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GETTING BETTER ALL THE TIME?

Issues and strategies for ensuring quality in community services for people with mental handicap

Edited by Linda Ward

GETTING BETTER ALL THE TIME?

Issues and strategies for ensuring quality in community services for people with mental handicap

Papers and reports from a workshop organised by
the Department of Mental Health (in association with
the Department of Extra-Mural Studies)
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INTRODUCTION

In 1980 the King's Fund Centre launched An Ordinary Life - a publication, and an initiative, which have proved enormously influential in subsequent thinking about services for people with learning difficulties (mental handicap).

An Ordinary Life has led to the establishment of a growing number of local residential services in the community for people with learning difficulties. It has also led to some important rethinking about services in other significant areas of people's lives - for example, employment in An Ordinary Working Life (King's Fund Centre, 1984).

The expansion of community based services has now been endorsed by government policy. The current emphasis is on planning for the rundown and closure of many long-stay mental handicap hospitals and a shift to 'community care'. What was once judged impossibly unrealistic - that many people with learning difficulties currently living in institutions could, with appropriate staff support, lead more ordinary lives in the community - is now accepted and commonplace (in service planning, if not, as yet, in actual services on the ground).

This shift in thinking, planning and, to a lesser extent actually providing services has been greeted with pleasure by those keen to pursue the ideas contained in An Ordinary Life. The pleasure has, however, been mixed with concern. Some people fear that the pressure on health authorities to close hospitals may result in a 'scramble' for community care - and that in this scramble, some of the guiding principles of An Ordinary Life may be lost. Others are anxious that people may be moved 'willy-nilly' into the community, without adequate daytime and evening activities or staffing, in services without adequate and permanent financial support. There are worries, too, that people with learning difficulties may end up living in the community but not as active, valued members of it. On the other hand, most people agree that the quality of life available to people currently living in mental handicap hospitals remains low, whatever the improvements and upgrading that have taken place over the last 10 years. The challenge for those involved in community services, therefore, is to ensure that the options and opportunities available to their users are better than those offered by the hospitals they have left behind.

It was concerns like these that led the Independent Development Council to set up a working party in 1984 to explore ways in which the quality of community services could be monitored. The resulting pamphlet Pursuing Quality? How good are your local services for people with mental handicap? sets out the fruits of their deliberations - and, in particular, outlines the role of Quality Action Groups in this area.

The workshop whose proceedings form the content of this publication arose from the same concerns outlined above. About twenty five professionals and researchers in the mental handicap field were invited to a three day residential workshop in Bristol, to explore 'issues and strategies for ensuring quality in community services for people with mental handicap'. The resulting collection of papers is presented here.

The papers are on a wide variety of themes, though all related directly to a particular aspect of the workshop's overall aim. Their variety reflects an important message from the workshop - that 'quality' in services, and in the lives of people with learning difficulties has to be a many-sided thing. There is no one technique, solution or answer. A variety of approaches, ideas and options must be involved.

The papers, like the workshop that gave rise to them, are organised and presented around four guiding themes.

First - two papers on the broad theme **'What is quality? How can we ensure it?'** Roger Blunden and Stephen Beyer outline one practical approach to pursuing quality - a Quality Action Group which could be established in any setting. A crucial aspect of this approach is its involvement of stakeholders, that is, those people who have some kind of stake in what the service achieves, most importantly, the service users. Alan Tyne's paper underlines the vital significance of values in any attempts to pursue changes - and quality - in services, and the work and findings of the organisation CMHERA in this field over the last seven years.

Second - two papers looking at **quality in residential services.** Lesley Hoyes reports her recent research in the private sector, and some issues, and suggestions for ensuring quality, in this area. Janet Maher addresses the question of providing good quality services for people with challenging (or difficult) behaviour. This issue was specifically included in the workshop programme out of a recognition that the Ordinary Life initiative has had little effect as yet on the lives of those individuals who pose severe challenges to the service system because of their behaviour. Many service plans envisage a continued reliance on segregated, hospital type, units for these individuals. Perhaps one criterion of a good quality service might be the extent to which the individual needs of all its clients - including those with challenging behaviour - are met according to the principles of An Ordinary Life? Janet Maher's paper suggests one possible strategy for doing this. More general points about pursuing quality in residential services for people with learning difficulties are included in the reports from workshop groups in Appendix A.

Third - two papers on the theme of **pursuing quality in community support services** (as distinct from residential services). The first paper outlines the attempts made by a community support service in South Bristol to improve the quality of life available to individuals with learning difficulties in its locality - and the lessons that may be drawn from this experience about achieving and maintaining good quality services. In the second paper, Stephen Beyer describes how a home support service in Cardiff set up a Quality Action Group, and how it worked in practice. Papers from the workshop groups looking at general issues of quality in community support services and community mental handicap teams are again included in Appendix A.

Finally - the concluding theme of the workshop and this report - **how can we build quality into developing services?** A paper by Oliver Russell on 'planning for quality' is followed by contributions from workshop participants on this topic, and personal pledges by some on the actions they themselves could take to improve the quality of the services in which they were personally involved.

As a collection, the workshop papers and reports of participants' deliberations, are rich, stimulating and very varied. There are no single solutions. There are many questions. Not only about achieving quality but about maintaining it at a time when services, and their management, seem to be regularly 'reorganised', and finances are tight. Clearly these papers are only a starting point in a debate which needs to continue, grow and be translated into positive action at a local level throughout the country, over the next critical years as community services expand. Hopefully, the concerns which are so apparent in these papers - for quality, for clear values, and for the involvement of users in the planning and monitoring of the services which directly affect the quality of their lives -will ensure the achievement, and maintenance, of good quality services for people with learning difficulties in the future.

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University of Bristol,
November 1986

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PURSUING QUALITY: A PRACTICAL APPROACH

Roger Blunden and Stephen Beyer
Mental Handicap in Wales - Applied Research Unit

In this paper two questions are addressed. What do we mean by quality in community services? What can we do to build quality into the service system? The context for this discussion of quality is a timely one. We in England and Wales are going through a period of great change, with de-institutionalisation for people with a mental handicap, and the advent of the All-Wales Strategy. There is a danger that emphasis will be put on quantitative change, on the number of places supplied in ordinary houses, on the numbers of community staff employed. Unless we are able to build a notion of quality into services the opportunities that this period of change offers us may ultimately be wasted.

What do we mean by quality?

It is possible to identify two aspects of service quality: its effectiveness and its user-friendliness. The effectiveness of the service may be assessed in respect of the impact it has on the lives of those it serves, and to what extent it meets the needs of those who use it.

User-friendliness is a term familiar to computer enthusiasts to describe how easy any particular computer system is to use. There are certainly analogies between the experience of service users and those people who have difficulty in using computer systems. Computers that are described as 'user-friendly' are approachable by ordinary people, who don't need to know a great deal of 'jargon' to use them. They are designed to fit in with the way ordinary people think and work, rather than relying on the user to fit in with the computer.

In service terms, 'user-friendliness' comes from a service being accessible which often implies it being locally based. The service must be available at the right time, when users need it most. The service offered must be comprehensive, both in the range of needs catered for, and in its coverage of all those people in its area who have a need for that service.

While both effectiveness and user-friendliness are important aspects of service quality, the effect of services on clients' lives has had the least attention in the past. It is in this area that the paper hopes to make a contribution.

Why are our services for people with mental handicap generally not 'quality conscious'?

One of the major reasons for our services not being quality conscious is that they often have no clear values, service objectives or criteria of success. Ultimately they do not state explicity what they seek to achieve for their clients.

Services may often be concerned with establishing minimum standards, and are concerned with avoiding scandals rather than pursuing quality.

The pursuit of quality is often viewed as an 'optional extra' that is to be included not as a mainstream activity, but as an activity to be carried out when time allows. The All-Wales Strategy for people with a mental handicap stressed the need for monitoring of service developments from its initiation. However, even when recognised as a priority it is only now, 3 years after the launch of the Strategy, that concrete steps are being taken across Wales to determine the best way to achieve effective monitoring.

Finally much creative effort goes into innovation and expansion, rather than sustaining what is good. Much money and talent goes into developing new services, with little attention or resources going into looking at those services we already have. In the Welsh example much of the resources coming from the All-Wales Strategy has gone into creating development teams and into new initiatives such as new group homes and respite-care schemes. The reorientation and development of existing day and residential services has been largely left for a later date.

Problems with monitoring where it does exist

Where monitoring of existing services does take place, there are a number of problems which conspire to reduce its effectiveness in ensuring and maintaining quality. Firstly, monitoring is usually an information gathering exercise that is divorced from action. The story given by front line staff on monitoring is often one of statistics collected without their knowing why or what comes from it. The link between information collected and the decisions made is, therefore, often obscure.

Secondly, information is collected because of its availability rather than for its link to pursuing quality. We all know of systems that monitor aspects of provision such as numbers of referrals to Social Services or Health Authorities, bed occupancy rates, time spent in therapy sessions, waiting lists etc. The link between these aspects of provision and outcomes for clients is tenuous, but these are pieces of information that can be generated fairly easily by the service.

Thirdly, monitoring is usually negative and bureaucratic. Information gathered goes up the service system managerial hierarchy, and little comes down unless it is criticism. Traditional forms of monitoring offer little, therefore, in terms of helping front-line staff to monitor what is good and what is not in their own work.

Fourthly, service users are often blamed for service deficiencies. When a placement or a service input fails then terms such as 'the client is not capable of benefiting from the service', or 'the client is not capable of moving into the community' are used. These failures are not looked at in terms of the failure of the service to provide the help that is needed.

Finally, monitoring has been concerned primarily with questions of 'how we are doing it', rather than 'how effective are we?' A recent conference to agree approaches to monitoring within the All-Wales Strategy identified a series of administrative and practice indicators that may be used to determine progress in establishing a Community Mental Handicap Team. The indicators identified by senior workers were indicators of whether certain elements of the service have been introduced, or whether certain 'hows' are there. Added to these in Figure 1 are an alternative set of indicators which are related to the effectiveness of these services in terms of the experience of the service by the client.

Figure 1: Possible indicators of progress in establishing community mental handicap teams

Administrative indicators	Practice indicators	Indicators of client experience
set up a team	identify unmet needs	know what's available
obtain a base	provide information	know who to contact
obtain finance	provide point of contact	get a helpful response
organise records system	organise assessment	receive practical help
help professionals collaborate	provide home support	learn new useful skills
establish links with other teams	provide skill teaching	live in the community
identify clients	provide advice/counselling	form relationships
ration resources	listen to people's problems	use community facilities
	introduce people to community facilities	families function more effectively
		resolve personal crises

Pursuing Quality - An Alternative Approach

What then can we do to build quality into services, and make services more effective in what they achieve for their clients? There seem to be four main elements which have to be taken into account.

- The service needs a clear sense of what it is trying to do for its clients, which means that it has to have an explicit sense of how it sees the place of people with mental handicaps in the world.
- Monitoring service quality is not just a task of management. Ensuring quality must be made central at many levels, and many other people in addition to managers must be involved in the process.
- Opportunities must be made for there to be positive as well as negative feedback for those involved in delivering services.
- It must be recognised that we all have control over some aspects of our work, and that any system that seeks to pursue quality must be directly linked to action.

The approach may be summarised as:

Stakeholders regularly reviewing the service's **Accomplishments** in the light of a clear **Value System** and taking **Action** to develop the service. Each part of this process is described in more detail below.

This alternative approach has been developed through an initiative by the Independent Development Council for People with Mental Handicap (IDC). It has involved a number of people in the production of a pamphlet on Pursuing Quality. (IDC, 1986).

Stakeholders

Thinking of who should be involved in pursuing quality a large number of groups come to mind:

Clients
Families
Service Staff
Service Managers
Service Planners
Professional Specialists
Politicians
The Local Community

Clients themselves have been virtually left out of discussions over the quality of services they use in the past. Yet it is they who arguably have the biggest stake in ensuring that services are of good quality. Families have also been largely overlooked in attempts to monitor and develop services. Where they have been involved, as in the All-Wales Strategy, there have been significant benefits. Parent participation is not, however, the same as client participation, there sometimes being conflicts between the two perspectives. The development of self-advocacy schemes may therefore be a necessary contribution to the involvement of all stakeholders in the process.

While service managers are often the prime participants in monitoring, the involvement of staff in pursuing quality in the service they provide is also an essential element of any system. Politicians are involved in policy making but are not often directly involved in the pursuit of quality. They are clearly another potentially influential group that may need to be involved in the process of ensuring quality. Lastly, people from local communities can play an important part in the plan of new style services, and are clearly affected by the implementation of such plans. They may need to be more involved in the monitoring of the quality of services enjoyed by some of their residents.

Value Systems

The value system under which a service operates is of vital importance. Before we can determine quality in terms of what the service accomplishes for the client, we need to know how the service sees the place of people with a mental handicap, and therefore what a quality service would need to do to bring it about. A basic set of conditions need to be pursued if a quality service is to result. The service needs to be based on explicitly stated principles. These principles should consider the status of the client and recognise that people with mental handicaps are not second class citizens and have a role to play in society.

The principles need to indicate the desired outcome for clients, the broad ways in which the service should set out to influence people's lives. O'Brien (in press) has identified five ways in which services can enhance the quality of people's lives. These may be expressed in the following way.

Community Presence - the right to take part in community life and to live and spend leisure time with other members of the community.

Relationships - the right to experience valued relationships with non-handicapped people.

Choice - the right to make choices, both large and small, in one's life. These would included choices in where to live and who to live with.

Competence - the right to experience a growing ability to perform functional and meaningful activities with whatever assistance is required.

Respect - the right to be valued and not to be treated as a second class citizen.

Finally, principles should indicate the general means for attaining the desired outcomes and should also be understood and shared by those involved in providing the services in question. The latter may well be the most difficult to achieve. In Wales, for example, much effort has gone into the reorientation of everyone involved to the principles contained in the All-Wales Strategy, and yet, three years on, there remain problems stemming from those involved not sharing these values. This can lead to subsequent problems in the direction of development. The issue of developing a shared set of values remains high on the agenda in the pursuit of quality.

Accomplishments

> **'It is important to distinguish between what people do (behaviour) and its effect on the world (accomplishment)'**
>
> Thomas Gilbert (1978).

If services are to ensure their quality then they must assess their progress in relation to what effect they are having on their clients. This entails a shift from traditional monitoring - of how services are delivered - to measuring their actual impact on clients' lives.

Services must then set out what they seek to accomplish for their clients. Accomplishments should have a number of characteristics.

The things to be accomplished should be statements about what clients will experience as a result of the services' help. The following are examples of statements of accomplishment:

'People make use of facilities in the community'.

'People participate in a wider range of community activities'.

'People have friends.'

'People are more independent in their domestic and personal lives.'

'People live in accommodation of their choice, with other people of their choice.'

Accomplishments should be in the control of the service under review. Although many other services may influence the success of a particular service, it is often easier to negotiate change in others from the basis of a strong knowledge of one's own service.

The accomplishments should refer to a small number of overall goals if progress is to be made. It is better to achieve one change than take on many and fail.

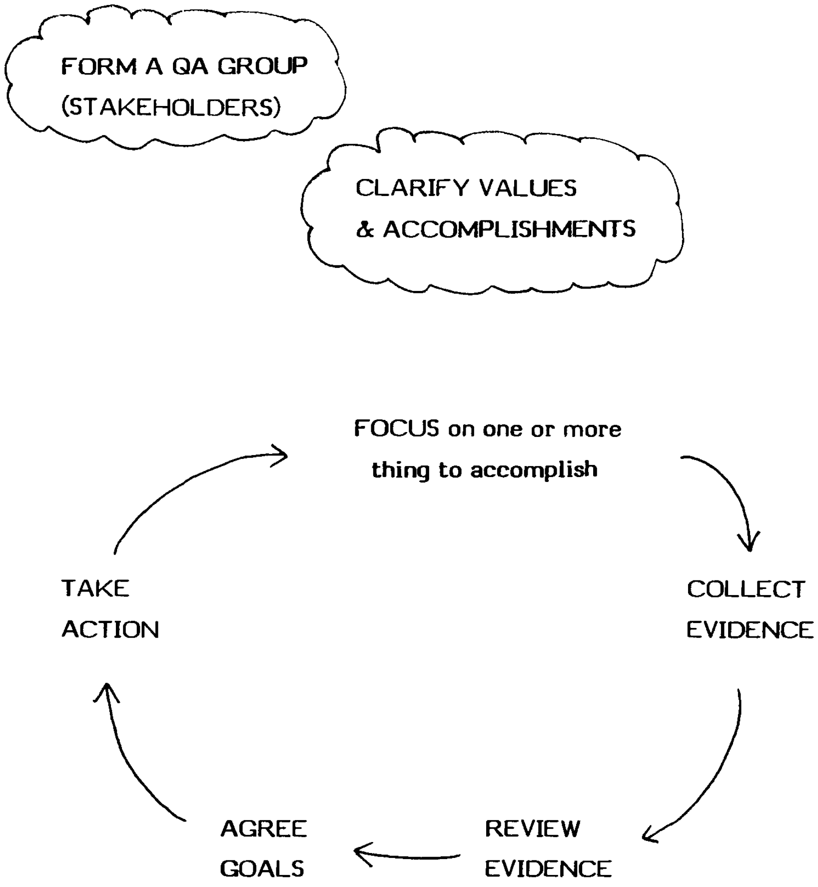
The accomplishments should be consistent with each other, and with the principles of normalisation. Without a value system it will be very difficult to establish a correct and coherent set of accomplishments.

