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IDENTITY DEVELOPMENT OF PEOPLE WITH LEARNING DIFFICULTIES THROUGH THE RECOGNITION OF WORK

A thesis submitted for the degree of Doctor of Philosophy

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"No other technique ... attaches the individual so firmly to reality as laying emphasis on work; for work at least gives a secure place in a portion of reality, in the human community."
Sigmund Freud

" I made pots and I made loads more pots, small pots and more pots and more pots and more pots. Loads of pots I made, for my mum, my sister. Made some pots for my Aunt and my other sister."
Alan Tyrell



TO DAVID WHITE
AND THOSE WHO LOVE HIM

PhD Thesis ABSTRACT

Title IDENTITY DEVELOPMENT OF PEOPLE WITH LEARNING DIFFICULTIES THROUGH THE RECOGNITION OF WORK

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This thesis examines the development of identity of people with learning difficulties. It concentrates on an aspect which has hitherto not received significant attention, that is the importance of recognition of work in the developmental process.

In order to do this the thesis defines work in a particular way, based on the work of E Jaques. It defines work in terms of the decision making process which leads to an external transformation of the world. It is the recognition of this transformation by another person which affirms the actor and enhances a sense of self. For this recognition to be effective, i.e. help in the development of identity, the thesis argues that it is critical to understand the way in which a person constructs their world and links intention with action. A general model is offered to describe this process whereby the person moves from a subjective construction of the world (a world of subjective discontinuity) to one which can be understood by others (interactive discontinuity).

Although the model can be applied generally the thesis examines problems faced by people with learning difficulties due to their relatively limited intellectual ability, communication skills and not least the particular social context in which many have lived, i.e. institutional care.

The thesis begins by examining the problem of the appropriate social role for such people given the current intention to allow each person to develop to their full potential. This involves a discussion of social policy leading to a consideration of institutionalisation and its alternatives. Then the model of identity development is presented in terms both general and specific to people with learning difficulties. In the context of methods of assessment a particular form of assessment, The Chart of Initiative and Independence, is considered in the light of the main thesis of identity development. Its subsequent use is then analysed and compared with other approaches in different settings.

The thesis concludes by appreciating the limitations of both the model of identity development and the C.I.I. and considering complementary approaches whilst underlining the significance of recognition of work in any setting.

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Ian Macdonald
7.9.90

CHAPTER 1

INTRODUCTION AND USE OF TERMS

"No matter how selfish a man may be supposed, there are evidently some principles in his nature which interest him in the fortune of others, and render their happiness necessary to him, though he derives nothing from it except the pleasure of seeing it."

Adam Smith[1]

Civilised societies may be judged as to how they treat their weakest members. Consequently it is relevant to examine society's treatment of people with learning difficulties. This thesis does so from a particular point of view. It argues that there has not been sufficient attention paid to the recognition of work as a means of affirming and developing a positive sense of identity. This is more difficult than it may appear since to recognise the work a person is engaged in, requires an understanding of how that person constructs their world. It is often easy to misunderstand ordinary people's purposes and intentions. It is even easier to misunderstand people with learning difficulties, not only in terms of their intentions but also how they understand us.

Current social policy states that all people should be enabled to develop, as far as possible, to their full potential, including people with learning difficulties.[2] For such a policy to be

evaluated there must be some judgement or assessment of potential in order to know if it has been realised in part or full. In order for anyone to realise even a part of their potential he or she must first have a sense of identity, a sense that he or she has a distinct sense of self with intentions and can act to realise those intentions.

It has consistently been argued that large institutions, for example mental handicap and mental illness hospitals, inhibit the expression of potential not only of inmates but also staff.[3] As a consequence many people living and working in such institutions have been underestimated in terms of their abilities. More fundamentally, such institutions undermine a sense of self and inhibit the development of identity. These inhibitory factors are not limited to the large institutions but can also apply to life in the community. The history of fear and ignorance on the part of society[4] has also restricted the realisation of potential.

The process which results in the loss of identity has been outlined, especially by Goffman. The process in hospitals and local institutions may cover a very long period, beginning with child or even baby care. Whilst previous theories outline the overall regime which destroys or weakens the person's sense of identity, there is much less information on understanding the development of positive identity, especially for people with learning difficulties, and also for staff or their carers.

A critical component of the development of a positive identity is the affirmation of successful action on the world i.e. work. The understanding of the importance of work and its recognition has hitherto not been clearly formulated in relation to people with learning difficulties, although it is implicit in some material which will be examined. The thesis rests on a particular definition of work (see below) which must be distinguished from other, more sociological, explanations.

Whilst the proposition that recognition plays a critical part in the development of identity would superficially not seem contentious, in actual fact the structures and systems designed to provide services to people with learning difficulties do not always facilitate such a process. This is partly because improvements in care have been based on concepts of human rights rather than a deep understanding of the specific processes of identity development or the nature of mental handicap.

This thesis first looks at social policy: the aim here is to outline the main determinants of change rather than to provide a complete social history. It then more specifically examines the nature and effects of institutionalisation. From this context the main thesis is articulated, examining the development of identity with respect to people with learning difficulties as well as those working with this client group and the population in general.

The argument is then examined with regard to current and recently used approaches to assessment. Next a particular form of assessment is considered, The Chart of Initiative and

Independence, (C.I.I.).[5] Its development and testing is discussed in the light of two research projects. The C.I.I. attempts to formulate and use the concepts of the thesis in a practical way. The use, and lack of use, of the C.I.I. in service provision is analysed. The C.I.I. is then discussed in relation to the concept of Individual Programme Planning, which also attempts to affirm the identity of the person. Another situation is examined where the Shared Action Planning[6] approach to individual planning was implemented. The last research project concerns testing the concepts in a different cultural setting, an Aboriginal community. This was done to examine how far the concepts were bound to Western thinking. A modified version of the C.I.I. was used in the context of a training centre for young adults. Finally these projects are analysed in terms of the thesis and limitations noted.

Definitions

Social science has a general problem with definitions. There are few if any universally agreed definitions for even basic terms such as intelligence or personality. The field of mental handicap is no better. Labels and definitions have changed, and do change. Within the last 25 years the client group has variously been known as mentally retarded, mentally handicapped, people with a mental handicap, people with learning difficulties.[7] At the turn of the century terms such as feeble-minded, idiot or imbecile were not colloquial terms of abuse but formal labels enshrined in law.

This thesis uses the terms people with a mental handicap and people with learning difficulties interchangeably. Other terms such as patient, resident or client are also used. The term patient is now hardly used as the relevance of the medical model and the place of such people in hospitals has been substantially questioned.[8] The thesis uses the term client more often than others especially when discussing people in receipt of services. It is important to offer some basic definitions used in the thesis.

Mental Handicap

This thesis assumes that all people develop intellectually but some more quickly than others. Pragmatically a person who is mentally handicapped is someone who is unable, on their own, to solve ordinary and basic problems that are expected of their age group and/or are necessary for basic survival. This includes activities such as washing, using a toilet, feeding, dressing and shopping for essentials.

Intellectual Capability

This term is used in the thesis to refer to (differences in) the ability to perceive and solve problems. That is the ability to imagine how a problem can be resolved with resources and within a time frame. A person who is mentally handicapped requires another person of greater intellect to reformulate and simplify everyday problems mentioned above so that they can be solved.

Handicap

The term is used to refer to an irreconcilable difference between imagination and realisation. Anyone who has ideas, or goals which they cannot realise (not merely find difficult or hard work) is handicapped. This may be a temporary or more lasting condition. For example a person in a wheelchair, unaided facing a flight of stairs is handicapped. This handicap may be externally imposed (as above) or it may be the result of internal conflict, for example, severe depression.

Thus mental handicap is not necessarily in itself a handicap. Someone with a relatively limited intellect may not have the ability to imagine more than they can realise.

Potential

The term potential is used in two ways. First current potential refers to what a person could do now if they were not restricted either by external or internal constraints. Secondly future potential is used as a developmental concept. It is a judgement concerning a prediction of the sort of problems a person will be able to solve sometime in the future but cannot solve now.

Identity

Here the term refers to a person's sense of differentiation from others. It is a sense of individual wholeness which affords a sense of significance with an ability to act in the world to produce demonstrable results. This sense may be either positive or negative. The difference is that in the former the person gains a sense of being able to produce constructive results, in the

latter results are destructive to self or others. A person with a weak identity has difficulty separating themselves from their context and is unsure of the effects of their actions.

Work

This thesis is based on a particular definition (Jaques) which describes work as: "the exercise of judgement within limits in order to achieve an objective." This goal directed behaviour in which work is the enactment of decisions required to realise an intention is in contrast to other types of behaviour such as musing, reverie, fantasy and dreaming. As Jaques explains .. "we may speak not only of employment work but of recreational work, housework, artistic work, learning work indeed all purposive behaviour".[9]

Recognition

This definition is complementary to the concept of work (above). Work results in a change in the context. The realisation of a goal which is a purposive transformation. Recognition is defined as, first, the confirmation by another person that the transformation has occurred and secondly the affirmation that the actor has brought it about (or contributed to the result).

Normality

Finally the term 'normal' is used in two ways. First as a purely statistical term. That is in the sense of the normal distribution. Abnormality is therefore defined in terms of standard deviations. In this context abnormality or deviation, despite their emotive connotation, are not used as value statements.

Such a use say in terms of intellectual ability does not imply the demeaning of a person who happens to be significantly less able to solve certain problems than most people of their age.

Normal is also used in a more general sense which is closer to 'ordinary'. It is used most often when referring to the literature on community care as in the 'right to a normal life'. This is used in an evaluative sense and is more precisely meant to mean a life where as far as possible inhibitions to the expression of current potential are removed. Thus it is a context where 'handicap' (as defined above) is minimised. Such a situation may not be statistically normal, and indeed is not 'normal' in a large institution for either inmates or staff.

This thesis presents the argument that this process of recognition of work, is critical to the establishment and maintenance of identity, and that this in turn affords the opportunity for people to test and realise their current potential with the possibility of achieving their future potential.

As was mentioned above, social policy currently has the goal of helping people to realise their potential and endeavours to provide services based on individual need. If this is the case, then the understanding of work, recognition and the nature of identity and potential is a necessary part of realising such a policy. This has not always been acknowledged either explicitly or implicitly, and the lack of understanding of the nature of "learning difficulty" or "mental handicap" has not helped clear formulation or realistic planning. Indeed, the disagreement over

what the nature of mental handicap is has obscured the better understanding of potential and the way in which such individuals develop their identities.

It is important to state at the outset that this thesis does not claim that the recognition of work is the sole determinant in the development of identity for anyone. Without loving relationships and basic care people will not develop a positive identity. This thesis however argues that these aspects have received significant attention and are explicit in the values underpinning current social policy.

The recognition of work is less clearly understood in this field and therefore needs to be explored in more depth. The recognition of work is not necessarily devoid of caring. Part of a caring relationship is the recognition of people's achievements. Recognition applies to both 'success' and 'failure'. It is feedback and can be given in a way which, rather than causing a sense of uselessness, offers an opportunity for learning and development.

CHAPTER 2

SOCIAL POLICY AND THE HISTORY OF SERVICES

"I was brought up from the age of five by my grandmother. She became ill and went into hospital. I was told by my family that I was going out for the night. I was brought to the hostel where I now live. I didn't know where I was going."

Helen Stewart: Thomas Fortune Work Centre, Glasgow.

(a) Prior to 1970

It is not the purpose of this section to repeat or significantly extend accounts of the history of services[10,11] Its purpose is to demonstrate that prior to 1970 the main intention of such services was not to help either inmates or staff develop a sense of identity or to prepare residents for a life in the community.

It must also be noted that families have always provided, and still do provide, the bulk of care for people with learning difficulties. Only a minority of people within this category have been placed in residential care. Such people were either too difficult for their families to manage, or had no families, or were legally detained. This thesis is largely based on research with people in residential care although the arguments concerning the development of identity have general applicability. Residential institutions are analysed because they demonstrate the most obvious barriers to the development of identity. They represent

the limiting case and as such give clear examples of problems in identity development.

Current social policy; to enable people to develop to their full potential[12] is not simply a continuation of past policy. Historically even the separation between mental handicap and illness has been unclear.

In the first half of the nineteenth century Lord Shaftesbury made the first real attempt to investigate and prescribe the nature and treatment of mental disorders. The Acts of Parliament (1845) attempted to set our broad regulations for the treatment and provision of care for lunatics. The Idiots Act (1890) and the Lunacy Act (1890) trod unclear paths. Although in the spirit of liberal, humane reform they were not based on clear concepts of the nature of illness or handicap, its causes or alleviation.[13] In fact for the 'mentally handicapped' the separation of 'defective' from 'ill' meant a gloomier outlook. As a result of the separation the mentally handicapped were not considered as curable and the consequence implied one or both of two solutions: segregation and sterilization. The concept of 'defective' which included a fear induced by ignorance, implied the absence of any worthwhile current or future potential. It implied at best a negative identity.

However, the 1908 Royal Commission[14] made some attempt to recognise that the mentally handicapped (known as feeble minded; idiots or imbeciles) were at least human, albeit defective and requiring some care and attention. The colonies

or large institutions were set up, initially under the Poor Law and eventually placed under Local Authority control. Despite such 'incurable patients' being under the care of doctors, admission was not exactly rigorous. Broad social or moral categories were used: such as, 'moral danger' (mainly women) or 'excessive aggression' (mainly men). The residents were often community rejects who were not engaged in productive work or who fell foul of local laws, many were simply not very bright with poor or inappropriate social skills.

The staff in such establishments also suffered. As the residents were cut off from their home community by geographical isolation, so the type of work and general attitudes separated the staff from their professional colleagues in more mainstream medicine and nursing.

The post of consultant in the psychiatry of mental handicap has never been a highly competitive position compared to other specialities. This has been partly because of the relatively poor working conditions and resources but also because the duties of the post were something of an anomaly in consultant medicine. Research and cure being replaced in priority by care and maintenance. The separation mentioned above was formally recognised by the establishment of separate Hospital Management Committees for subnormality hospitals in 1946.

Although the 1959 Mental Health Act again attempted to clarify issues there was still a tendency to group the mentally ill and the handicapped together as reflected by the term 'mental

disorder'. Even the title of the Act suggests that people who have a relatively slow intellectual development are somehow ill, or at least have a mental health 'problem'.

Some people objected to this on semantic grounds, pointing out the term disorder in the Act implied a prior state of order, which was patently not the case with the mentally handicapped, but the joint term was convenient and came into use.[15]

In essence the history of social policy has been one of administrative convenience and liberal humanitarianism. There was no coherent, agreed model of the nature of the condition which seriously informed or even influenced such policies. There was a general concept of 'low' intelligence but methods of treatment, development or education have not, until recently, determined the specific type of care for people. This lack of clarity concerning the client group some would argue perpetuates their existence as a social group.[16]

Policy Changes 1960s and 1970s

Whilst there has always been a preference for 'community care', or more realistically, family members caring for people at home, the role of institutions was still accepted as a last resort. The 1959 Mental Health Act and the 1962 Hospital Plan still envisaged a significant role for residential and hospital services. The fundamental challenge which influenced policy was not simply the intellectual arguments of Goffman and others but the series of enquiries in the late 1960s.

These enquiries shattered the illusion that such institutions were firm but caring places to live. The most notable of these were the enquiries into treatment of people at Ely, South Ockenden and Normansfield Hospitals.[17] They revealed methods and regimes which were harsh, at times brutal and which stripped inmates of basic human dignity. Whilst the focus was more obviously on specific cases of mistreatment, the background of lack of facilities, staff and basic amenities became more evident.

It is important to note that the impetus for policy changes was not driven by new understandings in theory or practice, as to how such people might better realise their potential, but rather driven by the absence of basic human rights. The historical antecedents were continued, the changes were initiated by a feeling that no-one should be treated like this, rather than an understanding that this was an inappropriate way to treat this client group. Similar assumptions or concerns were voiced about people with a mental illness in parallel institutions. It is fair to say that advances in chemotherapy made the contemplation of policy changes easier, particularly towards care in the community. However these medical breakthroughs were more in the field of behaviour suppressants (e.g. depixol) and were equally applicable in the field of illness as handicap.

It was again a judgement that a civilised society should provide a more humane lifestyle for such people which led to the most significant policy document of recent times: 'Better Services for the Mentally Handicapped'. This set out unambiguously the

preference for care in the community, the gradual run-down of large institutions, the questioning of the role of the Health Service in a field which was not essentially concerned with illness, treatment and cure and the establishment of basic standards which all people could reasonably expect. The policy of successive Governments has not fundamentally altered since then. The subsequent policies, for example set out in 'Care in the Community' (1982),[18] 'The All Wales Strategy'[19] to the most recent 'Caring for People'(1989),[20] all underpin a move to care in the community and maintaining standards: 'Making a Reality of Community Care'.[21] They are all concerned with providing basic, humane services. But these more recent policy statements stress the requirement for care to be based on individual need. The definition of need is left to a hoped for consensus arrived at between professionals, carers, the family and where possible the clients themselves. The fact that there is no consensus among professions on the nature of 'mental handicap' is not referred to as a major problem.

This Governmental policy change, spurred by enquiries, was also bolstered and encouraged by concerned pressure groups, professionals and academics in this country and abroad. The most influential being the 'normalisation' movement led by Wolfensburger.[22] This movement has as its main goal, some might say mission, the re-valuation of people with a mental handicap. This is reflected in the history of name changes: mentally subnormal, mentally handicapped, people with a mental handicap, people with learning difficulties, each trying to enhance and improve the status of such people. The

normalisation movement, more directly and vehemently demands rights for such people, to lead a normal life in the community, have access to facilities, receive ordinary services and be treated as similarly as possible to their fellow citizens. A slightly less evangelical style, but with the same goals can be found in the King's Fund papers; 'An Ordinary Life' [23] and 'An Ordinary Community Life',[24] both stress the need for community based care and an end to institutionalisation. Pressure groups such as The Campaign for the Mentally Handicapped and MENCAP (National Society for People with a mental handicap), also argue for total care in the community.

This apparently inexorable march towards the complete shutdown of large hospitals has its detractors. In the late 1980s organisations such as RESCARE[25,26] have questioned this approach. They are not against care in the community, but argue that there is still a role for institutions, called Village Communities, which could provide a protective but supportive environment for a larger group of people living together.

These policy changes, and perhaps more relevantly their causes, are an important part of the background to the understanding of the client group. These changes are a very clear example of a process which emphasises the need for people to have a positive view of themselves as valued members of a society. What these policies have in common, including those doubting the wisdom of total community care, is to demand that we recognise that these are people first and foremost. Indeed the normalisation and ordinary life movement is characterised by the phrase

'People First'. The policy supports that society must recognise their rights and enable them to exercise those rights.

What is also notable about these policies supported by pressure groups and academics as mentioned above is that nowhere, in any of the documents is there a clear definition, let alone a shared definition of mental handicap or learning difficulty.

This absence makes it difficult, therefore, to decide clearly who such services are for[27] and what we might expect them to achieve. Whilst there is much debate about what constitutes an institution and discussion of size of residential unit, these discussions are carried out in a definitional vacuum. There is no accepted model which puts forward different sizes of unit for different types of client, it is simply not discussed.

This is not to say there are no attempts to define need or ability but the general doubts, and now agreed limitations of the usefulness of I.Q. tests has left a gap as yet unfilled. Nevertheless the right of choice, and the involvement of people in planning their own care are put forward with vigour. Despite the non-existence of an agreed definition, or definitions clarifying sub-groups, the recent policies are even more explicit about the requirement of services to deliver on the basis of individual need. The most recent and typical example is succinctly put in the recent White Paper: Caring for People, where in the list of 'Key Objectives' the following is written: "-to make proper assessment of need and good case management the

cornerstone of high quality care. Packages of care should then be designed in line with individual needs and preferences"[28]

The policy distinguishes between health and social care. However, there is no clear definition of the difference between health and social care other than the assertion that some people need (or don't need) health services in the form of doctors and nurses. There is an assumption that people will easily know and agree such differences. This ignores the often bitter conflict between medical consultants, nurses, social workers and psychologists as to what constitutes a need for medical care and supervision. This difference of opinion was even more apparent in the days of the "Physician Superintendent".

SUMMARY

This chapter has not attempted to provide a complete history of social policy. Rather it has attempted to show that the general changes in direction of social policy have been determined by concerns over basic human rights rather than a greater understanding of the client group. Indeed this history is almost exactly paralleled by the policy changes with regard to people with mental illnesses and more recently the elderly and children. In essence the main spur to re-evaluate service provision was the series of enquiries mentioned above and a concern about institutionalisation.

It was not precipitated by breakthroughs in theoretical understanding of the nature of mental handicap and a clearer

view of the development of intelligence (problem-solving abilities) or specific knowledge of current or future potential. However the concerns about the negative effects of institutionalisation did reflect a greater understanding about the development of identity. The general treatment of people as an anonymous mass, the removal of dignity and self respect were as much a part of the critique as were the specific allegations of cruelty and maltreatment. (The fact that from time to time children are maltreated at school has not led for a general call to close all schools.) It was the understanding that there was an underlying, insidious process of which brutality was an extreme symptom, which provided the driving force for change coupled with an increased awareness and sympathy for people living in such conditions.

CHAPTER 3

INSTITUTIONALISATION AND EARLY ALTERNATIVES

"You never got bathed on your own, you'd get staff with us and you had to wait in queues. You weren't allowed to touch the baths yourself. Taps were took off 'cos they were like taps you had to screw on and when you'd had your bath they took 'em away, or else some people would kill themselves. Drown themselves." Grace.

Perhaps the most well known and influential writer in recent times concerning "institutionalisation" is Goffman.[29] Despite the original concept of Asylum, as a place of refuge and sanctuary, the latter part of the C20th has portrayed institutions, especially mental institutions as frightening places. They are characterised as cold, rigid regimes attempting to bring sometimes brutal order to a writhing mass of chaotic emotion. (See for example the 1930s film of Mary White's "Snake Pit"). Gradually, and partly influenced by writers such as Goffman, the emphasis has shifted from portraying the inmate as a fearsome person beyond reason to a victim oppressed or at least misunderstood by the system, as in for example Ken Kesey's "One Flew Over The Cuckoo's Nest" or more recently the Oscar winning film "Rain Man".

The use of the term 'institution' as a neutral, descriptive label has been superseded by a pejorative sense (in a similar way to

'bureaucracy'). The total institutions in Goffman's book are described in contrast to ordinary life: "a basic social arrangement in modern society is that the individual tends to sleep, play and work in different places, with different co-participants, under different authorities, and without an over-all rational plan. The central features of total institutions can be described as a breakdown of the barriers ordinarily separating these three spheres of life".

From a child's point of view (pre-school), a family would have the same characteristics. Whilst there is much debate about the 'nuclear' family most children do not develop the same set of behaviours associated with the depersonalising effects of institutions. The argument here is that while Goffman's description (above) is accurate that these central features are not the predominant cause of depersonalisation, nor loss of identity.

One fundamental difference between ordinary life and total institutions is the lack of clear distinctions between private behaviour and public behaviour. Private behaviour normally is controlled by the individual and is not available for others to see unless the subject permits access. By contrast behaviour in the public domain is where the subject has no such control and is open to scrutiny at any time. The second and more critical absence in institutions is the lack of positive recognition of individual transformations, (that is realisation of intentions) whether that be in work or play. Therefore despite more behaviour being available for observation there is less

recognition. This argument is based upon direct experience and observation of the nature of the regime in total institutions, in particular those involving the care of people with a mental handicap. (Periods of research work and publications from 1975-1990).

The original purpose of such institutions was to contain behaviour, literally and metaphorically. That is, people entered largely on the basis that their behaviour was judged to be a danger to themselves or others. The deciding factor for entry was that the person's behaviour was uncontrollable, in a normal setting, often on the basis of its unpredictability. Thus we have a collection of people with (statistically) abnormal behaviour. The regime was/is designed to produce predictable and benign behaviour and/or to control it, minimise its effects and variation whether through physical control and containment or later by chemical (drug) or surgical intervention.

Differentiation and Equalisation

One of the most striking aspectS of the total institution is the predictability of the regime and a predictability applied to all inmates. That is, nearly everyone gets up at the same prescribed time, washes (or is washed), has breakfast (is fed), dressed, etc all together at regular times. It is what is usually described as regimented. Individual differences are minimised. Thus the main force of the 24 hour regime, as Goffman later argues is that which seeks to blur identity, i.e. to treat everyone as if they are the same.

In other work[30] the author and others have pointed out the significance of systems in all organisations with regard to the way people are valued and gain a sense of worth. The most relevant aspect of that argument here is that all organisational systems can be divided into two categories: those which Differentiate and those which Equalise. That is, there are those systems which emphasise, and indeed are used to show how people are different and those which demonstrate how people are the same. In employment organisations the most obvious system of differentiation is pay, others include rank and title, perks, company car and so on. The most obvious system of equalisation is usually the safety regulations which apply to all employees, e.g. what to do in case of fire or the wearing of safety equipment. Others may include access to eating facilities, health care or sports facilities. It is always significant, and has a major effect on the culture of an organisation, when a decision is made (knowingly or unknowingly) to change a system of differentiation to one of equalisation (or vice-versa). For example when privileged or named car parking spaces are removed and anyone can park anywhere. A more recent example is the dramatic example of the Poll Tax or Community Charge which is perceived to be a change from a system of differentiation to equalisation.

When looking at any organisation one can investigate whether the systems of differentiation or equalisation are seen to be more important and how they are justified in terms of the purposes of the organisation. When such a change is made (from differentiation to equalisation or vice-versa) it must accord with

a sense of fairness to those affected by such a system. If it does not it will be strongly resisted. In total institutions it is the systems of equalisation which have predominated and this mitigates against the development or sustaining of an identity or a sense of difference. The counter-balancing systems, primarily individual care and attention have been highlighted by their exception. They are difficult to maintain with few staff (i.e. very low staff-inmate ratios) and disorderly inmates. In order to provide the basic, necessary care; warmth, food and shelter, with limited resources, inmates must conform to the regime. There is not room for a later breakfast, a deliberation over what to wear, in summary very little opportunity for choice and the demonstration of individual differences. As one nurse told the author in 1983, " I have two staff to wash, bathe, dress and feed thirty mentally and physically handicapped people, half of whom are doubly incontinent, between 7am and 9am. Don't ask me about Individual Planning."

The staff must attempt to create a set of predictable and uniform (a significant word) responses. Thus events are standardised, the critical element of individuality expressed in work; i.e. decision-making, is removed as far as possible. Rewards are given explicitly for conformity. 'Good' behaviour is invisible behaviour; not standing out, not causing trouble, not being difficult or, not attention seeking. This does not imply a complement of sadistic or even unfeeling staff, merely a small group attempting to control a large group and avoiding trouble. As will be discussed later, staff too have been subject to a

similar process. In summary the basic criterion for 'success' in such total institutions is to keep a low profile or avoid trouble.

Such a context does not enhance the possibility of individual work being either encouraged or recognised. Indeed, the main message is the converse. That is, while a few privileges are given for individual good behaviour (avoidance of trouble) the most obvious and public individual recognition is given for bad behaviour. That is, there is instant recognition for the inmate who punches a member of staff or who throws a chair through a window. Such transformations are responded to with speed and where possible the perpetrator is identified. Punishment is meted out not only to the individual but as a public demonstration to provide a deterrent. However, these negative behaviours form one of the few examples of the recognition of individual identity, the problem being they are almost exclusively negative.

Therefore (in terms of the definition in Chapter 1) it is difficult to work. It is difficult to create individually recognised events and few people are concerned to discover underlying individual intentions unless they are perceived to be dangerous. This sad state of affairs is now recognised in recent social policy, the implementation of such a policy is less easy.

If the positive development of identity is largely dependent on the social recognition of transformations, that is, work, we can look at this problem from a slightly different perspective and see again how it is difficult to work in total institutions. Jacques'

definition of work[31] explicitly builds in a 'maximum target completion time' without which it is not possible to say if anything has been done. Indeed, in many previous books[32] he has stressed the link between time and decision-making, arguing that the longer time to completion the more uncertainty and complexity is involved in task completion and the heavier the felt weight of responsibility. Consequently, the feeling of achievement is also related to the difficulty of the task. However this is dependent upon review and recognition. That is, if a person has struggled over 6 months to complete a task it is of little significance if it is not recognised, nor attributed to the person concerned. The timing of the review is important as part of the recognition of the realisation of intentions and the affirmation that work has taken place.

In total institutions not only is this recognition scarce but the concept of time has a different meaning. The repetitive regime, in operation twenty four hours a day, three hundred and sixty five days a year means that one day is very much like another. Apart from major events such as Christmas the system rolls on. The repetitive, predictable organisational system has similarities to the repetitive stereotypical behaviour which is seen as a pathological symptom when demonstrated as part of an inmate's behaviour, This predictable repetitive system has the effect of minimizing differences. This has been compounded by a shift system where even staff do not recognise week-ends (other than for extra pay). In essence one day is made to be as much like any other day. (Incidentally, this demonstrates the irrelevancy of test items which require knowledge of days of the week or

even who is Prime Minister and other general knowledge information which is part of the outside changing world.) Time becomes indeterminate, the significance of achieving a result by a certain time less and less relevant. This is further compounded by the fact that inmates rarely have a set release date.

In this setting at least, behaviour modification programmes form a small island of apparent clarity. At least here are some clear targets or projects for staff and residents with public and potentially shareable discontinuities in time. However in behaviour modification significant episodes or events are externally defined and controlled as part of the regime and so the inmates intentions are overwhelmed or made insignificant. Their own intentions may be interpreted as a nuisance, which in turn further erodes individual identity.

It is interesting to note that the colour most readily associated with 'institutions' is grey, symbolically an undifferentiated colour. The only clear boundaries are barriers; walls and doors, not always locked but always restricting access and movement. The whole system results in handicap and minimisation of individual differences and hence identity.

Different Types of Total Institution

Whilst the above description has focused on the large, mental handicap hospital there are of course features in common with other institutions, most notably, mental illness hospitals but also prisons. Are the effects the same? In considering their relative

effect the following section argues, that in terms of the development of identity, mental handicap (and also illness) hospitals are in fact even more debilitating than prisons.

To enter a prison, in general, you must be regarded as a rational human being. Although state of mind may be mitigating, the establishment of guilt, depends on the assumption that the defendant is of sound mind and the extent to which the act was deliberate and pre-meditated. This assumes the existence of an intention which was realised, or at least, a serious attempt was made to realise it, i.e. some work was done. There are even laws of conspiracy to act, where sharing the intention to act is itself a crime. Such laws are of course notorious since it is very difficult to prove (beyond reasonable doubt) the existence and nature of an internal, unrealised intent. Nevertheless, at least it gives the person involved the status of being able to initiate, formulate, realise and own behaviour, a recognition that he or she is capable of work. If a successful defence is made on the grounds of the defendant's <u>inability</u> to formulate ideas as in the case of mental handicap or illness then the person is regarded as <u>not</u> responsible for his or her actions.

Prison sentences, other than in a few extreme cases, are determinate, i.e. they have an end point specified. There may be attempts in prison to change, re-educate or train prisoners, the essential criteria for release or parole is good behaviour. This good behaviour or being a model prisoner involves not getting into trouble or committing further crimes during the sentence. The person is then released (whether they want to stay or not)

and returns to society again still with the status of a rational human being, i.e. the ability to make decisions for him or herself. This is not to ignore pressures experienced by prisoners which are similar to inmates of mental hospitals, as Goffman points out, for example the loss of identity during the stay nor to underestimate the stigma attached after release to an ex-convict.

However, this is contrasted to the position of the person entering a mental handicap residential institution. Although the person may not necessarily have broken any laws, they are judged not to be able to make decisions or formulate and realise intentions which will enable them to survive satisfactorily in ordinary society, i.e. they are not able to carry out 'work' to enable them to survive independently. Inmates in hospital are people who are regarded as not understanding, foreseeing and hence facing the consequences of their actions. Their apparent inability to realise intentions is deemed so great as to require supervision. The assumption is that such people are inherently handicapped. Their reason for entry is because of what they are unable to do.

This is consistent with the author's general definition of handicap: 'The irreconcilable difference between imagination and realisation'. (See Chapter 1.)

The hospital inmate, even more at a disadvantage than the prisoner is still subject to the process of institutionalisation which, to paraphrase Goffman:[33]

a) places the resident at the bottom of a service hierarchy.

b) tends to remove identity by lack of individual service and personal belongings.

c) creates an atmosphere where social survival may depend on an anonymous adaptation to the norms of the institution.

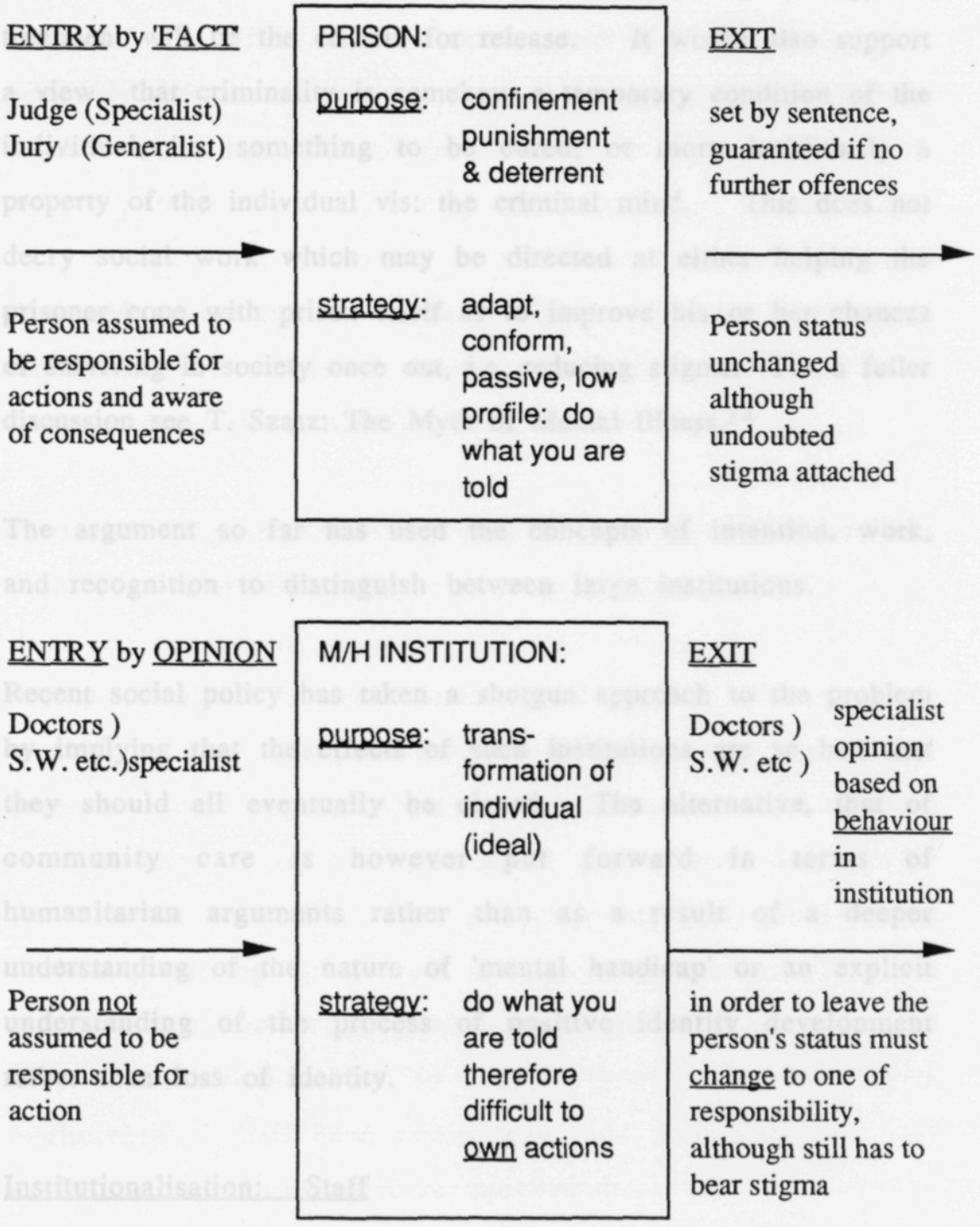
d) places the rule-making at the discretion of the staff.

e) limits freedom of movement.

A further debilitating difference for a hospital 'inmate' is that the actual care process may further preclude the person being seen as an active individual. Due to the constraints of time, resources, staff and expectations residents may have a lot done for them, since their active involvement may delay the process and/or is seen as unhelpful, reducing the opportunity for positive action which could be recognised.

Thus whilst both mentally handicapped people and prisoners may be subject to similar institutional pressures resulting in similar strategies for survival such as keeping a low profile; for the prisoner this is functional, i.e. despite the immediate cost it inevitably leads to release. This is not necessarily so for the mentally handicapped person. Unlike the prisoner, the patient must achieve a change of status, from a dependent person who cannot live (or survive) outside to that of a responsible decision maker. The failure to achieve this change for the patient, unlike the prisoner may mean that they remain in the institution indefinitely. Indeed, some staff would even argue that it would be cruel to move them. In either case it will be the staff who make or ratify the decision.

To summarise the model comparing hospital and prisons:



To the extent that prisons explicitly seek to change an inmate as the prime purpose of confinement, prisons will become like mental hospitals where the demonstrable results of therapy or treatment will be the criteria for release. It would also support a view that criminality is somehow a temporary condition of the individual, i.e. something to be cured, or more insidiously a property of the individual vis: the criminal mind. This does not decry social work which may be directed at either helping the prisoner cope with prison itself or to improve his or her chances of surviving in society once out, i.e. reducing stigma. For a fuller discussion see T. Szasz: The Myth of Mental Illness.[34]

The argument so far has used the concepts of intention, work, and recognition to distinguish between large institutions.

Recent social policy has taken a shotgun approach to the problem by implying that the effects of such institutions are so bad that they should all eventually be closed. The alternative, that of community care is however put forward in terms of humanitarian arguments rather than as a result of a deeper understanding of the nature of 'mental handicap' or an explicit understanding of the process of positive identity development rather than loss of identity.

Institutionalisation: Staff

Whilst the preceeding section has emphasised the inmates difficulty in developing a positive individual identity by living in large institutions, it is also suggested that staff are not immune.

Although they have more power than residents their role historically has not been conducive to the development of their own identities through work. If we return to the original purposes of asylums: containment and control, the work of staff employed in direct care roles has not until recently been positively defined. In general terms their task, like that of those in their care, has been preventative; to avoid trouble. Their main requirements are to turn up for work, ensure those in their care do not harm themselves or others, to feed people, clothe them and ensure they are sheltered. Underlying this is a general requirement constantly to know where people are and what they are doing (thus reducing choice and privacy).

Thus staff in general were not often required to achieve any real positive goals or objectives but to avoid negative ones. Of course there are exceptions, examples of staff, on an individual basis paying attention to needs, training, educating and trying to provide therapy. The point being made here is that this has not been a clear organisational requirement, i.e. not a role accountability. Good behaviour on the part of staff was seen as the basis for promotion. Thus promotion has been based on the criteria of turning up to work and avoiding trouble. This has established a system of promotion based on seniority rather than demonstrated ability to achieve positive results (i.e. a meritocracy). Staff have rarely been held accountable for real work, i.e. producing positive transformations.

The range of professions and the role of doctors has further confused accountability. There has not been a clear

organisational structure with agreed authorities and accountabilities associated with roles. The lack of defined objectives means that task assignment has been general; feed people, wash people rather than the assignment of tasks which are specific and related to individual residents' needs.

Although staff, unlike residents, are not subject to a 24 hour regime, many lived (and do live) on site. This results in a complex social network. Not surprisingly many staff are either related by blood or marriage and children follow parents into work. Thus the world does not extend beyond the walls for many staff as well as residents. The institutions became total in that they developed their own systems of rules and regulations hardly interfered with by the outside world which was happy with the containment role and correspondingly did not seem greatly interested in the world behind the walls until the enquiries mentioned in the previous chapter.

The repetitive regime with its regular routine has an influence on staff as well as residents/inmates. Routine becomes ritual but devoid of its original purpose and meaning, questioning the routine becomes heresy and discouraged. The staff therefore also suffer from a lack of individual recognition, through work. Their identities, like the residents are more influenced by social networks than achievement in their role. Under such circumstances, it is not surprising that developments of service, new ideas and proposals have been stultified by inertia. As mentioned, it was not until the hospital enquiries of the 1960s, coupled with a cultural questioning of 'normality' and social

behaviour, that these situations began to be examined and questioned and the nature of service delivery redefined.

Nevertheless, culture cannot be changed overnight and the depth of the problem was not even fully appreciated by the enquiries. A preferred explanation being that such behaviour was the product of a sadistic or at least uncaring minority of staff.

ALTERNATIVES TO INSTITUTIONAL CARE

"I went to St. Lawrence's Hospital when I was small. It was horrible in there. Tatty grub and tatty clothes. Viv got me out of there and I went into a group home. It was horrible. I didn't like it at all because there were too many rows.

I am in a flat on my own but I do not like it all that much. It is sheltered accommodation. I do not like it because Joan has arguments about me.

I would like to move to Chetwynd Road where my boyfriend is."

Carol

As was mentioned at the beginning of Chapter 2, most people with learning difficulties have not lived in hospitals. Many have lived at home and others have received residential services from Social Services Departments. At the time of the enquiries the alternative to hospital residential care was the Local Authority 'hostel'.

The hospital scandals and the general awareness of the effects of institutions and the continuing concern with basic rights and humane conditions added to the impetus to move people out of hospitals. It was (and is) also argued that, because such people were not ill hospitals were not the appropriate place for them

anyway, even if the compelling evidence of the nature of institutionalised care had not been so obvious.

However, the continued absence of a clear model or theory of development or even an agreed classification system to describe the client group led to a simplified and confused evaluation of care.

Development, was, and is, seen sometimes not so much in terms of what a person could, or might be able to do, (i.e. their present potential and future potential) but based upon where they receive services.

It is usually assumed that progress occurs along a continuum from 'hospital ward', to 'intermediate unit', to 'hostel' to 'group home' to 'the community'.[35] Despite this assumption such terms have never been precisely described other than in terms of their geographical location.

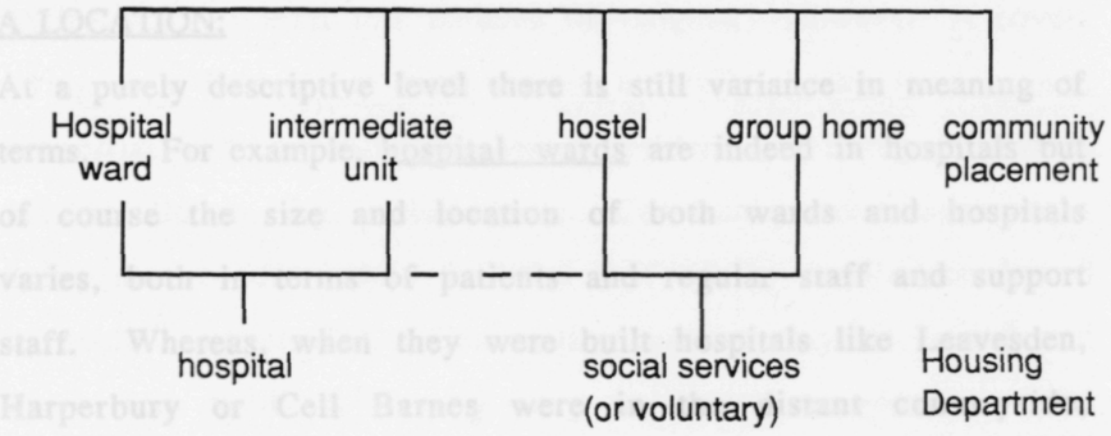
Physical location and independent life have become interwoven. To quote from P. Mitler:[36]

"... much of the public debate has been on buildings rather than what is to go on inside them."

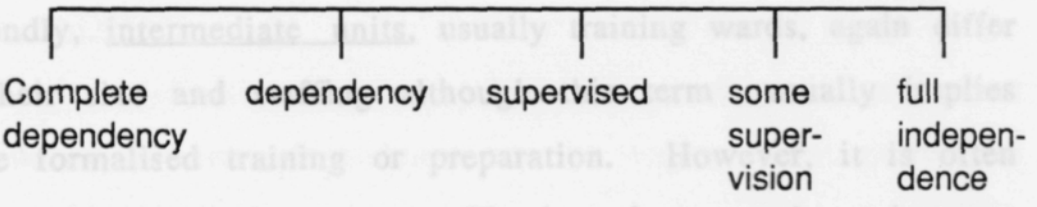
This continuum not only reflects a potential confusion between physical location and independence but also represents a value continuum where community is 'good' and large hospital is 'bad', thus reinforcing the stigma attached to hospital patients/residents.

There are three strands which need to be separated and the extent of their overlap examined:

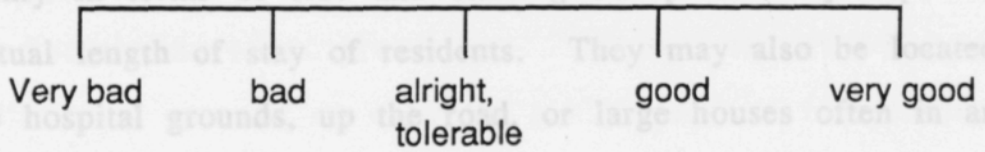
A Location



B Independence: on the basis of intellectual ability and/or physical handicap



C Value



The confusion of these strands has obvious implications for staff working in particular identified locations. It is not surprising that there is low morale and sometimes poor staffing levels in hospitals.

To take them in turn:

A LOCATION:

At a purely descriptive level there is still variance in meaning of terms. For example, hospital wards are indeed in hospitals but of course the size and location of both wards and hospitals varies, both in terms of patients and regular staff and support staff. Whereas, when they were built hospitals like Leavesden, Harperbury or Cell Barnes were in the distant countryside, urbanisation in the past 30 years has actually brought communities to the gates of the hospital in some cases. Currently 'wards' have new names: 'villas', 'bungalows', 'homes'.

Secondly, intermediate units, usually training wards, again differ in their size and staffing although this term usually implies some formalised training or preparation. However, it is often preparation for life in a hostel. The hostels are perhaps the most ambiguous social units. The variation here is again considerable not only in terms of size and staffing but particularly expected or actual length of stay of residents. They may also be located inside hospital grounds, up the road, or large houses often in an upper middle class neighbourhood (due to the size of property). Group homes are usually slightly less ambiguous, there is some shared notion of them being for a relatively small number of

residents (4-6). However, the level of involvement of staff may vary from living in to occasional visits or being on call.

Living in the community is a term which may include family home, group home, or hostel. The term community usually means not an institution and therefore is a definition by exclusion. At least this reduces the stigma. However, it covers living in a hostel, at home within a family, living in a council house/flat with or without other ex-residents or living in private accommodation, e.g. a bed-sitter. Community advantages mean being able to use public facilities (but are by implication linked to social competence). Community support may be varied and apart from field social work may well vary according to local voluntary groups' activities (e.g. the National Society's local branches), and the composition and function of the local Community Mental Handicap Team.

B DEPENDENCE:

Like the definition of mental handicap the definition of dependency and independence can be vague. Most definitions include the concept of supervision which is also vague. (This issue is discussed in more depth in Chapters 7 & 8.) Linking location and dependency results in a narrow view of both Health and Social Service provision. Some Health Service establishments can and do cater for a high level of independence (on the part of residents) and local authorities (SSDs) do cater for a high degree of dependency. The apparent need for nursing care as part of the definition of high dependency may add to this confusion. The false argument is as follows: because people who

need nursing care are sometimes the most mentally handicapped, and because nurses are in hospitals, then hospitals contain only the severely mentally handicapped people looked after by nurses.

Residential social workers behave very much like nurses in many instances and some hostels may have more restrictions (perhaps appropriately) than some hospital wards. Further, the roles of the professions especially in residential work are much less distinct than their titles.[37] However because there is a very general correlation between dependency and location as expressed on the continua these strands can become merged.

This analysis is not intended to argue against the current policy for more community care. It is rather to be clearer about the meaning of such terms.[38] Indeed, it is argued that in preference to the continuum of location could be specific statements about the type of relationship and discretion allowed to people by staff and other carers whatever their location. In this way two objectives would be achieved:

1 Policies of particular establishments could be clearer rather than relying on their broad name to convey the nature of their work:

2 Clients would be less disappointed when what they had believed to be a step forward is actually experienced as a step backwards in terms of discretion or the exercise of choice. This is a most crucial issue since many people are receiving social

training and skills ostensibly to equip them for community life only to find the particular, or only hostel place available means they can no longer go out when they like or have a drink or a bath when they choose. Under such circumstances it is not unusual for the resident to withdraw or become aggressive. In such cases they may then be returned to the hospital as a failure. The return may then be to a different, or disturbed ward and the failure is more easily seen in terms of the resident/patient's behaviour rather than confused policy or conceptual unclarity as to the original transfer. This aspect is further exacerbated by the fact that anyone leaving a hospital, discharged, is one more statistic supporting the policy for gradually running down the large hospitals.[39] Where they go and whether this actually does represent a developmental step in terms of independence is less carefully recorded.

The problem of defining the nature of the service rather than the location has received more attention recently. Organisations such as RESCARE argue that in some instances people are more neglected in the community than in hospital. The recent White Paper 'Caring for People', as well as the paper 'The All Wales Strategy", places an emphasis on monitoring standards and setting up criteria for community living. (See also for example the five competencies which are a set of criteria for judging the community care services.)[40] However, these criteria do not require a comparison of previous lifestyle with current. That is they are a set of bench marks to test policies in terms of the rights of individuals, they do not help to assess whether a person is capable of or would choose to use local facilities. Of course if

the facilities are not there they cannot be used. Such standards are more to help the removal of general handicaps, through increased opportunities. They do not help to test whether such services are relevant in individual cases based on ability or level of independence.

C VALUES:

The third strand of the continua, has also complicated the issue. As a result of the enquiries and influence of pressure groups, hospitals are seen as 'bad' and the community as 'good'. This simplistic dichotomy serves to detract from the basic argument concerning whether people are receiving appropriate care or whether they have opportunities to develop wherever that care might be given.[41]

The value continuum is of particular relevance since it is at the core of the current normalisation movement. Its introduction into the debate has a tendency to polarise the view that there are no redeemable features in hospitals, based on the evidence of institutionalisation. An equally forceful opinion is that life in the community is therefore good.[42] There are contradicting reports of the success of life in the community.[43] The debate is fuelled by ideological argument and emotion leading to a situation of believers and heretics. The evaluation of services, whatever their location, is made more difficult by the disagreement over the criteria for such evaluation.[44] This argument weaves qualitative and quantitative issues together as if they are interchangeable. For example the normalisation movement argues it is not good for people to live in groups of

more than six. There is no research to compare the lives of four, six, eight or twenty people living together.

The opinion as to whether two hundred people living together is bad is not based on any clear theory with regard to social relationships and numbers. The fact that many large institutions provide a poor service may not be simply because of the numbers involved but due to the original purpose and structure of the organisation. It may simply be that such places are run on poor systems and lack resources. This does not mean number per se is the determining factor. Nevertheless, small is beautiful when powerfully expressed by the openly value orientated pressure groups.

SUMMARY

This chapter has not attempted to make a complete analysis of either the history or current state of residential services for the mentally handicapped. The discussion has been mainly concerned with people receiving these services provided by Health and Social Services which offer twenty-four hour residential care.

It has tried to show that the history of the service does not reflect a coherent pattern of provision based on knowledge of the appropriate care for this client group. Many changes in law and practice have been either due to general, liberal, albeit humane reform or administrative convenience. Further, the location of the service across health, social service and education boundaries was not primarily because of the appropriateness of

these agencies. It has also tried to show that deciding who is mentally handicapped is no easy task and never has been. While there is some consensus especially among sub-groups of professions or voluntary organisations and associations, this is still at times arbitary and involves changing criteria.

However, the service imperative is to base care on individual need. This requires an assessment of need, not just in general terms but in relation to this client group. If there is nothing special about the client group then there is little justification for having a category, whether it be "mental handicap" or "learning difficulty".

There is an underlying assumption in social policy, which is very consistent with this thesis, that in order for someone to experience self-worth and maintain a positive identity their efforts must be recognised. In current policy this is reflected in terms of the expression of choice. This is very close to the concept of discretion in work as defined earlier and associated with intentional transformations.

What is generally agreed is that institutionalised care; the generalised routine which fails to clearly differentiate between people, has a debilitating effect on the development of identity, whatever the location. It has been argued that the current state of affairs although undoubtably more humane and considerate, is less informed than it might be because the actual process of the development of identity, related to intellectual capacity, is not explicitly understood. This leads to confusions for example,

as discussed above concerning location, dependency, value and rights.

In order to explain this argument more clearly, it is necessary to explain in more depth the central concern of the thesis, the relationship between identity development and the recognition of work. The next three chapters examine this process in much more detail and review the enactment of social policy in the form of assessment and individually based programmes of care.

CHAPTER 4

IDENTITY AND THE RECOGNITION OF WORK

"Later on I started doing man like things like laying the table before mealtimes ..... and later on I once made toast light brown .... and later on I poked a pencil in my throat and had to go to hospital. Poor old mum nearly lost me".
G E Wilkins

Current social policy towards people with learning difficulties, is based upon the requirement to plan and provide on the basis of individual need. This policy is supported by many professional and pressure groups. The enactment of this policy requires a better understanding of people as individuals, and particularly their needs and capabilities because people with learning difficulties form a group with a wide range of both needs and capabilities.

This increased understanding of need can be attempted by using common sense and experience. However common sense may be grounded in immediate experience and can be limited and/or misleading. This chapter attempts to outline an underlying process which may help to improve this understanding and test common sense. In doing so it is necessary to bear in mind both differences and similarities between individuals with learning

difficulties. By identifying similarities general principles can be articulated which in turn can serve as a basis of comparison for the testing and identification of differences.

The field of mental handicap contains many groups with strong beliefs[45] which have been influential in maintaining and furthering the policy for community care. It has become axiomatic that living in a small home with two or three others is better than an institution. However what is self evident at one time may be less so at another,[46] as exemplified by the current concern that some people are suffering neglect in the community (e.g. RESCARE). It is therefore important that people with learning difficulties are better understood. They may then receive more appropriate services and a valued place in society. To achieve this it is necessary to examine in more detail not simply the processes which inhibit or deny the development of identity but also the processes which enhance it.

THE DEVELOPMENT OF IDENTITY

This chapter proposes a model which attempts to explain how purposeful activity and its recognition is critical to the development of identity and consequential social relationships. The basic propositions are not limited to people with learning difficulties.

The thesis is that the basis of identity is founded upon an ability to distinguish self from context. That this process is established by acting upon the world and being able to order the world into discrete events or behavioural episodes. This process is

analogous to punctuating a flow of words in order to make sense of them. The ordering process, is based upon the experience of need which leads to a desire to bring about change or transformation in the environment, or to do some work as defined above. The extent to which the work is recognised through feedback from another will confirm or deny the person's experience as a positive entity and hence directly effect the development of their identity.

The formation of identity is essentially a process of discrimination; the differentiation of figure from ground which allows an emergence from a general blur to a distinctive, perceived identifiable entity. Many psychological theories[47] based on infant observation argue that the tiny baby has difficulty differentiating itself from its context. It does not have clear boundaries of self and other and consequently cannot reliably distinguish the effects of its own actions from those of others. Apart from the cognitive theorists, psychoanalytic and psychodynamic theory propose models of how the baby begins to organise itself in its world. From relative chaos a pattern and order gradually develops to form the sense that "I am". In Kleinian theory[48] the baby initially relates to 'part-objects' and is in a state of 'omnipotence'; not merely the centre of the universe but at times it is the universe.

Anxiety is aroused concerning what can be controlled and what is controlling, what can be constructed and what destroyed. Freud's[49] concept of 'primary narcissism' similarly places the infant centre stage with difficulty separating self from other, the

experience of separation is also a cause of significant anxiety. Mahler, Pine and Bergman [50] described the first months of life as 'normal autism': "a stage where longing and fulfilment were continuous or even fused, in a time apparently devoid of either process or effort".

If the baby has difficulty separating itself from its context then causal relationships and logical associations are extremely difficult to construct, and impossible to maintain over time.

This continuous, boundaryless world has to be broken if a sense of self is to emerge. In normal infancy this sense of differentiation gradually develops, because the context cannot be completely controlled. This process (of differentiation) becomes more complex. The sense of identity and concepts of what the self can articulate as need and subsequently achieve also become more sophisticated.

In Kleinian theory the price of identity is the loss of omnipotence; the realisation that not everything can be controlled. The reward is a sense of self with due regard as to what, realistically can be achieved due to work. In Freudian terms this is coming to terms with the reality principle. What the baby comes to know is that much of the world is beyond control, outside the realm of the self, refusing to be totally overwhelmed and engulfed. Thus it is the failure to control, the realisation of limits or boundaries, which develop the feeling of separateness and difference. (Specific problems experienced by people with learning difficulties are explored in Chapter 6.)

In the normal course of events primitive associations are made between the baby's actions and results, for example a parent returning the smile of baby. It is important to note here that the differentiation occurs not only through the action of the subject; but also through the action of the context, here another person, who may affirm or deny the action.[51] Erikson described this as an individual's "capacity to unify his experience and action in an adaptive manner".[52] The role of the other, particularly significant others is emphasised by many child psychologists and is seen as critical in the development of identity.[53] Kegan writes of this process from the point of view of a clinician in what he regards as the clinicians most fundamental activity: "conveying to the client that they understand something of his or her experience in the way he or she experiences it. Why this activity on the part of the therapist is so crucial to the client's thriving has not been well understood".[54]

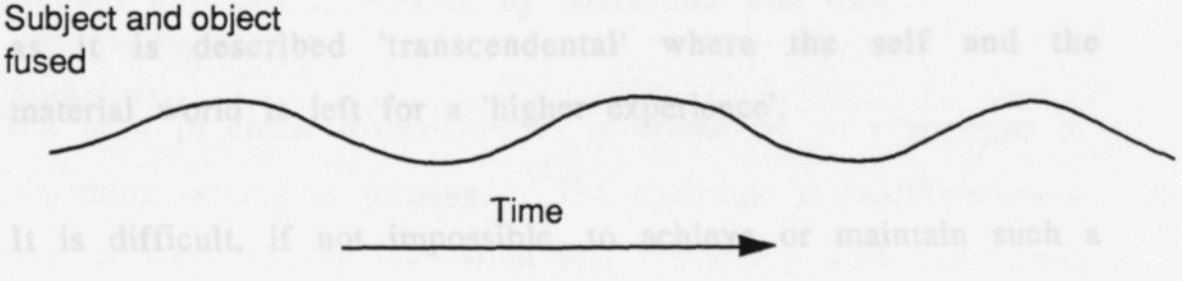
The role of the other is not limited to the psychodynamic school, indeed the concept of reward or reinforcement as a shaper of behaviour is the centre of the behaviourist model. In normal child development there is mutual shaping with parent and child reinforcing each other. However this assumes that parent and child both recognise that an event (smiling, cuddling) has taken place and can be identified in the general flow of behaviour.

MODEL OF IDENTITY DEVELOPMENT

The following model outlines three stages in the process of identity development. In general behaviour is continuous, in particular, it is discontinuous. It is possible to say 'I stopped walking', 'I have finished washing', or to contemplate future breaks; 'I will have finished painting by next Saturday'. However, it does not make sense to say 'in July 1984 I stopped behaving for two days'. In this sense there is a parallel between behaviour and existence. When we stop behaving we are dead. However, this does not mean that all behaviour or activity is consciously directed. We may not be fully aware of why we are doing something or even at times exactly what we are doing. What is of concern here is how people organise or 'chunk' behaviour into episodes or events. That is, how the continuity is broken and whether these breaks bear resemblance to the way that others might interpret them.

In order to do this it is first necessary to describe the extreme of undifferentiation:

A. UNDIFFERENTIATED FLOW OF BEHAVIOUR



Here there is a continuous flow of undifferentiated behaviour through time.

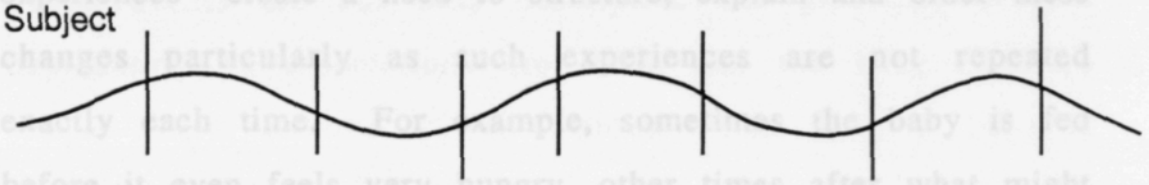
This state is hypothetical. As discussed above, to be in a state of undifferentiation, even at birth, is virtually impossible since it precludes any relationship with another or 'not me'. The model represents a state of pure continuity, of oneness. The closest approximation in reality is the new-born child. The consequence of such a pure state is the absence of figure-ground discrimination, the absence of separation of self from context and consequently no identity.

Despite the difficulty of attaining or maintaining such a state, it is a concept familiar in some religious teachings, Hare Krishna, Buddism, and is also common in the approach to deep meditation where the 'mind is emptied' and there is an attempt to experience 'oneness with the universe': Nirvana. This state of mind is achieved (or facilitated) by stillness (an attempt to minimise behaviour) and the repetition of a word or sound (the mantra) to exclude all else. It is no accident that the purpose of such religious experience is to minimise or eventually diminish to irrelevance the sense of self, or individual significance. It is as it is described 'transcendental' where the self and the material world is left for a 'higher experience'.

It is difficult, if not impossible, to achieve or maintain such a state of undifferentiation since the rest of the world has a tendency to break in. This thesis is concerned with the process of creating an identity or sense of self (whether or not we later

wish to transcend it). It is therefore necessary to examine the process of discrimination of self from the rest of the world and later how this is recognised.

B. SUBJECTIVE DISCONTINUITY:



In this part of the model continuous flow is differentiated into events by the subject only. That is, without reference to an external reference for agreement or affirmation. It is purely egocentric.

While undifferentiated flow (A) may be described as an impersonal or idealised state, subjective discontinuity brings the first sense of identity but is asocial.

In order to gain a sense of identity the continuous flow must be broken. This part of the model looks at how and why this is done from an egocentric point of view and then the next part explores how this is effected by interaction with others.

The need to create discontinuities is driven by an experience of something lacking or missing. The challenge to undifferentiated flow is made by the realisation that everything does not simply happen perfectly. Most obviously, for the normal infant this is brought about by uncomfortable experiences. Simple examples

are hunger, lack of warmth, being wet and uncuddled. The experience of lack, not instantly gratified causes confusion and the interruption of the flow demands explanation. The experience of being replete gradually gives rise to hunger then (hopefully) in turn returns to a sense of repleteness. These experiences create a need to structure, explain and order these changes particularly as such experiences are not repeated exactly each time. For example, sometimes the baby is fed before it even feels very hungry, other times after what might seem an inordinate length of time with hunger pangs. There is a need to create an internal explanation of what are now becoming events and noting that the characteristic of such experiences is that they have a beginning and an end.

Another example of the expression of the need to order and structure (but equally open to observation) is simply the way a baby pays attention to its surroundings. The baby begins to observe changes in the context, through watching (passive) and attempts at grasping (active). The context is changing with the appearance and disappearance of objects and people; most babies appear fascinated by the changing presentation of the world as it moves by. The subject may be in either a passive position, being held or moved, or active, moving its head, body, eyes. (This passive/active dimension is not an either/or choice since the baby is usually experiencing both at once.)

The baby must make some sort of sense of all of this and by doing so separates itself from its context. It begins to distinguish, at first primitively, those events which it can

influence and those it cannot, reaching for a spoon and reaching for the moon.

The markers in the diagram above simply represent the subject's emerging interpretation of the world into events. These events are not only descriptive but gradually become explanatory as associations are made and the baby develops simple causal notions or explanations where the self becomes ever increasingly active and productive.

Thus the markers represent a patterning process, a way of making sense of the world, initially only judged by the satisfaction of the subject. It is a subjective account of the world and as such is unique, hence subjective discontinuity. It is at once potentially both creative and destructive. Successes and failures in action are judged by results. The subject's explanations of the world are judged by their predictive power. The way in which the subject orders, discriminates, begins to form causal relationships clearly differs among people.

By definition subjective discontinuity is unique. However, the construction of an ordering mechanism is universal. The study of 'pattern recognition' has been a concern, particularly of cognitive psychologists, for a long time. The term recognition is not used here in the affirming sense defined above. It refers to the subjects discriminatory process. In many experiments, particularly in the field of perceptions, psychologists have discussed whether the ability to discern certain patterns, such as a predatory bird's wing-span is innate in chicks. Also learning

theory is concerned with the ability to recognise (again in the sense of observation) certain repeated events. The standard experiment of recognising a "visual cliff" appears to be common in young babies of about four months.[55] The representation of discontinuity, in the form of language, has also been the subject of debate, for example, by Luria, Vygotsky and Chomsky.[56]

What is not at issue is the necessity to order the world and then formulate and articulate the ordering process. Further, that to create such a process requires action and reaction in the world. It is not the fundamental purpose of this thesis to examine, the extent to which this process is innate but it is central to argue that

a) such processes exist and further
b) that they differ in the complexity by which information can be processed and that
c) their effective use is dependent upon recognition by another, recognition here <u>is</u> used in the affirming sense defined in Chapter 1.

Kegan[57] describes this as "intrinsic to the process by which we develop".

Another way of looking at this process is simply to assume that being in the world creates problems and opportunities. Meeting needs requires overcoming obstacles and solving problems. People will use different <u>problem-solving methodologies</u> in order to realise their needs. However, the nature and extent of the problem itself is a function of this ordering process. That is, the problem will be perceived, and the need articulated according to

the way a person constructs their world. The more complex the ordering process, the more complex the perceived problems will be.

The process of constructing subjective discontinuities can be linked to the definitions in Chapter 1, especially that of work using the writings of Schutz.[58] Schutz refers to a person's general sense of lack, that is an experience that something is missing. This general sense is formulated into a project. This is originally a mental construct but one which if realised in the external world will satisfy the need or remove the lack. Such a realisation requires a transformation in the external world.

Now this process may be entirely internal. For example, if I am upset by a particular situation I may transform the situation or myself. The former is more directly amenable to observation, the latter less so, for example, in a change of mind. However unless there is some transformation no work has been done. This transformation may demonstrate itself by a change in the external environment or a change in the subject for example I am no longer upset by the situation when it occurs again.

'Subjective Discontinuity' is only concerned with the subject's judgement of the transformation and whether it is in accordance with the subject's intention.

In summary a NEED is formulated into an IDEA or IMAGE which becomes an INTENTION which requires DECISIONS and ACTIONS

to create an external TRANSFORMATION of the CONTEXT to achieve an OBJECTIVE in time. Finally, the achievement of the goal requires that the subject RECOGNISES that the end result relates to and satisfies the original need. From the subject's point of view this becomes a behavioural act.

In this process it is never possible to guarantee either that the final result will satisfy the need or will perfectly reflect the original project. However, this ensures that the system is never closed: imperfections have to be explained, approximations examined and consequently learning can also take place. The extent to which this process is more or less complex, the images more or less abstract will depend upon the complexity of the subject's construal of the world. This in turn also determines the nature of the problem-solving methodology. This is similar to Jaques' concept of Cognitive Complexity[59] and the author's concept of Cognitive Strategy.[60]

At present the model has only dealt with the subject's construction of the world. The effectiveness of the construction is judged pragmatically on the basis of the subject's criteria. The construction of subject discontinuities demonstrates how the subject develops a sense of separateness and as part of this process how he or she perceives behavioural events, and comes to make distinct episodes out of the general flow of behaviour. This whole process allows the person to identify themselves as an active agent in his or her world and to conduct transformations. Simply put, the process of applying subjective discontinuities is the process of ascribing meaning, so far

meaning only from the point of view of the subject. In Kegan's words: "It directs us instead to that most human of regions between an event and a reaction to it - the place where the event is privately composed, made sense of, the place where it actually becomes an event for that person ... probably every personality psychology ... directs us in some way to this zone of mediation where meaning is made".[61] However to others this process may appear to be idiosyncratic, based on pure co-incidence or association. The next step in identity formation is interaction with others and their construction of the world.

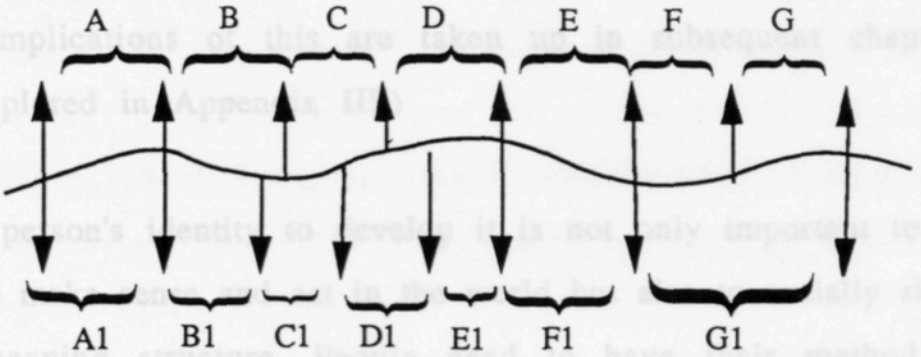
C INTERACTIVE DISCONTINUITY

There are two related problems with maintaining purely subjective discontinuities. First, there are a lot of other 'subjects' who cannot be ignored and secondly these subjects have their own discontinuities, ways of ascribing meaning and also their own intentions and purposes derived from their own needs. If there is no interaction with other subjects and consequently no affirmation or denial of social reality the self is in a precarious position to distinguish fantasy from reality. The absence of social interaction and its effects on the well being of very young children and babies is well documented.[62]

The process of creating subjective discontinuities represents the person's unique interpretation of the world and the ordering and categorisation of events. There is no guarantee, or likelihood that two people will exactly perceive and/or interpret an event in the same way.

Moving to the third part of the model, interactive discontinuity, let us consider how two people might make sense of or construe one person's (the subject's) behaviour. It is simpler to take this position for the sake of argument rather than at this point include the subject's interpretation of the observer's behaviour although this will usually be a part of the relationship. Let us return to the subject's behaviour flow and redraw it in terms of the subject's and the observer's application of subjective discontinuities.

Subject



Observer

Here we note that there is a coincidence of definition between both subject and observer for the first episodes A/A_1. After that there is divergence, convergence reappears between E and F_1 and the episode G_1 is subdivided into two by the subject F and G. If the observer and subject interact subsequently they may resolve differences and come to a consensus. This resolution will be affected by the nature of the relationship between the Subject and the Other (see Appendix III).

Sometimes it is not possible to check interpretations: for example, in the case of (a) small babies, (b) people who are severely mentally handicapped, because of communication problems or (c) observation where the subject does not know the observation is taking place or (d) the subject is no longer available, perhaps the interpretation is made through the use of video-tapes or (e) because to interact or ask the subject is ruled out because this is regarded as unscientific. The implications of a mis-match of interpretation will vary. If the observer is not intending to represent the world of the subject then such a mis-match is less important than if the observer is claiming to do so. (The implications of this are taken up in subsequent chapters and explored in Appendix III.)

For a person's identity to develop it is not only important to be able to make sense and act in the world but also to socially share that meaning structure. People need to have their method of ascribing subjective discontinuity recognised, and to have their transformations recognised. It is crucial that another person can see the link between need, idea, intention, transformation and objective as described above. If this does not happen a sense of isolation and alienation occurs where the person may feel or say: 'I didn't mean that', 'that's not what I was trying to do', 'but I've finished', 'you don't understand me', 'I don't need/want that', 'I <u>did</u> do that', 'but that <u>is</u> what I meant', 'can't you see what I mean'? Kegan sums up the importance of this process by saying "Our survival and development depend on our capacity to recruit the invested attention of others to us".[63]

RECOGNITION AS PART OF INTERACTIVE DISCONTINUITY

Thus the process of recognition, as described in Chapter 1, that is both the recognition of intention and transformation, is necessary for interaction and existence in the social world. Its absence leaves the feeling of, for example, 'we seem to have been at different events, from your interpretation' to the extreme of 'I might as well not exist for all the notice you pay to my contribution'. The next chapter explores the various implications of this lack of recognition for people with and without a mental handicap. A mis-match of interpretation is uncomfortable for any person. Although a mis-match may be a valuable part of learning, a way of reconstructing subjective discontinuity which leads to greater understanding it may also be a significant threat to the subject's whole world view including his or her identity.

The recognition of subjective discontinuities, even if it is not accepted as the best way of making sense of the world, affirms a person's identity, absence of recognition threatens identity.

The interpretation of experience is a changing process by which events are linked. The nature of the interpretation depends upon the developing complexity of problem-solving methodologies. If no one can understand this process of interpretation then in a social sense the individual has no meaning. At best it results in an alienated existence based upon self-sustaining belief which is difficult to separate from fantasy. Hence potentially the most lonely lives are lived by the brightest and dullest: Van Gogh or

the severely mentally handicapped i.e. those with relatively obtuse methods of creating subjective discontinuity which makes social interaction difficult since the discontinuities are not easily shared.

Kegan is one of the few who explicitly notes the importance of recognition: "Meaning is, in its origins a physical activity (grasping, seeing) a social activity (it requires another), a survival activity (in doing it we live). ... Meaning depends on someone who recognises you. Not meaning, by definition, is utterly lonely. Well fed, warm and free of disease you may still perish if you cannot mean".[64]

Any method of making sense of the world involves choice. There can never be only one way of constructing or ordering experience. Choice in behaviour and making sense of behaviour, underpins our existence and makes us unique individuals in that no two people will perceive and interpret an event in exactly the same way.

The exercise of discretion, making choices in order to solve problems and fulfil needs as a process is common to all humans (but not applicable to machines, however supposedly intelligent). The knowledge that such processes are understandable to others (although never perfectly so) is immensely reassuring as to our identity and sanity.

WORK

The definition of work used in this thesis is based on that of E Jaques (as in Chapter 1). It essentially refers to all purposeful (intentional) goal directed behaviour and is thus far broader and in some ways quite different from traditional, especially sociological definitions. [A discussion of those differences is not central to this thesis, consequently a fuller discussion of those differences is included as an Appendix (App I).] For the purposes of this thesis it is relevant to explicitly emphasise the importance of recognition and the social context.

It is argued that the social context of people with mental handicap or learning difficulties is highly relevant to their identity development. This social context includes significant social relationships often with employed carers, professionals who are in employment work. Resulting experience of a positive sense of identity is critical in the realisation of present and future potential of both groups (clients and carers). The extent to which the staff feel alienated or disconfirmed will directly effect the care they can offer and the nature of the recognition they afford to clients.

For adults work is a highly significant part of life and requires decision making and action. Dahrendorf[65] reflects the difference between the worlds of fantasy and work: "From biblical paradise ... , the dream of a world in which fried pigeons fly into one's mouth, so that one is spared even the work of eating, has attracted people". This is close to the state of omnipotence

described above where the image is magically transformed into the project which realises itself. (Presumably, in relation to need, the pigeons would also have to know who was hungry.)

This paradise according to this thesis would do nothing for identity development. It can be contrasted with Jacques[66] assertion concerning work as defined here being "... that behaviour which constitutes the primary plane of reality in which the individual relates his subjective world to the external world ... It is the behaviour through which the individual experiences the reality of his core identity".

This thesis extends the argument to say that work is not only a way of experiencing the reality of core identity but the way in which the identity is created, maintained and with appropriate recognition sustained.

Schutz describes that a person is working "when his behavioural flow is aimed towards the transformation of a specific part of the objective world so as to bring it into a state consonant with a state which he has in mind ... to produce an objective output which is the realisation of a subjective project".[67]

It is argued here that what is <u>also</u> critical is the recognition of this process by another. The absence of such recognition, or false attribution of the objective output will discourage the person from working and will lead to withdrawal from such activity and depression or an aggressive demand for recognition

perhaps through destructive acts more easily recognisable and attributed.

