UNIVERSITY OF SOUTHAMPTON

VALUING THE CARERS: AN INVESTIGATION OF SUPPORT SYSTEMS REQUIRED BY MENTAL HANDICAP NURSES WORKING IN RESIDENTIAL SERVICES IN THE COMMUNITY

VOLUME ONE

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'I believe in a world in which rumour is as influential as information, and in which guys are as good and as bad as the circumstances permit them to be; in which heroes are created as the need arises, and in which the villains often go unpunished if they attain a certain level of influence. This then is my world; it is of burning topicality because it surrounds us all at every moment, wherever we live, under whatever system' (Peter Ustinov 1984 p11).

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UNIVERSITY OF SOUTHAMPTON

ABSTRACT

FACULTY OF SOCIAL SCIENCE

SOCIOLOGY AND SOCIAL POLICY

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'Valuing the Carers'-An Investigation of Support Systems Required by Mental Handicap Nurses Working in Residential Services in the Community

by David Thomas Sines

This study of the attitudes and feelings of mental handicap nurses directly involved in the transition of hospital based care to care in the community, investigated the perceived roles that nurses played in support of their clients and the degree to which they felt satisfied with their jobs. The study also examined the support mechanisms that they felt were required to sustain their efforts to promote high quality services.

The study commences with an analysis of the historical and social context within which care for people with a mental handicap has evolved. Through the use of a standardised questionnaire and personal interviews the ways in which nurses have adjusted to the changes that were demanded of them in non-institutional settings were examined; overall it appeared that nurses welcomed the changes that working in the community required; they saw them as new opportunities to develop and demonstrate their skills. Some nurses felt insecure and unsupported in their work and expressed concerns about their futures but nearly all remained committed to meeting the needs of their clients which was found to be their primary source of job satisfaction.

On the whole staff were more satisfied with their jobs than were their managers, who felt isolated from their staff and, more importantly, from clients. New styles of management were emerging but these were not always seen to support staff in their new work; feedback on performance was inconsistent.

Few institutional attitudes were witnessed in the sample and these appear to have been replaced by an awareness of the need to develop a partnership in care with their clients. The majority of respondents were pleased to leave the hospital culture and identified a number of support mechanisms that they felt would enhance the success and quality of their new work practices.

ACKNOWLEDGEMENTS

My research was developed from a long-standing interest in the field of mental handicap, and has been nurtured by years of involvement as a nurse and manager in this speciality.

I would like to express my gratitude to the many people with learning disabilities (who are referred to as people with mental handicaps in this study as this remains the conventionally accepted title for this client group) and to their carers who have given so generously of their time and patience to assist in the completion of this study. To them I am grateful for sharing many intimate aspects of their personal and working lives and for enabling me to catalogue their many experiences, successes and concerns. As a result this study is dedicated to the many people who work (and often with invisible reward) to share and to create the vision of a brighter future for our clients which is based on the principles of equality and respect for fellow human beings as equal partners in society.

I would like to thank my supervisor Professor John Martin for his sound advice and support during the course of my studies and to Sean Cameron and June Collis for their encouragement. I also wish to thank Jill MacKean for her patience and assistance in the statistical analysis of the research Data.

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SECTION ONE

THE DEVELOPMENT OF MENTAL HANDICAP SERVICES

INTRODUCTION

Although it is always important to be aware of the views of users about 'their' services, it is also important to take into account the views of their carers, for these inevitably affect the quality of the service they provide. This study focusses on their carers and their practice in newly created services in the community for People with a Mental Handicap *. It is about the perceptions, aspirations and views of mental handicap nurses who have been recently transferred from long-stay hospitals to the community.

The first section of the study provides a broad outline of the development of the thesis and introduces the principal themes considered therein.

The study commenced some four years ago with the intention of reviewing the changing role of mental handicap nurses as they moved from hospital to community work. This was seen in the context of changing social policies and would also draw on the researcher's own understanding and experiences of these changes.

As the study progressed it was decided to illustrate the literature and social policy review by seeking the actual views and experiences of nurses working with People with a Mental Handicap in the new service. Consequently, the methods employed in this part of the study are described midway through the thesis in **Chapter VI.**

*** Footnote**

The term People with a Mental Handicap has been used consistently throughout the thesis in accordance with current Government terminology. It should be noted that this 'title' is not one subscribed to by the author in normal practice; he prefers the term 'People with a Learning Disability' because of the more positive image this communicates to others.

The **First Section** of the study considers aspects of social policy which have affected the way in which services for People with Mental Handicaps have developed over the past century. It details the main events that have influenced mental handicap nursing and presents an historical perspective of service delivery to users.

This section introduces the study from a social perspective and presents the policy background against which changes in the philosophy and delivery of care have taken place ; recent changes following the publication of the National Health Service and Community Care Act (July 1990) are recorded and their potential consequences are discussed.

The First Two Chapters consider the development of mental handicap services from 1870 to the present day and introduce the study from both a social and political perspective.

The Second Section considers the development of mental handicap nursing and commences with **Chapter 111** to provide a more detailed account of the growth and development of mental handicap nursing as a profession; it begins with a discussion of the origins of nursing care for service users and enlarges further on relevant aspects of social policy mentioned in Chapters One and Two. The remainder of the chapter traces the significant events which have shaped the nature of the profession and the concept of care in the community as a career option for mental handicap nurses. It goes on to consider the training implications of preparing a responsive workforce outwith the mental handicap hospital.

Chapter IV begins with an account of the hospital sub-culture within which nurses acquired their skills and practices. It offers some explanation and analysis for the persistence of this model of care within the context of evolving social policy The characteristics of the 'inmate' world of the hospital are detailed and described in order to provide an account of the mental handicap nurse's 'world' within the institution.

Consideration is also given to the ideological influences that were to be found in the hospital sub-culture and issues relating to social control and their inherent 'power struggles' are discussed.

In **Chapter V** the issues involved in creating a new culture for mental handicap nursing in the community are considered and the key factors involved in the development of a new ethos of care are explored. The defence mechanisms employed by nurses to cope with the stresses of their work are also noted and the adjustments that will need to be made to 'survive' in the community are discussed. These issues are developed within the context of change theory with particular reference to relevant sociological and ideological considerations.

The **Third section** considers the nature of (and discusses the results arising from) the present study and is concerned with developments for mental handicap nursing in the community. **Chapter VI** details the exercise of locating, obtaining and analysing the data used in this research. The chapter describes and explains the methods employed and sets out the framework within which the study is developed and the results analysed. The aims of the research are recorded and several hypotheses are postulated.

The nature of community based services is described in **Chapter VII** which also describes the six services included in the sample. The general characteristics of the services are summarised and the principles within which care is delivered are explored in order to determine the value base of the new service. The views of service users are also included.

The results of the study are presented and discussed in the following four chapters. These main findings are complemented by descriptive material obtained from respondents during the course of informal interviews. **Chapter VIII** begins with a discussion on the characteristics of the sample and isolates key staff attitudes that appear to be important prerequisites for the success of community based schemes. The need for staff training and preparation for work in the community is stressed.

Job characteristics are considered in **Chapter IX** and themes that appear to influence the demands placed on the new workforce (such as the variety and scope of work involved and the difficulties some respondents found in balancing their time and priorities between client and non-client aspects of their work) are explored. The nature of interpersonal support and feedback from managers is considered.

Issues relating to job satisfaction, responsibility and perceived role effectiveness are considered in **Chapter X.** The main features of the job that staff and their managers have identified as being important influences on their satisfaction at work are discussed and selected results are related to three dependant variables (job satisfaction, length of service and propensity to leave the service).

Chapter XI concludes the presentation of results and looks at the implications that rapid service change has had for the mental handicap nursing workforce in the community. The chapter commences with a review of the literature on stress, burnout and coping capacity and relates a number of theories of stress management to the perceptions and experiences of staff involved in this study. The chapter compares the features of the old hospital culture with those characteristics of the new service and identifies those aspects of the old system that staff miss most (and those that they were pleased to leave). Suggestions for 'bridging the gap' during the transition period are presented and the way in which staff and managers respond to the more stressful aspects of their work is considered.

Chapter XII is the concluding chapter and begins with a recapitulation of the aims, methods and principal findings from the study. The principal findings are considered against the original hypotheses presented at the beginning of the study. An appraisal of the ways in which staff view their new roles in the community is included and the debate progresses to an examination of staff attitudes and of the way in which nurses perceive their coping abilities and support needs. The chapter ends with a discussion of some of the broader implications of the research findings for the support of mental handicap nurses moving from hospital based services to the community. The practical application of findings arising from the study are considered and a summary of the main contribution of the thesis is presented.

Chapter One

Residential Care for People with a Mental Handicap:

An Historical Perspective 1830 - 1978

Introduction

Any discussion relating to current patterns of residential care for people with a mental handicap must acknowledge those aspects of history and social policy which have influenced the way in which services are arranged and organised to meet the needs of this client group:

> 'No informed conclusion about the future of residential care can be reached without paying careful attention to the kinds of external changes that are likely to determine its scale and character. That, in turn, cannot be done satisfactorily without some understanding and appreciation of those forces that have shaped its history. The most prevailing of these are located within prevailing social and economic structures" (Wagner 1988 p3).

Societal attitudes and beliefs towards people with mental handicaps have dictated the nature of the models of service delivery that have been provided over the last century and beyond. The deployment of staff skills, the philosophy of care applied and the environments within which people have been cared for are influenced by changes in public attitude, the allocation of resources and by changes in social policy.

Similarly there is a need to understand the nature of mental handicap and its presentation. Consequently it is the intention of this chapter to present an overview of the concept of learning difficulty, without elaboration and to introduce those aspects of social policy that have influenced the development of care for this client group within an historical context.

Whilst there is an accepted, universal definition of mental handicap, there is no one standard model of residential care either in the United Kingdom or elsewhere. This chapter considers the development of human services for people with a mental handicap since the latter part of the nineteenth century. In a chapter such as this it will not be possible to examine the conditions that have contributed to current service design in any detail but their importance should not be under-emphasised.

The concept and nature of mental handicap

Traditionally terms like mental retardation and mental subnormality have been used to refer collectively to three quite different phenomena: subnormal intelligence, reduced social and physical skills and deviant behaviour patterns. These components are themselves complex, at least as far as their causation is concerned. Subnormal intelligence, for example, may be on one hand related to identifiable causes and on the other to poor development opportunities, perhaps affected by cultural bias in intelligence testing procedures.

The use of such imprecise labels has made it conceptually difficult to distinguish between a person's inherent mental limitations and the social handicaps they might experience because of the effects of their impairments and functional disabilities on their way of life. This in turn has led to incorrect public assumptions as to the needs of this client group and a general belief of the impossibility of treating their behaviours and socialising them for integration into society. The strength of prejudice that exists today against people who have been labelled as having a mental handicap relates back to stereotyped images of insanity during the Victorian era; yet surveys have shown that many of the people put away in large subnormality hospitals were in fact of normal or near normal intelligence and ability (Morris 1969).

The term 'mental handicap' has been used for the past two decades to describe a particular condition related to learning difficulty. The legal definition of this term was originally given in the Mental Deficiency Act 1927:

> "Mental Defectiveness means a condition of arrested or incomplete development of mind existing before the age of eighteen years,whether arising from inherent causes or induced by disease or injury"
> (clause 23).

Craft (1979), stated that man has always known the difference between those persons retarded from birth and those persons affected by madness. He makes reference to the Bible by stating that it discusses those persons temporarily possessed by spirits. However the term idiocy was considered a generic term and it was Esquirol (1772-1840) who wrote that:

> 'Idiocy is not a disease, but a condition in which the intellectual facilities are never manifested; or have never been developed sufficiently to enable the idiot to acquire such an amount of knowledge, as persons of his own age, and placed in similar circumstances as himself, are capable of receiving' (p57).