The accomplishments should be measureable in some way. This may be measurable in a formal way, or in the same way as goals are set in Individual Programme Plans in a way that success can be recognised.

The Quality Action Process

We have a number of important elements that together can form the basis for pursuing quality in a service. The Quality Action process is a structure through which these elements can be formally brought together, and this is shown in Figure 2. This process has been tested as part of the Independent Development Council's initiative and an example of its application is given later (see p.45).

Figure 2. The Quality Action Process



The process consists of forming a group of Stakeholders to pursue quality in a service. The group may be formed at many different levels: at the county level for a range of services, in one particular service sector, in a Community Mental Handicap Team, or in a group home. The first task is to clarify the values the group shares. From this a clear idea can be gained of what the service sets out to help its clients accomplish.

These accomplishments would be defined in terms of what the client will experience as a result of the service's help. The Group would then focus on a small number of things to accomplish. They would then collect evidence on the extent to which these accomplishments were being successfully achieved by the service.

The evidence would then be reviewed by the Quality Action Group. From this review goals would be agreed for the service that would enable it to work towards achieving accomplishments. Action would then be taken to fulfil those goals. The process would continue with further reviews of accomplishments and selection of accomplishments for action. The process of review should take place regularly, although the period of review may vary from weekly to bi-annually depending on the circumstances of the service under review.

Where do we go from here?

We need to clarify our values.

We need to decide what we aim to accomplish for clients of our services.

We need to involve stakeholders in reviewing our accomplishments.

We need to take action to improve quality.

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SOME PRACTICAL DILEMMAS AND STRATEGIES IN VALUES-LED APPROACHES TO CHANGE

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'An idea that isn't dangerous
isn't worth calling an idea'
Oscar Wilde

In this paper I shall describe some of the lessons which we have learned from our efforts over the past seven years to affect the 'culture of ideas' available to people in service-giving organisations.

Organisational analysts such as Argyris and Schon (1978) have given accounts of what they call an organisation's 'theory in action' - what kinds of performances are valued; what the objectives of providing a service are; stories which explain the way the organisation relates to the wider social system. All these help people to make sense of what they are involved in.

We have tried to work on the sets of ideas about service-design, which are available to people who are planning and managing the developing community-based services for people with mental handicaps. We have attempted this through normalisation-based training and consultancy, and evaluation of services using PASS - Program Analysis of Service Systems (Wolfensberger and Glenn, 1975). The practical content of this work is most fully described elsewhere (Tyne 1986).

We don't claim this to be the only way to make changes. Nevertheless, we believe it to be an important part of the change process, alongside political, administrative and financial change - and one that as a small organisation committed to change, we were capable of tackling.

Normalisation

Our starting point was the set of ideas described as normalisation in human services, and most completely developed by Wolf Wolfensberger (1972, 1975). Over seven years of working and struggling with these ideas our sense of their meaning has evolved. It seems to us there are at least five different kinds of ideas involved.

Normalisation is ....

1. **A set of understandings of the life situations of people with handicaps. Authentic description, grounded in direct personal experience**

2. **Visions of alternative possibilities in people's lives. 'Ideal but real' images of people's futures.**

3. **A set of theorems about the consequences of organising services in various ways.**

4. **Practical agendas for action.**

5. **Networks of people who share those understandings, visions and a commitment to action.**

Values

So normalisation is a complex set of interwoven theory, belief and practical knowledge. Values - a sense of what is important, an order of priority in human affairs - form a central and declared part of this system of ideas. Of course, values form an essential part of almost any imaginable set of ideas, but for a variety of reasons they often remain implicit and undeclared.

Values are involved in the first set of ideas outlined above. Our work has tried to support people in making accurate, authentic, descriptions of what really happens in the lives of people with handicaps, and in the systems intended to serve them. This means gaining an understanding of the deeply-rooted devaluation of people with handicaps in our culture. Service-systems seldom do more than simply reflect the devaluation which exists in our larger culture. Most ordinary people, and many service professionals have a sense that 'things are not as good as they should be'. What is needed is for them to confront the systematic ways in which services perpetuate and sustain devaluation. Only then can they gain an appreciation of just how serious is the situation for people with handicaps, not only placed at a disadvantage in the world, but served by organisations whose major consequence is to further damage them. This appreciation can only be gained when people judge the quality of what happens in the lives of people with handicaps by the same criteria and standards as they would apply in their own lives and those of other valued people. Too often people make hidden and unquestioned assumptions about what is okay for people with handicaps, but which would be intolerable in their own lives.

Understanding the experience of people with handicaps is, for most people who do not have handicaps, a dilemma. It is something they probably can never fully understand. Yet if they do not understand it, they can never gain an understanding of the effect of human services on people's lives. Normalisation sets a challenge to people to continually grapple towards an understanding of something they may never fully grasp: to constantly review and test their own values, assumptions and beliefs.

The second set of ideas - visions and beliefs about what could be possible in the lives of people with substantial handicaps again involves values, and the adoption of very high criteria indeed in envisaging 'alternative futures'. Many people content themselves with goals and aspirations for people with handicaps which are in every way trivial ('well, what more can you expect...we content ourselves with small gains'...) If they applied the same criteria in their own lives it would leave them aghast.

The fourth and fifth set of ideas hold a challenge to values too since they involve practical commitments to working with others, and to action to change the lives of people who are substantially at risk of being thought of and treated as if, they really were 'of less value' than other people.

The key ideas, or values, of normalisation are broadly similar to those found in the belief systems of other movements for social change, e.g. socialism, feminism, racism awareness, third-world consciousness, ecological awareness, and many religious belief-systems too. There are certain common themes within these different belief systems - ideas of:

FAIRNESS - **prohibits exploitation in human relationships, promotes trust.**

STEWARDSHIP - **prohibits waste of human and material resources, promotes sharing.**

RESPONSIBILITY - **compels a commitment to direct personal action.**

The values of normalisation are not essentially different from those of many other belief-systems, or those held anyway by many individuals. However they have been elaborated with a particular focus - on the life-situation of people with handicaps, older people, people who have suffered a mental illness, or the consequences of drug or alcohol abuse, and others. What all these people share is the likelihood that on the basis of their devalued characteristic they will be treated substantially differently in life generally, unless thoughtful, purposeful and determined steps are taken to see this doesn't happen.

A major dilemma in a 'values-led' approach to understanding human services - that is, an approach which seeks to make explicit the values of service systems, and to challenge them with reference to 'higher order' values - is that for many ordinary people this seems to be extraordinarily difficult. There are many different kinds of obstacle (none of them necessarily insurmountable) which seem to get in the way of people's learning. They include:

Unfamiliar agendas

Many professionals labour under the impression that their training and qualifications somehow make them 'value-free'. It's an example of what Thorsten Veblen described as 'trained incapacity'. An intense and narrow focus on some things makes others 'invisible'. Many people seem to have 'shelved' questions of values because they seem 'messy', complicated and difficult to resolve. Either way, setting an agenda which explicitly calls attention to values may cause problems of sheer unfamiliarity.

The myths of progress

This is not to say that progress is a myth, but rather that there are many myths associated with 'progress'. For instance the notion that 'things are at least better than they were' means that everything is now okay. Of course they are not. There is ample evidence that despite substantial changes in institutional conditions, for example, they remain unremittingly disastrous for the people who are forced to use them. Another myth is 'See our plans.....' - the notion that planning itself consitutes a change for the better.

Distortions of 'devaluation'
New languages quickly gain currency in professional worlds. The language of 'values' and 'devaluation' has spread (and become distorted) rapidly. The meaning of 'devaluation', for example, is sometimes distorted now, to cover:-

having people disagree with you;
being 'not liked';
not conforming to particular norms;
having something unpleasant happen to you
people with real power and status temporarily experiencing poor living conditions;
being subjected to stress.

Most of these distortions involve some displacement of the focus of attention from people who really are substantially at risk, to people who are in fact highly valued, and have substantial off-setting advantages. The other distortion is what Wolfensberger has described as the 'de-toxification' process. In his own work he (as no-one else) has sought to draw clear attention to the sheer critical seriousness of the life-situations of older and handicapped people in our society.

Apartheid - and the belief in cultural separateness

Notions that 'they are not really like us' seem deeply imbedded in people's knowledge and experiences of the world. This is sustained by physical and social distance. Even many service professionals have never at any time shared any significant part of their lives with people substantially at risk of devaluation - nothing more than meeting them across an office desk or in their 'clinics'. Often this belief is linked to an investment in apartheid strategies of 'separate but equal development' in segregated and artificial 'village communities' or other institutional euphemisms.

Individualistic theories of human nature
To many professional and lay people, social explanations of human circumstances are unfamiliar. Our educational systems are still largely wedded to individualistic, or psychological theories.

Clash of loyalties
A normalisation-based analysis is an uncomfortable one. Service-providers are called to confront the part their profession or their organisation plays in the devaluation of people with handicaps. Many see the dilemma and understandably find it hard to know where their first loyalties lie.

Organisational imperatives
People may see the dilemmas, recognise the value-issues, yet feel bound by the imperatives of their organisational life -'don't rock the boat; go with the flow; seek power and try to change things from higher up; follow history...'.

The demand for personal commitment
The analysis of the issues is an uncomfortable one because it demands people do something about it. This requires priorities to change, an effort to be made, time or space or privilege to be relinquished. Change is usually inconvenient, often painful.

Exclusive ideologies

Some people who already have well worked out, explicit, value-systems still find aspects of normalisation problematic. Marxists or feminists, for instance, may be critical of much of what is currently valued in our society (e.g. the unequal distribution of wealth or power between different social or ethnic groups or between the sexes). They may feel we should be encouraging people to challenge these kinds of cultural values, rather than to aspire to them. They themselves continue to enjoy many of the advantages our society offers, however, while criticising its values and working for change. In a diverse society, this too can be a valued way of life.

Normalisation seeks to extend to people with handicaps and others exactly the same opportunities and advantages. Pursuing normalisation would extend to people with handicaps genuine membership of our communities, and would enable them (amongst other things) to join the struggles of wider social movements which seek to create a fairer world for all. The different ideologies (normalisation, marxism, feminism and so on) do not need to exclude each other. They can inform, and be informed by, each other instead.

The paralysing diagnosis

Some people see the threat to handicapped and older people so starkly they have come to the belief that 'there is nothing to be done, one can only accept with resignation'. Others argue that since the situation of these people is only a microcosm of the world-situation, nothing short of a revolution in society will help, and they either await, or work towards that day. Either way, this position discourages people from trying to bring about organisational changes - though they may still have important personal relationships with individuals with handicaps.

So in the endeavour to support helpful and useful ideas, these are some of the largely conceptual dilemmas and contradictions which often seem to get in the way. None of them seems insurmountable. Consistent, long-term advocacy of the rights of people with handicaps seems reasonably successful in supporting many individuals in resolving these dilemmas, and in clarifying and asserting their own values and commitments. Whether it changes organisations is hard to say, except insofar as the individuals who compose those organisations themselves change.

In our practical work of training and evaluation the dilemmas are met in other ways. The table below lists some of the dilemmas, and the strategies which seem most helpful, in the context of both teaching and learning at 'workshops' where people are exploring value-issues:

Practical dilemmas and strategies in exploring values through workshops

Dilemmas	Strategies
Some people are uncomfortable with the focus on values - they associate	Keep a clear focus on the workshop goals - understanding value systems,

it with religious conversion, evangelism, etc.	not changing them.
Some people seem acutely uncomfortable being with people with handicaps.	Model appropriate behaviour.
Many people are unused to sustained, disciplined learning.	Maintain a clear learning process.
Many people have few ways of coping with personal challenge, they - - try to re-interpret challenges in terms of their personal values - try to re-focus their attention and that of others on the process of learning, rather than the content.	'No surprises' - keep a clear pattern of work, explain and describe each step well in advance. Manage the work to make effective use of people's time and energies. Support people in taking responsibility for the ideas and for their own and others' learning.
Some people distance themselves from community values.	Create a group context for them to explore community values.
There are compromises involved in creating learning situations in which workshop participants intrude in the lives of people with handicaps.	Build organisational safeguards.

These then are some of the contradictions met in teaching and learning situations. Strategies which are 'value-based' pre-suppose that no valuable learning can take place without people first learning the 'higher order' values. 'Values-led' strategies maintain a clear sense of what the significant values are, but recognise the often untidy or erratic processes by which many people learn. They seek to keep people's attention engaged with key value-issues, but to create learning-structures in which people can move to and fro betwen highly general and more specific levels of knowledge.

Practical dilemmas

There are many practical dilemmas in the business of evaluating new community-based services. Many of these services are still delicately poised. They often betray a refreshing honesty and concern with quality in seeking to be externally evaluated. Nevertheless, evaluation exposes them to a systematic and searching glare that many better-established services would be tested to withstand. The danger in exposing their faults and failings is in potentially damaging what in truth you seek to encourage. The table below lists some common dilemmas:

Dilemmas	Strategies
Many good services nevertheless reveal substantial gaps in their understanding of and commitment to their work.	Being an 'interested outsider' - asking questions, setting agendas, giving 'permission' for self-review.
Many new services are very fragile: - administratively and politically weak in a hostile environment -subject to random bureaucratic responses to challenge, in the absence of more imaginative management.	Build networks between projects. Celebrate successes.
Many organisations have little capacity for learning.	Build the ability to accurately describe what is really there. Support people in embracing error and learning from history. Offer to 'walk part of the way' with people who are 'venturing into the unknown.'

Our experience of sustained conversations with three or four thousand people over a period of seven years has taught us some things. The ideas themselves are inherently challenging, they make demands of us, they are not simply grasped, but continue to engage our attention, skills and energies. Like dilemmas, which have no solutions, only different kinds of 'accommodation' to them, they require us to constantly struggle towards better understandings. There are few short-cuts, no 'easy' ways. 'Packaging' and presentation serves to increase the difficulties, rather than ease them. Much of the world of service-organisations offers people little support to engage in the struggle, little encouragement to seek and explore.

Most of the people we've met are eager for the ideas. Many are young, many have made deep personal commitments to people with handicaps. Most seem likely to remain around in the world of human services for a good long time. Some of the people who struggle most with the ideas are those who have already themselves achieved much in their own lives and work. Not everyone enjoys the challenge, but most welcome, even celebrate it!

Acknowledgements

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ENSURING QUALITY IN THE PRIVATE SECTOR

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Since January 1985 the Joseph Rowntree Memorial Trust has funded research at the School for Advanced Urban Studies into private residential care for adults with a mental handicap. The focus of the research has been an examination of the relationships between health and local authorities and proprietors of private homes.

During 1985 we carried out case studies in four health districts in the South Western Health Region, involving interviews with members and officers of health and local authorities and with the proprietors or managers of all the 24 private homes for adults with a mental handicap then registered in those districts.

We are currently conducting a national postal survey of all local authority registration sections to obtain data on the rate of increase of the private and voluntary sectors of residential care, regional variations etc. and to identify areas where collaboration between the public and private sectors is being attempted. Examples of 'good practice' or innovation are being followed up during the latter half of 1986.

The nature of the private sector

Before discussing our work in the South West it will be useful to provide a context to this by reference to the national survey. Although this is still in progress, around half of the 116 registration authorities have now responded and it is possible to observe some trends from a very preliminary analysis of those responses:

1. The main expansion in private residential care for adults with a mental handicap is in the shire counties, with very little activity in London boroughs or metropolitan areas.

2. Between December 1982 and December 1985 the number of such private homes increased by around 400%.

3. The average size of such homes decreased during the same period from over 17 bed spaces to around 12.

4. Those homes registered since January 1986 and applications currently being processed indicate a further reduction in the size of new homes, averaging around 9 bedspaces.

