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ACTION LEARNING

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Staff training based on evaluation of the services by the providers

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INTRODUCTION

The study Coordination of Services for the Mentally Handicapped undertaken June 1969 - September 1972 and financed by the King's Fund [1] was based on two factors fundamental to R W Revans's work in training for management in different disciplines in many countries.[2] One is based on his interpretation of the various learning theories, and the other on his conviction that those who are performing the task are the ones who should be monitoring its effectiveness and so learning by doing.

Revans' processes of learning can be described in five stages.[3]

1 Survey or input

The assembly of impressions, opinions, data and other elements together with a gathering awareness in oneself which stimulates curiosity and a desire to learn.

2 Theory

The rearrangement of information gathered to suggest new ideas, patterns or relationships relevant to the person's curiosity and need to learn. This reshuffle develops a new impression of the field of interest.

3 Action or trial

The testing of theories developed in stage 2. Do the theories stand when tried in the world of reality ? Organised debate with equally curious and well informed colleagues can be one method of testing.

4 Review

What are the results of action in the world of reality or trial by debate; does the theory fit; does the new impression developed in stage 2 still hold after trial action and debate ?

5 Consolidation

Confirmation, modification or rejection of the theory in the light of the review. If the review shows results to be much as predicted the idea underlying the theory can be accepted. If there is partial agreement, then that part which is agreeable can be accepted, if the results are totally different from expectations then the theory is rejected and remembered only as a failure.

If a group of people of various professions or trainings are collectively responsible for the giving of a service as was the situation in the study in coordination we describe, then they need to go through the five stages of learning together, to pool their knowledge, to develop shared techniques for monitoring and to gain from each other's expertise.

When providers of the service are given the opportunity collectively to examine the outcome of their behaviour the real learning takes place when the individual begins to see what is affecting and modifying himself as a person and can perceive how this awareness of self is able to improve his ability to communicate with others.

Choice of project

Following eight years study in hospitals, Revans was able to expose some of the dilemmas in hospital management which he claimed were affecting the health and welfare of patients and staff. In 1964 this culminated in a report, Standards for Morale - Cause and Effect in Hospitals.[4] In 1965 this report stimulated the Ministry of Health to give financial support to a further study - Hospital Internal Communications,[5] where Revans was attempting to put his theories of self learning into practice, using the hospital staff as learner instigators and practitioners, of problem solving techniques within their own hospital. From this study which ended in 1967, much about the value of awareness of self and the impact of self in communication with others can be recounted by the hospital staff involved.[6]

For Revans the fifth stage of learning, ie consolidation at the end of this highly original and controversial project, proved to be one of partial acceptance of his theory developed in Standards for Morale and in 1969 he was ready for another attempt to apply his modified theory in fresh fields within the health service.

Also in 1969 there was a demand for a study of the services for the mentally handicapped and the King's Fund offered financial assistance for research in this field.

Revans's ideas of action learning come under criticism from

a) those who hold that management can satisfactorily be learned in colleges by trainees divorced from the responsibilities of their daily work, and

b) those who find unacceptable his claim that valid research findings can be obtained by those learning research techniques within their own daily job of work.

A project had therefore to be designed to assist those providing a service for the mentally handicapped; to use the money for its intended purpose of research; and to give critics a further opportunity of examining another modification of action learning. In our search for a method we needed to

a) impress those responsible for the services with the need to allow themselves and other staff to become involved in a systematic study of the services, and

b) to allow standard survey research techniques to be modified to accommodate the involvement of the providers of the service.

The project we describe therefore offers a mixture of two strategies,

a) staff training and development, and

b) research and evaluation.

First approaches

It is necessary where possible, to obtain complete commitment to this type of project from those responsible for allowing research in their area to be undertaken.[7] This commitment is hard to obtain but uncommitted acceptance is not sufficient. It is necessary to hold conferences where the theory can be expounded, followed by discussions in, at which the sort of question 'What's in it for me ? What is the cost ? How much staff time ?' can be replied.

Time is needed for the committed to visit the uncommitted and vice versa within professional settings. Given an ideal situation those responsible for permitting the research should stimulate interest among the staff and encourage participation. It is also beneficial and equally important to have their continued interest and support throughout the project.