The term 'mental deficiency' has been replaced over the years by 'mental subnormality and by 'mental handicap' (Mental Health Acts of 1959 and 1983). These terms provide no indication of the precise nature or degree of learning difficulty presented by those people who had been characterised with one of these labels (Tredgold 1963). The 1927 and the 1959 Acts referred to above identified sub-classifications of handicap which were based on a categorisation of the absence of ability and intellect.

Intelligence was used as the primary criterion of mental ability. The work of Binet (1906) and his contemporaries at the turn of the century reinforced this approach and introduced the 'intelligence test' as a means of classification of grades of handicap. Educational criteria have also been used to determine the nature of mental handicap and the concept of ineducability has been used synonomously with that of incomplete development of mind over the years. The Education Acts of 1944, 1970 and 1981 have progressively identified the need for education for people with learning difficulties and the concept of ineducability has long been discarded by the mental handicap caring professions.

Up until the 1970s emphasis was placed on clinical diagnosis and treatment of mental handicap. Consequently the subject area attracted medical influence and research and the models of care which were introduced tended to be clinical and institutionalised in design and nature.

At the present time the 1983 Mental Health Act has transposed this approach into a more positive understanding of the needs of people with learning difficulties as individuals without the necessity of clinical diagnosis or medical intervention. The 1983 Act also removed the stigma of legal definition from this client group and confirmed the social and educative nature of present and future service design.

The social context of mental handicap care

As early as 1324 it is reported that the Crown had shown particular interest in the existence of 'Lunatics (Tuke 1882 p.287) when an Act of Parliament was passed (now lost) and confirmed by Edward II (17 Edward II. c.9). The Act was passed for the benefit of mentally affected persons. The words run:

> "The king shall have the custody of the lands of natural fools, taking the profits from them without natural waste or destruction, and shall find them their necessaries, of whose fee soever the lands be holden. And after the death of such idiots he shall render them to the right heirs; so that by such idiots no alienation shall be made, nor shall their heirs be disinherited" (p4, para iii).

Until the mid-nineteenth century care was provided in villages and towns within the context of the nuclear family. At a time characterised by the lack of technological development, when families were encouraged to be self-sufficient, rural and tribal societies have tended to display a greater acceptance of responsibility for their few severely handicapped members (Malin 1980). Similarly in the United Kingdom prior to the industrial revolution,the problems associated with mental handicap were not publicly evident and most members of the village community were able to contribute to the life and economy of the local society in some form or another. Differentiation of labour was less apparent and the range of tasks required of the population demanded less technical skill. People with learning difficulties were not so prominent in a society characterised by illiteracy and where hard manual labour was the accepted norm. Consequently, most villages were able to cope with their handicapped members in their midst,sometimes at the expense of ridicule and exploitation and sometimes with a sense of reverent regard for their simplicity. The protection of the 'village idiot' was the norm in rural society and when parents died the responsibility of care was transferred to other village members and to the church.

With the industrial revolution came new expectations of the labour force. Large towns developed and labour was attracted from villages with the result of mass migration to the towns and the erosion of close knit ties in the villages (Stone 1967; Schofield 1968; Laslett 1971). Value was placed on an individual's ability to produce for independent employers rather than to contribute to a self-sufficient community and people were judged by ability to cope with increasing demands of new technology in mills and factories. There also came an increase in recognition of the importance of education and literacy skills became a requisite if any form of social status was to be achieved. Similarly the introduction of a capitalist economy demanded new forms of industrial discipline and made the working classes totally dependent on their employers (Cohen & Scull 1983).

The emergence of the institution may be seen as an attempt to meet the increasing problem of pauperism and need for more stringent forms of social control and regulation. The workhouse appeared to be the answer and developed after 1834 (Brundage 1978) with the explicit aim of providing social relief to the working classes within the confines of an institution.

With the passing of the rural community, people with mental handicaps became more prominent and incompetent. Families faced increasing demands on their time to work for landlords and had little opportunity to devote to the needs of dependent family members. Effectively they were penalised for any distraction of their time away from the economic function.

In the nineteenth century adherence to the protestant work ethic (Weber 1930) emphasised the important role that the church had to play in ensuring that an efficient workforce was maintained and readily available. The connection between hard work, thrift, abstinence and religion served to create a division between those members of society who were able to contribute efficiently to the economy and those who were unable to do so. Poverty, low intelligence and handicaps were regarded as indicating a weakness of moral character.

The ideas of Social Darwinism with its doctrine of the survival of the fittest in a competitive society reinforced the work ethic principle (Bendix 1956) and identified low intelligence as being a potential threat to society and its norms. Many people with mental handicaps were encouraged to leave their families and to live with other, less fortunate, members of society in workhouses where, subjected to some degree of social control, they were cared for by the State and were able to contribute to the economy of the daily life of the workhouse community. Thus the emergence of industrialisation removed the responsibility for the care of dependent persons from their families and rural communities and placed it on the public authorities and thus released production time for family members.

The introduction of legislation

The Victorian era saw the publication of a number of Acts of Parliament introduced to provide public control of the care of people with mental handicaps (The Lunatic Asylums Act 1851; The Criminal Lunatics Act 1858; The Criminal Lunatics Act 1884 etc). These Acts were introduced during a time when mental handicap was characterised by myth and superstition. Demonic possession was believed to be a frequent cause of insanity (Tuke 1882) and exorcism was frequently carried out by the church. Herbal medicines, restraint, hard labour and segregation from the community were the prescribed treatments of the day.

For the rich private asylums were available (The Retreat in York 1792; Earleswood in Redhill 1855) but for the poor, workhouses or religious houses provided the only refuge apart from family based care. Standards varied between establishments and in his 'History of the Insane' Tuke (1882) describes conditions as unacceptably poor and inhuman (p395). The need for legislation became increasingly clear and a number of Select Committees (1815, 1822) were set up to consider conditions in asylums. As a result the County Lunatic Asylum Regulation Act 1828 was passed which established Metropolitan Boards and Commissioners appointed by the Home Secretary,who were responsible for the inspection and regulation of all private asylums and institutions. A number of other Bills were presented to Parliament during the 1840s which culminated in a new charter of rights for the insane with the publication of an Act to regulate the care and treatment of the insane (1845) extended visiting and inspection rights to public, county asylums as well.

Life in the asylums was characterised by rigid routines and communal living. Airing courts provided opportunities for physical recreation and occupation was provided for those able to undertake work on farms and in domestic industries,such as laundry and cookhouses. Privacy was disregarded and physical health often neglected. Far more obvious was the isolation imposed on in-mates who rarely left the institution or visited their families once they had been admitted. One basic premise which was accepted at the time, was that inmates would benefit from a closed society and regime and that given simple tasks to perform,might acquire new skills over time and thus contribute, albeit in a small way to the life and economy of the community. The Lunatic Asylums Act of 1853 and the Idiots Act of 1886 acknowledged this and empowered asylums and workhouses to provide occupation for their charges .

Unfortunately no distinction was made between the care of people with a mental illness or those with mental handicaps, and in the workhouses they often lived together with criminals, vagrants and the poor. By the end of the nineteenth century, however the various Acts of Parliament had differentiated between the needs of these various groups and institutions for mentally handicapped people were opened throughout the country in parallel to the provision of County Asylums for the mentally ill or 'insane' (Tuke 1832 p307).

From asylum to hospital

The turn of the century saw the introduction of intelligence tests and the publication of the first textbook on mental deficiency (The first edition of Tredgold's Mental Deficiency 1908). A Royal Commission of the same year considered how best to meet the needs of people with mental handicaps. The Royal commission noted that there were 271,607 certified lunatics or mentally defective persons in Great Britain at the time, who represented 0.83% of the population. The Royal Commission's recommendations formed the basis for further legislation and reform in the care of mentally defective persons and were later incorporated in the 1913 Mental Deficiency Act (see below). At the recommendation of the Royal Commission a 'Board of Control' was introduced as the responsible authority for the general protection and supervision of mentally defective persons. The duties of the Poor Law, Education and other Local Authorities were transferred to the new Authority who in turn delegated responsibility to Local Authorities to monitor service provision. In order to carry out the recommendations of the Commission the previous Acts under which the Education, Poor law and Lunacy Authorities performed their duties were repealed and the 1913 Mental Deficiency Act was passed to contain the necessary provisions for bringing a complete scheme into operation (Wormald 1913).

Many studies were published around this era to suggest the hereditary nature of mental handicap. In 1909 Tredgold published a paper in the Eugenics Review and stated that segregation from society was the only way to prevent propagation of mental handicap and then to protect society. Tredgold believed that people with mental handicaps would 'burden society by their non-productiveness' (Malin 1980 p40). He recommended that colonies or suitable farm and industrial establishments should be built, in which people with mental handicaps should be encouraged to work and to create a self-sufficient community of their own. The financial burden of maintaining these estates would be reduced by the inmates' contribution to the local economy and, above all, society would be protected and secure from 'their depredation and the danger of their propagation' (p54).

The link to the 'Eugenic' theory was cemented by the introduction of the 1912 Mental Defective Bill, which was sponsored by Mr. Hills, M.P., on behalf of the Eugenics Education Society and the National Association for the Care of the Feeble-minded (Wormald 1913 p3). Tredgold's theories were clearly influential in leading to the passing of the 1913 Mental Deficiency Act which recommended the retention of people with mental handicaps in institutions once they had been admitted

The inclusion of one category of mental defective requires particular mention - 'The Moral Defective'. The 1913 Act included a section (56) to protect mentally defective women of child bearing age from promiscuity or chambering. This was clearly in keeping with the beliefs of the Eugenic Society and the moralistic attitudes prevailing in society at that time. Wormald records the thinking at the time and quotes from a Visiting Committee's report to the Near Custodial Home for Feeble-minded Women':

> 'The object of this Institution is to detain women of child bearing age in order to prevent the propagation of persons of feeble-mind with its attendant evils to the community. About half were decidedly imbecile or idiotic,the other half being high grade imbeciles or young women whose defect was so slight that on casual observation it would not be evident' (1913 p44).

At this time, all asylums were controlled by county councils and by a Board of Control (Local Government Act of 1886) and the Boards were given powers to prevent the discharge of any person in their care should they regard them as unfit to leave, (Section 2(a) of the 1913 Act (v) stated that a person could be detained in an institution for defectives if, -"they had been found incapable of receiving education at school or that by reason of a disability of mind might require supervision after leaving school").

Wormald in his description of the operation of the 1913 Act heralded the new legislation as :

> 'The Mental Deficiency Act is the charter of real liberty to a large number of chronic mental defectives who are the Ishmaelites of a Society which in the past has neglected and left them to wander about

> the streets and highways of towns and villages to be the butt of ridicule and thoughtless sport and the victim of lust. They have been allowed to multiply themselves to an alarming extent and in their degradation and misery to be associated with the pauper, inebriate, criminal and immoral classes' (1913 p81).

The Act was imaginatively drafted and gave considerable scope for developing enterprising ways to meet the needs of mentally defective people which ranged from the provision of farm communities, colonies, institutions and boarding out arrangements. 'Certification' to institutions was introduced by the 1913 Act and was equally applicable to children and adults. The motivation behind the Act was segregation of 'undesirable' elements of society and the act succeeded to some extent in achieving this. The basic provisions included in this Act were to remain unaltered until the passing of the Mental Health Act in 1959. As a result the in-patient population of mental handicap hospitals showed a dramatic increase in the years between 1920 and 1950 (Table 1), which indicates the importance of social influence and thinking at this time towards the provision of segregated services for people with mental handicaps as 'residual deviants' in society. This era was to set the trend for long stay admissions for many people who did not necessarily require hospital care for any reason other than social or domestic reasons. As will be seen later in this chapter the significance of admission trends at this time was to influence the discharge and retention patterns of patients in long stay care in more recent times. The figures included in the following table show a dramatic increase in patient admissions in a relatively short period of time:

Table 1.1

Total number of Defectives Under the Care and Control of the Mental Deficiency Acts:

Year	Total No (rounded)
1920	12,000
1926	37,000
1939	90,000
1950	120,000

Source:Tredgold, A.F., A Textbook of Mental Deficiency (1952-8th edition).