The private sector in the four areas studied in the South West expanded even more rapidly than the national survey is indicating. At the time of our fieldwork in mid-1985, there were 24 homes, 20 of which had been established since December 1982. The average size of the homes we visited was 12.25 bedspaces - about the same as the national average at that time.

We identified three main factors contributing to this expansion:

1. The general availability of DHSS Supplementary Benefit to cover the fees of private homes since late 1983.
2. The willingness of health and local authorities to arrange placements of adults with a mental handicap in private homes.
3. The existence of a pool of qualified mental handicap nurses seeking to secure their professional futures on the closure of hospitals by establishing private homes.

These factors were evident in the homes we visited:

- most had been established since late 1983,
- 20 of the 24 homes set their fees in accordance with current DHSS Supplementary Benefit rates,
- over 90% of residents were wholly financed by DHSS benefits,
- two-thirds of the homes had taken all or most of their residents direct from health authority establishments with the active involvement of health and social services staff,
- over half of the homes had at least one proprietor who was a mental handicap nurse, most of whom had recently left employment in local hospitals.

Ensuring quality - causes for concern?

The health and local authority service development plans envisage residential elements of care in the community comprising domestic scale accommodation. Public authority staff often defined this in terms of houses for up to six residents. However, the majority of people discharged from hospitals over the past two years have been accommodated in private homes with an average of around 12 bedspaces and as many as 37. None of the 24 homes we visited had less than 6 residents.

In many cases, residents have been placed in private homes without a proper assessment of their needs or any real choice between alternative forms of accommodation. Most residents were, on the admission of both authorities and proprietors, the least dependent of the hospital population. The private sector is not generally willing or able to cater for multiply handicapped persons or those with difficult behaviour.

Residents of the private homes were relatively very young: 25% were under 25 years of age and less than 10% were over 65 years. Given the average age and low level of dependency, these people could reasonably be expected to have many years of increasingly independent lives ahead of them. However, we feel that with one or two notable exceptions, residents of private homes have very little chance of progressing to a more independent lifestyle.

We identified several factors as contributing to this depressing conclusion:

1. There was a strong tension amongst many proprietors between the objectives of providing a home and getting involved in 'training' residents.

2. Many proprietors had very limited expectations of their residents' capabilities and saw their role very much in terms of caring for, or looking after, residents rather than supporting their development.

3. There was very little involvement of health and local authority staff after placement, in initiating developmental work with residents.

4. There was often inadequate negotiation of support services, particularly day services, prior to placement. Less than half of the 286 residents received full-time day services; over 50 had no day services other than that provided by the homes - in some cases amounting to as little as 8 hours handicraft instruction per week.

Many of the regulations whose very aim should be to promote and maintain 'quality' in services do in fact combine to ensure that even small homes are effectively run as mini-institutions. Guidelines adopted by some authorities have been very much based on guidelines drawn up in relation to hostel-type accommodation for elderly persons and have little relevance in the context of ordinary homes for relatively young, fit adults with a mental handicap. Some requirements, for example, that bedroom doors be numbered, appear to be solely for the purpose of facilitating the job of the registration authorities.

The ultimate effect of regulations and the way in which they are implemented depends to a large extent on how the registration function is viewed within social services departments. The role can be a supportive, counselling one, seeking to influence by close liaison, or emphasis can be given to the controlling/inspection approach. Ideally, a delicate balance of both is required, but this calls for considerable skills and a good deal of awareness amongst officers. The political views of both elected members and officers and their attitudes towards private care can also influence the model of regulation adopted.

What can be done to ensure quality?

Firstly, health and local authorities could draw up clear guidelines specifying the basis on which they are prepared to use private homes as a residential resource. The guidelines should be based on the same principles as the authorities' own plans for service development. They should include not only physical standards but issues such as training of staff, involvement of homes in residents' individual development programmes, negotiation of day services etc. If proprietors are unwilling to meet these criteria, authorities should not encourage clients to use those homes.

Secondly, health and local authorities will have to compete with private homes in providing quality services. If many authorities' plans are superior to private provision, the fact must be faced that at present most existing publicly provided residential care is greatly inferior in practice to the majority of private homes.

Thirdly, it must be recognised that there is a substantial training task involved in ensuring quality. This applies both to public authority staff in relating to the private sector and to the proprietors/staff of private homes. Authorities have recognised the major need for re-training of existing staff to work in community based services; yet a large number of mental handicap nursing staff are moving directly from many years in large institutions to running their own homes with no such 're-orientation'. Authorities' training programmes must take account of the needs of the non-statutory sectors if quality is to be promoted throughout all elements of the service.

Finally, the most effective way to influence practice is to build up positive relationships. Most of the proprietors we met in the course of our research are not business people. They are people who are committed to working with people with a mental handicap. They want to be involved in thinking about wider issues of service development but sense a degree of resentment in the attitudes of public sector workers towards them. Admittedly, there are problems of achieving representation of such a highly individualistic sector, as there are with the voluntary sector. However, there are a few examples of multi-agency planning/implementation groups at a very local level where private proprietors are fully involved in looking at the whole range of services in the locality. If public agencies are to fulfil their responsibilities to all people with a mental handicap, wherever they happen to live, then a degree of partnership between all sectors of service provision can only facilitate this and contribute to ensuring quality.

KEY POINTS FROM DISCUSSION FOLLOWING THIS PAPER

Control over the private sector
There is relatively little control over the private sector in the U.K., as compared with the U.S.A. In the U.S.A., there is a close tie between the control of cash, regulations and monitoring, and the 'supply' of residents to private homes. In the U.K., there are three separate mechanisms - DHSS provides the cash, the local authority does the monitoring, the health authority provides the residents. There is little possibility of any control over that system, which is frightening.

'Big business' and the private sector.
The current situation, with lots of small proprietors offering fairly individualised services - may change. They may be 'mopped up' within a year or two by big corporations moving in on the scene - a worrying prospect.

Turnover of proprietors and the likelihood of take-over of homes.
There is some evidence from Norfolk that private homes for elderly people are closing down at an alarming rate. There is no evidence at present that small homes for people with handicaps are under economic pressure and selling up on any scale. Perhaps this is because the economies are different running homes for people with mental handicap: higher supplementary

benefit payable; lower costs than running homes for elderly people which have to be staffed all day long?

Costs and economics of running homes (and their effect on turnover/take-over).

In their first years, private homes tend to have high mortgage commitments. Some homes will make a loss if they are one resident down for more than a few months. However, mortgage commitments decline every year they manage to stay open. So their chances of continuing increase over time.

It is difficult to make predictions about the future stability of private homes when things are changing rapidly in the mortgage market. More time is needed before anything definite can be said.

N.B. It may not be losses that cause people to sell up, but a cool appreciation of the maximum economic advantage. What you can get in capital gains, selling up a going business, is likely to be much greater than anything you will make from income that accrues to you over the years.

Motivation/attitudes of proprietors.

Proprietors in the research study generally did not see it as a financial investment to be capitalised on. They talked about providing a home for life for their residents. They saw it as a commitment, their life work. Perhaps there will always be a few people who are very business minded, but generally that is not the sort of people who are opening homes.

The voluntary sector

This is increasing, but not at the same rate as the private. Interestingly, the decline in the size of homes is not so marked, or as rapid, in the voluntary as in the private sector.

Residents of private homes

Residents tend to be fairly 'able'. Most homes don't take people with 'challenging' behaviour. They don't have clear policies about what happens if/when residents become elderly or frail. They assume they will cope. They don't feel they would cope with people who become 'difficult'. The criterion is 'social acceptability' within the local residential area rather than level of physical dependency. 'If you go shopping, people round here don't like these people grabbing on to their hands'. In a couple of cases, people had actually been returned to hospital for this kind of reason.

ENSURING QUALITY IN SERVICES FOR PEOPLE WITH CHALLENGING BEHAVIOUR

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There are a number of people with mental handicaps who, at times, behave in ways which present exceptional challenges to the service planners and providers. The greatest challenges occur when people behave in the following ways:-

1. Attack other people e.g. biting, kicking, hitting
2. Exhibit extreme self-injury e.g. headbanging, eyegouging
3. Damage property e.g. arson, breaking objects
4. Create serious disturbances to people living with or near them e.g. prolonged screaming, setting off alarms, indecent exposure.

This paper attempts to address some of the issues involved and proposes a model for service design based upon 'An Ordinary Life' principles and the stated needs of clients, families and staff who experience these challenges directly. It arises from a concern that, to date, the 'Ordinary Life' initiative has had little impact on the lives of people with challenging behaviour, and those that are involved with them. The hope is that in the future good quality community services will specifically plan to include those who pose the greatest challenges to service providers, rather than exclude them, as has tended to happen in the past.

Challenging behaviours are not new to hospitals, hostels or some families who care for their relative with a mental handicap at home. With increasing commitment to locally based services comes a concern about the future without the traditional hospital base which has always provided the safety-net when the community cannot cope.

The plans of many health authorities contain proposals for residual hospital units or specialist units to cope with these challenges. Proponents claim that this is the only way people with these behaviours can be 'dealt with' (Day, 1983; Heaton Ward, 1984; Royal Medico-Psychological Association, 1971; Reid, 1983; Shapiro, 1971, 1974). The difficulties of reintegration and the safeguarding of the human rights of clients is balanced against the need to protect the community and the belief that treatment is only possible in such units.

In considering the appropriateness of this view there is a need to return to basic values and examine further the axiom:

> 'People with a mental handicap are developing human beings and services should assist them towards the greatest independence possible'. (North Western Regional Health Authority, 1982).

If service planners accept this principle, the yardsticks for designing a service for people with challenging behaviour can be found in the ten service principles set out by the Independent Development Council in the pamphlet Elements of a comprehensive local service for people with a mental handicap. (IDC, 1982).

The questions to be asked are:

1. Will the (prospective) clients or their families be consulted about the plans for services to people with challenging behaviour?

2. Will the service be aimed at promoting independence and developing skills and abilities for both clients and families?

3. Will the service reflect the unique needs of each individual?

4. Will the service help the client use ordinary resources?

5. Will the special needs of the client be met by locally coordinated and appropriately trained specialist staff?

6. Will the service be easily accessible?

7. Will the service be delivered to the client's home, school, ATC or place of work?

8. Will the service be delivered regardless of age or severity of disability?

9. Will the service plan for clients to return from institutions to live in localities where appropriate services are available?

10. Will the service have locally based teams who can visit families at home or at work?

Specialist units, by their very nature, make most of the above principles impossible to achieve. Is there, then, an alternative to specialist units which can promote an ordinary life for people with challenging behaviour without imposing undue risks for the community at large?

Individual case studies demonstrate that people with challenging behaviours can be helped in ordinary settings. Jim Mansell (1980) describes a successful intervention with a young woman moving away from hospital to a home with eight other young people. Alan Tyne (1982) gives accounts of five individuals with challenging behaviour, and how ENCOR (a community service in Eastern Nebraska) was providing services tailored to their individual needs in ordinary settings. Lovett (1985) gives considerable insight, through the people and examples he describes, into a helpful 'individual-centred' approach towards understanding and meeting the needs of people whose behaviour may pose severe challenges to the service system. In the Bristol and Weston health authority and the NIMROD service in South Glamorgan (Evans et al 1983; 1986) some expertise has developed in managing challenging behaviour in ordinary settings. The main reason often given when people have been admitted to institutions is not because the behaviour could not be managed in an ordinary house but because of the serious disruption to other residents' lives.

Planning a larger scale service covering, perhaps, the catchment area of a District Health Authority involves researching the case study examples in order to understand the key elements needed for an effective service. Examining available literature and discussing with colleagues involved in providing services for people with challenging behaviour, the following factors emerge:

1. There is enormous variability in both the degree and frequency of challenging behaviour for any one individual. People do not present the same challenges all of the time.

2. Most of the people living with an individual with challenging behaviour do not want a return to the institution but acknowledge the need for something away from home at times.

3. Living in small groups, with appropriate peer group models, with opportunities to learn new skills, helped by suitably trained staff provides the optimum setting for people with challenging behaviours to develop.

If the intention is to provide a high quality as well as an effective service, the perceived needs of clients, families and staff must be considered also. The needs represented below list the priorities as seen by nine clients with challenging behaviour and their families and twenty-four staff working with these clients as part of their duties.

Clients	**Families**
1. Stable relationships	1. Emergency call service at known place
2. Consistency from others	2. Help with training programmes
3. Control of their environment	3. Emotional support
4. Facilities to be alone	4. Access to 'respite' facilities

Staff

1. Appropriate training
2. Access to 'specialists' at all times
3. Support/guidance from line managers
4. Access to 'respite' facility.

The needs perceived by clients have been grouped and translated into general statements. The sorts of comments made by clients able to verbalise were:-

'I never know which staff are going to be here'
'I want to be left alone'
'I miss my mum and Susie'
'Let me have my blue dress'.

Families felt they were much more likely to cope if they knew who to phone if the situation was difficult. They wanted 'respite' facilities but, by preference, not a specialist unit. However, many had to accept this as the only available option. Although all wanted practical help with training programmes they also wanted someone to talk to, independently, with whom they felt they had some rapport.

Staff identified training as the key need, but in addition, felt access to specialists in behavioural methods - at any time - was required. As they pointed out the difficult times are often night time and weekends. Most disliked sending clients to specialist units where people with challenging behaviours were grouped together, but did not know what the alternative was when 'respite' was needed.

The model for an alternative to specialist units would need to allow for flexibility in staffing levels related to the frequency and degree of challenging behaviour. Most importantly, this flexibility is needed in the natural environments of the clients with prevention and training 'in situ' being the main objective. There would also need to be an alternative to the specialist unit for respite care should the problems become too difficult to manage.

A way of providing the flexibility would be to have 'one-to-one' teams, supernumary to established staffing levels. Teams of highly trained staff could provide a mobile workforce to assist, supplement and takeover, if necessary, in the natural environment of clients, be it A.T.C., school, family home or hostel.

The author has been involved in two case studies where one-to-one teams have been used effectively. In each instance the alternative would have been specialist unit placements. For one of the clients this would have involved placement in a secure facility a considerable distance from the family home.

TERRY

Terry was a 37 year old severely handicapped man. Although mobile, he had no communication skills and was totally blind. Terry had a number of behaviours which were difficult to manage - headbanging, screaming, anal 'digging' and smearing, refusing to wear clothes and pushing other residents out of chairs. The ward staff found him impossible to manage and were concerned for other residents, some of whom were multiply handicapped.

Three staff were recruited, volunteers from existing nursing resources, to work with Terry. Within twelve months most of the difficult behaviours had reduced to the point where ward staff were able to cope without one-to-one support. Terry had learned many new skills, including six Makaton signs. He went swimming and horseriding. His social behaviour was acceptable on visits to public places and he had enjoyed a summer holiday at a private address. The one-to-one team were gradually phased out. One of the team joined the ward as Terry's keyworker.

SIMON

Simon was 19 years old and had a history of poking at other people's eyes. This had resulted in the breakdown of a number of residential placements. He had returned home to live with his parents. Ordinary living became impossible as they were anxious about Simon participating in any activity with other people.

Two staff were recruited to provide one-to-one support, initially during weekdays. Additional relief for the family was arranged with weekend and holiday respite care. Simon had many strengths and was able to converse clearly with others about subjects he enjoyed. He wanted to learn to read and write and understand money. He enjoyed physical activities, sports and manual labour. These interests were incorporated into the programme plans prepared with Simon.

The staff worked with Simon over a period of eighteen months and gradually were able to reduce one-to-one suport from 75 hours per week to less than 20. At the time of writing, the phasing out of the one-to-one support is continuing.

In each instance, the formation of one-to-one teams was a response to a crisis situation. Earlier identification of potential problems would have enabled more effective planning of the service offered. The staff recruited to the teams received either crash course training or were helped to develop expertise 'on the job' and the only respite facilities available were on the hospital campus. Despite these drawbacks and although, in each case, progress was erratic on occasion, the general conclusion was that both clients benefited and that the use of one-to-one teams should be encouraged.