For this study six doctors in administrative posts volunteered to form a working party to which was added an officer from a department of education. For a year 1968/9 they met periodically under the chairmanship of Professor Revans to decide upon the avenue of research to be undertaken which could lead to benefits for the mentally handicapped. They decided to examine the services as they existed, they made the initial contact with the six local authorities and hospital boards. They appointed the research officer and together with him agreed to coopt a seventh pilot area, Hounslow, into the project. Some members of the working party then withdrew, others continued to be interested in the subsequent activities.

Although our approach to the seven areas in England where this study was undertaken was identical, the response was variable. We cannot claim to have been more successful in involving those who allowed us to invite staff to join in an examination of their services in this study than we were in the Hospital Internal Communications Project.

Letters were sent to the clerks of councils in six very different areas in England - Gateshead, Hull, Nottingham, Oxford, West Suffolk, East Sussex and latterly for purposes of pilot studies, Hounslow. Copies of these letters were sent to the medical officers of health and to the executive council secretaries in the area. Similar letters were sent to the secretaries of relevant regional hospital boards. All seven council clerks and appropriate regional hospital boards accepted the invitation in these letters for their staff to be involved in a study of services for the mentally handicapped in their area.

Involvement

Those who presented themselves for work connected with the research were accepted without question. There are many reasons why people are detailed to take part in certain studies, more often they are selected, some may volunteer and some may request to be

allowed to join in the research. The motives behind all these reasons are many and varied. Without yet having the statistics to prove it, we find the ones who request to join in, the ones who became the most involved. This ensures part of stage one in the learning process - a gathering awareness in oneself which stimulates curiosity and a desire to learn. Those who join simply because they are directed, or they think it their place to do so, are less likely and probably much slower to become involved.

The progress of this type of research, like all others, subjects those sharing it to swings of emotion between acceptance with enthusiasm through to incomprehension and despair. Support through all these waverings in the case of our study came from the involvement of the research officer to the project, who elected to be the coordinator between the seven areas as well as research techniques consultant to the whole group. He in turn recruited people to assist him in the use of the research tools as he designed them to fit the needs of the group and to help in the collection and analysis of data. His recruits became as much part of the large research group as himself, with an opportunity to learn about research and how to share it through involvement of staff in the area.

At the time the study was started in 1969, the mental health service in all local authorities was the responsibility of the medical officer of health. It was from his department that officers of the council came to be involved in the project. Some hospital officers also came in following correspondence with relevant hospital group secretaries. Only three general practitioners from three out of seven areas became actively involved in the study.

From the King's Fund report of this study we have a list of the approximate numbers of people involved in the actual examination of their own services in the seven areas and in two hospitals

48 social workers

30 medical doctors (general practitioners, psychiatrists and paediatricians)

16 nurses from hospitals for the mentally handicapped

14 teachers of the mentally handicapped

10 health visitors

9 administrators of a service (varying from an assistant in a department of education to a farm manager)

3 clinical psychologists as well as 3 other para medical professionals

2 members of volunteer organisations

11 part time research assistants

All those noted as involved and doubtless others gave some time to the project both during as well as over and above their legitimate hours of work. The spirit of enquiry may have prompted some to give much time and effort while apathy and incomprehension appeared to block action for the project from others. The research officer was the only person working full time on the project; his part time assistants varied from a clinical psychologist and an opera singer to students with limited time between terms.

The object of having seven very different areas involved in examining their services was to allow for an examination of a national sample. All other areas outside the project could then perhaps compare similar findings with those of this study. Because it was to be one study, the method had to be agreed and carried out in a similar fashion in all areas. It was therefore necessary for staff from each to meet and get to know each other well in order to cooperate as they had to work as one research team.

Obviously not all the 130 - 140 personnel involved could meet at one time, neither would it have been practical to try decision making among so many. The representation of people who were able to get together at any one time was not far from the same ratio as the rough totals we give and about 30 people attended each of the main meetings. The enthusiasts became the more regular attendants and as a result appeared to be the main decision makers [8] but in actual fact accounts of all the meetings and other papers were circulated and discussed in the areas between times.