SUMMARY

The relationship between identity, work and recognition has been outlined

i) in order to have any sense of identity, for a subject to know he or she is an individual it is necessary to distinguish self from context or more generally figure from ground.

ii) This distinction comes about because the context inevitably does not provide perfectly for needs.

iii) This leads to a sense of lack where discomfort must be alleviated, needs fulfilled.

iv) In order to fulfill these needs distinctions have to be made in the context, some sense or order must be imposed to make the context more predictable and consequently amenable to manipulation.

v) This ordering process is the ascription of Subject Discontinuities, making sense of the world by dividing it into events.

vi) This is done both actively and passively. The subject through interaction and observation tests out the reliability of

the subjective discontinuities through purposeful action (which can be repeated) and judging results.

vii) The experience of need presents a problem to be solved. The nature of the complexity of both the perception of the problem and the nature of the solution depends upon the complexity of the subjective discontinuities and varies between individuals and becomes more complex as they develop. (Described as problem solving methodologies.)

viii) The solution of a problem requires action. The process outlined starts with a need or lack which is then formulated into an idea of what is wanted, described as the project. The subject now has the intention to act. The realisation of the project requires decisions and actions to bring about a transformation in the external world. It is the ability to carry through this process which develops the sense of identity. Thus the subject gains knowledge through action that he or she exists as an entity and can be effective.

ix) The part of the process described as purposeful behaviour is what is defined as work.

x) This whole process is still not sufficient for sustaining a sense of identity. It also requires <u>recognition</u> by another. Since we live in a social world and cannot develop or survive without social interaction the response of others is critical. Recognition also allows the subject to discriminate between fantasy and reality.

xi) The extent to which the subject's interpretation of the world (subjective discontinuity) represented by their action in the world, transformations, the realisation of projects, or work is misunderstood or recognised will have an effect on the development of their identity. If such transformations are not recognised, for example if subjective discontinuities are misunderstood then the subject's sense of self will diminish. There will not be a consistent affirmation of existence and the subject will become alienated and isolated and the person will lose their sense of meaning i.e. as being an identifiable causal agent in the world.

Before moving on to examine the particular issues involved for people with learning difficulties, and those in institutions it is important to examine in more depth the affirmation of identity. The experience of another's appreciation of work is referred to as psychological ownership.

CHAPTER 5

PSYCHOLOGICAL OWNERSHIP

"I used to want to help at home but my mum wouldn't let me do anything. I used to get frustrated because I wanted to help her but I couldn't"
Beryl

"I wore a long dress that used to belong to my aunty. My sister put on an old dress as well. We tried on old shoes. When we were dressed up, we went to show what we looked like. My grandmother laughed. We showed Mum and Dad and made them laugh. They said 'What did you put that rubbish on for?.' We had put it on for a bit of fun."
Eleanor.

Behaviour as an active process is in itself a transformation of the external world whether intentionally directed or not; it produces consequences and in a social world invites interpretation. Bettelheim[68] refers to a prelinguistic stage:
"...the infant can make it clear, through the way he holds his body, whether or not he feels comfortably held, but he cannot ensure that this active expression of his feelings will meet with a positive response. That will depend on how his mother reacts. While he can and does act on his own behalf, his view of himself and the world will depend on the success or failure of his efforts."

Although the young infant is in a highly dependent stage it is a time where the development of identity, for the child/baby is closer to the stage of operating primarily on the basis of subjective discontinuity. The baby's subjective intentions and interpretations of episodes is paramount, or in Piaget's terms it is a period of intense ego-centricity. It is characterised by the expression of will to do what you want, to realise your own projects almost irrelevant of others needs. Indeed, Freud pointed out that the early onset of the super-ego, that is, a subjugation of the baby's own wishes to those of others, causes excessive repression in later life and a powerful sense of guilt. Also in normal relationships babies and young children gain an almost inordinate amount of recognition and attention from parents and, where possible, the extended family and friends who continually affirm their sense of identity. Almost any transformation is recognised with delight and pleasure or concern. Babies are difficult to ignore.

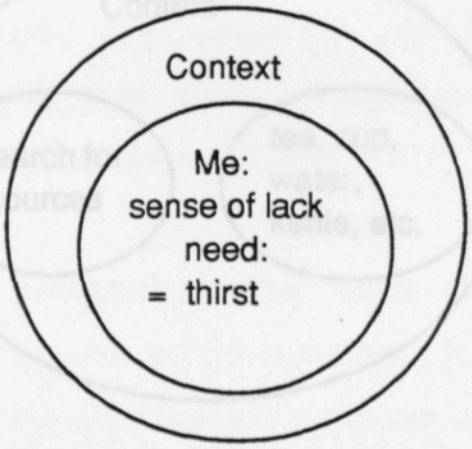
The extent of attention and recognition tends then to diminish, relatively as children learn to become more self-sustaining and less ego-centric. For example, the term "attention-seeking" now widely in common use usually implies an excessive desire for recognition and self-assertion.

This thesis proposes that whereas the form of recognition does change over time, and that there are longer gaps, or greater tolerances with regard to affirmation, that the underlying social need for recognition remains.

Popper[69] would argue that what a person observes is dependent upon the theory held by the person when he or she approaches the observation. The construal of events is dependent upon purpose and the 'problem-solving methodologies' available. Therefore for people to understand and recognise anothers' way of ordering the world and the 'work' that is involved, they must have an understanding of the method of ascribing subjective discontinuity - i.e. the subject's definition of a project and purpose.

One major assumption underlying the concept of work is a sense of self and identity. Without a sense of separateness there can be no context. The 'project' could not be <u>located</u>, because the sense of lacking would be <u>universal</u> rather than <u>particular</u>. Without a sense of identity there would be no attention, since figure and ground would be blurred. However, work and identity dynamically interact, i.e. from the first primitive notions of frustrations come relatively inarticulate projects of which some will result in action and transformations, which in turn serve to develop the sense of identity.

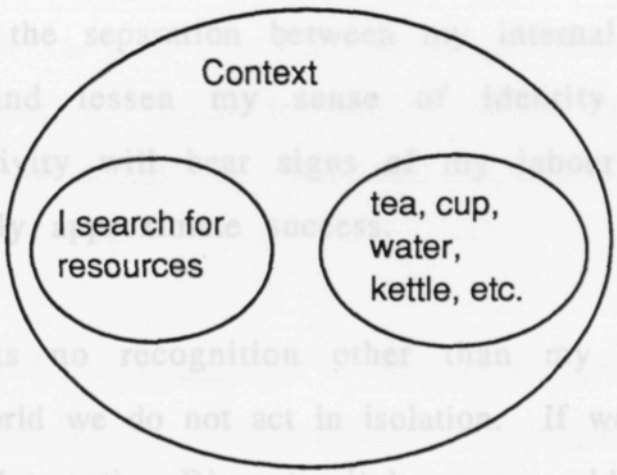
Take a simple example



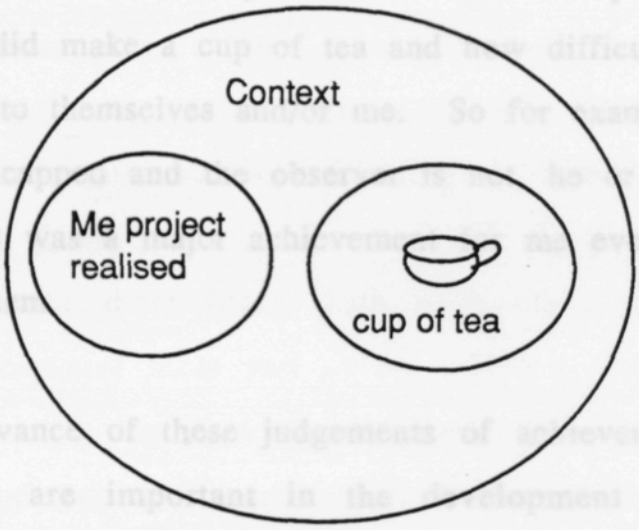
I then formulate a project to fill the need: make a drink, say a cup of tea:



This 'making a cup of tea' is now a problem to solve. The difficulty of the problem is dependent upon my ability to conceptualise the process of tea-making and the available resources in the context (clearly it is more difficult in the Sahara desert than in my own kitchen). Thus the next step is to focus on the context for resources and apply my problem-solving methodology:



Suppose I solve this problem



The cup of tea now exists in the context which has been transformed by my action.

I can point to the realisation of my idea and enhance my identity as having completed a piece of work. I am now, in part, a 'tea-maker'. The realisation will never exactly reflect my project: it is not ideal or perfect. This is because I can never exactly predict the result of interaction with the context. In fact, it is an important aspect of the realisation that it is not perfect. If it were it would reduce the separation between my internal and the external world and lessen my sense of identity and separateness. The activity will bear signs of my labour and frustration and hopefully approximate success.

At this point there is no recognition other than my own. However in a social world we do not act in isolation. If we use part C of the model (Interactive Discontinuity) we can add into

the context another person. This person, say for argument, an observer, will also have a view of my behaviour, and an opinion on whether I actually did make a cup of tea and how difficult a task that was, relative to themselves and/or me. So for example, if I am mentally handicapped and the observer is not, he or she may recognise that this was a major achievement for me even if it would be easy for them.

The accuracy and relevance of these judgements of achievement and relative difficulty are important in the development and sustaining of a sense of self and part of the process of recognition and assigning value to psychologically owned actions.

The experience of psychological ownership produces a sense of positive identity in contrast to a 'disowned' or alienated sense of self. There is considerable literature concerning alienation[70] and anomie, but relatively less discussion concerning positive, unalienated states. The Kleinian concept of "integration" or Maslow's[71] "self-actualisation" are general concepts in this domain. Both Jaques and Marx emphasise the importance of work, i.e. being able to identify, in the outside world, the results of your actions, which in turn are the results of ideas (or projects). This recognition, which is social, results in the subject's "psychological ownership" of action and enhancement of identity.

Now this ownership refers to the process as well as the product, but the ownership of the product is determined by the process. For example, the initial process is determined by initiative:

whose idea/project is it? Who interpreted the need, who formulated a project, who worked out the process, who carried out the process to its end point? Now it will be very unlikely that in major pieces of work, or large projects, e.g. building a hospital, setting up an export business, running a school, one person would or could "own" such processes. All the time, in social organisation people share ideas, help each other, watch others, learn, copy, reorganise ideas and so on. This is coupled with actions interpreting as yet unexpressed needs, i.e. anticipating needs, or creating needs and projects. Such intentions form a complex pattern of mutual dependency. However, individual behaviour is still identifiable. It is therefore possible to have individual accountability and make some statements as to who contributed to an end result, for reward or blame.

Psychological ownership of action refers to the extent to which a person feels they are responsible for what they are doing, and for problems they perceive and acknowledge. The extent to which the person can own their activity will determine the extent to which they can function as identifiable individuals and develop and sustain an identity.

If a person's activities are totally prescribed, that is they simply follow orders, this will demote, or eventually entirely eliminate, their sense of psychological ownership of that activity. This is the negative effect of institutionalisation. Action will be carried out "objectively", i.e. the person in action has become the object, or agent of another's will, their powers of choice, discretion and

will are not only unnecessary but a nuisance and to be kept outside the setting. This of course is much more serious if the setting is all embracing, e.g. in a twenty four hour residential setting. It is especially problematic for the 'individual' if

a) his external action in the world is completely prescribed (as far as possible),

b) this is extended over the full twenty four hours,

c) this also coincides with an attempt to control the internal processes, i.e. thoughts and fantasies, through mental treatments of one kind or another.

A person under those three conditions would stand little chance of psychologically owning any activity and little chance of establishing or maintaining any identity, because initiative would be stifled and enforced dependency would result. However even if consciously attempted it would be virtually impossible totally to prescribe any person's internal and external world. Even in residential establishments mentioned above the lack of staff means that such total control is not possible. This does not allow for complacency, as will be discussed below.

So far psychological ownership has been discussed in terms of external constraints. There are also internal defences against ownership. Because claiming psychological ownership leads to identification, and hence visibility, it can also be felt as dangerous. As discussed above, it enhances separation, with accompanying anxiety, and also emphasises the testable limits of

power or influence. For example, it may be easier for a student continually to read and learn other people's work, taking notes, paraphrasing, buying books, etc. and then regurgitating this work in the form of safe essays. In this way original ideas are never allowed to see the light of day or be developed because they may result in the identification of the student's ideas rather than the books and authors she or he had read. (The only positive contribution such a person can make is in being a walking reference library.)

Unalienated work, or psychologically owned action has the task of confirming identity and effectiveness. Paget[72] in his thesis goes further:

"... work may also be regarded as being an integrative function. In attempting to bring an object in the outside world into a state which corresponds to a preconceived model, we in some sense involve ourselves in "pulling together" or unifying elements of our environment. These elements may, initially have the appearance of being in chaos - in bits - and our task will, therefore, be concerned with imposing some kind of order of unity upon them" Paget refers to Jacques[73] comments that the act of bringing the pieces together into a complete whole may be invested with a great deal of symbolic meaning with regard to the felt effectiveness of the subject.

Work has been the subject of discourse for sociologists as well as psychologists. (As explained in Appendix I work is more interpreted to mean employment work and thus literature concentrates on the adult experience, although material on

alienation introduces general psychological considerations.) Nisbet[74] points out, there are differences in the concepts of alienation as put forward by Marx, Durkheim and Simmel but all refer to a sense of dislocation and isolation rather than constructive separation which enhances identity development. There are perhaps closest links between the ideas of Hegel and Marx and the ideas of Jaques, Klein and Schutz.

Hegel[75], referring to material rather than psychological ownership, outlines three ways of attaining property:

a) directly grasping it

b) forming it

and c) marking it as ours.

Hegel regards the first as being "only subjective, temporary and seriously restricted in scope". Despite this view, it is this method coupled with (c) (marking) which is probably seen to be the most obvious and tangible form of material ownership. Most possessions are held on to, locked away and marked so that if necessary the "owner" can recognise them. However, a deeper sense of ownership is implied in the second way (b). As Hegel continues "when I impose a form on something, the thing's determinate character as mine acquires an independent externality ... I have put my will into and so made it reflect my personality".

This is very close to the Schutzian notion of realisation of the internal project and the implied attachment which is created: it is an externalisation of the self.

If we examine the true nature of the value of possessions, it seems that those which are most treasured, in terms of our identity, are objects. e.g. clothes, furniture, books or even cars which have been used or which we or friends and family have made. That is, they are literally or metaphorically worn into shape and feel comfortable. Many such possessions, if for example stolen, may even be regarded as of little value and rather apologetically as having only sentimental value. They are precisely most valuable because they bear signs of our or others relationships, our realised projects. (In discussion with someone who has been burgled they often report these are the most painful possessions to lose and cannot be replaced easily, if at all.)

Thus Hegel is proposing that it is 'forming' something which is essential to ownership. Schacht[76] refers to Marx in terms of process rather than output: "a man's labour is only his own labour for Marx, when it is spontaneous, free and self directed". Schacht continues: "it is his own only if it reflects his own interests, manifests his own personality and is prompted by his own need to build or create something of his own choosing."

This is in essence what is meant here by psychological ownership as part of the development of identity. What perhaps is missing in this section of Marx's analysis is the fact that work

is essentially social. That while the above quote parallels Schutz's original project it must eventually be socially shared and recognised and verifiable. Marx's[77] main argument lies in the analysis that employment work under capitalism precludes the possibility of the worker sharing or determining the fate of the product and consequently denies psychological ownership: "labour is external to the worker, i.e. it does not belong to his essential being; that he therefore does not confirm himself in his work, but denies himself, does not develop freely his physical and mental energies but mortifies his flesh and ruins his mind ... it belongs not to himself but to another, and that in it he belongs not to himself, but to another."

In all relationships there is a possibility of reducing one side to that of an agent or object of the other's control. Where the person or group does not exert control or influence over either the process or product of their work, or where their influence is denied then psychological ownership is prevented and the person becomes alienated, their identity submerged by another. This is most effectively done by denial of the contribution through coercive power whereby an individual finds it more beneficial in the short term to collude in denying their contribution; to anonomise it. This can be done where the result or purpose of the activity is split off from the participants. The goal state or product assumes the illusion of independence from its production. The contributors may be ignored or deny their involvement as a defence.

One way of attempting to avoid this is by making the process or work as visible as the product. In this way neither products nor individuals can be seen in isolation but in terms of their relationships with one another. The result or product is traced back through the process of transformation, idea, project, identification of need as explained above.

This chapter and the previous one contain the central theoretical argument of the thesis. Its basic proposition is that a person will develop and maintain a positive sense of identity if they can

(i) separate themselves from their context

(ii) make an internal link between the identification of need and how that can be satisfied (construct a project, and select a problem solving methodology.)

(iii) realise that project through action on the world (transformation) which achieves a result (objective)

(iv) this process is recognised and associated with the subject by others in the context.

(v) this allows for psychological ownership of action which underpins identity.

For this process to be successful it requires that it is understood by another. This in turn assumes the other's ability to interpret approximately (if not perfectly) the way the subject construes the world i.e. their process of creating subjective discontinuities which allows for meaningful social interaction (interactive discontinuity).

Anyone who has been misunderstood or misinterpreted knows the consequences of failure. Anyone who really tries to understand the intentions or actions of another knows this is not simple even if it is critical to the affirmation of identity. The problem of understanding and attributing meaning has a long philosophical tradition. It is not the intention of this thesis to examine such philosophies in depth. A brief review of some of the ideas most relevant to this thesis is contained in Appendix II.

It is sufficient for the present argument to say that the world of subjective discontinuity must at some time be available to others if identity is to develop and be tested in the context of social relationships. Of concern here is how we articulate such discontinuities and know if anyone else understands them. Under what circumstances is it possible to determine who intended and actively did what and what was the nature of their contribution? How can we verify the assumed causal relationships necessary to establish and affirm identity as discussed above?

Hume[78] argued that the relationships between events are a human construction. He separated events in the non-social world ("noumenal") from experiences filtered by human understanding which result in "phenomena". Schutz was primarily concerned with the social world, as is this thesis. He (Schutz) accepted James[79] distinction between 'kernels' and 'fringes' which is similar to the concepts of distinction between figure and ground. What is useful about James distinction is that

the figure/ground concept is in constant flux according to the purpose of inquiry and observation.

How do we know how others construe the world, what their filters are, how they make subjective discontinuities? How do we know who they are, what they mean and intend?

The argument here is that this is achieved primarily through observation of behaviour and then making assumptions about projects and intentions from this, i.e. interpretation. How do we know if we are right, especially given the thesis here that getting it wrong or denying it (consistently) has disastrous effects on the development of identity?

Schutz assumed that people share a basic experience of ordering which permits communication. This he referred to as common-sense understanding which returns to the beginning of the previous chapter. After all we can simply ask most people, "Did you do that, did you mean to do that, why did you do that?" He assumed these common experiences were shared by all competent people. One of the concerns of this thesis is for those people who may not be competent, who may not even be able to speak. It is therefore much more difficult to be confident about understanding the way they construe the world and consequently give them recognition.

A first step is to be clearer about the general nature of the process itself which has been the purpose of these last two chapters. It is then possible to look at the specific problems

encountered in the process of identity development by people with learning difficulties and eventually how they might be addressed.

The concepts explained above can then be used as tools for better understanding and so to enhance the possibility of expression of current and future potential.

CHAPTER 6

IDENTITY DEVELOPMENT: PEOPLE WITH LEARNING DIFFICULTIES AND THEIR CONTEXT

"I was born a baby. My mum used to sing songs to send me to sleep. Hush-a-Bye, Baby. And she would rock me. She was nice and I had baby food. I used to suck my thumb when I went to sleep and I dirtied my nappy. Mum used to change it for me. When I got older I used to wash my face. I got soap in my eyes. I screamed 'Wah! Mum!' and she came and washed the soap out. Afterwards she took me for a walk to aunty's in the pram. I went to sleep. Those are happy memories, and now I'm grown up."

Alan Marshall

The last chapters put forward a general model of identity development but included propositions that were as relevant to people with learning difficulties as the rest of the population. This chapter examines some of the particular problems encountered in this process by people with learning difficulties. Some of these problems have already been mentioned as part of the general discussion. For example, it is easier to establish a negative identity, or that most people with learning difficulties will be unable to solve everyday problems that we hardly regard as problems.

The essential link between work and identity has been discussed, in essence it is that work and its results provide

objective evidence that we exist. To some extent we are what we create. People with learning difficulties may not be so obviously creative. It may not be as easy to understand their purposes and intentions. This chapter examines the particular problems faced by such people and begins to focus on the area of interactive discontinuity; it looks at the relationships which inhibit or handicap the person (as defined in Chapter 1).

The initial stage in identity development requires the distinction between self from the environment. Me and not me. There is no reason to assume that for a person with learning difficulties this does not occur since it is founded on the reality that the context is disturbing because it does not satisfy internally felt needs automatically. The basic needs of people with learning difficulties are no different from anyone else's from an objective point of view. They too, as babies, experience needs and must struggle to make sense of what is happening to them and what they can effect. They too must construct a set of subjective discontinuities. It is here that the differences emerge.

For the person with learning difficulties, as the name suggests, this is more of a problem. The associations, primitive causal links are much less sophisticated and much slower to be made. Sorting out the environment is relatively a much harder task, especially constructing an understanding of how they can affect the environment. The world must seem immensely more magical and remain so for a longer time. The context continues to be less predictable than for normal infants.

Even in the world of subjective discontinuity it is necessary to form an image to create an intention and a project. The person with a learning difficulty is in a more bewildering world. Their relative slowness in construction of projects may mean that the environment, in constant movement, has moved on before they can act. Also the associations are slower to build up, the mental image cannot be maintained for long enough to test properly given the relative slowness of action.[80] It is more difficult to discern events, especially with the self as actor, except through the most simple actions. In Piagetian terms the concrete operational stage is prolonged and much more simplistic.

This results in a more passive orientation to the world as it flies by in relative chaos. The emergence of identity, as a positive entity, is much more precarious and liable to confusion. This in turn may result in a poorly differentiated self, alienated from action and the rest of the world. Such an experience, although just described as magical is not necessarily exciting. Indeed it may be extremely threatening and anxiety producing, encouraging a regression to the unified or undifferentiated state. If we look at early interaction with the world then for the majority of children the most obvious form of interaction we call play.

One of the striking aspects of the behaviour of many children with learning difficulties, particularly those with severe difficulties, is the absence of play.[81] There is less apparent curiosity, activity and interest in the world. Now in this thesis, play is not contrasted with work. Indeed, it is work in that it is

purposeful activity. It is suggested here that apart from its immediate purpose (e.g. building a tower of bricks) the overall purpose of play is the external expression and testing of subjective discontinuities.

Three types of play are distinguished here. First, is play which is direct manipulation of objects. Here the objects are simply what they are or can be made to be, it includes building, banging a spoon, simply grasping, putting objects in one another or under etc. Here the objects are not representative or symbolic.

The second type of play is where objects (toys) stand for real objects. Such play is often absent in many infants with learning difficulties. In this type of play an object is used for what it represents, e.g. a toy car or telephone, the infant can pretend it is what it represents although it does not function in exactly the same way; toys are not simply perfect models or replicas. Whilst many infants of around one year use this form of play, infants with a learning difficulty, at this age are more likely to use such objects in direct manipulation if at all. Play of this second type is essentially testing and developing subjective discontinuities.

The third type of play is where objects are used in interaction to stand for something quite different; in this case play is used to model not only subjective discontinuities but interactive discontinuities. The purpose of this play is to rework the social interactions to the subject's purpose. This play, which includes scolding teddy bears or feeding imaginary friends is apparent in

most two year olds. It is rarely if at all seen in infants with a learning difficulty at the equivalent age, and for some it does not appear until teenage or adulthood. It is essentially role-modelling and role rehearsal where situations can be predictively or retrospectively worked through.

This play is an early method of testing and modifying subjective discontinuities and entering into and reflecting upon interactive discontinuities. It is a crucial part of the process of forming and testing identity through external transformations. This play is serious business, which is well known to any adult who tries to interfere with it. In other words, play is a method for the infant to discover who he or she is with minimal external constraints. It is work but not work as toil or labour (see Appendix I) since the infant is in command of purpose and can 'play' for as long or short a period as he or she wishes given the tolerance of the objects and the strength or fatigue of the subject.

Play is a means to cross from a completely internal world, or fantasy, to the social realities of managing interactive discontinuities.[82] It is a method of establishing identity through the active process of realising projects.

The absence, particularly of these last two types of play for the infant with learning difficulties has corresponding effects on their identity development.

It is more difficult for them to develop especially in social relationships. Play gives access for an outsider to make

educated guesses about the subjective discontinuities of the player and their intentions. It is complicated in the case of youngsters with learning difficulties by the fact that intellectual development may be slow but physical growth is often relatively normal. It is quite a different experience to interact with six month baby banging a cup on a table and a sixteen year old carrying out the same activity.

This process of slow intellectual development in terms of understanding the world, means that a positive, active identity is also slow to emerge. Interaction is less obviously meaningful and requires more thought and effort on the part of the other. This in itself may cause difficulties. Over activity on the part of the other may actually enhance the dependency. This is compounded in some cases by the slower development of those physical activities which normally enhance separateness such as, crawling, walking and talking. Thus paradoxically the state of omnipotence (as described above) may actually be prolonged as is the eventual egocentric world view. Parental (or carers) expectations may result in an overprotection. The less obvious availability of the system of subjective discontinuity may mean that actions are misinterpreted, recognition given at the wrong moment due to a misreading of subjective intention. In order to compensate parents may give, at times, an over-enthusiastic response to a tiny activity (compounding omnipotence) or conversely miss other transformations altogether.

It is more difficult to discern what problems the person with learning difficulties has constructed and is trying to solve and

also how their actions or problem solving methodologies are used to realise their projects.

The failure to perceive the subjective discontinuities from the point of view of the person with learning difficulties will lead to a misunderstanding of purpose and behaviour. In such a relationship it will at times be only a matter of chance as to whether the recognition of transformations actually occurs and consequently enhances identity development. The tentative relationship between internal projects and external transformations is therefore not consistently affirmed with a corresponding hindrance to development and the lack of feeling of psychological ownership as described in the previous chapter.

How can a person with learning difficulties be better understood and have their work recognised? The failure to afford recognition continues to blur the distinction between fantasy and reality and weakens identity. If the person remains in a state of what was described above as 'normal autism'[83] or the 'paranoid-schizoid position'[84] this can result in what is described in adult life as psychotic behaviour.

It is not simply a question of teaching the correct reality. This thesis puts forward an argument that we all have slightly different realities in terms of subjective discontinuities. However this is not to say that because we all construct reality differently that every reality is equally valid. (See Appendix II). A blow on the head with a brick has the same effect physically whether the person is 'psychotic' or not.

The testing of subjective discontinuities, comes through the transformation of projects through decision and action. The confirmation of reality, through interactive discontinuity, comes by way of recognition from another that an event has actually taken place. It is these two processes which are relatively difficult for people with learning difficulties and hence threaten their identity development and psychological ownership. This in turn undermines the expression of potential both current and future. The apparent absence of play or easily recognised expression of internal projects makes mutual interactive discontinuity more difficult.

If the person is unable to construct projects and cannot create a set of subjective discontinuities which have any clear effect on the world, even in play, there is a limited opportunity to enter into socially meaningful relationships. Such a situation is not sufficient to sustain identity. The external world remains unexplained and becomes more threatening due to its relative unpredictability. Since the wider world cannot be explained or ordered, too many problems remain unsolved causing a great deal of anxiety. In such situations it is not surprising that the subject attempts to live in a smaller, more explicable and thus predictable world which is under control. Thus an inadequate system is imposed on the world to form a predictable, repetitive and hence reassuring pattern. This is most clearly observed in stereotypical behaviour; constant repetition.

Examples of such closed, predictable systems are repeated rocking back and forth, hand gazing, twirling which often include

precise repetition and may be associated with repeated sounds. Such behaviour creates an almost completely predictable world where the beginning and end circle into this continuous repetition. Observation of people engaged in such behaviour (severely handicapped and/or disturbed) gives the impression of exclusion. It is very difficult to break, or even break into the pattern. In the case of autism (where stereotypical behaviour is concerned) it is very difficult for the therapist to enter this world. Whilst such (disturbed) states are not examples of pure undifferentiated behaviour i.e. where there is no separation of self and context, they have the effect of producing a controlled but closed world. It is a world of high prediction where novelty any surprise or even initiative is excluded. Whilst it is not the intention of this thesis to explore such clinical states in detail it is relevant to note that such behaviours are often a response to anxiety. They are a reaction to the inability to produce a satisfactorily ordered world and the repetition of known behaviour has the effect of reducing external or uncontrolled stimuli. It is also similar to (re)creating a sense of omnipotence.[85] This state is described by Melanie Klein as typical of tiny babies and called the 'paranoid schizoid position' because the world is split into very small manageable chunks. Thus the world is eventually ordered into a series of predictable events which flow into one another. Identity is temporarily protected by being sealed off.

The major problem for people with learning difficulties is not only their slowness in general intellectual development, it is the effect of this slow development on the development of identity.

The absence of successful projects, due to an inability to interact effectively with a complex environment means that very little work gets done. This in turn means that there is less opportunity for recognition. The resulting subjective discontinuities become detached from the external world. They are ineffective models of the world which become isolated.

Finally the absence of obvious, or easily understandable intentional behaviour (as discussed in the example of play) makes social interaction even more difficult. Since it is difficult to perceive and recognise episodes. This not only makes identity development more of a problem but also assessment. It is difficult to assess current or potential ability.

The next chapter examines assessment in the field of mental handicap and considers various approaches which to a greater or lesser extent take these issues into consideration.

CHAPTER 7

ASSESSMENT

"If people were identical in all their characteristics, there would be little point in devising tests'
Berger and Yule[86]

In the field of mental handicap or learning difficulty - the term assessment has many different interpretations.[87] Recent Government policy set out as a key objective: 'to make proper assessment of need and good case management the cornerstone of high quality care'.[88] The emphasis on individual care programmes designed to counter institutionalised care and their effective implementation of individual planning is critical to the success of recent policy.

This chapter demonstrates some of the problems involved in implementing this policy. It discusses assessment in general terms and examines some of the current methods. Next is an analysis that suggests a new approach is required which is discussed in the next chapter. The chapter does not attempt to cover the whole field in detail, a more detailed analysis by the author is appended (Appendix IV Assessment a Social Dimension) and a comprehensive account can be found in Peter Mittler's[89] book on this subject and another book of Papers edited by J. Hogg and N. Raynes.[90]

One confusion in the field centres around the differences in assessing ability and assessing need. The assessment of need can be based upon general criteria and assumptions concerning human need in general. For example, the fact that a person has a learning difficulty does not diminish their need for food, clothes, shelter, human company and so on. Further the deprivation of institutions has been highlighted in terms of the absence of privacy, personal possessions, access to basic facilities, toilets, baths, etc. There is no reason to suppose these are any less a need for people with learning difficulties. This has led to methods of assessing need which are actually not specific to any client group, (and will be discussed below). Such assessment practices ask the basic question, what does this person need in general in order to improve their life?

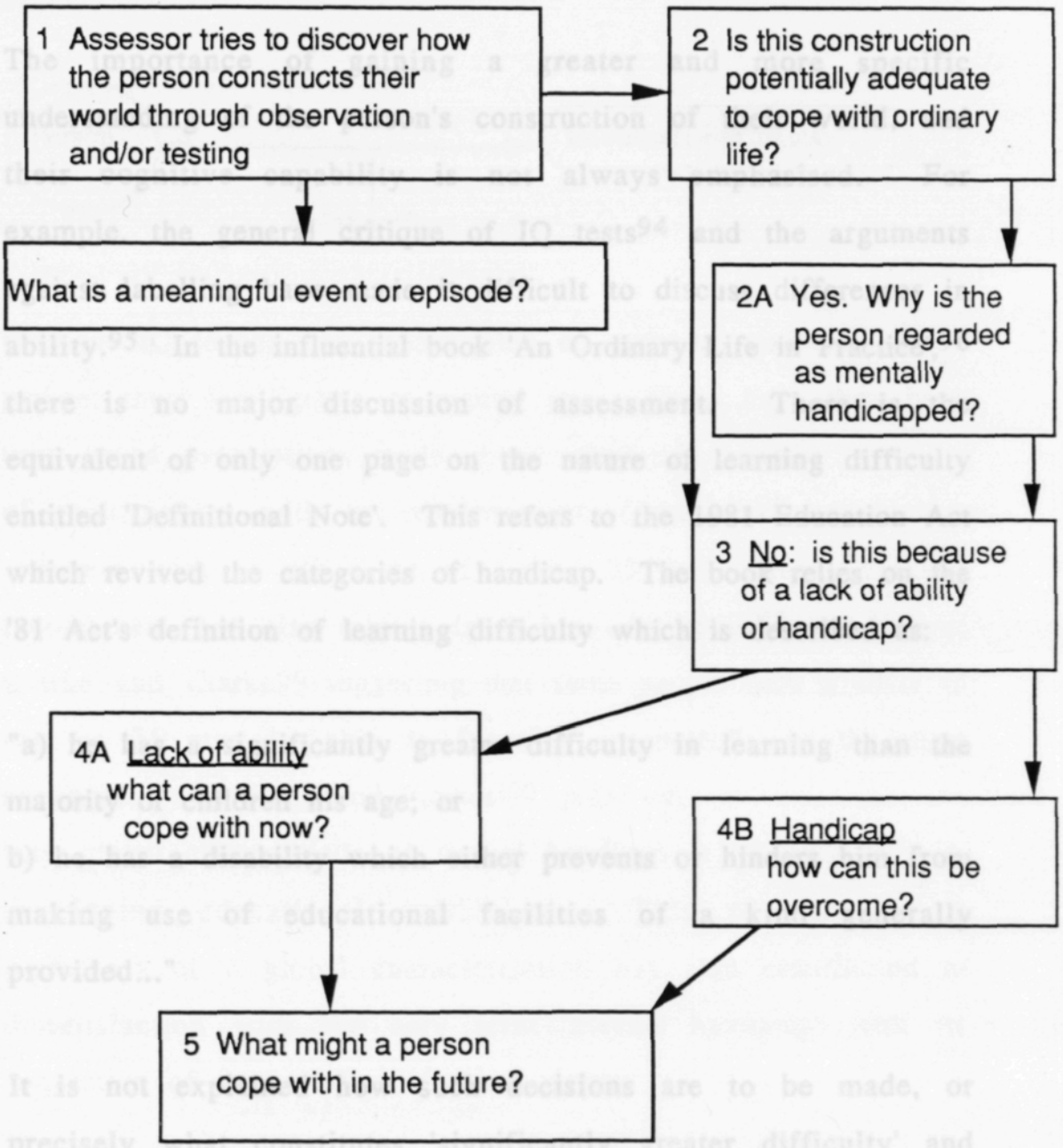
Assessment of ability is quite different in that it requires a judgement concerning the person's intellectual capability. This in turn must be based on some model or theory of development and individual differences. One major problem in the field of mental handicap is that there is no universally agreed model of capability, or developmental theory that can be applied. There are several proposed, some of which are potentially complementary. Many intellectual or cognitive methods of assessment are based upon Piagetian concepts.[91] Others offer more general models of development as for example, by the author[92] and Allen.[93]

These two aspects of intellectual capability and need are not independent. People's intellectual capability will influence their

needs, because the way they construct their world will effect their perception of need and how it might be realised, as discussed in previous chapters. A person may need food but their ability to understand how and why to cook certain foods may determine how that need is met. This is not simply a question of skill, the acquisition of a skill and certainly its appropriate use will again depend upon intellect. For example, one problem associated with people with learning difficulty is the transfer of skill, a person may be able to use a particular gas cooker, or washing machine in one setting but when moving to a new setting where there is an electric cooker and different type of washing machine, this may require a complete re-learning of the process. For some this is because they have learned, in a rote way, the mechanical processes involved but do not understand the underlying, more abstract concepts of, say, heat and energy.

Assessment, particularly of intellectual capability is an attempt to understand the way in which a person constructs their world. This can be done by observing behaviour, sometimes through direct testing, and making a consequential judgement as to what sort of situations the person can cope with, and whether they require help. Assessment can be seen as a way to elicit problem-solving methodologies, or in the case of cognitive tests, to try and find out what cognitive strategies a person can use and consequently what they may or may not be able to do.

In diagrammatic form assessment may follow the process described



In terms of the thesis an assessment is required to articulate and appreciate what work a person can do now, (current potential), whether they are handicapped, and what work they might be able to do in the future. Without this appreciation, either in a formal process of assessment or the social judgements made

through everyday contact, it is very difficult to provide appropriate recognition.

The importance of gaining a greater and more specific understanding of the person's construction of their world, and their cognitive capability is not always emphasised. For example, the general critique of IQ tests[94] and the arguments against labelling have made it difficult to discuss differences in ability.[95] In the influential book 'An Ordinary Life in Practice',[96] there is no major discussion of assessment. There is the equivalent of only one page on the nature of learning difficulty entitled 'Definitional Note'. This refers to the 1981 Education Act which revived the categories of handicap. The book relies on the '81 Act's definition of learning difficulty which is described as:

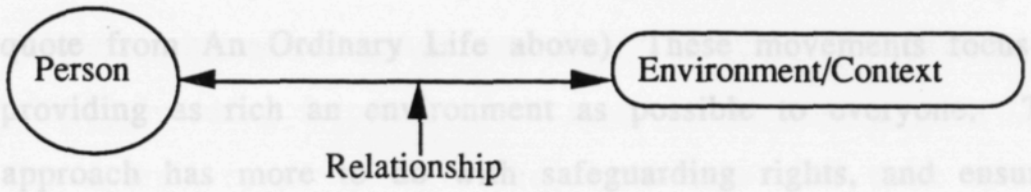
"a) he has a significantly greater difficulty in learning than the majority of children his age; or
b) he has a disability which either prevents or hinders him from making use of educational facilities of a kind generally provided..."

It is not explained how such decisions are to be made, or precisely what constitutes 'significantly greater difficulty' and why should this be?

Relationships

The nature and extent of the severity of any handicap is a function of both the individual and his or her context. It may be more useful to look at the handicap in terms of the relationship

between the person and his or her context. In the past there has been a concentration on one pole or the other (as in the diagram below)



Previous IQ testing has concentrated on apparent qualities of the person; their intelligence or mental age. There have then been very broad assumptions made about what this implies in terms of relationships with the environment. Gunzburg[97] argues that someone with an IQ score of below 25 will remain socially incompetent but also quotes from his own work[98] and that of Clarke and Clarke99 suggesting that some people with a score as low as 35 may be able to function successfully in the open community. As Hogg and Raynes[100] point out:

'any global characteristic of mental handicap is of little help in developing educational curriculum.... This rejection of a usefulness of a global characterisation has also contributed to dissatisfaction with the very term 'mental handicap' with its suggestion of a generalised internal deficit'

The basic problem with a score, or mental age, is that it gives in itself no evidence of how that score is achieved, what items or sub-tests, were completed or failed. Despite this it has been used to inform decisions as to whether a person is ready to live in the community.

On the other hand the Normalisation or Ordinary Life Movement has placed almost complete emphasis on the environment or context to the virtual exclusion of discussing the nature of mental handicap or learning difficulty, (as demonstrated by the quote from An Ordinary Life above). These movements focus on providing as rich an environment as possible to everyone. This approach has more to do with safeguarding rights, and ensuring humane treatment, rather than identifying needs based on an assessment of intellectual capability.

The concept of work links the person with their environment. The observable, and consequently recognisable, transformations are the evidence of a functioning person as described in Chapters 4 and 5. Therefore an assessment should concentrate on the work that a person is capable of (present potential) and might be capable of (future potential). Since the environment is an integral part of the working process there must be information as to that environment which may encourage or inhibit the opportunity to work. It is argued here that an assessment process should not focus on one pole or the other as the main determinant of behaviour but describe the process, or relationship between them, while at the same time referring to the poles in order to describe the relationship.

The purpose of an assessment is not or should not, merely be diagnosis, or categorisation but statements about what situations a person can and might be able to cope with, and under what conditions (for example, with training, support, education, etc.). Since this thesis is concerned with reality, and identity as social

concepts, then assessment is not only concerned with understanding the nature of subjective discontinuity, but making statements about interactive discontinuity. Very simply, an assessment should make some statement about how the person will act with others. Are they likely to share an understanding of what washing face and hands means? Or putting on a sock? Or is their construction of the world such that these are not meaningful transformations. It is important to understand the way in which a person assigns subjective discontinuities in order to pattern and order their world but only so far as this can be linked to social relationships (and hence interactive discontinuity). For example, if a person does not use or have available the concept of object permanence then this will effect the way in which he or she perceives and structures the world. If an object is removed from sight, it disappears, and there is no point in looking for it. Thus problems will be perceived and acted upon in a different way than for a person who does have the concept of object permanence; in this case the person will search for it.

Similarly if a person thinks pouring a liquid from a short, fat container into a long thin one increases the amount, then they will act differently (for example in choice of container) than someone who assumes the volume has remained constant.

The field of assessment which comes closest to articulating subjective discontinuities and the implications is that of Developmental Scaling, compared with Intelligence Testing:

Unlike Intelligence Tests development scales are based on attempts to articulate an underlying theory of development, or more properly maturation. These are generally based on the work of Piaget. In the field of mental handicap, Bricker[101] argued that the use of behavioural techniques should be influenced by increased knowledge of psycholinguistics and cognitive development.

Most of the Developmental Scales, if not precisely based on Piagetian concepts, do assume a developmental process. In this process the person passes through stages, of increasing complexity, whereby he or she uses different and gradually more complex strategies to make sense of the world he or she is interacting with. Whilst particular descriptions of stages do not gain universal agreement the general concept of developmental stages is less contentious. The gross differences between the sensorimotor, preoperational and operational construction of the world are evident to the observer of people with a mental handicap as well as children.

Piaget's associate Inhelder[102] is critical of intelligence tests on three main grounds, first that they are essentially concerned with outcomes or products and not with the cause of behaviour. Secondly, that the tests are simple increments and tell us nothing about the achievement of the score. Hogg and Moss[103] demonstrate that the same Mental Age can be scored by Down's children and non-handicapped but with a very wide differentiation in terms of how this score is achieved. Thirdly, that psychometric testing in general "tells us nothing about the

way in which behaviour is transformed at successive levels of mental development."

Currently the most widely used scale is the Uzgiris and Hunt 'Ordinal Scales of Psychological Development'[104] which is based upon the assumption of sequential, cognitive development. This offers some understanding of what developmental stage may be expected next but not necessarily when. For example, with regard to object permanence the scales list the following (quoting from the text)

'8. Finding an Object after successive Visible Displacements'.

a) Does not follow successive hidings.

b) Searches only under the first screen.

c) Search under the screen where the object was previously found.

d) Searches haphazardly under all screens.

e) Searches in order of hiding.'

Of course this structure or model is derived from observations and Piagetian Theory and although work has been done in the field of validity and reliability (Kahn)[105] this does not mean it is exactly representative of the person's construction of their world (Subjective Discontinuity). However, the testing process is closer to the discovery of Interactive Discontinuities than IQ tests since it is designed to use familiar objects, is often administered in the home or home surroundings and can be modified to the apparent interests of the subject.

Developmental scales are more useful than intelligence tests to the tester and/or carer since they:

a) give some idea as to how the person solves problems and hence by implication constructs the world and the sort of complexity that can be handled

and

b) give some idea as to what a person might move on to, what the next type of problem they might attempt to solve or be taught.

c) through the interaction necessary in the testing process provide some insight into Interactive Discontinuity.

What essentially is missing from such scales is a description of the usual opportunities afforded to a person in their everyday life.

The original identification of whether a person might be 'mentally handicapped' is most often made in a social context.[106] There is a social judgement that a relationship is not as it should be, or is expected to be: a child is not responding. If this judgement is examined by using IQ tests then we concentrate on the individual, one pole in the relationship (p115). This leads to a conclusion that a person <u>has</u> an IQ of 55, a person <u>has</u> a developmental age of six months. Such assessments, on their own, tend to underestimate the social aspect of the problem and the fact that abilities are never demonstrated in isolation but in the context of at least one other person. Further, the overall purpose of assessment lies in the completion of the process from identification of a problem to resource allocation. The result is

not just a score, not just an attempt to identify an attribute of an isolated individual, but a decision regarding what rights or resources are to be allocated to the individual and/or family. The resources are in the form of aids, professional help, financial assistance, premises etc. which are the actual manifestation of the plan or programme. This is the social meaning of the test score. It is equally meaningful if no resources are forthcoming. Consequently, the relationship between test score and resource allocation, while most important socially, is the weakest aspect of most of the tests by themselves.

Many tests, and forms of assessment, although general by their nature, are used not only to make general statements, but also particular statements to justify decisions concerning the future social life of individuals and their families. This is compounded by an emphasis on reliability and a blurring of validity. For example, despite the arguments concerning their prognosticating value, IQ tests are constantly updated, objectified and restandardized, but rarely validated. Cicourel[107] and Roth[108] point to the absence, in such tests, of a monitoring of the processes actually involved in the testing situation and claim that the products or results of such tests are seen to be derived from an individual (the individual being tested), although the social consequences are highly relevant.

Underlying a request for a specialized assessment is the question: how will this person cope in the world, given that he does not seem to be coping as he should? Even the 1959 Act placed an emphasis on social abilities: '..such a nature or degree

that the patient is incapable of living an independent life'. Resources, if any, are allocated on a basis of social competence, for example, the Social Security attendance allowance, hostel or hospital placement and social services. Educational resources in special education are likewise not aimed solely at increasing a person's intellectual abilities, but also at improving social competence.

Various research studies, for example, Mundy[109] point to the development of intellect (increase in IQ score) as a result of environmental changes and Clarke and Clarke[110] note the effects of environmental deprivation. However, there is no agreed scale of deprivation or a deprivation score. Few psychologists now would be satisfied with giving only an IQ score or a developmental scale result; they are increasingly concerned with social competence, how a person relates to others, which means that scales of social competence have become more widely used.

Scales of Social Competence or Adaptive Behaviour Scales

These scales are the most obviously practical with regard to caring or service provision since they are designed to investigate how a person copes with their social environment. 'Social Competence' has been defined by Heber[111] as 'the effectiveness with which the individual copes with the nature and social demands of his environment'. Despite their practical appeal there are no theories of social adaptability, no agreed developmental model, certainly not to the extent of Piaget's cognitive thesis.

What is fundamentally confused in such scales is the difference between articulating an adaptive process and the description of a set of acquired (or to be acquired) skills. Further, most of these scales do not require the specification of the context, despite them being 'social'. Over time the most popular has been Doll's Vineland Social Maturity Scale.[112] This scale is related to mental ability and, although it includes items like 'uses a pencil for drawing', does not specifically ask for the opportunity available to a person. The scale seems to assume a general availability of resources. It is not made entirely clear under what conditions behaviour may occur, and includes culturally specific items, some of which are difficult to score. The scoring also tends to be on a pass/fail basis.

Although the Vineland Social Maturity Scale is a scale of social competence it does not specify the other end of the relationship. For example items include 'follows complete instructions', but do not specify whose; mum or dad, a psychologist, a social worker, a Teacher? Shakespeare[113] criticized the Vineland Scale because some items depend as much on the parents' behaviour as on the child's ability.

These scales still assume that social competence is an attribute of an individual in much the same way as intelligence is regarded. This is consistent with Doll's own construction since the scale is designed to give a social age (S.A.) much as the IQ test gives Mental Age (M.A.). However it would be useful to know what the parental attitudes are since social competence assumes a social relationship. If it involves more than one person, it would

be useful to know what the other person is doing at the same time.

Appendix IV gives a more detailed analysis of some of the particular social competence scales. In general they are organised into skill groupings. Each grouping is associated with a particular domain, e.g. personal hygiene, social skills, self-help, communication, vocational skills, domestic skills, etc. They do not differentiate or highlight those areas in which a person shows interest, neither do they indicate whether the person knows why they are doing something. Despite their apparent concern with social adaptation they are essentially performance records of a person's behavioural repertoire with little information as to the social environment he or she is adapting to. In this sense the scales are less social then the Development Scales in which the context is described, and IQ tests where the context is prescribed (as part of the testing procedure).

Many of these Social Competence or Adaptive Behaviour Scales have now become the basis for individual planning of care programmes, in line with policy mentioned above.

One recent scale, called the HALO (Hampshire Assessment for Living with Others)[114], and another the Scale for Assessing Coping Skills[115] are purposefully designed to produce an action plan as an outcome. However they are still based on a check-list of skills. The HALO and SACS do however make mention of the social context. After correspondence with the author of this thesis, the SACS authors included a category similar to that in

the Chart of Initiative and Independence which indicates a lack of opportunity for the client. However there is no developmental scale and although five levels of 'difficulty' are included (again, like the C.I.I.) there is no analysis of complexity or explicit rationale for this scale.

The other commonality about these forms is that the items to be assessed are pre-printed. That is, the items are already prepared (in the case of SACS 180) and there is little encouragement for local variability or the addition or subtraction of items. These issues are discussed further when describing the development of the Chart of Initiative and Independence (for a fuller discussion of Adaptive Behaviour Scales both in the UK and USA see Adaptive Behaviour Scales by N.V.Raynes[116] and Appendix IV).

Assessment is not merely completing a check list. Its purpose is to decide whether a person qualifies for resources. In this way a 'failure', relative to normal results, in most of the above assessment methods increases the likelihood of achieving success in gaining resources. Nevertheless, the most socially powerful tests, IQ and to a lesser extent Developmental Scales, are those least related to specific resource provision. In the Overview to the book Psychological Assessment of Mental and Physical Handicaps P. J. Mittler writes: "In the past psychologists have tended to confine themselves to assessment and left others to incorporate (or ignore) their findings in whatever was done for the patient or client".[117]

This is far less true today but the question remains that, if, psychologists are no longer so confined, what else do they use? They may well discuss qualitative issues but there is still a demand for figures to provide answers i.e. quantitative or 'hard' evidence rather than qualitative or 'soft' information.

There is also the question of power being vested in the person who can define the problem. The professional assessor is in a position to label and categorise. He or she can then take over the management of the problem from the presenter. However, the means and language of definition, as described in the methods above, are not necessarily related to clear implications of management, in terms of training or prognosis. To continue Mittler's argument, "a change of emphasis in the aims and goals of psychological assessment is bound to effect a corresponding change in the nature of the assessment instruments used and in the whole assessment process".

This change also implies a change in professional role and authority. Professions are not noted for their desire to change practices or power bases, unless it is to increase them.[118]

The critical issue here is how far the assessor(s) can, with confidence, relate a plan of action to the results of a categorization process. From the above discussion, such a move may be a leap of faith or more usually grounded in common sense. The problem is that common sense for one person is not necessarily so for another. The most obvious example being whether a person should be moved from a hospital, where they

have lived for thirty years, into the community, some see it as cruel, others as a right.

Mittler calls for an "inclusion of a person's developmental history, experiences, that have affected his development, home background and environmental variables". All these variables are not easily, if at all, gained in a standardized testing context or open to fully reliable verification;. They are discouraged on the grounds of their subjectivity. However, the apparent difficulty is attaining this information does not make traditional methods any better.

So where and how can the social context be described and what are the relevant aspects to include? The most obvious place to look is not just at one pole; the person but also at the relationships they are and have been engaged in. This means that the status of the information held by relatives, nurses, teachers, or residential social workers is increased. The assessor is much more dependent on a wider social network to make a full appraisal. The 'assessor' can no longer define, or redefine, the problem based on one-to-one tests using the tools discussed above. Thus, changing procedure means weakening the assessor's power-base.

Therefore, there is a need formally to add in to assessment more social information. This is the information gained through constant monitoring, evaluation and judgement done by those around the person being assessed. The reason why such information has not been included so readily is that it is difficult

to summarise and as mentioned is seen to be subjective and by implication unscientific.

When the original problem arises, when a person is not performing as well as he apparently might do, parents do not rush for assessment at the first sign of such difficulty. A series of events will precipitate actions. When asked to recall these events, it is unlikely that parents will recall each and every one accurately. It would hardly be realistic or desirable for all families to record precisely everything that went on, including their beliefs and expectations, just in case they need to recall events if and when a problem arises. However, in the classroom and in residential care, teachers, nurses and residential social workers, are paid not merely to occupy those in their care for so many hours a day, but also to monitor progress. It is this information which could be most easily used to enrich the traditional forms of assessment. If we replace the objective/subjective duality with an explicit/implicit duality, then the criterion for useful information becomes whether such information can be explicated and put in a form which is public and testable in the sense of being open to question. In this way, beliefs, expectations, prejudices, observations, opinions can all be included in assessment, in so far as they can be explicated. This then opens up the assessment process to include the powerful social forces of role expectations, opinions and values.

The object of assessment is thus not an individual's performance in relation to a prepackaged task but a person's performance in relationships, including what pressure and expectations are

present in the relationships. Therefore a person can be assessed not merely in a deliberately neutral context, i.e. with the objective assessor, but in live social interaction. An assessment of relationships is needed because in real life people are not usually faced with predictable environments; indeed the point of including social competence is to find out how a person can deal with a changing environment. This is quite different from the usual assessment situation where the assessor tries to standardize his or her behaviour, i.e. act in a predictable, preprogrammed way as laid down in the manual. However, most of these day-to-day judgements traditionally remain implicit while the specialist activity of assessment is explicit, for example, in IQ scores or psychiatric diagnosis.

Individual Programme Plans (I.P.P's):

More recently the emphasis on Individual Programme Plans has stressed the need for a wider contribution to assessment. The multidisciplinary involvement, and the recent intention to include the service recipient and his or her family has placed less emphasis on the one off, specialised assessment. However, the involvement of such a range of professions has meant that the assessment systems used are extremely general and often free from any specific theoretical assumptions. A prime example being the Shared Action Planning system developed at the Open University.[119] The focus of individual planning is not on any theoretical knowledge but the process itself. Thus the forms could actually be used without any changes for many client groups; the elderly, children, mentally ill, as well as people with learning difficulties.

The basis of these I.P.P's is to try and systematically gather information, articulate need and develop a plan of action. The Nursing process,[120] designed for general nurses gives a succinct summary of such a process by dividing it into 4 stages:

1. Assessment: the articulation of need by reference to as wide a range of contributors as possible.
2. Planning: drawing up an agreed plan which is related to the assessment of need.
3. Implementation: a clarification of who is to do what by when.
4. Evaluation: a review of the effectiveness of the plan with a view to starting the process again.

The specialist professional assessments become a sub-set of 1. where professionals come to the process with their judgements perhaps based on their own methods with a view as to what they might contribute.

Usually associated with such a process is the idea of a 'key-worker' or 'care-manager', that is the appointment of an individual to chair the process and monitor progress. This may or may not be the same person who has most contact with the client or who has the major role in implementing the plan.[121]

This 'content-free' form of assessment relies not on theoretical agreement but on negotiations in the group and the members of the planning group being able to work together and share ideas. This implies a degree of mutual respect and clarity which is not

always easy and has been, in itself, the subject of considerable discussion and research, and will be referred to later in discussion of implementation of such planning processes.[122] The main problem with such methods is that while they grew out of assessments of ability they now constitute assessments of need where statements of ability, the types of problems and relationships a person can cope with, are lost in general or common-sense assumptions.

Summary

This chapter has argued that there are many different interpretations of the term assessment and many different methods serving different purposes. What is agreed is that individual assessment is a critical element of current social policy. What type of assessment is used both in content and process will have a real effect on the lives of people being assessed.

With regard to the main concepts in this thesis a major determinant of identity development is the recognition of work. Since work involves transforming the context, it is argued that work should be the focus of assessment. In work a person is in an active relationship with his or her context. Assessment should attempt to describe this process and in so doing may well, in itself, provide a form of recognition. In order to do this it is not only necessary to have a model about how the person constructs their world, as demonstrated through their actions (Subjective Discontinuity), but also a clear picture of the context as it exists normally for the person (not just in the assessment or

test context). Nearly all forms of assessment have failed to provide a picture of the normal context, other than in the most general terms. This has often been the case because such information is seen to be too variable or subjective. Yet it is precisely here that it can be discovered what actual problems are presented for the person to try and overcome.

The move to individual planning has returned the focus to individual need, but the articulation or judgement of ability has become even more general and no one model or theory is acceptable to the range of professionals now involved in this process.

Therefore what is required is a practical form of assessment which describes not only what a person does but also the context in which they act, also an assessment which does not demand as a prerequisite a set of predefined behaviours or skills to be assessed. In this way the work of the person can be seen in a context and the practical implications of their work and intentions judged.

CHAPTER 8

THE CHART OF INITIATIVE AND INDEPENDENCE (C.I.I.)

ITS DEVELOPMENT AND DESIGN

'Your child needs special help, Mrs.Williams... the case is beyond us...he still wears nappies under his trousers.. That's not right for a lad over six years old. It shows no sign of changing. Children can be very cruel they notice such things... they'll write to you with the name of a Special School. You'll get a letter from County Hall.' 'He can't undo his buttons yet; that's all.' Walter's mother turned away from the headmistress.
From Walter by David Cook[123]

The next two chapters examine the development and testing of the C.I.I. This form of assessment was designed to address the main problems outlined in the previous chapter.

Background

The original two year project (1975-77) was funded by the Department of Health's Small Grants Committee. The applicant was Miss A. Lancaster, then the Nursing Research Liaison Officer and the full time researcher was the author. A detailed account of this work was provided to the DHSS Small Grants Committee (1976 and 1977) and a general summary of the implications (but not the research process) published in 1978.[124] The purpose of this research project was: 'to design a tool for the recording of the social behaviour of low dependency mentally handicapped

adults which will provide information on which to base decisions regarding their readiness for transfer from hospital wards to intermediate units and from intermediate units to hostel accommodation.' The work was carried out at Leavesden Hospital (North West Hertfordshire) and in three London Boroughs (Hillingdon, Harrow and Ealing).

The general context of the work, in terms of social policy, has been described in Chapters 2 and 3. More specifically the context was one where, due to the realisation of the effects of institutionalisation, many of the people who were obviously inappropriately placed in hospital had been discharged, most living in the community in the care of Social Services Departments. Those who were, by common agreement, hardly handicapped at all had moved out but had taken up many of the existing Local Authority places. Whilst this was clear recognition of their (ex-patients) ability it had several consequences.

First, places in Local Authority accommodation had become scarce. Secondly, it was more difficult to ascertain who should move out next. Thirdly, hospital staff were under more pressure of work since many of those discharged had acted as unpaid help. This practice of using such helpers was (and still in some cases is) an unofficial way of recognising the ability to work. Despite criticisms of exploitation many of these people had a fairly positive sense of identity and few social problems. Fourthly, hospital staff were demoralised since they had come to equate their own success in work with the number of people being discharged to the community and the rate was slowing

dramatically. Finally, the methods of assessment were being tested more rigorously to see if they helped in identifying ability and/or needs, and as explained in the previous chapter, they were not always accurate or practical.

Therefore the staff required a method of assessment which would give a more accurate account of the way people behaved and in what context. Specifically, the research was required to identify objectives for training programmes and provide a basis for recording progress. The overall aim was to ensure 'better matching between each patient and the environment'. Further the assessment method designed should be adaptable to various settings, i.e. not restricted to hospital use.

Methodology: Social Analysis

The area for research had been identified at Leavesden, by the nursing and medical staff. Consequently the first part of the research began to clarify the problems experienced in the field. As the area of study emanated from the hospital itself, it was appropriate to use a methodology which takes this aspect into account (Social Analysis).[125] The methodology is one where the researcher focuses the problem which the field has broadly defined so that the resulting framework is seen and felt to be a production of the research relationship between the researcher and, in this case, the staff of the hospital and the social service departments. This methodology is consistent with the basic premise of this thesis in that it recognises the work of those collaborating in the research project. The testing process involves regular feedback to the staff of analysed material for

their comments, resulting in modification. This method differs from the more usual research methodology in which the researcher initially identifies a problem of interest, collects data and then feeds back a result at or nearing the end of the project. In this instance the researcher is required to make the existence of the research project public from the beginning and invite people to become involved, rather than pre-selecting a sample. This was done through the Steering Committee, a report in the local press, an article in the hospital magazine and a general introductory tour of the hospital i.e. meeting ward staff by visiting the wards and meetings with senior nursing staff. At no time did the researcher require access to particular wards but made it clear that any ward could invite him to work on problems of assessment as outlined in the research.

This methodology is an attempt to ensure that the research is of practical interest to the staff, that it becomes an integral part of working life and not something else to do 'as well as work'. This was a particularly relevant methodology at the time because of the pressures of work upon staff mentioned above. Using this method, individual discussions are confidential and individuals or situations are neither identified nor quoted without their approval. This is not experienced as a limitation. Indeed during the project there was no actual request that any material should remain confidential other than the names of patients. No executive authority is brought to bear to insist that wards should collaborate in the research. This research methodology, which is based on collaboration and confidentiality, means that all, eventually published material is cleared by the participants.

Consequently it is possible to refer to actual people and places (other than, as mentioned above, patients).

After an introductory phase the staff of two wards within the hospital (Heather Ward and The Willows) invited the researcher to help design a tool which they could use for assessment in general. In particular they wanted to look at criteria for entry, objectives of training and appropriateness of placement beyond the ward. The Willows operated a policy of 'de-institutionalisation' and had been involved in the original project proposal.

The next step in the work was to collaborate with staff to establish and analyse the nature of the problem. This was done in five main ways:

a) a series of unstructured interviews, often quite lengthy, which later became semi-structured, on the topic of assessment and placement;
b) observation; whereby the researcher spent time observing staff-patient interaction, on the wards concerned;
c) discussion on a wider basis, e.g. with the Psychology Social Work, O.T. Departments and clients within the hospital and staff, residents and some parents outside, especially in Social Services;
d) an examination of the standard assessment forms available to the hospital and various 'ad hoc' forms which were being used by wards and departments;
e) reference to other research and material in this area and in

general concerning human development and ability.

From this information there emerged a series of both technical and theoretical questions which the assessment tool would need to take into account. General points can be largely summarised as follows: the staff were concerned that the assessment should bring out the 'qualities of a person'; that it would take account of the opportunities or lack of opportunity a person has had; that it should not 'categorise' (in the pejorative sense); that it should relate to the everyday experience and intuition of the staff, and that it would be of direct and immediate relevance.

The technical points were that staff wanted a form that they could understand and fill in 'without needing a degree in Psychology' and which did not take hours to complete. The most interesting (and theoretically challenging aspect) was that staff felt fairly confident in their own intuitive assessment. They felt the main problem was in expressing and testing that intuition. Therefore one of the main purposes of the new assessment was to draw out these intuitive judgements more systematically and express and record them in a way that could be communicated and tested.

Problems with current methods

Various forms of assessment were in use throughout the hospital, many of which were referred to in the previous chapter. Most popular at this time were the Gunzberg 'Progress Assessment Charts'[126] (discussed in Appendix IV) but many

wards had their own recording and assessment methods, which they had adapted from published forms.

The main problems are summarised as follows:

A All of these methods concentrated on the outcome of behaviour (the transformation). There was rarely any attempt to describe the approach to problem solving. Neither was there any attempt to describe any overall approach to problems in general. The only assessments which described the process were the clinical tests mainly carried out by clinical psychologists but which were not carried out in the person's usual social environment, i.e. solving practical, day to day problems. The only notable exception was a process called mirroring, used with high-dependency patients and described later. (Chapter 12) Therefore the person's construction of the world and the way they made subjective discontinuities was not described.

B None of these approaches described the social environment in terms of what opportunities a person had, whether it was required that they solve certain problems or whether the problems were available to be solved.

C Few, at that time, required a plan to be formulated, with a clear set of objectives and a proposal as to how these might be achieved by whom and by when.

D None of these approaches recorded the judgement of staff, i.e. whether the actual behaviour of a person was in the staff's view a true reflection of the client's ability. Neither did they require any statement as to why a person might be underfunctioning.

E The question of ability was inferred in such approaches by reference to how much supervision a person apparently needed (why they needed it was not discussed). The term supervision was not defined other than in a general comparative way, i.e. 'a lot', 'little', 'some', 'none'. Supervision was not differentiated between that required because of ability (or lack of it) and that required because of policy. Prime examples of the latter were cases where people with uncontrolled epilepsy were not allowed in the kitchen on their own, and regulations on some wards required a staff member present during bath times. Sometimes, as with normal families, supervision occurred simply because of time constraints and lack of resources: it is quicker for staff to help. (The implications of this type of supervision have already been discussed in the chapter on institutionalisation.)

If the research was to produce an assessment method which was to describe the progress of an individual within a social context these issues needed to be clarified.

Interview Results

The observation, discussions and interviews with staff and clients and families where possible, revealed several significant common factors with regard to progress or development.

1. That everyone did make judgements about a person's ability. While this may or may not have been accurate it was critical in describing the social context of the person. Whether valid or not these judgements, by carers, set the level of environmental expectation. However, these judgements were rarely explicit although they determined what a person was allowed to do.

2. When people talked about, or responded to, progress, this was not simply in terms of outcome but more usually in terms of initiative. What inspired people most was when a person in their care tried to do something which they previously had not done. For example, trying to make a cup of tea, or dressing themselves. This often prompted renewed efforts on the part of the carer to teach the person a more effective process to reach a successful conclusion. This is significant in that it represents an identification on the part of the carer that the person has constructed a project and is attempting to realise it, i.e. is doing some work. It also afforded an opportunity to provide recognition.

Such accounts, and observations of interactions, were often accompanied by smiles and clear signs of pleasure and achievement, even when the result or outcome was technically unsuccessful. This was part of the recognition process and reinforced a positive sense of identity for both parties.

3. Such changes in behaviour were described as 'significant' by carers and represented a qualitative change. This was not

simply a case of observing movement along a continuum of improvement but a discontinuous development representing a change in approach and as such was more comparable to Piagetian theoretical constructs.

Theoretical Considerations

Clearly at the time of this project the theoretical propositions made in this thesis were not fully articulated, they were a result of this and other research described later. However, there were theories, other than Piagets' that proposed a discontinuous stratification of mental functioning. Jaques and Schutz have already been mentioned (see Chapter 4) in addition the work of Rowbottom and Billis,[127] Kohlberg,[128] Loevinger[129] and Isaac and O'Connor[130] among others, were examined. All suggested evidence that people (not simply people with a mental handicap) either develop through qualitatively different stages or switch to using qualitatively different strategies to solve problems depending upon the context. Further examples can be found in Wason and Johnson-Laird edited collection of papers.[131] This led to the construction of an assessment chart which tried to combine the theoretical considerations with the data from fieldwork and practical requirements of potential users.

Testing Prototypes of the C.I.I.

This section does not discuss in detail the testing of every version of the C.I.I., originally entitled the 'Measurement of Initiative and Independence'. There were five versions prior to the version published by the National Foundation for Educational

Research. This chapter identifies the significant changes which led to the final version.

The first chart separated out what were considered to be the three essential perspectives: (see chart: MARK I). These charts are reproduced in their original form.

Actual Functioning, that is what the clients actually did,
Potential Functioning, that is what they could do in the future,
Environmental Level, that is what they were allowed to do.

It was intended that one chart be completed for each person.

The complete version is included to provide a comparison with the final version appended and referred to in the next chapter. Other versions are not included in their entirety but extracts are included to show major differences.

CHARTS

(1) ACTUAL FUNCTIONING

MODES

degree of efficiency or measure of goal (output)	1 Goal & Plan externally set	2 Plan Initiative Goal set externally	3 Fixed Goal & Plan Initiative	4 Fixed Goal Flexible Plan Initiative	5 Flexible Goal & Plan Initiative
A					
B					
C					
D					

Remarks : -

(2) POTENTIAL FUNCTIONING

MODES

degree of efficiency or measure of goal (output)	1 Goal & Plan externally set	2 Plan Initiative Goal set Externally	3 Fixed Goal & Plan Initiative	4 Fixed Goal Flexible Plan Initiative	5 Flexible Goal & Plan Initiative
A					
B					
C					
D					

Remarks :-

(3) ENVIRONMENTAL LEVEL

MODES

degree of efficiency or measure of goal (output)	1 Goal & Plan externally set	2 Plan Initiative Goal set Externally	3 Fixed Goal & Plan Initiative	4 Fixed Goal Flexible Plan Initiative	5 Flexible Goal & Plan Initiative
A					
B					
C					
D					

Remarks : -

MEASURE OF INITIATIVE AND INDEPENDENCE

1. The purpose of this measure is to make an assessment of the environmental opportunities available to a person and to measure his or her use of those opportunities.

2. Therefore this form attempts to measure;
   a) the level of iniative of a person
   b) the level of iniative of that person's environment.

3. There are essentially three tasks;
   1) to fill in the form to record the person's ACTUAL functioning, that is his or her behaviour in general.
   2) to record the POTENTIAL functioning of the person, whether or not it is different from 1) above.
   3) to record the level of opportunity within the environment e.g. ward, hostel etc..

4. Therefore three forms should be filled in :
   (1), (2) and (3) (see forms attached.)
   Sample forms are given below with examples and instructions for each category.

5. The form sets out five possible developmental stages or MODES in terms of GOALS and PLANS.
   They are described broadly as follows:

6. "THE MEASURE"

6.1. GOAL AND PLAN EXTERNALLY SET

This is where there is virtually no iniative, either because of ability or lack of opportunity(to be specified). It is characterised by behaviour which is essentially imitative. That is, the goal and plan is entirely pre-determined(e.g. by staff) and the person is unable to reach the goal in a way that deviates from a prescribed formula. An example would be where a patient can only make a cup of tea (goal) if the elements needed(plan) i.e. teapot,tea,milk,water etc. are in exactly the "right" place and can only do so when told or asked. One would assume that the person is unable to understand principles of why the necessary actions are connected and reaching the goal is somewhat magical i.e. it is a mystery why it works but it does ! The extent to which a person needs assistance within this mode can also be observed and noted.

6.2. PLAN INITIATIVE

The situation is qualitatively different from that above in that, given a goal, there is an ability to conceive of a plan presumably based on some understanding of principles and thus the person (if allowed) can tolerate some frustration. Thus he would look for the tea if it wasn't in the correct place but would be unable to proceed if it was not in the kitchen. In this mode iniative is restricted to a plan of action within an instruction, thus the actual goal has been defined by someone else but the means to the end can be varied by the person.

6.3. FIXED GOAL/PLAN INITIATIVE

This is where the person can and does act at self - determined times e.g. washes when he thinks he is dirty. This requires an aspect of forward planning not presumed in either 6.1. or 6.2. e.g. drawing money from a Post Office account in time for shopping the next day. Making sure there are clean clothes for going out etc.. However, in the behaviour the goal remains constant and negotiation is difficult e.g. if the person wishes to have some money when the Bank or Post Office is closed, this may well cause frustration which cannot be easily coped with by the person involved, alone. In this mode there is no attempt to accommodate goals or plans to the needs of others. They are firmly rooted and usually characterised by taking the quickest route, no matter the consequences. This does not imply a "psychopathic" personality but rather a blindness or "tunnel vision" approach.

6.4. FIXED GOAL/FLEXIBLE PLAN INITIATIVE

As for 6.3. but the approach is less egocentric. Others' needs are attempted to be accommodated. Delay causes less frustration but the goal is fixed and a change of goal is not tolerated easily.

6.5. FLEXIBLE GOAL AND PLAN INITIATIVE

This final mode is similar to above 6.4. but the goal can also be modified to suit the setting. For example, substitutes are used to approximate the desired effect or the goal may be delayed altogether. The main point of this being that this modification does not cause intolerable stress upon the person(unless of course he perceives the obstruction to the goal as being deliberate.)

Now refer directly to the charts.

7. The person filling in the form is required to state for charts (1) and (3) in his or her experience over a specified period of time, which category applies to the person (1) and the environment (3). If it is not possible to place a mark in one single mode then more may be specified. If this is so then examples from each mode must be given below in the space provided. The lettering ABCD refers to the degree of efficiency or success of the OUTCOME or goal completion. The mode refers to the type of APPROACH.

8. Chart (2) is filled in in a similar way however as it is predictive. The space for comment must be filled in as it may be based on one single, unusual event. For this chart the context of the event must also be specified.

9. Examples : Taking each chart in turn, here are some examples of how to score the chart.

10. Chart(1). This is the chart that refers to the person's ACTUAL level of functioning.

11. Example 1.MODE 1 :GOAL AND PLAN SET EXTERNALLY.
A person shows no initiative, that is he or she remains inactive unless requested by another person (staff or patient) to do something. Even when this happens, the task has to be spelled out exactly and the performance is by imitation only. For example a person sits in a chair until a staff member asks him or her to lay the table. Assuming the person agrees, the staff member has to demonstrate each time how to set a place, knife, fork, spoon etc.. and the person copies as well as they are able. In this case the person scores in MODE 1. If the copying is perfect the score is MODE 1 A, if the copying is reasonable B, and if very poor C. If the person has hardly managed anything;D. If, for any reason, the person has remained in the chair, no score can be made but an explanation must be given underneath the chart. If the poor imitation is due to presumed physical handicap or it is good despite physical handicap, the score remains the same but an explanation must be noted below.

12. Example 2.MODE 2:GOAL SET EXTERNALLY,PLAN INITIATIVE.
Using the example (i.e. laying the table) the action would be dependent upon external stimulation. As above, the person would remain inactive unless someone else suggested laying the table. However in this instance once the goal was set, there would be some flexibility of plan, for example the person could lay the table without having to be shown every time and could identify should a fork be missing and obtain one from the drawer if he knew that was where they were kept. However, once the goal has been achieved, activity stops rather than the person himself deciding to do something else. The actual laying of the table would be characterised by an absence of checks to staff of questions such as "is this right ?", although "initiative questions" may well occur,e.g. "is it alright if I put orange juice on the table, not water ?". Again for this mode the ABCD is scored as in example (1) that is how well the task is actually completed.

13. Example 3.MODE 3:FIXED GOAL/PLAN, INITIATIVE.
For someone to score in this MODE he or she must act on their own initiative. That is to say that rather than following set procedures and being dependent upon instruction, the person acts in a self-determined way. This is not to say that the person disobeys rules but rather uses them. For example, if the sky was cloudy and rain was beginning to fall the person would not put his or her washing on the line even if that was the next step in a usual, logical sequence (i.e. after washing them). However this mode is characterised by highly egocentric behaviour . That is to say that the person, while able to decide what he or she wants to to do and how to do it, does not take into account the needs of others or the appropriateness of the behaviour. Thus if such person felt hungry and knew where to buy chocolate and had the money he would do it even if in a discussion, or at work etc.. Further, if the chocolate machine were empty, this would cause great anxiety as the fixed goal and plan have been foiled ! Also if a staff member says no to leaving the ward,hostel etc.,this also causes

anxiety and repeated requests despite refusal. These requests are characterised by repetition and do not include the question "why?". Because reasons are irrelevant. The experience is a war of attrition rather than argument. A power struggle rather than a negotiation of authority. Again the ABCD refers to the level of the produced goal so that if a person washes when he thinks he is dirty the ABCD does not measure the self-determination but how well he actually washed.

14. Example 4. MODE 4.FIXED GOAL/FLEXIBLE PLAN INITIATIVE.
This is as for example 3 but less egocentric. However it is the plan which can be altered. Using the chocolate bar example above, here the person would be accommodating and receptive to an argument of delay as long as the goal remains a believed possibility. Thus a person may ask a staff member,"can you take me to the shops ?". if the staff member replies "yes, but I must just finish the medication" this would be tolerated.However if the reply is "I don't know, I have a lot to do today" and if there is no-one else to take the person,then the anxiety described in example 3 would rise. Again the ABCD as above.