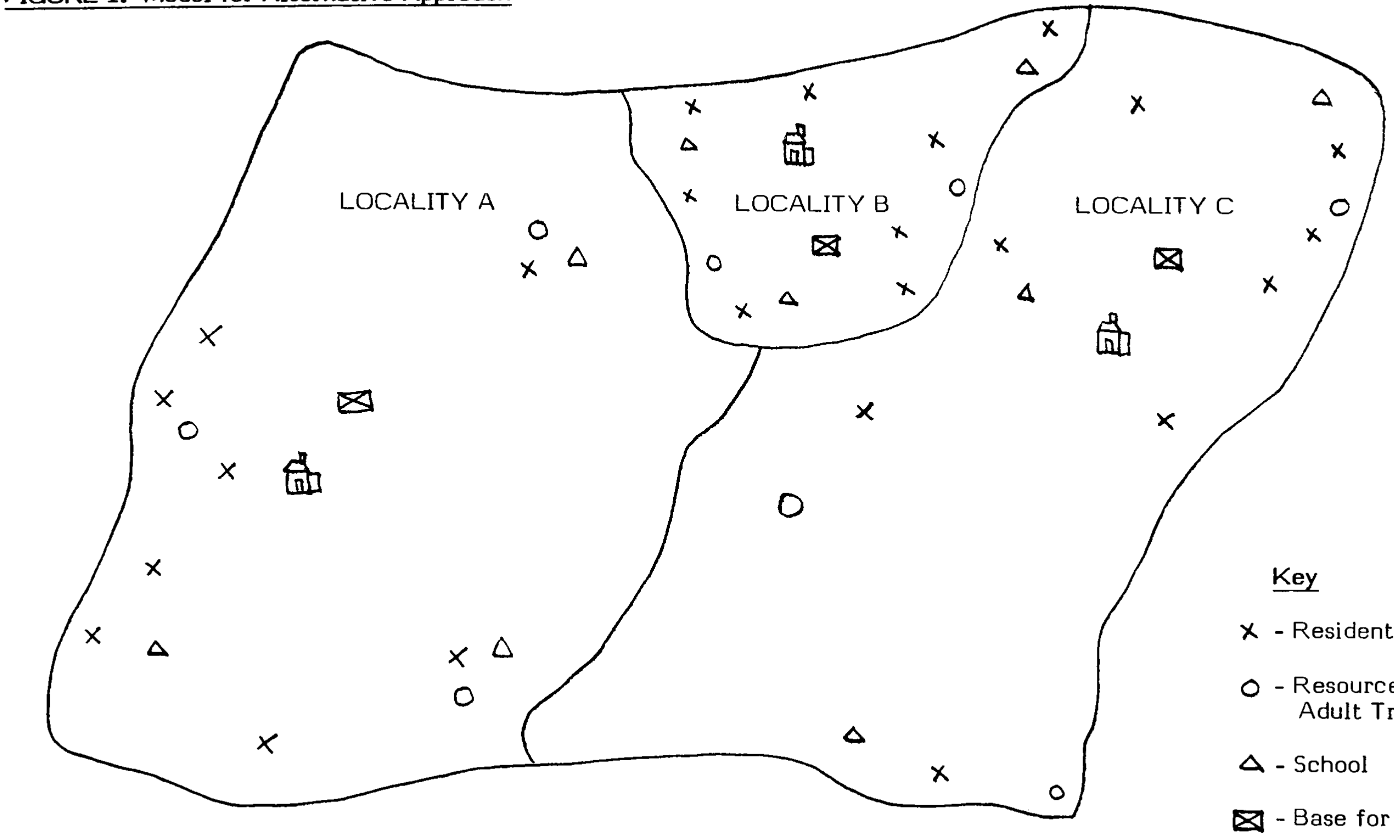
The other component in an alternative model to specialist units is the respite care facility. Figure 1 shows a possible design for a district service. Respite care for people with challenging behaviour could be provided either in the main house of an ordinary short-term care facility or in an adapted annexe, depending upon the frequency and intensity of the behaviour. One-to-one teams could accompany the client and provide support in either setting. The advantage of the separate annexe is that clients receiving short-term care in the main house are not disrupted by an individual with disturbing behaviours. The closeness of the annexe would allow for integrated activities when possible and give one-to-one staff access to colleagues in the main house.

In order to provide one-to-one support on a full 24 hour basis, each team would need a minimum of four staff. The number of teams in a district service would need to equate with the number of individuals, at any given time, who require this level of support. Published prevalence rates vary considerably (10-20 per million population - National Development Group, 1978; 30-50 per 100,000 population - Guy's Health District, 1981) indicating the need for local research.

Considerable interest in the model has been shown in the South West region. Proposals have been put forward for pilot schemes which could provide the basis for examining the alternatives to specialist units.

Hospitals will be with us for a number of years, thus providing a safety-net while alternative models are researched. The specialist unit should not become the accepted model by default, but only in the event of the alternatives being researched and shown by evaluation to have failed.

FIGURE 1: Model for Alternative Approach



Key

× - Residential homes

○ - Resource and Activity Centre/ Adult Training Centre

△ - School

⊠ - Base for community (mental handicap) team, and 1:1 team.

🏠 - Respite facility with annexe for 1:1 care

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KEY POINTS FROM DISCUSSION

Staffing
Volunteers from existing nursing staff were used, who were prepared to work in this different way, not normal nursing duties or shifts, but flexi-time and an element of risk. There was no shortage of volunteers.

Staff Support?
Staff needed access to round the clock (telephone) support, especially at the beginning. ('Did I do this right?')

Staff satisfaction
This came from regular feedback, support and their achievements - and more influence with decision-makers about what was needed.

Costs
Extra staff and staff support, in addition to residential, ATC, respite provision must be very expensive? When costed, the 1:1 service was not much more expensive than other options (e.g. regional medium secure units etc.) There was very little in the way of capital costs etc., and much better quality service anyway.

...and benefits
It is important to compare the quality of the service as well as the costs. Medium secure units tend to be grossly understaffed, even at the levels they're costed at.

Numbers of people with challenging behaviour
There may be a lot of people who need specialist help from different professionals, or highly intensive staffing. But only a few (1971 White Paper estimated 6 - 10 per million, or about 3 in a health district the size of Bristol & Weston) who need 1:1 team on top of specialist help and/or highly intensive staffing.
(N.B. There was some variation in opinion about this).

Residential services
People with challenging behaviour should not all live together, even in small groups of say, four. Individuals should live with their friends. It's a case of doing a lot of hard work to find out who can/will live with them, and vice versa. Ability level would not be the criterion here.
A 1:1 team would be a valuable back-up for existing local residential services/small staffed homes. Where 1:1 teams don't exist residents who have needed one-to-one attention at times of stress have had to be admitted to psychiatric or mental handicap hospital.

Services for people who are quite able, but have very occasional worrying behaviour (e.g. sexual offences with children).
This issue is not peculiar to mental handicap services. How to deal with 'low frequency' behaviours of this kind in very able people is something that is exercising mental health medium secure units, and special hospitals all the time. We should not provide special, separate services for people with a handicap who have these problems, when there are many other people who have them as well. We have to try and join forces with what other people are doing.

Systems-building or model building?

The need now is for the latter not the former. There is pressure to get into systems-building: 'How many beds in a district of a certain size are needed for a whole service?' But, we still need to uncover models of approach -a multitude of very small experiments to try and discover what is possible. Individual solutions for very individual needs.

Will it work?

We cannot say definitely that this particular approach will necessarily work, but it's important to try it.....and if it doesn't, to learn from that, and other people's experiences, and try again, another way.

PURSUING QUALITY IN COMMUNITY SUPPORT SERVICES
LESSONS FROM THE WELLS ROAD EXPERIENCE

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This paper describes the experience of a local service in its attempts to improve the quality of life available to people with learning difficulties. The paper looks in turn at:

1. How the service set about pursuing quality in this area.
2. How far 'quality' was achieved.
3. Problems in maintaining a service of this kind.

1. Pursuing quality through a community support service

The Wells Road Service was set up by Bristol and Weston health authority in 1982. A small-scale, local service (catchment area - 3 square miles; population - 35,000) it had two, interlinked, parts. A residential service was to provide a network of different kinds of homes, using ordinary domestic housing with varying degrees of staff support - along the lines suggested by An Ordinary Life. (King's Fund Centre, 1980). A community support service was to offer other kinds of support and opportunities to adults living in the area. (For general information on the Wells Road Service, see Ward, 1986b).

When the Wells Road Service was established, the provision of residential services along 'An Ordinary Life' lines was still new and relatively untried. The idea of a community support service was even more unusual. Most 'ordinary life' type services established at the time concentrated entirely on residential provision, particularly for people who were moving back into the community from long stay hospitals. The community support services at Wells Road was unusual in its commitment to enhance the quality of life of adults already living in the community, usually with their families.

On the one hand, these individuals would be offered the chance of a home of their own in the locality, rather than taking second place to those being 'resettled' from hospital, as in most other services. They (and their families) would be able to prepare gradually for a planned move away from the family home, in the same way as their non handicapped peers, thus preventing the trauma of sudden unplanned admissions to hospital at times of family crisis, sickness or death as in the past.

On the other hand, for those who were not interested in the prospect of a move away from the family home in the immediate future, the community support service had a wide variety of other options to offer. According to different individuals' circumstances, wishes and needs, there was the possibility of introduction to local groups, activities, friends and classes, help with particular skills or contact with other local agencies and professionals who might be of assistance. All of these options, and more (fuller details are given below) represented an unusual, if not, at that time, unique, approach, within community mental handicap services - a shift away from crisis intervention or simple skills teaching to a wider concern to offer each individual the opportunity for new experiences and relationships, and the enhancement of their quality of life.

The community support workers, and their role

The service was staffed initially by two community support workers. The innovatory nature of their role was underlined by their appointment on administrative and clerical scales. This unusual step was taken in order to permit the recruitment of potential staff from a variety of professional backgrounds and experience relevant to the new posts. Appointment on more orthodox NHS scales (e.g. nursing) would have restricted recruitment to one single professional group. The hope was that the community staff appointed would develop new options and opportunities which were right for particular individuals, rather than offer standard responses derived from one particular professional background or training. Flexibility and creativity were to be the keynotes of this new approach. (More information about the selection and initial training of community staff is given in Ward, 1984).

The following pages give some indication of the range of activities undertaken by the Wells Road community staff in their capacity as 'opportunity-creators'. In practice, of course, their activities have varied greatly, both in relation to different individuals, and at different times, as the service evolved and experience, expertise and ideas about the development of new opportunities and initiatives accrued. A fuller account of the work undertaken by the community staff over the last three years is given in Ward (1986 a). A summary on certain key aspects of that work is given below:-

Individual Programme Plans

The cornerstone of the service was the Individual Programme Plan system, through which every individual has had the chance to think through with those close to him or her, what changes or new opportunities they would like to experience in their lives over the next six months. As the service evolved, community staff developed considerable skills and sensitivity in tailoring the IPP process - as well as the outcome - to the particular needs of the different individuals alongside whom they are working. Out of the clear and expressed needs and wishes of different users for various opportunities, and in response to their particular preferences and strengths, many of the other initiatives and developments outlined below came about.

Support to families

The Wells Road Service was established as a service 'for adults and their families'. This was in recognition of the importance of working with and alongside families who were, after all, usually the people with the greatest interest, involvement and responsibility in the lives of the service users. Offering various kinds of support to families and also knowing when support would be more appropriately provided by others (for example, a local authority social worker), was an important strand of the community support worker's role. In this way, they managed to avoid the experience of many new community services which have encountered anxiety, hostility and even opposition from parents to new ideas and plans. Wells Road parents have become some of the service's strongest advocates. This has resulted perhaps from their experience of a combination of discussion, time, emotional and practical support on an individual level from the community support staff, and regular opportunities to meet with other parents involved in the service on a group basis.

Adult Education

One element of the job description of the community support worker was the development of opportunities for learning - not simply of the conventional 'training for independence' variety (learning to tie shoe laces etc.) but of widening horizons, developing confidence and opportunities for participation in activities and integration into the life of the community.

The work of the community support staff in establishing a small weekly class at a local community centre for a handful of individuals who had hitherto led fairly restricted lives, and the opportunities this class provided for the individuals concerned is described more fully elsewhere (Ward, 1986 a). Their enterprising work in establishing opportunities for integrated adult education - enabling students to develop the confidence to make choices and then join their chosen mainstream evening classes alongside other (non-handicapped) students is also described there.

Housing opportunities

A second initiative developed by the community staff, with the help of the regional officer of the National Federation of Housing Associations, and with the help of a grant from the District Health Authority, was the formation of the independent South Avon Housing Association. The Association was to acquire and manage the large number of houses required, both for clients of the Wells Road Service and individuals returning to the community during the phased rundown and closure of the local hospital. (Fuller information on the formation of the housing association can be found in Ward, 1986 c).

Leisure activities, friendships and integration

A third initiative undertaken by the community staff in conjunction with local churches was the establishment of a Manpower Services Commission community programme employing neighbourhood workers to work on a one-to-one basis with Wells Road and other clients, widening the leisure opportunities available to them. In this way, individuals have had a chance to sample new activities and broaden their experience. This has been one of the routes explored by the service and its users in the pursuit of friendships, and a chance for integration into the network of relationships in the locality. With the help of a companion - neighbourhood worker, volunteer, staff or family member, or best of all a friend - individuals may try out different activities and perhaps become involved eventually with particular leisure pursuits on a longer term basis. Shared interests or involvement in leisure activities, or membership of particular local associations, may then lead on to the development of further acquaintances. Over a period of time, these relationships may develop further into friendships - much sought after by service users who, like other people, are aware of the important contribution friendships can make to the quality of their life. (Atkinson & Ward, 1986).

Daytime opportunities, employment and work experience

The importance of worthwhile or congenial daytime activities, and work experience, has become clear to Wells Road staff over time. Some of their initiatives in the field of adult education and leisure have already been described. On the employment front, one local man has been employed on the community programme already described above, as a manual worker, doing household maintenance and gardening work for elderly people. After years spent as a resident in a mental handicap hospital, he is now the only employed member of his family. His sense of pride at his achievement and the growth of self esteem that has resulted is clear evidence of the importance of widening the employment opportunities available to people with learning difficulties. Meanwhile, as a result of a recent event organised for service staff and users, several other individuals are now pursuing the possibility of open employment with the help of the local Pathway Employment Officer.

Networks of support

In all these activities, a strong emphasis was given by community staff to the fostering and use of a whole range of networks of support within the local community, both formal (i.e. between different professionals) and informal (i.e. community groups and ordinary local people). This approach was facilitated in a number of ways:-

- the development of some initial guidelines indicating the different areas of work and responsibility of local professionals in the area (community mental handicap nurse, social worker, community support worker, home care assistant, psychologist, health visitor etc.)
- regular liaison meetings between these people
- the development of good sensitive working relationships between the community support worker, as a new breed of worker on the local scene, and their more established colleagues (particularly community mental handicap nurses and social workers)
- individual programme plans through which activities for any one particular individual might be coordinated so that the responsibility of different professionals was clear
- good relationships with and knowledge of the local community (with the pay-off that this might have in enabling people with learning difficulties to really become integrated into their local community).

2. How far was 'quality' achieved?

To what extent has the community support service been successful in its attempts to improve the quality of life available to people with learning difficulties in its area?

To answer this question (and others), the service was evaluated from the outset, supported by a grant from the Joseph Rowntree Memorial Trust. The activities of the community support staff were monitored and documented. More importantly, information was collected about the circumstances of individuals with handicaps in the area, both at the time the service started, and again, two years later. This information revealed in outline the changes in people's lives over that period, for example, in leisure and daytime activities etc.

A fuller picture of what these changes have meant in practice to the individuals concerned, has been built up through conversations, interviews and other contact with a sample of consumers and their families. With this, and additional information from the community staff, it has been possible to put together detailed accounts of the kinds of changes that have taken place in people's lives. (Some examples are given in Ward, 1986d. Further accounts, and reports of consumer views are in preparation. Here, for reasons of space, only a brief indication of some key points is possible.)

Consumer views

It is, perhaps, not surprising, that the responses of families to the service have been most positive. 14 (i.e. 40%) of the 35 families currently in active contact with the community support services (excluding nine families with relatives living in the residential service who were excluded from this study) were asked about their experiences, and views on, the Wells Road and other services with which they had been in contact, during the course of detailed interviews. Over a third had no contact with any other services at the time, and 37% had no day services.

The positive impact of the service on their own lives, and that of their relatives, is indicated by the quotes given below.

> Mrs. Thomas: 'Since the Wells Road started, you do feel as though you've got someone supporting you.....Now that you're having these meetings every six months you do feel as though you've got some support, you're not just going it alone...'
>
> Mr. Hardy: 'I would just like to say how wonderful the Wells Road Service has been for us, for all my family, my wife and our girl. It's made a wonderful difference. After nine years of nothing, along comes Shirley (Service Coordinator) and I must say I wasn't very nice to her because of what we'd been through, but now...nothing's too much trouble for them, it's wonderful...'
>
> Mrs. Wilson (about her son): 'Instead of an introvert, it has made him realise the outside world, because he never used to go out. He was always here. Now, he will go with Isobel (his sister) to have his hair cut. He wouldn't have done that years ago. If you sum it up in one word, I would say it has put confidence in him.'
>
> (And about the effect of the Wells Road Service on her and her husband): 'Well it's relieved us, hasn't it?'
>
> Mr. Wilson: 'Oh it's a lot better. Oh yes, much better for us two, knowing that there is someone who cares.....there are people that care'.
>
> Mrs. Smith: 'When they told me I was just inside the Wells Road area, I couldn't believe it - I could have cried, well I did cry. It was the best thing that happened to me all year'.
>
> Tom Bryant (who has spent many years in an institution, but is now employed on a local community programme): 'A year ago, I never thought I could do any of this'.