During the last two decades of the nineteenth century a major building campaign was embarked upon and a proliferation of asylums for mentally handicapped people were introduced (although the major increase in admissions was to follow later between 1920 and 1950).

During this time care for this client group was segregated from that of people with a mental illness, although in practice there was very little to distinguish between the quality of life or care received by either group. Physician superintendents managed the hospitals and a staff of attendants under the auspices of outdated poor law legislation which was to persist up until the National Health Service Act of 1946. Female patients were cared for by female staff, supervised by a matron, and males by male staff in strictly segregated hospitals or ward blocks within a common campus. Children were also admitted and were usually provided for in designated areas, apart from adults.

The 1913 Act required additional hospital/asylum provision to meet the increasing demands of people for admission under the relevant sections of the Act. The tendency to build institutions for over 2,000 people in isolated parts of the country continued from the Victorian era and in terms of economy the conversion of many of workhouses and lunatic asylums became the Nations's answer to an escalating problem (Tredgold 1952).

The nature of mental hospitals

The beginning of the twentieth century witnessed the transition of the old asylums into hospital type environments with an emphasis on clinical diagnosis, research and psychological testing. In practice care continued to follow the same routines of the previous century with an increasing emphasis on the importance of education and training. Mental handicap hospitals became established as social institutions in their own right, characterised not only as a place where some clearly defined objective is persued but also as a place where people worked and lived together within a complex social setting aiming to meet the often conflicting needs of the inmates, staff and of society.

The nature of such total institutions has been well documented and described by Goffman (1961) in his writings on the social situation of mental patients. Two basic features distinguish these total institutions from other social establishments, according to Goffman: their 'encompassing or total character' (p4) and the fact that the staff in 'their work,and hence their world, have uniquely to do with people. This people-work is not quite like personnel work or the work of those involved in service relationships; the staff, after all, have objects and products to work upon, but these objects and products are people' (p73). Because of these features, says Goffman, the total institution is a social hybrid, part residential community, part formal organisation and as such this unique combination provides a special interest for sociological investigation and interest.

Goffman provides an account of the characteristics of such institutions in terms of the staff and inmate 'worlds' and identifies three distinct elements of an individual's life- the tendency to sleep, work and play in different places under normal circumstances. These activities usually take place with different co-participants and without an overall, rational plan. The total institution does not distinguish between different activities and breaks down the naturally occurring boundaries that separate these three spheres of life. Others (Morris 1969; King 1971; Oswin 1976) have also demonstrated that all aspects of institutional life are conducted in the same place and under the same single authority. Daily activities are also carried out in the company of a large number of other people, all of whom are treated alike and required to do the same thing together at the same time, without reference to individual choice or interest. Systems operate to control the schedule of daily activities which are imposed and regulated by senior staff in complex, rigid hierarchies. Systems appear to be introduced to impose a degree of social control (Wagner 1988):

> 'Control was (and is) a remarkably complicated thread running through the history of institutions and if we are to understand its significance it is necessary to appreciate that complexity. How ,for example, does one assess the impact of the history of institutions upon the view that, at all costs, the admission of an elderly relative

> must be avoided? How far has the sense of obligation to care for such a relative been intensified by the long and sorry history by poor-law provision? Or how does one guage the contribution of institutions to the more general processes of social control when, for instance, a person in care could say in 1971: 'I always used to be threatened with being put away in a home where they are always nasty to you, that's the general impression everyone outside has" (National Children's Bureau in Wagner 1988 vol 2 p4.)

The idea of social control offers a valuable basis for considering the way in which hospitals for people with mental handicaps have operated throughout the last hundred years. Hospitals have traditionally relied upon a complex, bureaucratic structure to support their function (Goffman 1961; Revans 1974). The mental handicap hospital is characterised by the appointment of members of staff to perform specific tasks for which they receive an appointed salary. Career structures are identified for staff members who are adequately experienced and competently aquainted with the norms and practices of the organisation. The existence of a defined hierarchy ensures that an efficient division of labour is provided. Consequently all mental handicap hospitals were supported by an specific management structure within which clear communication systems and staff roles were clearly defined and non-negotiable (Revans 1974).

The desire to control behaviour was a primary objective of the workhouse and there was some degree of variation in terms of its success. Control relied upon incarceration from the rest of the community and in return inmates received moral and social education (aiming to reform their characters and to change unacceptable behaviours), training in occupational skills and religious indoctrination. Such forms of regimental segregation increased opportunities for the organisation to enforce methods of social control and to maintain social order.

Weber (in Gerth et al, 1948) identified a number of characteristics of efficient organisations which can be referred to total institutions. The existence of a defined hierarchy such as was found in hospitals, was precise, unambiguous and relied upon a strict division of labour and upon subordination of the majority of the workforce to the rules of the organisation. Certain aspects of the lives of the inmates are controlled by rules imposed from within the hospital eg parole and bed times (Owens & Birchenall 1979).

The failure to maintain relationships with the outside world has also been identified as a feature of total institutions (Goffman 1962; Morris 1969; Martin 1984). Morris found in her study that very little was done to encourage contact with the community outside. She found that natural barriers existed within the hospital and without to ensure that contact with the community was minimised. The location of many hospitals, in rural areas, remote from centres of population, provided a physical barrier to more positive communication. She found that 'hostility from the community was fortunately rare, but neutrality commonplace' (p207).

Martin also found that isolation could be personal, or intellectual when associated with poor support structures for the staff and when deficient/passive leadership was available. The concept of isolation and maintenance of contact with people and life outside of the institution may be seen as a relatively universal feature of the hospital, a point recognises consistently throughout the literature. Morris (1969) in her survey findings, related this to the importance of social order amongst the workforce and management:

> 'There is an unconscious resistance amongst staff at all levels to allowing the outside world to impinge upon the social equilibrium of the regime in which a vital component is 'order'. 'Order' is a very fragile thing, achieved only as a result of long and patient efforts on the part of the staff, and although easily disturbed, it can only with difficulty be re-established. Furthermore staff develop a proprietorial interest in their patients and for many of them responsibility, care and control are indivisible' (p208).

Negotiation of status and power within the hospital have been identified as common issues for staff and inmates of total institutions. Inmates are usually regarded as subordinate and constitute the largest number of people in the organisation and like the staff group they have to negotiate their own position within the hierarchy of the hospital (Loeb 1956; Goffman, 1962). These authors have shown that inmates follow a career pathway which is imposed upon them by the constraints of the organisation. Tacit rules exist to ensure that moral and ethical codes are observed amongst the staff and in-patient population.

The concept of security and custodianship have been been developed by Loeb (1956) and Brown (1973) who identified a number of symbols and cultural themes which represent the nature of the hospital subculture and which which characterise them as societies in their own right. The existence of status hierarchies is evident at all levels in the organisation with importance being attributed to office/living space and entitlement to information. Symbols of power such as keys, uniforms and access to telephones illustrate the position of people within the hospital.

Goffman (1958) acknowledges that similar status symbols and power rituals exist amongst inmates. The concept of a moral career is introduced in his writings which suggests that patients undergo a deliberate adjustment process in order to adapt to the life of the organisation. These 'secondary adjustments' are techniques which do not directly challenge the staff but allow inmates to obtain privileges which are not normally afforded to all patients. He further identified a career pathway for inmates which allows them to generate new coping skills in order to obtain mastery over their environment. A number of options and examples are provided which may be chosen by inmates ranging from open rebellion to withdrawal from the active life of the institution.

An analysis of the main characteristics of mental hospitals or total institutions, is an essential consideration in the history of mental handicap care. The features of the hospital described in this section are equally applicable to the majority of larger hospitals found in the United Kingdom and appear to have been developed irrespective of geography or local cculture. Oswin in her research has traced the similarities of modern hospitals to those of the latter half of the nineteenth century. The nature and philosophy of care practices appears to have been consistent throughout the early part of this century and it is only in the past few years that radical change has been introduced (Oswin 1973).

The provision of care 1900 - 1946

At the start of the twentieth century several types of hospital care were available:

1- Voluntary hospitals which were financed by the patients and by voluntary subscriptions and endowments, and which treated professional people and those from higher social classes (Abel-Smith 1964).

2- Public hospitals and workhouses which were financed by the rates and which cared for the sick poor and the chronically handicapped from poorer backgrounds.

3- Hospitals and institutions provided by religious orders and sects.

Hospitals began to separate from the sites of workhouses and the stigma attached to the association with 'poor-law provision' was gradually replaced by an acceptance of public responsibility to care for people with a mental handicap in hospitals, specifically designed for this purpose (Morris 1973; Owens et al 1979). However the role of the physician superintendent continued to dominate the hospital hierarchy and the concept of the total institution was consolidated (Goffman 1958).

At the beginning of the First World War the enormous number of casualties requiring care and treatment caused a number of mental handicap hospitals to be requisitioned by the War Office and the patients were transferred to less-suitable accommodation. In practice this often meant evacuation of large numbers of patients into the country where landowners, in a time of acute economic recession, had leased or sold their estates to the Government for highly inflated prices (Laslett 1971; Davis 1981).

Large, mansion houses were used in some areas to accommodate the patients who transferred with their staff. After the war many of these temporary hospitals remained and the vast amounts of land which surrounded them provided an ideal opportunity to encourage their development, in their own time, to become larger colonies or the 'villa-linked' system mental handicap hospitals which emerged as the pattern for residential care in the 1930's.

New theories regarding social care and deviance (Bowlby 1951) began to emerge as a gradual decline in religious domination was witnessed. The war years interrupted the general trend in social reform and resulted in a period of relative inertia throughout the 1920's.

Until the 1930's admission to all institutions was restricted to those people who had been 'certified' as insane or mentally handicapped. The stigma of admission to residential care was quite apparent and with the order came an acceptance that the period of residence in the institutions was likely to be considerable, if not for life. A Royal Commission of 1926 reported that people with mental handicaps were admitted alongside people with mental illnesses, some of whom were in an acute state of distress following delayed admissions due to fear of 'long-term' committal to the hospital on behalf of patients. Stigma was also attached to the systems of control exercised by the institutions which ensured that in-mates behaved according to local rules and expectations. The effects of these regimes were to label inmates with the social status of the institutions within which they lived and to deny them any sense of individuality or personalisation.

The payment for care, for those people without private means was borne by the poor-law until 1930 when the asylums were re-named 'mental hospitals' (Royal Commission 1926). Even after the publication of the Mental Deficiency Act 1913 it was still impossible for a person to be voluntarily admitted to an institution if they were a 'mental defective'. This situation was set to continue until the passing of the Mental Health Act 1959. The 1913 Act also empowered Local authorities to detain persons on a compulsory basis if their next of kin were destitute or unable to care for them. The negative images and associations of the mental hospitals were accepted by members of society without question .

The regulation of care and inspection of asylums and early hospitals rested with commissioners and Boards of Visitors who were appointed by the County or the Local Authority (Royal Commission on Poor-Laws 1909). An inspection of some of these reports highlights the range of diversity in provision between institutions as well as an overall commitment to social control. The special report of the 1909 Royal Commission on the Poor-Laws provides an illustration of the way of life in such accommodation and identifies the existence of a complex system of special privileges for residents depending on their ability to work and to conform to the rules of the organisation. Consequently as the institutions aimed to regulate the impact of individual behaviour in the community, they also served to control the behaviour of their inmates by imposing regimes which demanded discipline and conformity.

The Local Government Act 1929 transferred responsibility for the Poor-Law to the hands of counties and county boroughs in the form of their newly appointed public assistance committees. The Act also made provision for the transfer of designated Poor-Law hospitals to the local health services or,as was often the case, to re-classify their workhouse accommodation as 'hospitals'. The transfer of responsibility to health services became increasingly evident in the 1930's although this process was markedly selective. In practice the chronically sick and the handicapped continued to occupy sub-standard accommodation for which the health administration did not wish to assume responsibility, thus illustrating a conflict between the committees of the County/County borough Councils. Some handicapped people found themselves living in public assistance institutions without the benefits of social reform or increased public acceptability. Many of the older hospital buildings and the stigma associated with them lasted until the post-war years in the 1940's.