15. Example 5 MODE 5:FLEXIBLE GOAL/PLAN INITIATIVE
Here there is constant argument and toleration. Thus, although reasons may not be accepted at face value, there is an understanding of rational argument and the goal and plan, which are self-initiated are potentially open to modification and substitution. Thus if a person decided he wanted to see a particular film and had the money to go that night, he may still be persuaded to see another film or even not go out at all because he appreciates and understands the arguments presented; for example, that there is an activity on that evening for one evening only. The person does not become agitated and angry unless he perceives he has been deliberately frustrated. Thus, if a person applies for a job as gardener he is not too distressed if there are no vacancies or if the job has gone. He will also be able to consider applying for a different job altogether. Here the ABCD rating is scored according to performance of the eventual goal which because of this mode may be different from that originally envisaged. The mode is concerned with adaptability.

16. Chart (2) This is the chart that refers to the person's POTENTIAL level of functioning.

17. The examples for Chart (1) are the same for Chart (2). However in this case the question to ask is : "if the opportunity was available what level of functioning (expressed by modes) could this person achieve ?"

18. It may be that it is the same as the score on Chart (1). If so then this means that the person is judged to be functioning at their maximum potential.

19. Example : If a person was functioning in mode 1 and he was judged to be capable of mode 3 then there must be some evidence for this. It could take two forms:

19.1. That although generally the person's behaviour falls into mode 1(B) on one occasion he did something which would put him into mode 3(D). -e.g. went into the kitchen and made sandwiches during the evening, then this should be recorded by an explanation in the "remarks" section.

19.2. Although there is no specific behaviour to cite, the staff member filling in the form has a "hunch" or "feeling" based on intuition, that the person could function at mode 3, then an explanation again should be made in the "remarks" section.

20. The "remarks" section in Chart (2) must always be filled in to support the judgement expressed by the score.

21. Chart (3) This is the chart that refers to the level of opportunity within the environment.

22. Again the criteria for charts (1) and (2) can be used. However this time they do not relate to a person but to the environment. There is no value judgement implied in the levels. That is there is no assumption that a mode 5 environment is "better" that a mode 1 environment. Only that different environments offer different opportunities according to the level of ability of people within them.

23. The recording of this chart refers to the level of opportunity for each patient or resident. It is not intended to measure a uniform level for everyone. It may be that a ward or hostel does treat everyone equally, however the intention is to measure the level of opportunity for each person over the same period of time that charts(1) and (2) are being assessed on.

24. Thus, if the period of assessment was two weeks then:

24.1. Chart (1) would be filled in to record the person's actual behaviour over these two weeks.

24.2. Chart (2) would be filled in to record the person's potential level based on observation over a two week period.

24.3. Chart (3) would be filled in to record the level of opportunity for that person over a two week period.

25. These charts are purely experimental. They are as yet <u>not</u> for use in the formal assessment of patients/residents but "on trial" to see if staff find them to be potentially useful in the assessment procedure.

26. Would any enquiries or criticisms concerning these charts please be directed to : The Research Department

Ian Macdonald (Int.tel.396)

The key to the chart was (and is) the 'Modes'. These modes are descriptions of activity and represented a synthesis of reported significant differences in behaviour and theoretical considerations. At this time (1976) there were five such modes representing a developmental scale from complete dependency to independence, at each stage a different approach to problems was demonstrated. The key aspect was that the same basic scale was used for each of three perspectives. Two wards tested this version and completed 68 charts.

The reaction to this first version was varied. The conceptual framework of a scale of five modes and three perspectives was well received. Staff reported that the assessment of initiative was a more useful approach than completing a skills check list. However they also reported that the chart was not clear enough and it was noted by the researcher that many staff tried to assess the 'correct' mode or at least only one mode when it was to be expected that the same person might approach different situations in different ways, i.e. use more than one mode, according to the circumstances. In particular, one element which intended to rate the 'degree of efficiency of output' on a four point scale A - D was highly confusing in that it re-introduced a continuous scale the rationale of which was implicit and so contradictory to the purpose of the chart.

Two more versions were designed (Mark II and III). The redesigned format of mark II is reproduced:

MARK II

RESEARCH DEPT.
LEAVESDEN 1976

Page 1

CHART OF INITIATIVE AND INDEPENDENCE

NAME and AGE of Patient/Resident

STAFF MEMBER

Part 1 LEVEL OF OPPORTUNITY

This chart refers to the actual relationship between yourself(staff member) and the patient or resident. How much discretion do you allow this person ? If the relationship cannot be described in one mode then mark in more than one section of the chart and give examples of differences in the space below.

MODES

1	2	3	4	5
Goals & Plans set by you	Goals set by you Plans made & carried out by Patient/Resident but monitored by you	Goals & Plans set by Pat/Res but both monitored by you	Goals & Plans set by Pat/Res & Goal only monitored by you	Goals & Plans set & carried out by Pat/R You remain in the background unless the Pat/Res asks for your involvement

Examples of behaviour : Always fill in examples especially when you have filled in more than one section. You may also use the back of the page.

Page 2 Part 2

This refers to the patient/resident's actual mode of functioning or behaviour over a period of time previously set for observation by you.

MODES

1	2	3	4	5
Needs Goals & Plans set by you(or another Pat/Res/Staff)	Needs Goals set by you but can then carry out a plan initiated by him/herself	Can set own Goals & Plans but this is fixed inflexible & rigidly adhered to despite argument	Can set own Goal & Plans but the goal is fixed & cannot be substituted however when or how this goal is achieved remains flexible	Can set own Goals & Plans & is not only flexible about when & how but also the goal in itself but not in a totally passive way

Remarks: Is this person functioning in their optimum mode ?
(Optimum does not mean absolute maximum, but a level of functioning which does not cause fairly constant anxiety,stress or frustration) YES/NO

2. If NO can you give examples of situations or conditions which inhibit the person ? Please specify in as much detail as possible.

3. How might these inhibitions be overcome ?

Also use back of the page if required.

Page 3

Part 3

If the inhibitions mentioned above could be overcome, what do you think this person's potential might be in time ?

MODES

1	2	3	4	5
Will still need <u>goals & plans</u> set by someone else	Will still need <u>goals</u> set by others but could be left to carry out plans him/ herself	Could set own goals & plans but need constant monitoring as to their appropriate-ness	Could set own goals & plans only needs goals monitored	Could set own goals & plans & be relied on to <u>ask</u> for help when appropriate

Remarks:

Page 4 Part 4 WARD/HOSTEL POLICY IN GENERAL

This refers to the mode of relationship which you believe the ward or hostel is trying to achieve. It may be that for certain individuals it is not possible or appropriate to apply the policy (and will be shown in Chart 1). However this chart refers to the policy intention rather than what is happening at any one period of time. The modes are the same as for ~~Chart~~ Part 1.(If you are filling in more than one Chart you need only fill in Part 4 on one of the Charts.)

MODES

1	2	3	4	5
Goals & Plans set by you	Goals set by you. Plans made & carried out by Patient /Resident	Goals & Plans set by Pat/Res but both monitored by you	Goals & Plans set by Pat/Res & Goal only monitored by you	Goals & Plans set & carried out by Pat/Res. You remain in the back ground unless the Pat/Res asks for your involvement

Remarks: If there is no clear policy or a mixed policy, use this section to explain this. Also, if you wish to comment on policy use this section.

Part 5

Have you any comments on the chart itself as to whether it allows you to express your opinions adequately ? Use the back of the page if required.

The main differences were that:

i. the output rating was dropped

ii. each perspective was on a page of its own (providing more space for comments and examples)

iii. 'Environmental Level' became 'Level of Opportunity' more clearly indicating that this was meant to describe the behaviour of the carer and the rules and regulations of the context.

iv. Carers were asked specifically to comment upon what inhibited the person and how these inhibitions might be overcome.

v. Carers were asked to state more clearly what the person's potential was by stating how the person should be functioning in a specified time in the future.

vi. Most significantly a new section was added which required the carer to state what their ward or hostel policy was. For example, was there a general expectation that people should set their own goals and plans (objectives and ways of achieving them) or was it somewhere where the staff set goals and plans.

vii. A more complete manual; description of how to use the chart (now called the Chart of Initiative and Independence) was written.

Although these were all regarded as improvements staff were still reporting and experiencing difficulties in completing the charts and engaging in long discussions on which mode was 'correct'. The researcher sat in on many of these meetings (172 charts of version II and III were completed), It was explained

that discussion was part of the process and that the C.I.I. was not simply a checklist or scoring method but a planning process designed to articulate and test the assumptions of carers. As such it was not surprising that the carers needed time to discuss their judgements. However it was noted that there was a significant difference between discussion over matters of judgement and observation and discussion which occurred because of a misunderstanding of the concepts. If the criteria were confusing then there was no shared basis for the judgements. If the argument concerned the criteria this implied that the reliability of the C.I.I. was suspect.

However at the end of the first year, despite these shortcomings, the following conclusions were reported as part of the research findings:

"As yet the major theoretical assumptions still stand, i.e.

1. That there is a qualitative developmental scale which includes five stages (the five modes) to independent living.
2. That there is a complementary level of provision of service according to an individual's capacity (level of opportunity).
3. That both level of service and level of capacity can be expressed in terms of the amount of discretion allowed to express initiative in decisions concerning social functioning.
4. That if level of opportunity and level of capacity are not complementary, behaviour problems result.
5. Further that length of 'institutionalisation' is not significant in determining the rate at which a person can re-adapt to

take opportunities which are consistent with his or her capacity.'

At this time two significant developments took place. First three hostels, one from each of the London Boroughs of Harrow, Hillingdon and Ealing, invited the researcher to help them to use the C.I.I. This was particularly relevant in the case of Harrow where the Officer-in-Charge of a hostel, T. Couchman, wanted to test all the concepts and explore the C.I.I. as a method not only of assessing progress of residents but as a basis for training and developing staff and articulating an operational policy for the hostel. His continued involvement eventually led to him becoming co-author of the final version.

Secondly, in addition to other discussions mentioned above (with staff from elsewhere and academic colleagues), a workshop was held at Brunel University which brought together current users and people from other services and professions who had hitherto not been involved in the research work but who were knowledgeable in this general field.

The conclusion, from both of these sources, was that the major problem with the C.I.I. was not the scale of five modes nor the three perspectives, both of which were seen as significant advances in this type of assessment but the absence of specific activities or problems which could be rated using both the modes and perspectives (of Behaviour Opportunity and Potential).

Originally specific activities such as using a knife and fork, making a bed, dressing, washing, etc. had been deliberately excluded on two grounds.

First, the inclusion of a prepared list re-introduced one of the main difficulties encountered in using the skills check-lists already available. That is it assumed that these activities were relevant to all settings, many were not. Also it assumed that these activities were desirable and should be part of a developmental programme. From a practical point of view, it lengthened the process. Many skills lists (see Chapter 7) contain up to 250 items, which using the three perspectives, with an additional policy chart would mean 1500 ratings per resident.

Secondly, an inclusion of a prepared list assumed that such activities were understandable to the client. One of the main themes of this thesis is the proposition that it is important to try to understand the way in which a person constructs their own world. There was no guarantee that such activities, which can be equated with episodes forming subjective discontinuities as described in Chapter 4, were part of the person's construction. Although the basis of social behaviour lies in the area of interactive-discontinuity such a list does not represent an interactive relationship but the imposition of one set of discontinuities upon another person.

However all users reported the need to start off with a consideration of actual examples of real behaviour exemplifying problem solving in relationships and that it was extremely

difficult to start with the general and move to the particular. Direct carers especially, whether they be staff, parents or volunteers are most concerned to deal with concrete issues. Apart from the logic of this critique it would not have been consistent for the researcher to ignore the significance of the users construction of their world which is also recognised in the research methodology; Social Analysis discussed at the beginning of this chapter.

This problem was resolved by changing the format of the C.I.I., producing a guide to activities and making the process (and written guide) more explicit. The versions of the C.I.I. which resulted (Mark IV and V) were then tested in the five research locations (three hostels and two wards).

The recording format of Mark V is reproduced below:

Research Dept
Leavesden 1977

CHART OF INITIATIVE AND INDEPENDENCE

NAME of Patient/Resident _____ HOSTEL WARD _____

Contributors to the Chart	Role/Relationship with Patient/Resident

Period of time of observation FROM _____ TO _____

PART 1A This charts the person's present capacity and the extent to which they appear to be behaving above or below capacity. It also charts the most usual level of opportunity and the range of opportunity available to a person.

Indicate as follows:

the person's present capacity = blue profile

the range of behaviour = blue cross

the present level of opportunity = red profile

the range of opportunity = red cross

These descriptions refer to the modes of ... capacity.
For fuller description see Manual*

Activity	MODES 0 No opportunity to see	1 Needs goal & plan to be set & carried out for him/her	2 Needs to be told or shown what to do and how to do it	3 Needs to be told or shown what to do but can then get on and do it	4 Can set own goals and plans but these are fixed and do not take into account the needs of others	5 Can set own goals & plans Goal is fixed (as in 3) but the plan is flexible.	Can set own goals & plans which are both flexible in terms of needs of others & a changing situation.

	0	1	2	3	4	5
No opportunity is available	You set goal & plan & do it	You set goals & plans	You set goals Plans made & carried out by pat/res	Goal and plan set by pat/res. both monitored by you	Goal and plan set by pat/res. Goal only monitored by you	Goal & Plan set & carried out by pat/res You remain in background unless the pat/res asks for your help.

These descriptions refer to the levels of opportunity. For a fuller account of modes see manual. These modes refer to the amount of discretion you allow a person.

PART 1B

1. What is this person's overall optimum mode of functioning now ?
(Optimum does not mean absolute maximum, but a level of functioning which does not cause fairly constant anxiety, stress or frustration)

Circle 1 2 3 4 5

2. Can you give examples of situations or conditions which <u>inhibit</u> the person ? Please specify in as much detail as possible, including medical conditions. It should be possible to use PART 1 Chart to identify areas where capacity and opportunity are not consistent. If possible <u>all</u> ranges on the Chart should be referred to.

3. How might these inhibitions be overcome ? Specify a plan of action to be implemented by staff. This may contain particular programmes : e.g. b. modern psychology, refer here to where details of such programmes can be arranged.

4. Any further remarks ?

PART 2A If the Plan mentioned in PART 1B (Q3) is implemented, what is your assessment of:

the person's capacity in _____ months/weeks = blue profile

the range of behaviour in _____ " " = blue cross

the level of opportunity in _____ " " = red profile

the range of opportunity in _____ " " = red cross

MODES 0 1 2 3 4 5

These descriptions refer to the modes of capacity
For fuller description see Manual*

Activity	No opportunity to see	Needs goal & plan to be set & carried out for him/her	Needs to be told or shown what to do and how to do it	Needs to be told or shown what to do but can then get on and do it	Can set own goals and plans but these are fixed and do not take into account the needs of others	Can set own goals & plans. Goal is fixed (as in 3) but the plan is flexible	Can set own goals & plans which are both flexible in terms of needs of others & a changing situation.

	0	1	2	3	4	5
No opportunity is available	You set goal & plan and do it	You set goals and plans	You set goals. Plans made & carried out by pat/res	Goal & Plan set by pat/res both monitored by you	Goal & plan set by pat/res. Goal only monitored by you.	Goal & plan set & carried out by pat/res. You remain in background unless the pat/res asks for your help

These descriptions refer to the levels of opportunity. For a fuller account of modes see manual. These modes refer to the amount of discretion you allow a person.

PART 2B

1. What will the person's optimum mode of functioning be ?

Circle 1 2 3 4 5

1. Any further remarks :

PART 3 This part of the Chart refers to policy. These two sections are used to specify the entrance criteria of the ward/hostel and exit criteria. These parts only need to be filled in once for the whole ward/hostel. They only need to be changed when the policy is changed. Thus they should always represent the present policy for defining minimum suitability for coming into the ward/hostel and for leaving.

PART 3A This refers to the minimum limits which you are prepared to accept (in general) for entry to the ward/hostel. It may therefore be used as information for prospective candidates and their staff; as pre-selection material. It is not assumed that any person who meets these criteria will enter the ward/hostel. The Chart is filled out, in principle, exactly as PARTS 1A & 2A. However in this instance, rather than considering an individual in particular, you are considering in general terms.
Indicate:

1) the lowest limit of capacity which would be acceptable to the ward/hostel = blue profile
2) the range of behaviour which would be acceptable = blue cross
3) the lowest limit of opportunity which would be acceptable = red profile
4) the range of opportunity acceptable = red cross

MODES 0 1 2 3 4 5

These descriptions refer to the modes of capacity.
For fuller description see Manual*

Activity	Not relevant	Needs goal & plan to be set & carried out for him/her	Needs to be told or shown what to do and how to do it	Needs to be told or shown what to do but can then get on and do it	Can set own goal and plans but these are fixed and do not take into account the needs of others	Can set own goals & plans Goal is fixed (as in 3) but the plan is flexible	Can set own goals & plans which are both flexible in terms of needs of others & a changing situation.

	0	1	2	3	4	5
Not relevant	You set goal & plan <u>and</u> do it	You set goals & plans	You set goals. Plans <u>made</u> & carried out by pat/res	Goal and plan set by pat/ res both monitored by you	Goal and plan set by pat/res <u>Goal only</u> monitored by you	Goal & plan set & carried sout by Pat/ res. You re- main in back- ground unless the pat/res asks for your help

These descriptions refer to the levels of opportunity. For a fuller account of modes see Manual. These modes refer to the amount of discretion you allow a person.

At the bottom of the Chart state any further entrance criteria not otherwise stated.

PART 3B This part is exactly like 3A, however it represents the upper limits; i.e. when a person's profile and level of opportunity is above this, they are effectively ready to leave.
Indicate:

1) The upper limit of capacity for ward/hostel = blue profile

2) The range of behaviour which is acceptable for a person to leave = blue cross

3) the upper limit of opportunity = red profile

4) the upper range of opportunity = red cross

Activity	Not relevant	MODES 0 Needs goal & plan to be set & carried out for him/her	1 Needs to be told or shown what to do and how to do it	2 Needs to to be told or shown what to do but can then get on and do it	3 Can set own goal & plans but these are fixed and do not take into account the needs of others	4 Can set own goals & plans. Goal is fixed (as in 3) but the plan is flexible	5 Can set own goal & plans which are both flexible in terms of needs of others and a changing situation
		These descriptions refer to the modes of capacity. For fuller description see Manual *					

0	1	2	3	4	5
Not relevant	You set goal & plan & do it	You set goals & plans	You set goals. Plans made & carried out by pat/res	Goal and plan set by pat/res Goal only monitored by you	Goal and plan set by pat/res Goal only monitored by you	Goal & plan set and carried out by pat/res. You remain in background unless asked for.

These descriptions refer to the levels of opportunity For a fuller account of modes see Manual. These modes refer to the amount of discretion you allow a person.

These versions (IV and V) now required the staff to decide, prior to recording their observations and judgements, what activities they intended to assess. No activities were printed on the forms, thus avoiding the problems mentioned with regard to checklists. Instead, using the guide or manual of activities (see final version appended), staff decided for each resident what activities were relevant in each situation. They also had to bear in mind any activities which may not be obvious but which the person might show interest in. These could include 'negative' activities such as stealing, masturbating or absconding. Such activities may (and did) sometimes display more initiative and ability than more traditional activities. In this way staff/carers could start with the particular situation but not using pre-set content, (unlike other forms).

Having selected these activities, carers decided how to define them. The requirement was that a clear definition had to be shared (thus clarifying Interactive Discontinuities). This meant that say an activity like 'washing up' had to be unambiguous. All concerned agreed whether this included pots and pans, included drying up or not. This meaning had to be known to the resident prior to its assessment.

This process in itself proved very interesting since it exposed hitherto implicit differences in understanding amongst those concerned. To begin with people thought it rather pedantic but soon realised that what they meant by washing up might be quite different to someone else's' view. This lack of shared definitions was revealed as a central cause of misunderstanding

and lack of trust between care locations. For example, one group (say a ward) may in good faith tell another group (say a hostel) that a person could dress himself. The hostel, on receiving the person, found this not to be the case. In many instances this was because the definitions were different. To continue the example, the hospital ward may not have required the person to tie laces, or ties, or even do up buttons, a requirement which was assumed by the hostel. If added to this was a different interpretation of supervision (addressed now by the scale of modes in the C.I.I.) and the cultural perceptions of hospitals, situations arose prior to the use of the C.I.I. where some groups of staff assumed others were simply lying and not to be trusted when it was primarily a difference of definition of episodes or lack of shared interactive discontinuity. It became clear that the use of the C.I.I. although initially time-consuming, was able to clarify these misunderstandings.

It began to provide a consistent and common language between those using the C.I.I. and hence those providing care both within a team of carers and between teams and allow for more accurate recognition of the completion of tasks.

Having agreed on the definitions and what activities were to be assessed carers were now required to assess the three perspectives. First a clearer concept of <u>present</u> capacity (later to become Present Potential). That is what the person could achieve <u>now</u> if they were not inhibited or handicapped by internal or external constraints. Secondly Behaviour (actual functioning), and thirdly Opportunity (what the person was

required to do). These were distinguished by using three colours to outline three profiles against the modes.

A new addition was a sixth and seventh mode. One was a mode of No Opportunity. This meant that the person could not carry out a task, not because of lack of ability or because it was done for them but simply because the resources were unavailable. For example, a person on a locked ward has no opportunity to go shopping. Some people could not learn road safety as they were not allowed near roads.

This enabled carers to indicate areas of activity which either they thought or the resident thought might be useful despite its unavailability, for example, horse-riding or going on holiday.

The other new Mode was one of complete dependency (C/D) where the person experienced the activity but in a passive way. That is the carer carried out the activity for the person e.g. dressed them or washed them without their active involvement.

The profiles of the three perspectives could then more readily be visually compared to see if there was congruency or not. It might be the case (perhaps) that behaviour and opportunity matched but both were below present capacity. For example, a person might not be allowed into the kitchen to make a cup of coffee (opportunity), they may not try to do so (behaviour), but might be judged to be capable of doing so. It was therefore possible to identify areas of frustration where capability was limited and then examine the reasons why. In this case why the

person was prohibited from using the kitchen. This often led to a challenge of policy and rules, and/or the possibility of exceptions being made.

The C.I.I. was now also much more clearly a base for designing training programmes. Areas of inconsistency formed the basis for considering and deciding upon a plan of action. In some areas this was directed to the staff as in the cases of change of rules or policy. In other instances the plan was focused towards the resident, as in the case of teaching a person to make a cup of tea. However, these plans were not open ended. The C.I.I. now required the carers to fill out another form predicting what the situation would be like in X months time (the carers chose the exact time period). Again this predictive form used the modes and perspectives. This prediction was then compared with the actual situation in X months time. Carers were then required to explain discrepancies and make a new plan.

Policy and Harrow

The other new development was a more specific part of the form to articulate the policy of the residential unit using the same three perspectives. Here carers were required to clarify activities and then state what were the upper and lower levels of acceptable behaviour. This allowed for carers to be more precise as to their client group. For example, some catered for more or less dependent groups. The policy chart, needed only to be completed once and then updated as policy changed. Individual profiles could then be compared with the policy chart to show that some people were inappropriately placed, either

because they were too dependent or because they were too independent, i.e. above or below the general level for which that situation was providing a service.

Thus the C.I.I. provided a common conceptual framework to examine not only individual behaviour but also the relationship between resident and carer (opportunity) and the policy of any residential setting. This was most completely tested at the Harrow hostel. In Harrow the entire policy was reviewed in discussion with staff and residents. Activities were carefully defined and the equivalent of a dictionary produced (later to become the Manual of Activities). Activities were set for each resident and a consistency in opportunity required from staff. This consistency was very important since residents were often confused by different staff members offering different levels of opportunity. The case studies in the final version of the C.I.I. (Appendix V) exemplify this.

The use of the policy form gave staff a clearer picture of what they were expected to do as part of their role. It also served to give a time limit to experiments and plans and thus contain uncertainty. For example, one policy change was the removal of a prescribed bed-time. At first staff, more than residents, found this difficult to operate as residents stayed up late into the night, and some did not go to bed at all. However, this was based on Couchman's judgement of the residents' ability and as Officer-in-Charge he asked the staff to comply for 3 months. At the end of 6 weeks, the situation had settled down. Most residents were in bed between 11 p.m. and midnight and those who were not were

choosing to do other things, watching TV, talking. Even they were usually in bed by 1 a.m. In general the group behaviour was more representative of a usual household. Staff regarded this as a successful policy change, and one month before the due date, the review concluded that it would be continued. It also allowed for staff to reflect on their initial reticence.

Perspectives, Modes and Complexity

These general concepts became more precise as the research progressed. First the Three Perspectives:

1. Behaviour: Over the period of research this perspective became the requirement to describe what the person being assessed actually did (during the period of assessment). It was not a matter of opinion and was open to verification. A person either initiated an activity without being told, or had to be told. Behaviour of course could vary (and did). If this was the case the person would be rated in more than one mode. If this was so, staff were asked to say (if they could) which was more usual or under what circumstances different behaviour occurred. Also some staff observed one type of behaviour, other staff another type. This also would result in more than one rating, again with an explanation.

2. Level of Opportunity: This was a judgement made in the same way as 'Behaviour' but referred to staff or carers behaviour. Again this was not a matter of opinion. As for 'Behaviour' ratings for opportunity varied, some staff varied their own behaviour, others offered a different level of

opportunity to their colleagues. Also as for behavioural perspective more than one rating of opportunity with an explanation resulted. This produced considerable discussion as to why there were differences which directly related to the third perspective.

3. Present Potential: Having described the poles of the relationship, the concept of present potential linked them. Apart from policy constraints the main determinant of level of opportunity was the carers (hitherto implicit) judgement of the resident's current capability. Many carers had not had their judgements in this area either made explicit or challenged. The requirement to state what work a person was capable of doing produced considerable and at times heated discussion. The purpose of the C.I.I. as explained above was to make these judgements public and discussable. The team leader (e.g. Officer in Charge or Ward Sister) played a critical role in managing these discussions and creating an opportunity through the resulting plan of action to examine these assumptions. Hence the 'subjective' element which created the expectations and was a crucial but at times, a hidden, component of the social context was made evident and testable.

The Modes

There was never any intention in the construction of the C.I.I. to make people more independent. Rather it was to facilitate a match between capability and opportunity. The purpose of the C.I.I. is to ensure that people could realise their own projects, make meaningful transformations and have them recognised,

whatever their level of capability. Thus it was never intended that one mode should be interpreted as better than another. This aspect required considerable discussion (and still does) since recent policy and the normalisation movement can give the impression that independence is more highly valued than dependency in an absolute rather than relative sense. The essential point, also stated within social policy, is that everyone should be able to develop to their potential whatever that might be.

The definition of Modes were refined throughout the research. The descriptions which are published in the final version (see Appendix V) are reproduced here along with the summary chart and can be compared with Mark I above.

4. Level of behaviour >

This refers to what you have actually seen the person doing. It is separated into a *goal* – the end point of behaviour – and *plan* – the means to that end. Using the general description on page 15:

4.1 *N* = where you have not observed the person engaged in this behaviour for the period of observation, nor has it been done for them.

4.2 *c/d* = is where you have not seen any initiative in setting a goal or following a plan even under instructions (complete dependency).

4.3 If a person's behaviour is *MODE A* this means that they will do nothing; remain passive unless someone else sets *goals and plans* for them; e.g. a person may sit in a chair unless someone else suggests that they make a cup of tea. When this has been suggested the person still needs to have the plan told or shown to them, step by step; boil the kettle, put the tea in the teapot, etc.

4.4 If a person's behaviour is *MODE B* then as far as the initiating of a goal is concerned, the situation is as above (*mode A*), i.e. the person is dependent on the outsider to set goals. However, if a goal is externally set, the person will attempt to find a way to achieve the goal. This may be in the form of a rote learned technique. Their effectiveness may depend on training or experience but the point is that the person *will* initiate a plan. The plan, however operated, will be characterised by an *absence* of self checks, i.e. continually stopping, waiting to be told what to do next. The person may ask questions or seek approval: 'Is it all right if I put orange juice on the table, not water?'.

4.5 If a person's behaviour is *MODE C* then again (with regard to specified activities) the person can act at self-determined times; i.e. *identify* and act on a need: e.g. wash when he/she thinks he/she is dirty. The characteristic of mode C is that the *goal and plan* are fixed, indeed welded together precluding alteration. It is a perception of the '*right* way to do something in relation to *me*'. A very simple, black and white value system is used. There is very little, if any, toleration of frustration. If the goals and plans of the person in mode C coincide with external events, that is by chance. There is no attempt to accommodate goals and plans to the needs of others. If there is a change it will be the complete substitution of one way for another and the old way will now be rejected and perceived to be as useless and interfering as all others. If a staff member, for example, refuses permission to do something, this causes great stress and anxiety (which may be expressed aggressively or by withdrawal). It would create repeated requests and demands which are characterised by *repetition* and do not include the question *why,* as reasons are irrelevant. The experience is a war of attrition rather than an argument; a power struggle rather than a negotiation.

4.6 If a person's behaviour is *MODE D* there is not only an interpretation of *need* (as in mode C) but a realisation of the needs of others. However, this perception of others' needs is limited. It is limited in that the *plan only* is flexible. The goal is as fixed as in mode C. It is less egocentric than mode C but the toleration of delay and ability to cope with frustration breaks down if the *goal* itself is threatened. Thus a person may ask: 'Can I go to the shops?' If the reply is 'Yes, but can you wait until after lunch?', this could be tolerated. If, however, the answer raises doubts about the goal, 'Well, I don't know, you know you have visitors and you said you would cook the tea, etc.', then the anxiety, as in mode C, would begin to arise. Thus other people's needs can be accommodated but *only* if they do not threaten the goal which is self-determined.

4.7 If the behaviour of person is *MODE E* then the *goal* also can be modified according to his/her own needs and those of others. If a goal is frustrated, a substitution can be made: using soap, not shampoo: buying rice instead of potatoes: not going out because a surprise visitor has arrived. The point about this mode is that the substitution does not cause intolerable stress upon a person. They may be sad or disappointed but will not break down as in mode D, e.g. if a bus did not come. There may be argument but *also* toleration. Thus, although reasons may not be accepted at face value, there is an *understanding* of rational argument and the goal and the plan, initiated by the person, are *both* potentially open to modification and substitution. This mode concerns behaviour which is flexible and tolerant of frustration but *not* by a passive acceptance of authority.

4.8 An example which separates C, D and E is: if a person wanted to buy some chops and went to a particular shop and if that shop did not have chops, the mode C person would return frustrated and empty-handed. The mode D person would try another shop; if no shop had chops they would return empty-handed and frustrated. The person of mode E capacity would not *only* try other shops but would think of and buy a substitute; beefburgers or fish fingers, and would return with these.

4.9 The behavioural assessments are entered in the column under the appropriate letters using the > symbol. If, as is possible, the person behaves in more than one mode then this should be indicted. However, if the bahaviour is regarded to be very unusual it could instead be reported in the comment column.

5. Level of opportunity <

The next requirement is to state the present level of opportunity. *Present* means for the period of observation which culminates in the completion of the Chart. *The level of opportunity refers to the mode of relationship you have with a client.* The purpose of this section is to describe limits of discretion. The modes here do not necessarily relate directly to a person's capabilities, but to the limits set by you. These limits may be broad or narrow for many reasons: ward policy, personality, patient's capacity, staffing levels, legal restrictions, etc. What is most relevant is that you describe your relationship with an individual, over a period of time, as accurately as possible in terms of the modes specified.

5.1 The first column, 'N', means that for *any* reason you do not offer the person the opportunity to carry out an activity *but* nor do you do it for them. If for example a person was on a locked ward they may have had no opportunity to use local amenities. This would be recorded in the 'N' column.

5.2 If the opportunity is technically available but you actually carry out the activity on behalf of the person and, by implication, set the goal and plan, this is recorded in the column, 'c/d'. For example, in making a full meal, if the person is not allowed at present to prepare their own meal, because a cook prepares the food, this would be recorded in this c/d column. Also if you intervene in an activity; e.g. making a cup of tea, to the extent that you *actually* boil the kettle, put in the tea, pour in the water, etc. Then this also is recorded in this column of opportunity. The reasons for your actions may be specified in the comments column.

5.3 If your relationship is in *MODE A,* this means that you set the goal and plan but you allow the person involved to carry out your goals and plans; that is, you either tell or show the person what to do *and* how to do it. For example, having a bath would include breaking the goal into smaller steps; put in the plug, turn on the taps, etc., the point being that the person is carrying out *your* instructions.

5.4 If your relationship is in *MODE B* you are setting the goals. This may be in the form of telling a person what to do and/or showing them your expectation of the end product. For example, you may say, 'I want you to make your bed to look like that one'. However, you leave it up to the person involved as to how he/she does it. You may, of course, be checking how he/she does it and if the goal has been achieved. However, if the checking or monitoring becomes active instruction, the relationship is mode A again. Another example of mode B is if you tell a person to lay the table but leave him/her to get on with it.

5.5 If your relationship is *MODE C* then you are no longer telling what and how to do things but leaving the initiative to the person; for example, here you do not tell a person to make him/herself a cup of tea but wait for him/her to do it in his/her own way. However, you do monitor both goal and plan; you check: is it a cup of tea? have the required ingredients been included? has boiling water been used? to the extent that the monitoring becomes active involvement, then the relationship becomes modes A or B again.

5.6 If your relationship is *MODE D* then as for mode C you wait for the person to initiate action. In this case you monitor the goal *only;* for example, if a person wants to go out, you will want to know where he is going and why: to buy food, clothes, etc.? If you were then to check as to *how* he/she was going to get there, for example by asking, 'Do you know which bus?', 'Can I see if you have enough money?', etc., this becomes a mode C relationship again.

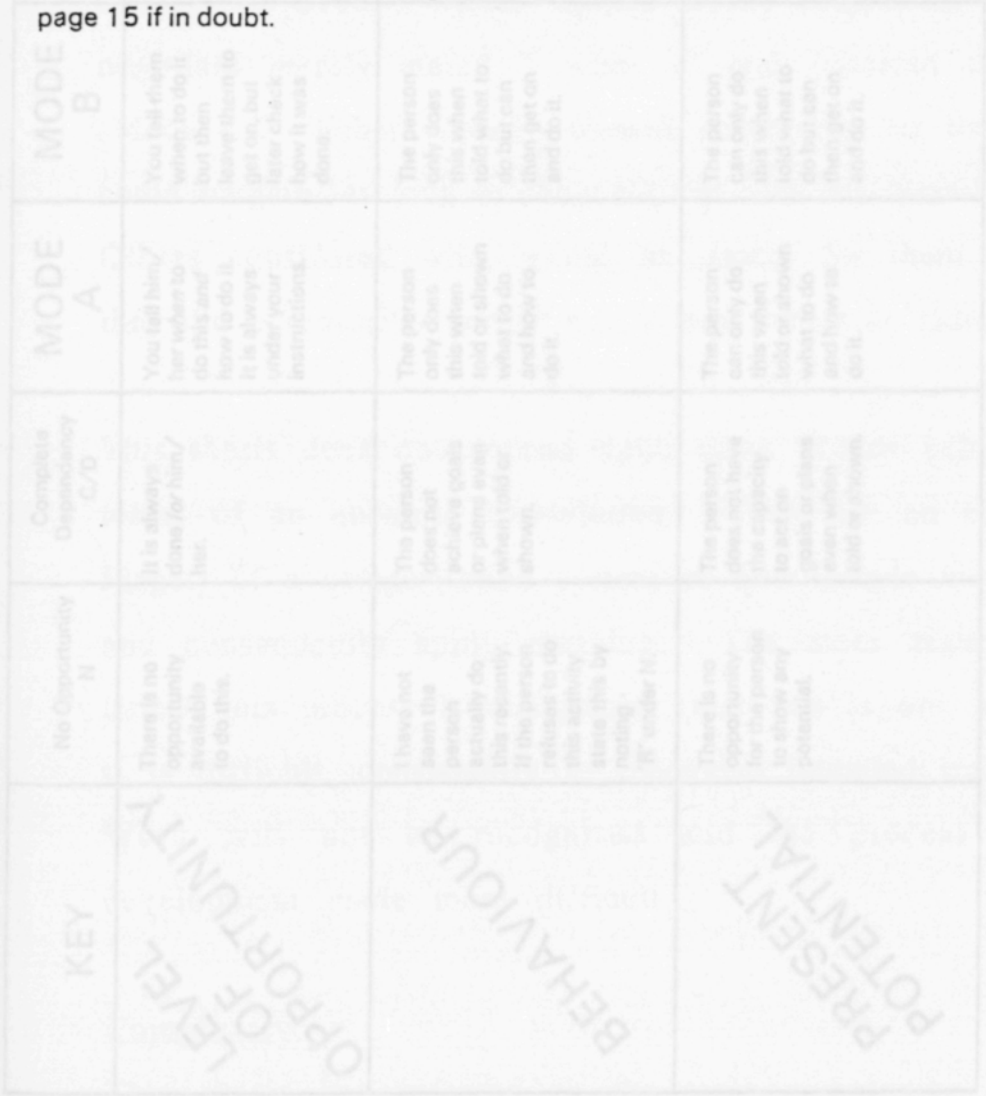
5.7 Finally, if your relationship is *MODE E* then you initiate no action whatsoever. The person has total discretion over his life, to do well or make a mess of it. You wait and intervene *only* when invited to do so by the person. The monitoring to be done is of yourself only. You ask only, 'Am I making myself available enough?' or 'too available?' There is no monitoring of goals or plans unless specifically requested. It is perhaps best illustrated by a normal G.P.-patient relationship. The G.P. does not normally check on you to see if you are all right because you have not been to see him for a year. You decide for yourself if you think you need to see a doctor. However, once you have asked for his involvement this may require specification. If you do begin to actively monitor, the relationship may become mode C or D.

5.8 Again, as with behaviour, the level of opportunity may vary and this can be recorded on the principles used for behaviour. (See para. 4.9.)

6. **Present potential** ○

This refers to what the client could do *now if* he/she were not held back by lack of opportunity, training or personal inhibitions.

6.1 Using the *behaviour* descriptive criteria, you can make a statement as to what you feel the person is *capable* of. This is an explicit statement of your intuition. For example, if a person never washed his/her clothes but you felt he/she was capable of doing so, you could rate this as present potential. It does not relate to *future* behaviour as a result of training but what he/she could do now. Use the figure on page 15 if in doubt.



KEY	No Opportunity N	Complete Dependency C/D	MODE A	MODE B	MODE C	MODE D	MODE E
LEVEL OF OPPORTUNITY	There is no opportunity available to do this.	It is always done *for* him/her.	You tell him/her *when* to do this *and* how to do it. It is always under your instructions.	You tell them when to do it but then leave them to get on, but later check how it was done.	You allow the person discretion to decide when and how to do something but you check *when* it is done and monitor *how* it is done.	You allow the person discretion to decide when and how to do something, checking *when* it is done but not monitoring how it is done.	You allow the person full discretion and do not check or monitor. You intervene only if requested to do so by the person.
BEHAVIOUR	I have not seen the person actually do this recently. If the person refuses to do this activity state this by noting 'R' under N.	The person does not achieve goals or plans even when told or shown.	The person only does this when told or shown what to do and how to do it.	The person only does this when told what to do but can then get on and do it.	The person does this activity without being told but both *when* and *how* they do this in a pre-set way.	The person does this activity without being told. The *when* is not fixed and others wishes are tolerated unless they threaten the goal of activity.	The person does this activity in a flexible way without being told. They can take into account the needs of others and substitute goals.
PRESENT POTENTIAL	There is no opportunity for the person to show any potential.	The person does not have the capacity to act on goals or plans even when told or shown.	The person can only do this when told or shown what to do and how to do it.	The person can only do this when told what to do but can then get on and do it.	The person is capable of doing this without being told but both *when* and *how* they do this is in a preset way.	They are capable of doing activity without being told. The *when* is not fixed and others wishes are tolerated unless they threaten the goal of activity.	They are capable of doing the activity in flexible way without being told. They can take into account the needs of others and substitute goals.

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The modes of behaviour were constructed from observation and discussion in the research and by reference to Piaget,[132] Kohlberg[133] and separately formulated by the author.[134] These differences in approach, including the handling of social variables and the ability to consider other views were not only evident in individual behaviour but also in group behaviour. For example, one time in the Harrow hostel, the hostel was given a donation of £100. Couchman asked the residents, as a group, what they would like to spend it on. Some literally had no idea, they had virtually no conception of money let alone an abstract concept of £100. Others wanted it for themselves and did not negotiate merely stated 'I want X' and repeated their demand (Mode C). Others clearly wanted something for themselves but could bargain, as long as they did not lose out entirely (Mode D). Others considered what would be useful for them all, even if they did not directly benefit e.g. a new carpet or radio (Mode E).

This thesis does not depend upon these Modes being correct in terms of an absolute formulation. They are an example (like Piaget) of a categorisation system of how people view the world and consequently apply meaning. The main argument is that unless this process is understood (and this is one attempt) then it is difficult, consistently to recognise intended transformations. Work will not be recognised and the process of identity development made more difficult.

Complexity

This thesis has referred to the term complexity meaning the level of difficulty of a problem. References have been made to

various categorisation systems which order complexity into a logical hierarchy (e.g. Piaget, Jaques).

Whilst the C.I.I. Modes form a developmental scale of dependency they are not in themselves a scale of complexity. However the mode or approach to problem-solving, will differ according to complexity. For example, if a problem is relatively straightforward and easy for the person it will not use their full intellectual capacity. Consequently such a person may be able to pay attention to other variables in their context, for example, other people's needs, and introduce flexibility into their solution. On the other hand, most people under pressure will have to concentrate hard on a difficult problem and in so doing attempt to ignore other variables which can become an interfering nuisance.

During the project considerable thought and discussion was given to the possibility of ordering the activities into a hierarchy of difficulty. This was rejected on several grounds.

1. First it would have meant the acceptance of one model or theory of complexity. Neither the researcher nor colleagues felt confident enough that any existing model sufficed. There was not sufficient time or resources to synthesise models or develop a new theory.

2. If activities were ordered, they would have had to be exactly predefined, and this brings with it the disadvantages of pre-packaged activity or skills lists discussed above. It would

not have been possible to allow for variation (or local definition) since this may alter the level of difficulty.

3. It is never possible to describe an activity in abstract and presume that it carries exactly the same level of difficulty in all circumstances. For example, dressing may be made more or less difficult according to what clothes are available. There would have had to have been a further relationship precisely clarified, between level of complexity and opportunity.

4. It was felt that if the staff/carers defined activities as carefully as they could, and made this public (as described above) then for practical purposes this would convey the level of complexity. Further that there is a common understanding that some activities are of the same sort of difficulty others more or less easy. So, for example, someone who can wash their hands and face in a handbasin can probably brush their hair or put their socks on. It was assumed, and turned out to be the case, that the more obvious disparities would become evident. (For further examples see the case studies in Appendix V). Also the inclusion of the judgement of present potential highlighted areas where a person was judged capable of carrying out some activities, even though they did not do so. That is this absence of behaviour was not simply because of the difficulty of the activity. Some people didn't like certain activities, or were precluded by policy, or were simply frightened or unskilled. In summary, in the light of the practical purposes of the C.I.I. the extra effort required to construct such a hierarchy and the disadvantages associated with it precluded such work being

explicitly incorporated. The author still regards such work (i.e. to develop a hierarchy of complexity) as worthwhile. However, this is more in the domain of refining cognitive tests (as discussed in Chapter 7). Also there is no reason why results of the analysis of cognitive or conceptual ability cannot form probabilistic statements about the sorts of activities a person should be able to complete successfully.

Summary

As a result of the two year project, and with further work with Couchman afterwards (1977-9) the final version of the C.I.I. was published in 1980. It had been developed and piloted in five locations and a total of 480 charts completed in their various forms. At the end of the research the C.I.I. was not merely a recording instrument but a process of assessment resulting in a reviewable plan of action. In addition, to the C.I.I., itself, a summary guide was written (see Appendix VI).

The purpose of the C.I.I. was always to ensure a better match between a person and their environment. This was to be achieved by understanding what people could do in terms of current and future potential and enhanced the possibility of offering the appropriate opportunities. It was not primarily concerned with the location of care. The central theme was that if a person could exercise discretion, carry out work which was consistent with their capabilities, then this in itself would enhance self-esteem. The project demonstrated this in many cases (for example the case studies in the C.I.I.). The physical

location was only relevant in so far as it provided or inhibited opportunities for people to work.

The C.I.I. also required staff/carers to examine themselves. Specifically, i) what they meant by an activity, ii) what their judgements were on present potential, iii) why they offered the opportunities they did, and iv) what they could do to improve the situation within a time frame.

In the guide to the C.I.I. (Appendix VI) there is a note which reads 'The objective of the C.I.I. is to help you to look at your relationship with mentally handicapped people, then to help you consider whether the relationship is appropriate and what you might do about it.'

The C.I.I. is not designed to make people more independent as a value in itself, nor is it a method to move people into the community. It is a method of examining a relationship. In the terms of this thesis it is an attempt to discover meaningful interactive discontinuities. It is intended to relate the subjective discontinuities of people to a social world whereby they can gain recognition for their transformations and enhance their identity. It helps the carer assess what problems are relevant to a person and consequently to set tasks which are a challenge and help the person realise their potential.

Work for Staff

The C.I.I. always required considerable discussion. People with a mental handicap are not cared for by one person twenty-four

hours a day. As such, carers need to share their views and challenge them and come up with realistic plans of action. This is work for the staff/carer. As the C.I.I. is concerned with relationships it is as much about the carers' work as the client or resident. It has an impact on individual work and its context i.e. the policy of the unit. These aspects are reflected in the three C.I.I. forms. The Individual Assessment, The Development Programme and the Residential Policy. This in itself was a major difference between the C.I.I. and other existing assessments which tended to view these aspects as separate issues or exclude some altogether.

At the end of the project (1977) it was clear that the organisational structure and administrative process had a significant impact on the use of the C.I.I. The resulting paper 'How to Use the C.I.I.' (Appendix VI) had as much content concerned with role responsibilities and administration as with the completion of charts. The role of the team leader and key worker were specified as was the responsibility of the team leader's manager (Middle Management). It was pointed out that the team leader should ensure the full participation of other carers and professionals, not simply the residential team, and where possible the clients themselves.

Thus the C.I.I. is a long way from a prepared check-list. In 1977 it contained all the components (and more) which were later articulated as Individual Planning and currently (1990) described as Case Management. It is important to remember that its development and design was carried out in five locations

by invitation as part of the social analytic research method. Its active implementation, especially in Harrow, was due to enthusiastic collaboration. Indeed, it could be said that the staff psychologically owned the process. This was reflected in the eventual joint authorship.

What remained a concern was, would others use it? If it was a method, which through the processes described above, broke down institutionalisation by concentrating on specific relationships and designing care plans accordingly, would it be used generally in traditional settings? It was this problem that the next stage of the research addressed.

CHAPTER 9

TESTING THE C.I.I.

"Few tragedies can be more extensive than the stunting of life, few injustices deeper than the denial of an opportunity to strive or even to hope, by a limit imposed from without, but falsely identified as lying within."
Gould 1981[135]

As has been explained in the previous chapter the C.I.I. focuses on relationships between carers and clients but it does not ignore the reality of differential capability, or general needs. Rather the C.I.I. concentrates upon the continuous interaction between a person and their environment so that, if necessary, the environment can be reconstructed to provide a more appropriate context.

If carers use a model which implies that all the limitations are within the client (as in the above quote) this can reduce the workload of the staff. If they believe there is nothing to be done, because of the handicap, then custodial care can be justified. One of the requirements of the C.I.I. is that it questions all staff assumptions and leads to a public plan of action which not only has to be justified but reviewed. This approach, not only of assessing the client, but examining working relationships was (and is) not common practice for all those employed in health and social services. Thus the next phase of research was

to determine whether the C.I.I. would be used and how it would be used or integrated into working practice.

This chapter summarises the research which was carried out between 1st February 1980 and 31st March 1983. The research was supported by the North West Thames Regional Health Authority as part of their general concern to review services for people with a mental handicap and their families.

There had been a delay of two years between this and the original project due to two factors. First funding was needed and it took this period of time to negotiate the required support. Secondly the C.I.I. took until 1980 to reach final publication by the National Foundation for Educational Research. The new research design did not change the format and content of the C.I.I. during the research because one objective of the research was to critically analyse the C.I.I. itself.

Methodology and Sample

This time the systematic research work concentrated on hospitals, and the C.I.I. was primarily used by nurses. The three largest hospitals in the Region, Leavesden (where the original work took place), Harperbury and Cell Barnes agreed to take part. The senior management team in each hospital were asked to select several wards to test the C.I.I. The research design endeavoured to gain a sample of wards representative of the mix in the hospitals.

At Cell Barnes and Harperbury three wards were chosen in each hospital. At Leavesden six wards were chosen. Three which had

some previous experience of earlier versions of the C.I.I. and three which had not. Each ward was asked to assess twelve residents every six months and use twenty activities. It is recognised that this is a more prescriptive use of the C.I.I. than is actually required in the published version but was requested to enable comparison. Unlike the previous project the method was not pure Social Analysis. Wards were asked if they would collaborate and although one condition was that no ward would have to collaborate if they did not wish to, the researcher did not wait for invitations (as in the first project).

This change in methodology was made because of the need to gain a representative sample of wards and residents for comparative purposes and because in working life new approaches are not introduced entirely at the initiative of the ward staff. The methodology thus reflected the difference between the purpose of the two projects. Despite the absence of a true social analytical approach the research had to be approved by the hospitals and Region. Mechanisms were set up to monitor the research and to receive reports as well as clear the work on ethical grounds and gain clearance from consultants and relatives. This proved to be a lengthy process and one which continued to be raised due to staff turnover and modifications of the design.

A full account of the research project is available.[136] It is not reproduced in its entirety since first it is as long as this thesis and secondly, it forms only part of the argument of this thesis. However one section concerned with the administrative progress

of the research in terms of monitoring groups is appended (Appendix VII) to demonstrate the administrative procedures required by each hospital. One major problem experienced at this time was a re-organisation of nursing staff in all three hospitals with accompanying industrial action. Also during the project the Nursing Process was introduced, it was at first seen as a separate initiative although it was argued that the C.I.I. met all the requirements of the Nursing Process and more.

Despite these problems the research continued and the data was gathered in two complementary ways. First, the main researcher (the author) met regularly with all the wards using the C.I.I. and discussed progress with them. These discussions were recorded in note form paying particular regard to the staff's behaviour and actual use of the C.I.I.

Secondly, a written questionnaire was administered in the latter half of the research project. Although the questionnaire was designed by the researcher it was independently administered by another researcher not otherwise engaged in the research. Participants were informed that the questionnaires would not be read or analysed until after the fieldwork stage. The inclusion of the questionnaire was to provide information which could be compared with the notes taken from discussions with the researcher. Further the questionnaire was also an attempt to control for bias since the researcher discussing with staff was also the co-author of the C.I.I. which was being tested. It was decided that a positive outcome might be attributed to

favourable comments (a reticence to criticism) without the independent evidence from the questionnaire.

SAMPLE

TABLE 1 - WARDS INVOLVED IN THE PROJECT

Hospital	Ward	Type	Dependency	Disturbed	Sex
Leavesden	1	Pre-hostel	mixed	some	mixed
	2	General	mixed	some	male
	3	General	mixed	some	male
	4	Locked	high	all	male
	5	Training	high	some	male
	6	Pre-hostel	low	some	mixed
Cell Barnes	1	Locked	high	all	male
	2	General	mixed	some	mixed
	3	Training	mixed	all	female
Harperbury	1	Child/Train	high	some	mixed
	2	Child/Train	high	some	mixed
	3	General	high	some	male

Table 2 summarises information about the number of assessments made, the number of people assessed and consultancy discussions with staff in the various wards.

Hospital	Ward	Patients Assessed	Charts Completed	Patients Assessed			Number of		Period
				once	twice	more	Disc	Visit	
Leavesden	1	38	60	16	22	--	40	54	2.80-end
	2	7	23	1	--	6	20	20	2.80-3.81
	3	7	7	7	--	--	12	15	2.81-9.81
	4	4	6	3	--	1	31	43	2.80-end
	5	10	34	2	1	7	35	42	3.80-end
	6	12	31	3	--	9	37	53	2.80-end
Cell Barnes	1	13	86	--	--	12	24	31	7.80-end
	2	9	11	7	2	--	18	25	7.80-9.82
	3	11	17	5	6	--	18	27	7.80-9.82
Harperbury	1	5	19	--	--	5	19	25	5.80-10.81
	2	6	20	--	--	6	18	24	6.80-10.81
	3	11	28	--	6	5	29	27	5.80-9.81
Total	12	133	342	46	37	51	301	386	

TABLE 2 - ASSESSMENTS AND CONSULTANCY IN WARDS

Table 3 summarises information about qualification and experience of the nursing staff participating in the project.

Status	Ward-sister	Charge-nurse	S.E.N.	Unqualified O.T.	Unqualified nursing assistant
n	10	10	1	1	1

Experience	5-8 years	8-10 years	10-15 years	more	unanswered
n	6	5	5	1	6

TABLE 3 - INFORMATION ABOUT STAFF IN THE WARDS.

RESULTS

The following section gives a summary of the results by hospitals followed by a more detailed analysis of the questionnaire results. More detailed results are reproduced in Appendix VIII.

1 GENERAL COMMENTS

a) Leavesden

Six main wards were involved in the project, in the period from February 1980 to March 1983. Two wards did not complete the project due to staff changes. The other four continued to use the C.I.I. after the termination of the project. The C.I.I. was also in limited use in four secure wards that were not included in this research.

A total of seventy-eight patients were assessed, of whom forty-six were assessed more than once, in one hundred and sixty-one completed charts. Review of the completed charts showed development of individual patients, in those cases where plans of action were implemented.

b) Cell Barnes

Three wards were involved in the project, from July 1980 to March 1983. One ward was fully committed to the research requirements. The other two wards used the C.I.I. sporadically, due to staff changes and/or reported time-shortage. The attitude expressed to the C.I.I. in all wards was positive and a desire was expressed by them to use it in other settings.

A total of thirty-three patients were assessed.

In general, patients showed progress in different aspects of their behaviour, as measured by the charts.

c) Harperbury

Three wards were involved in the project from May 1980 to October 1981. The hospital was going through major re-organisation, and as a result of it there were significant changes in staff and patients on wards. The commitment to the project was an extra burden on the staff.

The organisational situation seemed to be crucial to the effective use of the C.I.I.

A total of twenty-two patients were assessed and sixty-seven charts completed. All patients were assessed more than once. Patients' behaviour showed development as measured by the charts.

QUESTIONNAIRE RESULTS

Fifty questionnaires were completed by twenty-three nurses during different stages in the project. The majority of the nurses were at the charge nurse or ward sister level. Most had more than eight years experience in nursing mentally handicapped people.

The questionnaire covered many aspects in detail (see Appendix VIII). In general three main areas are summarised here:

a: the C.I.I.as a form of assessment

b: the impact of the use of the C.I.I. on ward work and

c: the impact of the use of the C.I.I. on patients.

a. The Chart and its Manual

Nurses answers with respect to the charts refer to a total of three hundred and forty-two C.I.I.'s completed, assessing one hundred and twenty-three patients. The average time for completion of a chart was one hour. At the beginning of the project the time for completion was longer than one hour, but it decreased as familiarisation with the procedure increased.

In general, staff reacted favourably to the C.I.I. They felt it was clearly presented, easy to use, and very relevant to their work.

There were a few problems with the understanding of certain sections in the Manual: particularly the Policy Format. The difficulties seem to reflect the difficulties nurses have in formulating an agreed ward policy.

b. The impact of the use of the C.I.I. on ward work

Some possible impacts of the use of the C.I.I. were investigated. Table 4 gives an overview of nurses' opinion on this aspect The five point scale has been reduced for this summary, as has the form of the questions (for further details see Appendix VIII).

TABLE 4 - NURSES VIEWS ABOUT THE C.I.I.

	Agree	Disagree
	%	%
gives a framework for work	84	4
helps formulate a plan	52	30
helps clarify policy	44	35
helps question judgements	57	30
gives a long-term view of care	91	4
promotes staff discussion	82	13
helps express view about patients	91	-
helps draw information together	74	9
helps in consideration of transfer	50	14
helps improve staff relationships	30	39
helps give a picture of patients strengths and weaknesses	82	4

From this overview it is noticeable that the C.I.I. was felt by nurses to have a considerable impact on their work. A majority of the nurses agreed that the C.I.I. gave them a framework and helped to express views about their patients.

Most of the nurses felt that the C.I.I. gave a long-term view of care. Its use promoted staff discussions, helped draw information together, and gave a picture of patient's strengths and weaknesses. The nurses agreed less on how far the C.I.I. helped them question judgement and make consideration of transfer. However most wards were considered as 'long-stay' wards. There was also less agreement about its usefulness in formulating, planning or clarifying policy.

It seemed that nurses felt less helped in questions that refer to policy and planning, and this may be a result of the fact that not all nurses feel these tasks to be part of their duties and responsibilities.

There was less agreement between nurses about the contribution of the use of the C.I.I. to the improvement of staff relationships. Although they felt that the use of the C.I.I. promoted discussions between staff, these do not seem necessarily to improve relationships. The reason for that may be that discussions can bring in to the open differences of opinions and conflicts which have remained hidden and consequently threaten relationships.

c. <u>The impact of the use of the C.I.I. on mentally handicapped people</u>

Fifteen items of the questionnaire referred to this issue. In general, nurses felt that the use of the C.I.I. contributed to care in: offering more considered care plans; giving a complete picture of the person's situation; helping mentally handicapped

people to have more opportunities; improving their social skills; and, consideration if not realisation of future placements. Nurses were less sure about how helpful it was to use the C.I.I. method with highly disturbed patients.

3 THE CONSULTANCY DISCUSSIONS

A total of three hundred and one consultancy discussions with the nurses were monitored by the researcher. On average the researcher had twenty-five discussion meetings on each ward. The discussions were unstructured, and this enabled the nurses to bring up not only issues strictly related to the C.I.I., but also subjects that were highlighted by its use. There were additional visits to the wards to check the general progress and understanding. These more general visits were made to keep the researcher in touch with the overall context of work at ward level.

The results of consultancy discussions gave a very similar picture to the questionnaire results but revealed more information as to what lay behind these results and therefore are the basis for the discussion below.

It is important to note that the C.I.I. is not a 'test' in the traditional sense of presenting carefully standardised problems with scores dependent upon the type of solution. It is rather a method to formalise observation, to make such observation more systematic and open to discussion, especially with regard to the implications of what is seen. It further requires staff to state beliefs and expectations so that they can be tested. The process

as a whole provides an opportunity for formulated reflection and review. With reference to the development of identity the project gave insight into the processes described in Chapters 4 and 5 in three main ways.

First it required the staff to consider what they meant by a behavioural episode. This was achieved by the definition of activities. It was necessary to ensure that such episodes were relevant to the resident. This is done by avoiding pre-written activities. For one person a meaningful episode might be washing their hands and face, for another it might be maintaining personal hygiene; a much more complex activity. For one person it might be dressing themselves, for another it might be putting on socks.

It was reported in the research that the use of the C.I.I. not only helped in expressing views about residents but helped to give a much clearer picture of residents' strengths and weaknesses, compared with other methods and compared with ordinary case/nursing notes.

Secondly, through the process of communication, more systematic observation and feedback, it provided for two further outcomes. The consistency of staff behaviour increased and consequently so did the level of opportunity. This in turn led to more feedback being given directly to residents and as such meant that they (residents) gained more recognition for their work.

Thirdly, the use of the C.I.I. produced action plans, which while rarely carried out completely provided a focus and purpose for staff/resident relationships. Despite the time taken to complete charts and plans, staff/resident direct interaction increased on all wards and so did the purposeful nature of that interaction in terms of individual rather than general needs.

DEVELOPMENT OF RESIDENTS

Whilst there is evidence of development for most residents involved in the project (from the analysis of the completed charts - see Appendix VIII) it should be noted that this is not necessarily due exclusively to the use of the C.I.I. In this research no control group was used (as under these conditions 'control' was virtually impossible). Also the implementation of social policy and organisational change created other pressures and stressed the importance of paying more attention to individuals including designing programmes of care. Development, was also due to the finding that the C.I.I helped residents take more opportunities. However this was not directly due to the C.I.I., but the implementation of plans which the C.I.I. helped to articulate. What the C.I.I. did was to provoke questions and stimulate the imagination of staff to offer new opportunities. From the sample of residents 88 people were assessed twice, and 51 more than twice. Of those, where development could be confidently analysed, the following analysis was made.

Most progress was made in the area of domestic activities. However the general result was that the behaviour of residents

became more consistent. For example, rather than residents behaving say in Mode C and Mode D and E, for an activity it was a common finding that the range diminished. For example in the first instance only several activities were rated at mode C and the rest at A or B, by the end of the project behaviour and opportunity had stabilised at Mode C.

The C.I.I. attempts to help in the development of people's potential and consequentially affirm their positive identity. Where it was used consistently, behaviour problems and destructive behaviour diminished. The release of potential was in some cases quite dramatic. For example, during the course of the project one resident moved from No Opportunity to Mode E for making a cup of tea. Most changes in Mode, other than for domestic activities, were in the area of social relationships where more consideration was given to other people's needs. The reliability of recorded progress was increased by the preciseness of the definition of the activity. However, in some cases these were still too general for staff to rate accurately, especially when there were staff changes.

On the more dependent wards the major change was from Complete Dependency to Mode A. That is where staff changed from carrying out an activity for a person (e.g. feeding) to one where the activity was done by the resident but with full instruction, i.e. they (the residents) held the spoon and put the food in their own mouth albeit with considerable assistance. In terms of the thesis this is at least as significant as a move from Mode D to E since it was often the first time a person was

actively engaged in an activity and gained a sense of psychological ownership of transformations.

Another benefit for residents was that the existence of the charts meant that transfers were less traumatic. It was agreed that the C.I.I. gave a more accurate and useful account of a person's behaviour and capabilities especially when combined with general reports. The structure of the Modes, especially with regard to level of Opportunity, meant that there was less ambiguity about what situations a person could cope with and what level of decision-making they were used to.

Further this information also included judgements concerning the relationship between opportunity and capability. Staff reported that it was very useful to receive information which specified that the reason a person had not participated in particular activities, or had not been allowed to make their own decisions, was at times because of policy, or staff restrictions rather than capability. Indeed, the clearest rationale for transfer was often because the capability of the person had exceeded the general opportunity available.

As can be seen by the detailed results (in Appendix VIII) staff regarded the use of the C.I.I. to have a beneficial effect on residents. This was particularly so with regard to the construction of action plans. More specifically, it appeared to enhance opportunities, lead to development of social skills and focused attention on appropriate placement. Even with regard to highly disturbed residents, not originally the intended client

group for the C.I.I., the charts were not regarded negatively even if they were not seen as positively as for more able clients.

This overall positive response to the use of the C.I.I., indicated especially by the questionnaire results, does not however give the full picture as observed and discussed through direct ward visits by the author. The difficulties encountered in the research were not so much a result of the technical content of the C.I.I. but due to the general problems associated with implementing an assessment process involving direct carers.

Apart from the general administrative difficulties of agreeing the research programme (outlined in Appendix VII) there were more specific day to day problems which produced an underlying but critical hypothesis for this thesis:

THE IMPLEMENTATION OF INDIVIDUALS' PLANS FOR CLIENTS DEPENDS UPON THE RECOGNITION OF THE WORK OF THE CARERS.

REACTION OF STAFF

Of the twelve wards that undertook to test the C.I.I. only one kept to the agreed timetable. At Leavesden the three wards that continued active involvement, albeit with a revised timetable, were all involved in the original developmental project. Of the other three, two effectively dropped out of the project half-way through and one continued on a much reduced basis. In each

case there was a change of Charge Nurse or Ward Sister during the project.

At Cell Barnes, two of the three wards continued throughout, one reduced the content of their programme, again due to a change of Charge Nurse. At Harperbury, all wards continued throughout; there were no significant staff changes at Ward Sister or Charge Nurse level.

The major problems that staff encountered were:

1 Involving all ward staff: because of the shift system it was difficult to involve staff from all shifts in the process of either assessment or the construction and implementation of plans, a critical part of the C.I.I. process.

2 Involving non-ward based staff: It was often difficult to involve other professionals or relatives. Due to the problems above, meetings were difficult to arrange involving psychologists, medical staff, physiotherapists, occupational therapists etc. Involving relatives and clients made this even more difficult.

3 Programmes were too ambitious: When plans were devised they often attempted to cover too many areas. It was easier for staff to identify what they should do rather than what they could do given limited resources. Particularly at the beginning of research this led to demoralisation, indicating to staff the mountain of work that faced them and highlighting inadequacies.

The researcher encouraged staff to be more realistic, concentrating on fewer activities and fewer residents.

4 Perhaps most significant was lack of middle management support. Where Nursing Officers were involved, the wards were more likely to maintain some sort of assessment programme. Where this was absent, the motivation for the work was left to the ward staff and/or the researcher. This was the case in the majority of situations. It was noted that the researcher began to be drawn into the middle manager role, i.e. providing support, advice, discussing programme, modifying the process according to resources.

There was rarely any sense of ownership of the process above ward level. Thus Ward Sisters and Charge Nurses who were personally committed to individual assessment continued with the work. Where this was not the case, the project foundered with little or no comment from above. This was in direct contradiction to stated policy, nationally, regionally and even in the hospitals themselves. Despite the apparent concern over individual plans, there was no differential recognition from management between those who were trying to implement such a process and those who gave up. Indeed in two cases staff who used the C.I.I. to demonstrate resource constraints and policy restrictions were regarded if not as troublemakers at least as nuisances.

Institutionalisation

The main inhibitions to the effective use of the C.I.I. therefore seemed not to lie in the design itself but in the context of its use. Its use demonstrated that the organisation of the hospitals was in reality more concerned with basic, routine care than the progress of individual residents. The ward staff gained recognition for work which avoided problems, not for implementing care plans. The structure which was further confused by re-organisation provided a middle management with too many levels. Tasks were not clearly assigned and most critically in terms of this thesis, there was no recognition, or feedback in terms of staff appraisals or review of work. In this context staff struggled to maintain a positive sense of identity. They had to provide their own feedback and saw their recognition in terms of their own judgement of progress.

This was compounded by other systems which were part of institutional life. For example, the shift system meant there were virtually three unconnected regimes. Unless the Charge Nurse or Ward Sister took extra effort to build a team by communicating across those three teams despite the organisational constraints, it did not happen. There was no recognition for those who did. Secondly Nursing Officers could and did move staff at will from one ward to another to cover shortages. This was often to cover dangerously low staffing levels on other wards but again interfered with programmes, undermined continuity and reinforced the message that individual care plans were not a high priority.

Consequently, the success or failure of the use of the C.I.I. and implementation of plans depended almost exclusively on the Ward Sister or Charge Nurse attempting to carry through this work without recognition, in a difficult environment. It may be surprising that the C.I.I. was used at all under such conditions. In general the ward staff were demoralised and in a double bind. On the one hand, policy statements were espousing the virtues of individual care and calling for an end to institutionalisation. On the other, the very methods which might help in this process were largely unsupported. Further, the organisational constraints, shift system, resources, the administrative systems of providing food, day care, centralised laundry, etc. were largely untouched.

These organisational systems have a major impact on work practices and staff morale.[137] They are dealt with in more detail elsewhere.[138] However the result of this project and in particular research at St. Ebba's Hospital in Epsom demonstrates the thesis here with regard to staff behaviour. As argued in Chapter 4, the recognition of work is critical if people are to experience positive self-esteem and if their action is to be sustained. Many staff working in such conditions developed an institutional identity. That is they carried out basic routine work which was recognised as valid. Other work which involved change and development especially of clients was not simply ignored but sometimes actively discouraged by middle management. The inertia of the institutionalised system crushed all but a few who sustained their identity by reference to other sources.

The sustaining of a positive identity for staff could only be maintained by reference outside the management hierarchy. In these cases staff referred to variously, their own beliefs sometimes explicitly moral and religious, outside pressure groups or peers within the system who thought in a similar way, or even to family and friends or outside experts. Such groups or individuals were not always looked upon favourably by the institution.

Thus one of the most significant outcomes of the testing of the C.I.I. was not simply a critique of its technical design, nor even the consideration of its benefits or otherwise for clients. It was that the question of identity, and the recognition of work was at least as critical for staff as for residents. What was not as clear was whether the restrictions on staff which minimised their use of the C.I.I., or in more general terms their implementation of individual plans, was due to general institutional factors outlined above or could be specified more precisely. This led to further research reported in the next chapter.

CHAPTER 10

THE RHONDDA VANGUARD:

INDIVIDUAL PLANNING IN ANOTHER SERVICE

"The overall aim of the Rhondda Vanguard Service is to bring about the practical changes that are required if all people with a mental handicap living in the Rhondda are to achieve the right to take their place as respected citizens of their community."

C. Notley, RVS Project Leader[139]

Individual Planning in Another Service

The previous chapter put forward various propositions with regard to why the individual planning process (using the C.I.I.) was not fully utilised, even though the process itself was seen positively. Generally staff's behaviour in both the North West Thames Project, and the St. Ebba's Project briefly referred to, indicated a learned helplessness.[140] They developed an identity which, in the absence of recognition, precluded active transformation of the environment and produced a resigned acceptance of the status quo. There were, as has been mentioned, notable exceptions, and despite the reality, very few staff appeared to be satisfied with this situation. This chapter concentrates on the effect of recognition of work for carers rather then those cared for and consequently continues the analysis of the previous chapter.

Research in the Rhondda Valleys of South Wales (1986-89) provided an opportunity to test further the implementation of individual plans in a totally different setting. This Welsh research project had a much wider brief. It was to help in the organisation and development of the Rhondda Vanguard Service (RVS) in order that a comprehensive service for people with learning difficulties could be provided in the community. The project involved action research, essentially social analysis, with service team members to help design and test the structures and systems required to deliver such a service. The results of the whole project have been reported[141] but the analysis and some of the results which follow were not included in that report as the research was not a comparative study of individual planning methods.

The RVS forms an interesting contrast to the hospital service discussed in the previous chapter:

	The Hospitals	The RVS
1.	Classically seen as institutions, all over 700 residents (except St. Ebbas)	New, community based service. Clients mainly in their own homes or small residential accommodation.
2.	Did not have a culture of multidisciplinary care or teamwork	Set up deliberately to work on a multi-disciplinary basis.
3.	Initially set up to provide custodial care.	Set up to provide comprehensive, individually based services in line with most recent social policy.

4.	Poor organisational structure, unclear role descriptions and operational policies.	Deliberate effort to clarify roles, and operational policies.
5.	Lack of systematic on the job training and staff development.	Training and staff development seen as an integral part of the service.

Although the RVS was not well organised at the beginning of the project, after the first year the structure was clear and yet there were very few individual plans completed for clients. The project work did not begin in full until 1986 but the RVS had existed prior to this as part of the initiatives of the All Wales Strategy.[142] This strategy was introduced to be at the forefront of social policy. The All Wales Strategy, like the recent community care policy (1990) stated explicitly that:

"1) People with a mental handicap have the same human value as anyone else and as such should enjoy the basic human right of being treated as individuals.

2) People with a mental handicap have a right to a normal life within the community.

3) People with a mental handicap will require additional help from the community in which they live and from professional services if they are to develop to their maximum potential as individuals. Therefore these services should:

a) Seek to enhance the status of the individual and be planned to meet his/her individual needs and aspirations.

b) Accept that people with a mental handicap have rights and can make choices which may involve risk taking. Exposure to unnecessary risk and over protection from risk are equally unacceptable."

Principle 3a clearly depended upon an individual planning process (not necessarily the C.I.I. but a process with the same overall objectives).

At the end of 1983, G. Evans of the Applied Research Unit, Mental Handicap, Cardiff, introduced the concept of individual planning. One plan was commenced using an approach previously adopted in local services (NIMROD). In 1984, a Staff Development Officer was appointed: C. Webb. Part of her role was to implement an I.P system throughout the service. During that year there was an initial training programme for individual planning. Issues unresolved were:

i. confusion about the essential principles
ii. disagreement over which system should be used
iii. not clear who would be accountable for what.

During 1985 and 1986 no more than eight individual plans were completed, for a client group of over three hundred. These were mostly initiated by the Clinical Psychologist. Towards the end of 1986 it seemed that a significant breakthrough had been achieved. The roles of team members had been clarified and it was agreed that the IP process should be the main responsibility of Zone Workers, that is fieldwork staff, who directly carried the case load. The Staff Development Officer then undertook a new

training initiative. This involved gaining agreement that the IP system to be used would be derived from the Open University/Mencap course 'Patterns for Living'.[143] The method used was called Shared Action Planning.[144] All the agencies: health, social services, education and voluntary organisations agreed to use this approach.

Despite the apparent level of agreement and a new training initiative in the first half of 1987 only six plans were completed by zone workers. C. Webb (the Staff Development Officer) noted that "the main explanation by staff was lack of time". Also staff perceived this as extra work, an additional burden added to case-work. What was striking about these comments was that they were very similar to the responses of nurses in the hospitals using the C.I.I. Also in more general terms RVS staff were voicing concerns about 'lack of support', again similar to the hospitals.

Although there was an absence of many institutional factors, assumed to be inhibitions to individual planning, the process was not being effectively implemented. This was so despite the agreement of a method and the agreement that such individual programmes were the central theme of the new service.

In June and July 1987 the Staff Development Officer and the author re-evaluated the situation. Discussions with staff revealed two related factors. First, planning, especially meetings to formulate individual plans, was not seen as 'real work'.[145] This was also a perception held by the nurses in the hospitals.

For many years there have been efforts to emphasise individual plans with regard to nursing. As far back as 1950 McManus wrote:

'The unique function of the professional nurse may be conceived to be 1) the identification of the nursing problem and 2) the deciding upon a course of nursing actions to be followed for the solution of the problem in the light of immediate and long-term objectives of nursing'.[146]

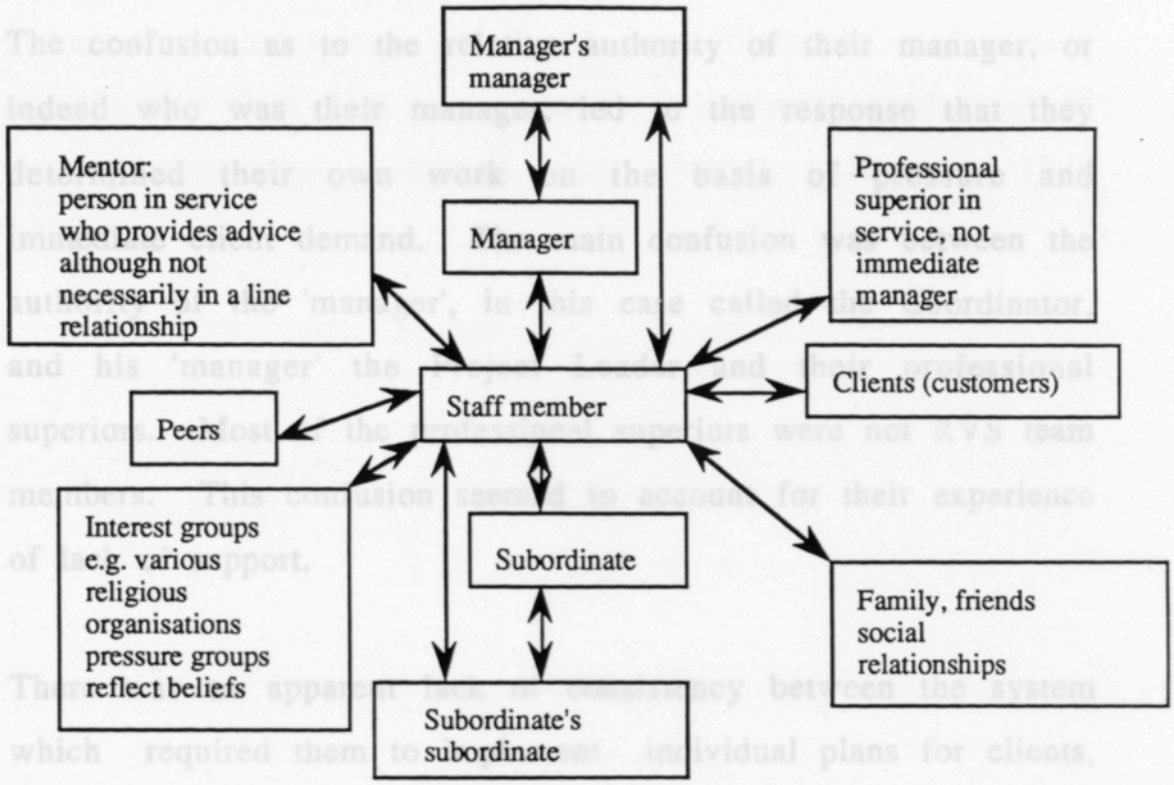
Thirty years later Pembrey wrote: "Each patient nursed in a hospital ward is dependent on the ward sister to ensure his individual nursing."[147]

However, experience in the hospitals, both with the C.I.I. and the implementation of the Nursing Process[148] demonstrated that this view was not universally translated into practice. Even in the RVS, a situation relatively free of past cultural restrictions, the practice was also lacking. Through discussion it emerged that the most valued aspect of work in the RVS (and in the hospitals) was direct action with or for clients. This was perceived as real work. In the hospitals this behaviour tended to be more activity based than individually client centred. For example, staff bathed, washed, changed linen, fed, dressed etc. as group activities. It was short-term task orientation. Although in the RVS there was much more of a client-centred focus, there was still little planning, formulation or justification of these actions.