Although a few of these families spoke positively of past experience with other professionals, many more drew a contrast between their satisfaction with the new service and the shortcomings of previous professionals in their lives:

> Mrs. Johnson: 'Oh, I had quite a few (social workers) come up from County Hall. They didn't do anything - just came and asked how I was getting on, and coping and that. Not a lot of help really.'
>
> Mrs. Porter: 'Well, the community mental handicap nurse used to come and talk to us, you know, and see how Charles was getting on , just that sort of thing. Of course, with Bridget, it's doing something more positive....(planning for a move into a staffed home nearby)....The social worker....we don't see her very often, but I've got to keep in touch with her, because when Charles goes up to 'Woodside' (short term care unit) there's forms to fill out. That's the main thing she's involved with'.
>
> Mrs. Mason: 'The social worker was good, but I think with Bridget (community support worker), she's there....We only have to ring up and if she didn't know herself she'd find out and then she'd come back, while a social worker - I just don't think they've got the time, because they're doing Jennifer (her relative), old age pensioners, I suppose, and one parent families. I know they've got a lot on their mind but when you're in difficulty you think, why isn't she here or why isn't she doing this for me? Bridget, I think, is ideal with the Wells Road, because they're involved in these people, aren't they, you know, just in these people, and I think that is the main thing.'

Such a positive response to the new service is hardly surprising. In the course of the interviews and conversation that went with them, the sheer lack of information and failure of services in the past were graphically related, alongside the everyday struggles to survive and the ever-present fears for what might happen in the future ('after I'm gone'). The arrival of a local service geared specifically to meet such needs was for many families little short of a miracle. Maybe the community support service could be improved (though few families had concrete ideas on how this might be). In the meantime, the evidence from the service's stakeholders - families, users (who also gave their views) and staff - was that the service had helped to bring about significant improvements in the quality of people's lives.

3. Problems in maintaining the service.

The relatively rosy picture conveyed above has also had its darker side. Although consumers and staff have felt positive about the service, it has been beset by a series of difficulties which have ultimately threatened its survival.

i. Professional roles

There has been an understandable preoccupation at different times among the different professionals involved in community mental handicap services in the local area about their respective roles. At the inception of the community support service, these anxieties were addressed and largely solved in a number of practical ways - e.g. the guidelines and regular liaison meetings already mentioned. In addition, the community staff, as relative newcomers on the local professional scene took great pains to ensure that they did not trespass on what other people felt to be their particular areas of work. Since existing local professionals were not in a position to meet the whole variety of client needs, fruitful working relationships with the local community staff generally developed, alongside a recognition that Wells Road staff could be a useful resource and ally.

ii. District plans

Wells Road was established as a pilot service. If it worked, it could be reproduced throughout the local health district. However, the district plan drawn up by Bristol & Weston Health Authority in 1984 contained other ideas. It advocated community mental handicap services based around traditional community mental handicap teams (one social worker and one community mental handicap nurse joined by other professionals on a part-time basis, as recommended originally by the Development Team in 1978), residential 'units' of ten beds, and ten localities across the whole district, whose catchment areas would cut across (and would therefore destroy) the Wells Road Service as it then existed. More importantly perhaps the role of the community support worker and community support service were ignored.

Subsequently, as a result of a number of fortuitous changes of personnel within the health district, this plan was redrawn. Residential services were replanned to return to the 'ordinary life' model already followed by the Wells Road Service. The Wells Road locality would be more or less retained with the same catchment area (its boundary being only slightly changed in order for it to be coterminous with the local social services department district's catchment area). However, the notion of the traditional community mental handicap team was retained, with little clear idea of how it would operate and a strong possibility that in the Wells Road area at least it might supersede the community support service which was already operating so well.

iii. Community mental handicap teams

Plans to introduce community mental handicap teams across the district once again heightened anxiety about prospective roles within, and the likely composition and core membership of, these teams. Fortunately, local professionals in the Wells Road catchment area were able to draw upon their accumulated experience over the preceeding two years in order to put together positive proposals for the operation of the teams which built upon, rather than ignored, the lessons of the successful inter-professional relationships of the preceding years. Positive ways of working, delineation of respective roles and areas of responsibility and action, and an acknowledgement of community support workers as important, integral members of the forthcoming teams, were put forward for incorporation into the district-wide draft operational policies for the new CMHTs. After a number of revisions and some setbacks, the important role of the community support worker within the CMHT was officially recognised, at least for the time being.

iv. General management

In 1985, the advent of general management 'Griffiths style' had a different kind of impact on the Wells Road Service. Under the Griffiths' reorganisation, existing managers within the mental handicap unit were redeployed elsewhere. The new manager - appointed on a six month temporary contract only - had been a driving force behind the establishment and development of the Wells Road Service, and was well aware of the positive impact of the community support service in the area. Once again, the future of the community support service in the Wells Road area, and prospects for the development of similar services in other localities in the district, seemed bright.

However, the Griffiths reorganisation had other effects too. In particular, nurses (both locally and nationally) were very concerned at the prospect of being managed by, and being accountable to, non-nurses. Relationships between different professionals locally were sometimes strained and fragile. Community nurses were also concerned that their training, skills and special contribution to the care of people with mental handicap were not adequately recognised. There was some feeling that community support staff should in the future work more like assistants to community nurses, in carrying out programmes devised by them, rather than in the autonomous innovative and flexible way which had developed.

v. Joint planning with the local authority

Meanwhile, complications had arisen with the local authority social services department over the community support worker role. In restructuring local authority day services, the social services department had adopted the same job title (community support worker) to describe its new outreach instructors, working with small groups of people in the community. There was pressure on the health authority to change the job title of the Wells Road staff to avoid confusion. There was also some feeling that it was not appropriate for health authority staff to be engaged in this kind of work anyway.

More significantly, under pressure from the Regional Health Authority, discussions were now starting about the possibility of the eventual handover of the Wells Road Service and other community mental handicap services by the health authority to the social services department. Again, the future survival of the flexible, individual-oriented community support worker role was in question. Moreover, the proposed speed of the handover (a few months only) was a source of great alarm, particulary on the health authority side.

Eventually, a compromise solution was worked out. The eventual handover of the Wells Road Service (and other community mental handicap services) to the local authority was agreed, but deferred for the time being, while detailed joint planning towards this end continued. For a while, the community support worker's role was preserved (though retitled 'groupworker' under the local authority's plans). Ultimately, however, the role was scrapped, on the grounds that the costs involved could not be found out of the budget available for transfer from the health authority to the social services department.

Conclusions

It is possible now to draw some conclusions from the experiences related above.

1. It is clear that it is possible to create a small-scale service which seeks not just to ensure that people with learning difficulties have the bare minimum necessary in life - as has so often been the case hitherto - but which seeks to address issues of quality and of quality of life, and succeeds in doing so.

2. It is equally clear, from the quotations and other evidence given earlier, that such a service is greatly valued by the stakeholders involved -the consumers and their families (and the staff involved too).

3. The strengths of such a service lie particularly in its small, localised, patch base; its individualised approach to working alongside individuals with very different circumstances, needs and desires; its flexibility of action (with no established professional history or rigid job descriptions to rule out certain activities as inappropriate).

4. Many of the difficulties are the other side of this same coin. They arise from the creation of a new breed of professional - the community support worker. With no established professional group to rely on, the community support worker has been vulnerable at times of uncertainty and debate about future plans.

5. Returning to the Quality Action Group theme of earlier sessions of this workshop, it is not clear that a Quality Action Group of itself would have helped the community support service through its recent crises. Clearly, the establishment of a Quality Action Group might well have improved the service in terms of the accomplishments it was able to achieve on behalf of service users. However, it seems unlikely that such a Quality Action Group would have itself strengthened the chance of the community support service's survival, since the threats to its future came from outside the service itself.

6. This underlines the importance of a commitment to informing the value base of managers at all levels of the service hierarchy, since they are the people who have the decision making power. Moreover, it will be vital to ensure that this is an ongoing process given the frequent changes of management which seem common within both health and social service agencies.

An early manager within the Bristol & Weston Health Authority Mental Handicap Services was involved at the establishment of the Wells Road Service in attending a normalisation workshop alongside Wells Road staff, and was henceforth an enthusiastic supporter of the service's development, until his redeployment at the time of the Griffiths reorganisation. At other times, however, different managers in the hierarchy were less well informed about the values of the service, and therefore not well placed to ensure they were maintained.

7. Finally, there is a lot to be learned from the literature that exists in other fields about the difficulties of maintaining small scale, high quality, flexible services, and even expanding them or reproducing them on a wider scale. (See, for example, Daniel Korten, 1980, on the outcome of externally funded projects in the third world; and Bignell & Fortune, 1984).

The innovative community support service established at Wells Road was only one part of a much bigger service system. Inevitably it was affected by the changes introduced elsewhere in the wider health - and later social - service systems. The key questions now to be addressed, if we are to learn from the Wells Road experience, are 'what conditions would have been necessary, both within Wells Road and outside it, to have ensured the survival of the community support service?'

8. Despite the planned demise of the community support service, the message from the Wells Road experience is not entirely bleak. Quality of life can be put on the agenda for action. Ways can be found of enabling individuals with learning difficulties to have access to a fuller life if that is what they want without resort to the standardised service responses which undermine spontaneity, flexibility, and the informal networks of resources

already existing in the community. In short, a community support service like that developed at Wells Road can have a vital role to play in the development of opportunities for integration for people with learning difficulties within the local community, and in the achievement by them of a higher quality of life.

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PURSUING QUALITY THROUGH A QUALITY ACTION GROUP: EXPERIENCES IN THE CUSS HOME SUPPORT SERVICE

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This session begins where 'Pursuing quality: a practical approach' (see pp.5 - 12) left off. One mechanism for pursuing quality, it was suggested, was that of the Quality Action Group, and a process for its operation was put forward. The Quality Action process has formed the basis for an action research project in the Cardiff Universities Social Services home support service in which a group was set up to pursue quality. The project formed part of the Independent Development Council's testing of the ideas on pursuing quality, now available as a pamphlet (IDC, 1986).

Identifying a 'Quality Action Group'.

At the beginning of the project it was thought that a number of factors would be important in the selection of a group dedicated to pursuing service quality. It was suggested that first and foremost the members should share a commitment to action on service development. Linked to this the QA Group should, it was thought, include stakeholders who have the power to take decisions. It was important that the members of the group shared a value system which laid emphasis on the rights of people with a mental handicap to be treated as valued individuals.

There should be a shared commitment to involving consumers and people speaking on their behalf. These are key stakeholders. This commitment would include a willingness to take practical steps to enable their participation through the way in which meetings were organised, and in their content. A willingness to learn new skills might be needed, as the process includes collecting evidence among a number of tasks that may be uncommon to some group members. Finally there appeared to be a need for a person to take responsibility for steering the group through the process.

After the decision was taken to test out some of the ideas in the IDC pamphlet on pursuing quality, CUSS were approached by the Mental Handicap in Wales - Applied Research Unit to see if they were interested in taking up some of the QA ideas. Cardiff Universities Social Services are a charitable organisation which provides a house for four people with mental handicaps, and a house for short-term residential care. In addition CUSS provides a number of opportunities for volunteers to become involved with people with mental handicaps, and a teaching service for adults - the Home Support Service. It was agreed that the Home Support Service would be the part of the organisation to take part in the initiative. The CUSS Home Support Service consists of two staff and a service manager, who also has a caseload, and administrative support. Their task is to provide a home teaching service for adults, to help develop their competence and independence in the activities of daily living we all take for granted.

CUSS selected a representative set of people to take part in the Quality Action Group, and the first meeting was held in November 1985. The initial focus for the group was to move through the QA process as far as possible by March 1986, so that feedback could be provided to the Independent Development Council.

The first meeting had as its agenda the following elements:

1. To identify the stakeholders in the service, and to ensure that all who needed to be were represented on the Quality Action Group.
2. To agree the value system and how group members view people with mental handicaps.
3. To define quality for the service through agreeing what it seeks to accomplish for its clients.
4. To agree on other important areas of service quality that need to be addressed.
5. To agree ways in which accomplishments and other areas of quality should be measured.

Stakeholders

The group consisted of ten members:

* The Director of CUSS who has overall control of the several parts of the CUSS organisation.
* The Manager of the Home Support Service who carried a caseload of around five cases.
* The two staff of the Home Support Service who carried a caseload of around nine cases each.
* Two clients of the Home Support Service.
* A parent who had a son in his mid-thirties who was a client of the service.
* A Community Nurse who was a member of the local Community Mental Handicap Team.
* Two researchers from the Mental Handicap in Wales - Applied Research Unit, one of whom acted as the facilitator for the group in the first important sessions.

Although the group was formed without a detailed knowledge of the process it was to follow, it compares favourably with the criteria for identifying a successful group put forward earlier. The group was formed at a time when the service was committed to a review of their current working practices, and at a time when their funding agencies were requiring that they produce a system to monitor that work. The group included front-line staff and managers, the people necessary to take action on all aspects of their work. CUSS has a tradition of involving people with mental handicaps and their families in service management, and this case was no exception.

It would be fair to say, however, that there was no awareness in the group that it would require them to learn new skills, but as the necessity arose for unfamiliar roles to be played, all members were more than willing to make an attempt.

Values

It would also be fair to say that the group members shared no formal value system. In particular, their awareness of the principles of normalisation varied a great deal. They were, however, able to agree on the basic set of statements describing how they saw the role of people with mental handicaps in society that formed a starting point for further work. These included the fact that:

* The users of the service were important human beings.

* The users of the service should be integrated into living in the community.

* The users of the service should be becoming more independent.

While these were agreed in the first session, a sub-group was delegated the responsibility of refining them. The sub-group consisted of the service manager, the two staff, and one researcher. From this basic starting point the sub-group formed a statement of principles for the operation of the service. This was presented to the group at its next meeting, amended and agreed. The final statement is shown in Figure 1, and this formed a firm basis for the setting of the accomplishments for the service.

Figure 1: Statement of Principles for the operation of the service

The objective of the service was:

'To further integrate the handicapped member into his or her community through the acquisition of new skills and access to new facilities.'

Where new skills were -

* **Skills that promoted independence within the limitations that environment creates for them.**

* **Taught in the places they would normally be done, with the people and materials that would normally be used.**

* **Those through which attempts may be made to widen expectation and therefore scope for further development.**

and where new facilities were -

* **Those which would be used by all of us in our daily lives.**

The approaches to be adopted were -

* **To recognise people are valued human beings, each being very different, with strengths and weaknesses not related to their handicap.**

- To develop a detailed relationship and knowledge of the client as a whole person to know how best to teach them.

- To teach skills relevant to the demands of their daily life, or that will be of help in the development of their independence in the future.

and to recognise -

- That the experience of these facilities, in spite of a person's competence to use them is of itself of worth, and may contribute to further development.

Accomplishments

It was decided by the QA group that the Home Support Service would be providing a good quality service if it were accomplishing particular things for the people it served. These accomplishments fell into two groups, those relating to developing independence, and those relating to integration. The service would be achieving a good quality service if:

Independence

- People were doing more for themselves, especially in new living situations.

- People were learning more about social skills, reading, and writing.

Integration

- People were finding new places to go during the day.

- People were making new friends.

- People were using ordinary facilities, such as cafes, shops, leisure centres, etc.

These accomplishments formed a first attempt which it would be possible to modify and add to as the process went on. The group decided to focus on one accomplishment. The sub-group was reformed to derive a set of measures that could be used to collect evidence on the use made of ordinary facilities by those currently using the service.

Measurement

The sub-group considered using a check-list of a large number of potential community facilities that may be used by people with a mental handicap. This was rejected in favour of a set of headings under which any facilities used would be noted. The headings are shown in Figure 2. The current caseload of the service was twenty-two. It was agreed to balance the need to collect evidence, with the demands of the work load of the service. Seven current clients were selected, along with three past clients, and the staff group collected evidence on the use made by these clients of community facilities. In the case of the past clients, two sets of information were produced, the first for the time at the beginning of the service's intervention, the second for their current use, some time after the service had been withdrawn. Additional factors noted were whether the facilities were used in a segregated fashion, and whether the facilities were used independently of helpers.