Development of a method of action learning

We believe there is no one right method employed to promote action learning. To assume there is a prescription to be applied in all situations leads to a further assumption that people can be instructed to carry out a set of actions in any situation in a prescribed manner and that they will learn by it. In this study we assumed only

a) the givers and receivers of a service are the ones most aware of the problems facing them

b) they are in the best position to examine and modify the service to overcome their particular problem

c) they have the opportunity to learn by so doing, especially if outside expert help can be called upon (eg in research techniques).

1 Survey and input: At their first meeting in the late summer of 1969 those attending explored their motives and expectations. They listened to Professor Revans explaining the request of the working party that the present state of the services for the mentally handicapped should be examined in the light of the suggestion that coordination between different branches of the service was poor. He suggested the group of professionals sitting round the table should define their problem, design their research, develop their tools, carry out the research, examine the findings and act upon the results. This one session where Professor Revans held the floor from breakfast to coffee was the only session in three years during the whole project which could be even remotely described as formal tuition.

The group came to be known as the research advisory group. They elected a general practitioner as their chairman. Through what was left of the first two day meeting they pooled their existing knowledge and professional view points finally deciding they wanted to know

a) how do parents of the mentally handicapped and those providing the service first suspect subnormality ?

b) what action follows suspicion ?

c) how do all those involved see the needs of the mentally handicapped and how much do they differ from each other in their respective perceptions ?

d) how do all involved see their roles with regard to the handicapped and those of other providers of the service ?

2 Theory: The group decided they would look at information they collected about a 5 per cent sample of mentally handicapped under the age of 30 years known to be living in the community and an equal number of patients from the same local authorities with matching dates of birth known to be residing in the hospitals.[9]

Questions to be asked of parents were agreed and it was decided that matching questions should be put to

General practitioners

Health visitors

Mental welfare officers

The records kept at the local authority

Questions once having been agreed by the group were put into questionnaires with the assistance of the research officer who himself aided by a pilot area social worker tested the questionnaires by interviewing parents outside the official sample.

At a later date after having had the opportunity to see information coming in this new format the group decided that matching questions were needed for teachers of the mentally handicapped and paediatricians demanded to be questioned also.

Two hospitals taking patients from the pilot area were invited to let staff be involved in the project. They formed their own subcommittee and decided they would use the questionnaires designed for use in the community but because of the extra number and variety of staff involved in the direct care of patients in hospital they would need to design matching questionnaires for a further list of people.[10]

Nursing staff	Psychiatrists
Hospital school staff	Hospital social workers
Speech therapists	Occupational therapists
Physiotherapists	Work shop, industrial training
Voluntary organisers	unit and utility department staff

Questionnaires to be completed by the interviewer were agreed by staff from all areas but there were differences between the seven areas as to whom should conduct the interviews. Some areas chose initially to have the research assistants doing this for them and some agreed to allow health visitors and social workers to do a share of them.

Enthusiastic accounts of the experience and the gain in knowledge concerning their clients from the pilot area staff helped to encourage others to attempt interviewing for themselves. Pilot area staff also were invited in to other areas to help for example, in obtaining a valid 5 per cent sample.

3 Action or trial: The staff in the six areas were impatient to begin their own study of their area before the pilot study was complete. This was due in part to their involvement in the preparation of the tools and the development of the research design

and also to the enthusiasm of the pilot area staff over the initial improvements they were able to make as details became available from the data as they were being collected.

It was a deliberate policy not to hold up any attempts to improve coordination as the findings began to show obvious gaps. Also, it became a policy not to ask the six areas to hold back their own studies until the pilot area had completed their data collection and analysis. It was thought better in both instances to make use of their keenness while it was there rather than waste time trying to revive it too late.

Not all the seven areas were ready to start at the same time which was as well for the research officer, who liked to supervise their early beginnings at the same time he was setting up the coding of material from the pilot area and assisting the hospitals with the formation of their extra questionnaires. Where areas were slow to start, the research assistant, by residing in the area and working in the office files, was able to give encouragement and stimulate action.

Some staff in some areas decided to use the research techniques they had developed to examine this particular service, to examine services for other groups of people and proceeded to carry this out over and above their project work. It was proving a valuable way of measuring services to clients and of improving communication between the professionals.

Because of the enormous amount of information to be analysed from the pilot study alone, Revans and the research officer became concerned about the problems of handling seven times as much. However, two attempts through meetings of the research advisory group failed to demonstrate at this stage any agreement on the part of the professionals to reduce the mass of information they were collecting.