Although the hospitals and the RVS were very different, as indicated, one aspect they had in common was that the direct service deliverers felt under stress and that they had more work than they could cope with. In such situations activity reduces anxiety.[149] Planning work, thinking and discussing tends to increase anxiety since it makes more apparent what needs to be done. Also this anxiety, in both situations, was not felt to be contained by management - ('lack of support'). In the absence of managerial feedback, service providers looked for work which gave immediate and demonstrable feedback and recognition. For the service providers at the RVS this was found to be in direct relationships with clients where they could see what they were achieving.

Consequently, the analysis was made that this 'lack of support' was based on felt lack of recognition from those in managerial roles. Service providers felt they were left to get on with their work. While this was positive in the sense that it gave them considerable discretion, (a plea often made in terms of 'professional autonomy',[150]) it also left them feeling isolated.

The following model, by the author, considers the sources of recognition for employees.



This raises the second point. Discussions revealed that while RVS team members felt their role and purpose was clear, <u>their role relationships were not</u>. They were unclear as to who their real manager was. They were not sure who could legitimately review their work, assign them tasks and consequently give them appropriate recognition. If the thesis concerning recognition is valid, it would presume that they would look for recognition elsewhere, which in fact they did. It appeared that the most significant source of recognition for service providers became their peers and clients (they had few if any subordinates). They were also influenced by their beliefs which

were consistent with the values outlined in the All Wales Strategy, except that they were not completing individual plans.

The confusion as to the relative authority of their manager, or indeed who was their manager, led to the response that they determined their own work on the basis of pressure and immediate client demand. The main confusion was between the authority of the 'manager', in this case called the Coordinator, and his 'manager' the Project Leader and their professional superiors. Most of the professional superiors were not RVS team members. This confusion seemed to account for their experience of lack of support.

There was an apparent lack of consistency between the system which required them to implement individual plans for clients, and the organisational system which did not provide recognition or a career plan for them.

Between July and December, C. Webb and the author attempted to design a system for clearer recognition of their (the service provider's) work. This involved asking every team member to respond to four questions in terms of who <u>does</u> and who <u>should</u>

1. Assign tasks to you and review them.
2. Monitor <u>how</u> you carry out tasks (professional or pathway advice)
3. Monitor your job description
4. Provide advice on your career.

The results were then collated and presented to the team. Some members could not answer some of the questions, others put down names of people who were unaware that they were perceived in that role. The results were discussed in the team meeting and then with each member individually until most of the answers were resolved with mutual agreement. (See following table.)

FEEDBACK AND SUPPORT SYSTEM

STAFF MEMBERS	TASK ASSIGN	PATHWAY ADVICE	MONITOR LIMITS	CAREER DEVELOP
Project Ldr.	Asst. Drctr.	Asst. Drctr.	Coord. Grp	SELF
Clerical Asst.	Admin Asst.	Admin Asst.	Admin Asst.	Admin Asst, /Staff DO
Admin Asst, Typist P/T	Coordinator SAA Admin Asst.	General Admin Asst.		
Typist P/T	Admin Asst.	Genrl Asst.		
Coordinator	Project Ldr.	Project Ldr.	Coord. Grp.	SELF
Accom Devel Officer	Project Ldr.	Project Ldr.	Coord. Grp.	SELF
Accom Tm Ldr.	Coordinator	Accom. DO	ADO	ADO/SDO
Accom Tm Ldr.	Coordinator	ADO	ADO	ADO/SDO
STC Tm Ldr.	Coordinator	ADO	ADO	ADO/SDA
Prin Clin Psych	Coordinator	Top Grade Psych	Top Grade Psych	SELF
S.W.	Coordinator	S/W III	S/W III	S/W III/SDO
S.W.	Cordinator	S/W III	S/W III	S/W III/SDO
S.W.	Cordinator	S/W III	S/W III	S/W III/SDO
Clin Nurse Spec	Coordinator	D.N.S.	D.N.S.	D.N.S.
Commun Nurse	Coordinator	C.N.S.	C.N.S.	C.N.S.
Commun Nurse	Coordinator	C.N.S.	C.N.S.	C.N.S.
Commun Nurse	Coordinator	C.N.S.	C.N.S.	C.N.S.
Prtcptn. Dev. Officer	Prtcptn. Mng. Committee	Nat. Cldrns Home	Prtcptn. Mng Committee	NCH/SELF
ATC Mng	Coordinator			
ATC Dev Officer Sen Instruct. ATC Instrs ATC	Project Ldr.			
House Ldr. MENCAP	Management Committee	Accomm Tm Ldr.	Management Committee	Accom Tm. Ldr/SDO
SCWs-MENCAP	Hse Ldr.	ATL	Hse Ldr.	ATL/SDO
Prj Ldr NCH Prj Staff NCH				
Educ Psychol	Coordinator			
Music Ther	Cordinator			
Dev Ofcr Fin Hcnsol Project Staff	Project Leader			
SDO	Prjc Ldr.	P A Trg	Prjc Ldr.	PA Trg/ SELF
Gen. Admin Asst				
SCWS (Commnty)	Zone Wrkrs (CN & SW)	Various Mnly CN & SW	Zone Wrkrs	ZWs/SDO
SCWS (Res)	Accom Tls	Accom Tls	Accom Tls	ATL/SDO

Between July and December 1987 many vague and unsatisfactory relationships were resolved and a new system, based on the research results, was devised to provide recognition from appropriate sources to team members. As can be seen by the table not all the issues were resolved by the end of 1987. Subsequent work clarified these issues further.

There was one final hurdle to overcome. Few of the team members wanted to implement a 'staff appraisal system'. Their view was that such systems were more related to situations of low trust. They associated them with reward and punishment rather than recognition or feedback. They were concerned that such systems were a way to introduce disciplinary processes and even dismiss people. The Staff Development Officer (SDO) and author proposed a system called the Feedback and Support System (FASS). This was not simply a semantic side-step but indicated that the system was devised to address the problem of lack of support and to provide feedback or recognition of work done.

The FASS depended upon the quality of the feedback and linking the information to individual training programmes. In this way the FASS as a process, mirrored the individual planning system (Shared Action Planning) for clients. The design and implementation of FASS was the responsibility of the SDO. The detail of FASS is reported elsewhere.[151] However in essence it required both parties prior to an interview, to consider

1. What are your aims?
2. What have you achieved?

3. What has helped? What has hindered?

4. What next?

and then to specify (A) Goals for the next six months and (B) what are the training and development needs.

Between March and June 1988 the FASS was implemented for all service staff. During this period the Coordinator (Team Manager) reset targets for the completion of individual plans as part of the FASS process. Through this new system a total of eighty-four clients were identified as needing individual plans to be formulated by the end of the year. This was six times the number completed over the previous four an a half years.

In that six month period fifty individual plans were formulated. This was still nearly four times the previous total. At the next review in September 1989 FASS had been in operation for all team members for nearly eighteen months. Most staff had been through the process three times. There was no longer any concern over lack of support, neither had the fears of disciplinary action materialised. Also during this period one hundred and nineteen individual plans were in operation.

It is interesting to note that by the end of this period there was no longer any need to set specific targets for individual planning. The process was psychologically owned by the team members and operated according to need. All clients who faced decisions regarding major changes in their lives, e.g. leaving school or home were already involved in the individual planning process.

Summary

This research project followed on from the C.I.I. testing in exploring the reasons why staff did not enthusiastically implement an individual planning system for clients even when they saw it as critical to the improvement of services. What the RVS project demonstrated was that among the range of factors identified in the hospitals project, including the obvious institutional influences the most critical was the lack of recognition and feedback for staff due to unclear management and a complementary work review system. Once the staff had their own work recognised they felt able to own and implement a process to enable clients to develop. This result appears to support the main thesis that recognition of work is significant in the development of identity and a positive, more active approach to interaction with the environment.

In order to achieve this it was necessary to explore the carers' construction of the world. They were asked to communicate how they saw the service with regard to role relationships. The formulation was a representation of their subjective discontinuities. This was then shared to produce interactive discontinuities which enabled them to engage in more productive working relationships and review their transformations of the world, i.e. the service they were providing.

CHAPTER 11

A CROSS CULTURAL TEST

"At this stage of development the majority of Aborigines at Weipa are handicapped persons, being unintegrated into the industrial demands of our society."
Comalco Arbitration Submission, 26 June 1963.[152]

So far this thesis has placed great emphasis on the relationship between individual identity and work. It has discussed methods by which the former can be enhanced by recognition of the latter. This could be seen primarily as a Western construction. Western industrialised societies have a particular concept of work and also place great emphasis on the individual which is reflected in their legal, social and political structures. The existence of individual, democratic voting rights are a major, if not the major, criterion for judging the requisiteness of society. There is therefore a question as to whether this thesis is limited to such societies. Whilst the author is not claiming to be writing in the field of social anthropology it is not assumed that the ideas expressed here are necessarily culturally restricted. This thesis is concerned with the structure of meaning, and concentrates on the processes of assigning meaning rather than specific content which might more obviously be culturally bound.

The author had an opportunity to work with an Aboriginal community in Northern Queensland, Australia (which at the time of writing is ongoing). This research provides, an albeit limited opportunity to (i) test the thesis in another setting and (ii) at least to explore cultural influences.

With regard to the concept of work, the definition put forward in this thesis is more general than that usually associated with employment work and labour. (This has already been discussed in Chapter 4 and specifically addressed in Appendix I.) The definition used here is primarily concerned with the process of constructing an external manifestation of an internal project: the realisation of an intention. There is no reason to assume that this is not a common process in all societies, The survival of a social group depends upon the ability to enact such a process. Even in a nomadic, hunter-gatherer society, like the pre-White Aborigines, people must obtain food and shelter and bring up their children. The concept of a society implies the existence of interactive discontinuities, shared ways of constructing the world, even if the discontinuities differ considerably from those of other societies.

The fact that Aboriginal society is (or was) nomadic and that their construction of the material world is so different from Western views does not argue against the need for such construction nor the absence of work. The Aborigines do not make a clear distinction between the material world and the non-material or spiritual world. Their life style avoids the need for significant material transformations, e.g. buildings, for work

or dwelling. Their explanations of the world create a more dynamic, interactive relationship with their environment which does not lead to a desire to control, tame or reconstruct it. It is much closer to a symbiotic relationship where interference, in the form of taming or even husbandry, is deemed unnecessary and spiritually wrong.[153]

The Aboriginal concept of Dreamtime is similar to the account in Genesis (The Old Testament). It is the foundation of spiritual life and the explanation of the origins of life and the world. For an Aboriginee the material world, as we would see it, is much more fixed. Historically it was determined by the spirits of the Dreamtime and is imbued with religious meaning and is assumed to be living. In a similar way to the material-spiritual duality, the Aborigines have no clear animate-inanimate duality. The myths and beliefs of the Dreamtime account for nearly all physical phenomena which allows more time to explore social phenomena. Their social relationships, awareness and kinship patterns are relatively more complex than current Western equivalents.[154]

However whilst these cultural differences do not preclude the need to work, as argued here, the transformations are not as in Western culture. The relationship with the material/physical world and its understanding are not gained by active, physical manipulation and there is no great emphasis on individual achievement (there are no builders or architects or landowners). However there are hunters and storytellers, elders, cooks and a complex set of rules based around kinship patterns of behaviour.

The research reported here cannot explore the issues in great depth since the community involved is not highly traditional. It has existed for the last 100 years in the context of white Australia. White Australia certainly had a concept of cultural difference between itself and the Aborgines. Whites assumed the subjective discontinuities and interactive discontinuities of Aborigines were both different and worse. They were seen as primitive, needing to be changed or eliminated.[155] This is an example of assumptions of difference by a dominant group justifying the imposition of one meaning structure on another (see also Appendix III). Two examples from James Miller's book demonstrate the point:

The first is from a letter to the Sydney Morning Herald in 1840: "the aboriginals of my native country are the most degenerate, despicable, and brutal race of beings in existence, and stand as it were in scorn 'to shame creation' - a scoff and a jest upon humanity - they are insensible to every tie which binds man to his friend - husband to wife - parent to its child - or creation to its God. They stand unprecedented in the annals of the most ancient and barbarous histories, as a nation notorious for the anti-civilizing propensities they put forth in opposition to every attempt made to reclaim them from their present wandering, abject, and brutal mode of life."

James Miller, himself an Aboriginee, although he rejects this term preferring the title Koori, describes this passage as "the most racist piece of bullshit I have ever seen written". However the clarity of racism in this letter is not shrouded by the

respectability that others gave to such opinions. In 1845 W N Gray, a Justice of the Peace at Port Macquarrie, told the select committee on the Condition of Aborigines that: "In my opinion it is impossible to persuade the men to give up their wandering life, but by taking the children from them very young and bringing them up in an establishment where they would have no opportunity of seeing any but Europeans, they would, I have no doubt, become useful members of society ... "

Indeed it did become practice for whites to take children from their parents with no right of appeal.

Thus we have a historical relationship where both groups realised that the other had a very different view of the world. The existence of alternative subjective discontinuities was certainly recognised by the whites. However their assumptions or attempts to understand the psychological meaning of the alternatives were crude and oppressive. They assumed that parents did not feel for their children, that there was no 'civilisation', and there was no value in this social group. The extreme effect of these views are now well documented and resulted for a time in a policy of virtual genocide.[156]

There are striking similarities between such attitudes and the early fear and loathing of the mentally ill and handicapped, if not the extremes of consequence. The Aborigines are a group who have also been forced to live in accommodation not of their choice, had their potential unexplored in any positive way and

where the differences of expression of their world view are seen to be bad and dangerous.

Also, as for the mentally handicapped, the opposition to this oppression was not really an attempt to understand their alternative construction of the world but a humanitarian reaction, based on human rights and decency. It could be argued that in both instances (Aboriginee and the mentally handicapped) the exposure and public recognition of maltreatment lead to a reaction through guilt to stop. The Rev J S White wrote: "The blood of the aborigines is on our head, and it will require more than oft recurring drought and floods and periods of commercial depression and national distress to expiate our guilt".[157]

Napranum

The research undertaken by the author between May 1986 and February 1990 was at the invitation of the Napranum community otherwise known as Weipa South on the Cape York Peninsula.[158]

The purpose of the research was to evaluate the effectiveness of the Nanum Wungthin Training Centre (NWTC) and to help to design systems where the progress of trainees could be recorded in a way which was meaningful both to the Aboriginal and white communities.

The Director of the Training Centre was Tony Tiplady who lived in the community, as did the researcher on his visits. The

centre's purpose was (and is) to provide a training service to the Napranum community particularly for those between 15-25 years old. The centre was/is funded by a trust: The Weipa Aborigines Society (WAS) and the Napranum Community Council.

Background to the Community and the Nanum Wungthin Training Centre

In 1955 it was realised that there was an extensive bauxite deposit in the Weipa area, previously devoid of industrial activity. The Western side of Cape York was to host the mining company Comalco whose rights to mine were given by the State of Queensland in 1957. The Aboriginal community was not empowered nor assumed to have any say in this matter. They were even excluded from discussions held between the Church mission authorities, the Queensland Government and Comalco concerning the future of their own people. It was proposed to move the people from Weipa South. Gradually, despite their absence in any formal negotiations, the Aboriginal people made it quite clear they did not want to move. This undermined the credibility of the Church and the Government. Comalco did not pursue the option, and the people stayed where they were.

The development of the mine had a significant impact on the local people. Comalco subsidised the building of houses in Weipa which were occupied in 1965. The Church relinquished control to the Queensland Government and the migration of whites to the area began in earnest. There was also a large movement of Aborigines and Torres Straits Islanders from other areas. The

Weipa South community was transformed in a few years. Cash and alcohol added to the disruption. The original community was now considerably outnumbered by the white immigrants. They were even outnumbered by other Aboriginal and Islander groups moving into the area.

Amongst these changes the Weipa South Council attempted to establish relationships within the community, and with the outside bodies. The mine grew, and the influence of the Church diminished, the Department of Aboriginal and Islander Affairs became the Department of Aboriginal and Islander Advancement, the Department of Community Services, and then the Department of Community Services and Ethnic Affairs. These changes in name brought changes in policy each time representing an attempt to hand more power and authority back to the people through their elected council. The process was not easy, particularly as the community had been subjected to so much change. In a period of some 30 years people whose identity had been questioned, who had been taught to be dependent and told they were irresponsible were now, in effect, asked to run their own lives. They were not ideally resourced to do so.

Despite the supply of Government Services, more was needed and the Weipa Aborigines Society (WAS) was formed. The nine member executive comprised and still does of three people elected by residents of Weipa South, two Councillors and four Trustees, one from the State and one from Federal Government and two from Comalco. Since 1976 W.A.S. has been entirely

financed by Comalco, its purpose to identify, finance and administer a social and educational development programme. The W.A.S. projects have included, amongst others, the development of a town plan, construction of a community hall, construction and operation of a pre-school, sealed roads, drainage and sewage and the original construction of the subject of this chapter, the training centre Nanum Wungthin.

Another major initiative during recent times has been the Community Development Employment Programme (CDEP). This has been funded by the Department of Aboriginal Affairs (DAA) and began in March 1986. Under this programme people in Weipa South were (and are) required to work to receive their social security payments. They had to work for the Council to provide community services such as house maintenance and painting, maintaining parks and gardens, town cleaning, arts and crafts, and farming. This meant people had weekly incomes related to work, it provided a coherent structure giving direction to the members of the community and controlled by them. It demonstrated a willingness to work, if that work was for and by the members of the community. In itself it represented a clear example of the significance of recognition of work and this process raised the self-esteem of community members and reduced alcohol abuse. It was the subject of an Australian national television programme.

THE DEVELOPMENT OF THE TRAINING CENTRE

First Ideas

The original idea of a training centre came from W.A.S. However, it was initially established for the Salvation Army's alcohol rehabilitation programme but the Salvation Army left in 1983. As a result the Aboriginal members of the W.A.S. executive committee raised the matter of how to use the now empty craft centre. The initiative coming from community members was developed and Ian Goudie and Allan Young (senior executives of Comalco) agreed to come up with proposals. The co-operation between members of W.A.S. was indicative of the new direction in the relationship between Comalco and Weipa South. This may best be summed up in a quote from the General Manager Operations (Ian Goudie) to General Manager Organisation (Allan Young) of 22.3.85 which referred to J E Tonkin 1976: "Our policy is to assist the Aborigines and Islanders, in concert with the appropriate Government agencies, to create an environment in which they can develop the competence and confidence to be able as independent individuals to take their place in the Australian Community on equal terms with like persons of any ethnic origin, and in a manner that utilises their full potential.

In this way they should have the capacity to choose the lifestyle they wish to adopt and the locality in which they wish to live."

This quote bears similarities with statements in the All Wales Strategy and Caring for People already mentioned.

It was clear that there were a significant number of young people between 15 and 25 years of age who were either unemployed or had only irregular employment. They had few practical skills either related to their own cultural background or related to an industrial setting. Ian Goudie proposed to W.A.S. that a "useful skills" programme be introduced. In the first instance these skills would be primarily relevant to the needs of the community.

The W.A.S. executive accepted this proposal and Allan Young was given the task of beginning the Project. Young approached Stuart Baird, the Comalco Senior Apprentice master. It was thought that his trade training background, energy, commitment and personality made him a good choice.

Work Begins

After a three month trial the level of interest and attendance was thought to be sufficient for the position to become permanent. Baird's secondment began in July 1984. The early months were a time of establishing a real purpose and identity for the Centre. it should be stressed that this project has always been owned by the community, it was not simply a good idea from outside. Further, the proposals, changes and reports all came through W.A.S., the only formal body with representatives from all the major parties (the people, Federal Government, State Government and Comalco). Thus W.A.S. has acted as the Steering Group and parallels the structure of such groups which monitored research work mentioned in previous chapters.

Baird's work was essentially pioneering. No other Training Centre had been effective in terms of skills learnt or even attendance. With backing from W.A.S., and in particular Allan Young, Baird set out to build from the needs of the people in the community. Initially it was tempting to go for the more obvious objectives and outcomes, e.g. full time employment, clearly measured skill acquisition, and to achieve this through the usual course type of approach of structured, hands on teaching with so many days or weeks to learn any particular skill.

However, Baird began by articulating a philosophy and discussing it with W.A.S. This has not substantially changed since 1984 and contains in it the reasons for Nanum Wungthin's relative success. What follows is an account of the process which eventually led to the establishment of a functioning centre.

<u>The Original Philosophy took account of the trainees perceptions:</u>
Various principles were made explicit which recognised the validity of the Aboriginal view: as these extracts from the original philosophy document demonstrate:[159] Quoted material in the rest of this chapter is taken from this document.

"inabilities are never used to embarrass"
"the skill programme is guided largely by what each attendee wants to learn"
"social and work activities are mixed to allow attendees to build self-esteem whilst learning skills which will be useful in day to day living"

These original principles are not very different from those espoused by the All Wales Strategy (see Chapter 10). Most of the young people attending were European education dropouts. They had little more than the equivalent of primary education and some less. Most drank heavily and had a poor self-image which was often demonstrated by defensive aggression.

Most training programmes for Aborigines run along Western lines. That is people have to sign up for particular courses of a set duration. At Nanum Wungthin they could choose to do what they wanted when they wished but with a critical proviso. If they began a project they had to complete it, e.g. welding a bar-b-que table. All activity was based around real productive work, there was no practice on models. This provided for the possibility of freely chosen interactive discontinuity with a real transformation.

Other constraints were that no-one was allowed to work when drunk. Discussions of projects were encouraged and young people were encouraged to tell the trainers about their lives and how and if they would use skills. Social activities were arranged in conjunction with work. Baird, commented that at this time trainees attended on an irregular basis and did not continue with one project, but that "this was a reflection of lives and expectations in the community. Most people felt a lack of control over their lives." This is a similar description to that which could be made concerning residents and staff in large institutions.

However he continues ... "they demonstrated they could regain control .. even if simply through more regular attendance and practice at skills. The gradual acquisition of skill increased confidence." This was enhanced when the NWTC began to produce a community newspaper (The Napranum Cha) and when trainees demonstrated their skills in activities at home, house maintenance, fixing a car etc. Gradually the NWTC began to be seen as an asset to the community, Baird again: "the centre has shown it can help provide a sense of identity, help the process of communication ... last but not least it provided Weipa North (the mining town) with an insight into Napranum and how people see their lives".

In 1985 Tony Tiplady joined the centre, he had a background in teaching Aboriginal people in the community. At this time (prior to CDEP) responsibility for tasks round the community ultimately did not rest with community people. Few Aboriginal people were in a position where they wanted to work.

In Tiplady's own account he mentions that even in the Centre there was a low expectation on trainees' work output. This was an area he sought to improve. Because he was known to the people he believes he was able to increase this expectation almost immediately.

Most of the teaching time was spent working alongside trainees, not doing the work for them but being available for advice, demonstration, checking, encouragement, praise and reprimand. They still needed a high degree of support, for example showing

how a task could be tackled. He regarded that it was important to provide encouragement not reprimand for instance, At the same time a high standard of finish was now required for the task. From his own account of that time Tiplady writes:

"Limits were kept to, particularly in the area of continuous working. 'Are you alright? Do you have something to do? Back to work fellas. Smokes over, etc'.

As has been mentioned, from the beginning all work at the training centre was real work. There was a brief period for practice, say half a day welding similar material, then it was into the real thing. If a job had to be finished by a certain time the responsibility for completing the job rested with the trainee. I wouldn't do the work for them. In most situations I took the role of tradesman's assistant while advising the trainee what to do. That is, I would hold things, lift things, etc.

Most trainees at this stage still did not have much confidence in their ability and needed lots of encouragement and praise while working on any particular task. At times all the encouragement and praise would not achieve the desired result. At times people 'boil up', i.e. get grumpy either with the job or me."

Another area which needed development was the trainees' communication skills and confidence in a cross cultural setting. The trainees were very reluctant to enter into any situation where they might have to deal with non-Aboriginal people, e.g. Comalco, retail outlets, shops, etc. This lack of confidence was

addressed in various ways. The main approach was to expose them to real situations where it was necessary to interact. Initially they weren't required to communicate just be there. In this way they became familiar with the situations, saw the people involved and heard what was said. Even so it was one to two years before many trainees had the necessary confidence to handle these situations.

To provide a contrast with this experience of white society, trainees learnt traditional skills from older Aboriginal people. This was achieved by having a one week camping trip where each of the trainees made a spear using traditional methods and materials where possible. There were other spin offs from the camp, for example: (1) Having to interact as a group in another environment; (2) Being together twenty-four hours a day for six days; (3) Having to prepare meals in teams. All this established relationships amongst trainees and forged links with white and traditional culture.

Tiplady commented on these camps: "On the camp I also got the trainees to keep a daily dairy. This surprised Stuart, blew him right out in fact. He didn't think any of them would write a thing. He was delighted to see that they did.

I guess I have always operated with the belief that Aborigines can achieve any goal they desire to achieve. That for any programme to work it must be community based. It must meet perceived community needs and as the trainees perceive their needs."

It can be seen that the principles used to set up and run the workshop demonstrated the main thesis concerning the relationship between the development of identity and work. People's confidence grew as they felt able to demonstrate their effectiveness and gain recognition for it. However a further problem remained: how to record the progress of trainees.

Recording Progress

As has been mentioned the culture of Napranum, while not a traditional Aboriginal setting had not been completely overtaken by white values, ways of living, or expectations. Nevertheless there was a demand, from Comalco and from the Federal and State bodies for criteria to evaluate the NWTC. Consequently the author sought a way to design a system which would be satisfactory to both cultures. Aborigines do not pay as much explicit attention to individual achievement as Western society. There is a tendency to remain part of a group and assign success to the group. However individuals did seek personal recognition in their work and were encouraged by it so long as it did not set them apart. Given the parallels mentioned above between the situation of Aborigines and mentally handicapped people in institutions it was proposed that a modified version of the C.I.I. should be used.

As can be seen from previous chapters it is the level of activity which primarily indicates complexity. It was decided to use the forms but with the activities reflecting the work of the centre e.g. boilermaking, carpentry, car mechanics, office work. It was decided that the system had to fulfill three functions :

1 It would provide recognition and feedback to trainees whereby they could see what they had achieved during their time at the centre.

2 It would provide evidence to back up references to people outside, if and when trainees moved on to further training and/or employment.

3 It would provide evidence of the work at the centre itself in more than simple output terms which are usually quantitative, e.g. attendance records, budgets, etc.

It is also important to state the parameters of the record form.

First and foremost it had to be relevant and meaningful to the trainees. Its design and purpose needed to be clear and presented in a way which made sense to the work and achievement of the trainees.

Secondly, it was seen as important to distinguish technical skills from social skills. As a result of discussions the progress and acquisition of technical skills will allow for and indeed make explicit <u>differences</u> between people. The social aspects of the centre should emphasise <u>sameness</u>.

That is, a system of differentiation should be complemented by a system of integration.

Various other considerations were seen as important.

Thirdly, the recording should be a process of agreement. It was not an independent evaluation by an outsider. It was seen to be the property of the trainee. Nothing in it was kept from the trainee and it was not shown to others without the trainee's permission.

All of these points emphasise that the recording system was designed to help the trainee not to categorise him or her for outside purposes.

The System Itself:

The Training Development Book (modified C.I.I.)

Each trainee received a book with their name on it and the date that they started at the Centre.

The first page is record of attendance. It is broken into four quarters with a review at week thirteen of each quarter. (This can be staggered so that the instructor will conduct between one and two reviews per week). The subsequent pages are subdivided into general skill areas.

1 Mechanical
2 Carpentry
3 Boilermaking
4 Secretarial/Office Skills
5 Newspaper (Napranum Cha)

Not all trainees will have all five sections only those relevant to their current work and interests.

The sections may be further subdivided:

e.g. Mechanical: Servicing a Mower
Servicing a Utility
Brake Overhaul, etc.

Each sub-section is then further subdivided if required:

e.g. Service a Mower
Cleaning Filter and Replacing
Checking Blades, etc.

These may not be very detailed if the trainee is competent in an area.

The activities mentioned above were then rated on a scale to show to what extent the trainees can do this activity on their own or need help.

This rating scale is a modification of the Modes of the C.I.I. It was reduced to four categories of relationship with respect to an activity. The first category approximates Mode A & B, the second C, the third D and the fourth E. The colours, representing ascending ability were chosen deliberately. The final three colours, are the colours of the Aboriginal and Islander flag, (red is the earth, gold is the sun and black the people).

The rating scale of colour-coded categories was as follows:

Green: Being taught (under supervision)

Red: Under supervision (at instructors discretion)

Gold: Instructor on call (at trainee discretion)

Black: On your own (instructor only available in emergency)

The results were recorded and reviewed again at the next quarter.

Whilst this system emphasises learning on the part of the trainee, there is always mutual learning. This is reflected in the collaborative nature of the recording system. The instructor(s) is required to identify ways of working and relating which can be of benefit across cultures.

General Lessons:

Several general points emerged from this work. First in setting up a service the service provider must take into account the needs and perceptions of the client: here the young people of Napranum.

Secondly the Aboriginal and Islander community at Napranum became engaged in a process where the way in which they wished to live and work together was articulated into a system which also takes account of, but is not taken over by, Western/European structure and its related values.

Thirdly anyone who is attempting to help in this process needs to be able to appreciate (as far as possible) how and why possible structures and systems are consistent with the values, culture and purposes of the Aborigines and Islanders. This need not primarily be in a written form. Even the verbal form of communication is not as necessary as in most Western work. At Napranum there is a strong emphasis on behaviour and the judgement of direct action rather then post-hoc rationalisation of behaviour. The Aborigines, even more than the Islanders listen and learn by watching and are highly sensitive to inconsistencies between action and stated purpose (verbal or written). This may be partly cultural and partly due to a realistic mistrust of white society which historically has not exactly treated them with honesty, dignity or respect.

Current Situation

The NWTC and its method of recording progress is now perceived to be an integral part of the Napranum community. Its relative success may also be noted in that it is no longer a high profile prestige project but an accepted way of life. The community psychologically owns the centre in a similar way to the trainees ownership of their activity and record of progress. These record forms were (and are) the only assessment forms in use which are acceptable to both communities.

The relationship between this managed process of work recognition and identity development is perhaps best exemplified by case studies of trainees. The following examples are left in the written form of their authors, both

trainers, to demonstrate the propositions of the thesis but without reference to the specific academic concepts as defined. This is because the concepts and propositions grew out of such raw data: the two case studies which typify the progress of trainees provide a contrast and demonstrate the realistic limitations of NWTC. These accounts demonstrate general progress rather then exemplify the specific use of the modified C.I.I.

Case Study I

My first impressions of B on arriving at the centre were that he had no staying power, ("now you see him, now you don't") and that he wasn't interested in doing any work.

Early in B's time at the centre wild horses wouldn't drag him into the local Woolworths supermarket. A trip into the Comalco store or workshops to pick up parts was out of the question, even if accompanied B would stay in the car. Gradually B's confidence and feeling of self worth grew with the knowledge that he was able to do good work and to complete tasks.

This frightening world where non-Aboriginal people worked and shopped gradually became less daunting and B began venturing into these places as long as someone else went with him. B progressed from firstly not talking at all. After a year or so he would talk as long as someone was there to tell him the correct things to say. It is now no trouble for B to venture into most situations outside his every day world.

B worked in each area at the centre, cabinet making, Motor Mechanics, even a week in the office doing the pays and answering the telephone but finally settled on Boilermaking.

Peer group pressure eventually forced B to start drinking. Initially this was moderate and didn't affect B's work, however the relatives B lives with drink every night and B was dragged into this way of living. B became irritable, and began missing days because of hangovers. B began to talk about having a break, stopping work for a while, pressure was mounting to a level he couldn't tolerate.

About this time, the way out of B's dilemma appeared. The Aboriginal civil earthworks crew could take on 2 trainees. This involved 3 months out bush away from the community. Every week B would ask "when are we going out". As the time to go came closer it became a daily question. He joined the Civil Earthworks group with one of the other trainees.

Everyone who lives on the community needs a period of change to break the tension built up by the social pressure in the community.

A recent incident at one of the local watering holes highlights B's growth. An older non-Aboriginal man whom B knows quite well but had never socialized with before was having a few drinks. B walked up to him and asked what he was drinking. The older man said "Look, I don't have any money left to shout you back", B said "That's OK" and bought the drinks and sat down for a

yarn. The older man was absolutely delighted to see that B was able to approach him with confidence in a social setting out side B's community.

After $2^1/_2$ months with the Civil Earthworks crew B has decided on a career path plan for the remainder of 1989. This in itself is a milestone, for us to get a trainee to plan ahead.

His plan is to take a permanent position with Civil Earthworks for the remainder of 1989 and do the necessary study at N.W.T.C. to help him enter his apprenticeship with more confidence.

Case Study II

M was one of the few Weipa South boys to go through to year 10 at school, although he didn't complete the year. Being the only Aboriginal male left in the class was too much after a time, especially when the Weipa South Aboriginal norm is to drop out of school much earlier than that. While M started year 10 his "real" year level as indicated by reading and writing was much lower than this.

On coming to the centre M started work with the cabinet making group. He was reserved and quiet, a lack of self confidence sometimes showing itself in verbal aggression and threats which (you knew) would never be carried through or even mentioned if the intended victims were present.

M was rarely self motivated preferring instead to work with others. This is normal early behaviour for all trainees and fits in with the Aboriginal learning style of observation of people with the knowledge, skills and experience.

His time in Cabinet making was not marked by any noticeable increase in skills acquired both in the trade area and in the interpersonal, cross cultural area.

He always helped myself and another trainee develop the screened photographs for the Napranum Cha. This activity took a full day each month and M became quite proficient at working in the darkroom.

After a period of time M changed to Boilermaking. While this increased his interest there was still some hesitation on M's part to work consistently. M's welding skills plateaued and on reflection it is hard to define why this was so. M appeared to have potential but was not ready to express it, personal immaturity played a major role here I feel.

At 17 M became a father and at his young age this placed rather a large burden on him to live with and provide for his newly acquired family. A personality clash also developed with another Boilermaking trainee which lead them to verbally and almost physically abusing each other. This was enough to cause M to leave the centre and not return, the other trainee stayed on. He moved from his community (due to the personal disagreement) and now works from time to time as a labourer.

A factor which has become apparent when working with more trainees in M's age group is that they are far more difficult to work with than trainees 17+ years. Trainees under 17 are in a state of greater turmoil. Less self discipline, less self confidence, lower self esteem.

The skills M acquired in the cabinetmaking, boilermaking and darkroom during his time at the N.W.T.C. never got a chance to develop past the basic stage due to community and family pressures. A story often repeated on communities. The activities and skills gained during this period were however a boost to M's self worth.

Summary

This chapter has been concerned with a very different client group. The research has been included partly to address some general cultural issues. It was also included for other reasons:

First the client group, Aborigines were in a similar position to people with learning difficulties. They had been treated, or dismissed as a valueless group. They were not considered to have potential and their differences were seen as strange and dangerous. They had been controlled and many forced into the equivalent of institutional settings. Also the improvements in their treatment had been driven by humanitarian and administrative considerations (see Chapters 2 & 3). In short, very few outsiders had seriously considered, even in a neutral way, how they constructed their world nor sought to recognise or affirm their identities.

Secondly this research provided an opportunity to test the central thesis in a different setting and hopefully demonstrated the generality of the thesis. The process of setting up the NWTC was analogous to setting up a service (see RVS chapter). It also demonstrated the importance of setting up clear purposes, role descriptions of the trainees, support for the trainees and critically the importance of designing systems which reflect the cultures involved. In this way a positive set of interactive discontinuities led, albeit in a modest way, to the development of identity for people involved (as indicated by case studies and the general findings).

Thirdly it provided another opportunity to test the principles of the C.I.I. Although different in format the NWTC progress recording used a scale of relationships rather than concentrating on one pole of a relationship. It made the context more explicit and allowed for the client's psychological ownership of the process. This is the only known method of assessment which is in use with cross-cultural acceptance and understood by both groups.

Fourthly it demonstrated more clearly the relationship between the theory and research methodology. As in the development of the C.I.I. and the RVS experience the researcher came in by invitation. In this case, for the author, it was the most demanding project of all. The Aborigines, understandably were highly suspicious of white intervention. Their history was not one which led them to trust outsiders. Their non-verbal skills and acute observational powers meant the researcher was

constantly under scrutiny for signs of betrayal. The research method was itself an example of recognition, the resulting outcome publically noted as not simply a research report but contributed to the WAS report.[160] The work of the trainers and trainees is recognised in similar fashion to the eventual RVS report and the C.I.I. itself in terms of shared authorship. The development, testing and refinement of the models and principles was due to the collaboration of community members.

The series of research projects, whilst concerned with a central theme, cover a wide area. The next chapter draws this work together.

CHAPTER 12

ANALYSIS OF THE C.I.I. - ITS LIMITATIONS AND APPROPRIATE USE

'Among the many things from which a practitioner's clients need protection is the practitioner's hopes for the clients' future, however benign and sympathetic these hopes may be.'
R. Kegan (1982)[161]

This final chapter summarises the main arguments of the thesis and the use of the C.I.I. So far the C.I.I. has been considered in terms of its development and use in a variety of settings. It has also been discussed in the context of assessment in general and individual programme plans in particular. However, the thesis is not only concerned with testing the C.I.I. but also with the deeper issues of understanding the process of the development of identity. As such the design and use of the C.I.I. has been considered in terms of that process as explained in Chapters 4, 5 and 6.

The importance of the recognition of work in relation to identity development has been constantly stressed including the difficulty of recognising the work of people with learning difficulties. The argument has been that the process of formulating intentions into projects for realisation and recognition is equally applicable to clients and staff.

The main argument can be summarised as follows. A person's initial sense of identity is gained from a sense of separation of self from context. This emergence from an undifferentiated state occurs because the context cannot perfectly provide for needs instantly. The first experience of identity is one of need or lack. In order for this need to be fulfilled the context needs to be differentiated or ordered. At first this is done egocentrically through creating subjective discontinuities. This ordering process is then constantly tested through action or work. Work is the attempt to realise an internal project through the external transformation of the context to meet a need.

Since we are social animals it is not sufficient to continue this process on an individual basis. The sustenance of identity depends upon other's recognition of the transformation; the realisation of the project. This requires the other to have some understanding of the subject's process and intention. The subject's identity will then be affirmed or diminished depending upon the accuracy or overlap of the interactive discontinuities.

Many relationships, especially when formalised into treatment or assessment do not take this process sufficiently into account. The C.I.I. attempts to do so, albeit with the imperfections of any project realisation.

A person's experience of need or lack and their formulation of projects may remain hidden. If the purpose of action is solely to satisfy an individual need the observer can only hypothesise as to the need which is being satisfied (or approximated) as well as

the process of formulation. For people with learning difficulties the formulation process may be very difficult to discern as to its complexity or even intention. It thus becomes difficult to see the action as having a specific purpose and consequently recognise it as having succeeded or failed, or as being a relatively difficult or easy project.

It is argued that understanding the project is the link between action and need. It is the key to meaning and intentional activity. If the action is social and the need to be met not merely individual but a shared need then the articulation of the process is critical, with regard to interactive discontinuities. For people with learning difficulty the communication of need and project is more difficult than for those with speech and more complex cognitive strategies. However, unless the process is shareable then recognition becomes a matter of guesswork with the cost of failure the inhibition of the development of identity.

The deliberate intention of the C.I.I. is to make this entire process: linking need, project and action, more explicit. It does so by considering what actions (activities) a person initiates. The separation of goal and plan (in the Modes) is a direct attempt to identify not only objectives but the process by which they are achieved. That is to explore the formulation and complexity of plans. It also involves the staff or carers through the specification of the level of opportunity and requires them to be explicit about their goals and plans. The explication of these processes is designed to increase the likelihood of mutual interactive discontinuity. This should lead to a clearer sharing

and understanding of projects and actions. The process itself then allows for more relevant and accurate recognition. The C.I.I. is designed to produce clearer formulations not only in terms of clients' needs but also service requirements. The Level of Opportunity and Policy sections allow the carers or staff to formulate plans in the light of the constraints and opportunities available to them. Action is always limited by resources and by specifying what is available and not available, the overall purpose of the C.I.I. can be realised, that is to try and provide the most relevant context (including resources) available for a client.

Essentially, therefore, the C.I.I. is a process of explication. It encourages carers to question and evaluate their own work including the models, expectations and assumptions they hold concerning the client. Thus the process is applied equally to clients and carers alike in order to improve the relationship and increase the likelihood of shared interactive discontinuities and appropriate recognition.

Limitations of the C.I.I.

Although it has been argued theoretically and empirically that the use of the C.I.I. should enhance the development of identity for both clients and carers, it is not assumed it is sufficient in itself to do so. The main thesis is not conclusively proven or disproven by the use of the C.I.I. Nor is the C.I.I. intended to address all the issues presented in the thesis. As the original project proposal indicated (Chapter 8) the C.I.I. was designed for 'recording the social behaviour of low dependency mentally

handicapped adults'. Later research (Chapter 9) indicated that it was most effective in this area. This is because the C.I.I. is easiest to implement when the client has some understanding of basic activities. Although the C.I.I. can be used with people who are highly dependent or disturbed it means that the onus is almost entirely upon the carer for an interpretation of the client's world, including their capability. The C.I.I. has more validity if the client can actively contribute and express their views albeit in a limited way since this provides an opportunity more directly to test the carer's judgement of needs, capabilities and meaning. If the client can express, in some way, their projects then this provides evidence for shared interactive discontinuities and a clearer opportunity for psychological ownership of the process.

Therapeutic Interventions and Recognising Intentions

The C.I.I. provides a conceptual framework for systematic observation leading to a considered plan of action, or care plan which is reviewable. In itself it is not a clinical intervention. It is intended to aid therapeutic interventions in that it should lead to their consideration and relevant implementation. As has been explained the conceptual framework of the C.I.I. is based upon the thesis relating work, recognition and identity. This section looks at some clinical approaches in terms of the thesis.

Even with the use of video tapes, observation alone may not reveal the projects of the client or even indicate clearly when a behavioural event is completed. The physical description of

behaviour may be more precise but the intention may remain hidden.

One approach is simply to ignore the particular way the other person (here the client) constructs their own world and impose a set of discontinuities. That is to replace the subject's world view with an external construction of events. This is in essence the approach of Behaviour Modification.

In some instances this is not deemed to be of great significance. For example, if a sequence of behaviour contains an episode that can be identified by the observer and regarded as detrimental to the person, e.g. head-banging or self-mutilation, then that is seen as significant by the therapist. The purpose is of less concern than the effect (personal damage). The observer (therapist/nurse, etc.) subsumes the purpose, assumes the role of carer (or parent) and seeks to modify or eliminate such episodes from the behavioural repertoire of the client. Such an approach, through behaviour modification techniques, has undoubtedly prevented or minimised harm to people. However, in such a relationship the person's own will has been subordinated and however positively practical the outcome we are no clearer as to the real purposes for that person, or indeed whether the episode was perceived to be a significant transformation for the subject.

The behaviour therapist observing and charting behaviour is not primarily interested in representing the internal world of the subject. The episodes may be, as in the example above, the

number of times a disturbed person bangs his or her head on the wall. The behaviour therapist assumes a role where he or she is deciding on behalf of the client what constitutes a relevant episode. In this example it is relevant to the care and physical well being of the subject.

Further, the therapist may regard the hypothesis of an internal world as an irrelevant construct. However, when it comes to reward or reinforcing behaviour, say in this case not banging his head for ten minutes, then there is an assumption of (a) an internal world which sees the reinforcing agent as significant (reflected in the fact that the therapist will need to find out what the patient finds pleasurable, e.g. sweets, praise, etc.), (b) an ability to coincide the subject's internal world view with that of the therapist, i.e. they must both agree what event or episode has caused the appearance of reinforcement and (c) that the subject, or in this case the patient, has been an active agent in gaining the reinforcement and can consequently repeat the behavioural episode.

Therefore the notion of an internally, discontinuously organised world is crucial, as is the notion of active participation, i.e. the recognisable expression of identity which can lead to the subject's ownership of the episode and hence the reinforcement. In effect the therapist is imposing an episode of interactive discontinuity.

It is also interesting to note that (contrary to popular belief) only positive reinforcers are used. In the case of people with learning

difficulties these are not simply sweets but include cuddles, smiles and other non-verbal cues which reinforce a potentially loving relationship and provide a non-threatening indeed potentially positive context. The use of punishment, exclusions, in institutions or homes is not consistent with behaviour modification principles as outlined by Skinner.[162]

Behaviour modification is in part consistent with the thesis here in that it does provide for an overlap of interactive discontinuity and the realisation of projects through action, even if that project has been implanted. The reinforcement provides external recognition of an event caused by the subject (even if that event is not to do something, e.g. head banging).

It provides recognition of the subject as an actor with an identity. A further advantage of such an approach is that it is fairly easy to administer and can be taught to non-professional carers.

However for the purposes of identity development it is insufficient continually to substitute the intentionality of the subject with that of the therapist. It is only in extreme circumstances, i.e. to avoid personal injury to self or others that this is condoned and exemplified by compulsory admission. The continuing argument over compulsory treatment and human rights demonstrates that social policy does not easily condone limitations on the expression of fee will.

Profound and Severe Mental Handicap

The expression of purpose through action is the critical part of being human. In circumstances where purposeful behaviour appears to be absent, for example, in the case of the very severely physically and mentally handicapped or people in deep coma on a life support machine we come upon boundary definitions of life and death. 'Brain death' is effectively the absence of any self-initiated behaviour, the total loss of any intentional behaviour.

The problem in the case of people with severe learning difficulties (especially when compounded with physical handicap) is to perceive any intentional behaviour, any signs of expression of subjective discontinuities. The derogatory terms of 'cabbage' and 'vegetable' may be a result of poor observation but are attempts to describe passivity. This can lead to an underestimation of potential as in the case of Joey Deacon and Christy Brown (recently the subject of the Oscar winning film My Left Foot). Physical handicap alone is a handicap as defined in Chapter 1, in that it is a barrier preventing the realisation of an existing potential. The projects remain unrealised. The person does not need help in the construction of solutions but rather the means to carry them out. In such circumstances technical aids do not create ability but allow it to be realised. The absence of obvious external, purposive behaviour does not in itself preclude purpose.

Mirroring

The realisation of projects and the recognition of transformations is argued to have a significant effect on identity development. It is clear such processes are much more difficult to discern for people with severe learning difficulties. The range of behaviour, including stereotypical behaviour which seems to have an overall purpose of minimizing relationships with the outside world, compounds the difficulty for an outsider to judge in terms of the subject's purpose or to guess at projects since events are difficult to perceive and match.

One process used, apparently simple in its concept but more difficult in its execution is that of mirroring. The work of G. Ephraim[163], with people with very severe learning difficulties is of direct relevance. The therapist (Ephraim) would literally physically imitate the physical and verbal behaviour of the subject. This was done as (physically) close as possible to the person. Whatever the subject did the therapist did also. After several sessions (of about 20 minutes) even the most apparently withdrawn people began to respond. People who had no recorded intentional behaviour even of eye contact would look at the therapist. From the argument presented in this thesis what was happening, perhaps for the first time, was that the subjects were able to associate activity in the context/environment with their own activity. The therapist's behaviour represented the subjects' effect on the world, a transformation which they could attribute to themselves. There are fundamental differences from behaviour therapy in terms of identity development because the subject is controlling the situation. It is their

projects that matter. The therapist does not implant a project. This allows for immediate psychological ownership on the part of the subject. The therapist at the same time as actually being the transformation is providing recognition of the subjective discontinuities without having to predefine events. Also the therapist is introducing, again perhaps for the first time, experience (for subject) of congruent interactive discontinuities.

Another factor which introduces reality into the process is the fact that the therapist cannot exactly copy the subject. First (obviously) he doesn't look exactly the same and secondly, he cannot exactly imitate the actions. This introduces the element of time into the process, critical for work. The short time delay and lack of perfect imitation means that this process is actually quite different from merely behaving in front of a real mirror. In real mirroring the absence of time delay and perfect imitation eliminates the essential qualities of work involved in the therapeutic sessions.

The author has also used this approach with people with less severe difficulties with similar results and with normal babies of between two and three months. With babies, facial imitation and hand movement imitation produces smiles and a prolonging of eye contact and general interaction, (the subjects were often willing to continue for longer than the author was prepared for).

As the process continues, and as the person becomes aware of their intentions being acted upon, variation can be consciously introduced, on the part of the subject or the therapist. In fact

novelty is intrinsically present since imitation is not perfect and Ephraim reports that stereotypical behaviour is in fact quite complex and difficult to copy especially hand and finger twirling.

This may also be the first time that the person has experienced play. The subject at times introduces new behaviour (new in the sense not previously demonstrated). This can be interpreted as a project which is turned into an event and recognised by the therapist. Ephraim himself used this process with more able people to alter rigid behaviour patterns. For example, one subject, a young woman, on seeing any cup, would, if possible, immediately raise it to her lips and drink its contents. This was not only at times socially unacceptable (it was irrelevant as to whether it was her cup) but also potentially dangerous as cups do not always contain benign liquids. Ephraim put unusual (but obviously not dangerous) items into the cups, for example a leaf. The surprise element led to a behaviour which eventually included looking into the cup prior to drinking. These and other similar actions were seen as a game, producing enjoyment and laughter.

It must be stressed that Ephraim knew these people well and began the active relationship from a general position of trust. Also, his lack of self-consciousness and general interaction did not give the impression of conducting dry, scientific experiments.

These approaches which it is argued here can be explained using the arguments presented in this thesis resulted in significant changes in behaviour on the part of many of the subjects which

began to introduce them into a social world without the need for imposed behaviour patterns. In general the person was recognised as having purpose intention and affirmed in their ability, however limited, to effect transformations. Also the recognition was almost immediate and led to a significant development of behavioural repertoires most notably social interaction (at least in the form of eye-contact).

The people were also able to psychologically own their own behaviour. This was rare for most, especially those living in institutions.

Psychodynamic therapy

Psychotherapy and counselling also provide insights into the world of the client. Psychoanalytic approaches have been used in one to one therapy.[164,165] It is interesting to explore this area as the thesis has drawn significantly upon psychoanalytical theory, from Freud, Klein and Jaques as well as Winnicott, Bowlby and other psychodynamic approaches. The usual view of an analysand is that of an intelligent middle class person. The medium of analysis, verbal interpretation, might not seem to be appropriate for people with learning difficulties. However Zawada[166], Parsons and Upson[167] have addressed these problems and indicate the successful use of psychoanalysis with such clients although the method needs to be modified.

This may not be entirely surprising as Klein pioneered psychoanalytical work with young children who at that point in their development are not able to use highly abstract cognitive

strategies, or complex problem solving methodologies. Essentially psychoanalysis is concerned with making explicit the defences the patient uses to cope with anxiety. This is done through interpretation. It has been shown that the use of defence against anxiety is not fundamentally different for people with a mental handicap.[168,169]

Symington[170] writes of psychoanalysis: "It is the psychotherapist's job to convey meaning. If the patient does not understand ... then it is his job to find a method to convey meaning to the patient in such a way that is acceptable.""

From these Tavistock papers it is clear that the major problem is the concrete way in which the patient hears interpretations, an interpretation and response is quoted from the same paper:

Therapist: "You feel you would like to do away with your father, you would like to kill him."

Patient: "You want me to go and murder him then?"

These papers emphasise the extended problem of omnipotence for people with a mental handicap (referred to in Chapter 6). From Symington's same paper[171] the following quote illustrates the point: "I believe that emotionally the core problem in these patients is that they are merged with their primary love object, which is normally the mother. They are so merged that they believe that an event that affects them will also affect the primary love object."

This is similar to the propositions with regard to the undifferentiated state and the anxiety aroused by separation and the inevitable failure of omnipotence (Chapter 4). It is the need to understand the world which necessitates the construction of subjective discontinuities. It is these discontinuities which the analyst is trying to interpret. In order to create interactive discontinuities the therapist must demonstrate his or her understanding of the mentally handicapped person's world. He or she may not always be able to rely on words.

The paper by Parsons and Upson (referred to above) cites that the therapy made considerable advances when the therapist saw that emotionally disturbed behaviour indicated that the patient was anxious "about being taken over by mother/therapist and having no identity of her own."

Finally with regard to the significance of recognition this is exemplified by a quote from the same paper referring to the often reported over-idealisation of the therapist on the part of the client: "we would suggest that in part it might be because these patients have so rarely in their lives had the experience of someone just being with them and doing their utmost to try and understand what they wanted to communicate."

In general the day to day relationships provide the most obvious opportunities for recognition, through smiles and hugs and words. It is clear for many mentally handicapped people such opportunities may be lacking or misdirected.

This chapter has not sought to compare or even describe all therapeutic interventions rather to: i) consider the limitations of the C.I.I., and ii) provide examples of ways in which the projects and transformations of even the most profoundly handicapped can be discovered.

The social context within which a person lives is a constant reminder and reflection of the person's identity. The institutional inhibitions discussed in Chapter 3 are as powerful in their negative messages as individual therapy can be positive.

Although this thesis has attempted to apply an academic analysis of relationships which lead to the development of a positive or negative sense of identity, the fundamental importance of basic love and care is not underestimated. The following account from Susan is taken from Know Me As I Am[172]: "I love my mum and dad very much because they are my family. They loved me too because they had me as a baby. I loved my brother because when it was my birthday and at Christmas, he liked parties and he danced with me. I loved my nan because she used to make bread pudding and Ovaltine when I slept at her house."

In this autobiographical account Susan picks out two events Christmas and birthday where a person is celebrated just for being born. They do not have to achieve anything. It is an unconditional love which provides a context for positive learning. In such a situation a person may feel freer to express their potential, whatever that might be. However this does not

argue that it is unimportant to offer realistic recognition of what the person actually does. This happy account is contrasted starkly with this anonymous account from the same Anthology: "I remember when I was born nobody wanted me. I can remember being whipped when I was small, I remember living in a noisy building...I can remember my dad hitting me when I was four."

Here is another demonstrating the conflict between the attempt to realise a purpose but where the intended transformation is denied: "I screamed because my mum and dad wouldn't let me light the candles. In the end they let me but I dropped the lit match on the table. 'You might have had the whole room on fire' said my dad, 'It would have cost your dad at least a thousand pounds to have the room repaired' said my mum."

Such accounts whether literally true or not reveal a perception of a threatening world where expression of projects is hardly likely to receive positive recognition, resulting in a generally negative identity. The point to be made is that the person needs to experience a basic acceptance, to be loved for themselves as the title of the book from which these quotes are taken suggests, 'Know Me as I Am'.

The emphasis on technical processes (the C.I.I. and others) and the articulation of cognitive strategies are not substitutes for loving relationships. The fundamental social relationship is mutual love. For the person to experience being wanted and

that they make a difference to the other, that they in turn can love.

The absence of a loving relationship precludes the possibility of open creativity, free play and work which reveals and develops the self. Winnicott[173] writes: "We experience life in the area of transitional phenomena, in the exciting interweave of subjectivity and objective observation, and in an area that is intermediate between the inner reality of the individual and the shared reality of the world that is external to individuals."

Finally the relationship between love and achievement, and whether we have to work to be loved is clearly experienced by Robert Kegan[174] reflecting on his observation of his daughter learning to read and finally, successfully pronouncing a word.

"... I find myself terribly moved by this tiny dignity. When her forehead furls and I see her there so intent ... I could even say in that moment that I love her a little harder because of this moment ... 'What? She has to do things in order for you to love? What happened to unconditional regard? And is it her effort that appeals to you or her success?' ... however much I might appreciate her being successful or smart this just does not seem to be finally what my experience of being moved is about. There is something simpler and deeper, something else. I have felt it before, with people who aren't in any way mine. Being in another's presence while she so honestly labours in an astonishingly intimate activity - the activity of making sense - is somehow very touching."

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APPENDIX 1

WORK: A DISCUSSION OF DEFINITIONS

Elliott Jacques defines work as follows: "The term work refers to activity, to behaviour, to that human activity in which people exercise discretion, make decisions and act so as to transform the external physical and social world in accord with some predetermined goal in order to fulfill some need."[1]

Further .... "When the work has been done, something has been manifestly transformed - there is an objective output to be observed." Jacques then goes on to refer to A. Schutz[2] who refers to the formulation of an idea in terms of a 'project', to be realised and which in time satisfies the need or felt lack. The results of transformation may be physical or relational, concrete or abstract.

Jacques and Schutz emphasise the importance of work and the activity they refer to differs significantly from work as defined by sociologists.

For example, Dahrendorf[3] in his paper: "Work and Life, or the New Fear of Freedom' takes perhaps a more traditional view in his quote: "Work, in the simple everyday sense of the word, has never been regarded as a particularly agreeable dimension of life. It was generally seen for what it undeniably is, that is, a necessity. man must work in order to live. There are important differences between *making* a living (by hunting and gathering,

tilling the soil, or even producing tools for gaining food and shelter), and *earning* a living. The medium of money has turned the relation between work and life into one that is often extraordinarily remote."

To emphasise this different view he quotes Harold Macmillan, the former British Prime Minister commenting wryly on unemployment: "I don't understand all this fuss about unemployment. When I was a young Member of Parliament, people were always clamouring for less work - so why aren't they happy now that they have got it?"

Dahrendorf, regarding work as a necessity, in economic terms cites the 'work ethic', underpinned by the increasing influence of Protestantism as a driving force behind increased productivity. He contrasts this with the more dilettante courts of the Middle Ages where leisure and arts were high ideals. Work became a moral necessity, it may be unpleasant but it is good for you. This may be contrasted with other utopias, as Dahrendorf does: "From the biblical paradise to *Schlaraffenland* and beyond, the dream of a world in which fried pigeons fly into one's mouth, so that one is spared even the "work of eating", has attracted people. Escaping necessity is perhaps the very essence of dreams and utopias. One of the first necessities which people always hoped to escape was that of toil and labour."

Here the association between work and toil and labour is clear. The distinction is essentially one of choice versus necessity. Aristotle noted the division between those who had to toil and

those who were able to think (this he regarded as a natural division). In essence the privileged few could indulge in activity of choice on the efforts of the labouring class. This was a theme of course taken up by Marx, the difference being Marx did not see this as a natural order. In "Capital" Marx, while recognising the necessity of 'work', referred to freedom as beginning where "that of necessity ends, that is to say when instead of working people are free to fish or write poetry as they please". To sum up in Dahrendorf's own words: "Thus work has been regarded as a necessity which is to be restricted if not eliminated."

This is quite a different concept from that which is the basis of this thesis. What Dahrendorf, Marx and Aristotle refer to is an alienated activity where the Schutzian 'projects' are not owned or internalised. Essentially the meaning of toil or labour is either doing someone else's 'work', i.e. realising *their* projects, or where the activity is only indirectly or begrudgingly fulfilling a personal need. A sense that "I wish I did not have to do this". That is, it has no intrinsic value. Perhaps the clearest example of a synthesis of these views would be forced labour in prison camps where the coerced activity is entered into as a means of survival or an avoidance of further punishment.

The essence of Jacques' definition, the exercise of discretion; making decisions takes a different perspective. One which is central to this thesis. Instead of referring to toil and labour Jacques[4] describes such activity as: " ... that behaviour which constitutes the primary plane of reality in which the individual relates his subjective world to the external world ... It is the

behaviour through which the individual experiences the reality of his core identity."

This thesis extends the importance of this view in that the argument here is that the development and nature of the experience of the "core identity" is fundamentally affected by the response of the "external world". The extent to which such behaviour is recognised and/or appreciated will influence the identity and well-being of the actor.

Schutz, like Jacques, places great emphasis on transformation. He defines that a person is working "when his behavioural flow is aimed towards the transformation of a specific part of the objective world so as to bring it into a state consonant with a state which he has in mind ... to produce an objective output which is the realisation of a subjective project".

It is argued here that in the development of identity this is certainly necessary but not sufficient. The recognition of such a transformation and the attribution of this transformation to the working person is also necessary, especially if such working behaviour is to be sustained.

The absence of recognition, denial, misunderstanding of the 'realised project' and/or the false attribution to another or even chance, luck or a mechanical process, will dislocate the working person. Over time they will withdraw from work, become depressed and place more emphasis, time and energy on other behaviours such as sleeping, dreaming and fantasising.

All work presumes some notion of identity in the sense of separateness, a distinction between internal and external processes. From this primitive sense of identity it is proposed that development is a process significantly affected by responses to 'work'. This thesis defines work as a concept referring to the process of external realisation of subjective projects and as such is not limited to employment or the activity associated with the occupation of a role (paid or unpaid). Thus one can see small children working hard, putting intense concentration and effort into the realisation of projects and inevitably at times becoming immensely frustrated, especially as they are often hindered by their lack of motor skills and strength.

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APPENDIX II

THE CONSTRUCTION OF MEANING AND CAUSAL RELATIONSHIPS

It is not the intention of this thesis to analyse all the psychological and sociological theories of work and identity (a monumental task). Rather than produce such a critique the attempt here is to produce a formulation with which to analyse a particular subject; work in the field of mental handicap, or learning difficulty. in doing so it may be useful to examine some of the philosophical roots of the construction of meaning and the assumption of causal relationships.

Hume's approach to causal relationships gave a new perspective to philosophy. Basically Hume[1] argued that understanding the world could not be separated from interpretation: human interpretation. Experience, Hume continued is not logically related, therefore all appearances are uncertain. Relationships between events are a human construction. It therefore became a fundamental problem to demonstrate the existence of relationship independent of its observation and interpretation by a person. Apart from the problems this raised for philosophy and science in general, it is of particular importance to social science which it could be argued was now the fundamental prerequisite of all sciences. Kant while continuing Hume's analysis separated the events in the non-social world (the "noumenal" world) from our experience which results in the humanly filtered result of "phenomena".[2]

In summary, observation is not a passive but active process. The rejection of the possibility of "absolute" knowledge, i.e. pure facts was taken up by Husserl. What he sought was not an absolute knowledge of what is "out there" (the noumenal) but the "absolute" qualities of appearances themselves. Thus he sought to avoid the isolationist and non dialectical approach that one man's reality is as good as another. The constant (if not absolute) element in appearance he called "essences".[3] He thus returned to a possibility of objective reality which was dependent upon and created by human consciousness. (The study of this reality he called phenomenology.) This study, suggested by Hume and Kant's work, was and is the primary science since before any knowledge could be explained or gained it would be necessary to understand how the conscious mind created the reality. Husserl attempted to define the "essences" by a sort of distillation which gradually removed all irrelevances from appearances until the essence was revealed. These irrelevances consist of the everyday assumptions we make ordinarily in observation. Therefore it is the task of the scientist to assume nothing, to take no previous "knowledge" or potentially biasing statements for granted.

Schutz, while being influenced by Husserl, placed even more emphasis on the social world, i.e. the understanding of relationships and it is this aspect of his work that this thesis draws upon. Thus I have followed Schutz's emphasis on intersubjectivity, i.e. shared social meanings which broke tradition with Husserl. Schutz like William James[4] argued the general principle of association, i.e. the way in which events

become linked through experience and then shared with other people who have made or could make similar links. Although Schutz rejected some of James' explanations of memory (neural chains) he agreed with the James analysis of the difference between "kernels" and "fringes" that is, a central idea and its surrounding. This is similar to the figure/ground discrimination central to the formation of identity. The point is that the kernel cannot be totally separated from the fringe, or more generally the argument that the individual cannot be entirely separated from his or her environment.

Schutz was also influenced by Henri Bergson[5] who emphasised the importance of time in the ordering of experience. He pointed not only to the relatedness of events but their continuity which he conceptualised as inner time. This inner time is Bergson's concept of the way in which we regulate experience. The continuous flow of experience, unseparated or undifferentiated, he called duree. It is this which relates to the first part of the model in the thesis i.e. undifferentiated flow. Such a flow does not allow for identity or identifiable action. Bergson pointed out that duree has no meaning until it is separated, or differentiated. it is also this aspect of Schutz's work, i.e. the contribution of the various concepts of time that Jacques elaborates and develops in his analysis of work behaviour.[6]

Unlike Hume, Kant, Husserl and Bergson, the argument here does not claim to solve the philosophical question of how anything can be known with certainty, but attempts to use these arguments to illuminate certain sociological and psychological issues of concern

in providing care in the field of mental handicap and examine the development of identity. Schutz recognises Weber's[7] attempt at constructing an "interpretive" sociology, that is constructing a social science around studying social behaviour by interpreting its subjective meaning.

Therefore, the argument presented here linked to (Jacques, Schutz and Weber) is that social inquiry is bound by the meaning to be found in the intentions of individuals, that is a sociology based on subjectively meaningful goal directed behaviour.

The basic problem being addressed is why and how do people construct meanings and how can two or more people share meanings. Schutz approached this problem by looking at commonsense understanding. He assumed that people share a basic experience of ordering which permits them to communicate. The basis of ordinary experience provides a possibility to act in a way to implicitly put experiences together to carry out, share and understand ordinary tasks. In this way most behaviour is based on experience which is taken for granted, for Schutz "typified". It is this part of Schutz's work which is most relevant to this discussion. For Schutz assumed these common experiences to be shared by all competent people. It is precisely this lack of sharing of interpretation of experience which characterises many mentally handicapped people. Husserl may well have been delighted at the lack of assumptions mentally handicapped people make. Indeed, it is very difficult to assume or take for granted the way that they will cut up or

organise their experience. (Perhaps they are fundamental phenomenologists). Certainly this provides a potentially most exciting challenge to a care worker in this field, who in attempting to understand the organisational world of mentally handicapped people must put aside or question all hitherto assumptions. Consequently staff must be especially aware of typification and from institutional pressures are most tempted into it.

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APPENDIX III

DIFFERENT TYPES OF RELATIONSHIPS AND THE RELATIVE EFFECTS OF RECOGNITION

The following relationships are discussed in terms of the terms of the extent to which:

(i) episodes are mutually recognised
(ii) there are specific sanctions involved with regard to such episodes
(iii) there is third party validation
(iv) there is freedom to opt in or out
(v) there are mutual obligations

A) Friendship

Friendships may result from an unobliged, freely entered into understanding and appreciation of the others subjectivity discontinuity. (This does not imply total agreement.) One of the main characteristics of friendship is understanding in the absence of a written or formally contracted obligation. This in turn implies no formal sanctions. In short friends can do as they please. The essential bonding is by mutual understanding and trust.

Of course friends make arrangements which are contractual; to meet at a station at four o'clock, to meet at the pub at eight o'clock etc. The point is that while arrangements may be

specified, due to external constraints, the process of the relationship cannot be. Therefore you can contract to meet at a certain time, (which an outside observer could note had been achieved or not) but two friends cannot contract to have a good time, i.e. "we will have two drinks each, tell seven jokes and that will be enjoyable". The point is that a true friendship involves freedom of choice. It is not possible to force people to be friends. Anyone can be friendly that is behave in the manner of a friend, but this us usually in circumstances where people meet for other purposes, e.g. an airport, on a bus, in a hospital ward, or in a school.

There are no rules in friendship concerning the imposition of sanctions if pre-determined goals are not met. There must be mutual respect and a toleration and flexibility of goals so that even if an arrangement has been made it can be altered because one of the friends no longer feels like going out. Of course in time if the friends lose an appreciation of each others subjective discontinuities or if they continually disagree about what they should do together, the friendship will eventually break up. The point is that the amount of toleration and flexibility, indeed the rules of the game are made and changed by the two people involved at their discretion. This allows for a wide range of friendship relationships not open to rules of definition of particular actual behaviour.

The lack of external sanctions and the fact that the rules are made by the friends means that the relationship may take on a collusive quality which is at variance with external reality as

judged by others. Because the rules are defined by those in the friendship this may be in conflict with the context. For example, two people may be so engrossed and tolerant of each other's behaviour they may ignore the effects this may have on others, both in a social or work context. The friendship may be excluding, or so consuming, as to interfere with other, including work relationships. It will, of necessity, be the pressure of contextual relationships that will affect the relationship rather then a comment on the internal relationship which only the friends can comment on. The exception being if the "friendship" is a disguise for another type of relationship and there is in fact not a mutual trust or respect of each others views, no real spontaneity, and where the person is in fact operating covert (or overt) sanctions. Such would be the case if the "friendship" was in fact one of complete dependency of one person on the other where the dependent partner becomes no longer free to express their wishes or opinions.

The reason that there is no need for sanctions lies in the fact that the relationship is not primarily externally productive. That is, the relationship is not made in order to create certain objects or a particular end product which can be counted or objectively observed. That is not to say that friendship is unproductive, or is not an important element in productive work. The point is that the friendship is created for the mutual benefit and support of the friends. It may indeed enable the friends to be involved in productive or creative work outside the friendship but essentially a friendship is an end in itself, it is not the

observable results which are objectively monitored, but the relationship itself, by the participants.

B) Partnerships

The 'productive' relationship which probably comes closest to a friendship is a partnership. A partnership is set up to produce something, e.g. solicitors, consultants, plumbers, painters, etc. the point is that although the partners may well be friends, the primary purpose of the relationship is to achieve certain objectives. Further the limits of the relationship are prescribed by law and are contained in a partnership agreement before the partnership starts. This is quite different from a friendship which has no legal definition and is not preceded by a specified agreement. The similarity is that for the partnership to work, the objectives and events (transformations) must be agreed mutually beforehand. That is, the partners must not only agree the overall aim of their association but also their objectives along the way. If the partners cannot agree, or if they can show the other partner is not fulfilling obligations that they have mutually agreed, the partnership can be dissolved. It is not possible for one partner to run the show. (Apart from the concept of a "sleeping partner" which does not really qualify for this type of relationship since by implication it is not an active association). For a partnership to exist, like a friendship there should be equal discretion even if at times one person is taking more initiative than the other.

C) Employment Work

In another relationship employment work, there may be a variation of discretion. In a non-partnership work relationship the primary purpose again is the achievement of predetermined goals. That is, objectives: the purposes of transformations are set out beforehand. While different types of work can be more or less prescribed all work must be objectifiable: that is, the product must be recognisable. Work is contractable, and the existence of an objectifiable end point and one open to contract means that:

a) I can agree to be involved in the definition of projects, and objectives;

b) there is a possibility of accountability;

c) I can get paid as there should be a recognisable outcome, i.e. an objective end to the episode; e.g. when a cup is made, a painting completed.

The point about the contract is that although this work relationship is potentially the least personal, (and potentially the most alienating) it is also the most social. This is because, unlike a friendship and more like a partnership, the rules, once laid down, can be monitored by a third person. That is, a work contract (and I mean explicit agreement, not just a legal document) must be in language understandable to a third party. Further, it is possible for the third party to arbitrate in the event of disagreement. Although this is similar to a partnership, for all intents and purposes the partnership welds the work relationship so that a "third" party treats the partners as one,

and the power relationship within it is equal. This is not so in a work relationship, hence the need for appeal, or arbitration. Elliott Jacques has written in much more depth on the concept of work, creativity and social justice.[1] However, the crucial elements in the relationship can be summarised as:

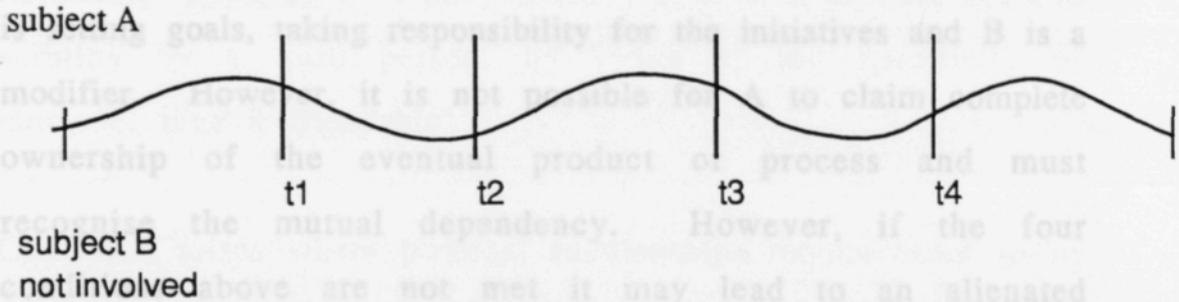
1 Full employment - this allows for choice in the entry of the contract.

2 An objective contract - allowing for accountability and fair payment.

3 Specification of conditions, which with the contract allows for the possibility of arbitration and appeal.

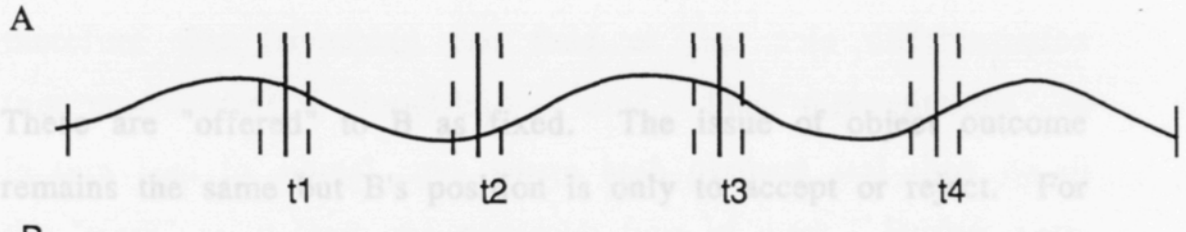
4 Systems which allow for such contracts and appeals.

Let us now look at two types of work relationship, one "negotiated" another "alienated".