Figure 2: The measurement of accomplishments - use of community facilities

- **Work**
- **Education**
- **Transport**
- **Shops**
- **Leisure**
- **Holidays**
- **Generic services**

With the additional factors of:

- **Were facilities used in a segregated fashion?**
- **Were the facilities used independently of helpers?**

For those clients the service was currently working with, the collection of information took roughly ten minutes, while for past clients some additional work was required in contacting them.

The information was brought back to the full group. It was found that for the seven current clients, under the 'work' heading, the majority were attending ATC or Social Education Centre. A few people attended evening classes, half used public transport, the rest using segregated transport, such as Mencap mini-buses and Adult Training Centre buses.

In terms of shopping and leisure, again half the group used shops in the centre of town, in addition to local shops, although the majority did so with personal help. Holidays were taken with parents, or in segregated groups with ATCs or clubs for people with mental handicaps. The majority of people used generic medical facilities such as clinic based GPs or dentists, although the majority did so with personal help.

For those people who no longer use the service there were positive and negative findings. In general, there had been an increased use of evening classes, while for one person the whole pattern of her daytime occupation had changed. She had now left her Social Education Centre with the help of the service and was now occupied in voluntary work in an elderly persons home, a pre-school playgroup, an animal sanctuary, and in a cafe, all virtually independently. Advances had also been made in the use of public transport and in the number and non-segregated nature of leisure facilities used.

However, the study also revealed the fact that, for two people, some part of the use of facilities they had gained with the service had not been kept up since the service had been withdrawn.

Action

The feedback to the QA Group as a whole by the sub-group pointed out both the positive aspects of what the service had achieved with past clients, and the situations in which current clients found themselves, and which the service now had to address. It was agreed by the group that the use of community facilities survey of current clients should be repeated when they left the service to assess the change due to the service's intervention.

It was agreed that the set of headings used in the survey should be included in a general review of all forms of information collection used in the service. Potentially it could be used to target future service involvement , whether in terms of increasing the range of facilities used by its clients, or changing the quality of use through helping clients to be more independent in their use, or to use them in a non-segregated way.

It was agreed that the staff needed to build up a wider knowledge of useful community facilities thereby offering a wider range of options to the people they serve. It had been recognised that the staff did tend to use the facilities they knew for teaching, rather than seeking out new options that might better suit individual clients.

The issue of skills or use of facilities falling into disuse after the service withdrew, led to a number of actions. Firstly, the service manager agreed to contact key workers in the Community Mental Handicap Team who were responsible for coordinating Individual Programme Planning sessions for particular people. The goals set for the Home Support Service's involvement with people were often set at these meetings. In some cases it was subsequently realised that the goals were inappropriate. The skills or facilities identified for action were not likely to be used by the individuals concerned in their ordinary daily lives in the future, when the Home Support Service had withdrawn. The objective of contact was to ensure that the Home Support Service was involved earlier in goal setting.

A secondary problem involving the way IPPs were conducted was also identified. The Director of CUSS undertook to pursue joint training on how to run IPP meetings between Community Mental Handicap Teams and Home Support Staff as well as others.

Finally the issue of maintaining the use of facilities and skills after the service withdrew was seen by the group as important enough to include it as another thing to be accomplished by the service. This was added as an accomplishment in the following terms:

* People would continue to use the skills or activities learnt after the Home Support Service had withdrawn.

The sub-group was given the task of following this up and bringing suggestions on how it could be pursued back to the QA group. This work is still in progress.

QA Group Agendas for subsequent meetings

It seemed that the following issues needed to be taken into account in subsequent QA group meetings. Meetings should be regular. There should be specific preparation for each meeting to ensure business is carried out effectively which means someone taking responsibility for collating information. If the participation of clients and parents is to be made effective, then thought needs to be given to the timing of meetings so that they can attend. Materials need to be presented in a way which avoids jargon, and makes it easy for everyone to understand. In addition, the meetings need to be structured so that it is made as easy as possible for all stakeholders to understand what is being done. The form of agenda followed by the CUSS Group to date is as follows:

Review progress
Review accomplishments
Review other important areas of quality
Agree goals
Work on goals between meetings.

Conclusion

The QA group process offers only one route to bringing together stakeholders, value systems, accomplishments and action. It has strengths and some weaknesses. The researchers' experience of its application in the CUSS Home Support Service would indicate the following are significant.

Strengths	Weaknesses
*The QA group was a source of support for front-line workers.	*The pace followed in the CUSS case was too quick to enable much progress to be made between each meeting.
*The process was not threatening and allowed people to talk over their service frankly.	*Parents and people with mental handicaps did not get a real say in what went on.
*Going through the process helped staff to clarify the boundary of what their service does, and what it can't do.	*Information was not clear enough to enable parents and clients to take part fully.
*It provided a direct link between monitoring and action.	*It is easy to slip off into trying to change the relationship between this and other services, rather than to improving client outcome from this service.
*It gave staff confidence to attempt to 'measure' the quality of their work.	

The CUSS group continues, and changes are being made to address some of the 'weaknesses'. Meetings are now to be 3-monthly and last a day. This will hopefully allow more time for working individually with group members with handicaps to ensure their opinions are fully considered. New methods of recording and efforts to be clearer in speaking are to be adopted to help those with difficulties. Some questions remain, and only time will tell if these will cause major limitations on the use of QA Groups to pursue quality in services.

- Is the process one which can be sustained over a prolonged period?
- Would the process work without someone from outside the service being there to direct the group?
- The measurement of accomplishment is an important part of the process. Is measurement by QA members purely a question of confidence rather than one of expertise?
- To what extent can the process be successful without a value system that is fully shared by all group members?

The QA Group process provides a mechanism by which all those with a stake in improving a service can come together in a supportive environment to do so. The process enables stakeholders to bring together an appreciation of what are good principles in service provision, with a critical appraisal of what their service sets out to accomplish for those it serves, and links all these to action. QA Groups are, as a result, a process that should be considered by all those interested in pursuing quality in their services.

References

Independent Development Council for People with Mental Handicap (1986): Pursuing Quality: How good are your local services for people with mental handicap? London, IDC.

KEY POINTS FROM DISCUSSION

Membership of a QA group
It is helpful if the people involved are open to new ideas and to developing the service.

Sustaining a QA group
You need people who are committed to change, and one or two people who will help to steer the group along.

How have service users in QA groups felt about it?
They have enjoyed it, and made particular efforts to participate, read papers etc. Everyone in the QA group in Cardiff wanted it to continue.

Can IPPs (Individual Programme Plans) perform the same function as QA groups?
IPPs do focus on individual outcomes etc. However, with IPPs you're only looking at individual outcomes for one person at a time. This may not enable you to say things about the structure of the service, and how the

service is delivered, or to translate information about this into positive change and action.
Service managers are more likely to be represented in QA groups than at IPP meetings, which may make QA groups a more effective vehicle for service change.

QA groups as 'disorganisers'
A QA group is important in getting people together to think about things in different ways from usual. Just getting a group of people to sit back and reflect on where they're going and what action needs to be taken is important.
'Disorganisers', like a QA group (or like this workshop), away from one's ordinary setting, or grouping, are very important in aiding learning.
Setting up a QA group upsets the usual tramlines people are set into in their day to day work. It may be very productive, providing space for people to think in a different way - a structured way - about what they're trying to do.

Are QA groups the only way forward in monitoring for quality?
No, but their focus on fundamental objectives - values, on the individual's experience and on client outcomes are unique and vital.
Some other process (less routinised than QA procedures) would be just as good, if it incorporated all the above. At the moment, no other process does.

N.B. There is increasing emphasis in some places (e.g. Wales) on the need to monitor services, but ideas on how best to do this are not fixed. QA groups may be a useful part of this process.

PLANNING FOR QUALITY

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The central message which we shall take away from this workshop is clear - that we cannot begin to plan new services until we have defined the values upon which these new services are to be based. In his presentation Alan Tyne left us in no doubt that any service providers who do not begin the process of planning by stating the values upon which their proposed service is to be based are likely to compromise the interests of the clients whose needs they are attempting to meet. In this paper I shall consider some of the work which has been undertaken on planning for quality in the field of business and commerce and discuss some of the practical issues which I believe that we need to confront if we are to plan and develop high quality services for people with mental handicaps.

A system of values

If we think about the organisations in which we work we can nearly always recognise that the value systems upon which these organisations are based are not static. The values which underpin such organisations are in a state of dynamic equilibrium. Economic, cultural and technological forces constantly affect the ways in which the organisation discharges its function and as a consequence influences the prevailing set of values held by the workers. Those who work in services for people with mental handicaps have in the past seen themselves in a dual role. On the one hand, they have been concerned to protect disabled people from a hostile outside world while on the other hand they have felt obliged to provide safe custody for some of those in their charge who have posed a threat to the wider community by committing delinquent acts. As a consequence the system of values which has historically underpinned services for mentally handicapped people has encouraged the development of philosophies of care based on segregation and custodial treatment.

Improvements in conditions of service for staff working in mental handicap hospitals over the past twenty five years, particularly improvements in wage rates and changes in staff:patient ratios, have brought about an escalation in the relative costs of providing residential care. The economic burden of these increases in cost have largely fallen on the district health authorities. Although efforts have been made by central government to give mental handicap services priority in the queue for extra resources, the acute services continue to be more successful in the competition for the limited funds available. There has therefore been economic pressure within the health service to develop a pattern of care and support which will enable a high quality service to be provided at lower cost.

Recent changes in attitude within society towards minority groups have created an opportunity for disabled people to establish clearer definitions of their needs and of their rights. These changes within our culture, which have been slow to manifest themselves, have provided another set of forces which have gradually reshaped our understanding of the nature of disability and of society's response to disabled people. One of the most significant ways in which these cultural changes have manifested themselves has been in the development of the philosophy of normalisation.

The technological advances which have most influenced the value systems underpinning our attitudes to mental handicap have been in the field of teaching. In the early nineteen-fifties, Tizard and O'Connor (1952) and the Clarkes (1954) showed that individuals with severe learning difficulties were able, once they had been provided with the appropriate help and support, to learn quite complex tasks and to undertake supervised employment. The results of these experiments have had a far reaching effect, not only on the development of techniques for teaching skills to people with severe learning disabilities, but also on the value systems within which we recognise the rights of disabled people to be given opportunities for training and employment.

Economic, cultural and technological changes have thus combined over the past twenty or thirty years to shift our perceptions of the needs of disabled people and have enabled new value systems to be developed. If these value systems are to have an influence on the pattern of services which are provided then they will need to be incorporated into the planning process.

Planning

For some time I have been closely involved with a number of colleagues in the development of services for people with a mental handicap in Bristol and Weston health district. I have been deeply concerned about the muddles and confusions which have arisen during our discussions on how to plan more effectively. We repeatedly find ourselves forced into making decisions based on expediency rather than principle. Opportunities to develop plans which offer valued choices to our clients are frequently lost because of the lack of any coherent set of values in our strategic plans.

In Bristol, in common with many other parts of the country, services for people with mental handicaps are passing through a period of major change and reorientation. The system which once existed to provide services is no longer capable of the tasks which it is called upon to perform. Although there is enthusiasm to plan and introduce new patterns of care and support, the existing services still have to be maintained during this period of transition.

I think that it is useful to consider the formulation of plans under three headings:

1. the need to think strategically;

2. the need to build an appropriate culture for the organisation;

3. the need to identify the new tasks that have to be undertaken.

1. Thinking strategically

A number of books have recently been published for the North American business community which are concerned with the promotion of high standards of quality in business and in human service agencies. Although these manuals are clearly written for business executives in training and directed at the commercial community, I think that they have much to say that is relevant to our own needs.

In their book, Creating Excellence, Hickman and Silva (1985) have described what they call 'six skills for new age executives'. Their list provides an appropriate starting point for our analysis of what is meant by 'thinking strategically'. Their list is as follows:

a. Creative insight: asking the right questions

b. Sensitivity: doing unto others as you would wish to be done by

c. Vision: creating a picture of the future service to share with others

d. Versatility: anticipating change

e. Focus: implementing change

f. Patience: living in the long term.

These six 'skills for new age executives' are clearly relevant to the work which needs to be done in preparing a strategy for any high quality service. A useful first step in the compilation of such a strategy is the production of a 'strengths and needs' list. In constructing such a list one is forced to analyse the organisation's strengths and the client's needs and discover whether a better match can be made. The following strengths and needs list is adapted from Hickman and Silva (1985).

Capitalising on the strength of your organisation

1. Carefully list each of your organisation's strengths and weaknesses. Be ruthless and objective. Look for strengths and weaknesses that you have perhaps never considered before.

2. Think of all the new ways in which you could apply your organisation's strengths to provide new choices or new services. How can you strengthen the weaknesses?

3. Evaluate the buildings, services, and other assets of your organisation as if they were a portfolio of investments.

4. Think about how your organisation's strengths could be developed. What part might be played by staff training or by restructuring?

Satisfying client needs

1. Consider the individual needs of the clients for whom you are providing services. Think creatively about the needs which some may have in common. Are there actions which you could take which might bring benefits for them all?

2. Consider all of the different ways your clients (and their families) perceive your organisation and push yourself to uncover previously unconsidered ways that they might view you and what your organisation is doing.

3. Mentally explore all of the needs which your clients have which are not being met. Don't be satisfied until you can clearly visualise at least one such need.

4. Identify in your mind all future potential client needs. Consider any needs or choices which you might be able to create rather than merely satisfy.

It should be possible to build on these strengths/needs lists to produce a strategic plan for the service - in the same way that an individual programme plan can be developed from a strengths/needs list drawn up for an individual client.

2. Building an appropriate culture for the organisation.

I would like to turn now to look at the second set of issues which I listed, namely the 'culture of the organisation'.

In his book Gods of Management, Charles Handy (1985) explores the different cultures of management which can be found in organisations. He uses the gods of ancient Greece to depict the differing management styles that he encountered. I think that his creative use of symbols is helpful and relevant to our search to find effective ways of building quality into services for people with a mental handicap.

Handy uses four Greek gods to symbolise what he sees as the four key ways in which organisations are managed. He uses the names of the four gods to identify different cults or philosophies of management. He also provides for each of these cultures a formal, more technical name as well as a diagram cum picture. The name, the picture and the Greek god each carry its own overtones, and these combine to build up the concepts that he is trying to convey.

The culture	The picture	The god
The Club culture	A spider's web	Zeus
The Role culture	A Greek temple	Apollo
The Task culture	A fishing net	Athena
The Existential culture	A cluster of stars	Dionysus

Let me try and describe each of the patterns which Handy has so skillfully identified.

.The Club culture (Zeus)

The picture which he draws is that of a spider's web. There are lines radiating out from the centre. However, in this culture these are not the lines that matter. In this model it is the encircling ones that are crucial - the ones that surround the spider in the middle of the web. These pathways carry the power and influence.

The club culture is particularly well suited to speedy decision making. Any situation where speed is vital will benefit from this style of organisation. Speed does not of course guarantee the quality of decision making. That depends on the calibre of those at the centre of the web. Handy believes that the culture of Zeus achieves speed through an unusual form of communication - empathy. There are no memoranda, no committees, no formal authorities. Those involved in this pattern of relationships function on close understanding and trust. Because those in the inner circle trust each other they can quickly agree decisions. Planning for quality depends on the inner circle having a feel for what the service needs and making this happen.

The Role culture (Apollo)

Handy sees this culture as being built around the definitions of jobs to be done, not around the personalities of the individual performers of those jobs. The picture which he draws is that of a Greek temple. The pillars represent the functions and roles of the members of the organisation. The pillars are joined only at the top, where the heads of the different functions and divisions join together to form an executive committee.

In this culture it is assumed that people are rational and that everything can and should be organised in a logical fashion. The task of the organisation can be subdivided into component parts until there is a system of prescribed roles (specified by such things as 'job descriptions') and held together by a whole set of rules called manuals, or procedures. Handy comments:

> 'The Apollo style is excellent when it can be assumed that tomorrow will be like yesterday. Yesterday can then be examined, pulled to pieces, and put together again in the form of improved rules and procedures for tomorrow. Stability and predictability are assumed and encouraged.' (Handy 1985, p.21).

In this culture planning for quality derives from a careful analysis of existing service provision. Procedures and protocols are continuously revised and reviewed to ensure that improvements are made on the basis of evidence and not on the whim of the managers.

The task culture (Athena)

In this culture, management is seen as being concerned with the continuous and successful solution of problems. The task is first to define the problem, then allocate to its solution the appropriate resources and give the resulting group of people the authority to go ahead. Performance is judged by the success of the individual managers in solving problems.