4 Review: In February 1971, it was unfortunate for everyone involved in the research that at this peak of involvement and enthusiasm they should hear funds were not forthcoming to allow the study to continue until 1974 as had at first been hoped.[11] This meant once the data had been collected, analysis had to be done by Revans, the research worker and his assistants with only the minimum of participation by the staff in the areas.

Information from the computer was delayed, therefore some important findings, mainly from the parents' questionnaire were analysed manually in order to give some information back to the seven areas for their comment and further action

a) with regard to the findings for their own areas, and

b) with regard to the project as a whole.

A very small subgroup of the advisory group did eventually manage to make a list of salient information which they felt more important than the rest to be extracted from the questionnaires. The whole advisory group contributed towards the analysis by suggesting three methods

a) individual coordination histories of mentally handicapped clients taken from the 6 or 14 questionnaires relating to each

b) a record of critical incidences where they occur in the lives of clients in the sample, making constructive use of a demonstration of the gaps in service which could have contributed to the incident

c) an analysis of all the information collected which could lead to retaining only those findings considered relevant when forming new tools for measurement of coordination which could be for general use.

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To give all the feedback material which the analysts were able to present to the seven areas would be impossible within the confines of this article but some indication of the value of their study to suit their own purposes can be given by attempting to see how the information fits their original questions formed at their first meeting.

(a) How do parents of the mentally handicapped and those providing the service first suspect mental subnormality ?

TABLE I

TABLE IA

TABLE IB

The above tables giving reasons for suspicion can be compared one with another, and with a table of answers from files in the mental welfare offices. General practitioners were given the opportunity to give detailed clinical reasons for suspicion.

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(b) What action follows suspicion ?

TABLE II

TABLE IIA

TABLE IIB

There are other relevant tables given in the findings such as who did for example, the mental welfare officer contact and why. Also, how many contacts were made between each agency.[14]

(c) How do all involved see the needs of the handicapped and how much do they differ from each other in their respective perception ?

Those involved in this study have discovered,through discussing and using the five books of tables presented to them, that the needs of the handicapped and their families form a pattern. The needs are greater at some stages in their lives than others. They have discovered that the parents of those with the most handicaps demand and receive the most attention from the services; they are able therefore to benefit their child and as a result are more satisfied with the services than are the parents of less handicapped children who demand less. The tables also demonstrate the parents greatest periods of anxiety are just after the child has entered school and when parents themselves are getting too old to continue to watch over their offspring.

The difference in attitude of professionals towards the handicapped is related to how they see their particular responsibility towards them.

(d) How do all those involved see their own roles with regard to the handicapped and how much do they differ from each other in their respective perceptions ?

TABLE III

TABLE IIIA

These two tables help to answer the providers original two part question above without need of further explanation here.

5 Consolidation: The staff in the seven areas met together in May 1972 for two days study of the findings. They pooled their ideas on the value of the project to themselves,

the families of the mentally handicapped and the better coordination of the services. The degree to which the staff in the areas had been able to participate was reflected in the amount of change or further use of the method they had been able to instigate in their area. One area gave a useful explanation as to how the evidence in the project for them had demonstrated the need to have a person through whom all requests for help and help given out should be channelled. They chose to have a social worker responsible for the coordination of all services in this particular field of mental handicap. Whether the services were or were not the responsibility of local government, it should be through this officer that efforts were coordinated.

Shifting of responsibility from one service to another was evident to the participants as their awareness of their own actions grew. It was for this reason they gave the title to the report "I Thought They Were Supposed to be Doing That".

In this type of action learning there is no end because one finding prompts action which in turns prompts more study.

In September 1972 those involved from the seven areas decided to end their project by holding a conference [15] for council and staff from other local authorities. They used this opportunity to demonstrate their participation in a research project and to recommend this type of action learning to be adopted in other areas.

For Revans and those assisting him, the learning had been as great as in the seven areas, the staff had shown that management techniques can be improved by pooling experiences on the job, by examining one's own actions and comparing perceptions of it with others. The staff also demonstrated their ability to construct and use research tools to give valid results which are the richer for their collective varied professional knowledge. The whole study of action learning within the health service however, could still be described as in the review stage of learning. We need to know more about what stimulates organisations to take part and motivates participants in this type of self examination. How can organisations learn in this way through their daily work without prompting from us ? We have great hopes of learning more however, knowing that London Boroughs Association are interested in adapting this method for the training of local authority staff.