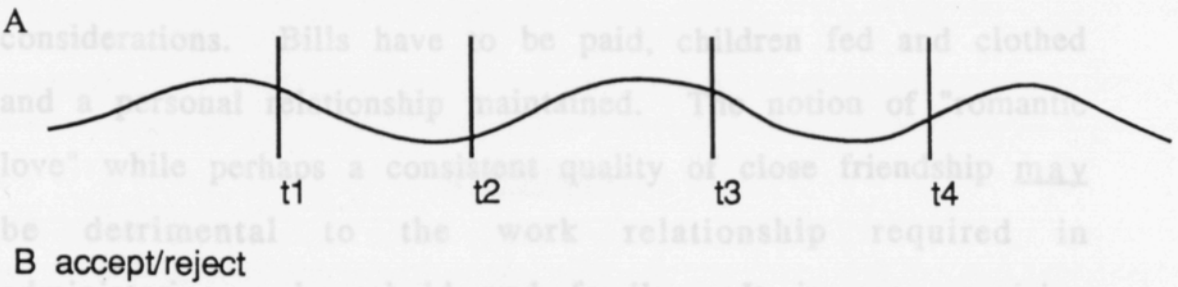


Here subject A lays out a plan of action with objectives and a pre-determined plan leading to outcomes at t1, t2, t3 and t4. Let us say that A cannot carry out these objectives and plans alone. He or she can offer them to B with suggested payments, say at

t1, t2, t3 and t4. If the system is truly negotiated then B (or elected representatives if B is a group) can agree and modify A's plans, objectives and payments to achieve:



the dotted lines represent the tolerated limits in objectives and time. Work can then proceed and both A and B can hold each other to the agreed contract. According to the trust between A and B (perhaps based on a previous work-relationship) the contract may be more or less detailed.[2] The difference between this model and the full partnership is that the original ideas and objectives belong to A. B now shares the objectives. However, A is setting goals, taking responsibility for the initiatives and B is a modifier. However, it is not possible for A to claim complete ownership of the eventual product or process and must recognise the mutual dependency. However, if the four conditions above are not met it may lead to an alienated relationship: here A sets out his "markers", i.e. the goals and the plans.



These are "offered" to B as fixed. The issue of object outcome remains the same but B's position is only to accept or reject. For B to accept on A's terms A relies on

a) a lack of alternative prospects for B

b) a lack of organisation on B's part

c) an absence of appeals procedures.

For B to enter such a relationship means that B cannot own either the process or product and will be alienated in the "relationship".

The work relationship is essentially less personal than a friendship <u>because</u> it is more social. That is, it is more open to scrutiny by a third person, by virtue of the specificity of outcome, than a friendship.

Confusion arises where personal relationships require work to be done. For example, in marriage (not accidentally referred to as a contract) there are tasks to achieve requiring predetermined goals and plans, as in <u>work</u>, particularly if marriage partners own a house and have children. Once "obligations and responsibilities" are entered into the spontaneous free choice qualities of the friendship can be overwhelmed by work

considerations. Bills have to be paid, children fed and clothed and a personal relationship maintained. The notion of "romantic love" while perhaps a consistent quality of close friendship may be detrimental to the work relationship required in administering a household and family. It is not surprising therefore that friendship can fade or that role differentiation (not predominant in friendship) is used. Such differentiation can in turn lead to mutual envy where both partners feel they do all the "work" or at least one particular type of work. Further even, or especially, sexual relationships are divided into pleasurable or productive (pro-creative). Thus a marriage has to synthesise friendship and work over an indefinite period.

The commonality between the second and third part of the discontinuity model (see Chapter 4) is that the continuous flow of behaviour is broken up. What varies is the extent to which the subject can legitimise his or her system of organisation or subjective discontinuity. That is, can the person psychologically own their initiatives in behaviour and gain a sense of identity which is recognised or open to recognition.

Whilst the above relationships differ in their qualities, with regard to production, third party arbitration, freedom of choice of association, and sanction, they are similar in that they require a recognition of episodes. Further, that this recognition may allow the participants to psychologically own their work in terms of process and product and hence enhance their identity.

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APPENDIX IV

ASSESSMENT: A SOCIAL DIMENSION

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CHAPTER 4

ASSESSMENT: A SOCIAL DIMENSION

by Ian Macdonald

Introduction

The central concern in this chapter is assessment in the field of mental handicap. While some of the issues raised have broader implications and are developed in other parts of the book, this chapter is addressed to the concerns facing families, workers and mentally handicapped people when and where an 'assessment' takes place. The way in which this is to be done here is first to look at the purposes of assessment, including what tools are used and their inherent problems. Secondly, I examine problems, not only of the tests themselves, but also the social context of assessment, including implications for policy making. Then finally I offer a method of assessment which, perhaps, goes some way to fill some of the gaps, without necessarily replacing other forms of assessment.

In recent years screening during pregnancy and tests at birth have identified certain conditions, for example, Down's syndrome and phenylketonuria (Smith, G. and Berg, J., 1976; Hsu, L. et al., 1973; and Gibb, N., 1959). However, in the majority of cases pregnancy and birth do not lead to an identification of the possibility of mental handicap. In one survey of hospital patients Leck (1967) found no identifiable cause for subnormality in over 70 percent of cases. Aetiology is not easy to establish; even in profound mental handicap known causes do not account for anything like the total population.

Therefore the reason for a detailed or special assessment rarely arises simply from a direct and early medical diagnosis. In the majority of cases an assessment is the result of a *socially identified* problem. That is, for one reason or another, a relationship is unsatisfactory or causing distress: a parent may feel worried that their child is not apparently developing like

others they know; a teacher may be worried about a child who is consistently unable to keep up with classmates; a health visitor or doctor may be worried by behaviour during routine visits or surgery. In all cases someone will be concerned that 'something might be wrong'. They will have come to this conclusion by feeling uneasy, in comparison with their expectations. Therefore, a problem precipitates anxiety. Usually the parents will attempt to reassure themselves by reference to friends or relatives. This may lead to them attempting to 'put things right' themselves, by playing more with a child, talking more or deliberately teaching skills. This may also lead to a denial, a refusal to admit anything is wrong (Schaefer, N., 1978) or a belief that help is needed in the relationship. Here professionals and parents may be at odds because of differing views.

The main point here is that the first 'assessment' is made *before* a 'specialized assessment'. This first 'assessment' is based on personal beliefs and expectations about normal parent-child relationships. The extent to which parents feel guilt about their child's possible disability is in part due to a recognition that parents are usually expected to be able to provide the context in which a child should develop 'normally'. Therefore even a semi-formal recognition of a parent's fears may as easily lead to denial, relief, or sorrow that someone else has 'noticed it too'. This is exemplified in the book *Walter* by David Cook (1978); here the headmistress carries out in principle the main elements of assessment: (i) identification of a problem, (ii) comparison with other children, (iii) prognosis and (iv) possible treatment/intervention.

> Your child needs special help, Mrs. Williams . . . the case is beyond us . . . he still wears nappies under his trousers. . . . That's not right for a lad over six years old. It shows no sign of changing. Children can be very cruel they notice such things . . . they'll [the education authorities] write to you with the name of a Special School. You'll get a letter from County Hall.' 'He can't undo his buttons yet; that's all.' Walter's mother turned away from the headmistress.

Although she has known this for some time the formal statement by the headmistress, the explicit confirmation, has robbed Walter's mother of her fantasy of the relationship she might have had with her son, like other mothers:

> Through the window she could see other children being collected by other mothers – boys swinging school satchels, boys with ties and long socks, held up by garters, beneath short trousers which showed the shapes of their clean little bottoms.

Therefore *preceding* the formal, special assessment *is a prior set of beliefs*

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about relationships at home, school or work, about appropriate roles and social behaviour which confer status and stigma and an anxiety that the special assessment will show, despite wishes to the contrary, that there *is* something to worry about.

Therefore the assessment cannot only be concerned with identifying the problem within the child, but must take into account the social context, in the knowledge that an easily identifiable cause and prognosis is unlikely.

Purpose of assessment

In her article 'Severely Subnormal Children' Rosemary Shakespeare (1973) puts forward four aims of assessment:

1 *General Diagnosis – is there a handicap;*
2 Degree of Handicap – the extent of such a handicap;
3 Plan for Training – the best methods to use;
4 Prediction – what can be predicted for adult life.

One of the main problems in assessment is that the tools used to achieve these aims do not achieve all four. That is, whereas some may be useful for one and two, there may well be a split between these and the last two. Also, there is no predictable relationship between these aims and social policy and no clear link between the assessment and the roles of people involved: parents, teachers, psychologists. These emerge more specifically when the plan for training has been formalized. Then it is possible to ascertain whether there is anyone to carry out the programme, and if there is, whether they are, or they regard themselves, as appropriate – professionals or family or volunteers.

Taking a slightly different perspective the purpose of assessment may be seen from several points of view: the purpose for the family, including the mentally handicapped person, the purpose for the assessor (including professional responsibilities and career aspirations), and the purpose for the agencies potentially providing resources; i.e., it will be of concern whether this is a 'medical', 'social', or 'educational problem'. However, to return to the four aims, the first diagnosis is in direct response to a family's needs and is congruent with the need to order experience. That is, the first question is whether the person to be assessed is, or is not, significantly different from others. The 'others' in the assessment procedure are the group that the test was standardized on, rather than known children in the neighbourhood or school. This aspect of assessment, 'general diagnosis', is a *location* of one

person, at one point in time, relative to others at relatively the same point in time. Once this location has been established, by the test scores being perhaps equivalent to co-ordinates on the apparent map of normality, so the first fears are dispelled or confirmed. Clearly location alone is insufficient, so the second aim, 'degree of handicap', is attempted. This is essentially to see if the person, while not 'ordinarily normal', is part of another group and can be classified as, for example, severely subnormal. This consequential classification can give the illusion of an alternative normality; i.e., your child is a 'normal', severely handicapped child. The child now belongs to an identifiable group and at least is a member of an apparently known entity. The possible illusion, for the parents at least, is that this subgroup is homogenous in something other than their scores on the test. In the field of mental handicap at least, this is not so evident. Secondly, it may give the illusion that there *are* known consequences, or a clear prognosis. Again this is not necessarily so. Therefore, the crucial step is the link between the categorization and the consequences: the 'plan for training' and 'prediction'. This plan and prediction is also inextricably bound up with current policy and resources allocation since the implication of any plans and actions depends upon the availability of resources. It is the steps between categorization and plans or programmes, and programmes and policy implications, which need examining in terms of the current assessment tools and processes available. In summary the procedure may be represented as shown in Figure 4.1.

Current methods of assessment

Although this section does not attempt a full critique of all methods of assessment (IQ tests alone could fill and have filled volumes), it is important to outline the main types in relation to the problems raised above. For the purpose of this chapter assessment is seen in three types in the field of mental handicap.

1 Cognitive tests, the main being IQ tests;
2 Developmental scales; and
3 Social competence scales.

This does not mean this is the full extent of assessment. So far the discussion has centred around two meanings of assessment: first, that made by families, or non-experts, on the basis of common sense, intuition and/or

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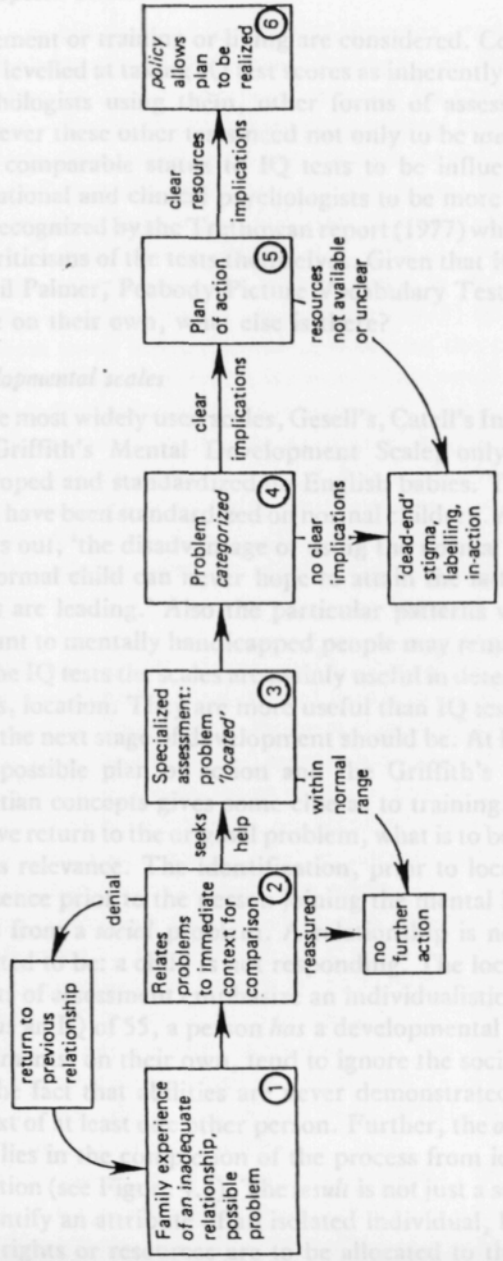


Figure 4.1

social expectations; this assessment usually raises the possibility of assessment of the second kind – 'specialized assessment'. It is the particular methods used in the second kind which will now be discussed.

Cognitive tests

The main intelligence tests used are the Wechsler Adult Intelligence Scale (WAIS), the Wechsler Intelligence Scale for Children (WISC) and the Stanford Binet IQ test. The first problem is one of the testing situation itself. The standardization required to ensure the test is used reliably means a relatively unfamiliar and possibly foreboding context. While many educational and clinical psychologists are undoubtedly aware of this it cannot be discounted, especially when considering that the reason for referral is usually perceived as trying to find out if anything is wrong. The implications of 'failure' for the family and person being tested are crucial, even if they are unclear; indeed, the unclarity may increase the anxiety. Also, many people, particularly young children, are regarded as untestable or simply cannot complete any of the items, and although they score a theoretical zero obviously they do not have zero intelligence.

The 1959 Act defines severe subnormality as 'a state of arrested or incomplete development of mind which includes subnormality of intelligence and is of such nature or degree that the patient is incapable of living an independent life. . . .' There is an inherent assumption of causality or at least a relationship between low intelligence and independent living. While H. Gunzburg (1973) argues that an IQ of below 25 will always mean a person will be socially incompetent, he also cites evidence from Clarke and Clarke (1965) and from his own work (Gunzburg, 1968) that people with IQs even as low as 35 do not preclude successful functioning in the open community. Further, he claims that low IQ scores may be more relevant in a context of academic achievement, i.e., school years, than in later life since the criteria of success are more congruent. Illingworth (1966) attributes some of the poor predictability to an over-reliance on a pass/fail scoring system and the ignorance of qualitative variables.

IQ scores are most used at the location and categorization stages. Scales are standardized on normal children and are based on an assumption that intelligence is normally distributed, which in itself would predict a lower number of mentally handicapped people than there apparently are. Scores calculated by standard deviations from the mean are used in the UK and USA to categorize, usually as borderline, mild, moderate, severe and profound (Heber, 1959). The crucial aspect of this or any other form of categorization, as mentioned above, comes when the implications for

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placement or training or living are considered. Certainly with all the criticism levelled at taking IQ test scores as inherently meaningful, not least by psychologists using them, other forms of assessment need to be used. However these other tests need not only to be *used* but they must be of at least comparable status to IQ tests to be influential. The campaign by educational and clinical psychologists to be more than test administrators was recognized by the Trethowan report (1977) which also accepted some of the criticisms of the tests themselves. Given that IQ and similar tests (e.g., Merril Palmer, Peabody Picture Vocabulary Test for children) are inadequate on their own, what else is there?

Developmental scales

Of the most widely used scales, Gesell's, Catell's Infant Intelligence Scale or the Griffith's Mental Development Scale, only the Griffith has been developed and standardized on English babies. These scales also, like IQ tests, have been standardized on normal children. As R. Shakespeare (1973) points out, 'the disadvantage of using the normal as a standard is that the subnormal child can never hope to attain the latter levels to which these scales are leading.' Also the particular patterns which may be especially relevant to mentally handicapped people may remain unrecognized. Again like the IQ tests the scales are mainly useful in determining where a child is, that is, location. They are more useful than IQ tests in that they also show what the next stage of development should be. At least this gives some clue to a possible plan of action and the Griffith's scale broadly based on Piagetian concepts gives some clue as to training.

If we return to the original problem, what is to be done, the IQ tests seem of less relevance. The identification, prior to location and categorization and hence prior to the person joining the mental handicap group, usually stems from a *social* problem. A relationship is not as it should be, or is expected to be: a child is not responding. The location and categorization aspects of assessment emphasize an individualistic assumption: that a person *has* an IQ of 55, a person *has* a developmental age of six months. Such assessments, on their own, tend to ignore the social aspect of the problem and the fact that abilities are never demonstrated in isolation but in the context of at least one other person. Further, the *overall* purpose of assessment lies in the completion of the process from identification to resource allocation (see Figure 4.1). The *result* is not just a score, not just an attempt to identify an attribute of an isolated individual, but a decision regarding what rights or resources are to be allocated to the individual and/or the

family. The resources are in the form of aids, professional help, financial assistance, premises which are the actual manifestation of the plan or programme. This is the social meaning of the test score. It is equally meaningful if no resources are forthcoming. Consequently, the relationship between test score and resource allocation, while most important socially, is the weakest aspect of most of the tests by themselves. These tests, and forms of assessment, although general by their nature, are used not only to make general statements, but also particular statements to justify decisions concerning the future social life of individuals and their families. This is compounded by an emphasis on reliability and a blurring of validity. For example, despite the arguments concerning the prognosticating value, and simply what an IQ test *does* measure, they are constantly updated, objectified and restandardized. Cicourel (1974) and Roth (1974) point to the absence, in such tests, of a monitoring of the processes actually involved in the testing situation and claim that the products or results of such tests are seen to be individual phenomena (from the individual being tested), although the social consequences are highly relevant.

Underlying a request for a specialized assessment and the consequences of it is the question: how will this person cope in the world, given that he does not seem to be coping as he should? Even the 1959 Act put the emphasis on social abilities: '. . . such a nature or degree that the patient is incapable of living *an independent life*'. Resources, if any, are allocated on a basis of social competence, such as with the Social Security attendance allowance, hostel or hospital placement and social services. Educational resources in special education are likewise not aimed solely at increasing a person's intellectual abilities, but also at improving social competence.

Various research studies, for example, Mundy (1957), point to the development of intellect (increase in IQ score) as a result of environmental changes and Clarke and Clarke (1959) note the effects of environmental deprivation. However there is no agreed scale of deprivation or a deprivation score. Few psychologists now would be satisfied with giving only an IQ score or a developmental scale result; they are increasingly concerned with social competence, how a person relates to others, which means that scales of social competence may become more widely used.

Scales of social competence

The most widely used are the Vineland Social Maturity Scale and the Gunzburg Progress Assessment Charts. The Vineland Scale, designed by E.A. Doll in 1935, was, like the scales above, based on studies of normal

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children but designed for use with mentally handicapped people. This scale is related to mental ability and, although it includes items like 'uses a pencil for drawing', does not specifically ask for the opportunity available to a person. That is, the scale assumes a general availability of resources, is not entirely clear under what conditions behaviour may occur, and includes culturally specific items, some of which are difficult to score. The scoring also tends to be on a pass/fail basis. Although it is a scale of social competence it does not specify the other end of the relationship (e.g. 'follows simple instructions', but whose? mum or dad? a psychologist? a social worker? teacher? etc.). Shakespeare (1973) criticizes the Vineland Scale because some items depend as much on the parents' attitude as on the child's ability. However this assumes that *social* competence is an attribute of an individual as much as intelligence. This is consistent with Doll's own construction since the scale is designed to give a social age (S.A.) much as the IQ test gives Mental Age (M.A.). It would be useful to know as clearly what the parental attitudes are since *social* competence is dependent on a social *relationship*. That is, if it involves more than one person, it would be useful to know what the other person is doing at the same time.

PAC

Gunzburg's (1960) charts, unlike any forms mentioned so far, do not compare mentally handicapped people with results gained from a normal population. Instead, his Progress Assessment Charts are based upon the skills of a population of mental handicapped people. This means that 'location' has already taken place, as has 'categorization', and that this is progress within a category. As discussed above the process of categorization may mean that a person may be 'normal' relative to their own subgroup, rather than the population as a whole. This 'normality' is what the charts assess. Gunzburg does not claim that the PAC is a quantitative measure of achievement. The 'result' is a chart which indicates an individual's deficiencies in social knowledge and competence and this suggests a plan of action and, by implication at least, the resources required to carry it out. Although not a quantitative measure, Gunzburg has established average achievement levels based on IQ groupings. It is one of the few methods of assessment which has, as part of its design, specific implications beyond location and categorization.

So far two types of assessment have been considered – the initial recognition of a problem and the formalized methods of ascertaining whether a problem exists. In summary the ultimate purpose of assessments carried out

by welfare state/voluntary organization assessors is to decide whether a person qualifies for resources. In this way a 'failure', relative to normal results, in most of the above assessment methods *increases* the likelihood of achieving success in gaining resources. Assessment is not merely to locate and categorize a person, but to do so for a purpose. Nevertheless, the most socially powerful tests, IQ and to a lesser extent Developmental Scales, are those least related to specific resource provision. The closest form giving a clear picture of what might be done is the Gunzburg PAC and this assumes that a person has already been designated mentally handicapped. In the Overview to the book *Psychological Assessment of Mental and Physical Handicaps*, P.J. Mittler writes: 'In the past psychologists have tended to confine themselves to assessment' (here called location and categorization) 'and left others to incorporate (or ignore) their findings in whatever was done for the patient or client.'

While such practice is not entirely over, the question remains that, if, as argued above, psychologists are no longer so confined, what else do they use? They may well discuss qualitative issues but there is still a demand for figures. This demand stems both from the medical model where diagnosis is in terms of the attributes of individuals, and where figures tend to be interpreted in terms of absolute rather than relative values. It also stems from power being vested in the person who can define the problem. The professional assessor is in a position to label and categorize, be apparently more familiar with the problem than the presenter or owner of the problem. He or she can then take over the management of the problem from the presenter. However the means of definition, as described above, do not necessarily lead to a clear statement of management, in terms of training or prognosis. The only method that does, the PAC, is the least effective in defining, in terms of a score or a single result. To continue Mittler's argument, 'a change of emphasis in the aims and goals of psychological assessment is bound to effect a corresponding change in the nature of the assessment instruments used and in the whole assessment process.' This change also implies a change in professional role and authority. Professions are not noted for their desire to change practices or power bases, unless it is to increase them (Packwood and Macdonald, 1978). This is of particular relevance since, although categorization may relate in general to some sort of homogeneous grouping, it is the 'borderline' cases on which the results of referral are most contentious and far-reaching.

If the assessors are to widen their repertoire then they will have to question the assumptions that statements about constructs, such as intelli-

gence, are directly relevant when moving from categorization to a plan of action. Mittler calls for an 'inclusion of a person's developmental history, experiences, that have affected his development, home background and environmental variables'. All these variables are not easily, if at all, gained in a standardized testing context or open to fully reliable verification; they are argued out on the grounds of subjectivity. However they are crucial in the person's social world, the world they have lived in and may or may not continue to live in. The apparent difficulty in attaining this information does not make existing traditional methods any better. The point is that the methods which are used to gain statements about locations and categorization do not have well-established behavioural or psychological correlates. It is no longer sufficient to attempt to define attributes of individuals and expect them to predict specific behaviour without reference to social context.

So where and how can the social context be described and what are the relevant aspects to include? The most obvious place to look is not *just* at the one person referred but also at the relationships they are and have been engaged in. This means that the status of the information known to relatives, nurses, teachers, or residential social workers is increased. The assessor is much more dependent on a wider social network to make a full appraisal. Indeed the validation, if not the appraisal itself, lies *in* that social network and the 'assessor' can no longer define, or redefine, the problem based on one-to-one tests using the tools discussed above. Thus, changing procedure means weakening the 'assessor's' power base.

At a wider level this perspective is borne out by the Warnock Report (1978). This report argued that rigid classification of children with significant disabilities or difficulties stands in the way of effective flexible educational provision. It also argued that terms were, far from leading to relevant help, oversimplifying problems and perpetuating stereotypes. With regard to assessment the Committee pointed to the need for assessment within schools, by teachers, i.e., part of their social world, and for only the latter two of five stages to be conducted by 'multiprofession' analysis of a child's special needs. This 'specialist assessment' could therefore be more systematically informed of the child's continuous relationships.

Therefore, there is a need to add a third type of assessment, related to the first (usually by the parents). It is the constant monitoring, evaluation and judgement done by those around the person being assessed. The reason why such assessments have not been included so readily is the lack of organization of this information, the PAC being an exception.

When the original problem arises, when a person is not performing as

well as he apparently might do, parents particularly do not rush for assessment at the first sign of difficulty. A series of events will precipitate actions. When asked to recall these events it is unlikely that they will recall each and every one accurately. It would hardly be realistic or desirable for all families to record precisely everything that went on, including their beliefs and expectations, just in case they need to recall events if and when a problem arises. However, in the classroom and in residential care people, teachers, nurses and residential social workers, are paid not merely to occupy those in their care for so many hours a day, but also to monitor progress. It is this information which could be most easily used to enrich the traditional forms of assessment. This has been decried as being 'too subjective'. The traditional forms are 'objective'; teachers' and other 'face-workers' ' observations are 'subjective'. This need not be so. Let us replace the objective/subjective duality with an explicit/implicit duality. In this way the criterion becomes whether information can be explicated and put in a form which is public and testable in the sense of being open to question. In this way beliefs, expectations, prejudices, observations, opinions can all be included in assessment, in so far as they can be explicated. This then opens up the assessment process to include the powerful social forces of role expectations, opinions and values. The object of assessment is thus not an individual's performance in relation to a prepackaged task but a person's performance in relationships, including what pressure and expectations are present in the relationships. Therefore a person can be seen not merely in an apparently neutral context, i.e., with the 'objective' assessor, but in live social interaction. Therefore both sides of the relationship need to be described if this is to contribute to a fuller understanding of the problem. The usual reason for ignoring the 'other side' is that usually the assessor tries to standardize his or her behaviour, i.e., act in a predictable, preprogrammed way as laid down in the manual. An assessment of relationships is needed because in real life people do not always cope with predictable environments; indeed the point of including social competence is, in part, to find out how a person can deal with an unpredictable and changing environment.

Since ordinarily parents have no need or desire to be formally noting their relationship with children, or friends with one another, initial referrals will always be problematic in gaining insight into the history of a social relationship. However there are many people already in care, in hospitals and hostels, already diagnosed or labelled as mentally handicapped. They are also assessed, not just on entry, but as part of their lives and to decide when

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they may leave. Judgements are made continuously about their daily needs as well as their relevant place in society – in hospital or in the community. Their access to the world and resources is being constantly monitored by staff immediately caring for them. However most of these day-to-day judgements remain implicit while the *specialist* activity of assessment is explicit, for example, in IQ scores, psychiatric diagnosis. Further intuitive judgements may be influenced by stereotype views gleaned or half-learned from the specialist. Tautological explanations are used to maintain status rather than challenge it (for example: 'he does that because he is severely mentally handicapped – severely mentally handicapped people always do that'). This can lead to a resignation coupled with all the pressures of institutionalization which do not question the original assessments (Goffman, 1961). Indeed the specialized assessments gain a status not perhaps even intended by the assessor.

Assessment and policy

Discontinuities in bureaucracies are marked by official procedures. For example, however the informal networks and systems may effect the realities of day-to-day life, the major changes are bound by rules: admission, discharge, appointment of staff, promotion, dismissal, and so on. These discontinuities are essentially bound up with status, i.e., they are about ascribing roles and authority which, despite the influence of informal power structures, remain the public presentation of the organization. For example, although a staff nurse may, in terms of informal influence and power, have more influence in a ward than the ward sister, the public statement is that the ward sister is senior in terms of the organizational structure. Since the discontinuities, as mentioned above, are typified by rules, they are typified by formal procedures. Therefore the 'opinion' of the residential workers or families has less importance, publicly, than a written report containing a formal layout with figures, scores and results of other formal procedures, that is, the specialized assessments. These assessments therefore are bound up with the formal ascription of status for residents or patients. The problem really comes when these formalized procedures bear little relationship to the actual day-to-day life of the relevant organization.

This in turn relates to policy. The formal procedures are part of the *written policy* and history of an organization; that is, they can be seen – in organizational charts, memos, policy documents, minutes of meetings, etc.

This may be separate from the *spoken policy* – what can be heard in and around the establishment, the interpretation of policy – and *enacted policy* – what actually goes on whether written down or not. If these three strands are separate then there will be a considerable degree of alienation, for staff and clients, and a split between authority and power. This is further compounded by formal policies being ambiguous. Kushlick (1975) and Mager (1972) make the distinction between 'a performance' and a 'fuzzy'. With performances you know whether they have been completed or not, with fuzzies you do not. Much of the formal policy of institutions abounds with 'fuzzies', for example, improve hospital morale, improve the quality of life, increase potential. It will never be possible to fully integrate these strands, indeed if this were done the establishment may merely be over-run with specified rules and procedures which may in turn preclude creativity and change. However one of the major criticisms of some of the methods of assessment mentioned above was that they do not relate the assessment to action and in turn policy. That is, not only do they tend to overlook the social context in terms of the immediate environment but also in terms of a wider environment of policy setting.

One way to attempt to integrate these aspects would be to take into account the experience and effect of that environment in the assessment procedure itself. This would entail an explicit statement of the relationships of a resident, for example, between staff and resident, and a statement about the constraints acting on the staff. In this way the staff (in this case, although it could be the family) must be involved in the assessment. There is no doubt that staff in close contact with the mentally handicapped person (Kushlick's category of direct-care staff) are continuously making judgements and assessments which constantly affect the lives of those in their care. What is more doubtful is how much of this social world is publicly recognized in formal assessments, especially when it comes to the major decisions mentioned above. The inclusion of this social dimension has two major problems. Firstly to recognize it may undermine the 'professional assessor's' position and, secondly, it may expose the disparity between the 'public' organization and actual daily life within it.

The Chart of Initiative and Independence (CII) (Macdonald and Couchman, 1980)

There is of course the further difficulty of how this might be done even if it were possible. The CII is an attempt to achieve these aims, and bring the

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social dimension into a formal, in the sense of explicated, assessment procedure. The CII makes three assumptions. First, that information about the daily relationships between carers and cared for are both crucial and valid parts of the assessment procedure. Second, that this information should be organized in a way that reveals information in terms of who makes the decisions in the relationship and why. Third, that assessment is a continuous process and recording the 'result' is more analogous to a comma than a full stop. The point about recording is not to make an absolute statement but to make public the current state of affairs so that it can be challenged and questioned. Therefore the objective of the CII is to provide a method of assessment for the direct-care staff whereby they can describe the behaviour of a person in their care within a specified social context, i.e., the limits put on that behaviour by, for example, peer-group, staff, policy, *as well as* the person's own inhibitions, physical handicap, illness or dislikes.

This is done by first asking the staff to outline the policy of the residential unit in terms of the level of discretion allowed and required of residents for admission and discharge (the Residential Policy Format). To do this staff must first decide what activities are important. This is no simple task as there may be many different assumptions as to what the unit is concerned with: personal hygiene, social relationships, domestic skills, financial dealings, use of services, leisure, etc. When this is done staff are then asked to look at these activities for individual residents, again specifying the level of discretion, i.e., what they are allowed to do and what they are not, and why not. When this is completed staff must also comment on what they intend to do for the resident, the plan of action (this is the Individual Assessment Format). They then are asked to state the outcome of these action programmes, that is, what the resident might achieve and by when (the Development Programme Format). At the end of the programme *another* individual assessment is recorded which can then be compared with what should have happened and a new plan of action constructed. This continuous process is characterized by not only recording the behaviour of the resident but also the behaviour and the expectations of the staff.

One of the most influential aspects of daily residential life is not just what staff and residents do, but also what staff *believe* residents can do. These beliefs and expectations are not usually recorded as part of a formal assessment. They are seen to be too subjective. However staff will react differently to a person's behaviour according to whether they *believe* the person is doing their best or merely 'being lazy', whether they have 'hard evidence' for this belief, or prejudice, or not. These expectations are included in the

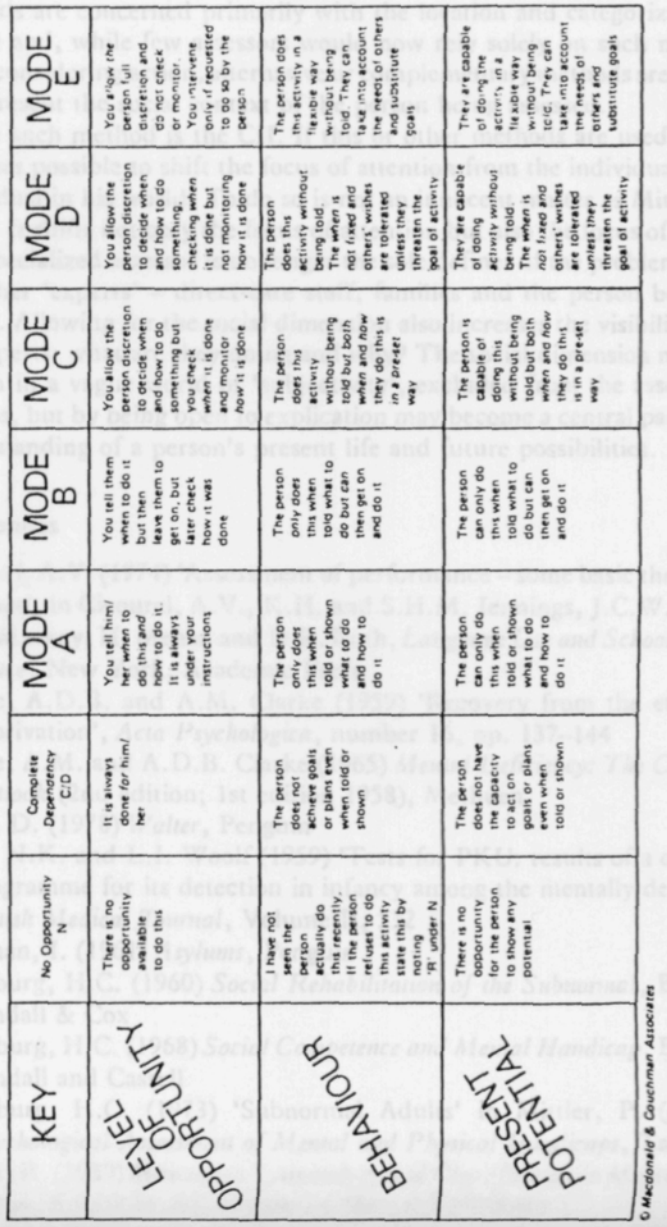


Figure 4.2

CII (under 'present potential' – see Figure 4.2) on the grounds that they can be explicated and separated from observable behaviour. The reason that the staff's behaviour (level of opportunity –see Figure 4.2) is included is not only to make the other end of the relationship clear but also to show where staff limit residents' behaviour for administrative convenience. For example, a mentally handicapped person may be woken up, washed and dressed by staff even though they are capable of deciding for themselves, because it is felt to be the only way thirty people can be sure to have their breakfast and be out of the ward or hostel by 9.30 am.

The 'scale' of discretion is shown in Figure 4.2. Here the range is from no opportunity to where the person is making his or her own decisions and where they only call in help when *they* see fit. The scale itself has relevance to our earlier discussion in which the main concern for parents and staff was the extent to which a mentally handicapped person could make decisions and do things for himself if given the opportunity to do so. These considerations can be made whatever the IQ level or developmental age of the person. The main variations can be made in the choice of activities. For example, one person may be allowed to make decisions about what job to apply for, another only about choosing his socks.

The main point of the CII is that the mentally handicapped person is not seen in isolation. He or she is seen as part of a social reality which includes those in charge of their welfare and the conditions under which they work or live. This does not mean that information is inherently less 'objective' than in other methods of assessment. What it attempts to portray is a social situation and where responsibility for action or inaction lies. In the CII behaviour cannot be explained solely in terms of the inherent attributes of an individual. Further, development depends on specific action being taken which in turn implies the availability of resources. If these resources are not available at least this can be made public and the consequences apparent. In this way policy can be negotiated in the light of 'performances' rather than 'fuzzies'.

Conclusion

This chapter has tried to argue that the 'specialized' assessment of individuals is insufficient in itself because it ignores a wealth of information that is, and could be made, available. Further, that assessment is a continuous process which starts with a felt lack in a relationship and implies the eventual allocation or withholding of resources. Traditional assessment

methods are concerned primarily with the location and categorization of people and, while few assessors would now rely solely on such methods when considering action, alternative or complementary methods are needed to represent the social context of the person being assessed.

One such method is the CII. If this or other methods are used then it becomes possible to shift the focus of attention from the individual to the individual in his world. To do so is not an innocent matter as Mittler has noted. It shifts not only the focus of attention but also the focus of power. The specialized assessor is no longer the sole definer of the problem; there are other 'experts' – direct-care staff, families and the person being assessed. Allowing for the social dimension also increases the visibility of all the experts: what are they doing and why? The social dimension need not remain in a vague world of 'subjectivity', excluded from the assessment process, but by being open to explication may become a central part in the understanding of a person's present life and future possibilities.

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APPENDIX VII

ADMINISTRATIVE ISSUE IN THE NORTH WEST THAMES PROJECT

APPENDIX VII

ADMINISTRATIVE ISSUES IN THE NORTH WEST THAMES PROJECT

The researcher was already known at Leavesden both to the senior officers and some of the ward staff. Although the researcher was known to individual members of staff at the other two hospitals there had not been any previous working relationship to build upon. Essentially, as can be seen in the attached notes, Leavesden showed the most active interest in the project outside the wards.

Leavesden

The fact that some wards had used the C.I.I. in a previous form was both a help and a hinderance. It was useful because basic ideas were understood but difficult to introduce modifications as they were already used to a different version. At Leavesden there were three levels of intervention over and above the direct research relationship with the wards.

a. Steering Group: this was a meeting with the Div. N.O. to which other disciplines were invited and discussed the overall effect and direction of the work.

b. Working Group: involved nurses (charge nurses and/or ward sisters) actually using the C.I.I., meeting with their Nursing Officers under the Chairmanship of a Senior Nursing Officer to discuss the progress of the project and related problems. The researcher attended both a. and b. meetings.

c. Nurses Group: meetings between nurses using the C.I.I. arranged by them and for them to discuss any issues raised by the C.I.I. (the researcher did not attend). This was to facilitate the emergence of a core group of users who could work without the researcher.

All these groups naturally ran into problems. The meeting of the Steering Group was obviously influenced by the change of Div.N.O. and the eventual re-organisation. The Working Group was also influenced by the re-organisation, the uncertainty of Nursing Officers and changes in the shift system as well as industrial action. The Nurses Group were also unclear, at times, as how often they should meet and what to do if others did not attend.

Overall, during the project at Leavesden, there was most active support for the project at all levels. There was an attempt to view the project in terms of the whole institution and involvement from other professions. Although the medical staff were not directly involved with the researcher they did not undermine the ward based work.

Addendum 1

Leavesden Hospital: Meetings concerning the Progress of the Project other than Ward Visits

1980	
Jan.-Feb.	Discussions with large groups of nursing staff on the overall aims of the project, the use of the C.I.I. and the required commitment from staff.
Feb.	Meeting with M.E.C. to clear the project. Initial wards chosen: Ash, Forsythia, Bluebell, Peacock and Lark. Only Peacock and Forsythia felt they could be involved.
Feb.	Established relationship with SNO (Mr. Hubery) who would take control of the project. Inclusion of Plover ward.
Feb.	Discussion with Psychology Department.
Feb.	First Steering Group Meeting. Meeting with Div. N.O.. Agreed on Forsythia, Peacock, Heather, Willows and Plover. Established Leavesden Steering Group.
March	First Working Group. Meeting with SNO, NO and C/Ns and W/Ss to be involved in the project. The meeting was to establish the research conditions. This working group was to meet monthly - chaired by the N.O.. The guidelines were agreed.
March	Formal letters were sent to relevant consultants.
April	Continued to set up the project on the wards.
April	Second Working Group. Discussed problems with beginning the work.
May	Meeting with Psychology Department. Discussion to try and establish role of psychologist/ researcher and nurses. Clinical issues most relevant. Concern about overall professional roles and relative authority.
June	Third Working Group meeting. Cancelled because N.O.s were not available. First serious issue of senior support lacking.
August	Re-arranged third Working group meeting: (a) serious problem concerning the support role of the N.O. not resolved; (b) need for simpler manual;

(c) introduced questionnaire.

Sept. Second Steering Committee Meeting:

(a) progress not up to timetable;

(b) importance of N.O. role;

(c) attitude towards assessment is ambiguous.

Oct. Fourth Working Group meeting:

Higher attendance of N.O.s and active involvement of SNO. SNO argued that staff should set aside time for assessment; suggested independent meetings of C/N and W/S. All wards not proceeding at the same pace.

Oct. First Regional Report

Nov. Meeting with SNO to clear questionnaire.

Nov. Published manuals introduced.

Nov. Fifth Working Group meeting:

(a) nurses were meeting independently to discuss the C.I.I.;

(b) need for summary paper;

(c) re-negotiated timetables;

(d) general view that N.O.s were not actively involved.

Nov. K. Pugsley (Div. N.C.) resigns from Leavesden to take up DHSS post.

Nov. Meeting with Psychology Department:

Discussed progress on wards.

Dec. Sixth Working Group Meeting:

Identified problems of actively involving ward staff.

1981

Feb. Seventh Working Group Meeting:

Introduced C.I.I. summary handout. Staff reported that they were now really using the C.I.I. to help in their work and had moved beyond the 'learning' stage. Programme not to original timetable. Proposal that ideas be put to students.

Feb. First meeting with A. Jackson - new Div.N.O.

March — Eighth Working Group meeting:

(a) possible involvement of new wards;

(b) contact with School of Nursing re. teaching; School ordered materials.

April — Ninth Working Group meeting:

Poor attendance - S.N.C. but no N.O.s. Forsythia dropped out of the project. Nightraven now definitely involved. Discussed role of C/N and W/S more generally.

May — Tenth Working Group meeting:

(a) possible involvement of secure wards;

(b) how to create an expert users group in the hospital;

(c) discussed use of assessment and multi-disciplinary work.

June — Eleventh Working Group meeting:

Poorly attended: discussion again on possible work in the secure units.

June — Second Regional Report

July — Third Steering Group:

Discussed regional report.

July — Twelfth Working Group meeting:

Cancelled due to problems in attendance.

Dec. — Fourth Steering Group meeting:

Discussed revised second regional report. First part of research is complete, i.e. there is virtually enough data concerning use and problems with the C.I.I.. Decided to drop research conditions on use of C.I.I. (i.e. 12 patients assessed at pre-set periods). Identified serious problems of role of N.O. in implementation.

Dec. — Meeting with Combined Officers:

To renegotiate how and where the C.I.I. would be used at Leavesden.

1982

Feb.	Meeting with N.O. and ward staff re. secure units: Discussed use of C.I.I. on four new wards: Acacia, Aster, Kestrel and Kiwi. It was emphasized that this initiative came from the hospital.
Feb.	Problems with number of manuals available at the hospital.
Feb.	Meetings with SNO re. progress of project (substitute for Working Group). N.O. need training in the implications of the C.I.I..
March	Progress report to Leavesden including ward training for secure units.
March	Meeting with Psychology Department: report of research.
April	New NHS re-organisation:
April	Twelfth Working Group meeting: Used to allow new staff to meet experienced staff using the C.I.I.. "Expert" group proposed.
April	Meeting with N.O.s: difficult discussion but used the idea of the Nursing Process to explain the C.I.I..
April	Meetings with C/Ns and W/Ss re-established.
May	Thirteenth Working Group meeting: Discussed multidisciplinary involvement in the C.I.I..
May	Second N.O.s meeting explained the technical side of the C.I.I..
May	Due to re-organisation and staff changes, training of the specialist group was postponed.
June/July/ Aug./Sept.	General issues held up due to re-organisation and industrial disputes. From this time on work on general issues was sporadic. Work on the secure units held up by lack of clarity of role of nursing officers.
July	Meeting with Senior Nursing Staff: Began involvement with Nursing Process now it is clear that this will be implemented.

Sept.	Continuing discussion of relationship between Nursing Process and C.I.I.. Presented paper on Nursing Process to senior nursing staff.
Sept.	Discussions concerning the new nursing structure and the project including the responsibilities of ward staff and nursing officers.
Sept. '82 Jan. '83	Discussed the future of the use of the C.I.I. including final conferences and workshops.

Cell Barnes Hospital

The research was slow to develop at Cell Barnes but this was partly deliberate to allow the work and nature of the project to be as public as possible. Once the wards had begun work there was a change in the Div. N.C. post; Mr. Jackson left to replace Mr. Pugsley at Leavesden. While this did not affect the work directly at ward level it meant there was a gap in reporting the work. The new Div. N.O. had many other concerns in a new post and so it was some time before there was a renewed active involvement at senior level.

There was not a regular steering group as at Leavesden. The discussions were mainly between the researcher, the Div. N.O. and one S.N.O. who remained constant throughout the project. As at Leavesden, the active involvement at N.O. level did not really materialise. However, there was contact with the Nurse Training School and sessions were given on a regular basis so that students and pupils went onto wards with some prior knowledge of the basic principles. There was no opposition from medical staff and in one case the consultant attended several ward meetings to discuss progress of the C.I.I.. There was also contact with the Psychology Department. The Head of the Department was informed of work. He knew of the previous work at Leavesden when he was working there and so the Department were able to support the project in general.

The project moved on to a more general footing in June 1982 when the work with the C.I.I. was linked to the introduction of the Nursing Process. The researcher joined the working group and helped produce several papers for the hospital.

Overall the work was affected by the expected quota of staff changes but more specifically the re-organisation of the service and industrial action, which intervened at crucial times during the research project. This may be in part why N.C. involvement was so limited.

Addendum 2

Cell Barnes : Non ward based work

1980

April	Meeting to introduce project - 40 - 50 staff members including psychology, medical and social work staff as well as nurses. Explained project outline and programme.
	Research cleared by medical staff; discussions of relevant wards.
June	Second large meeting split into two; another general introduction then initial meeting with potential users: ward nursing staff. Three wards chosen: 10A, 22A and 13 (see ward notes for progress).
Sept.	Discussion with Div. N.O. (Mr. A. Jackson) re. progress. This is equivalent to a Steering Group meeting, and there were several meetings during this period.
Sept./Oct.	Submission of first Regional Report.

1981

May	Project now under direction of S.N.O. since Mr. Jackson had left to take up the new post at Leavesden (see Leavesden notes).
June	First talk at the invitation of the Nurse Training School which then continued on a regular basis every few months until the end of the project teaching small groups of students.
July	Meeting (Steering Group) with SNO.
July	First meeting with Mr. M. Fricker - new Div.N.O.
July - Dec.	Series of meetings with the SNO and Div.NO as issues arose rather than on a regular time-tabled basis.

1982

March	Discussed the research with the Div.N.C. and SNO in the light of staffing and organisational changes proposed at Cell Barnes and in particular the second Regional Report. Reviewed the possibility of a regular working group (as for Leavesden) perhaps linked with the Nursing Process.

June	Re-organisation of the project (after discussions at the Region). Previous conditions were dropped. Discussed the formation of a working group for the Nursing Process.
Sept. to end of project	Work shifted to the implementation of the Nursing Process and the C.I.I. via regular attendance at the Cell Barnes Nursing Process Group.
Nov. to end of project	Preparation of final reports and conferences. Particularly what whould happen at the end of the project.

Harperbury Hospital

As has been mentioned in previous reports, there were major problems encountered at Harperbury. In addition to the general issues of re-organisation, industrial action and the implementation of the Nursing Process, there was the internal re-organisation effecting all the wards involved in the project. This last point was the most influential. In addition the original N.O. who had actively invited the work to proceed left soon after the initial stages. The new N.O. had never expressed a particular desire to be involved and also had the internal re-organisation to arrange. Consequently, work centered around the wards and this was emphasized because of administrative issues. However, a vacuum developed between the wards and the hospital in general and so issues were not seen in a broader context. When this eventually happened the external organisation was in progress and demanded a higher priority.

As in the other hospitals the possible introduction of the Nursing Process and industrial action also complicated the research programme. At Harperbury there was an even greater need for mechanisms to discuss the project on a broader basis. The lack of interest at N.O. level was not significantly greater than anywhere else however, it was more conspicous due to the other circumstances. Mechanisms were more easily developed at Leavesden partly because of the previous working relationship with the researcher. Superficially Harperbury could be seen as a relative failure. In terms of the research project this is too simple a conclusion. The very fact that there were so many problems at Harperbury meant that valuable lessons were learnt. It must be stressed again that the purpose of the project was not solely to implement the C.I.I. but to discover under what conditions it could or could not be used. In general the nursing staff attempted to continue with the project. The problems were clearly identified if not always solved. Also the issue of assessment was discussed and because there was a shared understanding of problems the project was not abandoned and the ideas are still part of the hospital's, and especially nursing staffs', work (see Final Sections - Conclusions and Future Work). Also the results of the questionnaire, discussed above (section G) show that the project did not result in a completely negative view or even a consistently less favourable response at Harperbury.

Addendum 3

Harperbury: Non ward based work

1980

Feb.	Introductory meeting: general discussion with a wide range of staff concerning the intended project.
March	Meeting between Harperbury staff and staff from Leavesden and social services who had experience using the C.I.I.. It was made clear that the research was not concerned with active implementation but to find out what help was needed.
end of March	Confirmed the three wards to take part in the project with the clearance of medical staff. All wards in one Area, under one N.O..
June	Several discussions with N.O. as to the nature and extent of the project within the three wards.
July	Despite possible re-organisation of the unit, affecting all three wards, it was decided to begin the project.
July	Talk to student nurses training at Harperbury.
Oct.	N.O. left, new N.O. in post. Also first Regional Report presented to Harperbury.
Nov.	Working Group: involving ward staff and N.O.s to discuss progress. Problems were identified including lack of staff.

1981

Jan.	Meeting with Psychology Department to discuss the research.
July	Meeting with N.O. to discuss re-organisation of the wards involved in the project. Serious problems were arising because of the uncertainty of the exact dates and extent of this re-organisation.
Oct.	Second Regional Report to Harperbury. This report highlighted the main difficulties at Harperbury.
Nov.	The wards were now actually moving and being split up. Continuation was quite sporadic.

1982

Jan.	Ward programmes were very haphazard due to this internal re-organisation.
June	Correspondence with reference to the second report indicated the need for a meeting at senior level.
July	Meeting with Div.N.O. and S.N.O.. Internal re-organisation now complicated by general re-organisation. Discussion centred around what could be continued given the continuing uncertainty. An interested group was identified rather than physical location. There was also a discussion as to the relationship between the C.I.I. and the Nursing Process.
Sept.	Meeting at Harper House, initiated discussions at Harperbury concerning the implementation of the Nursing Process.

APPENDIX VIII

QUESTIONNAIRE RESULTS: NORTH WEST THAMES PROJECT

APPENDIX VIII

QUESTIONNAIRE RESULTS: NORTH WEST THAMES PROJECT

The questionnaire was in two parts. Part 1 was concerned with variables which were less likely to change over the period of research than variables in the second part. (The questionnaire - parts 1 and 2 - are reproduced in Appendix 2.)

The questionnaires were independently administered to the ward nurses by other research staff. The objective was to gain the attitudes and opinions of the nurses to the C.I.I.. Further to test whether these attitudes and opinions changed over time. The results are presented without need for constant reference to the Appendix. (For a fuller discussion of methodology see Part 2, section E.)

1. Sample

Discussion

During the course of the project 50 questionnaires were completed which were suitable for analysis. There were three others which had to be rejected as major sections had been omitted or clearly misunderstood. The answers from the 50 questionnaires were completed by adding relevant data from Part 1 which did not vary.

The sample of nurses in the study consisted of an almost equal number of males and females and an exactly equal number of completed questionnaires from male and female staff. The large majority of nurses completing questionnaires were at charge nurse/ward sister level and had at least eight years experience in nursing mentally handicapped people. Nearly all had an RNMS qualification. There was an almost equal distribution of staff and questionnaires from the three hospitals although more wards were involved at Leavesden. Consequently, this part of the study is not particularly biased towards any one hospital.

Although the description of ward work was fairly consistent with the original purpose of the design of the C.I.I. i.e. they were mostly described as training or pre-hostel wards, the type of patient was not consistent with those involved in pilot work. The C.I.I. was originally designed for low dependency mentally handicapped adults and was not specifically designed for highly disturbed patients, although the principles should be applicable to such groups. The sample of wards with a large number of disturbed and high dependency patients provided a good opportunity to test this assumption. Most wards had at least two full-time qualified day staff and at least one full-time unqualified staff member.

However, this varied considerably and, as will be shown, was an important factor (see Part 3). (See Figures below.)

Figure 1 - Questionnaires

23 nurses completed questionnaires of whom:-

10 were ward sisters;

10 were charge nurses;

1 was an S.E.N.;

1 was an unqualified O.T.; and

1 was an unqualified nursing assistant.

There were three more questionnaires which were incomplete and so could not be analysed.

8	nurses completed	1 questionnaire	=	8
7	" "	2 questionnaires	=	14
4	" "	3 "	=	12
4	" "	4 "	=	16
23	nurses			50 questionnaires.

There were 25 questionnaires from female staff and 25 questionnaires from male staff.

Figure 2 - Qualifications

Of the sample:

2	were unqualified;
1	was an S.E.N.;
18	staff with RNMS;
2	staff with RNMS and CCETSW
23	

Figure 3 - Years in Nursing : mental handicap

6	nurses had been in nursing between	5 - 8 years
5	" " " " "	8 - 10 "
5	" " " " "	10 - 15 "
1	" " " " "	more than 15 years
6	nurses did not answer this question.	
23		

mean = 8 - 10 years: therefore most nurses received their training at least 8 years ago.

Figure 4 - Hospitals

	No. of wards	Nurses	No. of Questionnaires
Leavesden	6	9	19
Cell Barnes	3	7	15*
Harperbury	3	7	16
	12	23	50

Figure 5 - Type of Ward

2	locked wards
3	open general
2	pre-hostel
5	training wards
12	

Figure 6 - Sex of Patient (by ward)

6	male only
1	female only
5	mixed
12	

* including 1 from the Nurse Training School.

Figure 7 - Dependency of Patients (by ward)

6	high dependency
1	low dependency
5	mixed
12	

Figure 8 - Behaviour (by ward)

3	disturbed only
9	some disturbed
12	

Figure 9 - Other qualified full-time staff

2	wards had 1 other full-time qualified staff member
5	" " 2 " " " " "
3	" " 3 " " " " "
1	" " 4 " " " " "
1	ward did not provide information.
12	

2.27 full-time qualified staff other than respondent therefore mean for ward = 3.27 qualified staff - full-time.

Figure 10 - Other unqualified full-time staff

1	ward had no other full-time unqualified staff member
5	wards had 1 " " " " "
3	" " 2 " " " " "
1	" " 3 " " " " "
1	" " 4 " " " " "
1	ward did not provide information.
12	

mean = 1.64 full-time unqualified.

Mean total: full-time staff per ward = 5 (4.91)

2. Completion of the Charts

Discussion

Over the whole period of research completion of the C.I.I. took between ½ hr. and 2½ hrs. No one spent longer than 2½ hours completing one chart. Of this time, the longest task was the discussion. Staff spent twice as long discussing a patient than completing any section of the chart itself. This is an encouraging sign since it was hoped that the technical details would not be too much of a distraction and one of the stated aims of the C.I.I. is to promote discussion.

As can be seen from Figures 13 - 16 the time spent on the completion of charts decreased over time. It was anticipated that this would be so and the results of the questionnaire confirm this. The time spent on all sections of the C.I.I. followed this trend. The overall time is reproduced in Figure 12.

In all cases the charge nurse and/or ward sister were involved in the completion of C.I.I. charts, although in some cases it was to monitor other nursing staff. Staff involved, other than charge nurses and ward sisters, were as follows:

Figure 11

	involved		directly		indirectly	
Ward nursing staff:	100.0	100.0	71.4	73.9	28.6	26.1
Ancillary staff:	29.2	31.8	22.9	27.3	6.3	4.5
Psychology staff:	16.3	17.4	6.1	4.3	10.2	13.0
Medical staff:	4.1	0	0	0	4.1	0
Other professional staff:	20.4	8.7	6.1	4.3	14.3	4.3
Relatives:	10.2	4.3	0	0	10.2	4.3
Patients:	10.6	8.7	8.5	0	2.1	8.7

In each case the first column refers to results from all 50 questionnaires; the second column refers to results from 23 questionnaires, 1 from each nurse involved in the project.

Length of time to complete a C.I.I.: Over the whole project (50 questionnaires) the time taken to complete each C.I.I. was:-

Figure 12

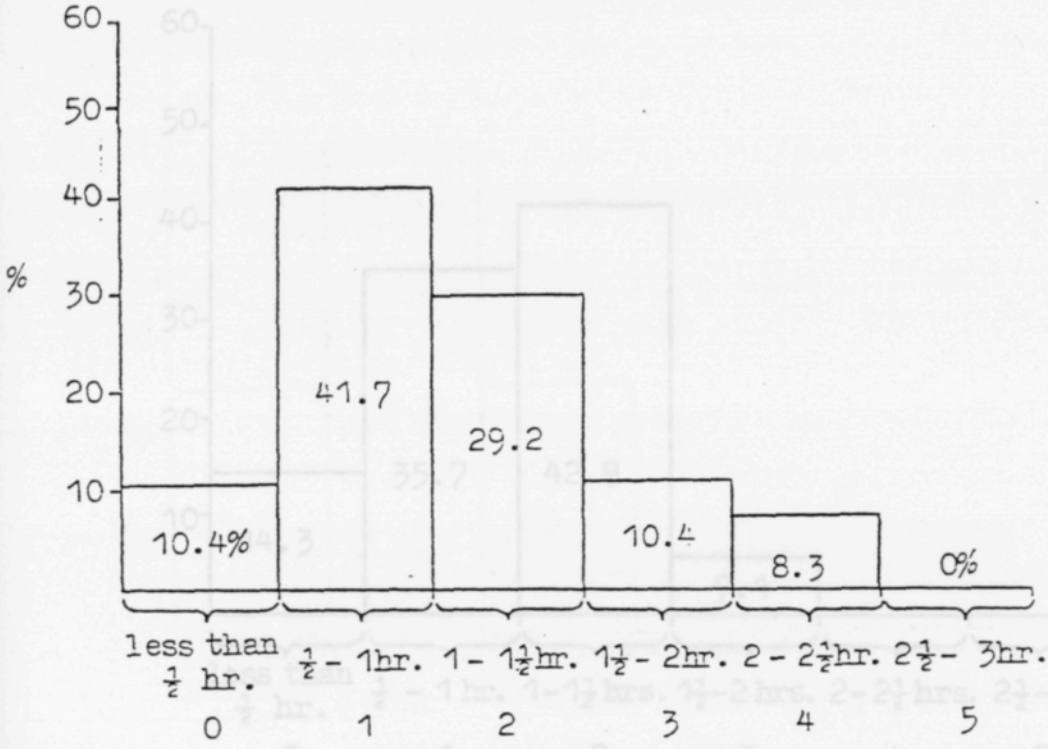


Figure 13 - Time to complete charts over period of project

1st Questionnaire

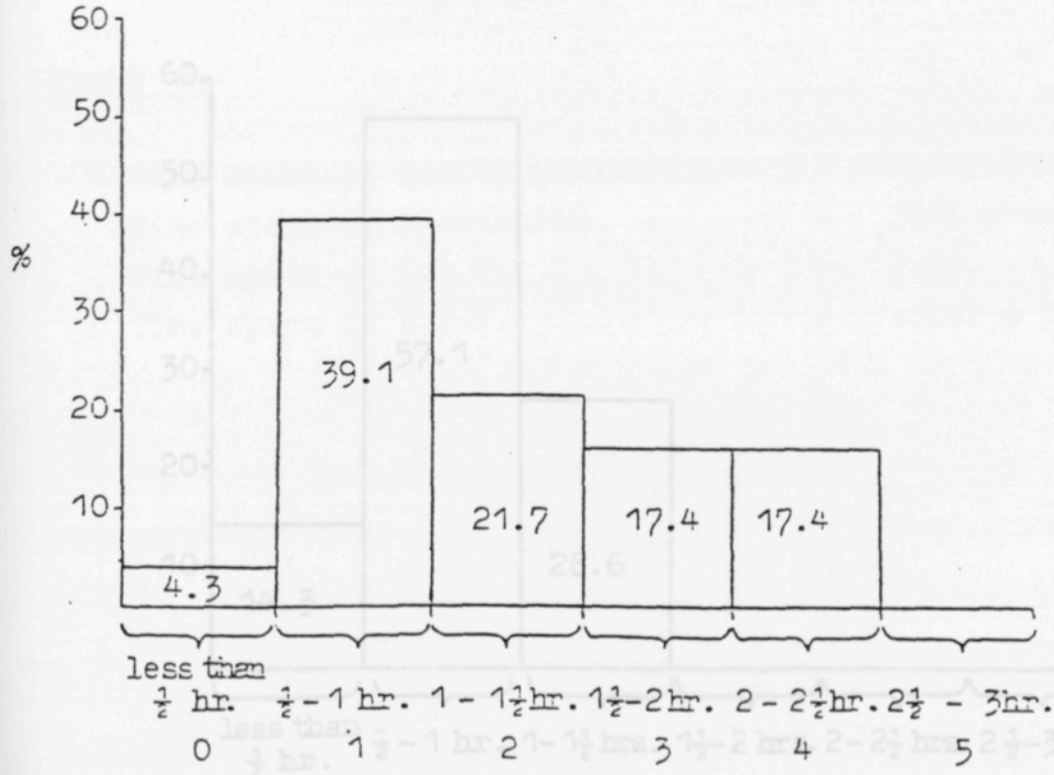


Figure 14 - Time to complete charts over period of project
2nd Questionnaire

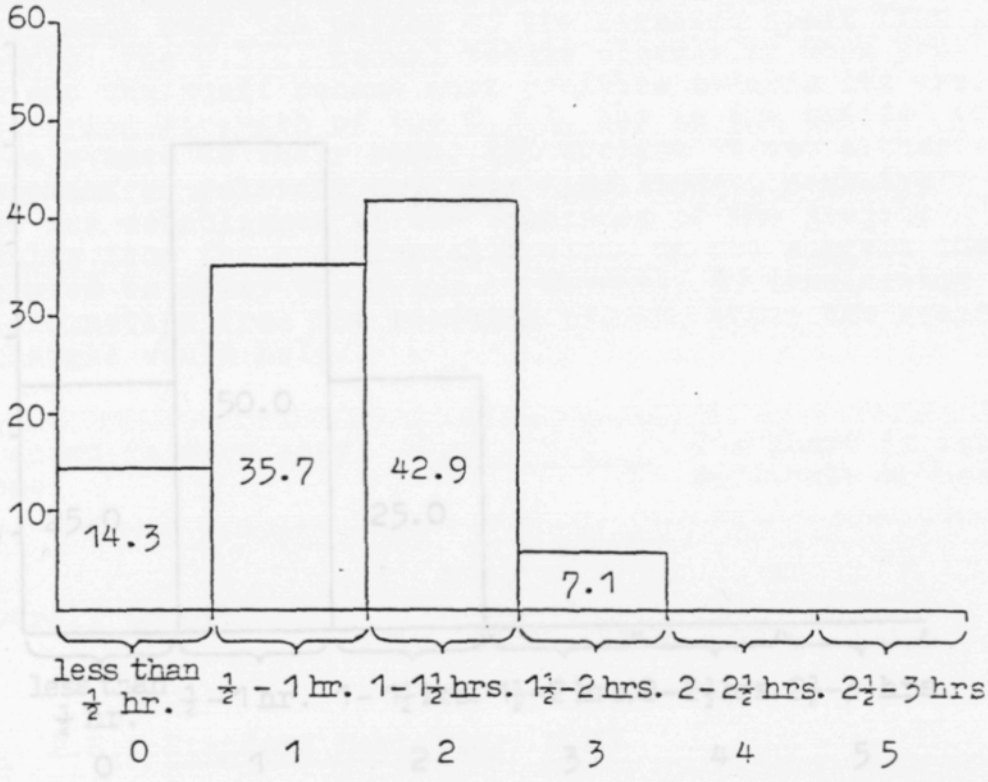


Figure 15 - Time to complete charts over period of project
3rd Questionnaire

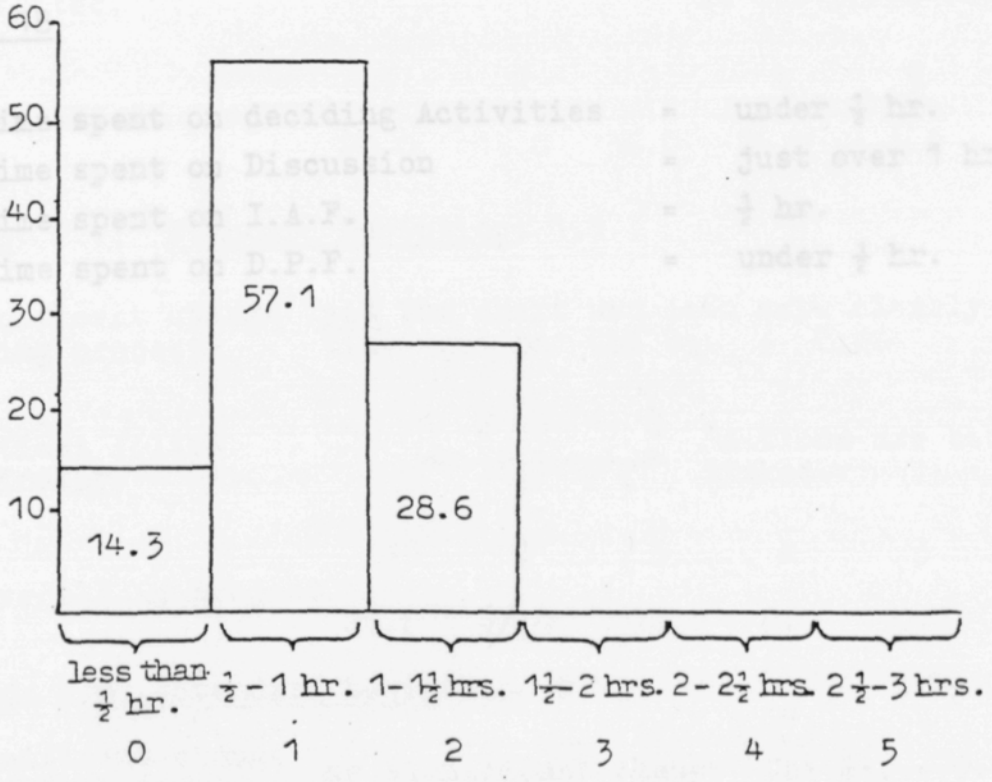
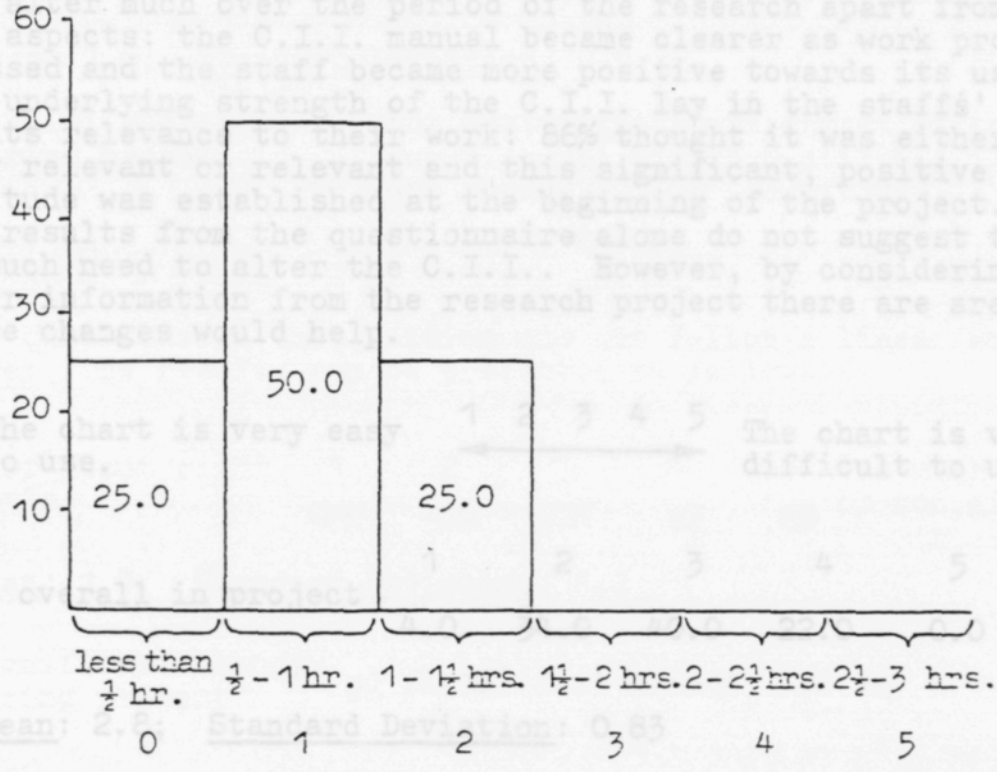


Figure 16 - Time to complete charts over period of project

4th Questionnaire



The mean times for each part of the C.I.I. were as follows:

Figure 18

Time spent on deciding Activities	=	under ½ hr.
Time spent on Discussion	=	just over 1 hr.
Time spent on I.A.F.	=	½ hr.
Time spent on D.P.F.	=	under ½ hr.

3. Comments on the Chart in general

In general, staff reacted favourably to the C.I.I.. In particular, they found the ideas relevant to their work and the ideas clearly and logically presented. Their opinions did not alter much over the period of the research apart from two aspects: the C.I.I. manual became clearer as work progressed and the staff became more positive towards its use. The underlying strength of the C.I.I. lay in the staffs' view of its relevance to their work: 86% thought it was either very relevant or relevant and this significant, positive attitude was established at the beginning of the project. The results from the questionnaire alone do not suggest there is much need to alter the C.I.I.. However, by considering other information from the research project there are areas where changes would help.

1. The chart is very easy to use. 1 2 3 4 5 The chart is very difficult to use.

	1	2	3	4	5
% overall in project	4.0	34.0	40.0	22.0	0.0

Mean: 2.8; Standard Deviation: 0.83

significant change during project: no real significance: Chi Sq. = 0.16

2. The chart is clearly presented. 1 2 3 4 5 The chart is confusing in its presentation.

	1	2	3	4	5
% overall in project	20.0	18.0	36.0	26.0	0.0

Mean: 2.7; Standard Deviation: 1.1

significant change during project: yes the chart was seen more clearly as time went on: Chi Sq. = 0.06

3. Sections follow logically: 1 2 3 4 5 Sections are badly linked.

	1	2	3	4	5
% overall in project	26.0	48.0	26.0	0.0	0.0

Mean: 2.0; Standard Deviation: 0.7

significant change during project: no significant change: Chi Sq. = 0.87

4. Ideas are very relevant to my work. 1 2 3 4 5 Ideas not very relevant to my work.

	1	2	3	4	5
% overall in project	54.0	32.0	12.0	2.0	0.0

Mean: 1.6; Standard Deviation: 0.8

significant change during project: the most significant aspect of this question was how this attitude did not change during the project.
Chi Sq. = 0.97

Other questions in this section did not follow a linear scale. However, the results can be presented as follows.

	1	2	3	4	5	
5. just about right style.	60%	40%	28%	2%	6%	Too much jargon or too simplistic.

Mean: 1.9; Standard Deviation: 1.2

significant change during project: no significant change: Chi Sq. = 0.12

	1	2	3	4	5	
6. right length.	52%	8%	24%	2%	14%	Too long or too short.

Mean: 2.1; Standard Deviation: 1.5

significant change during project: no significant change: Chi Sq. = 0.59

	1	2	3	4	5	
7. right amount of demands.	60%	32%	4%	4%	0%	Too demanding or not demanding enough.

Mean: 1.5; Standard Deviation: 0.8

significant change during project: no significant change: Chi Sq. = 0.94

	1	2	3	4	5	
8. right amount of help.	44%	10%	18%	2%	26%	Not enough or too much help.

Mean: 2.6; Standard Deviation: 1.67

significant change during project: yes significant change; the amount of help was improved.
Chi Sq. = 0.07

4. Clarity of sections of the C.I.I.

Only a few of the nursing staff felt that sections of the C.I.I. manual were completely unclear and that they should, consequently, be left out. There was, however, a tendency for the scores to be skewed towards the left-hand pole of the scale. In this section all questions were in the 'same direction'. The results may be seen as having a bias towards the positive pole. Consequently, it may be more prudent to ignore the fifth point of the scale which was rarely used. Further, it seems sensible to regard items with a mean score of 2.0 or less as being acceptable (rather than 2.5). Those items scored between 2.0 and 2.5 are thus deemed as needing examination for possible rewrite and any score equal to or higher than a mean of 2.5 as needing serious consideration and revision.

This section was concerned with staffs' understanding of each section of the C.I.I. manual. The results presented in Figure 17 are the overall scores on clarity of understanding over the whole project. (To read this section, it would be useful here to refer to an actual C.I.I. manual.)

Figure 17

	clear and useful				unclear/could be omitted
	1	2	3	4	5
The Introduction	14%	55.8%	27.9%	23%	0%
	Mean: 2.2; Standard Deviation: 0.7				
	1	2	3	4	5
Concepts of Modes	26.5%	32.4%	35.3%	5.9%	0%
	Mean: 2.2; Standard Deviation: 0.9				
	1	2	3	4	5
No Opportunity	42.9%	36.7%	18.4%	2%	0%
	Mean: 1.8; Standard Deviation: 0.8				
	1	2	3	4	5
Complete dependency	42.0%	36.0%	18.0%	2.0%	2.0%
	Mean: 1.8; Standard Deviation: 0.8				
	1	2	3	4	5
Mode A	36.7%	42.9%	18.4%	2.0%	0%
	Mean: 1.9; Standard Deviation: 0.8				

	clear and useful				unclear/could be omitted
	1	2	3	4	5
Mode B	34.7%	42.9%	20.4%	2.0%	0%
	Mean: 1.9; Standard Deviation: 0.8				
	1	2	3	4	5
Mode C	26.5%	42.9%	26.5%	4.1%	0%
	Mean: 2.1; Standard Deviation: 0.8				
	1	2	3	4	5
Mode D	22.4%	46.9%	26.5%	4.1%	0%
	Mean: 2.1; Standard Deviation: 0.8				
	1	2	3	4	5
Mode E	26.5%	42.9%	26.5%	4.1%	0%
	Mean: 2.1; Standard Deviation: 0.8				
	1	2	3	4	5
Level of Opportunity	22.9%	52.1%	25.0%	0%	0%
	Mean: 2.0; Standard Deviation: 0.7				
	1	2	3	4	5
Behaviour	27.7%	55.1%	21.3%	0%	0%
	Mean: 1.9; Standard Deviation: 0.7				
	1	2	3	4	5
Present Potential	31.1%	40.0%	26.7%	2.2%	0%
	Mean: 2.0; Standard Deviation: 0.8				
	1	2	3	4	5
Optimum Mode	10.0%	40.0%	32.0%	12.0%	6.0%
	Mean: 2.5; Standard Deviation: 0.9				
	1	2	3	4	5
Key Page	38.3%	38.3%	21.3%	2.1%	0%
	Mean: 1.9; Standard Deviation: 0.8				

	clear and useful				unclear/could be omitted
	1	2	3	4	5
Flow Diagram	22.0%	22.0%	43.9%	7.3%	4.9%
	Mean: 2.6; Standard Deviation: 1.2				
	1	2	3	4	5
I.A.F.	21.3%	53.2%	21.3%	4.3%	0%
	Mean: 2.1; Standard Deviation: 0.8				
	1	2	3	4	5
Plan of Action	34.8%	34.8%	26.1%	4.3%	0%
	Mean: 2.0; Standard Deviation: 0.9				
	1	2	3	4	5
D.P.F.	21.3%	40.4%	29.8%	6.4%	2.1%
	Mean: 2.3; Standard Deviation: 1.0				
	1	2	3	4	5
R.P.F.	22.9%	22.9%	40.0%	8.6%	5.7%
	Mean: 2.6; Standard Deviation: 1.3				
	1	2	3	4	5
Manual of Activities	24.4%	31.7%	31.7%	7.3%	4.9%
	Mean: 2.4; Standard Deviation: 1.2				
	1	2	3	4	5
Case Studies	23.3%	23.3%	46.7%	6.7%	0%
	Mean: 2.5; Standard Deviation: 1.3				

Figure 18

	mean	status
Mode Complete Dependency	1.8	Clearly presented, useful and acceptable.
Mode No Opportunity	1.8	
Key Page	1.9	
Concept of Behaviour	1.9	
Mode A	1.9	
Mode B	1.9	
Concept of Level of Opportunity	2.0	
Concept of Plan of Action	2.0	
Concept of Present Potential	2.0	
I.A.F.	2.1	Need examination for possible re-write.
Mode C	2.1	
Mode D	2.1	
Mode E	2.1	
Concept of Modes	2.2	
Introduction	2.2	
D.P.F.	2.3	
Manual of Activities	2.4	
Case Studies	2.5	Need serious consideration for revision.
Optimum Mode	2.5	
Residential Policy Format	2.6	
Flow Diagram	2.6	

5. Impact of the Charts : over period of the whole project

This section of the report is one of the most important in the research. Whether staff could or could not understand the C.I.I. was one issue. Whether it helped or hindered their work was more important to assess. Consequently, this section is looked at first as a general result from all the hospitals. Later sections will look more closely at how the wards and/or hospitals differed.

