis</th>
<th>Crisis</th>
<th>Post-Crisis</th>
</tr>
</thead>
</table>
| Manager      |            | Have meetings with neighbours/po
cice in handling situation. Con
tact, explain and soothe neighbour
s. |             |           |
| Professional |            |         |             |
| Carer        |            |         |             |
| Client       |            |         |             |