The medical model of care that was becoming increasingly popular around this time, provided families with some degree of acceptability in the eyes of their neighbours. Admission into hospital was diagnosed by doctors who were held in high regard and thus exonerated families from responsibility or blame for their child's condition or handicap. This was clearly important for families who were facing increased demands to contribute to the economy by working. The financial burden of care was accompanied by a growing belief that institutional care for the handicapped was the best solution to their needs and problems. Opportunities for education, medical supervision and to be 'with their own peer-group' encouraged the growth of residential care at this time (Scull 1979 p39).

The National Health Service Act 1946

After the Second World War attitudes to health care in general encouraged the introduction of the National Health Service Act 1946. Under the new Act control of certified institutions passed from local councils to the Minister of Health and through him to the Regional Hospital Boards established by the Act. Many of the previous colonies or work-house institutions became 'hospitals' overnight and care staff, doctors and inmates gradually entered the main stream of an integrated health service.

Public attitudes and care practices did not immediately alter and after many years of segregation this was hardly surprising. Tredgold (1952) in the eighth edition of his book, reflects the feelings of some members of the community at this time, when he commented that some mentally handicapped people:

> '...... are not only incapable of being employed to any economic advantage, but their care and support, whether in their own homes or in institutions, absorb a large amount of time, energy, and money of the normal population which could be utilised to better purpose. Moreover, many of these defectives are utterly helpless, repulsive in appearance and revolting in manners. Their existence is a perpetual source of sorrow and unhappiness to their parents, and those who live at home have a most disturbing influence upon other children and family life. With the present shortage of institutional accommodation there are thousands of mothers who are literally worn out in caring for these persons at home. In my opinion it would be an economical and humane procedure were their existence to be painlessly terminated' (p267).

In education public attitudes regarding the capabilities of people with a mental handicap encouraged the reinforcement of stereotyped beliefs about their intellectual capabilities. The Education Act 1944 identified the existence of a group of children 'incapable of receiving education at school,' and as such severely subnormal children were excluded from the education system. Employment opportunities for older people with mental handicaps were also reduced following the Second World War and prospects of being regarded as employable diminished as competition in the labour market became more pronounced and jobs fewer for men returning from the war (Malin 1980). Hence opportunities within the labour market at this time were particularly restricted as skilled labour skills were required at a peak time of inflation. According to the Jay Report (1979) the expert opinion was that people with a mental handicap 'deserved more than a life of confinement, regimentation and idleness and that education and training were necessary (even if some were pessimistic about the likelihood of much improvement in the patient's condition)' (p11).

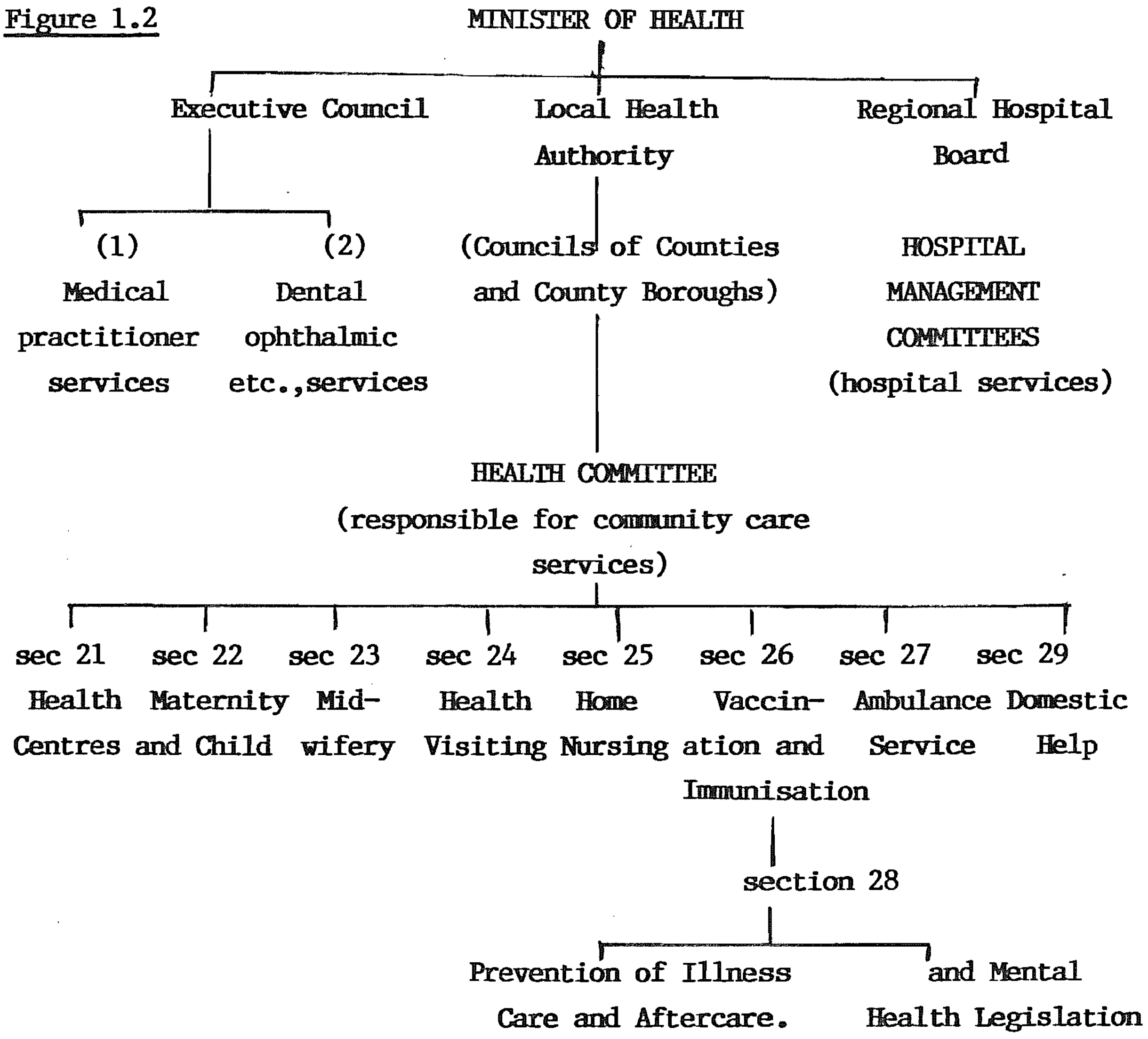
In July of 1948 the National Health Service Act became operational, and assumed responsibility for the institutions which were, in many cases, in urgent need of repair (Oswin 1971). Voluntary hospitals were also transferred to the Health Service and with them came a wide variation in the quality of environment and care. Divergence from the institutional model did, however commence and smaller residential homes began to be opened for this client group based on a gradual change in philosophies of care previously found in the institutions (Davis 1981). Davis believed that the turning point in social care was witnessed in the post-war years when members of the community began to question the conventional wisdom that custodial care was the only possibility for people with dependent needs.

The National Assistance Act of 1948 also provided opportunities for people to select care options where alternatives to the hospital/institution existed. Pensions and benefits also improved the lifestyles, of many although people with mental handicaps were restricted in their choice of residential accommodation and spending power by the regimes practised in the hospitals. The inheritance of outdated buildings, better suited to another era, also restricted the range of choice available. In summary the National Health Service, at this time, boasted one model of care - the mental handicap hospital.

Changes after 1948

Edwards (1961 p61) provides a helpful illustration of the arrangement and deployment of responsibilities for health services under the 1946 Act:

Figure 1.2



1)Provision of residential accommodation.
2)Training and Occupation Centres.
3)Appointment of Mental Welfare Officers.
4)Guardianship functions.
5)Ancillary or supplementary services.

Section 28 of the Act identified the specific duties of Local Health Authorities towards the care and support of dependent persons which ranged from the provision of centres for training and occupation to the provision of equipment and maintenance of residential accommodation. The appointment of officers to act as Mental Welfare Officers was also a requirement of the Act who had responsibility, (amongst others), to exercise functions relating to guardianship.

The early days following the introduction of the National Health Service raised some questions regarding the suitability of statutory control for voluntary hospitals. Topliss (1978) describes the benefits of financial security for these hospitals that the new Act provided but also refers to their potential loss of independence (p45). The Local Authorities had also lost control of their hospitals to the new service and as a result a tripartite system was introduced of hospital boards, general practitioner executive councils, and local authority health departments. The three divisions led to difficulties, according to Topliss, in coordinating the functions of these distinctly managed but interdependent branches:

> 'Each service could act in ignorance of the interventions of the other two...there was increasing concern regarding the division between primary and specialist services. The gulf between the specialist hospital doctor and the generalist doctor in the community had been growing in the inter-war years' (p.45-6).

For people with a mental handicap the new legislation provided few changes in their daily life or care. The statistics assembled by the Royal Commission on the law relating to Mental Illness and Mental Deficiency (1954 - 1957) show how extensive the elements of compulsion and detention remained despite the growing use of voluntary admission into hospitals. The Commission reported that although only 18% of patients received into mental hospitals in 1955 were certified, about 70% of all patients in hospital at the end of that year fell into that category. In total there were 58,000 certified patients in mental deficiency hospitals in England and Wales in 1955 which was three times the number at the beginning of the century [Source: The Royal Commission Report 1957 pp 62-63].

The 1950's were also characterised by a general belief in the 'therapeutic process'. Changes in pharmacology had witnessed the introduction of major tranquilliser drugs such as Chlorpromazine, which provided chemical restraint for disturbed patients. Behaviour problems became more controllable and the need for physical seclusion and restraint less apparent (Owens 1979). Hospitals provided for the majority of the residential needs of people with mental handicaps and the staff who worked with them attempted to apply humanistic approaches to care within a changing philosophy based upon the understanding that their charges were educable. Martin (1984) identifies this change in emphasis in care practice:

> 'It was a reasonable assumption that hospitals existed to do good to their patients, or at least provide civilised care; their staffs were dedicated and the reduction of abuse was seen as a natural by-product of improving standards as a whole. The beneficent role of the hospital was almost taken for granted. It was not that everything was thought to be perfect, but there was an air of optimism engendered both by the therapeutic revolution of the 1950's and the constitutional revolution brought about by the Mental Health Act 1959' (p115).

The introduction of therapy into mental handicap care did not provide patients with any assurance that the quality of their lifestyle would improve. Dick (1986) describes the life of patients at this time:

> 'Imagine a large dormitory. It was a bleak place. The walls are bare, grey, featureless and there is no carpet on the floor. It is cold and there are seventy metallic beds pressed close to one another with identical linen. There is one bath, four wash hand basins and a row of lavatories with half doors, no lockers or cupboards for clothes, only a bare and tidy room.
>
> Next door is a crowded dayroom. Many people sit quietly in rows of chairs doing nothing. They are good patients, so the staff in the ward do not pay them any attention. Others are walking restlessly about; others are disturbed. Some staff are high-handed,

> authoritarian,, but others, despite the circumstances are compassionate and with great skill and are able to persuade them to be quiet.
>
> From time to time one of the patients becomes especially noisy and is locked in a padded cell. There is a reek of paraldehyde. The food is dull; there is no choice of menu. Most wear identical clothes and have identical haircuts. The door is locked' (pp55-56).

The 1950s therefore saw people with a mental handicap still existing within a legacy of segregative policies and practices. Various professional and social groups have espoused or assumed different notions and pursued a variety of policies, often within the framework of services designed with quite different expectations of social policy. Not surprisingly it was difficult to find an appropriate balance in care and treatment between complete, if often benevolent, segregation from ordinary people and attempts to integrate people with mental handicaps in the community. What is clear is that staff as well as residents shared similar lifestyles and yet symbols of power, control and status kept the two groups firmly apart (Owens 1979).