The results table is presented in a slightly summarised form for clarity. The results on the first line are derived from the entire sample of questionnaires. The results on the second line are taken from the last questionnaire to be completed by all nurses. (For the exact wording and order of questions see Appendix 2.) Staff were asked to agree or disagree with the statements.

Questions related to ward nursing work:

	Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree	Mean	Standard Deviation	Chi Sq
	%	%	%	%	%	%	%	%
1. It has given me a useful framework to look at my work.	22.0	62.0	12.0	4.0	0	1.9	0.7	0.26
	21.7	60.9	13.0	4.3	0	2.0	0.74	
2. It has made me look closely at why I do or do not do things for patients.	24.0	40.0	10.0	26.0	0	2.3	1.1	0.34
	34.8	26.1	8.7	30.4	0	2.3	1.3	
3. It has hindered my work	2.0	6.0	20.0	62.0	10	2.3	0.8	0.80
	0	4.3	17.4	60.9	17.4	2.1	0.7	
4. Less time for observing patients.	2.0	2.0	8.0	56.0	32.0	1.9	0.8	0.90
	0	43.0	0	52.2	43.5	1.7	0.7	
5. Helped formulate plans and programmes.	12.0	48.0	16.0	24.0	0	2.5	1.0	0.65
	13.0	39.1	17.4	30.4	0	2.7	1.1	
6. Helped plan effectively in general.	6.0	54.0	20.0	20.0	0	2.5	0.8	0.14
	4.3	60.9	21.7	13.0	0	2.4	0.8	
7. Helped clarify policy.	8.0	34.0	26.0	32.0	0	2.8	1.0	0.72
	8.7	34.8	21.7	34.8	0	2.8	1.0	
8. Confusing to work.	0	2.0	4.0	74.0	20.0	1.9	0.6	0.89
	0	4.3	4.3	60.9	30.4	1.8	0.7	

	Strongly Agree	Agree	Uncer tain	Dis- agree	Strongly Dis- Agree	Mean	Standard Deviation	Chi Sq
	%	%	%	%	%	%	%	%
9. Helped express views about patients.	10.0	78.0	4.0	8.0	0	2.1	0.4	0.67
	17.4	73.9	8.7	0	0	2.0	0.7	
10. Helped question judgements.	10.0	48.0	14.0	26.0	2.0	2.6	1.0	0.80
	13.0	43.5	13.0	30.4	0	2.6	1.1	
11. Gives a long term view of care.	10.00	80.0	6.0	4.0	0	2.0	0.6	0.97
	13.0	78.3	4.3	4.3	0	2.0	0.6	
Impact on Staff Relations:								
12. Lowered morale.	2.0	2.0	18.0	72.0	6.0	2.3	0.81	0.34
	0	4.3	21.7	65.2	8.7	2.3	0.81	
13. Promoted staff discussion.	20.0	54.0	8.0	18.0	0	2.2	1.0	0.45
	26.1	56.5	4.3	13.0	0	2.0	0.9	
14. Improved work with ward staff.	2.0	28.0	24.0	38.0	8.0	3.2	1.0	0.57
	4.3	26.1	30.4	34.8	4.3	3.1	1.0	
15. More aware of others opinions.	6.0	64.0	8.0	20.0	2.0	2.5	1.0	0.21
	8.7	60.9	4.3	21.7	4.3	2.5	1.1	
16. Alienated from medical staff.	0	8.3	10.4	60.4	20.8	2.1	0.8	0.14
	0	13.6	9.1	59.1	18.2	2.2	0.8	
17. Improved relationship with psychologists.	0	25.5	12.8	46.8	14.9	3.5	1.0	0.36
	0	34.8	8.7	39.1	17.4	3.4	1.2	
18. Made staff more committed.	4.0	44.0	14.0	34.0	4.0	2.9	1.1	0.63
	0	47.8	8.7	39.1	4.3	3.0	0.9	
19. Helped communication with senior nurses.	2.0	50.0	18.0	24.0	6.0	2.8	1.0	0.72
	4.3	60.9	8.7	21.7	4.3	2.6	1.0	

General Comments	Strongly Agree	Agree	Uncer tain	Dis- agree	Strongly Dis- Agree	Mean	Standard Devia tion	Chi Sq
	%	%	%	%	%	%	%	%
20. Had no effect on work.	2.0	22.0	24.0	40.0	12.0	2.6	1.0	0.56
	0	17.4	21.7	52.2	8.7	2.5	0.8	
21. Wasted time.	0	6.0	18.0	64.0	12.0	2.2	0.7	0.85
	0	0	26.1	56.5	17.4	2.1	0.7	
22. Drawn information together.	10.0	48.0	14.0	26.0	2.0	2.6	1.0	0.80
	8.7	65.2	17.4	8.7	0	2.3	0.8	

Discussion

In general staff agreed that the C.I.I. did have an impact on their work. Several of the questions are directly related to the claims of the C.I.I. Below is a comparison of the views of nurses from the last questionnaire results and results from all questionnaires.

Figure 19

1. Does the C.I.I. provide a useful framework?

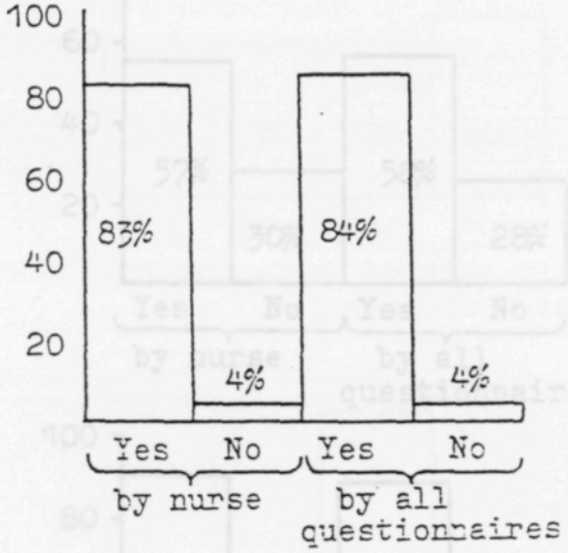


Figure 20

2. Helped formulate plans and programmes.

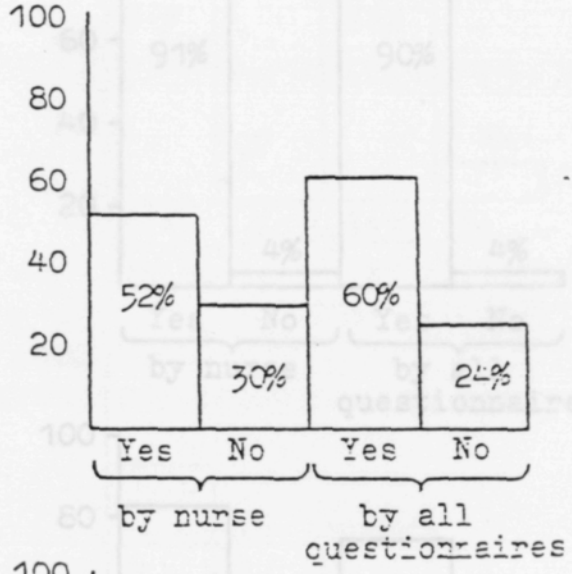


Figure 21

3. Help clarify policy

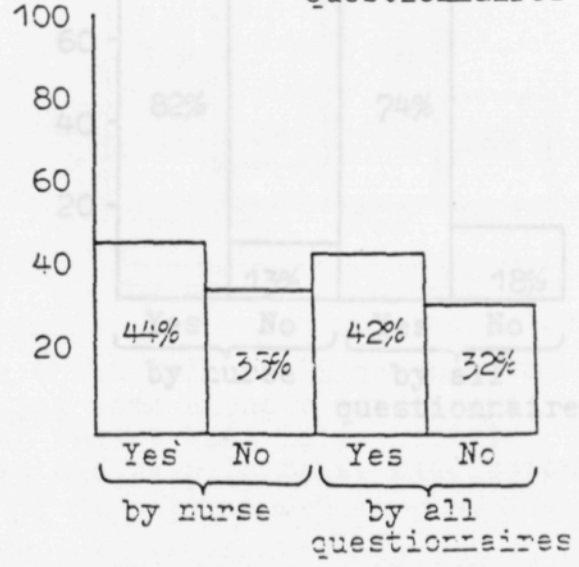


Figure 22

4. Help question judgements.

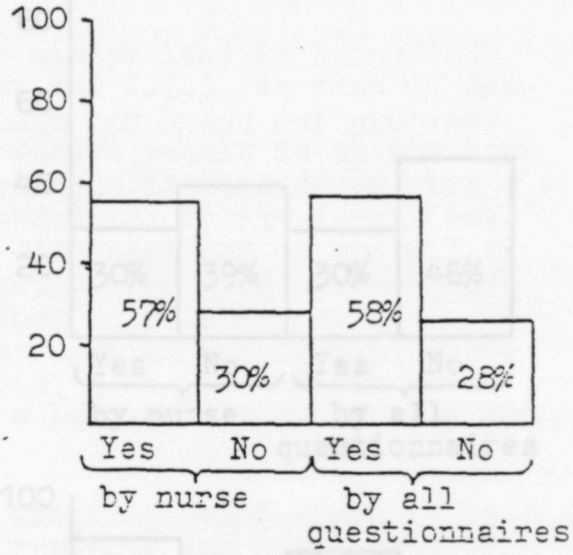


Figure 23

5. Gave a long-term view of care.

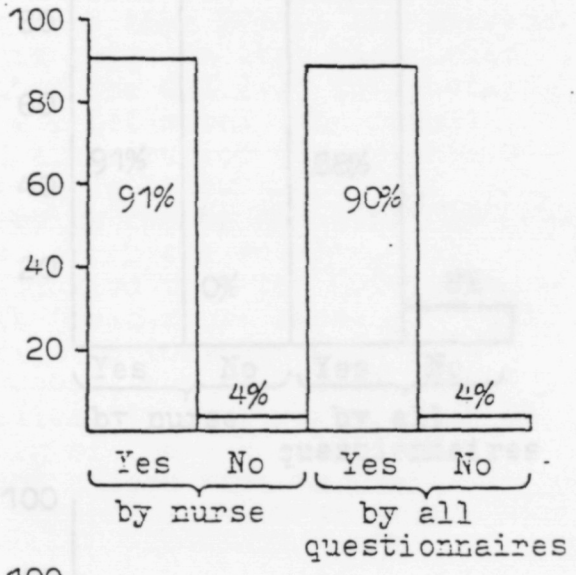


Figure 24

6. Promoted staff discussion

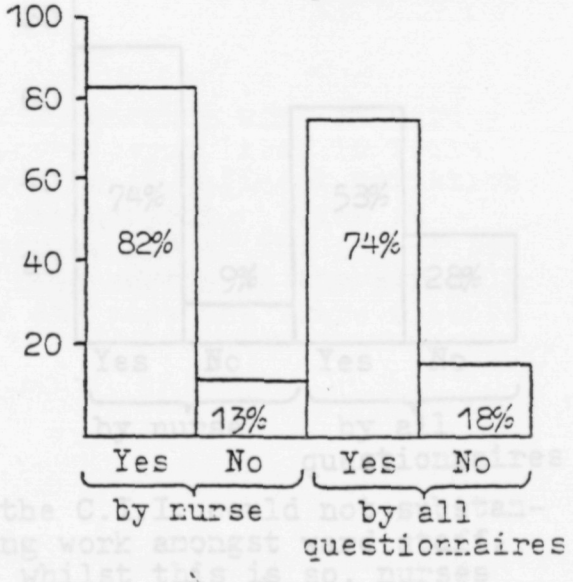


Figure 25

9. Improved work with ward staff.

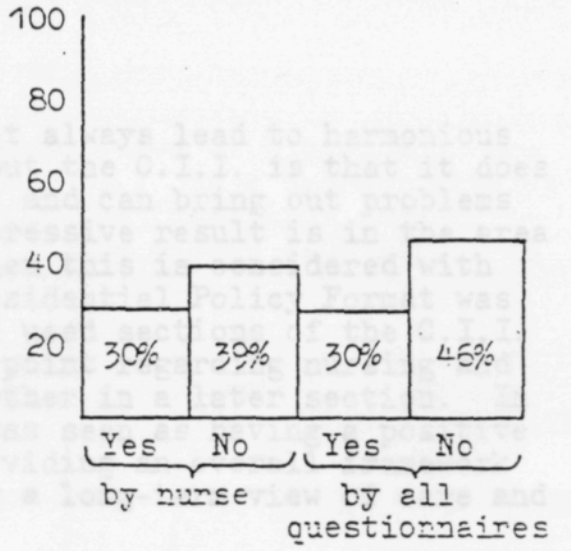


Figure 26

10. Help express view about patients.

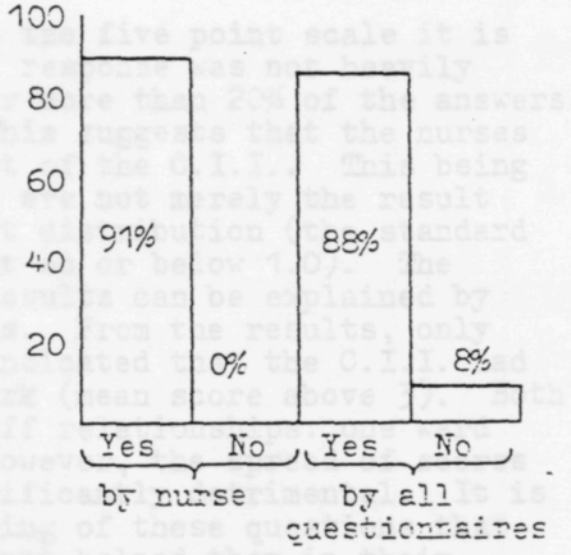
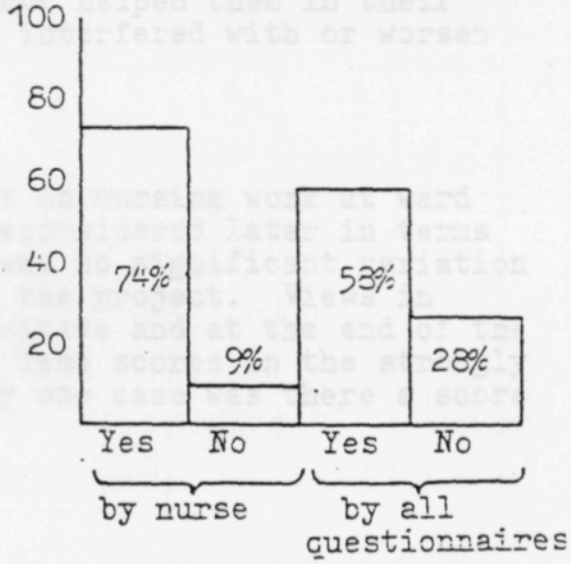


Figure 27

11. Help draw information together previously disparate.



Therefore, the only area where the C.I.I. could not substantiate its claims was in improving work amongst ward staff. It is interesting to note that whilst this is so, nurses reported overwhelmingly that it did help increase discussion.

Clearly, this discussion did not always lead to harmonious working. One of the points about the C.I.I. is that it does make working practices explicit and can bring out problems hitherto hidden. Another unimpressive result is in the area of clarification of policy. When this is considered with the previous result that the Residential Policy Format was one of the least understood and used sections of the C.I.I. it is not so surprising. This point regarding nursing and policy setting is discussed further in a later section. In all other aspects, the C.I.I. was seen as having a positive impact. Particularly so in providing an overall framework to look at nursing work, giving a long-term view of care and drawing information together.

Looking at all the questions on the five point scale it is noticeable that the 'uncertain' response was not heavily used. Rarely did it account for more than 20% of the answers (9 out of 44 possibilities). This suggests that the nurses had definite views on the impact of the C.I.I.. This being so, the positive impact ratings are not merely the result of mean scores taken from a flat distribution (the standard deviation is more often than not on or below 1.0). The almost bi-modal nature of the results can be explained by the differing views of hospitals. From the results, only two questions in this section indicated that the C.I.I. had a negative effect on nursing work (mean score above 3). Both of these are concerned with staff relationships: one ward staff, one psychology staff. However, the spread of scores suggests that this was not significantly detrimental. It is important to note from the wording of these questions that the staff reported that it had not helped them in their relationship rather than it had interfered with or worsen the relationship.

Conclusion

The C.I.I. had a positive effect on nursing work at ward level. These results will be reconsidered later in terms of each hospital. Also, there was no significant variation in attitudes over the course of the project. Views in general became slightly more positive and at the end of the data collection there were even less scores in the strongly negative category indeed in only one case was there a score of above 10%.

6. General views of use

Introduction

This section refers to the nurses' views of the general use of the C.I.I.. It considers the C.I.I. in a broader setting than the nurses' own ward. Again the first line shows results from all questionnaires. The second line refers to results from the last questionnaire.

	Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree	Mean	Standard Deviation	Chi Sq
	%	%	%	%	%	%	%	%
1. It should be used by all ward staff in hospital.	8.2	44.9	30.6	14.3	2.0	2.6	0.9	0.88
	4.3	47.8	30.4	13.0	4.3	2.6	0.9	
2. It should not be used outside hospital	0	2.0	18.4	69.4	10.2	2.1	0.6	0.97
	0	0	17.4	65.2	17.4	2.0	0.6	
3. It requires more training before use.	8.2	63.3	14.3	12.2	2.0	3.6	0.9	0.59
	8.7	69.6	13.0	8.7	0	3.8	0.7	
4. It should only be used on training ward.	0	2.0	4.0	88.0	6.0	2.0	0.5	0.55
	0	4.3	8.7	82.6	4.3	2.2	0.7	
5. All ward staff should be involved.	38.0	62.0	0	0	0	1.6	0.5	0.96
	39.1	60.9	0	0	0	1.6	0.5	
6. parents/families should not be involved.	4.0	6.0	28.0	60.0	2.0	2.5	0.9	0.93
	0	4.3	26.1	65.2	4.3	2.5	0.8	
7. Patients should know they are being assessed.	8.0	52.0	18.0	22.0	0	2.5	0.9	0.87
	4.3	52.2	30.4	13.0	0.	2.5	0.8	
8. There is no need to involve ATC, school, work, etc.	0	2.0	20.0	68.0	10.0	2.1	0.6	0.64
	0	0	26.1	65.2	8.7	2.2	0.6	

	Strongly Agree	Agree	Uncer tain	Dis- Agree	Strongly Dis- Agree	Mean	Standard Devi- tion	Chi Sq
	%	%	%	%	%	%	%	%
9. It is a useful contribution to assessment.	20.0	76.0	4.0	0	0	1.8	0.5	0.86
	30.4	69.6	0	0	0	1.7	0.5	
10. Nurses should not be required to formally assess patients.	0	4.0	8.0	88.0	30.0	1.9	0.7	0.67
	0	8.7	13.0	56.5	21.7	2.1	0.8	
11. It is helpful when considering transfer.	12.5	37.5	35.4	12.5	2.1	2.5	0.9	0.36
	9.5	38.1	33.3	14.3	4.8	2.7	1.0	
12. It gives a true picture of strengths and weaknesses.	22.0	68.0	8.0	2.0	0	1.9	0.6	0.37
	26.1	56.5	13.0	4.3	0	1.9	0.8	

Discussion

Again the views on the wider use of the C.I.I. were very favourable. Nurses thought that it should be used more widely both within the hospitals and outside. The results show that nurses think it should not be restricted to training wards and that all ward staff should ideally be involved. They saw no reason why parents/families should not be involved or that patients should not know they were being assessed. They saw good reason to involve outside agencies like ATCs, school and work and on balance thought it was useful in making transfer decisions. They thought it gave a true picture of patients' strengths and weaknesses and saw it as a useful contribution to assessment which they felt was part of nursing work. However, they did think it required training before staff could use it.

Figure 28

a. Should be used by all ward staff in hospital.

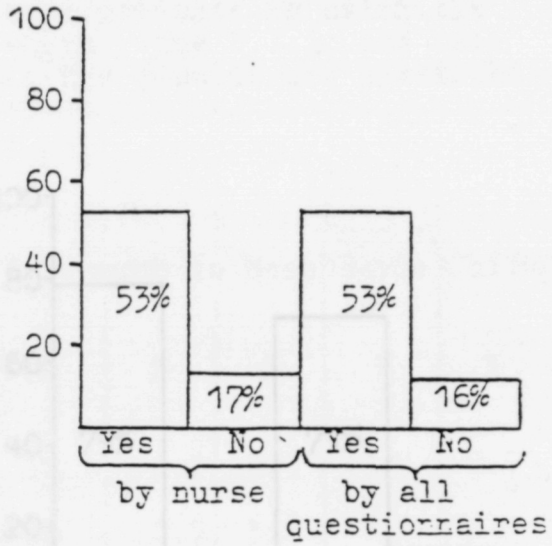


Figure 29

b. All ward staff should be involved.

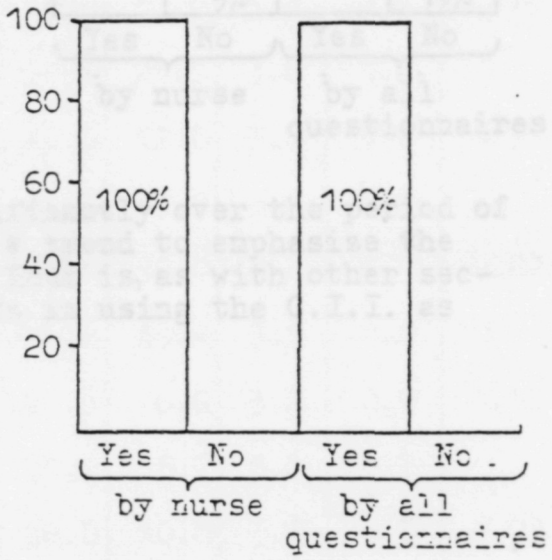


Figure 30

c. Gives a true picture.

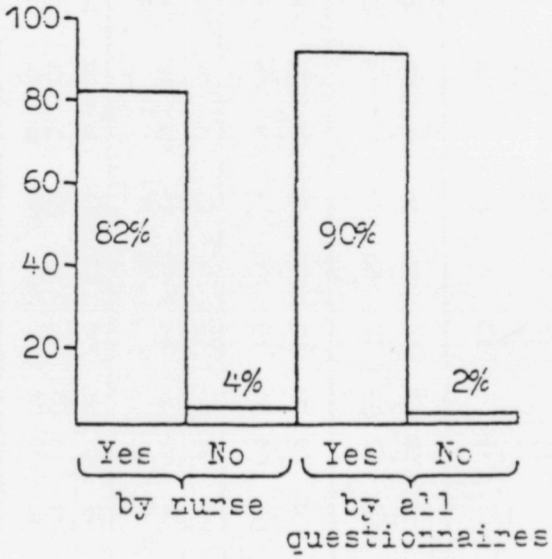
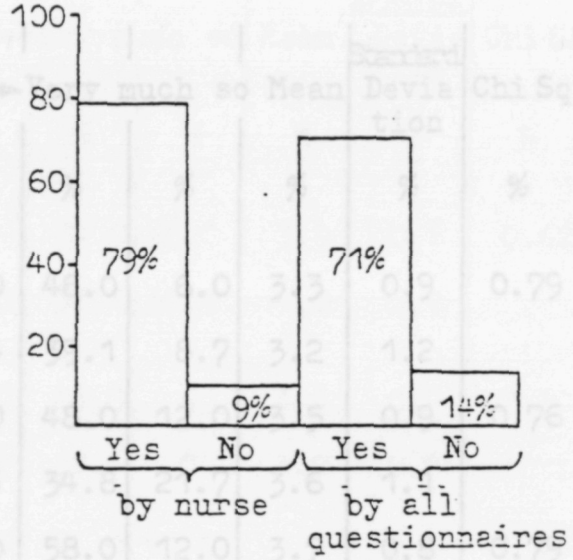


Figure 31

d. Requires more training.



None of these views altered significantly over the period of the research but again there was a trend to emphasize the positive results of the C.I.I.. That is, as with other sections, the nurses saw more benefits in using the C.I.I. as they became familiar with it.

7. Benefit to patients

This section considers the benefits to patients by using the C.I.I.. Nurses were asked to say whether the C.I.I. has been helpful in achieving the following. The results are presented as for the previous two sections.

	Not at all ← → Very much so					Mean	Standard Deviation	Chi Sq
	%	%	%	%	%	%	%	%
1. Spending more time with patients.	6.0	14.0	28.0	46.0	6.0	3.3	0.9	0.79
	13.0	8.7	30.4	39.1	8.7	3.2	1.2	
2. Improving patients personal hygiene	2.0	14.0	24.0	48.0	12.0	3.5	0.9	0.76
	4.3	13.0	26.1	34.8	21.7	3.6	1.1	
3. Improving domestic skills.	2.0	6.0	22.0	58.0	12.0	3.7	0.8	0.79
	4.3	4.3	30.4	47.8	13.0	3.6	0.9	
4. Improving social skills	2.0	6.0	22.0	54.0	16.0	3.8	0.9	0.87
	4.3	4.3	21.7	52.2	17.4	3.7	1.0	
5. Improving patients view of themselves	4.0	12.0	54.0	24.0	6.0	3.2	0.9	0.48
	4.3	4.3	60.9	21.7	8.7	3.3	0.9	
6. General patients general behaviour.	2.0	10.0	50.0	28.0	10.0	3.3	0.9	0.77
	4.3	8.7	56.5	17.4	13.0	3.3	0.9	
7. Improving high dependency patients.	8.2	10.2	34.7	40.8	6.1	3.3	1.0	0.50
	9.1	9.1	31.8	40.9	9.1	3.3	1.1	
8. Improving low dependency patients.	2.0	2.0	48.0	36.0	12.0	3.5	0.8	0.63
	4.3	0	43.5	34.8	17.4	3.6	0.9	
9. Improving highly disturbed patients.	8.2	14.3	61.2	14.3	2.0	2.9	0.8	0.42
	13.6	9.1	54.5	18.2	4.5	2.9	1.0	
10. Allows patient more freedom.	2.0	10.0	32.0	50.0	6.0	3.5	0.8	0.16
	4.3	4.3	34.8	47.8	8.7	3.5	0.9	
11. Help patients take opportunities.	2.0	6.0	24.0	52.0	16.0	3.7	0.9	0.97
	4.3	4.3	17.4	43.5	30.4	3.9	1.0	

	Not at all ← → Very much so					Mean	Standard Deviation	Chi Sq
	%	%	%	%	%	%	%	%
12. Offering considered programmes and plans.	2.0	2.0	14.0	64.0	18.0	3.9	0.8	0.62
	4.3	0	13.0	52.2	30.4	4.0	0.9	
13. Helping patients tolerate each other.	4.0	8.0	60.0	28.0	0	3.1	0.7	0.30
	8.7	8.7	52.2	30.4	0	3.0	0.9	
14. Opens up future placement.	2.0	4.0	30.0	54.0	10.0	3.7	0.8	0.77
	4.3	0	17.4	69.6	8.7	3.8	0.8	
15. Gives a more complete picture.	0	2.0	18.0	64.0	16.0	3.9	0.7	0.48
	0	4.3	17.4	69.6	8.7	3.8	0.7	

Average mean for nurses = 3.50

Average mean for Questionnaires = 3.48

Combined mean =

$$\frac{\text{Nurses} + \text{Questionnaires}}{2} = 3.49$$

Rank ordering these results in the following table:

1.	offering considered programmes and plans	very helpful
2.	giving a complete picture	
3.	helping patients take opportunities	
4.	improving patients social skills	
	considering future placement	
6.	improving domestic skills	
7.	improving personal hygiene	
	improving low dependency patients	
9.	allowing patients more freedom	helpful
10.	improving high dependency patients	
	improving patients view of themselves	
	improving patients general behaviour	
	spending more time with patients	
14.	helping patients tolerate each other	uncertain but not negative
15.	improving highly disturbed patients.	

Discussion

The C.I.I. does not claim to be of direct benefit to patients. That is, filling in a form does not in itself immediately improve anyone's life. However, as should become clear throughout the report, the C.I.I. should be instrumental in improving patient care; by helping staff organise their thoughts, consider and question their work and plan more effective programmes. Consequently, it is not surprising that the results of the questionnaire show the C.I.I. was most helpful in "offering considered programmes".

The other major benefit was pointing to new opportunities. This is one of the main features of the C.I.I. and so this result substantiates one of its main claims. Staff also found the C.I.I. very helpful in specific areas: improving social and domestic skills and personal hygiene. Again the C.I.I. does not tell staff how to do this and so the interpretation is that the C.I.I. helped staff consider and organise plans in these particular areas.

Overall staff were very positive about the C.I.I.'s instrumental benefits to patients. Even the lowest rating - improving highly disturbed patients' behaviour - was only 0.1 below the mid point on the scale. Therefore, although this was very slightly more unhelpful than helpful it was the only area reported as such.

It can be concluded, therefore, that the nurses felt the C.I.I. was helpful in achieving improved patient care.

8. The place of assessment

Two of the starting assumptions of the C.I.I. are:

i. That it is requisite to complete written information regarding individual patient care and progress;

ii. That this can and should be done by nurses at ward level.

This of course is not limited to the C.I.I. - any ward based assessment system would require this (for example, the PAC). However, if nursing staff do not share these assumptions they are unlikely to be favourably disposed to any assessment forms. Already assumption ii. was tested in a previous section (section 6, question 10)

"nurses should not be required to formally assess patients."

As reported 78% of nurses either disagreed or strongly disagreed. However, 9% agreed and a further 13% were uncertain. Therefore, it is reasonable to assume that 22% of the sample of nurses were not favourably disposed to formal ward based assessment by nurses of any kind. This is not a black and white issue and consequently, nurses were asked to state their opinion regarding the place of assessment. They were asked whether the saw formal assessment as:

i. a necessary and integral part of their work;

ii. necessary but separate from daily work;

iii. useful if possible;

iv. neither useful nor harmful;

v. not part of nursing work.

Only a score of 1 would be fully consistent with the values expressed and implicit in the C.I.I.

The results of this question were as follows:

Figure 32

Total Sample: 50 questionnaires

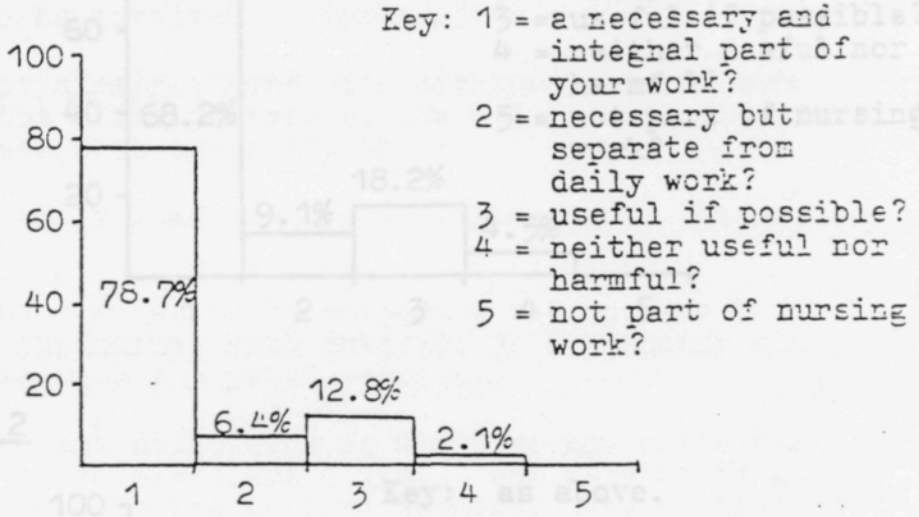


Figure 33

By nurse: total sample 23 nurses

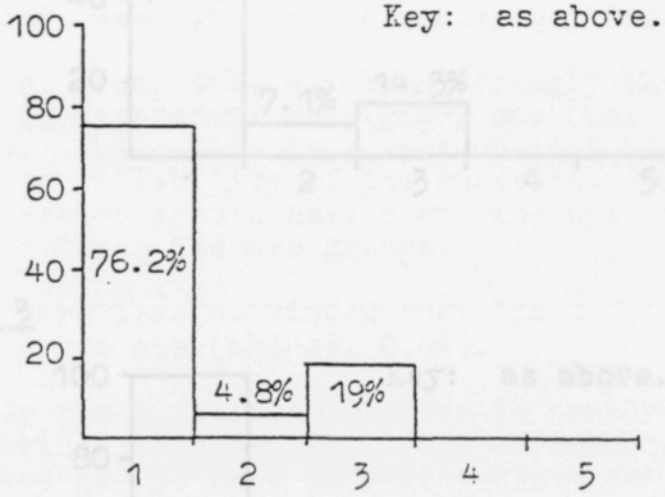


Figure 34

By questionnaire number: Questionnaire No. 1

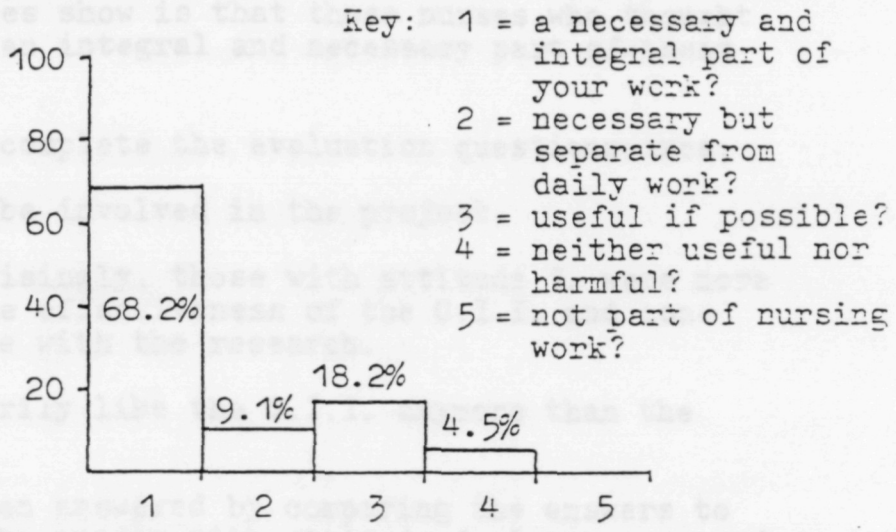


Figure 35

Questionnaire No. 2

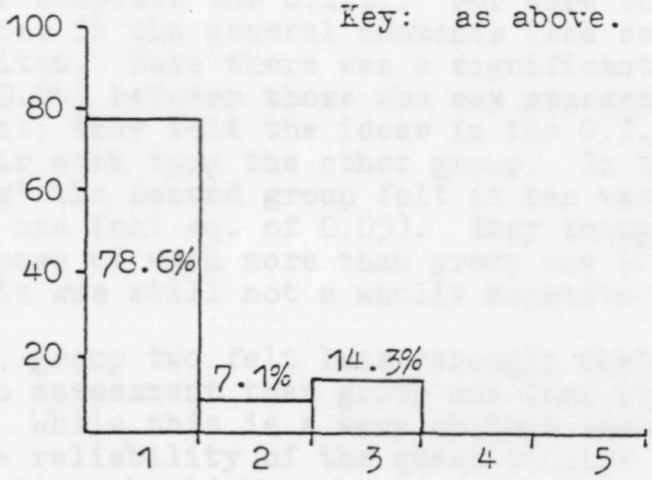
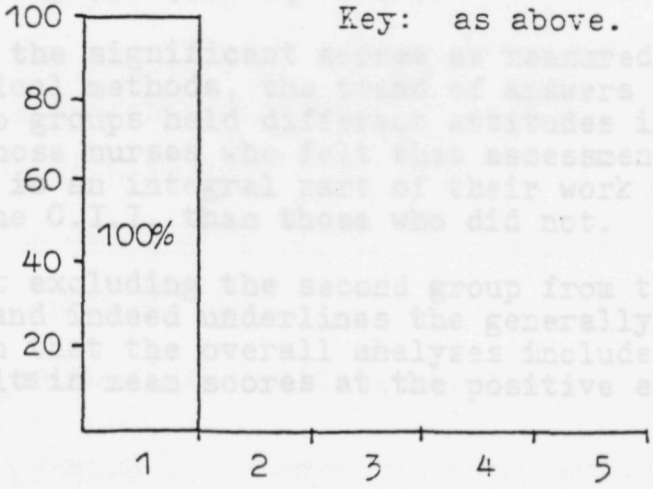


Figure 36

Questionnaire No. 3



This does not mean that there was a shift of attitude in the project. What it does show is that those nurses who thought that assessment was an integral and necessary part of their work:

a. continued to complete the evaluation questionnaires;

and b. continued to be involved in the project.

Therefore, not surprisingly, those with attitude 1. were more committed to test the effectiveness of the C.I.I. and continued to collaborate with the research.

But did they necessarily like the C.I.I. anymore than the other nurses?

This question has been answered by comparing the answers to all questions from the nurses with attitude 1. (necessary and integral) with those with any other opinion.

There was no significant difference in these groups concerning how long they took to complete the C.I.I.. Nor were there any significant differences in the general comments (see section 3) except for the last item. Here there was a significant difference (chi sq. of 0.04) between those who saw assessment as necessary and integral; they felt the ideas in the C.I.I. were more relevant to their work than the other group. In the section on "time wasting" the second group felt it has wasted more time than group one (chi sq. of 0.05). They thought it had confused the purpose of work more than group one (chi sq. of 0.04) although this was still not a wholly negative view.

As would be expected, group two felt less strongly that nurses should be involved in assessment than group one (chi sq. 0.005 - highly significant). While this is a very obvious result it does help to show the reliability of the questionnaire itself. This cross-check question should have been, and was, a very good discriminator between the two groups.

Finally, group two were less convinced that the C.I.I. improved social skills than group one (chi sq. 0.04).

While these are only the significant scores as measured by conventional statistical methods, the trend of answers suggested that these two groups held different attitudes in general. That is, those nurses who felt that assessment by nurses at ward level is an integral part of their work were more favourable to the C.I.I. than those who did not.

This does not warrant excluding the second group from the analysis of results and indeed underlines the generally favourable results given that the overall analyses includes this group and still results in mean scores at the positive end of the scale.

9. The C.I.I. and other approaches

Experience of Other Forms

Nearly all the nurses had some experience of other methods of assessment:

41% had used other published forms

45% had used published forms and their own

9% had used their own (only)

5% had no experience of formal assessment.

Comparison

From its original design the C.I.I. was not seen as in direct competition with other methods. It was designed to be as complementary as possible and to fill a gap in assessment. This was reflected in the answers from nurses:

15% thought it was better than anything else;

15% thought it was comparable to other methods;

8% thought it was not as good as other methods; and

62% thought it was best used in combination with other methods.

Problems

Overall nurses reported that they did not have serious problems of co-operation when completing the C.I.I.

i.	Ward staff	61% no problem
		39% problems
ii.	Senior nursing staff	69% no problem
		31% problems
iii.	Other staff	76% no problem
		24% problems.

In relation to the research staff:

92% said they had no problem contacting research staff

8% said they had problems; and

96% said they had no problem obtaining materials from research staff

4% said they had problems.

One result which checked a previous question on training reinforced the need for guidance:

12% said they did not need further help; but

88% said they needed further guidance i.e. beyond the printed material.

In particular, staff reported they would like:

- more training on and off the ward;
- improvement in the manual;
- support during its use.

Most nurses required only some of the above and overall an approach is outlined later but the elements are:

i. a clearer manual with simpler forms;

ii. initial basic training off the ward prior to use;

iii. monitoring its use for the first period;

iv. refresher courses and an opportunity to discuss the C.I.I. with other users.

Apart from comments mentioned in previous sections (for example, impact of C.I.I. and general comments) the most popular request was to simplify the manual. However, 72% had no particular comment to make on the changing of the C.I.I..

The results so far have been analysed by looking at responses as a whole. When re-analysing the data by looking at certain variables, other interpretations can be made. As discussed previously, those nurses who thought assessment was a necessary and integral part of nursing work were, not surprisingly, more favourable to the C.I.I.. Similarly, the data can be analysed by questionnaire number, that is by looking at attitudes at different times during the project. It has already been shown that the time to complete the C.I.I. decreased with use. Again, not surprisingly, staff attitudes became more positive as time progressed. Although this was to be expected, it is important to substantiate these expectations as 'obvious expectations' can sometimes turn out to be false. Apart from the time to complete the C.I.I. there were not many significant changes during the research. This is partly because the staff attitudes were already quite positive by the time the first questionnaire was administered (on average about six months into the project and after three months use of the C.I.I.). However, there were some aspects which did change. First, by the end of the project nurses felt the C.I.I. was more clearly presented and had become much less confused (chi sq. 0.06). Secondly, by the end of the project staff thought they were getting the right amount of held (chi sq. 0.07). This does not undermine other comments concerning the need for training, especially during, or even before, initial use of the C.I.I.

Dependency

One of the major questions to be tested was whether the C.I.I. was more suitable for use on certain wards. As the original work had been concerned with designing a method of assessment for low dependency wards it was important to see if it was only helpful on such wards. The results of the overall questionnaire suggest that it was helpful for both high and low dependency patients although marginally better for low dependency. To look more specifically in this section of the analysis, the wards were divided into two groups. As can be seen from the sample, there were six high dependency wards, one low and five mixed. From these two groups were constructed:

Group 1 consisted of the six high dependency wards; and

Group 2 consisted of the low and five mixed wards.

The sample was biased towards high dependency wards and the overall results indicate that the C.I.I. is not limited to the care of low dependency mentally handicapped people.

In the results and discussion the groups are called 'high' and 'mixed'. Only the statistically significant results are presented.

	high	mixed	Chi sq.
1. Time to complete the C.I.I.	quicker		0.01
Manual			
2. Easy/difficult to use.	easier		0.07
3. C.I.I. manual logical/poorly organised.	more logical		0.01
4. Too much jargon/too simplistic.	about right		0.06
Impact on staff			
5. Useful framework to look at work.		more useful	0.01
6. Promoted staff discussion.		more discussion	0.003
7. Look at why I do things.		more questioning	0.01
8. Observation of patients.		more observation	0.04
9. Helped work better with ward staff		less so	0.09
10. General effect on work.		more effect	0.002
11. Helped express views to senior nurses.	more help		0.003
12. Helped question judgements.		more questioning	0.004

	high	mixed	Chi sq.
General Use			
13. Should be used by all ward staff in hospital.	stronger support		0.05
14. All ward staff should be involved.		stronger support	0.02
15. Families should be involved.	stronger support		0.001
16. True picture of strengths and weaknesses.		truer picture	0.02
Benefits to Patients			
17. Spend more time with patients.		agree	0.06
18. Improves social skills.		better	0.06
19. Improves opportunities for patients		more so	0.06

Discussion

The significant scores were quite interesting because the high dependency group were generally better able to cope with the manual and completing the charts. On examination this could be because of the nature of the activities chosen. Often high dependency patients' charts were simpler than others in that the categories were less ambigious. For example, lifting a fork may be easier to observe and assess than making a bed. Because the activities were more discrete this may have led to easier understanding and faster completion. However, the impact on the staff were more significant for the mixed dependency group. This may well reflect the need for more discussion partly because there is more ambiguity over observations. Also this group could be seen as having a 'greater potential' in the socially acceptable meaning of the phrase and there would be more room for discussion and argument. The mixed group found the charts less helpful in improving working relationships than the high dependency group. Again, it must be emphasized that these results are relative i.e. do not necessarily indicate opposing views.

Overall, it seems that the mixed dependency wards were characterised by staff groups who spend a longer time on assessment and discussion. The C.I.I. encouraged the process of debate amongst all ward staff while at the same time appearing beneficial to patients. The high dependency wards seemed to see the assessment as more task orientated. They completed it with less "fuss", were positive about its use but did not necessarily find this more beneficial to patients.

Therefore, it would seem that there is no reason to assume that one type of ward either prefers the C.I.I. or gains more from it. The work itself varies across wards and the C.I.I. can be complementary to various methods of working. It was hoped that the C.I.I. would be flexible enough to be used in different ways in different settings.

10. Analysis of results by hospital

Although the results of the questionnaire have been reviewed as a whole, the research visits and analysis of progress by ward suggest that there was a significant difference between hospitals. Before assuming that to be so, it is worth re-examining the questionnaire results by hospital.

First, the significant results are presented, listing the hospitals in terms of most ←→ least positive - 1st, 2nd or 3rd. Again, it must be emphasized that generally all three hospitals were positive to the C.I.I. and the results below do not necessarily reflect a negative attitude even for the 'third' hospital. The results are relative statements and do not argue against the conclusions drawn so far.

	Leavesden	Cell Barnes	Harperbury	Chi Sq.
1. Length of time to complete.	3rd	2nd	1st	0.001
Manual				
2. Ease of use.	3rd	1st	2nd	0.07
3. Clarity of presentation.	2nd	1st	3rd	0.002
4. Logical sequence.	3rd	1st	2nd	0.08
5. Appropriate style of writing.	3rd	1st	2nd	0.01
Impact				
6. Useful framework for work.	1st	2nd	3rd	0.04
7. Promoted staff discussion.	1st	2nd	3rd	0.0003
8. Made me look more closely at work.	2nd	1st	3rd	0.02
9. Helped me work better with ward staff.	3rd	1st	2nd	0.03
10. Helped plan more effectively.	2nd	1st	3rd	0.02
11. All staff are more committed to work.	3rd	1st	2nd	0.02
12. Helped clarify policy.	2nd	1st	3rd	0.002

	Leavesden	Cell Barnes	Harperbury	Chi Sq.
13. Not wasted time.	1st=	1st=	3rd	0.008
14. Helped express view to senior nurses.	3rd	2nd	1st	0.006
15. Helped question judgements.	2nd	1st	3rd	0.008
16. Helped long-term view of care.	1st	3rd	2nd	0.05
General Use				
17. Should involve all ward staff.	1st=	1st=	3rd	0.04
18. Patients should know.	2nd	1st	3rd	0.03
19. It is a useful for of assessment.	2nd	1st	3rd	0.05
20. Nurses should be required to assess patients.	1st	3rd	2nd	0.03
Benefits to Patients				
21. Helps high dependency patients.	3rd	2nd	1st	0.04
22. Allows patients more freedom.	3rd	1st	2nd	0.09
23. Expresses strengths and weaknesses.	3rd	1st	2nd	0.05
24. Place of assessment.	1st	3rd	2nd	0.1

Discussion

The results presented above are only the most significant. However, they reflect an underlying trend, even where the results are not as significant. First, the results are discussed in terms of the questionnaire and then in terms of the research visits.

From the questionnaire it can be seen that Harperbury took least time to complete the charts. Overall, Cell Barnes found the manual easiest to understand with the other two hospitals experiencing about the same amount of difficulty. The most interesting results are concerned with the overall impact of the C.I.I.. Cell Barnes reported most 'impact', then Leavesden and Harperbury significantly less. On most variables Cell Barnes and Leavesden were fairly close. While there was generally a positive view from all hospitals, Harperbury found the C.I.I. less helpful in promoting staff discussion, examining work, planning, policy making, making good use of time and questioning judgements. The surprising exception was on expressing views to senior nurses where Harperbury found it more helpful than the other two hospitals. Overall, Harperbury staff spent less time using the C.I.I. and derived less direct benefit from it.

In terms of general attitudes to the use of the C.I.I. Cell Barnes was the most positive and Harperbury the least. However the differences were not so marked and the general views of hospital staff were not as varied. Cell Barnes also found the C.I.I. of most direct benefit to patients, although again the difference over all the variables was not especially significant. Harperbury found it most helpful for highly dependent patients but there was a higher proportion of highly dependent patients on the Harperbury wards.

One interesting result is that the staff at Cell Barnes were personally less committed to assessment than the other two hospitals. At first sight this seems to undermine the result that: if nurses have a positive view to assessment they will find the C.I.I. most useful. However, it must be remembered that these results are by <u>hospital</u> and in fact there were nurses in each hospital who held views, either positive or negative against the trend of the hospital. Thus, for example, while Cell Barnes nurses in general were less sure that assessment was an integral part of assessment, one group of staff were both committed to assessment <u>and</u> very positive to the C.I.I.. Therefore, this one ward enhanced the positive view of the C.I.I. at Cell Barnes, but numerically was less influencial in the place of assessment as a variable on its own.

In general, the questionnaire results must be seen only as a guide. As statistical results, they do give an accurate general picture of attitudes but do not explain individual variations. Furthermore, they are in the main attitudes and opinions and as such do not perfectly predict (or in this case, perfectly reflect) actual behaviour.

11. Questionnaire Results: Open-ended questions

Most of the questions asked were closed, that is to say, they either asked for specific facts or required the respondent to state an opinion. There were however several questions which were open-ended. For example, "why do you work in the field of mental handicap?" and "what do you see as the purpose of your work?" Originally it was envisaged that these questions might be significant in distinguishing certain groups of nurses i.e. one particular reason might correlate with a positive or negative attitude to a certain aspect of the C.I.I.. However, the distribution of the scores, once coded, virtually precluded this as often a high proportion of results fell into one category. However, it is worth noting the answers to these questions. This section is not significant in terms of the usefulness of the C.I.I. but gives some idea of the nature of the sample using the C.I.I.

Question: Why do you work in the field of mental handicap?

1.	Make their life better	9.0%
2.	Help them in general	9.0%
3.	Help them with specific training	9.0%
4.	It is a rewarding job	30.5%
5.	Subject area is of interest	4.0%
6.	Wanted a professional career	4.0%
7.	Combination of above	13.0%
8.	No answer	21.5%

As can be seen, the largest single response was for a rewarding job. The results showed that despite difficulties there was an underlying feeling of job satisfaction. Some answers are reproduced below.

- "Why not! Its what I like doing and I'm good at it. Rewarding and meaningful."

- "In the first instance it was due to lack of any other job. Now I like it so much and find it so interesting. I have no thought of any other job."

- "I want to help the mentally handicapped person to lead a more normal life by being independent and making their own decisions."

- "I like to work with people and feel needed. I find satisfaction in my work to help mentally handicapped people to reach improvement and bring out this participation to the full. My biggest reward is that I feel they come to me with trust and

love for all their needs and share all their happiness. After a long time of training a standard is reached whereby the resident can go to a hostel or home. This is the best reward for me."

- "I work in the field of mental handicap because I know that some of the patients can be trained to do things for themselves, for example, self-help skills, personal hygiene, domestic chores, through a lot of encouragement and reassurance. Patience and tolerance is important."

- "When I started this job straight from college I only intended staying about six months; six months turned into six years.

Even though I entered this job originally as a 'fill-in' I had still had a vague notion that I was doing something worthwhile, something of a service to an area of human existence long condemned to the backwaters of public attention (and mine), something that would be of value to me in terms of personal development and experience.

The reasons I have stayed so long are connected to the fact that I chanced to be placed on a ward where those nebulous feelings and ambitions could, to an extent, be realised. The people I have worked with show a common will to push against the constraints and try to make things better.

The fact that I am on a children/adolescent ward has obviously been more interesting for me since it offers more potential for change (or perhaps it should be less resistance to change). There is also, I am sure, something of an attraction for me in acting the role of a part-time surrogate parent."

Question: <u>What do you see as the main purpose of your work</u>?

1. Prepare for life in the community	4.0%
2. Reach full potential through training	39.0%
3. Combination of help people to enjoy life and training	35.0%
4. Personal development of staff (career) and work objectives	9.0%
5. No answer	13.0%

Most staff reported a combination of purposes. 80% mentioned training, education, development or rehabilitation. That is, the sample saw their purpose as active; to help mentally handicapped people develop even if this was only in a very limited area. Many also mentioned that this should be done in the context of a "family atmosphere" or happy surroundings. Examples are as follows:

-"To get the patients to live their lives to their full potential with independency as to decision-making. Make sure that they develop as far as possible psychologically and socially create a family type environment."

-"Give patients a useful happy life. Enhance their present situation. Train and educate to maximum. Offer new experiences. Improve and develop skills. Train new nurses. Improve (and offer advice to) the environment. Improve the role of R.N.M.S."

-"To encourage patients to become more independent and take full advantage of any opportunity that is offerred to them. To supply a stable and happy ward within the hospital until such time as smaller units are provided within the community."

-"As Charge, I am responsible for running the ward as effectively as possible, promote health and design training programmes in conjunction with various teams in order to achieve full potential. To cut short, I act like a manager."

-"To understand the needs of the patients and stimulate a suitable environment while setting a pattern of therapeutic care and maintaining a high standard of living for all patients. Ensure the welfare and safety of all patients within the ward. Participate and fully support ongoing programmes i.e. patient training and recreations."

-"My main purpose of my work is to train patients to live as freely as a normal human being. Also to teach them how to behave in the public when they go out shopping or on holiday. As has been mentioned over and over again, given enough staff, I personally feel that these patients will improve where self-help skills are concerned."

-"There are two main strands in this, two strands that sometimes pull against each other but which are inextricably intertwined.

Firstly, (only because I have to put one first, not as an indication of priority) to care for the children i.e. to try to make their lives more enjoyable, more comfortable, to endeavour to create an environment within which self-expression and fulfilment of personal needs can take place.

Secondly, to make myself redundant, to develop enough independence in the children to make my presence superfluous - an unachievable goal, but one to work towards.

These are ideals, motivating forces that govern my role as a 'care-worker'."

The other open-ended questions were concerned with the C.I.I..

Question: Are there any specific alterations that should be made to the C.I.I.?

Most of the staff felt that they had already had the chance to comment on the specific aspects of the C.I.I. (see above - clarity of sections of the C.I.I.) and consequently most staff did not answer this question.

1.	No changes needed	4.0%
2.	Remove Development Programme	4.0%
3.	Provide activities on the chart	4.0%
4.	Clearer instructions	4.0%
5.	Remove the flow diagram	4.0%
6.	Shorten manual	4.0%
7.	No answer	76.0%

Of more interest was the question concerning general comments on the C.I.I..

Question: Are there further specific comments you would like to make about the C.I.I.?

1.	Too complicated	17.5%
2.	Needs more ward staff to operate	13.0%
3.	Takes too much time	4.0%
4.	Allows staff to decide content (positive)	9.0%
5.	Makes work easier to understand patients	4.0%
6.	No answer	52.5%

Some examples of comments are as follows:

- A useful and well thought out project. But it appears that we need to educate the higher ranks of staff to appreciate how useful it could be in the right environment.

- 'One of the better assessment techniques that I have come across. Allows for more freedom to ward staff to specify what they want to do and how they want to do it."

-"Basically an excellent idea. Charts take rather a long time to fill in. I find manual very lengthy and complicated. Charts promote healthy discussion between staff about patients."

- 'It still needs too much counselling. It looks more complicated than it actually is - an off-putting factor."

- 'The C.I.I. has helped me with my daily work even though at times its hard work and frustrating, especially when we are under staffed. It has helped me to find out what these patients can do and most probably they have always been overprotected by the nursing staff all those years. The involvement of the nursing staff is very important, and it has made them more committed to their work."

- 'The C.I.I. is a good form of training for residents provided there are enough staff to carry out training programmes for residents. The paper work is too much."

- 'Chart generally good - need people trained and experienced in chart readily available at hospital. Should be explained to all staff and they should be made willing/helped to use it."

The last open-ended question - Further remarks - again was not completed by the majority of staff (65% made no remark) as they felt the questionnaire had covered their views and opinions. Of those who answered, the following is a representative sample. (It is worth noting that there were no negative comments in this section.)

- 'Definitely a positive contribution because of:

  a) the assessment;

  b) the opportunity - it means that we look not only at what is given, but why and also why it is not a truthful picture of the opportunity we deny, even if we think it is denied for the best reasons."

- 'We are now finding the forms easier to use as time goes on. As far as I know there is no other assessment form that covers and records initiative and independence."

- 'Result is slow to come with charts. PAC was easier to use but staff began to lose interest. Individual programmes more benefit than any chart and strength of the C.I.I. is that it could help to design individual programmes."

- 'Have found that to obtain a true and detailed picture of a patient's behaviour, it is essential to have meetings involving all the staff. This ensures that all staff concerned are aware of the 'plan of action' and is able to

participate in this area. I feel that staffing levels have to be consistent in order to carry out the 'plan' effectively. Also there is a need for the consultants and doctors to appreciate the use of the charts especially the 'residential format'."

-"I found the programmes stimulating and positive. I regreted we were unable to devote more time to charting and carrying out the tasks. We were constantly short of nursing staff. It is for this reason that this research programme should not have been commenced without the active support of the DNC at whose request we undertook to carry this out. We were openly discouraged from starting by an SNO because of lack of staff. It was in this climate that the C.I.I. got underway. Not the best way to promote a therapeutic programme."

-"Given time and patience, in my opinion, I think the patients who are already involved in the C.I.I. will improve and benefit from the activities they are doing at the present moment. We also must have a lot of support from the senior nursing staff (we hope in the future)."

In conclusion, staff were asked:

"Overall do you think the C.I.I. is a positive contribution to the care of mentally handicapped people at ward level?"

The results were:

Yes	94.0%
No	0.0%
Don't know	6.0%
No answer	0.0%

THE CHART OF INITIATIVE AND INDEPENDENCE

Complete Manual (C.I.I.)

APPENDIX V

THE CHART OF INITIATIVE AND INDEPENDENCE
(published version)

I. Macdonald and T. Couchman

NFER Publishing Company

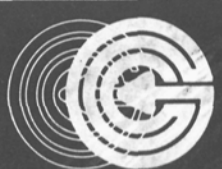


CHART OF INITIATIVE AND INDEPENDENCE

Manual for the

CHART OF INITIATIVE AND INDEPENDENCE (C.I.I.)

Including Manual of Activities

Ian Macdonald and Terry Couchman

NFER Publishing Company



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* Training Courses and Instruction on the use of the Charts are available from Macdonald and Couchman Associates 2 Glebe Road Uxbridge Middlesex. UB8 2RD Tel. UXB 37944 West Drayton 40650

CHART OF INITIATIVE AND INDEPENDENCE

THE CII MANUAL

Ian Macdonald and Terry Couchman

RESIDENTIAL ASSESSMENT FORMAT

PART I – INTRODUCTION

1. This manual is for the Chart of Initiative and Independence (CII) and is written to explain the use of the CII in its various forms. The CII is a product of a research project carried out at Leavesden Hospital, Hertfordshire, and in conjunction with the London Boroughs of Ealing, Harrow and Hillingdon. It has subsequently been revised and developed by further research and consultancy work.

2. The purpose of the CII is to record an assessment of environmental opportunities available to clients and to record an assessment of their current and potential use of those resources. This version of the CII has been developed for use with mentally handicapped adults although the concepts involved have wider implications and more general applicability in other residential settings.

3. This manual is divided into four sections, each relating to a particular form of the CII. These sections are:

   I The Introduction which is complementary to:
   II The Individual Assessment Format (IAF)
   III The Development Programme Format (DPF)
   IV The Residential Policy Format (RPF)

   The relevant forms of the Chart should be viewed when reading this manual. These are reproduced in figures i to vii of appendix A.

4. The Manual of Activties is reproduced in appendix B. There is also a separate Manual of Activities available for use with any of the above formats. Case study examples of the use of charts are available in appendix C and the Preliminary Assessment Format, for use by field social workers, is reproduced in appendix D

How the CII has been developed and used

5. The forms of the CII have been developed and designed for staff, paid or voluntary, who have most contact, in time, with the mentally-handicapped person. This usually means hostel or ward staff but can include parents and/or day care staff. As mentioned above the chart grew out of a research project which had as its aim the design of a tool for recording the social behaviour of mentally handicapped adults which would provide information on which to base decisions regarding their readiness for transfer from hospital wards to intermediate units, and from intermediate units to hostel accommodation and other community housing. The research was based at Leavesden Hospital but included the hostels: Bessborough Road (Harrow), The Retreat (Hillingdon), and Parkhill (Ealing).

   The main question staff were concerned with was how to evaluate their work in terms of the development of the people in their care. They were particularly concerned to be able to answer this question within the context of day-to-day living and care. Consequently standardised clinical tests, while valuable, were not assessments made in the ongoing

ward/hostel environment. Further, the external judgements made about the quality of life and progress often tended to be based primarily on *physical* location. Hospitals were not seen to be 'as progressive' as hostels which were not 'as progressive' as group homes, etc. The research problem was to find a way of describing relationships which would not be so influenced by such assumptions about location. Now this is not to assume location plays no part, but we found that some patients in hospitals were allowed more freedom of action and choice and greater responsibility than others in hostels or in the community. Consequently, the mentally handicapped person cannot always assume that transfer to a hostel means a less restricted life. One of the few clues to this problem lay in the use of the word 'supervision'. This seemed a very woolly concept and had come to be easily misinterpreted when staff talked to each other, especially when staff were from different establishments. Despite these problems staff felt they often intuitively knew what progress was being made and whether they were achieving something with the people in their care. It was often very difficult to express this intuition clearly and they felt that to do so was crucial when handing the responsibility for care on to another person.

6. Of course the CII did not develop overnight, and the present version is the result of many modifications, but in response to the problems expressed above we felt that certain basic features were crucial.

6.1 Everyone needed to be clear about what it was they were observing.
Often staff assumed that they all shared an understanding of what made up a piece of behaviour, e.g. washing up. It turned out this was far from always the case. Some would include drying, some rinsing only, others extended the notion to include putting things away. This sometimes aroused conflict as to whether two staff thought a person had completed a task or not. It was also noticed that staff often assumed that a list of activities would be quick to draw up as they needed only to describe what was important in their work. This again proved to be no easy task. The process of describing and actively constructing a list of activities to be observed, was not seen as just a preliminary acitivity to be eventually replaced if *we* could design an 'accurate enough' list. Staff found that the process itself was a useful, if sometimes frustrating exercise, which helped them to share a common focus and discuss and argue about the importance of certain activities. This is why the process has become a prescribed part of the CII and the Manual of Activities is seen only as an aid to this process and a guide to writing your own activities.

6.2. Activities are not just 'can's' or 'can'ts', neither are they clarified significantly by adding 'with' or 'without supervision'.
Staff found it more useful to consider under what circumstances results were achieved. This is essentially what the 'modes' are concerned with. Different *types* of supervision were described so that they reflected definite differences in a relationship. Now staff did not talk about more or less supervision but rather about the different types of relationships which they felt to be appropriate in a particular situation. This meant considering not only *what* a person did but *how* they did it. The different types of approach are described by the modes (see below). Consequently the staff could not only describe whether a person could do any activity or not but also how much involvement was needed on their own part. This led onto the next point:

6.3. Assessment in the living situation needs to include a personalised statement of the staff's behaviour.
As the research proceeded it became clear that it was not enough to specify the handicapped person's behaviour. On the ward, or in a hostel no one lives in a vacuum. Social relationships, by definition, include the interactive behaviour of others. Also ward or hostel life cannot be 'standardised' in the same way as the conditions in a clinical assessment. This is how the 'level of opportunity' in the CII developed. Here the level of opportunity refers to the limitations set by staff. 'Limitation' was not and is not seen in a

negative way, it is not synonymous with restriction. All staff set some sort of boundaries, however broad, and this was a way of making those boundaries explicit so that they could be changed when necessary. This left one more major consideration:

6.4. Assessment in the living situation needs to include the staff's expectations.
Although we now had descriptions of the specific behaviour of the staff and the handicapped person we realised that, in any relationship, evaluation is not purely concerned with clear observable 'facts'. Staff reaction to their own and patients'/ clients' behaviour was influenced by their assessment of whether that behaviour was representative of optimum functioning. For example, if two people (lets say A and B) both need to be told to cook a snack and how they should cook it, the relationship will feel very different if the staff member believes that Mr A is doing the best he can while Mr B is quite capable of making the decisions for himself and carrying through the activity. The problem here was that there was often no obvious evidence to back up these feelings. However these feelings were sometimes the main force which motivated the staff member to continue with their help for the person. This tended to relegate expectations to the world of subjectivity which traditionally is not part of an assessment procedure. Instead we decided to separate out staff expectations and use them (Present Potential) to compare with behaviour and level of opportunity.

6.5. Assessment statements are made within a context of overall policy.
Just as it is difficult to know the meaning of individual behaviour and relationships without reference to any expectations, it is also difficult to know the meaning of behaviour *and* expectations without reference to the overall policy of a hostel or ward. We needed to ask the staff whether they felt that their work was primarily concerned with caring for low or high dependency groups of people. For example, suppose you have the task of designing a training programme to help a person to use a spoon when eating. This task will be felt to be very different according to the overall policy of the hostel or ward. If the policy is to care for highly dependent people the achievement of such a programme will be more central to the aims of the hostel/ward than if the hostel/ward is caring for a low dependency group. In the latter case the programme will be a precusor to the 'real' work of the hostel/ward. In this way we used the activities and the modes to describe the upper and lower limits of the types of relationships that staff felt they should be engaged in. This also proved to be a far from simple matter in practice. Again this is regarded as an integral part of the process of assessment and not merely a preliminary to a 'real' assessment.

6.6. The assessment procedure itself is action orientated.
The staff were concerned that assessments did not become labels and that once carried out, assessment would be over. To this end the process continued by setting targets based on assessments and served to alter or at least question expectations and assumptions. This was the part which removed the notion of assessment from the realm of the one-off specialised activity, and made it consistent with the ongoing activity of the staff. Each assessment made was not complete until a further assessment had been made as to where the person might be in x months/ weeks time. This then served as a comparison for the next formalised assessment at the end of the target time. In this way the staff had a method of evaluating their work.

6.7. Methodology.
The above account explains retrospectivley a set of concepts which emerged. As we have pointed out earlier these did not emerge overnight. The process originally started by the staff being dissatisfied with existing forms of assessment. Their dissatisfaction led to funds being raised for the original project from the DHSS by Miss A. Lancaster, then Regional Nursing Research Liaison Officer for the North West Thames Regional Health Authority after discussions with nursing officers at the Region and at Leavesden Hospital.

The research methodology used was based on the Social Analytic approach.[1] This meant that all formulations were tested as they arose with staff in the hospital and the Boroughs, tried out in action and then, where necessary, modified. It was not until near the end of the first year of the project that a full version was ready for testing. Since then the Chart has been further modified in the light of working experience, in other health and social services settings to its present form which although in its appearance is a far cry from the original, in essence is substantially the same as the main principles have stood up to testing in those settings.[2]

7. There are three main uses for the CII (using all three formats).
   A) To assess whether a provisional placement is appropriate.[3]
   B) To provide information with regard to the readiness of a client to move from their present context.
   C) To record ongoing assessments with no transfer decision as a necessary outcome.

8. The basis of the three formats of the CII is the analysis of modes for the *Level of Opportunity, Behaviour and Present Pariential* with regard to certain activities. In summary, they are as described on page 15, where the reference to 'this' refers to any specific activity, e.g. a catering activity, like making a cup of tea.

9. The first task for any of the three formats is to compile 'a list of activities' using the *Manual of Activities*. The *method* of agreeing on the range of activities is not standardised to allow for maximum flexibility in each situation, the inevitable variation within each residential establishment and differences among clients' needs.

[1]See Social Analysis by R. W. Rowbottom, Heinemann 1977.

[2]For a further discussion see Chapter 14 'Health Services' edited by E. Jaques, Heinemann 1978 and 'Levels of Abstraction in Logic and Human Action' edited by E. Jaques, Heinemann 1978 [Chapter 18].

[3]This may be used with a further version of the CII: the Preliminary Assessment Format for use by Social Workers in a Field Setting. (See appendix D).

THE INDIVIDUAL ASSESSMENT FORMAT (IAF)

1. This form is to record a client's behaviour, the level of opportunity offered in this environment and his or her present, potential and optimum modes of functioning.

2. As explained above, the first task is to decide on relevant activities as described in the Manual of Activities. Blank charts are provided because, in the initial stages, certain activities may be tried and rejected while others are added. Once a core of activities has been agreed upon charts can be written up to include these. These activities are written down the left hand side of the Chart, or the list reproduced and attached to the activities column.

3. To complete the Chart first fill in the details at the top:
   - 3.1 The client's name, date of birth and sex.
   - 3.2 The period of assessment, that is the time set for observation, not less than two weeks, and the number of the assessment, i.e. the first or second etc. in a sequence.
   - 3.3 The type of establishment: group home, hostel, ward, etc. This could be expanded to describe an overall level of opportunity, number of places, staffing, etc. Also add the address of the establishment.
   - 3.4 The contributors to the Chart include the staff member in charge of the establishment. This could also include the role, social, family relationship with the client.

4. Level of behaviour >

This refers to what you have actually seen the person doing. It is separated into a *goal* – the end point of behaviour – and *plan* – the means to that end. Using the general description on page 15:

- 4.1 *N* = where you have not observed the person engaged in this behaviour for the period of observation, nor has it been done for them.
- 4.2 *c/d* = is where you have not seen any initiative in setting a goal or following a plan even under instructions (complete dependency).
- 4.3 If a person's behaviour is *MODE A* this means that they will do nothing; remain passive unless someone else sets *goals and plans* for them; e.g. a person may sit in a chair unless someone else suggests that they make a cup of tea. When this has been suggested the person still needs to have the plan told or shown to them, step by step; boil the kettle, put the tea in the teapot, etc.
- 4.4 If a person's behaviour is *MODE B* then as far as the initiating of a goal is concerned, the situation is as above (*mode A*), i.e. the person is dependent on the outsider to set goals. However, if a goal is externally set, the person will attempt to find a way to achieve the goal. This may be in the form of a rote learned technique. Their effectiveness may depend on training or experience but the point is that the person *will* initiate a plan. The plan, however operated, will be characterised by an *absence* of self checks, i.e. continually stopping, waiting to be told what to do next. The person may ask questions or seek approval: 'Is it all right if I put orange juice on the table, not water?'.
- 4.5 If a person's behaviour is *MODE C* then again (with regard to specified activities) the person can act at self-determined times; i.e. *identify* and act on a need: e.g. wash when he/she thinks he/she is dirty. The characteristic of mode C is that the *goal and plan* are fixed, indeed welded together precluding alteration. It is a perception of the '*right* way to do something in relation to *me*'. A very simple, black and white value system is used. There is very little, if any, toleration of frustration. If the goals and plans of the person in mode C coincide with external events, that is by chance. There is no attempt to accommodate goals and plans to the needs of others. If there is a

change it will be the complete substitution of one way for another and the old way will now be rejected and perceived to be as useless and interfering as all others. If a staff member, for example, refuses permission to do something, this causes great stress and anxiety (which may be expressed aggressively or by withdrawal). It would create repeated requests and demands which are characterised by *repetition* and do not include the question *why,* as reasons are irrelevant. The experience is a war of attrition rather than an argument; a power struggle rather than a negotiation.

4.6 If a person's behaviour is *MODE D* there is not only an interpretation of *need* (as in mode C) but a realisation of the needs of others. However, this perception of others' needs is limited. It is limited in that the *plan only* is flexible. The goal is as fixed as in mode C. It is less egocentric than mode C but the toleration of delay and ability to cope with frustration breaks down if the *goal* itself is threatened. Thus a person may ask: 'Can I go to the shops?' If the reply is 'Yes, but can you wait until after lunch?', this could be tolerated. If, however, the answer raises doubts about the goal, 'Well, I don't know, you know you have visitors and you said you would cook the tea, etc.', then the anxiety, as in mode C, would begin to arise. Thus other people's needs can be accommodated but *only* if they do not threaten the goal which is self-determined.

4.7 If the behaviour of person is *MODE E* then the *goal* also can be modified according to his/her own needs and those of others. If a goal is frustrated, a substitution can be made: using soap, not shampoo: buying rice instead of potatoes: not going out because a surprise visitor has arrived. The point about this mode is that the substitution does not cause intolerable stress upon a person. They may be sad or disappointed but will not break down as in mode D, e.g. if a bus did not come. There may be argument but *also* toleration. Thus, although reasons may not be accepted at face value, there is an *understanding* of rational argument and the goal and the plan, initiated by the person, are *both* potentially open to modification and substitution. This mode concerns behaviour which is flexible and tolerant of frustration but *not* by a passive acceptance of authority.

4.8 An example which separates C, D and E is: if a person wanted to buy some chops and went to a particular shop and if that shop did not have chops, the mode C person would return frustrated and empty-handed. The mode D person would try another shop; if no shop had chops they would return empty-handed and frustrated. The person of mode E capacity would not *only* try other shops but would think of and buy a substitute; beefburgers or fish fingers, and would return with these.

4.9 The behavioural assessments are entered in the column under the appropriate letters using the > symbol. If, as is possible, the person behaves in more than one mode then this should be indicted. However, if the bahaviour is regarded to be very unusual it could instead be reported in the comment column.

5. Level of opportunity <

The next requirement is to state the present level of opportunity. *Present* means for the period of observation which culminates in the completion of the Chart. *The level of opportunity refers to the mode of relationship you have with a client.* The purpose of this section is to describe limits of discretion. The modes here do not necessarily relate directly to a person's capabilities, but to the limits set by you. These limits may be broad or narrow for many reasons: ward policy, personality, patient's capacity, staffing levels, legal restrictions, etc. What is most relevant is that you describe your relationship with an individual, over a period of time, as accurately as possible in terms of the modes specified.

5.1 The first column, 'N', means that for *any* reason you do not offer the person the opportunity to carry out an activity *but* nor do you do it for them. If for example a person was on a locked ward they may have had no opportunity to use local amenities. This would be recorded in the 'N' column.

5.2 If the opportunity is technically available but you actually carry out the activity on behalf of the person and, by implication, set the goal and plan, this is recorded in the column, 'c/d'. For example, in making a full meal, if the person is not allowed at present to prepare their own meal, because a cook prepares the food, this would be

recorded in this c/d column. Also if you intervene in an activity; e.g. making a cup of tea, to the extent that you *actually* boil the kettle, put in the tea, pour in the water, etc. Then this also is recorded in this column of opportunity. The reasons for your actions may be specified in the comments column.

5.3 If your relationship is in *MODE A,* this means that you set the goal and plan but you allow the person involved to carry out your goals and plans; that is, you either tell or show the person what to do *and* how to do it. For example, having a bath would include breaking the goal into smaller steps; put in the plug, turn on the taps, etc., the point being that the person is carrying out *your* instructions.

5.4 If your relationship is in *MODE B* you are setting the goals. This may be in the form of telling a person what to do and/or showing them your expectation of the end product. For example, you may say, 'I want you to make your bed to look like that one'. However, you leave it up to the person involved as to how he/she does it. You may, of course, be checking how he/she does it and if the goal has been achieved. However, if the checking or monitoring becomes active instruction, the relationship is mode A again. Another example of mode B is if you tell a person to lay the table but leave him/her to get on with it.