The picture is that of a fisherman's net. The mesh of the net symbolises how resources are drawn from various parts of the organisational system in order to focus them on a particular knot or problem. The power of the system lies in the meshwork of the net, not at the top, as in the Apollo culture, nor in the centre as in the Zeus organisation. The pattern of management is based upon a network of loosely-linked units, each unit being largely self-contained but with a specific responsibility in an overall strategy.

This culture is built around the assumption that expertise is the only recognisable basis for power. Those who contribute to the group offer talent and creativity, a fresh approach and new intuitions. Since the group has a common purpose (the solution of a problem) there is a sense of enthusiasm and joint commitment. Handy describes it as being 'a purposeful commando'. The task culture talks of teams where others talk of committees. Planning for quality is seen as a task for the team to solve. The successful solution will usually be based on a great deal of creative and original thought.

The Existential culture (Dionysus or the prima donna)

In the existential culture the organisation exists to help individuals to achieve their purpose or goal. This makes it antithetical to the other cultures where the individual is subordinate to the organisation. The picture is a cluster of individual stars, loosely gathered in a circle. The picture will however remain essentially unchanged if a star or two departs - those who are the stars are not mutually dependent.

The existential culture is excellent where a talent or professional skill of an individual is the crucial asset of the organisation. Within this culture professionals can preserve their own freedom and identity and are only accountable to the clients that they serve. And yet they can be part of an organisation. Handy comments that:

> 'Dionysians recognise no 'boss', although they may accept coordination for their own long-term convenience. Management in their organisation is a chore, something that has to happen, like housekeeping.' (Handy 1985, p.29).

Organisations as a mix of cultures

Handy's models are useful because they help to sharpen our awareness of what it is that we are doing when we set up new management systems. With the advent of 'General Management' in the health service we have become acutely aware of the importance of systems of management which will facilitate and sustain new structures. For example in an organisation which adopts the 'club culture' speedy decision making will only happen if the leaders of that organisation have taken time to build up trust among themselves. None of the organisations that we shall be discussing exist in the form of a pure culture. All will contain recognisable features of the different cultures that I have mentioned. Handy suggests that if we examine the history of most organisations we shall find that they have progressed through the club culture to the role culture, to which they have subsequently added the task culture and the existential culture as they have needed to change and develop. Most of the organisations which we know are a mix of all four.

3. Identifying the tasks

Although organisations may have general understandings about the arrangements through which they identify priorities for action, there is usually a mix of opportunism and chance about the ways in which changes are actually initiated. The list which follows provides a sequence which has proved to be useful in thinking about the implementation of change in our own service in Bristol where we have attempted to develop a plan for a service in which 'quality' is a key item on the agenda. The following were the sequence of tasks which we identified:

Strategic tasks

1. Creating a vision of a model service to share with others.
2. Writing a strategic plan (jointly with others).
3. Developing this into a detailed plan for implementation and recruiting support for the plan from those in authority.
4. Implementing change.

Culture building

1. Preparing structures appropriate for the management of the organisation.
2. Identifying potential leaders and managers.
3. Exploring the organisation's staff training needs.
4. Creating an environment in which staff can achieve a high degree of motivation.

Task identification

1. Identifying clients' individual needs
2. Appraising the strengths of the organisation
3. Assessing the level of available resources
4. Attempting to achieve a good fit between needs and resources.

When I reflect on our experiences in Bristol over the past four or five years, I am conscious of the fact that we have probably spent far too much time writing and rewriting strategic plans and that we have not devoted anything like enough time to 'culture building'. I suspect that the same shortfalls are to be found in many other services. It is relatively easy to create models but very difficult to build new cultures. When an organisation moves on from developing a 'model project' or 'pilot scheme' to implementing the major changes required to set up a fully comprehensive service, the amount of work needed to be done on establishing a new culture should not be underestimated.

Tasks involved in monitoring quality in a resettlement programme

One of the areas which is particularly crucial to the establishment of high standards of quality in care and support is the planning of the resettlement process for hospital residents moving out to live in the community. The process which we have followed locally is one which begins with statements about values and choices and ends with evaluations by the community team of the accomplishments which clients have actually been enabled to achieve.

The major revolution which has occurred over the last thirty years in the ways that we think about and plan for people with mental handicaps has had repercussions at every level of the service system. In planning a resettlement programme we are asking staff and families to take part in a process which threatens their security and which may force them to look again at some painful and difficult issues. For example, some parents are likely to feel extremely anxious if asked to contemplate the return of a son or daughter, who has for twenty years or more lived in the security of a distant hospital, to return to live near to the family home. Some families may of course welcome the move out of hospital but for many elderly parents the news of the imminent discharge of their son or daughter to a community home brings mixed emotions.

Although many staff will welcome the challenge of moving with their residents to a community setting there will be some for whom the prospect of resettlement in the community poses a threat and not a challenge. Staff who are impatient for a change will often lose their enthusiasm if the planned changes become stretched out over too long a period of time.

Charles Handy's analysis of the ways in which we can build appropriate cultures for the systems in which we work is relevant here. It is likely that we shall need to devote substantial time to the development of an acceptable framework wihtin which new patterns of service can be developed. The hierarchical management structure of a large institution is unlikely to be an acceptable or appropriate method of managing a small locally based service which needs to be able to react rapidly to changes in its environment. The model which Handy describes of the 'Task culture' based on a network of loosely linked units of management is more likely to be attractive in such a setting. On the other hand the operation of a community team may draw heavily on the 'Role culture' where procedures and protocols have such importance.

Monitoring quality in a resettlement programme will inevitably involve:

> economic considerations - including an appreciation of the cost effectiveness of the new service;
>
> technological considerations - including the major challenges of training staff to work in new and more innovative ways;
>
> and considerations of the most appropriate management culture for the new organisation.

The steps that we have taken locally in the preparation of our resettlement programme can be summarised as a list:

1. Strategic planning
   - based on statements about values.

2. Preparing a detailed implementation plan
   - derived from mutually agreed policies.

3. Preparing individual programme plans
   - detailing specific goals and objectives for individuals.

4. Setting up resettlement teams
   - a reviewing process.

5. Convening an executive resettlement group
   - confirmation of standards in the services being offered.

6. Establishing community teams
   - means of monitoring the service's accomplishments (i.e. the effect of the service on clients' lives).

A major advantage of the sequence of steps outlined above is the ability to monitor for quality at more than one level of the planning process.

Summary

Planning new services will never be easy. Economic constraints will frequently limit the scale and pace of development. Staff who are employed in any existing institutions will need to be reassured about their own job prospects before they will commit themselves with any enthusiasm to their involvement in new patterns of services. Clients and their families will need to be convinced that the new service will offer better support and a more adequate range of choices.

Planning is essentially about the implementation and management of change. Building quality into developing services is about the incorporation of values into that process of change. Our task as innovators is to ensure that those values reflect the best choices for the people we are serving.

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KEY POINTS FROM DISCUSSION

Building the culture

Who is going to build the right culture? New models cut across line management, which people adhere to quite strongly. Who is going to help overcome opposition and negative reactions to organisational change?
How easy is it, in fact, to build the kind of culture you want? The health service has always operated on a 'role-culture' model. It is going to be very difficult to change people's assumptions about the way in which they work.

General management and building the culture

General management may enable managers to introduce elements of 'task-culture' if they want to and actually set up groups that are multi-disciplinary. However, isn't the idea that you can try and create a particular culture that you want, even as general manager of a service, a bit too simple? The problem is - what kind of culture are you working with?
The ideas are very important, but it is easy to underestimate just how powerful existing cultures may be.

Organisational culture, style and values

The assumption so far seems to have been that an organisation's culture is about style - about how it goes about doing things. The difference between

Handy's analysis and Peters & Waterman's analysis of excellence (and the difference between Peters & Waterman and all the others who have attempted to copy them and put 'excellence' in their book-title) is that the pale imitators have largely latched on to issues of style. The essence of what Peters & Waterman was talking about was content - about the nature of values in organisations, about what it was the organisation was trying to achieve.
Handy's four kinds of culture, or styles of operating, all seem to be able to work reasonably well, but none would be any good unless anybody's got any idea of what they want them to do.
The shift to new patterns of management in the health service has simply refocussed on style, rather than content or values.

Sustaining quality

The Wells Road Service (see pp. 44-53) seemed to be moving towards excellence. Now it seems threatened. What lessons can be learned from this experience?
It was easier to do things flexibly for a small-scale service. People were not too worried because it was a 'one-off' service. Once it looked as though the service would be replicated on a larger scale in the district there was more anxiety and opposition.

Values also came into it. Some people worried about replicating the service elsewhere because of the cost. It gets back to values nationally, regionally and down to unit general manager level and below. People have different values.

Commitment by managers to service users.

When it comes to organisational change (e.g. the proposed handover of services from a health authority to a local social services department) is there a personal sense of responsibility for the people with mental handicap affected by the change? Or when the time is ripe do people say 'let's give them to somebody else' without really thinking through what changes will happen to people in their daily lives as a result, changes to things that are of immense importance to them?

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Peters, T. & Waterman, R. (1982) In search of excellence. Lessons from America's best-run companies. London, Harper & Row.

LAST WORDS FROM THE WORKSHOP

Values are central to the whole process of thinking about quality

Quality Action Groups are a useful tool for putting the subject of quality on the agenda.

How to sustain quality is a vital issue. We need more accounts of how it has been done. Can we learn anything from how low-quality services have been sustained over the years?

Incentives/rewards for thinking about quality and questioning current services need to be built into the system. The present system favours stability and conservatism instead.

Staff need to feel valued by managers, and service users by staff. If everyone feels valued, that brings intrinsic rewards.

Pursuing quality is difficult because people with handicaps are not traditionally valued in our society.

Support from the community is essential if we want people with handicaps to have valued roles in the community. How do you begin to develop that kind of support?

What can we as individuals do? We can all do something towards improving the quality of services in which we are involved. (See the Personal Pledges on pp. 81-2 for examples.)

APPENDIX A - PAPERS AND REPORTS FROM WORKSHOP GROUPS

SESSION I. WHAT IS 'QUALITY?' HOW CAN WE ENSURE IT?

Tasks for Workshop Groups

Work through the first steps in establishing a quality action group for one (or more) of the following services:-

a citizen advocacy project
a Pathway employment scheme
a family based respite care service.
a volunteer sitting-in service
a short-term care house (for adults).

1. Who are the stakeholders?
2. Are there clear, agreed values?
3. What are the important ways in which the service should affect users' lives?
   (i.e. list 3 - 5 accomplishments).

* What other strategies do you feel could be important for ensuring quality in this service?

Note down

- any particular problems/issues/difficulties that may arise
- any ways these may be overcome.

SESSION I. WHAT IS 'QUALITY'? HOW CAN WE ENSURE IT?

Notes from workshop groups

1. Example - Citizen Advocacy Scheme

Who are the people?

- abandoned/desolate people (no one committed to them in their lives) - this is revealed especially in times of crisis.
- rights denied/routinely abused (this is service-defined and legitimated)
- petty privileges denied
- threat of major sanctions e.g. Mental Health Act or withdrawal of service
- high risk of denial of rights
- not having an independent set of relationships
- few useful resources
- labelled - denied 'face value' legitimacy

Potential stakeholders

Definite - people with mental handicaps
- advocates.

Possibles - people from local communities (e.g. vicar/bank manager).
- scheme coordinator
- other professionals

Not - parents?

N.B. May be better to have a 'self-selecting' group who share a common vision than a representative group. Need to be open to learning and challenging their value systems.

Values

Fairness: it isn't right for these things to happen in people's lives

Stewardship: it's not necessary for people's lives to be wasted, talent squandered.

Responsibility: citizens should be supported in taking direct personal action.

Accomplishments

People will have a 'person' to represent their interests as if they were their own (unconditional) - a person to reduce abuse through alerting/reporting/protecting

people would be seen to make more choices

people would have a wider social circle

people would spend time, over time, with someone they can trust.

2. Some general points about the quality action process

Stakeholders

- how far up the management tree do you need to involve people in QA group?
- what mechanisms are there to include those people not included in the quality action group?

Values

- parents/professionals/management/clients may all have different values/needs, therefore may need to compromise?

Outcomes for clients

- not just talk, but accomplishments (i.e. what they will experience as a result of the service)

Issues

- do people who control the service need to know the users?
- how to allow unorthodox alternatives to conventional service responses
- how to relate philosophy to practice
- how to get quality on the agenda

N.B. The power of words and terms - can we use them to our advantage? (E.g. if an authority, or a service, has made a commitment on paper to certain principles, like 'An Ordinary Life', can we use this to bring about action for change, for achieving better quality services by reminding them of this commitment, and what it should mean in practice?)

SESSION II. PURSUING QUALITY IN RESIDENTIAL SERVICES.

Tasks for Workshop Groups

Thinking of a high quality residential service:-

1. Who are the stakeholders?
2. Are there clear/agreed values?
3. List 3 - 5 accomplishments
4. What evidence could be collected to show progress on these?
5. What strategies would be helpful to enable progress on each?

* What other strategies could be important for ensuring quality in a residential service?

Note down:

- any particular issues/problems/difficulties that may arise
- any ways these may be overcome
- anything different/particularly important where someone with challenging behaviour might be concerned.

SESSION II. PURSUING QUALITY IN RESIDENTIAL SERVICES

Notes from workshop groups

1. Example - a small home for three children and eight staff

Who are the stakeholders?*
(*i.e. someone with a stake in the outcome of the service)

the children
their families
staff - manager(s)/home staff/administrative staff
management committee
placing authority
charitable foundation who set it up
other professionals - local G.P., physiotherapist, education?
local community

(Which of the above should be included in a QA group?)

Values

There will be different values in a group to start with.

Differences need to be acknowledged.

Working on common goals may help clarify values and increase agreement.

(This process should promote coherent decision making).

Broad agreement between staff, e.g. it is important that children should have contact with non-handicapped people.

Side issues

Who to include as stakeholders - when values differ?
when/if the group gets too big?

N.B. There will be different values within each group of stakeholders, as well as between them.

Accomplishments

Each child will have the opportunity to make and experience long-term relationships.

Each child will have support in developing and expressing their own identity (e.g. contacts with natural families; a life story book).

Each child will become involved in defining the accomplishments of the house.

Each child will develop into a fully participating adult member of the community.

2. Example - Residential service for 3 clients with challenging behaviour.

Who may suffer or gain most if quality is poor/high?
(i.e. who are the stakeholders?)

Potential stakeholders

Clients
Advocates
Direct care staff
Families
Neighbours
Management
Planners
Those involved in setting service up e.g. - 'research input'
psychologist
Other staff - e.g. occupational therapy; consultant psychiatrist; etc.
Social Services
Politicians/councillors
Day Services/Centre
Field social workers
Leaders in Community

Values

Different for different aspects, of service, or groups involved?
No common set of values for stakeholders

Defining accomplishments for this service

What to measure

Choice
Community participation/involvement
Reduce 'difficult behaviour'
Having full, varied day (diaries)
Treated with warmth, respect, dignity (how to measure change, activities, descriptions)
Opportunity to make acquaintances (diaries).

How to measure

Diaries, descriptions, numbers, checklists.

3. Example - Residential services generally

People who have lost their homes, relationships, roots, or are at risk of this, need:

- support to live in a house - unconditional support even when they don't conform to expectations - and continuity
- support to rebuild/build relationships and maintain lives in a community
- practical support - rates, heating, meals, washing
- help in finding and having choice of activities that are varied, real and valued
- their own practical and emotional base for activities and relationships outside
- real control over their environment and space - what and where it is; who is there (who share with and who comes and goes); what's there; time spent there and outside; whether to move; privacy; income and use of money

So: a residential service should accomplish the following:
(i.e. people will experience these things)

- the feeling they really have a home
- a house or flat of quality that is accessible, equipped, valued etc.
- practical support when needed, where needed (see above)
- emotional support when and where needed - from a variety of sources (the service shouldn't get in the way, might facilitate and may have to offer this)
- real control over their activities and space, e.g. who comes in or spends time with them and what's in the place and whether or not to stay there (see above)
- relationships that are maintained, extended, added to with assistance as required that doesn't detract from or subvert these relationships.

Evidence (needed to show progress on above accomplishments)

Accurate descriptions of people's lives - built up from a variety of perspectives (need clearly defined value base).

Tangible differences, e.g. number of friends, possessions, and the frequency and time spent in contact with others outside the service.

Documenting opportunities for choice and control.

SESSION III. PURSUING QUALITY IN COMMUNITY SUPPORT SERVICES.

Tasks for Workshop Groups

Thinking of a community mental handicap team:-*

1. Who are the stakeholders?
2. What should its accomplishments be? (List 3 - 5)
3. What evidence could be collected to show progress on these?
4. What strategies would be helpful to enable progress on each?
5. What other strategies could be important for ensuring quality in a community mental handicap team?