Jones (1972) describes the trends in mental health care at this time in her study of 'The History of Mental Health Services'. Jones identified some of the new therapeutic treatments which which were being introduced during the late 1950s such as Electro-Convulsive Therapy (ECT) and noted increasing awareness of the benefits of the use of major tranquillisers. Martin (1984) described the benefits of these new treatments and suggests that some patients were 'able to be treated in the community' as the need for physical restraint and hospitalisation became less apparent (p116). However, regardless of the new 'therapies' and humble beginnings of community care, Jones believed that the role of institutions would remain prominent for many years to come despite the Government's acceptance of their unsuitability:

> "these bold words ...imply nothing less than the elimination of by far the greater part of this country's mental hospitals as they stand

> today. This is a colossal undertaking, not so much in the physical provision which it involves as in the sheer inertia of mind and matter which it requires to overcome. There they stand, isolated, majestic, imperious, brooded over by the gigantic water tower and chimney combined, rising unmistakably and daunting out of the countryside- the asylums which our forefathers built with such solidity" (Part of a speech by the Minister of Health, Enoch Powell. Quoted in Jones 1972 pp 321-2).

1959 Mental Health Act

The Royal Commission of 1957 maintained that many people living in mental handicap hospitals were there for social and economic reasons and not necessarily for reason of illness or nursing care. The Commission's terms of reference were limited to legal and administrative considerations, with emphasis on the legal machinery for certifying patients as mentally ill or subnormal. Public opinion and acceptance of the report's findings on 'wrongful detention of patients led to to the immediate introduction of legislation in the House of Commons to remove the traditional use of the process of 'certification' from the text book, although many people, previously admitted under the old legislation still remained in hospitals and continued to be detained under certain circumstances (Wagner 1988 p13).

The report recommended that there should be a general impetus towards community care - "There should be a general re-orientation away from institutional care in its present form and towards community care", (Recommendation 4 Part V).

The Commission noted that many people in hospitals were there as a legacy of historical admission practices:

> 'It is not now generally considered in the best interests of patients who are fit to live in the general community that they should live for long periods in large or remote institutions such as the present mental and mental deficiency hospitals, in which they are inevitably largely cut off from the normal world and from mixing with other people' (para 601).

The 1959 Act made provision for admission into care without the need for legal confinement. The new Act heralded the reform of mental health legislation and also saw the improvement of physical standards of care, as well as the use of smaller units and greater flexibility in the arrangements for admission and discharge. In addition the 1959 Act drew public attention, for the first time, to the needs of many people, in institutions who had previously been labelled as 'deficient and immoral in character'. Changes in public attitude at this time, according to Topliss, set the scene for a more casual acceptance of the needs of this client group in society.

The new legislation did not make recommendations in respect of the type of care to be offered for 'the protection' of mentally handicapped people nor did it prescribe any duty to ensure adequate education or occupation for them. Similarly the buildings in which care was provided still continued to be sub-standard in many cases. Townsend (1962) for example, as a prelude to his study on the residential care needs of the elderly, found that in 1958, of nearly 3,000 establishments, 11% were former Public Assistance buildings and they accounted for 80% of all the homes with more than 100 residents, so that these large buildings housed a quarter of all the residents. Not only did these old buildings remain but, no matter how far they were 'upgraded', renamed or refurbished, they still retained the characteristics of the old poor-law institutions, especially in the eyes of the local public, who may have been able to recall the hospitals in earlier times and with their previous negative associations.

According to Martin (1984) the 1959 Act 'accelerated the change in status of patients from "detained" to "informal" (p10) but this change was not always welcomed by staff (Farleigh Hospital Enquiry -1971). The Act also changed the official terminology relating to this client group and introduced the terms 'mental subnormality and severe mental subnormality' into professional language. They replaced the less acceptable 'labels' of 'mental deficiency' (although this term continued in use until 1983 in Scotland and Northern Ireland),'idiot', 'imbecile' and 'moral defective'. Whilst removed from legal terminology these words still found themselves embodied in everyday language and slang (Owens 1979).

The rights of individuals were also protected by the 1959 Act with the introduction of Mental Health Review Tribunals, Official Visitors and through the introduction of a new Court of Protection to safeguard the affairs of in-patients (Sections 122, 108 and 100 respectively). A clear separation between the medical diagnoses of mental illness and mental handicap was made, and a distinction between criminal reasons for admission and informal reasons for 'reception into care' introduced. The outcome of these changes was to improve the social acceptance of people with a mental handicap and to remove some of the older associations with criminality and insanity.

The review of mental health provision was not confined to Great Britain and at the same time as the Royal Commission of 1954-7 was sitting, the World Health Organisation published a report by its Joint Expert Committee (1954) providing a set of guiding principles on mental deficiency legislation. These proposals recommended that whilst avoiding overprotective practices, that all people with mental handicaps should be protected against exploitation, families against the pressure of a handicapped child and the community against antisocial actions. It also called for legislation to ensure that adequate supervision of institutions was provided. It also recommended that a distinction be drawn between, and different provision provided for, the mentally ill and mentally handicapped and that legal, compulsory detention should only be adopted as a last resort.

Overall the Royal Commission of 1954-7 and the emergent 1959 Mental Health Act formed a watershed in the history of mental handicap care. The rights of individuals to voluntary admission and the clarification of legal categories for detention represented a new charter for care. For many the Act was to provide opportunities for discharge into the community and indeed, the early 1960's saw the transfer of many 'high-grade' people from hospitals into boarding houses, guest houses, hotels and lodgings (Boswell 1975). In terms of provision no one model or standards of care were proposed but the removal of 'certification' and the introduction of voluntary admission provided two key measures which were to facilitate change in care practice and philosophy during the next decade. This was more commonly known as the 'open door' policy (Malin 1980 p50).

Emerging Trends and changing philosophies.

The 1960's witnessed the introduction of major changes in service philosophy and provision. The family became recognised as a primary care provider in its own right (Owens 1979) and opportunities to experiment with alternative models of care emerged. One such experiment was 'The Brooklands Experiment' which was pioneered by Dr Jack Tizard (Tizard 1964). He placed severely handicapped children in the care of permanent care staff in a community unit which was designed to run on the basis of substitute family care. He demonstrated that educational techniques could be applied to mentally handicapped children in their homes through individual care, love and structured play/learning techniques. The socialisation and caring functions of staff were emphasised as was the importance of providing the children with ordinary learning opportunities in the community. For Tizard the uniforms and hierarchies that were present in hospitals were characteristic of an outdated model of care, better suited to institutional concepts of care in the earlier part of the century. Tizard proved that community care was possible and introduced a key challenge to the hospital model.

Family Units were also being introduced throughout the country. Owens (1979) mentions a model of care in County Durham (p45) and reports that in one hospital, the psychiatrist and nurses decided to operate family units of care as control groups. By integrating selected adults and children together in ward areas the team was able to introduce stability and constancy into the resident's lives whilst enriching personal experiences for all concerned. The model also recognised that 'all in the garden is not rosy' and in consequence living in a group made it necessary for children to learn to cope with more difficult personal situations. In terms of outcomes, the children developed intellectually and emotionally from the experience and the adults gained a sense of purpose in their lives and a sense of personal responsibility.

The family unit concept and the introduction of community care were also accompanied by the realisation that in order to provide individual support for residents, staff had to undergo a basic change in attitude. This attitude change was characterised by a growing awareness of the needs of people with mental handicaps as individuals with rights and responsibilities. This process of 'Normalisation' has been described by Bank-Mikkelsen (1969) as "letting the mentally retarded obtain an existence as close to normal as possible" (p126) and by Nirje (1970) as "making available to the mentally retarded patterns and conditions of everyday life which are as close as possible to the norms and patterns of the mainstream of society"(p53). Wolfensberger (1972) defines normalisation as "the utilisation of means which are as culturally normative as possible in order to establish and/or maintain personal behaviours and characteristics which are as culturally normative as possible" (p12).

The principle of normalisation may be seen as 'a bridge between the the notion of human rights and the implementation of these rights by society's care giving structures' (Bronston 1980 p21). The Kings Fund have also encapsulated some of the main themes in this process in a project paper :

> "Our goal is to see mentally handicapped people in the mainstream of life, living in ordinary houses, in ordinary streets, with the same range of choices as any other citizen, and mixing as equals with the other, and mostly not handicapped, members of their own community" (1980 p8).

The principles underlying this philosophy fall into three main groups:

- the setting;
- the pattern of life;
- social relationships.

In an institution opportunities for the realisation of these key principles is restricted by the environment, the care regime and by the allocation of financial and human resources. The pattern of life incorporates the set regimes and patterns of the day, and the attitudes of the organisation and its staff. Some staff had difficulty in realising the principles of normalisation which created a major conflict for carers who were used to more custodial approaches to care. Before some of these conflicts are considered further, this section identifies some of the key principles involved in the philosophy of revaluing people with mental handicaps. It is these very principles which underpin the philosophy and value base of modern, community based services for this client group in modern times and in order to appreciate the slow rate of their assimilation into the culture of the mental handicap hospital and thereafter into the training syllabi of nursing staff, their origins require exploration. O'Brien and Tyne (1981), argue that:

> "If we implement the normalisation principle by working to encourage more mentally handicapped people to participate in the lives of a variety of community members, they will begin to grow a network of relationships which not only provides support, but also changes the status of the person and the group he/she represents in the eyes of others. Over the long run, this will reduce the level of de-valuation of people with handicaps" (p29).

The concept of integration within the community figures as a key concept in the theory and practice of normalisation. The relocation of people with mental handicaps from hospitals is a goal within this process (Grunewald 1972). The establishment of social networks or 'the total social field in which the individual is embedded' (Mitchell and Trickett 1980 p33) was studied in 1967 by Edgerton amongst a group of former mental handicap patients discharged into group homes in the community. He found that former networks developed in hospital were difficult to replace in ordinary neighbourhoods due to the dependency of former patients on the rigid patterns of dependency created by institutions.

The philosophy of normalisation, individual care practices and the recognition of the importance of neighbourhood integration were also influenced by changes in Education and Social Work Practice. According to Wagner (1988) the local authorities recognised its responsibilities to provide residential accommodation for people with mental handicaps following the publication of the Mental Health Act 1959 (p128). This was confirmed the main conclusions recorded in the Younghusband Report (1959) which reported on the need for appropriate training for specialist social workers and on their subsequent need to have a variety of resources with which to meet the identified needs of their clients.

By the early 1960's the main service providers were still the hospitals with local authorities developing some training facilities in the community and introducing home visiting routines to families through the appointment of Mental Welfare Officers. A few residential homes and hostels appeared 'here and there' but provision was 'patchy' and variable (Wagner p128). Care for mentally handicapped people was provided by relatively small teams of specialist social workers employed by health authorities who complemented the local authority Mental Welfare Officers who were under the control of medical officers. In 1968 a report was published which changed the organisation of field work social workers (Seebohm 1968). According to Watkin 1975, Seebohm's main priority was to coordinate the branches of social work practice into one unified structure.

Seebohm recommended the introduction of a family service, designed to remove duplication between agencies and to plug the gaps in service provision. It called for the establishment of a Central Council for the Education and Training of Social Workers (CCETSW), the development of Area Offices and for a revision of all specialist social work functions.

The reorganisation of social work departments led to the creation of unified social service departments, staffed by 'generic' social workers, which involved the complete disappearance of the profession of psychiatric social work, and a widening of the gulf between hospital and community based services. Consequently the concept of the specialised social worker for mental health, which had developed between the wars (specialist vocational training in mental health commenced in 1914, [Watkin, 1975]), was replaced by one generic worker, responsible for the coordination of all social services. As F.M. Martin, noted (1984), the consequence of this change on the quality of service provision were difficult to assess, but he concluded that:

> "there developed among psychiatrists and many of their colleagues an almost universal impression that the mentally handicapped received

> scant attention from the reorganised social services; and that this was due to ......the emergence of entirely different and unanticipated priorities" (p38).