SUMMARY

This is an account of a study in action learning undertaken in seven local government areas where those providing the services for the mentally handicapped examined the services they were giving to a 5 per cent sample.

Through the instigation and under the guidance of Professor R W Revans, approximately 130 - 140 staff from local authorities, hospitals and education centres together studied coordination of services for the mentally handicapped. They defined the reason for their examination, designed their research tools, conducted the research and took action as a result of the findings.

They were assisted in their learning while working, by a research officer and 11 part time assistants. The research officer coordinated the study in the seven areas and guided the staff through the research techniques. The assistants helped in the areas but mainly with the analysis of the data which lack of time and finance prevented the professionals doing for themselves.

As a result of taking part in this study, those giving the service were more able to see the effect of their own action and its impact on others. The research findings demonstrated for them the strengths and weaknesses of the service they were giving and enabled attempts at improvements to be made.

A method of participative research which can be adapted to suit other organisations has been prepared and knowledge has been added to the field of action learning, particularly within the confines of health and social services.

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Coordination of Services for the Mentally Handicapped Project

QUESTION: What made you suspect it ?

	7 AREAS IN THE SURVEY							
	A	B	C	D	E	F	G	TOTAL
Parents did not suspect	5	6	6	11	3	9	5	45
Connected with known syndromes, eg mongolism	3	2	6	11	6	4	2	34
Connected with slow development of child	6	2	20	12	9	20	9	78
Connected with fits, convulsions, tantrums	2	-	5	3	1	5	-	16
Connected with education - admission to school, performance at school	1	1	6	4	2	4	2	20
Connected with behaviour problems	3	1	2	5	-	3	3	17
No specific reason for suspicion mentioned	-	-	1	1	-	-	-	2
Physical reasons	-	-	1	2	1	1	2	7
No information provided	-	2	2	1	1	-	-	6

REASONS FOR SUSPICION OF SUBNORMALITY BY PARENTS

TABLE 1

QUESTION: What made them suspect it ?

7 AREAS IN THE SURVEY

	A	B	C	D	E	F	G	TOTAL
Connected with known syndrome, ie mongolism etc	1	1	3	1	-	5	2	13
Connected with slow development of child - milestones	-	-	1	1	1	4	1	8
Connected with fits, convulsions, tantrums	-	-	1	-	-	1	-	2
Connected with behaviour problems	-	-	-	-	-	1	-	1
Connected with other problems not listed above	-	-	2	-	1	-	-	3
Don't know	-	-	-	-	-	7	-	7
No reason mentioned, no information	1	1	1	1	-	-	-	4

REASONS FOR SUSPICION AS GIVEN BY HEALTH VISITORS

TABLE 1A

QUESTION: What made them suspect it ?

	7 AREAS IN THE SURVEY							
	A	B	C	D	E	F	G	TOTAL
Connected with known syndromes, ie mongolism etc	5	-	8	6	4	8	3	34
Connected with slow development of child - milestones	7	-	10	5	7	5	4	38
Connected with fits, convulsions, tantrums	-	-	1	-	-	2	1	4
Connected with education - admission to school, performance at school	6	1	10	1	1	9	5	33
Connected with behaviour problems	1	-	-	1	2	1	1	6
Connected with other problems not listed above	1	-	2	2	2	3	1	11
No specific reason for suspicion mentioned	-	-	2	-	-	1	-	3
Don't know	2	-	1	22	1	12	1	39
No reason mentioned, no information	-	4	6	5	2	-	-	17

REASONS FOR SUSPICION AS GIVEN BY MENTAL WELFARE OFFICERS

TABLE 1B

NB In QUESTIONS in tables 1A and 1B, "them" means whoever first suspected subnormality.

QUESTION: What did you do about it ?