5.5 If your relationship is *MODE C* then you are no longer telling what and how to do things but leaving the initiative to the person; for example, here you do not tell a person to make him/herself a cup of tea but wait for him/her to do it in his/her own way. However, you do monitor both goal and plan; you check: is it a cup of tea? have the required ingredients been included? has boiling water been used? to the extent that the monitoring becomes active involvement, then the relationship becomes modes A or B again.

5.6 If your relationship is *MODE D* then as for mode C you wait for the person to initiate action. In this case you monitor the goal *only;* for example, if a person wants to go out, you will want to know where he is going and why: to buy food, clothes, etc.? If you were then to check as to *how* he/she was going to get there, for example by asking, 'Do you know which bus?', 'Can I see if you have enough money?', etc., this becomes a mode C relationship again.

5.7 Finally, if your relationship is *MODE E* then you initiate no action whatsoever. The person has total discretion over his life, to do well or make a mess of it. You wait and intervene *only* when invited to do so by the person. The monitoring to be done is of yourself only. You ask only, 'Am I making myself available enough?' or 'too available?' There is no monitoring of goals or plans unless specifically requested. It is perhaps best illustrated by a normal G.P.-patient relationship. The G.P. does not normally check on you to see if you are all right because you have not been to see him for a year. You decide for yourself if you think you need to see a doctor. However, once you have asked for his involvement this may require specification. If you do begin to actively monitor, the relationship may become mode C or D.

5.8 Again, as with behaviour, the level of opportunity may vary and this can be recorded on the principles used for behaviour. (See para. 4.9.)

6. Present potential ○

This refers to what the client could do *now if* he/she were not held back by lack of opportunity, training or personal inhibitions.

6.1 Using the *behaviour* descriptive criteria, you can make a statement as to what you feel the person is *capable* of. This is an explicit statement of your intuition. For example, if a person never washed his/her clothes but you felt he/she was capable of doing so, you could rate this as present potential. It does not relate to *future behaviour as a result of training but what he/she could do now.* Use the figure on page 15 if in doubt.

7. Optimum Modes:

This refers to an overall level of functioning and opportunity now. It does not mean maximum or average but a level which does not cause constant anxiety, stress or frustration. If no single mode is realistic this should be stated.

8. **Flow diagram (page 16)**
This flow diagram can be used for working through examples to decide levels of Opportunity and Behaviour. You start at the top left hand box and substitute any of the activities listed, then proceed to follow to the right or downards according to 'yes' and 'no' answers. This may also give clues as to present potential where 'yes' or 'no' answers are instead: 'sometimes', 'rarely', 'once'.

9. **Notes**
From the assessment of level of opportunity, behaviour and present potential you are asked to give examples of situations or conditions which *inhibit* the person; in general, to expand the comments column. These may include possible medical conditions, personality problems or environmental problems. These environmental problems may be due to lack of staff or facilities. For example, a person may be inhibited because you are unable to offer him sufficient attention or cannot provide funds to pay for trips out. Ideally the ratings on the Chart should coincide, with no ranges. This would mean you are offering a level of opportunity which matches the person's present potential which, in turn, is being used to the full. This situation will probably be very rare; it would represent a perfect service. However, as the likelihood is that behaviour, potential and opportunity do not match and do have ranges, these should be explained fully here. For example, a person may be of mode D present potential but his behaviour for a certain activity, say ironing, indicates that he operates in a mode B way. This would mean that he/she does not do the ironing unless told to. In this section this should be explained: does the person show anxiety? does he/she lack confidence? is this part of a fear of electrical implements? does he/she just not like ironing? has he/she been shown how to iron?, etc. Some descriptive information should be given here.

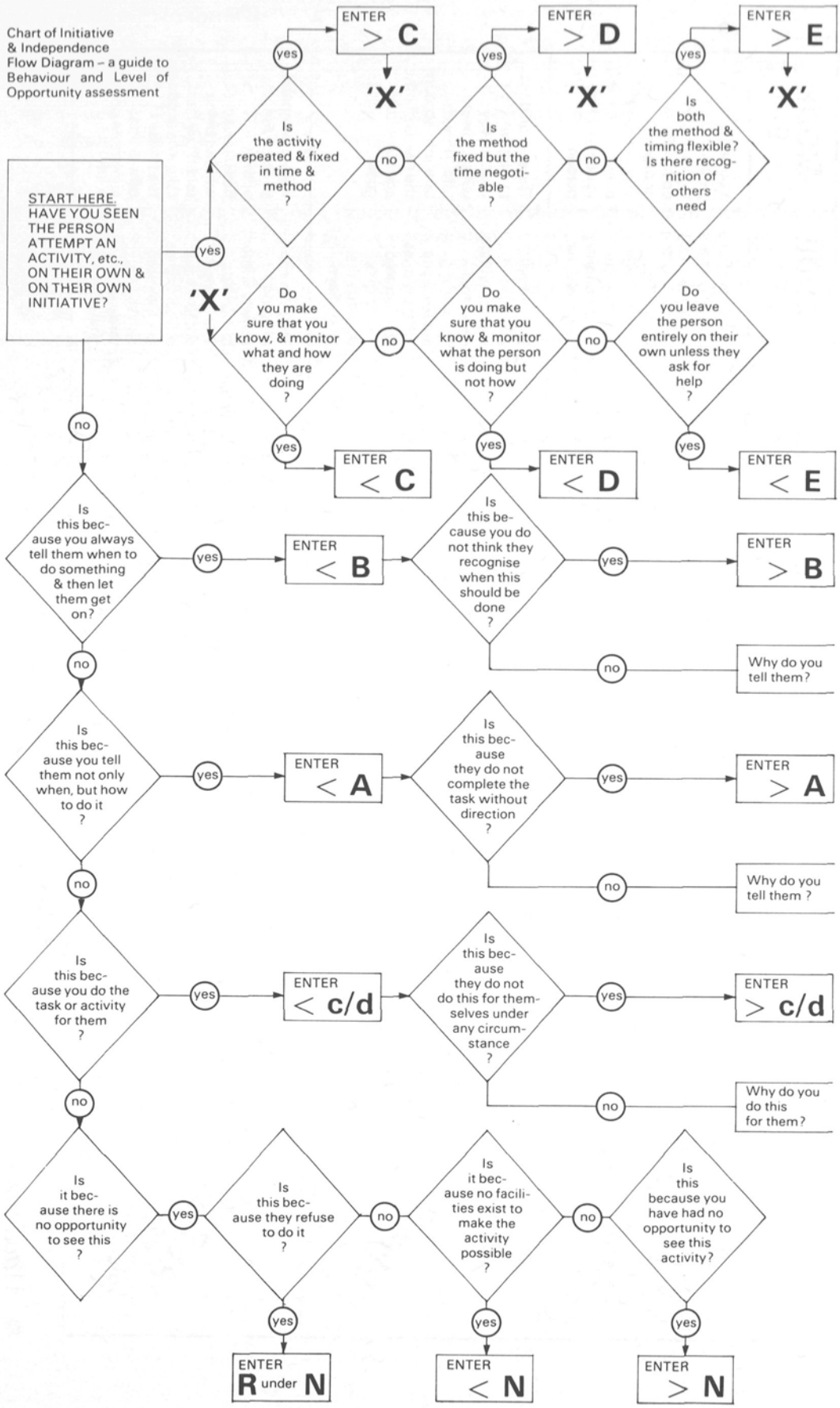
This leads directly to the next question; for the inhibitions stated above there should be a *plan of action* outlined here to overcome them. This plan of action may be directly related to the client and/or to the level of opportunity; e.g., the plan of action may be to let a person go out more often, or to stop monitoring them or increase monitoring. Some inhibitions, e.g., medical conditions, physical handicaps, may be more permanent, others transitory, for example a temporary state of depression. However, this section is a specification of *action;* what you, as staff, agree to do to overcome problems. It may not be possible to give a full description of the plan, for example a behaviour modification programme or psychotherapy. However, reference should be made to such programmes including information on where more details can be found.

The last section is simply to give an opportunity to make any further comments which have not been included above.

KEY	No Opportunity N	Complete Dependency C/D	MODE A	MODE B	MODE C	MODE D	MODE E
LEVEL OF OPPORTUNITY	There is no opportunity available to do this.	It is always done *for* him/her.	You tell him/her *when* to do this *and* how to do it. It is always under your instructions.	You tell them when to do it but then leave them to get on, but later check how it was done.	You allow the person discretion to decide when and how to do something but you check *when* it is done and monitor *how* it is done.	You allow the person discretion to decide when and how to do something, checking *when* it is done but not monitoring how it is done.	You allow the person full discretion and do not check or monitor. You intervene only if requested to do so by the person.
BEHAVIOUR	I have not seen the person actually do this recently. If the person refuses to do this activity state this by noting 'R' under N.	The person does not achieve goals or plans even when told or shown.	The person only does this when told or shown what to do and how to do it.	The person only does this when told what to do but can then get on and do it.	The person does this activity without being told but both *when* and *how* they do this in a pre-set way.	The person does this activity without being told. The *when* is not fixed and others wishes are tolerated unless they threaten the goal of activity.	The person does this activity in a flexible way without being told. They can take into account the needs of others and substitute goals.
PRESENT POTENTIAL	There is no opportunity for the person to show any potential.	The person does not have the capacity to act on goals or plans *even when* told or shown.	The person can only do this when told or shown what to do *and how to* do it.	The person can only do this when told what to do but can *then get on* and do it.	The person is capable of doing this without being told but both *when* and *how* they do this is in a preset way.	They are capable of doing activity without being told. The *when* is *not fixed and* others wishes are tolerated unless they threaten the goal of activity.	They are capable of doing the activity in flexible way without being *told. They can* take into account the needs of others and substitute goals.

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Chart of Initiative & Independence Flow Diagram – a guide to Behaviour and Level of Opportunity assessment



EXAMPLE ASSESSMENT CHART:

This example sheet relates to all the versions of the Chart of Initiative and Independence. Below are ten examples of various configurations forming part of an assessment profile. There are, of course many other combinations that are possible and many more activities that could have been used. The principle is much the same, however, whatever criteria are chosen.

For the five explicit examples of activities given there is a brief interpretive explanation below the chart. The additional registers (6 to 10) are included so that we may get an impression of the approximate 'Optimum Modes' register for Behaviour >, Level of Opportunity <, and level of Present Potential **O**.

ASSESSED ACTIVITIES MODE:	N	c_d	A	B	C	D	E	SUMMARY OF OTHER PERTINENT INFORMATION (e.g. Inhibition)
1. COLD SNACK			>		<	O		TENDS TO WAIT AND LET OTHER PEOPLE 'MAKE' FOR HIM.
2. IRONING			X		O			BEING TAUGHT – LEARNING SLOWLY – NOT KEEN ON THE ACTIVITY.
3. PUBLIC TRANSPORT				>	<	O		USES BUSES AND TRAINS AT THESE LEVELS, NOT KNOW TO USE TAXI.
4. GOING TO WORK						⊗		HE ENJOYS HIS WORK AND THE EMPLOYERS ARE HAPPY WITH HIM.
5. HOBBIES						⊘	<	COLLECTS STAMPS AND MAKES MODEL BOATS. BOTH AT THE SAME LEVEL.
6. etc.					X	O		etc.
7. etc.				>	⊘			etc.
8. etc.				>	O	<		etc.
9.					>	O	<	
10.						>	⊘	
OPTIMUM MODES (NOT AN AVERAGE)					>	⊘		

1) For 'Cold Snack' the client waits to be told what to make and how to make it (behaviour 'A'). What is more, the opportunity is there to make snacks, although the activity would be monitored (level of opportunity 'C'). The intuitive assessment is that the person has the present potential to function at mode 'D'.
2) Here the level of behaviour > and the level of opportunity < both match at mode 'A'. The person is being told when and how to iron, and is judged to have the potential to do this on his own, although in a limited way, at mode 'C'.
3) Here the level of opportunity 'C' is higher than the behaviour 'B' but the level of opportunity is below his potential 'D'.
4) Here the level of behaviour matches the level of opportunity at 'D', but it is felt that he is at his level of present potential, for the moment at least. What he does is still being monitored, although he is allowed discretion as to how.
5) His potential and behaviour are considered to coincide at mode 'D', but the level of opportunity 'E' means that there is no monitoring unless the client asks for help.

PART III

THE DEVELOPMENT PROGRAMME FORMAT (DPF)

1. This part is, in principle, a repetition of Section II (the Individual Assessment Format). However, instead of looking at *present* behaviour, potential and level of opportunity, this is an assessment of *future* behaviour, potential and level of opportunity. The Developmental Programme Format can be used as a *target* chart, i.e., it can be used in conjunction with the plan or action from the previous section (IAF). First, estimate a time, in months or weeks, and then complete this chart on the same principles as the previous section (IAF). Let us say you have chosen three months as a target date. In this instance first fill in the level(s) of opportunity you hope to be providing after three months. Then predict what modes of behaviour and then potential the person will have achieved by that time, given the implementation of the outlined plans. Thus, it is your assessment of how far the person will have developed given the new level of opportunity.

2. If a transfer is being considered the opportunity profile may be filled in, based on the level of opportunity in *another* establishment. In this case it will be necessary to obtain from the new establishment that level of opportunity. The development programme could therefore be geared to prepare the client to deal with this new level of opportunity. To check these targets a *new* IAF should be filled in when three months has passed and the DPF compared with the *new* IAF for consistency, with particular reference to the level of opportunity.

PART IV

RESIDENTIAL POLICY FORMAT (RPF)

1. While sections II(IAF) and III(DPF) refer to assessments of individuals, the RPF is a general assessment of policy. It is necessary *not* to think of individual cases. Any policy will have exceptions. It is only when these 'exceptions' become more regular that the policy alters. Further, it is recognised that many hostels and wards do not have explicit policies and as such this Chart may require a policy-making discussion rather than just a recording of existing policies. The purpose of the Residential Policy Format is to make explicit the general context of the two previous sections. Whereas the IAF and DPF need to be completed for each person being assessed, the Policy Format need not be. It is possible to complete the Policy Format and use one completed Chart for all individual assessments, for this is concerned with the *general* context. It is, of course, necessary to monitor and update the Policy Format; however, this may be done at any time, including when no specified individual assessment is taking place. This is in two parts: on the left is the *entry* criteria, on the right the *exit* criteria.

2. The principles for completing the RPF are the same as for the other two sections, the modes and activities remaining as for previous sections. This part refers to minimum limits in general for the ward or hostel. Because it is *not* assumed that all people who are above those limits will enter the ward/hostel, this section could be used as a pre-selection chart, to inform other establishments as to your policy and enable you to short-list candidates.

3. First, indicate *on the left* the lowest limit of behaviour which would be acceptable to you. For example, if your policy for personal hygiene is that people must be able to wash even if they have to be told when, then the lower limit is mode B. Indicate this with $>$ under B.

4. Similarly, indicate on the left with $<$ the lowest level of opportunity. This is the minimum level you are prepared to provide. For example, you may think it would be detracting from the work of the hostel/ward to need to set goals for certain activities. Thus, the minimum level here would be mode C. If the behaviour and opportunity profiles coincide, still mark both.

5. Your decisions may be affected by an outsider's assessment of *present potential.* If this is not substantiated by behavioural evidence you will need to discuss the basis of this, essentially intuitive, assessment with the referring staff or family. A decision based on evidence of potential may result in a trial period of residence which could be covered by a specific assessment period of not less than two weeks.

6. On completion of the left-hand column you should have completed a full picture of entrance criteria.

7. The column on the right is the section on exit criteria. It is, in principle, exactly like that on the left but a statement of *'exit' transfer* levels.

8. Using the same criteria for behaviour and opportunity, again indicate with $>$ the upper limit of behaviour and with $<$ the upper limit of opportunity required for transfere out from ward/unit hostel.

9. Once completed, the right-hand column is a statement saying anyone whose profile extends above these limits would have achieved all you have to offer. If the person is still

in your care, it would probably be for reasons such as lack of immediate suitable alternative environment to move to.

CONCLUSION

The different formats of the Chart of Initiative and Independence are seen as complementary: part of a single picture which brings together an assessment of *hostel policy,* admission and discharge, present *relationships* and *potential development.* Together they should form a coherent picture which can either be used as a continuous record in one situation or provide information for decision-making with regard to transfer. Once a transfer has occurred it provides the new staff with insight *not only* into the previous development of the handicapped person but *also* the context and types of relationships whereby the development took place; it allows establishments to be clearer about each other's policy and what they are trying to do. It is intended as a method of organising and recording valuable material from ward and hostel staff which otherwise might not be expressed systematically.

APPENDIX 'A'

THE CHART FORMATS

Figure i Individual Assessment Format (I.A.F.) front sheet.
Figure ii Individual Assessment Format end of chart and Inhibitions reporting section.
Figure iii Individual Assessment Format outline plan and additional notes section.
Figure iv Development Programme Format (D.P.F.) front sheet.
Figure v Development Programme Format end opf chart and additional notes section.
Figure vi Residential Policy Format (R.P.F.) front sheet.
Figure vii Residential Policy Format end of chart and additional policy statement section.

Fig i

C.I.I. INDIVIDUAL ASSESSMENT FORMAT (I.A.F.)

CLIENT'S NAME: D.O.B.: MALE/FEMALE ASSESSMENT PERIOD: to ASSESSMENT No.: LAST ASSESSMENT DATE: ESTABLISHMENT TYPE: ADDRESS:								OFFICER IN CHARGE: CONTRIBUTORS:
key	ASSESSED LEVEL OF BEHAVIOUR	>	REPORTED LEVEL OF OPPORTUNITY	<				
	LEVEL OF PRESENT POTENTIAL	○	COINCIDENCE OF BEH'R & L/O	×				
ASSESSED ACTIVITIES: MODE	N	^{c}d	A	B	C	D	E	SUMMARY OF OTHER PERTINENT INFORMATION: (e.g. Inhibitions)
OPTIMUM MODES (NOT AN AVERAGE)								IF A SUPPLEMENTARY SHEET IS USED THIS REGISTER IS CARRIED OVER.

Fig ii

ASSESSED ACTIVITIES: MODE	N	^{C}d	A	B	C	D	E	SUMMARY OF OTHER PERTINENT INFORMATION: (e.g. Inhibitions)
OPTIMUM MODES								

SITUATIONS OR CONDITIONS WHICH INHIBIT THE PERSON:

Fig iii

OUTLINE PLAN OF ACTION:

ADDITIONAL NOTES:

DATE: SIGNED:

Fig iv

C.I.I. DEVELOPMENT PROGRAMME FORMAT (D.P.F.)

CLIENT'S NAME: DATE OF PROGRAMME OUTLINE:					ASSESSED OPTIMUM LEVELS: > < O ESTIMATED TARGET DATE:					PROGRAMME CO-ORDINATOR: *CONTRIBUTORS:*
key	ASSESSED LEVEL OF BEHAVIOUR		>		PROPOSED LEVEL OF OPPORTUNITY		<			
	EXP'TED LEVEL OF FUTURE POTENTIAL		○		COINCIDENCE OF BEH'R & L/O		×			
ASSESSED ACTIVITIES: MODES	N	^{C}d	A	B	C	D	E	OUTLINE OF PROPOSED TRAINING OR DEVELOPMENT PROGRAMME:		
PREDICTED OPTIMUM FUNCTIONING										

Fig v

ASSESSED ACTIVITIES: MODES	N	^{C}d	A	B	C	D	E	OUTLINE OF PROPOSED TRAINING OR DEVELOPMENT PROGRAMME:
PREDICTED OPTIMUM FUNCTIONING								
ADDITIONAL NOTES:								

Fig vi

C.I.I. RESIDENTIAL 'POLICY' FORMAT (R.P.F.)

NAME OF ESTABLISHMENT: TYPE OF ESTABLISHMENT: TYPE OF UNIT:		ADDRESS: OPPORTUNITY MODE RATING: OPPORTUNITY MODE RATING:			No. OF RESIDENTS IN ESTAB No. OF RESIDENTS IN UNIT No. OF STAFF IN ESTAB No. OF STAFF IN UNIT POLICY BY: POLICY DATE:
key	LIMIT OF THE LEVEL OF BEHAVIOUR	>	LIMIT OF THE LEVEL OFOPPORTUNITY	<	
	LIMIT FOR LEVEL OF POTENTIAL	○	COINCIDENCE OF BEH'R & L/O	×	

ASSESSED ACTIVITIES: MODE	N	^{c}d	A	B	C	D	E	ENTRY CRITERIA	N	^{c}d	A	B	C	D	E	EXIT CRITERIA
OPTIMUM MODES : FOR ENTRY								FOR EXIT								

Fig vii

ASSESSED ACTIVITIES: MODE	N	^{c}d	A	B	C	D	E	ENTRY CRITERIA	N	^{c}d	A	B	C	D	E	EXIT CRITERIA
OPTIMUM MODES : FOR ENTRY								FOR EXIT								

ADDITIONAL POLICY STATEMENT:

APPENDIX 'B'

CHART OF INITIATIVE AND INDEPENDENCE (CII)

The Manual of Activities

This manual is complementary to the explanatory documents which accompany the CII. The CII has several formats and the manual is complementary to both the Residential Assessment Format and the Preliminary Assessment Format (Field Setting). The Charts are used to assess the way in which a person approaches and achieves tasks or activities. The ways that they do this are described in terms of five modes, which when charted indicate the extent to which handicapped people can make decisions for themselves and how far they are allowed to do this. The activities to which we refer in this manual are in the form of a list; these are registered on the left hand side of the Chart and these are used against which to note the appropriate mode of functioning for the individual during that activity. For example; 'washing' may be the activity and then an assessment is made as to whether the person decides when to wash or needs to be told.

It is the objective of the chart to provide a method of describing the behaviour of a handicapped person within a specified context; i.e., the limits put on that behaviour by peer group, staff, policy or circumstances, etc. It is also necessary that this description can be understood by other staff members or the family of the handicapped person, so that the description can be tested, challenged and used as base from which to work. To do this it is necessary to define the activities so that when a residential social worker or field social worker is referring to 'shopping' there are mutually held limits as to the meaning of the term 'shopping'. *This is the purpose of this manual.* In a sense it is a kind of dictionary of terms for use in compiling an activities list. Unlike a dictionary it does not cover all the possible activities that clients may be engaged in, or that you may wish to include. If you wish to use activities *not* mentioned in this manual this is possible, and indeed probable, if the Chart is being used to look at the individual and the opportunities being offered in greater depth. However, where activities are added it is the responsibility of the person(s) adding the activities to define the limits of such activities. Thus the list below is to be used at the discretion of staff. Not all the activities listed need be included on the Chart.

The only prescription concerning these activities is that they are 'neutral'. What this means is that in specifying an activity it should not include either an implied level of discretion *or* a rating of the outcome. For example: 'washing clothes *without help*' would not meet these criteria, nor would '*washing clothes well*', but '*washing clothes*' would be acceptable. This should not only apply to the activities listed but also to any of those added by yourself.

When constructing a list it would be as useful to include activities which are relevant to an individual, although these may not be an established part of formal training or rehabilitation programme. For example: leisure activities or hobbies could be included and may give valuable information relating to the amount of initiative the individual can show. It may also be useful to include activities which are not 'allowed', or are precluded, perhaps because of lack of facilities. These facilities, or the necessary permissions may become available at a later date.

THE MAIN ACTIVITY CATEGORIES

The Activities are organised into ten main categories:

A) PERSONAL HYGIENE
B) MEDICAL
C) DOMESTIC
D) CATERING
E) SHOPPING
F) USE OF SERVICES
G) FINANCES
H) SOCIAL ORGANISATION OF TIME
I) LEISURE
J) SOCIAL INTERACTION

These categories are not intended as *the* list within which all activities *should* fall. It may be as necessary to increase the categories as it is to increase the number of items within each category. It is also possible to simply chart these main categories without specifically charting each of the individual listed items. It is important that these more specific items are still listed, but under the major heading however. If any of the main categories (shown above) are then scored (e.g., 'use of services' – mode 'B' behaviour and mode 'B' level of opportunity – with no regression or development), the reader of the Chart should then be able to assume that all the activities listed below the main category are in the same mode.

Convenient sets of more specific activities are given on page 27, These are included under the major headings similar to those listed above. Before turning to these, however, there are some important points which should be covered. The whole point of the assessment is to ascertain the degree of initiative which a person brings to bear on the situation, or how much you as a staff member or parent have to *set* the goal of plan of an activity. The higher modes are precisely about substituting ways and means to achieve a goal, or changing the original focus of activity. In these cases it is not so much a question of setting out *pre-planned* stages towards a goal, each to be monitored and checked. It is more to observe and note the extent to which it is felt to be necessary to intervene or instruct.

One problem which may therefore arise is how does one define the limits of a particular activity when there are no externally set 'fixed' criteria for goal completion. The answer to this lies in common social meanings. If 'social meanings' lead to ambiguity, clearer statements of activities are needed. For example: 'ironing'; does this include folding the clothes afterwards? Does it include piling them neatly? Putting away the ironing board and the iron? Simply the answer is *no*, the activity should only include what is written in the left hand column of the Chart. However, if the assessed person were to throw his or her clothes in a mess on the floor, after having carefully ironed them, this would call into question the nature of the goal of the activity. At least it would need to be specified on the chart as an inhibition, if this seemed to be at variance with the ironing behaviour or activity itself. Another question which arises is: given the limits of an activity, what are the criteria for goal completion? The criteria again rests upon common social meaning; would it be reasonable to class these clothes as ironed? Thus the goal or task completion would seem to be broad. The level of initiative demonstrated by the individual is more relevant in distinguishing between awareness and/or non-awareness of the criteria which govern what is the end product of a particular activity. If the clothes are poorly ironed and the person doing the ironing is aware of this, he or she may consequently choose to improve their ironing or else choose to 'make do'. In this form of assessment, the level of awareness of the individual, reflected in the modes, is more crucial to the interpretations of an activity than a score based upon the outcome alone. Level of awareness is not purely a subjective evaluation but is noted in the extent to which the assessed person comments upon, or asks about the activity. A fuller account of these issues is given in the explanation of the use of the chart: 'The Manual of the Chart of Inititative and Independence'.

THE MORE SPECIFIC ACTIVITIES

The activities are described on page 27. The comments act as a guide when a problem has arisen during the assessment of an individual against one of these activities. Space has also been made available for including your own comments where problems may arise due to more specific conditions that are particular to the assessment environment or the *group* of individuals being assessed. This should be used only for general difficulties with certain activities. Particular problems relating to individuals only should be included in the comments column of the chart itself. Also new sections/activities may be added by the user and facility for this has been made available at the end. It would be useful, therefore to keep this Manual of activities with the assessment charts in the residential situation. It could be used to help explain the Assessment Charts to new staff members, for collecting general comments to improve and update your 'personalised' activities list and to show staff of other residential establishment, with whom you may need to co-ordinate, how you actually use the Chart in respect of these activities (as in the case of transfer of a resident to another establishment).

Which categories and activities you select from this list will depend upon the nature of your establishment, the type and level of functioning of its residents, the demands made upon the establishment in terms or policy and practices, and the personal preferences of the staff generally. There will also, no doubt, be other factors affecting choice of these activities. Apart from choosing which activities to include and what other additional activities may be included, it is also important to consider the amount of information that the staff group can cope with. The number of residents who reside in the home, the number of staff available (or the ratio between these), the general level of work demands made by residents, and the frequency of assessment of each individual, will all affect your committment to the assessments. Some kind of balance needs to be found so that the task can be effectively and comfortably undertaken. The number and nature of your choices will be important here and it is advised that some consideration is given to achieving this balance.

ACTIVITIES	***COMMENTS***
SECTION 'A'	An overall general category which can be scored on its own.
PERSONAL HYGIENE	
1) Washing	Hands & face need only be included, but this also includes drying.
1a)	Drying may, however, be separated out as another activity.
2) Cleaning Teeth	Specify tooth paste/powder or denture cleaner.
3) Hair Tidying	This does not include hair cut, merely general use of brush and/or comb.
4) Hair Washing	Does include drying even if that is simply leaving hair to dry.
4a)	Drying may be separated out as another activity.
5) Shaving	Can be an electric or a safety razor. May include hair remover; specify on individual charts.
6) Sanitary Needs	Does include use & disposal of tampons, pads, toilet paper, incontinence pads, hankerchiefs etc, Specify on individual charts. Disposal may need to be separated out.
6a)	
7) Toileting	Basic urinal & faecal processes, using suitable facilities; eg toilet, bed pan, urine bottle etc. Specify on individual charts.
8) Bathing	Includes running bath to drying, unless these need to be separate activites.
8a)	
9) Dressing/Undressing	Includes nightclothes, work/day clothes and other occasions (ie clothes changing), unless these need to be separated out.
9a)	
9b)	
10)	
SECTION 'B'	This is general medical care, not including emergencies or serious illness. It does include; dealing with first aid, colds, mild 'flu, and regular ill-health conditions.
MEDICAL	
1) First Aid, etc. No Doctor involved	Includes dealing with obtaining assistance for minor cuts, bruises and burns, etc.
2) Non-prescribed drugs	Includes using medication obtained at a chemist without need of a prescription. e.g. aspirin, cough syrup, stomach powder etc.
3) Prescribed medicines	Includes the use of any drugs or treatment
3a)	prescribed by a G.P. It may also include
3b)	regular or repeat prescriptions, e.g. for
3c)	control of diabetes, heart cond., epilepsy.
4) Use of Medical Practitioners	Non emergency attendance at surgeries and hospitals. Specify types of practitioners used on each chart.
5)	

ACTIVITIES	COMMENTS
SECTION 'C'	General domestic work which covers the person and his/her immediate living environment. This can be scored as a general heading but includes many activities within it.
DOMESTIC	
1) General cleaning	Some items may need to be separated. Sweeping, vacuuming, polishing & dusting. It may be useful to distinguish between
1a)	the person's own room or 'area' and shared
1b)	areas like the lounge, stairs, etc.
2) Making a bed	Includes the persons 'own' bed, and
2a)	includes changing sheets. If needed, changing sheets may be a separate activity.
3) Dish washing	Does not need to include drying or putting
3a)	things away. It does include washing and rinsing the variety of utensils used.
4) Dish drying & storage	This includes all activities from after the utensils are washed & drained up to where they are ready for use again.
5) Washing Clothes	This includes the whole washing process,
5a)	including drying them. If needed the activity
5b)	could be divided (hand/machine/dry).
6) Ironing	This does *not* include putting away board & iron, or the clothes. It does include a
6a)	neat arrangement of articles so as to minimise creasing – this may be separated out.
7) Clothes Care	This includes the hanging and storing of
7a)	clothes in wardrobes, cupboards, drawers &
7b)	clothes stands etc. Does not include
7c)	mending clothes.
8) Mending Clothes	This includes minor repairs; buttons, tears holes, etc. Does not include complex needle-
8a)	work. Use of tailors may be separate item.
9) Care of Shoes	This is specifically the cleaning & polishing
9a)	of shoes. It may include brushing suede,
9b)	'whitening' etc. These and shoe repairs may
9c)	be separated out as other activities.
10) Locking up & Security	This includes the security care of any property, & securing doors and windows.
11) Safety checking	Switching off gas taps, lights and pulling out plugs, etc. Specific items may be separated out.
12) Household D.I.Y. Tasks	This activity can contain as many sub items
a)	as is felt necessary, or left out. Items to
b)	be considered; mending a fuse; changing
c)	a light bulb, tap washer; fitting plug;
d)	unblocking sink; decorating; calling in an
e)	expert; minor repairs, etc.

ACTIVITIES	COMMENTS
SECTION 'D'	This is an overall category dealing with the preparation of food and drinks and use of equipment to these ends.
CATERING	
1) Use of Kitchen Utensils	This item includes the use of all the commonplace kitchen equipment, saucepans, fryingpans & kettle etc. Does not include use of stove, pressure cooker or casserole.
2) Use of Cooking Stove	This is the use of an electric and/or gas
2a)	cooker (specify on individual chart if nec.)
2b)	Grill, rings & oven may be separated out as
2c)	individual activities if needed.
3) Make Hot Drink	This would include drinks like tea and coffee, chocolate, cocoa and any other variations the client may choose etc.
4) Sandwiches/Cold Snacks	Includes the making of any cold snack. i.e. does not require cooking in the widest sense.
5) Hot Snack	Cooking 'convenience' foods. No food preparation
5a)	inherent in the task; *no* peeling
5b)	slicing or dicing no judgment of weights
5c)	or proportions. Just opening cans, breaking an egg, etc. Items may be separated out.
6) Full Meal	Includes all preparations & serving of non-
6a)	ready foods; i.e. actions to prepare the
6b)	original food for cooking and any preparations
6c)	required before serving, e.g. draining.
7) Non-essential foods.	Preparation & cooking of foods such as cakes or biscuits which do not form an essential *part of a diet.*
8)	
9)	
SECTION 'E'	This refers to all forms of shopping, buying any items from sweets to furniture, etc.
SHOPPING	
1) Minor Purchases – within residential setting	This applies if there is some kind of shop 'in establishment' for purchasing personal & day to day items. (May also include any
1a)	purchases between residents)
2) Minor Purchases – at local shops	This includes items as in (1) but should also require going into nearby shops and probably requiring negotiating a road.
3) Shopping at Local Shopping Centre	This includes above items and also groceries, clothes, & other general needs. It includes a
3a)	journey where transport *could* be used – even
3b)	if it is in fact not used. More complex
3c)	shopping could be separated out.
4) Furniture Puchases	Includes ornamentation items. Specify according to priorities/policy
5) Luxury Puchases	

ACTIVITIES	COMMENTS
SECTION 'F'	In general this refers to the way in which a person uses amenities.
USE OF SERVICES	
1) Use of Telephone	It may be useful to distinguish between social
1a)	calls & "business" calls (appointments) and
1b)	also between private phones and call boxes.
2) Public Transport	Unless otherwise stated this includes using
2a)	*bus* & *train* services, but can extend to all
2b)	forms of transport; planes, taxis, boats etc.
3) Local Facilities	This includes swimming pools, libraries,
3a)	parks, leisure centres. It could also
3b)	include any social clubs etc. which require
3c)	social interaction or declared interest.
3d)	Items may be separated out if needed.
4) Emergency Facilities	This includes not only dramatic cases of
4a)	serious accident or fire, but use of a
4b)	casualty dept. local G.P., dentist & Police.
4c)	under emergency conditions.
5) Social Services	This includes items not included in 3 & 4
5a)	such as social security and benefits,
5b)	obtaining bus pass, social work help,
5c)	various statutary rights, housing, etc..
6) Use of Private Amenities	This includes activities and facilities not included above, such as cinema, Pubs,
6a)	restaurants, cafes and other privately
6b)	run enterprises; eg a private club
6c)	
6d)	
7)	
8)	
SECTION 'G'	General management of money and financial transactions.
FINANCES	
1) Paying Bills	This includes rent, electricity, gas, tele-
1a)	phone, H.P. agreements and other sundry
1b)	bills for services and delayed purchases.
1c)	Here items may be separated.
2) Saving	Includes how a person deals with money not
2a)	used for immediate expenditure. It may include
2b)	P.O. account, Building Soc., or any
2c)	other institution offering interest.
3) Use of Spending Budget	Refers to how the person organises and
3a)	keeps cash, which is not being saved, to
3b)	pay for everyday expenses.
4) Financial Transactions	Refers to how a person handles immediate
4a)	financial transactions, e.g.; is money
4b)	available taken account of during purchases.

ACTIVITIES	COMMENTS
SECTION 'H'	This general category refers to the way in which a person organises their life to enable work and leisure activities to be fitted in.
SOCIAL ORGANISATION OF TIME	
1) Going to bed	This includes how and why the person decides when to go to bed & how they organise the evening activities to achieve this.
2) Getting up	This includes how the person organise *themselves in order to wake up and rise* within a determined time range.
3) Going to Work	This refers to any time organisation relating
3a)	to any kind of work activity; A.T.C.
3b)	sheltered workshop, employment, etc. & how
3c)	they ensure that they arrive and 'work'
3d)	within reasonably prescribed limits.
4) Making & Keeping Appointments	These are included together but may be separated if the individual shows differing
4a)	levels of initiative in each; i.e. good at
4b)	making appointments but poor at keeping them.
5)	
6)	
SECTION 'I'	This refers to the use of & 'making' time for any "non-work" activities. The work-leisure differentiation being between "The 'Work' situation + 'domestic work'" and "Free Time" (see section 'F' 3 & 6).
LEISURE	
1) Hobbies	This includes activities like; model making,
1a)	collecting, photography, etc. It does not
1b)	include "games" but may be linked with clubs
1c)	or societies. (see section 'F' 3 & 6).
2) Television	The use of television relates to the modes through the element of choice and the regard for the wishes of others.
3) Games	This refers to all types of games involving
3a)	at least two players which are relatively
3b)	sedentary; e.g. board games, snooker, darts.
4) Sports	This has been partly covered by 'Use of
4a)	Facilities'. However, it refers to 'partici-
4b)	pation in' sports; e.g. Tennis, football,
4c)	canoeing, horse riding etc. It may be
4d)	necessary to specify these individually on
4e)	the chart.
5) Holidays & Breaks	This refers to trips away from the local
5a)	environment. It may be a day or a fortnights
5b)	holiday or a weekend with the family. It
5c)	may be useful to specify on chart or separate
5e)	out here.
6)	

ACTIVITIES	COMMENTS
SECTION 'J'	Much of this is implied in many of the activities listed above and also in the modes themselves. However this refers to generally how a person relates socially to those around him/her.
SOCIAL INTERACTION	
1) One to One Relationships	This includes general social interaction between the client/resident and any other person. This will often be a staff member with regard to some tasks. (This may be separated out if necessary)
1a)	
1b)	
2) Sexual Relationships	This is a fairly general category but assumes the basis of the relationship could lead to an explicit sexual relationship.
3) Group Interactions	This includes interaction with peer group, resident group and/or any other social group, each of which may be separated out.
3a)	
3b)	
3c)	
4) Use of Property	This refers to the person's approach to his or her own, and other peoples personal property, and/or personal space. Again this area may be sub-divided.
4a)	
4b)	
4c)	
5) Community Interaction	This refers to the individual's general relationship, interactions and transactions within the wider community setting and links with many of the categories listed above. (e.g. E 2 & 3, F, H 3 & 4 I 3 & 4 etc.) It may include voluntary work, politics, etc.
5a)	
5b)	
5c)	
5d)	
6) Birth control	Specify method.
7)	

SOCIAL WORKERS/STAFF SECTION.	FOR ADDITIONAL ACTIVITIES . . .
I	
II	
III	
IV	
V	
VI	
VII	
VIII	
IX	
X	
XI	
XII	
XIII	
XIV	

Although this is the end of a specified list of activities, it is emphasised that this list should not limit staff. Different activities can be used and not all those given above need be used, either generally for resident group, or more specifically for individual client/resident assessment. Also, as mentioned in the comments column, many of the activities can be sub-divided. The main principle is that the activities should be written in such a way that the elements of discretion and supervision are 'left out', to be charted using the modes.

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APPENDIX 'C'

CASE STUDY EXAMPLES OF USE OF THE CHART OF INITIATIVE AND INDEPENDENCE

Each of the following case study examples are based upon actual individuals who were assessed and trained using the various chart formats of the CII. Personal details and dates have been modified so that the privacy of the individual and their families can be maintained. Every attempt has been made to ensure confidentiality although in all but one case the person being assessed was involved in the assessment and were happy that these be used for the present purpose. In as much as it is possible we have attempted to make any of these changes 'proportional' so that they reflect a true developmental pattern. For practical purposes, the actual client/patient to staff ratio ranged between 14 to 1 and 6 to 1 during any developmental periods. There were times when these ratios reached more critical states and developmental programmes were severely affected, the consequences of this will be well known. It was found, however, that the charts and the concepts that underly these were of great help in maintaining at least a 'tick-over' level of monitoring and continuous assessment of individuals under these conditions.

The case studies described here are summaries of more detailed accounts and in-depth assessments using all the formats outlined in the main text. We have attempted to retain as much of the more important and representative information as we can. To give some perspective, all but one case has been the subject of more than 5 years of study from which some aspects of the CII assessment schema were developed. It is hoped that these and others will be available in more detailed form at a later date. For our present purpose, however, it is necessary for us to give only a representative picture in order to aid you in the use of the charts. Consequently each case study takes a particular aspect of the CII and its use over different periods, with different types of patient/client problems and reflecting different primary uses within the services framework. The following will give some idea of each case studies orientation and purpose:

Case study:

No.

1) A late middle-aged woman with spasticity, having undergone a long period of institutionalisation. Development charts are omitted and a series of 'Individual Assessment Formats' reflecting progressive stages of her development are offered and described. The 'Residential Policy Format' is included to show the broader boundary conditions affecting 'level of Opportunity' and transfer, in this case to a local housing flat. (This format may be used as a standard for other case studies although it is not meant to represent an ideal.)

2) This study demonstrates the formulation of an initial assessment of a severely mentally handicapped adolescent using the 'Individual Assessment Format'. It is followed up with an outline of a 'Development Programme Format' setting the staff/resident goals for the following 6 months. An account describes the progress and changes made during continuous and charted assessments. The long term expectations are that the client will require long term Hostel accommodation. Autism is a seriously considered complication.

3) This describes a young woman who is mildly handicapped with some inhibiting emotional problems. She has been allowed to underfunction due to poor counselling in the past. The study demonstrates the use of the 'Preliminary Assessment Format' during an interview with her mother. (There were follow-up interviews.) It also

demonstrates an early short-term, hostel placement assessment and an end of training placement assessment, both using the 'Individual Assessment Formats' (DPF's were also used). Compare these with fig 4.

4) This case study demonstrates the use of the 'CII' formats on a one-off basis during a short term placement. The charts, with a detailed account to explain them and a supporting report (the case study account), were supplied to the social services area office. A field social worker was able to successfully follow up on the basis of this information. Fig 10 also shows a typical use of the summary section of the 'IAF'.

5) This describes an individual who appeared to be severely handicapped during childhood and adolescence. It was later suspected that childhood autism may have been a complicating factor. Recent psychiatric assessment indicates schizophrenia. The initial assessment chart (IAF fig 11) was used as a basis for a residential social worker report to the social service department. Subsequent charts, using the 'Individual Assessment Format' are supplied so that you may be able to follow his progress after a succession of developmental programmes.

6) This case study describes the short-term assessment (using the IAF) and a series of follow up short-term placements in co-operation with local ATC and field social worker. The aim was to enable the parents to encourage their daughter towards her 'high level' of present potential in all important areas, whilst continuing to live at home.

CASE STUDY NO. 1

Jenny, aged 43 years at the start of our study, had spent over 30 years in special hospitals and other institutions. As a young child Jenny had been quite severely handicapped by poliomyelitis and her parents were unable to cope with her at home. During the process of assessment at that time she was also classified as 'mentally handicapped'. When I first met Jenny she had just moved into a local authority hostel for mentally handicapped adults. She was only semi-ambulant and wore callipers for walking. Even so, she was dependent upon some assistance from care staff for this. It seemed evident, even at this time, that she was more capable than was apparent in her behaviour. During the period from 1974 to 1976 she settled into her new home and made some general progress. She had discarded the callipers and would go out for walks, though still with some assistance. Other than this she still demonstrated the same level of overall dependency that was evident on her transfer.

The in-depth study began in 1976 involving counselling and history reporting. methods. This was soon followed by the use of the earlier version of the CII as a means of assessment of initiative. This enabled the staff to more clearly explicate their intuitive feelings about Jenny's potential for development and offered a clearer framework in which to discuss, plan and assess the institutional changes required to enable any of the predicted developmental changes we anticipated. It was from this point that it was possible to make considered preparation for initiating any changes in Jenny that it was felt she was capable of.

Our earliest CII assessment of Jenny showed her to be optimally functioning at mode 'C'. That is, she was able to demonstrate to us her ability to undertake tasks on her own initiative but that when she did do so these tended to be decided and carried out in a rather fixed way. When we looked at her involvement in tasks at a more particular level it was frequently found that she would avoid taking any initiative. Sometimes this would be done by re-delegating the initiative for a task back to the staff member. Often she would use her optimum initiative to get other residents to undertake tasks. (See fig. 1.)

Before we consider the first assessment, I should remind you that this is a summary assessment. The CII assessment shown in this first figure was part of the initial one (and will be used as the basis for her subsequent assessments). It gave us an overall impression. Concerning our judgement of Jenny behaving at optimum mode 'C', we can see that she frequently achieved mode 'C' in her behaviour. Further evidence to support this appraisal came from the intuitive assessment that her present potential is frequently at 'C' when the level of opportunity is somewhere below 'C'.

With the exceptions of those activities where Jenny has progressed beyond behaviour 'C' we can conclude that the optimum level of opportunity should be at 'C'. Care being taken to increase the opportunity by appropriate increments'. The present potential ratings vary considerably between 'B' and 'E'. When considered against the other factors (and further activities assessed) a 'D' rating seemed most appropriate for assessing the optimum potential. It is this overall information which allowed us to formulate a development programme for the next year – with continuous and intermediate assessments of course. The development programme sheets are not presented here but these used the DPF formats and planned out the 'level of opportunity' changes and the 'expected' behavioural changes in Jenny.

An overall impression of these can be seen in fig. 1 and it is important to remember that there is a lot of information contained in the graphics of the chart itself. It will be necessary to refer to the descriptions and 'activities' sections of the manual to gain this information if you are not fully acquainted with the concepts. We can now go on to the next assessment example of Jenny, approximately one year later, and compare it with the initial one. (See fig. 2.)

As you can see, I have chosen to use the same assessed 'Main Activities Categories', the only change being the sub-category; 'television' to 'hobbies'. The reason for this is that Jenny has made some considerable advancement in the area of 'leisure' and the watching of television has now fallen in line with her level of initiative in the general category. On the other hand, 'hobbies' have tended to lag behind at the original 'general' level.

It can be seen that during the intervening year that staff have, by two or three month assessment reviews – and the assistance of Jenny, gained some considerable progress in their developmental programmes. Stage by stage Jenny was led through from her assessed 'behavioural' level to her 'present potential' level. Each new 'Development Programme Format' (see main text) was essentially constructed by transposing the 'behaviour' key to the original position of the 'present potential' key. Then an anticipation was made of what her **new** 'present potential' would be at the time of the estimated 'Target Date'. It was then necessary to decide what **new** 'level of opportunity' would be appropriate to encourage the expected development in each area or activity. It has already been mentioned that this should not be too large. In this case, we did in fact, gradually bring the level of opportunity up to her optimum potential (or down to it if necessary), in each specific or general activity.

At each assessment review we were able to monitor Jenny's progress. The progression from the initial assessment through 'Development Programme Formats', to the assessment (fig. 2) when this 'Target Date' was reached was by no means a smooth and continous affair. Sometimes we would over-estimate present potential, setting a target too high, thereby attempting to push Jenny too fast or too far. This would tend to result in her becoming stressed or anxious and perhaps even regress temporarily. At other times we underestimated her initiative potential and this sometimes resulted in similar effects to those described above. Alternatively she would stay static or regress to a lower level of 'initiative behaviour'. It was for this reason that we found the CII reviews and the continuous assessment, using its concepts, as essential for ensuring the maximum development with a minimum of risk and stress to the client or patient.

It would now be useful to take more specific areas and activities for considerating Jenny's development, and also to more clearly illustrate the wealth of information contained in the 'mode' ratings allocated. Besides any pictorial representation of the developmental process, each rating represents, in a concise way, a clear and unambiguous statement about the individual's performance. We could compare, for example, the 'Domestic (general)' category between assessments 1, 2 and 3 (see fig. 3). The initial assessment's category is quite

straightforward. Put into words, according to the modal descriptions, the symbols and comments would read as follows, considering Chart '1' as a basis:

> 'At the time of the initial assessment Jenny's performance in general domestic activities were such that she only undertook tasks when told to do so but could then get on and do them on her own (Mode B behaviour). It seemed to us however that she was capable of undertaking tasks without having to be told when and how they should be done. It was recognised that this would probably be in a rather fixed way, both in time and method (present potential Mode C). At this time we assessed that we were allowing her the discretion to decide when and how to do domestic tasks but were checking when they were done and just keping an eye on how she was doing it. In terms of maintaining her room and making her bed we felt that she had already achieved this potential and got on with these activities without having to be told when or how (behaviour Mode C). In these specific areas we estimated that she then had the potential of carrying out these tasks in a flexible way without having to be told, and that she was capable of bearing in mind the needs of others sharing her room, etc. (potential Mode E). If we now consider the subsection 'care and mending of clothes' we can see that she showed no signs of having control in these activities. This could be because staff had not actually seen the person undertake the task at all or because she simply refused to do these tasks. A refusal has not been indicated (behaviour 'N'). In these areas we felt that her present capability was that she could in fact undertake these taskes having been told what to do. Again, it was estimated that would be fixed, at least at first (Potential B). It would seem significant that the discretion we allowed her in order to enable her to engage in the activities was zero, (n.b. no opportunity for training programme), (Opportunity Mode N). In the main these tasks were undertaken by staff.'

If we now consider the assessment of a year later, assessment number 2, (see fig. 2) we can now see that general domestic tasks are performed at the level of the estimated potential of the initial assessment, i.e., this refers to the statement where her behaviour is now Mode C. It is interesting to point out however that she is described as behaving in Mode D also, i.e., there is a 'spread' of behaviour across two modes. In behaving at Mode D, it can be seen from the chart that this coincides with both her estimated present potential and the level of opportunity offered. Taking room and bed care as a separate item on the second chart we find that she has met her full potential according to this chart. Her behaviour and potential are such that she is capable of, and actually carries out, the activities in a flexible way and she now takes into account the needs of her room mate. Not unexpectedly we find that staff have assessed the level of opportunity offered as allowing the person full discretion and intervening only when requested to do so by Jenny (all criteria at Mode E). Care and mending of clothes has shown some improvement. Her behaviour has now reached and to some extent progressed beyond our original estimate of 'present potential' giving a spread of behaviour between Modes B and C. It should be noticed also that behaviour, the **new** 'present Potential' and level of opportunity coincide at Mode C. By the third assessment the picture is far simpler. Over a year had passed, she had made even further progress and we now find that we need only assess general domestic activities overall.

In the meantime she had moved into a single bed-roomed flat which she shares with another mildly mentally handicapped person. In terms of behaviour in domestic activities there is a spread between Modes D and E, with behaviour, present potential and level of opportunity coinciding at Mode E. Any monitoring required for her behaviour when at mode D is now appropriately done by her flat mate, who in turn is monitored by Jenny. In this area and in other areas described in the third chart the various modal assessments would seem to be appropriate for any middle-aged to elderly couple living together. They now draw upon the normal community services like the rest of us might do from time to time (e.g., doctor, social services, friends, etc.) totally on their own initiative.

The quoted explication given above should give you some idea of how to draw out from the graphics the fullest meaning of the symbols used and their 'Modal' position in the charts. By referring back between the case studies and the main text of the manual it may be useful for you to experiment with explicating other general or specific assessed activities. This should

enable you to clarify the concepts which underlie the quoted modal categories. It is also worth noting that the 'Summary of Other Pertinent Information' are important qualifications to the original assessment. Assessment Charts 1, 2 and 3 (figs. 1, 2 & 3) may be compared with the 'Residential Policy Format' which is supplied (Fig. 4). With the use of the manual it will be possible for you to see the transfer criteria required for Jenny's transfer from the hostel to the flat. You will be pleased to know that Jenny and her flat mate are managing successfully in their new home and still maintain voluntary contact with the hostel and their friends. They even, at times make their own arrangements for visits and holidays, although they will still use the voluntary agencies, etc., when it suits their purpose.

Fig. 1
C.I.I. INDIVIDUAL ASSESSMENT FORMAT (I.A.F.)

CLIENT'S NAME: Jenny Compton — D.O.B.: 16/10/33 — FEMALE

ASSESSMENT PERIOD: 3/9/76 to 31/10/76 — ASSESSMENT No.: 1. — LAST ASSESSMENT DATE:

ESTABLISHMENT TYPE: 13 bed hostel — ADDRESS: 42, Brampton Rd, Newtown

OFFICER IN CHARGE:

CONTRIBUTORS:

key				
	ASSESSED LEVEL OF BEHAVIOUR	>	REPORTED LEVEL OF OPPORTUNITY	<
	LEVEL OF PRESENT POTENTIAL	○	COINCIDENCE OF BEH'R & L/O	×

ASSESSED ACTIVITIES: MODE	N	Cd	A	B	C	D	E	SUMMARY OF OTHER PERTINENT INFORMATION: (e.g. Inhibitions)
PERSONAL HYGIENE						>	×	All sub-sections are the same rating, inconsiderate about 'how'.
MEDICAL			<	>	○			All sub-sections same, seems more willing to take own medication.
DOMESTIC (GENERAL)				>	⊘			Seems to be consistant in most areas, the following are exceptions –
Room and bed care					>	<	○	Quite good results – a bit institutional.
Care and mending clothes	×			○				No opportunity for training programme.
CATERING	>		×		○			Very little opportunity.
Hot drink & sandwich					>		⊘	Seems to be developing here with increase of opportunity.
SHOPPING			×			○		Physical disability seems to inhibit, also reluctant.
USE OF SERVICES	>		×		○			In the main relies upon others.
Telephone					>	○	<	Learning – tends to overdo things.
FINANCE		>	<		○			Usually unable, sometimes operates under instruction. Knows money.
SOCIAL ORGANISATION OF TIME					×			Occasionally gets moody and time-keeping breaks down.
WORK				×	○			Parameters set by outside agency.
LEISURE			>	×	○			Most activities organised from outside or by Officer in Charge.
Television					>	○	<	She does not consider others' programme wishes: See Social (group).
SOCIAL INTERACTION ONE TO ONE						>	⊘	Forms good interpersonal relationships with a few people (persists).
Group interactions			×		○			Seems to find it difficult to get on in groups.
Sexual initiative	®				<			Seems to be sexually inhibited. Mainly mother's influence.
Use of property					>	<	○	Maintains to a reasonable standard, sometimes forgets to give back.
Community Interaction			>	<	○			Unable to demonstrate her potential – physical limitations.
OPTIMUM MODES (NOT AN AVERAGE)					×	○		IF A SUPPLEMENTARY SHEET IS USED THIS REGISTER IS CARRIED OVER.

Fig. 2
C.I.I. INDIVIDUAL ASSESSMENT FORMAT (I.A.F.)

CLIENT'S NAME: Jenny Compton — D.O.B.: 16/10/33 FEMALE — OFFICER IN CHARGE:
ASSESSMENT PERIOD: 1/6/77 to 1/7/7. — ASSESSMENT No.: 2. — LAST ASSESSMENT DATE: 31/10/76 — CONTRIBUTORS:
ESTABLISHMENT TYPE: 13 bed hostel — ADDRESS: 42, Brampton Rd, Newton

key

ASSESSED LEVEL OF BEHAVIOUR	>	REPORTED LEVEL OF OPPORTUNITY	<
LEVEL OF PRESENT POTENTIAL	○	COINCIDENCE OF BEH'R & L/O	×

ASSESSED ACTIVITIES: MODE:	N	Cd	A	B	C	D	E	SUMMARY OF OTHER PERTINENT INFORMATION: (e.g. Inhibitions)
PERSONAL HYGIENE							⊗	It was now felt that she had reached normal social standards
MEDICAL						>	⊗	Has become less hypochondriacal and goes to G.P. on her own
DOMESTIC (GENERAL)					>	⊗		Some spread but real improvement in organisation and co-operation
Room and bed care							⊗	Totally looks after her own room organisation and decor to limited. extent.
Care and mending clothes				>	⊗			Care of clothes improved, mending requires more training
CATERING				>		⊘	<	Can now cook hot snack – more training required fo main meals
Hot drink							⊗	Standards are now good, safe with cooking light meals and drinks.
SHOPPING						×	○	Now goes out on her own for personal items.
USE OF SERVICES						×	○	Travels by bus now, has used train
Telephone							⊗	Has now realised that phoning someone too often can be irritating to them.
FINANCE			×			>	⊘	Most operations are high, the lower rating refers to savings account use.
SOCIAL ORGANISATION OF TIME							⊗	Now at full potential, considers others as well as own needs, negotiates
WORK					<	>	○	She's beginning to challenge the constraints of A.T.C.
LEISURE						>	⊘	Making own decisions, more co-operation, more adaptable
Hobbies				>		○	<	Has not yet developed interests in hobbies as such
SOCIAL INTERACTION ONE TO ONE							⊗	Now shows most of the courtesies and more polite, chooses friends carefully.
Group interaction					>	○	<	Now shows some improvements in group co-op. signs of flexing.
Sexual initiative	>				○		<	Still inhibited but less aggressive to opposite sex
Use of property						>	⊘	Has become more flexible about usage, still not considerate of others
Community interaction						>	⊗	Now gets on very well with those she regularly meets and deals with.
OPTIMUM MODES (NOT AN AVERAGE)						>	⊘	IF A SUPPLEMENTARY SHEET IS USED THIS REGISTER IS CARRIED OVER.

Fig. 3
C.I.I. INDIVIDUAL ASSESSMENT FORMAT (I.A.F.)

CLIENT'S NAME: Jenny Compton D.O.B.: 16/10/33 FEMALE
ASSESSMENT PERIOD: 25/9/77 to 29/7/78. ASSESSMENT No.: 3. LAST ASSESSMENT DATE: 1/7/77
ESTABLISHED TYPE: 1 bed shared flat ADDRESS:

OFFICER IN CHARGE:
CONTRIBUTORS:

key				
	ASSESSED LEVEL OF BEHAVIOUR	>	REPORTED LEVEL OF OPPORTUNITY	<
	LEVEL OF PRESENT POTENTIAL	○	COINCIDENCE OF BEH'R & :/O	×

ASSESSED ACTIVITIES: MODE:	N	Cd	A	B	C	D	E	SUMMARY OF OTHER PERTINENT INFORMATION: (e.g. Inhibitions)
PERSONAL HYGIENE							⊗	Reasonable and normal social standards – good
MEDICAL							⊗	As independant and knowledgeable as many women of her age
DOMESTIC (GENERAL)						>	⊗	Works in co-operation with M.H. flat mate who monitors her
								Competent to good standards in all listed activities although still
								has some difficulty with mending. Buys own clothes.
CATERING						>	⊗	Now able to competently undertake all listed activities
								in co-operation with flat mate who monitors main meals cooking.
SHOPPING						>	⊗	Does most of her own shopping in co-operation with flat mate
USE OF SERVICES							⊗	Now is able to use all listed facilities according to her own choice:
								Frequently seen around community.
FINANCE						>	⊗	Now deals with most of her own finances in co-operation flat mate
SOCIAL ORGANISATION OF TIME							⊗	With consideration of below no change since last assessment.
WORK – OCCUPATIONAL							⊗	Has now retired from the A.T.C. and occupies herself as a housewife. She is thinking
								of getting a part time job. Makes herself busy about the flat and community.
LEISURE						>	⊗	Cinema, bingo, clubs and holidays.
SOCIAL INTERACTION (GENERAL)							⊗	Is of normal, average politeness etc. Choosy about friends.
Group interaction						○	<	Will co-operate in group activities on her choice with no real problems.
Sexual initiative					○		<	Has formed one or two male-female relationships of, we think, a closer
								nature. Her and their ages may be inhibiting. She tends to be rather
								fixed in her responses to mens advances though this feels natural.
OPTIMUM MODES (NOT AN AVERAGE)							⊗	IF A SUPPLEMENTARY SHEET IS USED THIS REGISTER IS CARRIED OVER.

Fig. 4
C.I.I. RESIDENTIAL 'POLICY' FORMAT (R.P.F.)

NAME OF ESTABLISHMENT:
TYPE OF ESTABLISHMENT: Hostel
TYPE OF UNIT: Bedsitter.

ADDRESS:
OPPORTUNITY MODE RATING: A to E
OPPORTUNITY MODE RATING: C to E

No. OF RESIDENTS IN ESTAB :13
No. OF RESIDENTS IN UNIT : 2
No. OF STAFF IN ESTAB : 4
No. OF STAFF IN UNIT 0
POLICY BY: R. Johnson, Area Officer.
POLICY DATE: Jan 1976

key

LIMIT OF THE LEVEL OF BEHAVIOUR	>	LIMIT OF THE LEVEL OFOPPORTUNITY	<
LIMIT FOR LEVEL OF POTENTIAL	○	COINCIDENCE OF BEH'R & L/O	×

ASSESSED ACTIVITIES: MODE	N	^{c}d	A	B	C	D	E
PERSONAL HYGIENE			>		⊘		
MEDICAL			>	⊘			
DOMESTIC (GENERAL)			>	○	<		
Room and bed care			>	○	<		
Care and mending clothes	>			⊘			
CATERING	>		○	<			
Hot drink and sandwiches	>			⊘			
SHOPPING	>		○	<			
USE OF SERVICES	>		○	<			
Telephone	>		○		<		
FINANCE	>						
SOCIAL ORGANISATION OFTIME			>	○	<		
WORK			>	○	<		
LEISURE			>	○	<		
Hobbies	>		○		<		
SOCIAL INTERACTION(GENERAL)	>		○		<		
Group interaction (peer group)				>	⊘		
Sexual initiative	>		○		<		
Use of property				⊘	<		
Community interaction	>		○	<			
OPTIMUM MODES (–) FOR ENTRY							

ENTRYCRITERIA MODE	N	^{c}d	A	B	C	D	E
Note:						⊘	<
These criteria describe						>	⊘
the minimum behaviour						⊘	<
'or' the minimum							⊘
'present potential'. –						⊘	<
Level of Opportunity						>	⊘
ratings are the max-							⊘
imum to be offered in						>	⊘
initial period for						>	⊘
those assessed at or						⊘	<
near these levels.						⊘	<
						>	⊘
A.T.C. included.						⊘	<
						>	⊘
						⊘	<
						>	⊘
							⊘
						>	⊘
							⊘
						>	⊘
FOR EXIT							

EXIT CRITERIA
Note:
These criteria describe
the minimum
behaviour and/or
'present potential' of
the individual
provided they can
tolerate the level of
opportunity described
for at least one week.
They are the criteria
for semi-independent
accommodation at
least.
SHEET.

CASE STUDY NO. 2

Arthur, aged 16, was admitted into the hostel as a long term resident after a crisis had arisen in his family home. Little is known of his background except that he went to a special school for ESN(S). Here he presented a great many problems which the hostel was later to experience. He is a small fellow, even for his age, otherwise quite normal in appearance. It was evident from the outset that there may be some element of autism reflected in his behaviour. This was later confirmed by the Psychiatrist on a visit to the hostel. Arthur had already been in the hostel for over a month before a full CII assessment was done. Only the more significant aspects have been included here (see fig. 5). His initial impact upon staff and other residents was very disruptive and even by the time of the assessment he was still presenting great problems. One particular problem is noted against 'Toileting' on the 'Individual Assessment Format', but his general inquisitiveness also presented many problems and upset some of the other residents.

All staff made contributions to the assessment, including domestic staff. Although he presented difficulties for all, staff seemed to have a certain affection for him. The assessment chart is a summary of the consensus of opinion regarding Arthur's present level of initiative and independence and his potential for future development. Some staff felt more optimistic than others but all agreed that some progress should be possible in spite of his low IQ rating (below 30). In examining his chart it will be seen that his behaviour is frequently marked in more than once against a particular activity. It is important to recognise that this does not represent a difference of opinion amongst staff (although these did exist) but as so often is the case, reflected variations in Arthur's behaviour at different times. These variations could be associated with changes in Arthur's moods but could equally be due to fluctuations in the level of opportunity that a staff member was able to offer at particular times. Only the more detailed assessments of two or more would confirm how much influence variations in level of opportunity played. Arthur's mood changes were more his own affair, provided they did not interfere with others (as they frequently did). An example of two registered levels of behaviour assessment can be seen against washing face and hands. Normally this had to be done for him but as his stay progressed he would sometimes take some initiative himself, possibly learned from watching other residents getting on by themselves. Other examples are: 'washing up and tidying up', 'social organisation of time', and 'one to one social interactions'.

To get the fullest picture of Arthur's behaviour it will be necessary to 'translate' keyed 'modes' by using the descriptions (see text). The same is the case for discovering the then current expectations for him and the overall level of opportunity that was being offered as a context for his behaviour. As is often the case in a first assessment the level of opportunity offered did not correspond particularly well with Arthur's behaviour, or the estimation of his present potential. There was, however, enough information for staff to decide his optimum levels of behaviour and present potential given an appropriate level of opportunity. To obtain these one needs to look at and consider all those areas where initiative of some kind is shown. Then, using the chartered information and the comments, estimate the 'comfortable' level at which he is able to operate (optimum level of behaviour within the context offered him). His optimum level of 'present potential' (in many ways the most important measure) is obtained by looking for the highest ratings of present potential which are also supported by his behaviour, whether or not these are against the same activity category. In this case, disregarding 'Inquisitiveness' because of its somewhat negative aspect in some respects (negative initiative was shown at times), the estimation was not too difficult. It was decided, because of Arthur's sometimes disruptive effects that the optimum level of opportunity, at least for the time being, should coincide with his present potential. This would seem to be appropriate anyway but in cases where it is felt that an individual can be stretched a little more (e.g. where they are seen to be competent but reluctant) the optimum level of opportunity may be increased a little.

Having obtained an optimum picture it is still necessary to keep in mind those areas where Arthur is functioning below this. All we have are the upper limits. To enable him to progress in any particular area staff needed to consider, stage by appropriate stage (through assessment reviews), what new level of opportunity including any appropriate training, or what changes in

level of opportunity (up or down) would be most effective in encouraging development. Whilst the individual is still learning skills in a particular area it would be appropriate to offer a level of opportunity which coincides with their present behaviour. Once the basic skills are established, however, it would be more appropriate to let the level of opportunity correspond to their present potential (were this is different). It is in this way that staff set out the 'Development Programme Format' chart. This was to act as their considered goal towards which they would encourage Arthur to develop. In this case the target date was set at six months (see fig. 6). Weekly or fortnightly meetings reviewed his progress, and where it was felt useful another charted assessment was done. Stage by stage they worked towards the goals they had set, sometimes having to back step where it was found that an increase in level of opportunity was premature and was causing anxiety or distress to Arthur. In this particular case a new target date and an upgrading of predictions was made, some staffing difficulties for a while hindered progress but eventually Arthur reached most of the new estimated levels and seems to have settled around behaviour mode 'C', potential mode 'C to D'. There are occasions where there are temporary regressions (ill health, interpersonal conflicts, etc.) and in some areas he is now showing additional potential. In the main though, this is the present picture of Arthur and any further development will be a new chapter in his and the staffs' lives.

Fig. 5
C.I.I. INDIVIDUAL ASSESSMENT FORMAT (I.A.F.)

CLIENT'S NAME: Arthur Johnson — D.O.B.: 4/7/61 MALE

ASSESSMENT PERIOD: 6/3/77 to 11/7/77 — ASSESSMENT No.: 1. — LAST ASSESSMENT DATE:

ESTABLISHMENT TYPE: 14 bed Develop'l Hostel — ADDRESS: Beechwood Hostel, Grange Rd. Ivor.

OFFICER IN CHARGE: P. J. Thomson

CONTRIBUTORS: All Staff.

key

ASSESSED LEVEL OF BEHAVIOUR	>	REPORTED LEVEL OF OPPORTUNITY	<
LEVEL OF PRESENT POTENTIAL	○	COINCIDENCE OF BEH'R & L/O	×

ASSESSED ACTIVITIES: MODE:	N	Cd	A	B	C	D	E	SUMMARY OF OTHER PERTINENT INFORMATION: (e.g. Inhibitions)
PERSONAL HYGIENE		×	○					Poor awareness of personal needs. Enjoys bathing however. See below:
Toileting					⊘	<		Usually functions as indicated, occasional negative initiative when disturbed,
Washing face & hands.			>	<	⊘			i.e. smearing faeces, urinating in bedroom sometimes washes without being told.
MEDICAL		×	○					Shows little sign of his medical needs even when injured.
DOMESTIC (General)		×			○			Only limited domestic involvement but does attempt to help clear
Washing up & tidying up			>	×	○			up any mess he makes and helps with the washing up etc.
CATERING (General)		×	○					Only limited involvement in this area but does try to help with
Hot drink & sandwiches			×	○				making tea and sandwiches.
SHOPPING	×	○						It is not possible to offer a higher level of opportunity at present.
USE OF SERVICES	×	○						
FINANCES	×		⊘					As above. He is getting some practice in the hostel only.
SOCIAL ORGANISATION OF TIME				>	⊘			Awareness of time seems limited but is beginning to get a routine.
LEISURE					⊘			Watches T.V., listens to records, dances & sometimes plays games.
SOCIAL INTERACTION			>		○	<		Very rarely speaks. Sometimes shows affection. Usually insular.
1 to 1 relationships			>	>	⊘			Usually responds only none-verbally, if at all. Occasionally takes
								some initiative in such interactions, prefers touch & smell.
Group interactions				>	⊘			Will join in group activities and seems to enjoy them but does not
								really get involved except at the 1 to 1 level of activity.
SAFETY-RISK ACTIVITY ELEMENTS	×		○					He has a poor awareness of risks and dangers in all activity areas.
INQUISITIVENESS						⊘		For all his limitations he shows keen interest in what goes on.
OPTIMUM MODES (NOT AN AVERAGE)				>	⊘			IF A SUPPLEMENTARY SHEET IS USED THIS REGISTER IS CARRIED OVER.

Fig. 6
C.I.I. DEVELOPMENT PROGRAMME FORMAT (D.P.F.)

CLIENT'S NAME: Arthur Johnson
DATE OF PROGRAMME OUTLINE: 15/7/77
ASSESSED OPTIMUM LEVELS: > B. < C. O C.
ESTIMATED TARGET DATE: 15/1/78
PROGRAMME CO-ORDINATOR: Miss J. Lawrence.
CONTRIBUTORS: All staff.

key				
ASSESSED LEVEL OF BEHAVIOUR	>	PROPOSED LEVEL OF OPPORTUNITY	<
EXP'TED LEVEL OF FUTURE POTENTIAL	○	COINCIDENCE OF BEH'R & L/O	×

ASSESSED ACTIVITIES: MODES	N	^{C}d	A	B	C	D	E	OUTLINE OF PROPOSED TRAINING OR DEVELOPMENT PROGRAMME:
PERSONAL HYGIENE			×	○				Develop all necessary skills, use rewards for +ve initiative.
Toileting					⊗			Behaviour modification in respect of negative initiative (Psychologist)
Washing face & hands.					⊗			Develop his skills within a routine, reward level 'C' initiative.
MEDICAL			>	⊘				Encourage none-verbal communication of needs. Keep eyes open!
DOMESTIC (General)			>	<	○			Encourage and develop skills when initiative is shown by Arther.
Washing up & tidying up.					×	○		Put Arther into the rosta for washing up & encourage tidying initiative
CATERING			×	○				Allow him to 'help out' with limited tasks with Cook & other staff.
Hot drink & sandwiches					×	○		Develop natural initiative in this area into a skilled routine.
SHOPPING			⊗					Take him on shopping expeditions with other residents, let him try out.
USE OF SERVICES			⊗					Concentrate on local facilities, park, pub etc., may learn from others
FINANCES			>	⊘				Continue giving opportunity to handle money – contact A.T.C.
SOCIAL ORGANISATION OF TIME					⊗			Reinforce routine which is developing. We may see higher potential.
LEISURE					>	⊘		Reinforce present initiative & broaden range of activities available
SOCIAL INTERACTION				>	⊘			Use none-verbal skills to full. Contact speach Therapist if possible.
1 to 1 Relationships					×	○		As above – Give more 1 to 1 attention where possible. use verbal &
								none-verbal at bath times, during dressing & making bed etc.
Group interactions					×	○		Given the limited verbal communication, encourage other residents to
								accept Arther more & use verbal & none-verbal means.
SAFETY-RISK ACTIVITY ELEMENTS			×	○				Through normal activities demonstrate risks & dangers where possible.
INQUISITIVENESS						⊗		Use his inquisitiveness to productive ends – follow his initiative?
PREDICTED OPTIMUM FUNCTIONING					×	○		IF A SUPPLEMENTARY SHEET IS USED THIS REGISTER IS CARRIED OVER.

CASE STUDY NO. 3

Catherine, aged 19, was admitted to the hostel from a very caring family home for periods of assessment and training. In her childhood she had been assessed as mentally handicapped and had attended an ESN(M) school. Since leaving school Catherine had been attending the local Adult Training Centre where she had been found to have the same kind of problems as at home. She was basically a very serious girl, particularly about her appearance, polite with good manners and a very caring and considerate nature. She was however, very reserved and introspective, finding it difficult to communicate with strangers and only able to converse after a long period of introduction, and then only if she felt she could 'trust' the individual. She rejected anyone to whom she felt inferior, or who exhibited an impersonal or aggressive nature. When an informal, friendly atmosphere developed she responded a little better but required 'introducing' into conversation and constant encouragement to maintain it. Once stimulated she exhibited a reasonable degree of intelligence and proved to be very expressive and discerning.

During home visits a 'Preliminary Assessment' was undertaken. I found Catherine to be a pleasant and likeable girl although her reserve did tend to make one feel ignored or disliked, a feeling that her parents also complained of. I felt sure that this was not deliberate most of the time, being merely a symptom of her nervous nature. It appeared she often needed reminding that people only wished the best for her, as she often became bewildered by people's variable attitudes and the initiative allowed her. She was, it seemed, particularly sensitive in response to remarks (not necessarily derogatory or critical) made to, or about, her and this sometimes resulted in her becoming upset or crying. The most effective method of reducing this in the hostel was to ignore it if possible and if that was not practicable to spend a little time gently rebutting the crying with phrases such as, 'Don't you think this is a little childish?' or, 'How can you expect people to talk to you if you simply cry at the least suggestion?' The improvements tended to be long term but she seemed to regress if treated harshly.

I understood from the preliminary assessment (see fig. 7), that her parents had great difficulty in getting her to talk to them. I attempted, on a number of occasions, to encourage Catherine to converse with her parents, and finally, with the help of a female residential worker, managed to get her to talk, in depth, to her mother about her problems. In a further conversation with her mother she confirmed that Catherine was now talking to her more freely and that she had also improved domestically and had done some household tasks voluntarily. We attempted a similar method in order to encourage conversation with her father and it appeared that she had one lengthy conversation and other brief chats with him which we felt sure it would be possible to encourage further. The parents said they were particularly interested in Catherine's relationships with boys and indicated that they would like to see a boyfriend or two. We endeavoured to introduce her to as many people as possible in the hope that she would broaden her circle of friends. Cathy was also encouraged to work in other parts of the A.T.C. She helped in the office for a while and enjoyed helping the physically handicapped in the Special Care Unit.

Catherine often complained, like many adolescents, that her parents did not understand her and in some areas this seemed to be true. She was not particularly interested in the television, preferring to read or write in her room and this perplexed them. In fact Catherine had a very real ability and a natural, artistic application towards prose and poetry in which she appeared to lose all the inhibitions that were apparent in her conversation. She also had a natural aptitude for the piano, with good retention of pitch and metre, indicated by her ability to play a simple sequence of five or six bars at a time, after only three or four demonstrations.

When Catherine first came to the hostel I found it very difficult to encourage her to talk freely. She would rarely speak voluntarily and often broke into tears over the smallest mishap or slightest criticism showing negligible self confidence. It was only with patience and persistence that one induced her to answer a question. I persuaded her to write a note whenever she wished to explain any problem or worry and this she began to do. I then proceeded, with the help of a female worker, to encourage her to discuss whatever she had written, and she will now more readily converse or answer questions. Catherine showed real ability in those areas in which she was interested, particularly reading and writing. Not

surprisingly perhaps, she showed little interest in current affairs although I tried to convey to her that conditions in the world would not improve in the slightest by ignoring the facts, in the hope that she would take an interest in newspapers and news items on the television. Her interests did not stretch to politics, where she states she is hopeless, although she is fairly able in the relevant areas.