In education, following the publication of the Education Act 1944 local authorities were obliged to provide special education facilities for every child who required them. Provision had to take into account the the age, ability and aptitude of the child (sec 9) and placed responsibility for this provision on the Minister. The Minister was charged to make regulations to define the several categories of children requiring special education. Appropriate methods for teaching each category of child required definition. Such regulations did not appear until 1959. The Handicapped Pupils and Special Schools Regulations (Statutory Instrument 1959 No. 365 part 2) identified ten categories of children in need of special education which included children with all children with mental handicaps without exclusion. However not all children were felt to be suitably educable in the education sector and the National health Service Act 1946 catered for such children by ensuring that local health authorities provided junior training centres for the more severely handicapped person. The Mental Health Act 1959 specified that some severely handicapped children seemed to be 'unsuitable for education at school'. Thereafter, during the 1960's the division of responsibility for the education of handicapped children was clear. The Health Service catered for severely mentally handicapped children and the education authorities made provision for the more able or educationally subnormal person.

No child was compelled to attend school and the shortage of places in junior training centres made attendance impossible in some parts of the country. 'This state of affairs often left the child bereft of any education whatsoever, and stagnation at home was the final outcome' (Owens 1979 p68).

For those children who attended the junior training centres, little attention was paid to academic subjects and instruction was provided by a staff of mainly unqualified teachers. Despite the slow rate of change, the use of educational theory began to influence curriculum design for people with mental handicaps and it was at this time that there was a growing awareness of the educational potential of handicapped pupils. This was later to lead to the publication of the Education (Handicapped Childrens) Act (1970), and the transfer of responsibility for special education for all children to the local education authorities. This change in legislation was to separate residential care provision from educational practice and was to make attendance at schools for handicapped pupils compulsory.

Whilst changes were taking place in education, changes were also apparent in residential care practice. King et al (1971) distinguished 'resident orientated' care practices from 'institution-orientated' practices found in hospitals. The latter included 'block treatments', rigidity of routine, social distance and depersonalisation. In order to overcome some of the salient features and care practices found in the hospitals, one Regional Hospital Board, the Wessex Regional Hospital Board, began to develop smaller, locally based hospital units situated in residential communities (The Wessex Experiment). According to Felce (1983) these units were designed to avoid the negative effects of hospitalisation as identified by King (1971) and by Morris (1969). They were at the time considered to be 'home-like' with 20 - 25 beds in each unit. Staff were allowed a certain degree of autonomy (up until then unknown in hospital care), and were located within easy reach of local neighbourhoods and community facilities. Despite their size the units were designed to encourage family care in separate living areas and they represented a major shift in models of care provision within the National Health Service. Comparisons of care models between the Local Based Hospital model and traditional hospital based services were carried out by the Wessex Health Care Evaluation and Research Team which compared the quality of life/ care of residents between service models (Felce et al 1983).

The Team compared quality of care on a number of different measures ranging from client progress, level of client engagement in activities, contact with families, social contact/interaction and staff performance. The results according to the Team, were accepted universally as conclusive and supportive of small based service models. Their concluding comments were that 'Superior outcomes were achieved (in the small units) at no greater revenue cost' (p238).

The publication of a book by Mrs Robb in 1967 - 'Sans Everything', reviewed the plight of many elderly people in hospital throughout the country and added to the growing perception of the indignities of residential care at the time. As a result of this publication, the Minister of Health decided that allegations of poor or mistreatment should be investigated by committees of enquiry, instigated by Regional Hospital Boards. This book received controversial acceptance from professionals and from the public but clearly directed the government to consider the needs of hospitalised persons seriously.

The quality of hospital based care came under further question in the second half of the 1960's following allegations of poor treatment and cruelty in a mental handicap hospital in Wales (Ely Hospital Report 1969). The problem of understanding the gap between aims and performance in care practice has been the subject of study. Townsend (1973) saw a wide variation in care practice and drew attention to a range of environmental conditions, from appalling Victorian institutional provision to the commissioning of new hospitals at this time such as Northgate in Northumberland. These hospitals were to continue to be built well into the second half of the 1970s and reflect the difficulties that service managers have often experienced when planning new provision for their clients in terms of the rigid planning cycles which may delay commissioning of new services by up to ten years from when they were originally designed.

Townsend identified that any study of quality and standards of care was a complex process:

> "The fate of the mentally handicapped is determined not just Parliament, Ministers of State and local councils but by the powers entrusted in or assumed by all those caring for them. The Sociologist's interest in 'bureaucracy' and 'organisation' leads him to investigate special problems like those of rough treatment in hospitals. But he tends to review social control in terms both of internal structure and external relationships" (p196).

The first major public enquiry into mental handicap hospital care (Ely Hospital 1969), was launched following allegations which had been published in a Sunday newspaper in 1967. By the end of that year an independent committee of enquiry was established by the Welsh Regional Hospital Board under the chairmanship of Geoffrey Howe, which was submitted to the Secretary of State for Social Services, Mr Richard Crossman in 1968. (The Department of Health was amalgamated in this year to become The Department of Health and Social Services).

The report did not just find members of staff at fault in their treatment of patients but traced responsibility through the senior nursing staff to the Chief Male Nurse, the Physician Superintendent, the Hospital Management Committee and its officers, The Regional Hospital Board and, finally the administrative structure of the National Health Service itself. (This included the authority exercised by the Minister). It was thought that junior staff were victim of an inadequate system and of inadequate resources provided by the Government, the Boards and local authorities involved in the system (Ely Hospital Enquiry 1969 p128).

Needless to say the publicity given to these findings (Mr Crossman decided to publish the results of the enquiry), generated sympathy and insight into the way in which people with mental handicaps lived and were cared for in hospital settings. The Secretary of State took a personal interest in care provision and visited several hospitals himself. In response to his visits he established a working party to advise him on mental handicap care policy.

Crossman's motivation for publishing the results of the Enquiry may be questioned as he states himself in his Diaries:

> 'the whole thing had to be published. The Report completely substantiated the News of the World story and I might as well make the best of it by outright publication. But I was also clear in my own mind that I could only publish and survive politically if in the course of my statement I announced necessary changes on policy including the adoption by the Ministry and the RHBs (Regional

> Hospital Boards) of a system of inspectorates central and regional, such as there are in almost every other Ministry and such as the Health Service has never yet permitted' (1977 pp408-9).

Crossman was also aware that he might have had to face cross-examination by one of the cleverest conservative lawyers of the day who was aware that Nursing Officers at the Department had visited Ely earlier in the year and had reported that 'scandalous conditions existed for patients living there (this internal report was reported to have been filed without further action).

Crossman concluded:

> 'So the Ministry did in fact know and I am pretty sure they have a shrewd idea that there are a great number of unspecified long-stay hospitals with conditions not very different from those at Ely' (p411).

At the same time, Pauline Morris (1969) published her research findings from a national survey of mental handicap hospitals, which had been financed by the National Society for Mentally Handicapped Children. This publication restated, with a wealth of factual evidence, the need for reorganisation of care provision, while the work of Tizard and Kushlick (1964, 1977), also provided research data indicating that structural change was necessary.

"Better Services for the Mentally Handicapped".

Following the debate on promoting positive attitudes to mental handicap care, which ensued in the 1960's, the Government published a White Paper, (Cmnd no.4683 1971), entitled "Better Services for the Mentally Handicapped". The White paper presented a fundamental restatement of a principle - the **desegregation and community care of the mentally handicapped** - that was established prior to and contained within the Royal Commission Report relating to mental deficiency (DHSS 1954-7). The White paper was heralded as providing a cornerstone upon which future services would be judged and developed and is still quoted by service planners and providers in current debates on community based care for people with a mental handicap. The paper introduced, for the first time, official recognition of the term 'mental handicap' in place of the previously accepted title 'mental subnormality' although it was acknowledged that the latter was the official legal term in use at the time.

The first chapters of the report specified the numbers of people with mental handicaps who were likely to require services from the health and social service departments at intervals in their lives. Differences between mild and severe mental handicap were examined and recommendations made for the pattern of services clients should receive. Hospital based provision was seriously questioned as being the most appropriate form of care for this client group and a review of their contribution to the care process was called for. It was noted in the paper that hospitals were over-crowded, isolated and unsuitable in design for the achievement of community based models of care and for the goals of normalisation to be practised (para 81). Reference to outdated views on the nature of mental handicap was made and the lack of appropriate financial resources to improve services to clients blamed for much of the general state of hospital and local authority provision that prevailed at the time. The picture which they described was indeed poor, with a scattering of local authorities introducing hostels and adult training centres. Priority was given to children in the community and to those mildly mentally handicapped people who were not living in long-stay hospitals.

An acute shortage of trained staff was reported 'as a limiting factor on the quality and further development of every part of the local authority service' (para 75) and the shortage of social workers to support families in the community and to work in adult training centres gave cause for concern. (In 1969, about 2,000 mental health social workers were employed by local authorities of whom just over 600 had been trained in social work...para 76).

In the hospitals it was noted that old attitudes were gradually being replaced by more positive principles such as those that underpin the philosophy of normalisation. Recognition of the learning potential of many hospitalised people was also emphasised (para 87), as was the general increase in public awareness of the needs of this client group. The hospitals still gave rise to concern and their isolation created difficulties in staff recruitment and their size militated against individual approaches to care.

> "At the end of 1969, 7 of our hospitals for the mentally handicapped contained over 1,500 beds; 2 of these had over 2,000. Another 3 clusters of hospitals administered as single hospitals had over 1,500.....(para 94)....Even more important is that most of the present hospital buildings were designed for custodial care, and for less severely handicapped patients. It is extremely hard, though creditable attempts have been made, to create a homely atmosphere in a barrack-like institutional building;...(para 99)....Almost all the hospitals are overcrowded, or have overcrowded wards" (para 99).

These extracts taken from the report characterise the general impressions of care provision during the late 1960's. For nursing staff the report identified a massive shortfall in numbers 'to care properly for heavily handicapped patients, to give all patients the personal interest and social stimulation they require, and to relieve the nurses of domestic work' (para 108). In real terms a major increase in the number of nursing staff had been witnessed from 10,000 in 1959 to 14,600 in 1969 and along with this was a 20% increase in domestic staff.

The White Paper recommended that all statutory services involved in care provision should work together locally to produce a 'blueprint' for service delivery. The role of the voluntary sector and of education was discussed and the extension of residential services to families recommended through the provision of home counselling and support. The number and the type of residential and day places required was presented in terms of the number of places per 100,000 population, a planning norm which still exists today. Quantitative targets were set for all parts of the statutory services to meet the needs of projected population norms. Increases in social work and nursing staff were called for as were increase in the number of residential and day centre places. For hospital services, fewer beds were forecast with an emphasis being placed on treatment and assessment through a variety of admissions ranging from outpatients, short stay patients and longer term residents. Each Regional Hospital Board was required to 'work out a developmental programme to achieve these targets' (para 221). For those older hospitals the report recommended that five year improvement plans were undertaken to 'upgrade the hospital services as an interim measure to secure a better quality of life for patients' (para 226). New hospital design was recommended to build 'separate small or medium sized hospitals or hospital units which was to set the pace for future service developments which was latter to be challenged by the advocates of small house developments as being inappropriate and unnecessary. The following quotation presents the thinking at the time which was based on statistical planning norms rather than on the needs of individual service users:

> 'Such hospitals or units will not contain more than 100-200 beds for in-patients (in addition to places for day patients) and many will be considerably smaller. The reasons for this figure is that eventually 200 in-patient beds would eventually be all that would be necessary to meet the needs of a population in excess of 250,000; a hospital serving more people than this would be too remote from many of them' (para 245).

The role of the voluntary sector was introduced in this report into mental handicap hospital care. The isolation of so many hospitals might be reduced, they suggested, if volunteer transport and visitors were engaged.