Note down:

- any particular issues/problems/difficulties that may arise.
- any ways these may be overcome.

* If there is time, or you prefer,

Work through the same questions for a different kind of community support service.

SESSION III. PURSUING QUALITY IN COMMUNITY SUPPORT SERVICES.

Notes from Workshop groups

1. Example - Community mental handicap team

What is a community mental handicap team about?

- identifying needs
- developing supports that don't at present exist
- providing a comprehensive set of services to an area
- providing specialist services to people in the area
- crisis intervention
- coordination of existing services
- building 'monitoring' into services (both old and new)
- providing specialist advice for other services
- 'resettlement team' - bringing people back into the community from hospital
- breaking down professional barriers, leading to a better service
- providing one point of entry to other services
- planning the intervention of services in people's lives
- shifting the emphasis from 'specialist' to generic services.

Teams should be about bringing together appropriate resources for people with needs.

If a team was working effectively, people would experience the following:

- people would get specialist help when needed, where they are (i.e. more of what other people also need sometimes e.g. physiotherapy, speech therapy, educational opportunities etc.)

- people would know where to go if they have a need/crisis

- people would get their specialist services at high quality from the generic services we all make use of

* BUT DO YOU NEED A TEAM TO ACCOMPLISH THESE?

Strategies for re-directing existing teams

- develop a shared vision of what problems (and opportunities) are presented/faced by people with handicaps, and what their lives should be like

- do this by spending time with people with handicaps (managers as well, as they may control service values)

- develop a strategy for having enough control or support from the system to enable action to move towards the vision

- work with the healthy bits of the system

- try to reconnect people in the team to parts of the system they don't deal with

- network with people with like minds
- reorganise work along different lines (issues-based, maybe?)
- be selective on what you tackle; target bits of the system to try and influence
- encourage high quality models within the team (e.g. personal behaviour and demeanour)
- exemplars of practice - if you can only do a small project, do it well and make sure everyone hears about it.

2. Example - Community support service (other than Community Mental Handicap Team)

Accomplishments of a good community support service

- the users will always have access to someone to talk with, when they want
- people will be able to get the information that they need about local resources
- people will have the support/help they need to make use of local resources
- people who might need the service, will know about the service
- people will experience less stress.

Issues

- specialist versus generic services for people with handicaps
- is the service for the individual with the learning difficulty or the family?
- is community support to be offered to all individuals in an area or just some: if latter, how are they to be selected?

Strategies for ensuring quality (other than Q.A. group)

- an on-call network of support
- obtain knowledge about local neighbourhood
- forge links with other local services/facilities
- IPPs
- flexibility/a range of options and services, as and how needed

- 'getting to know you' (i.e. service providers/planners spending time getting to know individual service users)

3. Further points about community support services

- Supporting clients in community may mean support to families, but emphasis is on client and choice s/he makes:

  - where you live
  - how you dress
  - clubs you join
  - opportunities for work.

- Is support continuing? Does it entail:

  - finding things, like a place to live
  - maintaining someone in the environment that's been established
  - helping with development of new skills?

- Community support also means helping someone to cope (being there) when a problem arises; as opposed to a specialist service stepping in.

- Community support addresses itself to families, acting as a link with other services, especially where a new phase of personal development is being encouraged.

- Community support looks to the future.

- Community support implies an understanding of others' ('specialists') perspectives - liaison, acting as a channel of communication: an enabling role. (NB families are also specialists.)

- Community support continues to build up networks even where there is no immediate demand. So community support is not dependent upon a referral and allocation system.

- A community support model is not a problem-centred (crisis intervention) approach but a developmental (unmet need) model.

- In some places (small teams, large geographical area) community support (as outlined above) is not easy to organise.

- Consumer perceptions are necessary to get teams unstuck.
  (NB. If you ask people what their needs are, they need to know what is possible).

- Community support has a planning dimension: need therefore to know/define area, number of people.
  Support teams should develop, not be formed.

- Community support role may not be to provide service, but to facilitate a service.

- Community support has to:

  - identify clients
  - identify opportunities for change
  - offer continuity
  - prepare for change
  - maintain contact
  - identify other key people (who might also do these things)
  - identify key resources
  - open door to other resources

- Community support has to promote:

  - integration: opportunities for people to live, work alongside non-handicapped people
  - experience and advantage of a variety of relationships
  - skills to enable continuing personal development
  - opportunities for choice
  - ability to make a choice when choices offered and to stay with consequences of that choice
  - ability to speak for oneself
  - opportunities for non-handicapped people to have contact with handicapped people in valued ways.

SESSION IV - BUILDING QUALITY INTO DEVELOPING SERVICES.

Tasks for Workshop Groups

How can we monitor for quality in the planning and management of services?

- Is a quality action group approach feasible/appropriate?
- How would it work in practice?
- What other strategies might be helpful?

Note down:

- any particular problems/issues/difficulties that may arise.
- any ways these may be overcome.

* What about inter-agency/joint planning and/or management?

Final task

List three things you yourself can do when you get back to work to improve the quality of a service in which you are involved.

Note down:

- any particular problems or difficulties you foresee
- any ways you might overcome these.

SESSION IV. BUILDING QUALITY INTO DEVELOPING SERVICES

Notes from Workshop Groups

Building quality into planning and management of services

Importance of ensuring commitment to quality in outcomes for clients amongst those with responsibility, e.g. authority members/councillors + very senior managers.

Importance of valuing staff at all levels if they are to be concerned about quality.

Is it possible/necessary to be clear about disagreements about certain issues, while still retaining respect for individuals? Directness and honesty to others about what is important (while retaining respect) is difficult but may be important

How is shared understanding actually arrived at?

Being together working on a common problem (a problem requiring exploration rather than requiring 'a decision') can be - is essential for - common understanding.

What is the significance of 'commitment' to paper plans, whose implications may not be understood fully, or at all?

Issues

Managers change (new ones have different values)

Power is in the wrong place! (should be vested somewhere else)

Communication vital (especially upwards, from the grassroots), but how to do it effectively?

Role of 'the stars' (key people in service or agency) is important (but can they always be trusted?) Links with other people vital.

Strategies

It is important to get people to put their values on the table - but how do you do this?

- identify people with similar/shared values

- need first to identify people with skills
  at identifying organisational/personal issues
  at identifying people with shared values
  at clarifying corporate objectives

There is uncertainty about objectives amongst senior management.

- uncertainty about what actually needs to be done to implement broad objectives.
    - try and get (small scale) models rather than try and define systems
    - need to have good examples of success to show people and tell people about
    - need an information network within agency and between agencies
    - need for budget for dissemination of information and discussion of problems.

Blockages - the culture/belief is that many of these problems are insoluble

- exploring and defining failures and reasons for failure can be helpful

ONCE A HIGH QUALITY SERVICE IS SET UP, HOW DO YOU MAINTAIN IT?

Self monitoring may be left, put into a drawer.

- Time for self-reflection is needed
- Time and space for managers to reflect especially on quality of services already running

Spelling out/itemising measurable accomplishments may become routinised.

- How does one keep returning to what should be the basic accomplishments of the service?
- Monitor at both 'concrete' levels (measurable accomplishments) and at level of service objectives and clients' needs.

How does one compare what was intended/what happens?

Is there a need/role for outsiders to 'look in?

Problem - 'doing' is seen as more important than reflecting/monitoring.

- Value based reflection and exploration of the reality of clients' lives may be a vital technique.

Can one do this for all clients? should one? how translate back to service objectives?

- Advocates may be very useful
    - as outsiders
    - to look at quality of service experienced by individual

WHAT DO WE MONITOR?

- What you've said you are going to do.
- Examine: is what was previously set, still appropriate?
- Need to look developmentally - do the goals, activities change, do staff look towards the future?
- From whom come the goals and outcomes?
- Do clients look towards a future?
- Need to examine how much day-to-day aspirations are encouraged/discouraged
- Do individuals' perceptions of their futures concur with staff and others' perceptions - are the clients' hopes validated? Are they translated into day to day programmes/activities?
- How highly are clients' perceptions valued?

WOULD A QUALITY ACTION GROUP HELP FULFIL THESE TASKS????

- How would such a group relate to people devising IPPs?
- How would such a group relate to managers?
- Is it essential for managers (especially senior managers) to be part of such a group so they cannot distance themselves?

N.B. Need to ensure that it is accepted that quality assurance is responsibility of all stakeholders - including managers.

HOW DOES IT ALL FIT TOGETHER AT HIGHER LEVELS OF MANAGEMENT?

(and how does the service enable staff to ...?)

V. SOME PERSONAL PLEDGES BY WORKSHOP PARTICIPANTS

"When I get back to work I will:-

- Continue to try to develop a quality action process for a small part of the service I work for (7 people)
- Try to sell this to people who are relatively powerful and permanent within the system so it will be maintained.
- Keep closer to people.

....

- Encourage each member of the management committee to become part of a quality action group for each house in the project
- Form a "quality action group" (or other title) for staff training course which includes two people who are users of the local mental handicap services.

....

.. Draw up pen pictures with staff of some individual clients and how their lives have been enhanced by our service.

.. Spend time with staff to give some continuity/support in the period of transition ahead.

.. Spend time with key officers in the health authority and social services department to remind them of commitments that have been made by the service to different users, which must be honoured, whatever reorganisation takes place of service management arrangements.

....

- Look at the objectives of my involvement in all direct clinical work, set new goals, taking into account user needs.
- Encourage line manager to set up quality action group in at least two areas.
- Examine objectives of resettlement group: set new goals looking closely at user needs.

....

- Look at results of any intervention (e.g. social skills training programme) in terms of 'quality of life' enhancement from clients' point of view, rather than in terms of other outcomes/results achieved (e.g. how much eye contact maintained.)
- Direct attention to the needs to address the issue of 'quality' (as it is experienced by client) in schemes to assist friendships.
- Write final report of project in which I am involved (on personal relationships of people with learning disabilities) with eyes slightly wider open.

....

- Keep up the momentum of values-led strategic planning in the agency in which I work.
- Tell more good stories.

....

.. Think about it and then

.. Replan next year's work.

....

.. Re-write proposals for voluntary organisation development locally to include stronger emphasis on quality, values and consumer involvement.

.. Tell my team about the issues discussed here - verbally and in writing - with a view to enhancing awareness and inform current ideas.

.. Keep in touch with some of the people from this workshop.

....

VI. LESSONS FROM THIS WORKSHOP

Need for commitment to values. How to get that through to members (Authority members/councillors, etc.)?

Focus on a quality monitoring process - from values through to action.

Important to get small, good quality models which can show quality in action and provide good stories.

Establishing networks to allow the dissemination of good stories is vital - both within and without the agency.

Helpful to clarify issues on quality - e.g. getting away from checklists to issues such as respect, dignity and warmth.

Importance of devoting creative energy to find ways of sustaining quality in services.

Users' views - need to ensure they are included.

Challenging people about their values is important, but is there a need to agree at some point to disagree?

Key issues are:
- values
- power (to influence good quality service for better or worse)
- maintenance (of high quality service)

Importance of values ('We've been full circle and come back to values')
- link between values, and the individuals, their circumstances, who they are
- the search for values shouldn't stop action ('Don't wait for the revolution').

Importance of professionals examining their objectives in terms of accomplishments and what individuals really want
- don't confuse people's needs with professionals' needs
- devise ways of measuring what is achieved - 'observable outcomes' (there need to be many ways of evaluating service success).

Importance of maintenance of high quality services
- need to be prepared for attacks on vulnerable services - marshall defences to preempt attacks
- need to be versatile when things change/good services are threatened
- need to protect good quality services (through alliances, pragmatic compromises)
- may need to be political to do this
- researchers may have role here, communicating ideas.

Useful strategies have emerged/become clear, e.g. QA groups,
BUT...
- elegant techniques (like IPPs, QA, CMHTs) are not enough
- tools are not solutions (need many other strategies)
- beware the QUAG mire!

Remember -

People have to experience what you give them; take account of their perceptions.

There are limits to what any 'service' can do - we don't define those boundaries well enough.

You won't just get quality right, it's a continuing struggle. (You'll always need to be open to new ideas and new strategies)

Pursuing quality is ....frustrating
and..........can be dangerous!

APPENDIX B - WORKSHOP PROGRAMME AND LIST OF PARTICIPANTS

GETTING BETTER ALL THE TIME?

Issues and strategies for ensuring quality in community services for people with mental handicap

University of Bristol, May 7th - 9th, 1986

Programme

Wednesday, May 7th

3.30 - 4.30 Arrival, registration, tea.

4.30 - 6.00 Session I - What is "quality"? How can we ensure it?

"Pursuing quality: a practical approach".
Roger Blunden, Mental Handicap in Wales - Applied Research Unit.

"Some practical dilemmas and strategies in values-led approaches to change".
Alan Tyne, CMHERA.

Chair: Oliver Russell, University of Bristol, Department of Mental Health.

6.30 Dinner

8.00 Workshop Groups I
(pursuing issues and tasks arising from Session I.)

Thursday, May 8th

8.00 Breakfast

9.15 - 10.45 Session II - Pursuing quality in residential services.

"Ensuring quality in the private sector".
Lesley Hoyes, School for Advanced Urban Studies, University of Bristol.

"Ensuring quality in services for people with challenging behaviour".
Janet Maher, Bristol and Weston Health Authority.

Chair: Barry Gray, King Alfred's College, Winchester.

10.45 - 11.15 Coffee

11.15 - 12.45 Workshop Groups II
(pursuing issues and tasks arising from Session II).

12.45	Lunch
2.15 - 3.45	Session III - Pursuing quality in community support services "Lessons from the Wells Road experience". Linda Ward, University of Bristol, Department of Mental Health. "Pursuing quality through a quality action group: experiences in the CUSS home support service". Steve Beyer, Mental Handicap in Wales - Applied Research Unit. Chair: Carol Robinson, University of Bristol, Department of Mental Health.
3.45 - 4.15	Tea
4.15 - 5.45	Workshop Groups III (pursuing issues and tasks arising from Session III)
6.30	Dinner Evening free.

Friday, May 9th

8.00	Breakfast
9.15 - 10.00	Session IV - Building quality into developing services. "Planning for quality". Oliver Russell, University of Bristol, Department of Mental Health. Chair: Linda Ward, University of Bristol, Department of Mental Health.
10.00 - 10.45	Workshop Groups IV (pursuing issues and tasks arising from Session IV)
10.45 - 11.15	Coffee
11.15 - 11.45	Workshop Groups IV (continued)
11.45 - 12.30	"Lessons from this workshop"
12.45	Lunch
2.00	End of workshop.

LIST OF PARTICIPANTS

PETER ALLEN	Principal Clinical Psychologist, Newham Health Authority.
STEPHEN BEYER	Research Officer, Mental Handicap in Wales - Applied Research Unit.
ROGER BLUNDEN	Director, Mental Handicap in Wales - Applied Research Unit.
MARK BURTON	Clinical Psychologist/Team Coordinator, Beechmont Resource Centre, Manchester.
LINDA DAVIES	Research Associate, University of Bristol, Department of Mental Health.
CATHERINE DOBSON	Principal Clinical Psychologist, Bolton.
ERIC EMERSON	Lecturer in the Social Psychology of Mental Handicap, University of Kent, and Team Leader, Special Development Team in Mental Handicap.
MARK FEINMANN	Clinical Psychologist, Sheffield Health Authority.
HUGH FIRTH	Principal Clinical Psychologist, Northumberland Health Authority.
JULIAN GAUNT	Research Officer, Sheffield Health Authority.
BARRY GRAY	Senior Lecturer, King Alfred's College, Winchester.
LESLEY HOYES	Research Fellow, School for Advanced Urban Studies, University of Bristol.
STUART HUMPHREYS	Research Officer, University College of North Wales, Bangor.
TIM LISTER	Clinical Psychologist/Regional Training Officer, Ann Street Health Centre, Tameside
TESS LOMAX	Development Worker (Mental Handicap Services), Plymouth & West Devon Social Services Department.
JANET MAHER	Top Grade Clinical Psychologist, Bristol & Weston Health Authority.
JUDITH McBRIEN	Principle Clinical Psychologist, Plymouth Health Authority.
DAVID RACE	Consultant (Handicap), Church of England's Children's Society.
MARK RAPLEY	Research technician/psychologist, Northumberland Health Authority.
JUDY RENSHAW	Research Fellow, PSSRU, University of Kent.

CAROL ROBINSON	Research Associate, Department of Mental Health, University of Bristol.
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community services
quality of service
learning difficulties

£3.00