She managed all the personal tasks set her in the hostel with skill and care and when the opportunity arose undertook other tasks, e.g., cleaning and helping in the kitchen, with the same enthusiasm and ability. She was reliable and performed well without supervision when allowed to do so. It was in social areas that she had her greatest problem and we felt that her slowness in developing socially was the result of a number of criteria:

(a) her introspective nature
(b) an oversensitivity to other people's approaches
(c) lack of parental patience/tolerance (diminishing)
(d) lack of self confidence
(e) an intense dislike of violence, real or fictional, as exhibited in the media or society
(f) insufficient 'direct' contact with normal society, especially girls with similar interests, i.e., writing, poetry and music.

The last point was thought to be the most likely problem in slowing her social development and the source of some of the others., (See fig. 8.)

Cathy continued to have short term placements and came for weekend stays. With each stay her skills and initiative improved and her parents reported similar improvements at home. Her parents even became interested in the possibility that she may be able to live more independently, perhaps in a group home. With this in mind she was eventually given a longer training placement in the hostel to see if it were possible to get her to the required levels of functioning. During this period most of the critical areas which were still lacking were remedied and the hostel's latest assessment outline can be seen in fig. 9. If this is compared with fig. 4 (a typical 'Residential Policy Format') it is clear that she fulfills all the requirements for transfer from a hostel. In fact she has since returned home and now lives more independently there. Her parents now offer her the appropriate level of opportunity and Cathy in turn contributes willingly to helping around the home. Relationships are reported to have sustantially improved between Cathy and her parents and also with the wider circle of family and friends. She has, in the meantime, found a new boyfriend and they are talking of engagement.

Fig. 7
CHART OF INITIATIVE AND INDEPENDENCE (P.A.F.)

POTENTIAL RESIDENT: Catherine Kirkland D.O.B.: 9/1/56 FEMALE
PRESENT ADDRESS: 14 Camberly Street, Bromley, Kent.
SOCIAL WORKER: P. J. Thompson (O in C Beachwood Hostel) S/W Team: Residential, West 3.

INTERVIEWEE: Mrs. Kirkland
RELATIONSHIP: Mother
PLACE OF INTERVIEW: Family Home
DATE(S) OF INTERVIEW: 24/10/76

key

REPORTED LEVEL OF BEHAVIOUR	>	REPORTED LEVEL OF OPPORTUNITY	<
LEVEL OF PRESENT POTENTIAL	○	SEE EXPLANATION FOR FURTHER DETAILS*	

ASSESSED ACTIVITIES: MODE:	N	Cd	A	B	C	D	E	SOCIAL WORKERS SUMMARY OF OTHER PERTINENT INFORMATION:
PERSONAL HYGIENE					>	<	○	Cathy normally is of good appearance and keeps herself clean. Mrs.
								Kirkland said that she could rely upon Cathy in this area.
MEDICAL				X	○			Mother always goes with her to surgery. Cathy goes in on her own.
								Mother said that the doctor sometimes has difficulty examining Cathy.
DOMESTIC				X		○		Mother complains that Cathy is not very helpful most of the time,
								but will help out only if pushed. Feels she is capable.
CATERING	X			○				Mother said that she doesn't let Cathy do the cooking because she is
								(Cathy) afraid of gas. Cathy doesn't make tea. Mum feels she could.
SHOPPING						⊗		Cathy does all her own personal shopping for bits and pieces but
								mother goes with her to buy clothes etc.
USE OF SERVICES						⊗		Cathy goes to the local M/H club and mother likes to know when she
Mental Handicap Club							⊗	will be in. Cathy sometimes goes by public transport on her own.
FINANCES				>	⊘			Mother said that Cathy is quite good with money but a bit careless
								at times. Mother does most of the budgeting & saving etc.
SOCIAL ORGANISATION OF TIME				>	⊘			Mother said that she always has to get Cathy up in the mornings. When
								Cathy is going somewhere she likes her time keeping is better.
LEISURE					>	<	○	Cathy likes reading and playing records, doesn't watch T.V. much.
Writing, music & Dance						X	○	Mother wishes Cathy would broaden her interests a bit more.
SOCIAL INTERACTION				>		○	<	It would seem that Cathy has difficulty getting on with mother and
Boyfriend relationships				>		○	<	Father and all but a few close friends. Breaks into tears a lot.
OPTIMUM MODES (NOT AN AVERAGE)								IF A SUPPLEMENTARY SHEET IS USED THIS REGISTER IS CARRIED OVER.

Fig 8
C.I.I. INDIVIDUAL ASSESSMENT FORMAT (I.A.F.)

CLIENT'S NAME: Catherine Kirkland (Short term placement) D.O.B.: 9/1/56 FEMALE
ASSESSMENT PERIOD: 5/1/77 to 28/1/77. ASSESSMENT No.: 2. LAST ASSESSMENT DATE: 24/10/76
ESTABLISHMENT TYPE: 14 bed Develop'l Hostel. ADDRESS: Beechwood Hostel, Grange Rd, Ivor.

OFFICER IN CHARGE: P. J. Thomson.
CONTRIBUTORS: All staff members.

key

ASSESSED LEVEL OF BEHAVIOUR	>	REPORTED LEVEL OF OPPORTUNITY	<
LEVEL OF PRESENT POTENTIAL	○	COINCIDENCE OF BEH'R & L/O	×

ASSESSED ACTIVITIES: MODE:	N	Cd	A	B	C	D	E	SUMMARY OF OTHER PERTINENT INFORMATION: (e.g. Inhibitions)
PERSONAL HYGIENE						>	⊘	Even with increased L of Op. Cathy maintained good standards.
MEDICAL				>	<	○		Limited observation, but it was apparent that Cathy would often
None-prescribed medication.				>	<	○		complain of pains, etc., and frequently call on staff for attention.
DOMESTIC (General hostel)					×	>	○	Showed willingness to help where she could. Not always asked.
Room, Clothes care & Bed making						>	⊘	Few problems and maintained good standards with minimal supervision.
Washing & Ironing				>	⊗			Was a little anxious at first but learned quickly and progressed.
Washing up, drying etc.					×	○		Soon got into routine with other residents and took her turn.
CATERING (General)					×	○		Fear of gas confirmed. Otherwise quick to learn and willing.
Hot drinks & cold snacks							⊗	Soon demonstrated her full potential at this level of activity.
SHOPPING						>	⊘	Limited observations. What shopping she did was done independently.
USE OF SERVICES							⊗	Used local facilities like library & social clubs independently.
Telephone.					×	○		Was anxious at first but learned to use it competently.
FINANCES						⊗		During her stay she looked after her own money, no problems apparent.
SOCIAL ORGANISATION OF TIME					×	⊘		Usually required waking but began to get into a routine, O.K. otherwise
LEISURE (writing, games & music)							⊗	Sometimes seemed at a loss but liked to help & join in with others.
SOCIAL INTERACTION					×	○		Presented herself well, at least initially, when within a group.
1 to 1 Relationships					⊗			Once established these were more settled but prone to breakdown.
Sexual Relationships & Birth Cont.				>	⊘			Has a steady boyfriend, frequently rows & anxious about getting B.C.
Group Interactions & Property						>	⊘	Is quite stable in this area & often helps other residents. Keen.
Community Interactions.					×	○		Varies according to conditions as described above. Generally good.
OPTIMUM MODES (NOT AN AVERAGE)						>	⊘	IF A SUPPLEMENTARY SHEET IS USED THIS REGISTER IS CARRIED OVER.

Fig 9
C.I.I. INDIVIDUAL ASSESSMENT FORMAT (I.A.F.)

CLIENT'S NAME: Catherine Kirkland (Training placement) D.O.B.: 9/1/56 FEMALE
ASSESSMENT PERIOD: 3/3/79 to 5/6/79. ASSESSMENT No.: 5. LAST ASSESSMENT DATE: 24/6/78
ESTABLISHMENT TYPE: 14 bed Develop'l Hostel ADDRESS: Beechwood Hostel, Grange Rd. Ivor.

OFFICER IN CHARGE: P. J. Thomson
CONTRIBUTORS: All staff.

key

ASSESSED LEVEL OF BEHAVIOUR	>	REPORTED LEVEL OF OPPORTUNITY	<
LEVEL OF PRESENT POTENTIAL	○	COINCIDENCE OF BEH'R & L/O	×

ASSESSED ACTIVITIES: MODE:	N	Cd	A	B	C	D	E	SUMMARY OF OTHER PERTINENT INFORMATION: (e.g. Inhibitions)
PERSONAL HYGIENE							⊗	Standards & level of functioning satisfactory in hostel & at home.
MEDICAL (Prescribed drugs & F. Aid)						>	⊘	Takes responsibility for own medication as required – cautious.
Use of medical facilities - doctor							⊗	Goes to the doctor on her own when she feels this is required.
DOMESTIC (General)						>	⊗	Some variation in level of behaviour but all high initiative.
Sweeping etc., Clothes mending					>	⊘	<	Still developing these skills with steady progress.
Locking-up & safety checks							⊗	Has shown herself to be very competent in this area.
CATERING (General)							⊗	Now undertakes all tasks in this category, see below:
Full meals & non-essent. Cooking.					>	○	<	Has made great progress in this area (at home also) fear of gas reduced.
SHOPPING (General)						>	⊗	In cooperation with mother she now buys her own clothes also. This
Use of shopping centres.							⊗	involves travelling to other shopping centres.
USE OF SERVICES (General)							⊗	Makes full use of service facilities as necessary (see medical)
Social services						>	⊘	Now has her own field social worker who she contacts herself.
FINANCES (General)							⊗	Shows competence, consideration & high initiative. See below
Paying bills							⊗	Now pays her rent during short stays at the hostel, reliable.
SOCIAL ORGANISATION OF TIME						>	⊗	Now organises herself competently, makes her own appointments etc.
LEISURE							⊗	Cathy's interests have not changed much. More tolerance at home.
SOCIAL INTERACTION						>	⊗	Considerable general improvement. Shows more confidence
1 to 1 Relationships					>	>	⊘	These are much more stable, although she may occasionally regress.
Sexual Relations & Birth control.						>	⊗	One steady boyfriend – takes more initiative, uses birth control.
Community interactions.							⊗	Now has a 'normalised' position in local community & is accepted.
OPTIMUM MODES (NOT AN AVERAGE)							⊗	IF A SUPPLEMENTARY SHEET IS USED THIS REGISTER IS CARRIED OVER.

CASE STUDY NO. 4

Sally came into the hostel for a short term stay and assessment with a view to long term hostel placement or living on her own. Her mother was getting old and was concerned about her future. Sally showed herself to be fairly competent and reliable in the areas covered by personal behaviours such as health, hygiene and clothing management. She showed similar competence in her person-environment relationship, especially in relation to aspects of catering, shopping, room tidying and cleaning. When she did do domestic activities about the rest of the hostel, although this was low initiative, she performed well. Some skills were still lacking but she seemed to have the capacity for further development. She required only minimum supervision in all areas and operated confidently. Her domestic skills were generally well developed but she needed encouraging, while the more personal skills were of a good quality, although she did, at times, fall down in hair maintainence and foot hygiene. (See fig. 10.)

Her ability to organise herself in various social settings was good and quite socially appropriate and competent. Her skills at social interaction were again appropriate in the main and reasonably well developed, although her behaviour tended to be adolescent in nature at times and she seemed slightly juvenile in relation to the opposite sex. She still had a bit to learn about men!

Her ability to maintain safety standards and minimise risks indicated considerable competence and she showed herself able to learn quickly. Social safety risk factors (the ability to discern or recognise dangers of a social or interpersonal nature) were doubtful, but I felt that the risks involved in this area were no greater than they would be for any adolescent girl. Non-recognition, by others, of her lack of experience for her age could cause some concern, but these can to a great extent, be limited by careful counselling. The bulk of this experience can only be gained or learnt by normal interaction within the community, as with any other girl.

Sally showed some skill in financial dealings, but she seemed to lack a full understanding of the use of money. She managed to get by using the skills she had developed to compensate for her lack of understanding, i.e., she was able to 'project' herself as socially and financially competent, thereby reducing the chance of being cheated. This is often done by people who have no real sense of money values and in some cases they may well fare better than those of us who have the understanding but don't bother to check.

To summarise, I would say that Sally was generally competent with some considerable skill in relation to maintaining herself independently. She demonstrated a fair degree of initiative and does not seem to be inhibited to any real extent other than in the area of finance and some areas of social interaction and transactions. More experience in these areas, coupled with counselling, some training and encouragement should go a long way to rectifying these discrepancies. She should be able to live independently if the need arise. Under these circumstances I would consider a transitional period in the hostel prior to a placement in a group home to be a good idea. In any event, any form of accommodation would be viable for consideration as Sally seems to have the capacity to learn quickly and to adapt to any changes. (See fig. 10.)

Epilogue

Sally's assessment was seen by her social worker who then came to get further details and to check various points. The social worker felt that the assessment fairly represented her own intuition and observations relating to Sally. The social worker then engaged in some intensive counselling with the mother of Sally. The outcome of this, and further short term stays at the hostel, was that the mother took a new perspective with her daughter. The mother came to accept that some form of semi-independent accommodation, or monitoring in the family home would be appropriate for Sally's future if anything were to happen to mother. Sally now takes a more active part in helping her mother to run the home and their roles have begun to reverse to some degree. It was also contracted that in the event of an emergency of any kind Sally would be able to come into the hostel for the period of the emergency. The latest information available is that this arrangement has continued successfully.

Fig. 10
C.I.I. INDIVIDUAL ASSESSMENT FORMAT (I.A.F.)

CLIENT'S NAME: Sally Wandsworth (Short term resident) D.O.B.: 9/9/45 FEMALE
ASSESSMENT PERIOD: 6/3/77 to 25/3/77. ASSESSMENT No.: 1. LAST ASSESSMENT DATE:
ESTABLISHMENT TYPE: Hostel – Short term bed ADDRESS:

OFFICER IN CHARGE:
CONTRIBUTORS:

key

ASSESSED LEVEL OF BEHAVIOUR	>	REPORTED LEVEL OF OPPORTUNITY	<
LEVEL OF PRESENT POTENTIAL	○	COINCIDENCE OF BEH'R & L/O	×

ASSESSED ACTIVITIES: MODE:	N	Cd	A	B	C	D	E	SUMMARY OF OTHER PERTINENT INFORMATION: (e.g. Inhibitions)
PERSONAL HYGIENE & HEALTH						×	○	Sally shows good standards generally but for hair care.
Hair Care & Feet Hygiene					>	⊘		These are areas of personal hygiene which requires checking.
MEDICAL					×	○		Few observations were made but knows what to do in most circumstances.
DOMESTIC (In hostel generally)				×		○		Short term only allowed limited observations. Helps when asked.
Room and Bed maintenance						>	⊘	She showed almost total independence (within the short term limits
Clothes Care						>	⊘	imposed) in the more immediate personal/domestic areas.
CATERING (General)						>	⊘	Most observations included only up to 'Hot snacks'
Full meal & None-essential Cooking					×	○		She showed willingness & competence when asked to help in these areas.
SHOPPING						>	⊘	Did her own personal shopping & occasionally offered to do 'others'
USE OF SERVICES (General)						>	⊗	Made her own decisions within a limited range known to her.
N.B. EMPLOYMENT (General)							⊗	Fully independent upon this scale. Required no supervision etc.
FINANCES (General)						>	⊗	Fully independent on this scale, except for below:
Budgeting income						>	⊘	It would seem that mother usually dealt with this. Sally has difficulty.
SOCIAL ORGANISATION OF TIME							⊗	Fully independent & considerate of others needs. Into normal range.
LEISURE							⊗	Kept herself reasonably occupied within limits available to her.
SOCIAL INTERACTION (General)							⊗	Independent in most areas with some variation as shown below:
Interpersonal – one to one (new)						>	⊘	Shyness seemed to reduce her initiative in new 1 to 1 interactions.
EMPLOYER INTERACTION					>		⊗	Sally described a range of responses, etc., to and with her employer,
								normally getting on with what was given but sometimes standing-up
								to her boss when she felt imposed upon. Thinking of a new job.
OPTIMUM MODES (NOT AN AVERAGE)							⊗	IF A SUPPLEMENTARY SHEET IS USED THIS REGISTER IS CARRIED OVER.

CASE STUDY NO. 5

This case study example is in the form of a residential social worker's report to her senior supervisor at a social services area office. The report was based upon an original assessment chart to which she had access, and a number of reviews that she attended. This social worker was acting as the key worker to the client and had confirmed most of the observations made by other staff. The assessment chart to which she is referring is shown in fig. 11. The other charts (figs. 12 to 14) demonstrate the client's progress over the period that she and others were engaged in a developmental programme. This programme was aimed at encouraging the client towards greater independence in his actions and the progressive development of the taking of initiative. In this way he would be able to take more responsibility for his own actions and thereby reduce many of those anxieties which were primarily induced by external influences and controls.

By now it should be possible for you to gain a fair idea of the progress in the client's initiative behaviour at each stage and in the various activities, by examining the charts themselves. With the steady progress towards successive estimations of 'present potential' and by offering an appropriate 'level of opportunity' in each area and stage, etc., the client became better able to control his anxieties and behaviour even with a 50% reduction in behaviour controlling drugs. It would be predicted that progress could continue provided that an appropriate level of opportunity is maintained which remains consistent with his optimum level of behaviour and current potential. This would demand flexibility in the particular level of opportunity offered, allowing for the variations that one may expect in any individual's capabilities and skills, particularly one with such deep rooted problems. The client will be vulnerable for some time whilst his trust in people is developing, and failure to consider the context in which he behaves will lead to regression and the re-establishment of inhibitions. The report that follows corresponds to the chart in figure 11:

SOCIAL WORK REPORT ON JAMES WILLIAMS *23rd. May 1976*

James was admitted to the hostel in the February of 1975 before I knew him. He seemed a quiet, nervous young man who spends most of his time alone in his room. He is 30 but looks older, being short and partially bald. His face and teeth have an unattractive irregularity about them caused by frequent self injuries and one eye has a slight turn which becomes especially noticeable when he is angry.

James has never really wanted to be part of the hostel. He realises that it is important for his mother to have a break and he prefers the hostel to a hospital but his one wish is to return home. He recognises the reasons behind his having to leave home but as yet does very little to try and kerb his anxiety or aggression, often finding his behaviour and his mother's patience with him a source of amusement. He still returns home every weekend unless there is an outing on the Sunday that he wishes to go on. He looks forward to and enjoys these outings even though they cause him a lot of anxiety. He becomes very agitated when travelling and aggressive, mainly towards himself, when asked to compromise his wishes with those of other residents. Other residents, in their turn, have become extremely intolerant of his behaviour, some to the extent of refusing to go if James is going. He does share a room with Roger and the arrangement does work, primarily due to their differing life styles, i.e., James gets up early and goes to bed early whereas Roger is the exact opposite.

James tends to be a very rigid individual having a considerable number of fixations that make his life very difficult. From the chart it can be seen that there are a number of mode C behaviours, both personal and social, indicating set goal, set plan operations that if thwarted produce great anxiety. He has a deep fear of soiling his clothes and his bed related to memories of his father's death from cancer. This means that whenever he goes to the toilet he has to wash himself, even when in public lavatories. At night he wakes up several times and visits the toilet just to be on the safe side. This has caused great antagonism towards him from other residents that he disturbs by banging doors and shouting. Another obsession is with tea and he will make himself one cup after another. Any attempt to modify this behaviour

by either cutting down or making tea for others results in great anxiety. Conversely he does not seem to enjoy his food. Any hint that certain foods may upset people causes him to refuse them as he dreads anything that may upset his stomach, consequently there are very few foods that he feels safe with. He bolts his food and spends much of the time at the dinner table heaving, which doesn't exactly endear him to other residents.

James has to do everything in a hurry as any delay cannot be endured. At domestic tasks he seems clumsy but the real reason is lack of patience. Other aspects of time however, are strictly regulated. He always goes to bed very early and gets up very early, a habit seemingly acquired at hospital and one which he refuses to break. He must always have a bath on the same day, shaves, changes his clothes, etc., to a strict routine, any break in which seems to upset him.

At a personal level this type of regulated behaviour is not necessarily a bad thing, we all do many things by habit. The main problem is that James cannot cope with the frustration of not being able to do things exactly when he wishes. Socially his behaviour is similar and makes him difficult to relate to. Whether in a group or at an interpersonal level Jamesd can be very polite and pleasant. His exaggerated manners and love of old fashioned ideas can make him very entertaining as well as informative in a number of areas. He has exceptional ability to remember things that are important to him, he can always tell you what people were wearing and can recognise and name pieces of architecture and interiors of buildings immediately. He also has a very good sense of humour and is quick to notice the things in everyday life that can make us all appear ridiculous. However, he has very little regard for anyone else's feelings and conversations tend to be rigid and one sided. They serve either to reassure him about his anxiety or they concern his love of architecture and art, but in either situation James' flamboyant means of communication results in him being the centre of attraction. The lack of concentration and patience that he exhibits socially seems to be compensated for in his ability to draw. He spends a lot of time painting historical buildings with a memory and imagination that are extremely good. However, subject matter remains fixated and it has proved virtually impossible to broaden this so that his drawings have a rather disappointing predictability about them. With time we hope that his art therapy sessions at the local general hospital may prove valuable in this area.

As the chart shows he has had very little opportunity to do domestic tasks for himself. The reason for this tends to be that his mother does most things for him. At present she takes all his washing home with her at weekends, she does his mending, she changes his bed and despite our protestations James is happy to let her do all of these things. Obviously this is not desirable and certainly in James' case it is unnecessary as his capacity for all these things is high. His mother's involvement must be one of the main areas to concentrate on but her anxiety and guilt about James' behaviour causes her to rely on these activities as a form of compensation. The move must be gradual and she must be persuaded that her actions are not necessarily the best thing for her son if he is to learn to become more responsible.

James' main problem at present is in controlling his anxiety. He is unable to tolerate uncertainty, words such as 'possibly' or 'maybe' being virtually catalysts to anxiety attacks. He is very attached to certain people, objects or places, being over-possessive and obsessed by them. The absence of these people, the loss of certain objects or the possibility of not going somewhere, however temporary the threat may be, can all produce anxiety. He starts to sweat and panic, if no solution of absolute certainty is found quickly he can become aggressive, striking out at residents or furniture and often hitting himself in the face.

Once he has become this anxious very little can be done or said to aleviate it. If he is worried about anything and as a consequence begins to panic he also feels guilty about his behaviour. Thus the reassurance he primarily required is no longer possible as he can no longer believe he deserves it. For example, if he has misbehaved his one anxiety is that he may be sent back to a hospital. He will apologise for his behaviour and then pester repeatedly about these fears. Often no amount of reassurance that this is not so will help. James finds it difficult to believe people, especially when he knows that he deserves to be punished anyway. This question of trust is crucial and we must be careful not to promise or to threaten anything that cannot be done.

Epilogue

Gradually James must be helped to realise that he influences his own life. At present misbehaviour and consequent lack of privileges is seen as betrayal on the part of the staff who had formally allowed them. He cannot as yet tolerate the idea that things are his own fault, blaming a variety of things such as drugs, noise and other people. He believes that his drugs do him good and thoroughly enjoys his injections as they make him better. One reason for his misbehaviour is therefore seen as the doctor's fault for not giving him enough. Other reasons include the noise of the television which he refuses to go near, or indeed any noise which he dislikes such as children screaming. Complaints about other residents upsetting him are unfortunately usually true, he is not popular and some residents do tend to tease or to lose their patience with him quickly. The crucial answer seems to be to attempt to gain an initial stability in his relationships and his environment in order to eventually help him to tolerate uncertainty and disappointments. In a practical sense there is going to be no problem in getting him to a satisfactory level of independence in a relatively short time. The problem will be in helping him to achieve some kind of emotional stability if he is ever going to use these skills in any real sense. (See also fig. 4.). Fig 12 to 14 describe how he progresses as his skills are developed and the 'level of opportunity' is changed. His emotional stability & behaviour remains closely tied to the level of opportunity that is offered him to use his initiative.

Fig. 11
C.I.I. INDIVIDUAL ASSESSMENT FORMAT (I.A.F.)

CLIENT'S NAME: James Williams D.O.B.: 14/7/45 MALE
ASSESSMENT PERIOD: 2/8/75 to 17/11/75. ASSESSMENT No: 1. LAST ASSESSMENT DATE:
ESTABLISHMENT TYPE: 24 Bed Hostel – with Bedsits. ADDRESS:

OFFICER IN CHARGE:
CONTRIBUTORS:

key

ASSESSED LEVEL OF BEHAVIOUR	>	REPORTED LEVEL OF OPPORTUNITY	<
LEVEL OF PRESENT POTENTIAL	○	COINCIDENCE OF BEH'R & L/O	×

ASSESSED ACTIVITIES: MODE:	N	Cd	A	B	C	D	E	SUMMARY OF OTHER PERTINENT INFORMATION: (e.g. Inhibitions)
HYGIENE (Washing, shaving & teeth)					⊗			Very fastidious and rigid. Often obsessional with washing.
Bathing, hair, nails & foot care.	×				○			Is insistant that these are done for him although capable himself.
MEDICAL					⊗			Rigid about getting his drugs on time, panics about injuries.
DOMESTIC (Hostel – General)				×	○			Does not volunteer help. Stays in his room when he can.
Room maintenance (Tidies only)	>				⊗			A domestic does the cleaning and he gets anxious about things moved.
Bed making	>			×	○			Often just throws the covers over. Better results when supervised.
Clothes; buying, washing & ironing	<	>		○				He has had no experience in these areas. Mother did them for him.
Clothes; changing, hanging, storing.					⊗			Quite rigid about what to wear and how he stores his clothes.
CATERING (does not include cooking)					⊗			Will make hot drink or sandwich for self but leaves mess for others.
SHOPPING			>	⊗				Usually goes with a group of residents with staff. Will play up often.
USE OF SERVICES (A.T.C. & Pub)				>	⊗			Can be difficult at A.T.C., though he is liked. Is taken to Pub.
FINANCES (General)	<	>	○					Tends to be careless with money. Staff deal with most finances.
Budgeting pocket money					⊗			Runs out of money quickly and is often supplemented by mother.
SOCIAL ORGANISATION OF TIME					⊗			He is a very good time keeper but again rather rigid & anxious.
LEISURE (No T.V. or Games etc.)					>		⊘	Has a strong interest in collecting Victoriana & bric-a-brac. He
								also seems to have a strong aesthetic sense. Paints and draws vividly.
								Keen interest in and knowledge of history.
SOCIAL INTERACTION (1 to 1)				>	>	⊘		Pleasant enough and interesting – Hates to be disturbed by others.
Group & Community interactions				>	⊘			Seems to intensely dislike large groups, especially if noisy etc.
Sexual relationships			×					He seems very confused in this area Sexuality worries him frequently.
OPTIMUM MODES (NOT AN AVERAGE)					⊗			IF A SUPPLEMENTARY SHEET IS USED THIS REGISTER IS CARRIED OVER.

Fig. 12
C.I.I. INDIVIDUAL ASSESSMENT FORMAT (I.A.F.)

CLIENT'S NAME: James Williams — D.O.B.: 14/7/45 MALE — OFFICER IN CHARGE:
ASSESSMENT PERIOD: June 76 to 18/9/76. ASSESSMENT No.: 2. LAST ASSESSMENT DATE: 17/11/75 — CONTRIBUTORS:
ESTABLISHMENT TYPE: 24 Bed Hostel-with Bedsits. ADDRESS:

key

ASSESSED LEVEL OF BEHAVIOUR	>	REPORTED LEVEL OF OPPORTUNITY	<
LEVEL OF PRESENT POTENTIAL	○	COINCIDENCE OF BEH'R & L/O	×

ASSESSED ACTIVITIES: MODE:	N	^{C}d	A	B	C	D	E	SUMMARY OF OTHER PERTINENT INFORMATION: (e.g. Inhibitions)
HYGIENE (Washing, shaving & teeth)					×	○		James remains rigid and is still, though more rarely, obsessional.
Bathing, hair, nails & foot care.	×					○		He is still resistant to do these himself, seems like high -ve Init'v.
MEDICAL					×	○		Beginning to show signs of flexing about medication. Still panicky.
DOMESTIC (Hostel – General)					×	○		Still doesn't volunteer but less resistant at the same level (Ass. 1).
Room maintenance (tidying +)			>		×	○		Is now having 'cleaning' lessons from domestic staff (Pre Art Therapy)
Bed making				>	⊘			Still needs supervision but is more cooperative.
Clothes; Buying;	<	>		○				
Clothes; Washing & Ironing.			⊗					Now getting lessons in washing, cooperating, no real results yet.
Clothes; changing, hanging, storing						>	⊘	James has become less rigid and open to discussion on these matters.
CATERING (Not full meal etc.)					×	○		He has now begun to cook simple snacks, learns quickly & is pleased.
SHOPPING					⊗			Still goes with staff but now uses more initiative. Still plays up.
USE OF SERVICES (A.T.C., Pub, Library)					×	○		Rather rigid but has leveled up. Goes to library for Architectural Bks
FINANCES (General)	>		○					Staff still deal with major finances. He now takes his earned income
Budget pocket money & earned Inc.					>	<	○	but is given the responsibility to save a little each week.
SOCIAL ORGANISATION OF TIME					>	<	○	Still at previous level of Behaviour – improved signs of potential.
LEISURE					>		⊘	Tends to mix in a little more, says he hate the T.V. and is continuing
								with his Art and History interests, willing to talk about these.
SOCIAL INTERACTION (1 to 1)					>	⊘		Interactions more stable but still irritated by disturbances.
Group & Community interactions					⊘	<		much as above, but will join in for a laugh or a joke now & then.
Sexual relationships			×	○				Have chatted with him about problems he has. It will be slow going.
OPTIMUM MODES (NOT AN AVERAGE)					>	⊘		IF A SUPPLEMENTARY SHEET IS USED THIS REGISTER IS CARRIED OVER.

Fig. 13
C.I.I. INDIVIDUAL ASSESSMENT FORMAT (I.A.F.)

CLIENT'S NAME: James Williams — D.O.B.: 14/7/45 MALE — OFFICER IN CHARGE:
ASSESSMENT PERIOD: Sep. 76 to May 77. — ASSESSMENT No.: 3. — LAST ASSESSMENT DATE: 18/9/76 — CONTRIBUTORS:
ESTABLISHMENT TYPE: Hostel Bedsit. — ADDRESS:

key

ASSESSED LEVEL OF BEHAVIOUR	>	REPORTED LEVEL OF OPPORTUNITY	<
LEVEL OF PRESENT POTENTIAL	○	COINCIDENCE OF BEH'R & L/O	×

ASSESSED ACTIVITIES: MODE:	N	Cd	A	B	C	D	E	SUMMARY OF OTHER PERTINENT INFORMATION: (e.g. Inhibitions)
HYGIENE (General)					>	⊘		James has made some progress, seems to be able to tolerate frustration
Bathing, hair, nails & foot care.					×	○		Since his last ass. James has taken responsibility for bathing himself.
MEDICAL					×	○		James now carries his own medication. Taking it is checked.
DOMESTIC (Hostel General)					>	⊘		He now takes his turn for duties and is beginning to enjoy these.
Room maintenance					>	⊘		James now cleans and tidies his own bed-sitting room (recent move)
Bed making					>	⊘		He has got into a routine and does this well now.
Clothes Buying				>	⊘			Now goes to buy his clothes with a member of staff. Advised choice.
Clothes Washing & Ironing				>	⊘			He has made good progress here and enjoys the praise of success.
Clothes, Changing, hanging, storing						>	⊘	He is much less anxious now he is on his own. Less fixed routine.
CATERING (General)					>	⊘		Has recently had lessons in more complex cooking, progress good.
SHOPPING					⊘	<		He now goes off to buy small items on his own (see Pub also).
USE OF SERVICES					>	⊘		We feel that he can now be trusted more on his own. A few problems.
FINANCES				>	⊘			Has been going with staff to get Soc. Sec. Now started on his own.
Budget Income						×	○	Pays his rent, willing to put some by and spends most of the rest.
SOCIAL ORGANISATION OF TIME						>	⊘	He has become less rigid without losing time keeping ability.
LEISURE					>	>	⊘	Varies a bit. Listens to the radio now. Painting less. Still draws.
SOCIAL INTERACTION (1 to 1)					>	⊘		Still stabler and a little less irritable. Goes to Pub. on his own.
Group interaction (peers)					>	⊘		Spends a little more time with other residents. Sometimes upset.
Community interaction					⊘	<		Still needs to learn a lot and needs guidance.
Sexual relationships				>	⊘			Getting on better with women. Some progress in understanding.
OPTIMUM MODES (NOT AN AVERAGE)						⊘	<	IF A SUPPLEMENTARY SHEET IS USED THIS REGISTER IS CARRIED OVER.

Fig. 14
C.I.I. INDIVIDUAL ASSESSMENT FORMAT (I.A.F.)

CLIENT'S NAME: James Williams — D.O.B.: 14/7/45 MALE — OFFICER IN CHARGE:
ASSESSMENT PERIOD: 15/3/77 to 12/6/77. — ASSESSMENT No.: 5, — LAST ASSESSMENT DATE: 5/2/77. — CONTRIBUTORS:
ESTABLISHMENT TYPE: Hostel Bed-sit. — ADDRESS:

key				
	ASSESSED LEVEL OF BEHAVIOUR	>	REPORTED LEVEL OF OPPORTUNITY	<
	LEVEL OF PRESENT POTENTIAL	○	COINCIDENCE OF BEH'R & L/O	×

ASSESSED ACTIVITIES: MODE:	N	Cd	A	B	C	D	E	SUMMARY OF OTHER PERTINENT INFORMATION: (e.g. Inhibitions)
HYGIENE (General)					>	⊘	<	James has levelled off somewhat. Tolerates frustration with lapses.
Bathing, hair, nails & foot care						⊗		He takes responsibility for these areas and has stabilized.
MEDICAL						⊘	<	James now goes to G.P. on his own.Collects own prescription etc.
DOMESTIC (General)						>	⊘	Since he moved into a bed-sit he remains helpful, though not required.
Room maintenance						>	⊘	James now has full responsibility for his own room. V. Independent.
Bed making						>	⊘	He has progressed as far as required & shows good results.
Clothes Buying					×	○		Has recently bought shoes & trousers on his own. Well done.
Clothes Washing & Ironing					×	○		Is now quickly reaching high independence. L of Opp will be 'upped'.
Clothes Changing, Hanging, storing						>	⊘	Staff no longer feel they need to monitor. Much more flexible.
CATERING (General)						>	⊘	Now cooks his own dinner and eats in his room, except special occasions
SHOPPING					>	⊘		Given allowance. Goes out to buy his own food for dinner, etc.
USE OF SERVICES						⊗		Goes to 2 or 3 different Pubs. Travels home to see mum on P. Transport.
FINANCES					×	○		Gets own Soc. Sec. Budgets for food & fares etc. Sometimes overspends.
Budget Income (overall)						×	○	Does well in all areas but finds it difficult to save. Trys hard.
SOCIAL ORGANISATION OF TIME						>	⊘	Good time keeping for work & G.P. appointments. Accepts change better
LEISURE (T.V. News & Docum't. inc.)						>	⊘	Tends to join in more, when in the mood. Maintains his interests.
SOCIAL INTERACTION (1 to 1)						⊗		Has made a few friends outside the hostel. Tends to get attached.
Group interaction (peers)						>	⊘	Is now taking a more active part in group activities. More tolerant.
Community interactions						⊗		Seems to be doing better. One or two problems now & then (acceptable).
Sexual relationships						⊗		Less anxious about women. He is less inhibited & more knowledgeabel.
OPTIMUM MODES (NOT AN AVERAGE)						>	⊘	IF A SUPPLEMENTARY SHEET IS USED THIS REGISTER IS CARRIEDOVER.

CASE STUDY NO. 6

Karen aged 27, was admitted to the hostel for a short stay. She had been assessed as mentally handicapped, had attended an ESN(M) school and had been working at the Adult Training Centre since leaving school. She was a reliable, friendly, tidy girl, quick to learn and eager to please and a willing and able helper. Though reserved in strange company, she readily 'opened up' when encouraged and finally converse quite freely, even on the first meeting. When an informal, friendly atmosphere had developed she would take the initiative and speak frankly and intelligently, with confidence, on any subject in which she had interest or contact. She had a sense of humour, though she seldom joked and didn't appear to have any sensitive areas. She didn't seem to worry about being considered 'different' from others in society and indicated that she didn't consider herself different. She was very accepting of working at the ATC or any other situation and there was the possibility of exploitation as a consequence. The greatest problem was that she would be unacceptable in outside employment of her choice, as a result of being classified rather than because of a lack of ability or speed. Her social development needed to be encouraged so that she would be able to instill her confidence in a prospective employer or any local community in which she might live.

Karen attended a social club regularly and mixed very well, enjoyed dancing and regularly encouraged those who were too self-conscious. Her interests in music were wide-ranging and she had a good sense of rhythm. She appeared to be shy with boys and although friendly with many, has not developed a deep relationship with anyone in particular. However, she undoubtedly had some confidence and her 'coyness' was possibly a feminine ploy but more likely indicated embarrassment due to the progress of her emotional development which appeared to be slow and at a late adolescent stage. She often talked about her home life and appeared to love and respect both her parents and her brother. She did, however, seem to be over-protected, having very few outlets outside of her family other than the ATC and the social club. Even so her comments suggested that she wanted to travel and socialise more than she did.

During a conversation Karen indicated that she would like to get a job in outside employment and said that her mother was willing to allow this. She told me that she was looking for any kind of work, perhaps in a store-room or shop, a greenhouse or a school kitchen, showing greatest interest in the latter. I knew from the Cook of the ATC canteen, whom Karen helped during the day, that she was a useful and reliable helper, slightly better than the average kitchen assistant. The Cook was very enthusiastic and felt that Karen could be accepted anywhere in this work, as she was very happy and interested in cooking. She also related that Karen had once shown interest in being a waitress.

Karen was generally a pleasant and polite girl, with an amiable personality. She rarely showed extremes of emotion and I never saw her angry or aggressive. The only examples of her being upset were due to physical pain, once when she burnt her hand and cried for some time, rejecting any offers of help, and when she had toothache which made her depressed and irritable.

She is usually accepted socially as a girl of a lower age, although when she is treated as an adult she invariably reacts as one, exhibiting a good social manner. However, she did have certain mannerisms which tended to be noticed and sometimes remarked upon, restricting her social development in relation to others. These were:

(a) an air of overconfidence in her manner
(b) a distinctive walk, lacking deportment
(c) coyishness

All of which indicate, with other criteria, the adolescent stage of her development which could be remedied, gently, by social and physical training. See fig 15 to get some idea of the assessment of how she was able to function in different areas and activities at this time.

Epilogue

Karen began to make great strides in her development. Over the course of the following year, with cooperation between the ATC staff and Karen's social worker she was able to get a job

of her choice. She began working in a catering kitchen as a general assistant and now works as an assistant cook. Reports fed back to me through the ATC cook (who maintained some contact with Karen and her supervisor) indicate that she is a well respected and hard worker. Apparently there had been a period of conflict and confusion on the part of workmates, who were concerned that she would be a drain on them. This later developed into animosity because Karen showed herself to be a competent and willing worker but after two to three months the work situation stabilised and the present working relations are suitable to Karen. Over the same year period Karen continued to come to the hostel for short term placements. Contact was maintained with the mother, both directly and through the social worker. The parents are now offering Karen a more realistic context for her to develop and mature and she has been able to reach her potential in most areas of home and work life.

Fig. 15
C.I.I. INDIVIDUAL ASSESSMENT FORMAT (I.A.F.)

CLIENT'S NAME: Karen Stone D.O.B.: 12/6/49 FEMALE
ASSESSMENT PERIOD: 3/9/76 to 18/9/76. ASSESSMENT NO.: 1. LAST ASSESSMENT DATE:
ESTABLISHMENT TYPE: ADDRESS:

OFFICER IN CHARGE:
CONTRIBUTORS:

key				
	ASSESSED LEVEL OF BEHAVIOUR	>	REPORTED LEVEL OF OPPORTUNITY	<
	LEVEL OF PRESENT POTENTIAL	○	COINCIDENCE OF BEH'R & L/O	X

ASSESSED ACTIVITIES: MODE:	N	Cd	A	B	C	D	D	SUMMARY OF OTHER PERTINENT INFORMATION: (e.g. Inhibitions)
PERSONAL HYGIENE						>	⊘	*Maintains good standards in all areas (over two week period)*
MEDICAL (First aid & medication)						>	⊗	Shows good sense and is willing to help out (epileptic fits etc).
Use of doctor					X		○	Mother goes along with her apparently. Said she could manage herself.
DOMESTIC (General)							⊗	*She is competent in all listed areas at this level. Very helpful.*
CATERING (General)							⊗	As above, doesn't need asking. Shows skill in cooking main meals.
SHOPPING					X	>	○	Does her own small purchases under her own initiative. Shops for
Buying clothes & shoes.					X		○	*mother under instruction. Would like to buy her own clothes & shoes.*
USE OF SERVICES (actual)							⊗	She attends the local M/H club and goes to the A.T.C. but feels
USE OF SERVICES (anticipated)	>		<				○	she would like to do more than she is allowed to do.
FINANCES					>	○	<	Not so good at the *mechanics but uses money competently (more education)*
paying bills						>	○	Took the initiative to pay her rent each week. Dealings were O.K.
SOCIAL ORGANISATION OF TIME							⊗	Seemed to be quite independent in this area generally. Helped others.
WORK (A.T.C.)							⊗	*Keen to get there, reported to work well. Enjoys her work.*
LEISURE-home					X		○	(see Use of Services) She made the best of being in the hostel.
LEISURE-hostel							⊗	Went for walks, taking other residents and used the pub 'sensibly'.
Hobbies						>	○	Main interests were music and domestic-like activities – Knitting etc.
SOCIAL INTERACTIONS (General)						>	⊘	Social skill are good though a little immature at times. Acts coy!
Sexual relationships						>	⊘	Behaves rather like an adolescent – Knows the facts of life.
Community interaction						>	⊗	When she is allowed to be seen as 'normal' there are few problems.
OPTIMUM MODES (NOT AN AVERAGE)						X	○	IF A SUPPLEMENTARY SHEET IS USED THIS REGISTER IS CARRIED OVER.

Fig. 16

SITUATIONS OR CONDITIONS WHICH INHIBIT THE PERSON:
No significant inhibitions other than those imposed by lack of experience in normal lifestyle.
She seems to have some difficulty, at times, in the use of money, particularly budgeting. This appears to be imposed to some degree by the fact that her mother usually
takes the initiative and responsibility in this area.
Sally also lacks 'normal' experience in some areas of social interaction, particularly one to one interpersonal interaction, and perhaps especially with the opposite sex
(although she does have a steady boyfriend). Again, lack of a 'normal' interactive lifestyle could be the inhibiting factor here.
In those areas where her optimum level of functioning has been suppressed, e.g. Some areas of general domestic activity, use of medical facilities and appliances
and full-meal catering, the inhibiting factors would seem to be lack of wider experience and the limitations upon the level of opportunity (in the kitchen) available in the
family home.
OUTLINE PLAN OF ACTION:
I would suggest that the findings of our assessment be communicated, by a field social worker, to Sally's parents and that in cooperation with them, through other
short term or training placements, we attempt to develop any skills which are lacking.
A longer term possibility would be for Sally to come into the hostel for final preparation for the transfer to an un-staffed group home, a shared tenancy or her own flat.
This preparation will involve encouraging her to take her optimum initiative in those areas where she does not yet do so.
ADDITIONAL NOTES:
I would point out that her general level of competence and high degree of independence, coupled with fairly high level of initiative would allow her to live a semi-
independent life, say in a supervised group home, in the very short term.

APPENDIX 'D'

Ian Macdonald and Terry Couchman

ASSESSMENT OF MENTALLY HANDICAPPED ADULTS FOR RESIDENTIAL PLACEMENTS

PRELIMINARY ASSESSMENT FORMAT FOR USE BY SOCIAL WORKERS IN A FIELD SETTING

This should act only as a guide to placements for potential residents

PART I – THE ASSESSMENT PROCEDURE.

1. This form is based on the 'Chart of Initiative and Independence', by Ian Macdonald, and Terry Couchman developed at Leavesden Hospital in conjunction with the London Boroughs of Harrow, Hillingdon and Ealing. It has been modified through further research and discussion to meet some of the fieldwork needs of a social service department wishing to rationalise its placement allocations.
2. It is intended that this particular format should be used in three basic stages:
   a) A discussion with a residential social worker/allocations officer, to clarify establishment(s) entry criteria and assessment needs.
   b) An initial semi-structured interview (using page 69 of is document) with the parent guardian, or another referring agent.
   c) A second more detailed assessment (using the chart on page 71 of this document) having established a mutually meaningful list of 'assessed activities' against which the 'client' may be considered.
3. The result of 'b' and 'c' will act as a guide to a mental health allocation team meetings. No final decision about allocation of a client to a particular establishment need be made at this stage. The initial assessment can be followed up, using the full procedure, after a provisional client placement.
4. (Part 'a') First discuss the package with a residential social worker to ascertain how you both might use the assessment. Here it would be useful to do one or more worked examples in order to clarify the procedure.

(Part 'b') Page sixty nine describes different ways in which people *approach* tasks, and different ways in which people are *allowed* to carry out tasks.In the first interview start with a general question and then continue to use the descriptions on 69 to follow up the answers.

For example:

'What sort of things does (possible resident) do and/or like to do?' – 'How do they do this?'

'Is there anything you encourage/discourage them from doing?' – 'How do you encourage/discourage them?' – 'Why have you chosen to do this?'

Make a general record of the interview, *for example:* ''The potential resident likes to do domestic work which he/she does in a routine way which cannot be easily modified. He/she is not allowed into the kitchen or out of the house unles mum or dad is with them, or for a specific purpose.

(Part 'c') At a subsequent interview a more systematic account can be made with regard to more specific activities (refer to page 69 onwards). What follows is a brief explanation and an operational outline.

5 At this later interview the intention is to record the views of the interviewee, who may be a relative or guardian of the mentally handicapped adult. It should contain the following:
   a) *their account* of the (possible) residents behaviour;
   b) *their account* of the level of opportunity they offer the (possible) resident;
   c) *their account* of the *present* potential of the (possible) resident;
   d) *your* comments on the interviewee's account.
6. It does not rely upon any direct observation of the potential resident, although this could be indicated in the comments column where it has proven possible to do so.
7. These accounts are in terms of activities listed on the left. There are spaces left for you to put in more activities if you wish to. The blank spaces under each section can include activities related to that section, e.g., add hair-washing to personal hygiene. These additional activities can be taken from the 'Manual of Activities' and/or can include the particular interests of the potential resident.
8. *Behaviour* refers to an actual observation made by the parent or guardian
   Level of Opportunity refers to what the person is or is not 'reported' to be allowed to do by parent, guardian or circumstances.
   and *Present Potential* asks what they could do *now* if they were not held back, either by lack of opportunities or personal inhibitions.
9. The comments column can be used to include your own opinions relating to the functioning of the potential client and the relationship with interviewee.

10. The flow diagram (page 70) is an aid in the chart on page 71 (part of 'c'). If you start at the top left hand box and substitute any of the activities listed (page 7 & MofA) then one proceeds to follow to the right or downards according to the yes or no answers.

PART II – OPERATIONAL OUTLINE

11. This outline is not intended as a full guide to the use of the chart which should not be used until you have cleared its potential use with a residential social worker and/or the allocations officer. A fuller explanation of the concepts, methods and techniques used in the 'Assessment of Initiative and Independence of Mentally Handicapped People' and any of the 'Charts of Initiative and Independence', can be found in the 'Manual for the chart of Initiative and Independence'.
12. The 'assessed activities' categories that are listed on the assessment chart on page 71 are rather general. For the purpose of a preliminary or initial assessment such general categories are useful only for getting an overall impression of how the potential client functions in that area. This overall impression will have been gained from more specific instances which arise during an interview. You may feel that some of these more specific 'activity' categories are worth registering on the chart under the more general heading supplied. Included are supplementary assessment sheets so that you may extend the 'assessed activities' categories if you wish.
13. During your discussions with the residential social worker it is likely that they will have outlined some general, or perhaps some specific, 'activities' which they feel would be useful for considering the individual for a particular residential home, etc.. In order to help enable you to consider and decide on what criteria to use the Manual of Activities, referred to earlier, has a list of major headings, each with a set of more specific activities that may be useful. These are just suggestions, however, and any number of other viable 'activities' may be considered. It is essential that these activities are assessable in terms of the modes 'A' to 'E', so check them out against these (see page 69).
14. During your initial assessment interview, described in part 'b' of the format, you may have already established a reasonably firm idea of what level the potential resident functions at and any limitations on them that may be imposed by the level of opportunity offered. It would be useful, therefore, to choose additional assessment categories which will help to confirm or contradict this first impression. For instance, if the first interview indicated that the individual functioned at or below mode 'C' but the level of opportunity seemed to be higher than this, to choose a category like 'washing face', or 'cleaning teeth' may only really serve to confirm functioning below mode 'C'. One might tend to see these activities as 'appropriately' mode 'C' operations anyway. In order to test the possibility that the individual is able to function at a level higher than mode 'C' it would be more useful to choose a category which clearly demands up to mode 'E' functioning in normal circumstances. How the individual functions at 'purchasing sweets, cigarettes, or clothing', or, 'organising their leisure time activities' may indicate an ability or a potential to function above mode 'C', at least more readily than the more habitual activities.
15. Having investigated and considered the individual's normal behaviour in a particular area or activity one should next question as to whether there are any exceptions to this 'more usual' behaviour. These variations may be of two kinds. The individual may at times revert to a lower mode of operation from time to time, or else may seem to operate at a higher mode for short periods or in particular instances. In the case where an individual reverts back to a lower mode of behaviour this may be due to the fact that they were going through a distressful period. Alternatively, this may be due to the fact that the level of opportunity they are offered is inappropriate. Other possibilities may arise during the course of the interview and these should be noted. In the instances where the individual occasionally functions at a higher modal level this may serve to indicate that the level of opportunity is inappropriately low and they are demonstrating an ability to function at this higher level. Alternatively, this may merely indicate that the person is showing some evidence of their level of present potential for development. Again other evidence from the interview may indicate other reasons, these also should be noted. If the frequency of

occurrence of these variations in overt behaviour are substantial enough it may be more appropriate to register their behaviour in more than one mode. Where the frequency is relatively low it would be more appropriate to consider this as evidence to support the interviewee's and your own estimation of the client's level of present potential.

16. OPTIMUM MODES refers to the most comfortable, overall levels of behaviour and opportunity, and should not be registered as an average. This section of the chart should be completed at the end of 'all' the assessed categories, including those which you may have incorporated itno suplementary sheets.

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KEY	No Opportunity N	Complete Dependency C/D	MODE A	MODE B	MODE C	MODE D	MODE E
LEVEL OF OPPORTUNITY	There is no opportunity available to do this.	It is always done *for* him/her.	You tell him/her *when* to do this *and* how to do it. It is always under your instructions.	You tell them when to do it but then leave them to get on, but later check how it was done.	You allow the person discretion to decide when and how to do something but you check *when* it is done and monitor *how* it is done.	You allow the person discretion to decide when and how to do something, checking *when* it is done but not monitoring how it is done.	You allow the person full discretion and do not check or monitor. You intervene only if requested to do so by the person.
BEHAVIOUR	I have not seen the person actually do this recently. If the person refuses to do this activity state this by noting 'R' under N.	The person does not achieve goals or plans even when told or shown.	The person only does this when told or shown what to do and how to do it.	The person only does this when told what to do but can then get on and do it.	The person does this activity without being told but both *when* and *how* they do this in a pre-set way.	The person does this activity without being told. The *when* is not fixed and others wishes are tolerated unless they threaten the goal of activity.	The person does this activity in a flexible way without being told. They can take into account the needs of others and substitute goals.
PRESENT POTENTIAL	There is no opportunity for the person to show any potential.	The person does not have the capacity to act on goals or plans even when told or shown.	The person can only do this when told or shown what to do and how to do it.	The person can only do this when told what to do but can then get on and do it.	The person is capable of doing this without being told but both *when* and *how* they do this is in a preset way.	They are capable of doing activity without being told. The *when* is not fixed and others wishes are tolerated unless they threaten the goal of activity.	They are capable of doing the activity in flexible way without being told. They can take into account the needs of others and substitute goals.

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Chart of Initiative & Independence Flow Diagram – a guide to Behaviour and Level of Opportunity assessment

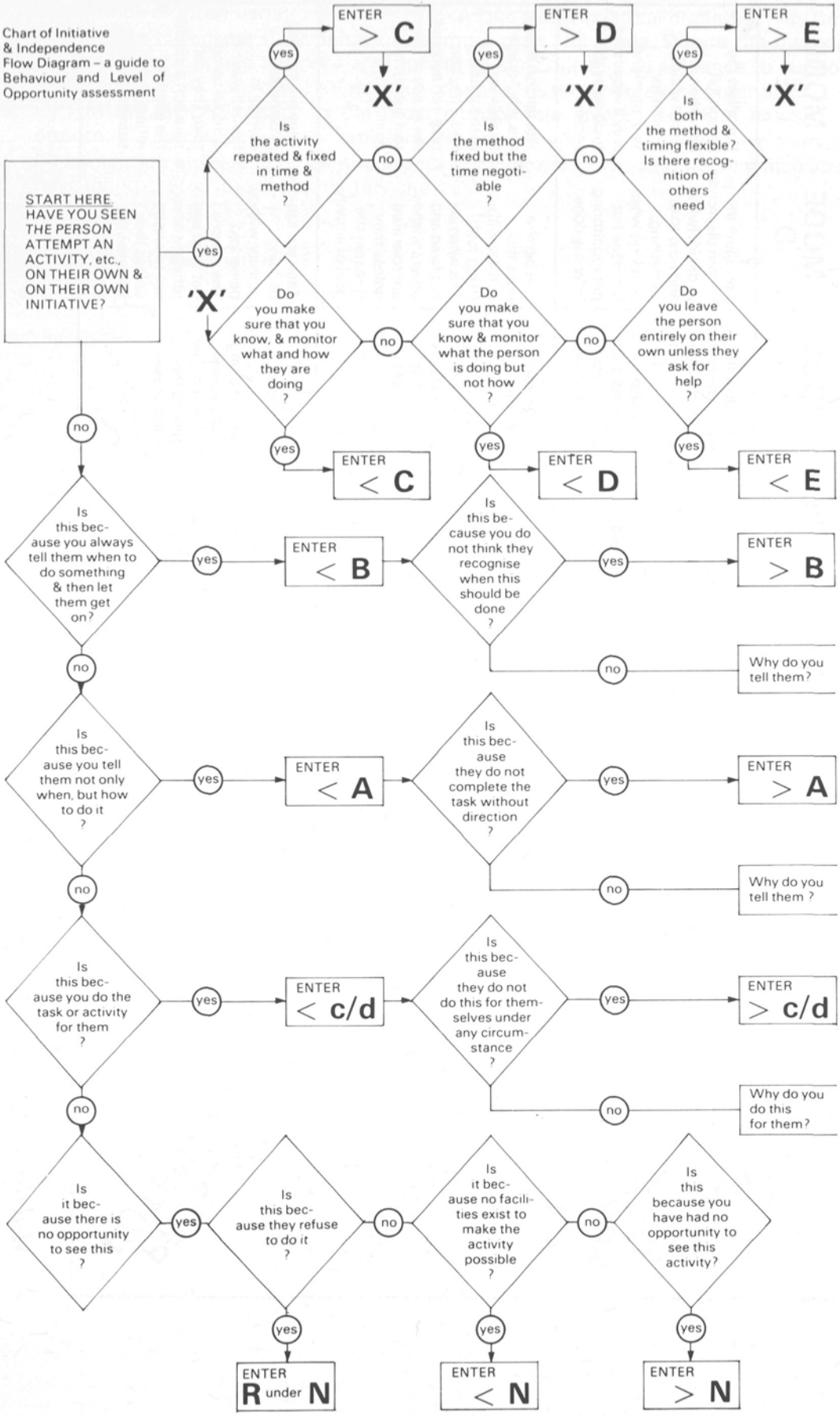


Chart of Initiative and Independence (C.I.I.)

Preliminary Assessment Format for Use by
Social Workers in a Field Setting

Ian Macdonald and Terry Couchman

POTENTIAL RESIDENT: D.O.B.: MALE/FEMALE PRESENT ADDRESS: SOCIAL WORKER: S/W TEAM:											INTERVIEWEE: RELATIONSHIP: PLACE OF INTERVIEW:
key	REPORTED LEVEL OF BEHAVIOUR		>	REPORTED LEVEL OF OPPORTUNITY		<					
	LEVEL OF PRESIDENT POTENTIAL		○	SEE EXPLANATION FOR FURTHER DETAILS*							DATE(S) OF INTERVIEW:
ASSESSED ACTIVITIES: MODE:	N	c/d	A	B	C	D	E	SOCIAL WORKERS SUMMARY OF OTHER PERTINENT INFORMATION:			
PERSONAL HYGIENE											
MEDICAL											
DOMESTIC											
CATERING											
SHOPPING											
USE OF SERVICES											
FINANCES											
SOCIAL ORGANISATION OF TIME											
LEISURE											
SOCIAL INTERACTION											
OPTIMUM MODES (NOT AN AVERAGE)								*IF A SUPPLEMENTARY SHEET IS USED THIS REGISTER IS CARRIED OVER.*			

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SUPPLEMENTARY SHEET:

ASSESSED ACTIVITIES: MODE	N	c/d	A	B	C	D	E	SUMMARY OF OTHER PERTINENT INFORMATION: (e.g. Inhibitions)
OPTIMUM MODES								THIS REFERS TO THE MOST COMFORTABLE OVERALL LEVELS, NOT AN AVERAGE.

ADDITIONAL NOTES:

MENTAL HANDICAP SERVICES UNIT

HOW TO USE THE

CHART OF INITIATIVE AND INDEPENDENCE

C.I.I.

APPENDIX VI

HOW TO USE THE
THE CHART OF INITIATIVE
AND INDEPENDENCE



HOW TO USE THE

CHART OF INITIATIVE AND INDEPENDENCE

C.I.I.

The C.I.I. is available from N.F.E.R. Nelson Publishing Company Limited, Darville House, 2 Oxford Road East, Windsor, Berks, SL4 1DF

Mental Handicap Services Unit, Brunel Insitute of Organisation & Social Studies, Brunel University, Uxbridge, Middlesex, UB8 3PH. Telephone Uxbridge (0895) 56461 Telex 261173G

ASSESSMENT AND THE C.I.I.

This paper is most usefully read in conjunction with either the C.I.I. manual or the Introduction of the C.I.I.

The C.I.I. is part of a group of assessments which is called "process assessment". This means that it is concerned with recording changes as they happen. It is about the RELATIONSHIP between you and another person. In this case you and people with a mental handicap. It is important to distinguish this from clinical assessments or TESTS which are usually trying to identify things which do not change, or at least change very slowly. For example, compare an intelligence test with the C.I.I. Your intelligence does not vary from day to day and not much from year to year - however, the way you use your intelligence does. Some days you may appear or feel particularly stupid or clever but you have not necessarily become stupid or clever. A test like the IQ test measures the underlying trait; a process assessment like the C.I.I. measures its everyday appearance.

The main consequence is that a test will give you a score, which should not vary (or vary in a predictable way - like a developmental score). The C.I.I. gives you a range of descriptions from which you draw your own conclusions and implications.

PRINCIPLES OF ASSESSMENT

If someone wants to use the C.I.I. (or any assessment) the first questions is WHY

1) They have been told to do so and so the process will only be a ritual. There is no point in continuing.

2) They have some real purpose in mind and they think it will help in their work - in this case they will need some help from you.

The first principle is to:

DISCOVER THE PURPOSE OF AN ASSESSMENT

Every time a person or group sits down to complete a C.I.I. they must have a real objective.

The C.I.I. can be used:

A) TO MONITOR PROGRESS AND CONSTRUCT PROGRAMMES. This will involve activities set by those concerned with care, and may include the client.

B) TO HELP GATHER AND PRESENT INFORMATION FOR POSSIBLE TRANSFER: This will involve information from the proposed setting.

C) TO LOOK AT A SPECIFIC AREA OF COMPETENCE: This will involve a more detailed and specific view of activities.

The C.I.I. can be used in other ways but it is primarily only to be used when some action is possible as a result of the assessment.

The basic assumptions of the C.I.I. are as follows:

1. ASSESSMENT SHOULD CONSIDER THE CONTEXT OF BEHAVIOUR. This is the LEVEL OF OPPORTUNITY in the C.I.I.

2. ASSESSMENT SHOULD CONSIDER OPINIONS AS WELL AS FACTS: This is what is meant by PRESENT POTENTIAL in the C.I.I.

3. ASSESSMENT SHOULD MAKE CLEAR STATEMENTS ABOUT WHAT THE PERSON IS DOING: This is what is meant by BEHAVIOUR in the C.I.I. - it should be observable.

4. ASSESSMENT SHOULD HAVE IDENTIFIABLE AND REALISTIC IMPLICATIONS: This is the PLAN OF ACTION.

5. ASSESSMENT SHOULD BE A CONTINUOUS PROCESS: There should be a date set for the evaluation and next assessment.

In summary the C.I.I. should tell you:

1. WHAT IS HAPPENING NOW (RPF and IAF)

2. WHAT YOU WANT TO DO ABOUT IT (PLAN OF ACTION)

3. WHAT YOU AIM TO ACHIEVE (DPF)

The C.I.I. is not just a matter of completing forms it is an ATTITUDE TO WORK. People who use it must be prepared to question their assumptions and working practices.

These notes are intended as an initial guide for people who wish to use the C.I.I. and the C.I.I. manual.

The Chart of Initiative and Independence has been designed for those providing a direct service. The original work was done with staff working with people with a mental handicap. It is based on field work with social work and health services staff in various residential settings since 1975.

The objective of the C.I.I. is to help you look at your relationship with mentally handicapped people. Then to help you consider whether the relationship is appropriate and what you might realistically do about it.

The Chart of Initiative and Independence consists of a manual and three appraisal forms. The material assumes that the development of independence grows from the degree of initiative shown by an individual and the extent to which that initiative is encouraged or limited. Its use will hep you to:

a) provide a means to increase the opportunities offered to people with a mental handicap.

b) enable staff to make objective decisions about their relationships with and judgements on clients.

CONTENTS

The three forms are:

1. The Individual Assessment Form (IAF)

   An individual client profile recording, Level of behaviour - what the person actually does; Level of opportunity - the limits set by the member of staff on that person; Present potential - what the person could do if those limits were not set.

2. Development Programme Format (DPR)

   Looks at future behaviour, potential and level of opportunities. This can be used as a target chart for a plan developed on the Individual Assessment Form or, if a transfer is being considered, it can be used to prepare the client for a new level of opportunity.

3. Residential Policy Format (RPR)

   Clarifies the background of the two previous sections by developing a record of overall policy. The form is in two parts: entry and exit criteria for the establishment.

AIMS

The three major uses of the Chart of Initiative and Independence are:

1) To record assessment in progress.

2) To decide whether a client is ready for transfer.

3) To decide on a provisional placement.

WHAT YOU HAVE TO DO

You must look at who makes decisions and why.

1. You are first asked to make a list of activities which are important in everyday life. For example, dressing, washing, or making a hot drink.

Having decided on these (the number of activities is up to you)

2. You then look at what happens in the setting. This is done by recording the level of opportunity; who says when and how these activities take place; you or the resident/client. Then you record the actual behaviour of the client; do they do these activities on their own initiative whether you allow them to or not? Then you must record your present expectations: present potential. That is what do you think the person is capable of, right now, (whether they actually do it or whether you can allow them). The level of opportunity and actual behaviour may not give a full picture without this statement of your belief about someone in your care.

3. Next you describe what you think inhibits the relationship; perhaps lack of resources to allow trips out, or a physical or emotional problem for the client.

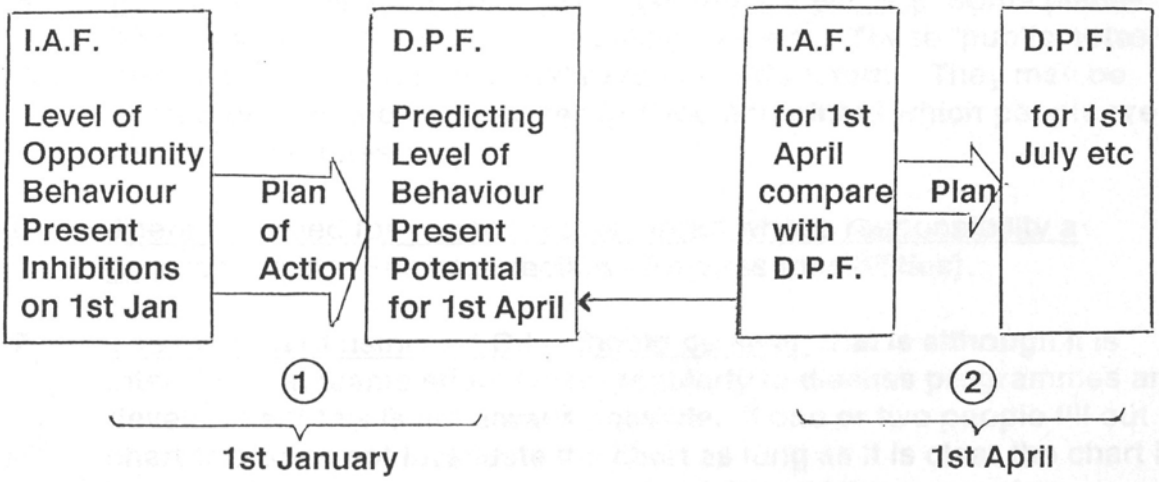
4. Having recorded this the most important part of the C.I.I. is to note what you are doing, both to overcome the inhibitions you have noted, and to allow the person more or less choice and discretion in carrying out the activities you have listed. This is the Plan of Action.

All of the 4 steps are part of the Individual Assessment Format (IAF). At the same time as you complete this you may also complete a Development Programme Format (DPF). You do this in the same way as the IAF but looking forward in time. The question you ask when filling this out is - "if my plan of action is put into operation when this (the DPF) is what I expect things to look like in 3 months time" (or whatever time you have chosen).

In 3 months time you complete a second IAF and then compare it with the previous DPF (the one you completed 3 months before). Have your plans worked? What activities have improved? Why haven't some parts of the plan worked? In the light of experience you then complete a second DPF for a further 3 months time based on your new plan of action. In this way a continuous assessment, monitoring and planning can go on as long as you decide. (Of course you may vary the length ot time according to need).

You may choose to concentrate on one or two activities or many in your plans - the numner of activities chosen, the number you work on and the time period is entirely your chose, judged according to your own circumstances and changed as you see fit.

The procedure is summarised as follows: for example



The level of Opportunity, Behaviour and Present Potential are assessed on scale of Independence - who decides and how much freedom is allowed - this scale is reproduced on page 11. The whole scale looks at how dependent, or independent a person is. Do you let a person choose their own clothes, if not why not? It may be because you think that they cannot make the choice, or they only have one set, or your workload means that it is easier to do it for them.Whatever the reason is you fill in the chart and then explain in the relevant places on the chart.

PROCEDURE

There are several points of procedure which make the chart easier to use administratively.

1. The C.I.I. can be used for several purposes. It is helpful if you are clear about which purpose you have in mind: a decision about transfer; a general survey of the residential setting; an intensive training programme for an individual; preparation for a case conference.

2. A person's charts should be kept together, in one file, so that development, if any, can be seen easily by comparing the charts.

3. In between filling in the charts, you could use a method of noting behaviour so that you have information ready when you meet to fill out a chart. A small notebook may be sufficient.

4. It must be clear that the C.I.I. does not replace other methods. Indeed it is very complementary to Goal Planning. This has proved to be the case in several settings.

5. Individual plans and targets could be public if agreed. Some places have dovetailed the C.I.I. with existing systems. These "public notes" need not be as complex and detailed as a C.I.I. form. They may be posted on a notice board to remind you and others which people are on which progammes.

6. There is a need for you to be clear about whose responsibility a programme is. (See next section - Role responsibilities).

7. The method of using the C.I.I. should be clear, that is although it is intended that teams should meet regularly to discuss programmes and development this is not always possible. If one or two people fill out a chart this does not invalidate the chart as long as it is clear the chart is based only on the observations and opinions of those people.

8. Whoever, individual or group, fills out the C.I.I., it must be clear who is finally accountable for the information recorded. Although some information recorded is personal opinion (present potential) this does not mean the C.I.I. is entirely a matter of individual opinion. The sections on Behaviour and Level of Opportunity are quite testable and observable. Also the plan of action and target chart represents a contract between the team and client and among the team. This too is not merely a matter of individual opinion but agreed judgement.

The relative responsibility and accountability of the team must be made clear if the C.I.I. is to be used effectively.

This model makes a major assumption which it is appreciated cannot be taken for granted:

That those involved in service delivery constitute a coherent team. That is there is at least a regular care group who will not be moved at a moments notice. (It is recognised that the shift-system in nursing may be the most important factor in undermining the reality of a coherent Team).

ROLE RESPONSIBILITIES

First line Manager or Team Leader

The most central figure in implementing the C.I.I. is the first line manager or Team Leader. It is the responsibility of this person to:

i) allocate key workers to clients;

ii) decide what sort of programmes and assessments are relevant for each client;

iii) decide the nature and extent of the plans of action for individuals and the subsequent modification of those plans within given time periods;

iv) agree an overall policy for and with the team within which the above assessments and plans can be implemented.

Responsibility of the Team and Key Workers

The team members may be divided into key workers. That is regular members involved in the initial discussion of which people would be assessed. Then each member would have one or more person for whom they are responsibile.

Responsibilities of the Key Worker

a) To observe and monitor "their" client(s) so that they can monitor the care programme. This is a 24 hour responsibility. As people do not work 24 hour shifts, seven days a week, it is the responsibility of the Key Worker to inform other people as to the crucial parts of a programme. For example, if a programme was designed to encourage someone to dress themselves the Key Worker must make sure other people know this and do not dress the person.

b) The Key Worker is also responsible for suggesting changes in the programme as a result of information they have gathered by direct observation and monitoring and by discussions with others.

c) The Key Worker would also present and lead the discussion with others.

This role would not undermine the overall authority of the first line manager (who may also be a Key Worker). The first line manager would still have the authority to sanction the suggestions of the Key Workers, for example, in the case of policy. More actively, the first line manager would monitor all Key Workers and see the overall implications of the individual programmes. For example, although the first line manager may agree, on an individual basis, that all clients need to learn how to cook, it may not be possible for them all to learn at once.

The other members and unqualified staff would be responsible for their general duties as now but also be responsible for carrying out such duties in line with the individual programmes.

"Middle Manager"

The first line manager's manager would be responsible for monitoring the assessment process in general. This would not include authority to instruct which people have or have not to be fully assessed or the detailed content of programmes (the work of the first line manager). The middle manager would have to be satisfied that the assessment was being used as effectively as possible within the agreed policy. The middle manager would hold the first line manager accountable for the accuracy of the statements made in the assesments, e.g. if an assessment said a person could make a cup of tea without instruction.

This system of using the C.I.I. is an integral part of the actual assessment procedure. It is not a clinical assessment tool but a method of describing actual relationships in a changing environment so that they may be examined and/or changed.

PROBLEMS AND A WAY FORWARD

The most frequent problems encountered are:

1. Filling in more than one mode - encourage this, behaviour and opportunity do change.

2. Activities - team members are often vague about the extent of an activity i.e. where it begins and ends. One way roung this is to encourage staff to keep a "dictionary" and use corresponding numbers on a chart. (There already is a dictionery in the C.I.I. Manual: The Manual of Activities.)

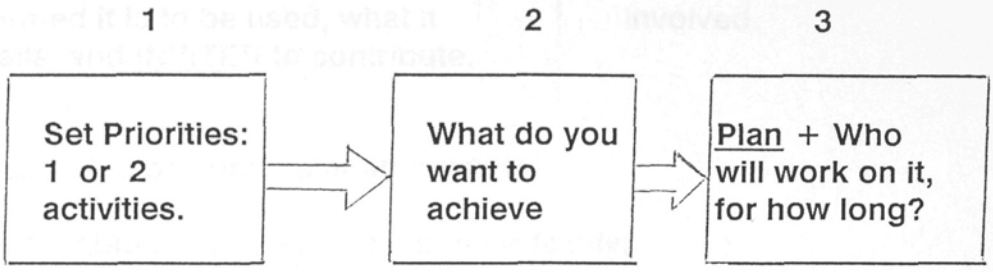
3. Plan of Action - plans are often too vague. It is important to specify:

a) What the exact nature of the plan is;

b) Who is responsible for it; and

c) When it will be completed or reviewed.

One way to approach this is to set a target and priorities first - then to work out how it is to be achieved. Team members must not be encouraged to work on too many activities. It is usually realistic to work on only one or two per person at any one time.



These problems only arise when the C.I.I. is in practice: what are the necessary conditions to get it under way.

Ideally there will be a regular team in contact with other professions and the family and with a supportive relationship with senior staff. Every now and again you may come across a situation which does not exactly fit this description.

	NECESSARY	ADVANTAGE
1.	There must be a way to inform people that this method is available (e.g. by meetings,seminars, etc.)	
2.	The team leader must want to use the C.I.I. and want to try it out	If all qualified staff are willing to try it.
3.	Initial training to be continued when in practice.	
4.	Key workers must be allocated (see roles description).	If some unqualified staff are Key workers.
5.	Key workers must at least co-ordinate programmes.	
6.	Key workers should be full time team members.	

7.	All the teams must contribute (if only verbally).	All staff can complete C.I.I.
8.	Must be possible to call a team meeting.	Regular contact as part of work
9.	Domestic staff and unqualified staff must be aware of programmes (and not undermine them).	Domestic staff actively involved.
10.	Other staff and family must be informed it is to be used, what it entails, and INVITED to contribute.	If everyone is actively involved.

It may be useful to pay particular attention to:

a) the contribution of the client and their family;

b) agreeing clear roles and responsibilities, especially for the Key worker;

c) motivation of team members;

d) relationship with senior staff;

e) relationship with unqualified staff.

KEY	No Opportunity N	Complete Dependency C/D	MODE A	MODE B	MODE C	MODE D	MODE E
LEVEL OF OPPORTUNITY	There is no opportunity available to do this.	It is always done *for* him/her.	You tell him/her *when* to do this *and* how to do it. It is always under your instructions.	You tell them when to do it but then leave them to get on, but later check how it was done.	You allow the person discretion to decide when and how to do something but you check *when* it is done and monitor *how* it is done.	You allow the person discretion to decide when and how to do something, checking *when* it is done but not monitoring how it is done.	You allow the person full discretion and do not check or monitor. You intervene only if requested to do so by the person.
BEHAVIOUR	I have not seen the person actually do this recently. If the person refuses to do this activity state this by noting 'R' under N.	The person does not achieve goals or plans even when told or shown.	The person only does this when told or shown what to do and how to do it.	The person only does this when told what to do but can then get on and do it.	The person does this activity without being told but both *when* and *how* they do this in a pre-set way.	The person does this activity without being told. The *when* is not fixed and others wishes are tolerated unless they threaten the goal of activity.	The person does this activity in a flexible way without being told. They can take into account the needs of others and substitute goals.
PRESENT POTENTIAL	There is no opportunity for the person to show any potential.	The person does not have the capacity to act on goals or plans even when told or shown.	The person can only do this when told or shown what to do and how to do it.	The person can only do this when told what to do but can then get on and do it.	The person is capable of doing this without being told but both *when* and *how* they do this is in a preset way.	They are capable of doing activity without being told. The *when* is not fixed and others wishes are tolerated unless they threaten the goal of activity.	They are capable of doing the activity in flexible way without being told. They can take into account the needs of others and substitute goals.

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