> 'Voluntary help is especially important for these hospitals, where many patients are far from their homes and relatives, and staff are short. ..The employment of voluntary help organisers, usually full-time is an important new development'....(para 296).

Transitional measures between hospital care and care in the community were described in paragraph 224 of the report and whilst acknowledging that many in-patients were in fact institutionalised, recognised that there were a substantial number of residents capable of living in the community if appropriate services were developed to meet their needs:

> 'Opinions differ on how many of those who have become institutionalised through long-term residence in hospital can be successfully rehabilitated and return to life in the general community. Some maintain that between a third and a half of all patients now in hospitals for the mentally handicapped could be discharged if residential and other facilities were available in the community. Others regard these estimates as far too high' (Para 224).

For the staff employed in hospital services the comments and recommendations appeared to be welcomed. Many nurses were encouraged by the emphasis placed on the individual needs of their patients but in terms of the numbers of patients who might be involved in any relocation plans, they felt secure in the knowledge that their continued employment in hospitals would continue for a significant group of highly dependent patients. They regarded the transfer of the 'more able' clients as a natural progression in community care. The paper also acknowledged that the staff were as anxious as they were to realise radical reform in service provision but were cautions enough to recognise that a major shift in attitude and philosophy was required to make their proposals for community care work:

> ' The principal training need in the hospital service is reorientation of staff originally trained in an older tradition, and the interchange of new ideas and experiences. The programme of 'interim measures' was accompanied by a special training project for nurses to enable them to make this transition. Its object is to help hospital staff now working with the mentally handicapped, both senior and junior, to understand the principles on which current policies are based, so that they will be able to take full advantage of the opportunities for more personal and positive patient care which the

> five year improvement programmes should bring to their hospitals. Many of the nurses and other staff have longed for such an opportunity' (Para 231).

The report also recommended that a series of seminars to share good practise and research projects should be engaged upon in order to assess aspects of the prevention of mental handicap, ways of enhancing the social environment of hospitals/hostels and in respect of the application of educational techniques for clients (para 313). Scope for further research was recorded in respect of family based care, community models of day and residential care and into the specialist needs of severely handicapped people.

The conclusions of the report were contained in a series of general principles which emphasised that mentally handicapped people and their families should have the same need for general support services as other families and in addition, need special provision. The report emphasised the need to pursue family based care except where that care places undue hardship on the family. Residential care should be provided in a 'homelike' environment, local enough to allow previous contacts to be maintained. They also recommended that local services should be developed as an integral part of the Local Authority Social Services and planned in conjunction with the health services.

These principles were stated at a time when the realisation of community care was still at a stage characterised by staff scepticism and ignorance. Many received the report as a statement of unachievable goals and precepts. Others regarded the report as 'an over simplification of the real problems facing the profession and client group at the time' and queried the financial logic of the recommendations (BASW 1971):

> 'The government will need to play a major financial part, whatever else, or local authorities will have no hope of achieving the many desirable aims set out in the White Paper. We are convinced that that government injections of additional money into the mental handicap field so far are proving pitifully inadequate if the government's own programme is to be realised' (BASW 1971 paras 4.37 and 4.38).

According to Martin (1984) the White Paper adequately describes and publishes the government's philosophy and official policy for mental handicap services at the time. The early drafts of this document were written by Professor Brian Abel-Smith who, at that time was acting as Richard Crossman's personal adviser (Crossman 1977). Martin (1984) regarded the document as placing clear emphasis on improving standards of care (p128) but sadly he acknowledged that the proposals identified in the report were 'not taking place as planned' due to a number of economic pressures which 'slowed down the rate of change and so gave the public and staff opinion more time to adapt to new policies and practices' (p134). Martin acknowledged that service change could not be achieved by the publication of Government papers alone:

> 'The image of a department of state is significantly affected by what it publishes. The great White Papers on 'Better Services', the HAS reports, the publications of the National Development Group for the Mentally Handicapped (see below), all gave the impression of intellectual and moral leadership which cannot be sustained by the occasional circular and the proliferation of handouts of ministerial speeches. A review of the work of the last Quinquennium would not be an adequate make weight, but it would be better than nothing' (p145).

'A proliferation of papers' and advice on mental handicap services!

If one acknowledges that the White Paper was written against the background of the Ely Hospital Enquiry (1969) and followed the publication of books such as 'Sans Everything' (Robb 1967) and 'Put Away' (Morris 1969), then it is particularly important to consider why it has taken nearly two decades for the government to seriously promote its policy of 'Care in the Community' and to realise its objectives in practice.

In 1980, a review of the progress made in implementing the recommendations of the White Paper was published by the DHSS (Mental handicap: Progress, Problems and Priorities 1980). The review identified the way forward to translate the objectives of the earlier report and these recommendations will be considered later in this chapter. Some important conclusions were drawn in the review:

> 'Finally, assumptions in the White Paper about public expenditure have proved to be unrealistic. The White Paper was written at a time of expansion. Since then restraints in public spending have meant that authorities could not progress as rapidly as was originally hoped, despite the priority which successive governments have continued to attach to the development of mental handicap services. At the present time, there seems little prospect of an early end to such restraints' (p2 para 1.6).

Others have accepted that financial restraints were not the only reason for the slow progress which had been made. The White Paper did not, for example take account of local needs and circumstances but made overall recommendations which often did not match reality or local resources. Staff skills and training were also sadly lacking and were not in keeping with the philosophy of service provision and care asserted in the report. What was required to realise the objectives in the report was a revolution in social care practice, an updated and enlightened workforce and progressive managers, willing to face the challenge of change demanded rather than maintaining the status quo of the hospital institutions.

The government was equally aware that the pace of change was not as they would have hoped or expected. The first measure taken was to set up an independent team of experts whose function was to provide advice for the Secretary of State on mental handicap services and to publish information to guide practitioners in the field on how to plan and deliver services in accordance with the main principles outlined in the White Paper. This group was called the 'National Development Group for the Mentally Handicapped' and was introduced in 1974 by the then Secretary of State for Social Services, Barbara Castle. A second level team soon followed in 1976, 'The National Development Team' whose function was to 'offer advice and assistance to health and local authorities in the planning and operation of their services to the mentally handicapped' (Development Team for the Mentally Handicapped 1978 p1).

Barbara Castle in a speech to the Commons in 1975, expressed her concern for the poor conditions that were still existing in many hospitals as exposed by the continuation of a number of section 70 enquiries (Farleigh Hospital 1971; South Ockendon Hospital 1974). As a result pressure was mounting to review the provision of hospital care and provision. Mrs Castle said in her speech:

> 'We are satisfied that further reorganisation would create more problems than it would solve. We also have also considered whether overall progress could be speeded up by transferring existing mental handicap , or at least their residential and training facilities, to Local Authority Social Service departments. But, again this would throw up great problems of strain on Social Service departments....and probably have a serious strain on the morale of very large numbers of hospital staff who would be effected by the transfer" (Castle 1975 p2).

From 1976 onwards a series of pamphlets were published by the Group offering advice on children's services, day care, short term care and comprehensive service models. The advice offered in these reports was widely circulated and adopted by practitioners in the field. Issues relating to strategy and the implementation of policy were examined and guidance offered centrally to services. This approach was complemented by the work of the Development Team who by 1980 were able to state that their members had visited nearly every health district and their associated social services department in England. These visits were field visits and usually consisted of a team of between ten and fourteen professionals and parents spending up to two weeks in a locality, working with and advising on service systems and improvements. Team members were seconded from their daily work places and were selected from a total team membership of over one hundred people.

Martin, 1984, refers to such external advice, as being primarily of a professional nature and yet implicitly they have also had their effect on the management of services. Following visits to individual districts and authorities in England the National Development Team was expected to publish a confidential report on their findings. The information in these reports was often leaked to the press and the public and as a result criticism of local provision often ensued. The reputation of the Team led some authorities to regard their visits with some degree of trepidation and the independent right of access of the Team's Directorate to the Secretary of State led, in many instances to additional resources and changes in local practice (eg St Lawrences Hospital Croydon in 1981 and Normansfield Hospital Teddington in 1981).

The incoming conservative government of 1979 abolished the National Development Group as part of its initiative to reduce the number of government affiliated advisory groups. During its life the Group contributed to the development and planning of mental handicap services throughout the country. Respect for its advice and recommendations shaped the pattern of service delivery at this time and many authority planning teams were influenced by their publications and blueprints for service change and planning. At the conclusion of the Group the Director, Peter Mittler, published a paper entitled '<u>Unfinished Business</u>', in which he advised the Secretary of State, Patrick Jenkin, of a number of issues requiring 'urgent attention'. These are best summarised in the conclusion of an unpublished summary of this paper presented to Patrick Jenkin by the National Development Team (NDT [RD7], May 1980):

> 'We see a need for firm government guidance and for clearly thought out suggestions on how authorities can maintain and develop their services for mentally handicapped people at a time when harsh decisions on priorities have to be made. Many authorities have begun to develop better services but there is now a real danger that we shall be returning to levels of provision which we thought we had left behind many years ago. It is not too late to intervene but intervention in some form there has to be. Speeches and the White Papers are not enough. We look to the Government to propose concrete and specific measures to protect the interests of this vulnerable group of citizens who have already borne more than their fair share of hardship" (p8).

The Team published a series of biennial reports during its life which describe the methods employed during visits and make recommendations in respect of the local and general trends in service provision identified by panel members during the visiting period. Over the past fifteen years the National Development Team and Group have played a significant role in shaping the history and nature of current mental handicap services within the statutory sector of care provision in England.

Advice was not just restricted to residential service provision and the National Development Team also recommended that Health Authorities extended the range of their service provision to meet the needs of people with mental handicaps and their families. The concept of a team of professional staff from a variety of backgrounds was introduced in 1975 by the Team and thus was born the notion of 'The Community Mental Handicap Team' (NDT 1976 p44-56):

> 'The Community Mental Handicap Team would be a specialist multidisciplinary team involving both local authority and NHS staff. 'The functions of the community team will be to provide the necessary help and support to the mentally handicapped individuals requiring their assistance at home and also to maintain links between those in hospital and their families. This will have the general aim of helping the family to continue to care for the mentally handicapped individual, to make a positive contribution to management and training' (NDT 1976....p45).

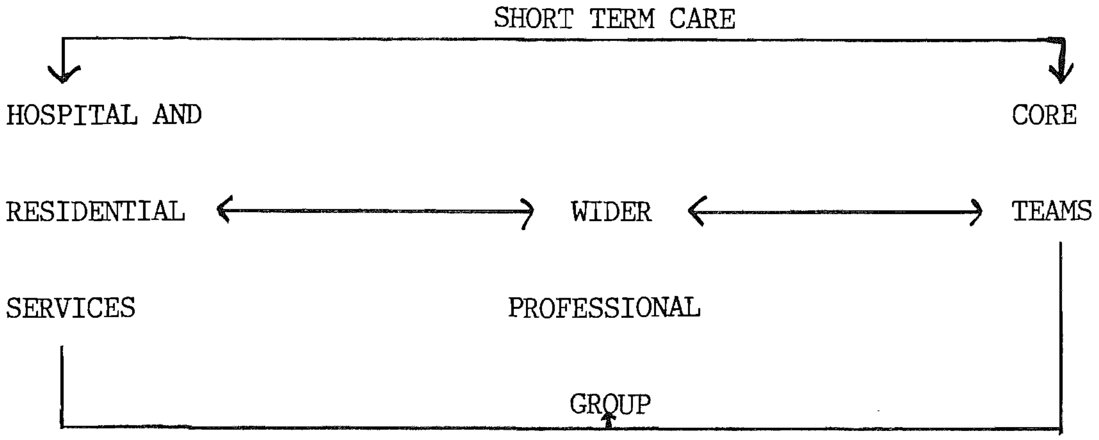
The CMHT was identified as the cornerstone to district based services by the team in their first publication 'Planning Together' and the following functions of the Team were prescribed:

1- to act as a first point of contact for parents and to provide specialist help and advice on problems related to mental handicap;
2- to coordinate access to services;
3- to establish close working relationships with generic and voluntary services for people with mental handicaps;

4- to provide specialist advice on the direct management of day to day needs of mentally handicapped people in respect of behaviour problems, skills development and training programmes.