	7 AREAS IN THE SURVEY							
	A	B	C	D	E	F	G	TOTAL
No action taken	7	6	10	9	9	9	9	59
Consulted friends, relatives, neighbours	-	-	-	-	-	-	-	-
Consulted voluntary organisations	-	-	1	-	-	-	-	1
Consulted other parents with handicapped children	-	-	-	-	-	-	-	-
Consulted own GP	3	2	22	19	8	21	10	89
Consulted other specialists	1	-	10	11	3	11	1	37
Consulted HV	-	-	-	-	-	2	-	2
Consulted clinic doctor	4	1	5	7	1	3	3	24
Consulted mental health department	1	-	2	3	1	-	-	7
Consulted others	4	1	2	4	2	1	-	12
Not clear what action taken	1	3	3	1	1	1	-	10

ACTION TAKE BY PARENTS ON SUSPICION OF SUBNORMALITY

TABLE II

QUESTION: Have you or any other health visitor been approached by other agencies for help for this family ?

OTHER AGENCIES CONTACTING HEALTH VISITORS

TABLE IIA

	7 AREAS IN THE SURVEY							
	A	B	C	D	E	F	G	TOTAL
No one contacted	2	1	6	2	1	14	2	28
Yes contacted - School	-	-	1	-	-	-	-	1
Yes contacted - Voluntary organisation	-	-	-	-	-	1	-	1
No records - don't know	-	-	-	1	-	-	-	1
No information	-	1	-	-	-	1	-	2

QUESTION: Have you ever contacted any of the services to get some help for the family ?

GENERAL PRACTITIONERS REQUESTED HELP OF OTHER SERVICES

TABLE IIB

	7 AREAS IN THE SURVEY							
	A	B	C	D	E	F	G	TOTAL
None requested	12	2	35	19	12	21	13	114
Yes requested - Mental Health	-	1	1	2	2	4	1	11
Yes requested - Welfare Department	-	-	3	1	-	1	1	6
Yes requested - School	-	-	-	2	1	1	-	4
Yes requested - Voluntary organisations	-	-	-	-	1	-	-	1
Yes requested - Other	-	-	-	-	-	2	1	3
No records - don't know	-	-	-	-	-	1	-	1
No information	-	1	2	1	-	3	2	9

CATEGORY	NUMBER OF CASES
Agreement on the needs of the child	43
Agreement on the needs of the family	21
Type 1 - disagreement on the needs of the family	45
Type 2 - disagreement on the needs of the family	29
Type 3 - parents state nothing is required, MWO says otherwise	32
Type 4 - MWO states nothing is required, parents say otherwise	16
Not possible to make a comparison	76
Number of cases compared	136

TABLE III SHOWING A COMPARISON OF THE PERCEPTION OF THE NEEDS OF 136 HANDICAPPED CHILDREN AND THEIR FAMILIES BY PARENTS AND MENTAL WELFARE OFFICERS

P = Professional role
C = Coordinating role

	Role of MWO		Role of GP		Role of HV		Role of MOH	
	P	C	P	C	P	C	P	C
Opinion of MWO	42	25	56	14	45	12	15	33
Opinion of GP	52	50	104	50	109	42	13	98
Opinion of HV	74	111	134	44	126	70	27	147
Opinion of parents	129	61	127	16	- *	-	48	63

TABLE IIIA SHOWING HOW THE PROVIDERS OF SERVICES SEE THEIR PROFESSIONAL VERSUS THEIR COORDINATING ROLES

Interpretative note: The important thing to note in this table is not the absolute figures but the ratio between the professional and coordinating roles in each box.

* Parents were not asked to state the role of health visitors

FOOTNOTES AND REFERENCES

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Much discussed by these business management experts and has relevance for managers in the health and social service fields.

8 Cortazzi Diana and Baquer Ali
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London, King Edward's Hospital Fund, 1972 (THC 72/736), pp 103.

Hospital staff did not attend the early meetings in large numbers. The pilot study in Hounslow was completed and work started in the other six areas before the research officer was able to give his attention to the extra problems of the hospital survey which entailed a different group of staff caring for the mentally handicapped.

9 Time and Finances allowed only two hospitals serving the pilot area to design the extra tools required to examine the coordination within the hospital.

10 Spare copies of the questionnaires involved are obtainable on request to the King's Fund Hospital Centre, 24 Nutford Place, London W1H 6AN. 5p per questionnaire.

11 It was because of this curtailment in our activities that we were unable to use the questionnaires designed by paediatricians to be answered by all paediatricians in the research areas. Also, the hospital study was not developed further than that already achieved in the pilot area hospitals.

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