The core membership of the CMHT was a community mental handicap nurse and a social worker with additional support being offered from psychologists, consultant psychiatrists and other para-medical staff. In order for these teams to work effectively the provision of short term care facilities for community clients was essential to provide family support in times of crisis. At first these facilities provided the teams with the safety valve they needed before they were able to prove their true value through identified case work with people in their homes. According to Elliott-Cannon (1981) families and mentally handicapped people need help right from the very start, which is lifelong, obtainable and consistent; and facilities which should be flexible, local and available. The following diagram illustrates some of the key dimensions of the Team's role and function:

Figure 1.3



In practice these teams began to appear from 1977 onwards and were particularly responsive to the needs of those people with mental handicaps who were denied access to mental handicap hospital care at this time. Union activity developed during the mid 1970s in the form of 'action committees' whose purpose was to limit the admission of further patients into long-stay care at a time of increasing criticism and pressure on nursing staff who were still working in overcrowded wards. Hospitals, anxious to improve conditions of care and to maintain harmonious relationships with their staff and the unions, agreed in many areas to restrict new admissions until staff/patient ratios improved to acceptable levels. In most areas a 'two to one' policy operated with one admission planned for every two discharges or deaths. The action committees were usually made up of union stewards, managers and staff representatives and as a result of their joint efforts, admissions were successfully restricted. As an inadvertent consequence of these activities, the advent of CMHTs was heralded as a positive success by families and provided the teams with an opportunity to demonstrate their skills and support for families at home.

There is little published information on this important and significant dimension of the role of Trade Unions in drawing public attention to the poor staffing levels which existed at this time. However Martin (1984) does make reference to the role of unions at this time at a neighbouring hospital, Brookwood, where disputes were entered into with management in respect of inadequate staffing levels (p48). Martin has also confirmed the importance of public recognition of the conditions that existed in hospitals at this time:

> 'Typically a hospital, or its staff, or people connected with it, deliberately publicize the existence of bad conditions .Sometimes this has taken the form of 'leaking' or revealing to the Press the contents of reviews or conditions such as those made by the Development Team for the Mentally Handicapped. Others have been brought to the notice of feature articles in the press, or in one instance by the trade unions representing the staff of one hospital who produced a joint report criticizing conditions' (p60).

Certainly the growing awareness of mental handicap care by the public caused concerns of its own. The press, eagerly anxious to receive information on hospital conditions, (and particularly following the Section 70 enquiries of this period), published reports on local services which culminated with the presentation of Nigel Evans' famous documentary '**The Silent Minority**' (1981). This documentary exposed the conditions which prevailed in St Lawrences hospital in Caterham, Surrey , which at that time served a population of 2775 patients. The conclusions were sadly predictable and familiar to many hospitals at the time, poor staffing levels, under-resourced, excessive staff overtime and very few nurses. Support from the local community was poor and support services few and far between. This cycle of underfunding, low staffing and low morale proved for many to be a recipe for institutional care and an explanation for slow progress towards implementing the now widely accepted goals of normalisation and the objectives of community care published in the 1971 White Paper.

The advice offered by members of the public was reinforced by the acceptance of the role of volunteers in mental handicap hospitals. Schemes to encourage community integration were prolific such as those introduced by the '**One to One scheme**' (1976), which attempted to provide 'an experiment in community participation in long-stay hospitals' . The appointment of coordinators of voluntary services produced an increase in volunteer recruitment into hospitals. This in turn had the advantage of raising public awareness, sharing conditions of care and of providing the early roots of citizen advocacy for clients.

New advice was also freely available on the size and design of buildings within which to house and care for people with mental handicaps. The most famous of the studies on this subject at the time was published by Dalgleish (1979), in respect of the '**Sheffield Experiment**'. In Sheffield in the 1970s, specially designed and purpose built buildings were planned and developed by health and local authorities as part of the Sheffield Development Project. The model was the 24 bedded hostel which aimed to provide family based care in separate units of eight. In her evaluation of the project Dalgleish noted problems with hostel and group size, as well as with design and physical features. This model was replicated in Wessex and evaluated by Kushlick's, Health Care Evaluation Research Team (1977) and later by Simon in his account (1980) of '**An Operational Brief for Community Units for the Mentally Handicapped**' in the West Midlands. As a result standard designs of buildings began to appear in large numbers and were suitably criticised by Heron (1982):

> 'this marked preoccupation with buildings led to the provision of purpose-built miniature institutions. The lack of any underlying philosophy meant the residents lived in hostels, and not in the community' (p52).

Interest was also being generated at this time in the measurement of quality of service design and the costs of service delivery. Kushlick (1977) produced a model of research for residential services on a large scale basis which explored the incidence and prevalence of mental handicap in the population and also presented some radical solutions to meet them. The starting point for his research was recorded by Tizard (1974):

> 'Kushlick's starting point was a practical problem facing Wessex Regional Hospital Board, the health authority responsible for meeting the needs of a total population of two million people. The authority knew that it had a shortage of residential places for people with a mental handicap in the region, but it was uncertain as to the amount of provision it was likely to need in the future, and it was doubtful about the wisdom of adding to the size of existing hospitals. It was in this setting that Kushlick carried out his survey of the prevalence of mental retardation over the whole region' (p848).

Kushlick went on to develop the now well recognised model of the Local Based Hospital Unit (LBHU), which was designed to provide off-site accommodation for twenty five people with mental handicaps in areas local to their original homes. Most of the residents had lived in hospitals and Kushlick designed a series of quality based measures to evaluate the success and effect of this model on clients, families and staff compared to their previous experience of hospitals. His model was adopted by Wessex in preference to building a new 600 bedded hospital to meet the increasing demand for places at the time.

Studies such as these are exceptionally difficult to carry out. First, they require an active partnership between research workers and the authorities responsible for delivering and managing the services. This may present problems in respect of the complex communication structures that existed in the hospitals at the time. In this situation the researcher is likely to wish to influence policy or recommend changes and yet as a researcher he is unable to direct policy. He must also remain impartial and detached from the institution if he is to evaluate the effectiveness of the service. Secondly, measurement of the effectiveness of quality can be realised if the objectives of the service can be specified. In practice this is rarely done and aims, if set at all are usually set in general terms. Finally comparative studies of this nature require the isolation of certain variables of performance and quality which can then be compared to other residential units of similar design. This also presents a problem for the researcher since most services varied widely in structure and design and indeed patient types have also been known to vary widely due to admission criteria being determined by the clinical interests of consultants in some cases. Such studies also take a considerable amount of time to complete and in some cases the results may not be available before the design stage of building projects enter the operational stage of construction! Kushlick and his contemporaries have therefore been criticised for their work but there is no doubt that the impact of their work introduced a new emphasis on quality measurement and the results of their research led many to question the cost-effectiveness of the hospital and the quality of their services.

The exploration of other measures of quality of care was restricted at this time and ranged from attitude questionnaires to staff, through direct observation in ward situations of patient and staff behaviour and so on. These were the approaches adopted by Morris (1969), King (1971) and by Oswin (1971) in their famous studies of hospital life. The results of their work certainly produced comparative data and explored the differences between types of institutional care and nature of the impact of care on consumers. Other measures have been developed in the form of checklists and ward audits, designed to provide staff and managers with guidelines against which to measure the quality of their services. The National Development Group produced such a checklist in 1980 - **Improving the Quality of Services for Mentally Handicapped People**. The Secretary of State, Patrick Jenkin, in his foreword to the checklist stated:

> 'We are all concerned to improve services for mentally handicapped people and in particular to develop those services which enable a mentally handicapped person to live as near a normal life as possible whether in hospital or in the community. For this we need policies and programmes which set us in the right direction and the skills to use available resources to their maximum effect. The 1970's witnessed some remarkable developments in the care of the mentally handicapped We are all aware of how much more needs to be done and of the constraints imposed by limited resources, existing buildings and systems of organization which cannot easily be changed. The problem now is how to translate widely accepted basic criteria into specific elements of a local service' (pIII).

Services for Children.

The 1971 Education Act was the first piece of legislation to bring mentally handicapped children into the education system. Responsibility for educating children with mental handicaps was transferred from the hospital authorities to the local education authority, although in practice many children resident in hospital continued to attend schools located within the periphery of the hospital grounds.

There was an increasing realisation in the mid 1970s that children with mental handicaps should be treated as a priority in respect of improving the quality of care and life they received and experienced. It became accepted practice to keep children at home with their parents as a first option. However there is considerable evidence to prove that many parents had to cope with little if any support from domiciliary support services (Bayley 1973; Wilkin 1979).

In 1974, the DHSS published a paper entitled **'Mentally Handicapped Children in Residential Care'**. This paper outlined proposals to monitor and improve the quality of care for children in all forms of residential care. The report was originally commissioned in response to a scandal in a private home in Suffolk. The report published the following statistics regarding the number of children with mental handicaps in residential care in 1973:

Figure 1.4 - England and Wales

Total population under 16	12,000,000
Severe mental handicap- total	32,000
Of which: at home	23,500
in residential care	8,500
Residential Care- Children under 16:	
In hospital	6,500
In local authority homes	1,000
In voluntary homes	600
In private homes and schools	300
In foster homes	100
Total:	**8,500**

The recommendations of the report numbered 31, and included a plea to ensure that conditions should be as near to 'normal home-life' as possible for the children, that services should be coordinated and that parents should be encouraged to continue to share in their children's care once they have been accepted into alternative care. Annual reviews of child care practice, inspection of homes and liaison with the child's education department were also emphasised.

In 1975 The National Development Group published their second pamphlet and this time their advice was specifically directed at improving services for children. They reported that the number of children in hospitals for the mentally handicapped was falling at an approximate rate of 450 per year. The decrease for 1973-5 for the under fives was 12.1%, for those aged between five and nine 13.4% and for those over nine it was only 6.7%. The team noted that despite a fall in long term children resident in hospitals, there was an increasing number of admissions for short term care. The NDT recorded their support for this trend and encouraged a greater increase in the use of short-term care services. A checklist for action was provided alongside comprehensive assessment profiles to use in association with annual reviews of children's care plans and needs. This report is remembered for its public recognition of the unsuitability of hospital care for the majority of children.

The role of the community mental handicap teams was reinforced in this advisory pamphlet and the importance of a comprehensive children's service was examined and its components described. The National Development Group followed their preliminary advice with a more explicit set of recommendations in their 1978 publication, **Helping Mentally Handicapped People in Hospital**. The advice contained in this document was not restricted to children, but they did have a specific section outlining proposals of **'Putting Children First'**. By this time hospital care was positively discouraged for all children except for those with very special needs. For those remaining in hospital their right to a high quality service was explained and recommendations for good practice presented.

Stopping admissions was a main theme in this report and a list of alternative provisions to hospital was provided to assist social workers and CMHT members when working with families and for whom residential care was being considered. A call for staff ratios to be boosted was made and home-making skills acknowledged as pre-requisites for staff. The significance of bonding between carers as substitute parents and their charges was the basis for this change in emphasis and the work of Bowlby (1953) on this subject helped to increase awareness of family substitute care. His work stressed the importance of maternal and stimulation during the early years of child development and the stultifying and damaging effects of maternal deprivation and impersonal institutional treatment in children's homes and hospitals. Whilst Bowlby's work had great influence on the care of ordinary children, even by the 1970's progress with mentally handicapped children was slow. The following table represents the number of children in mental handicap hospitals during this period:

Figure 1.5: ESTIMATED NUMBERS OF CHILDREN UNDER 16 IN MENTAL HANDICAP HOSPITALS.

Year	1970	1971	1973	1974	1975	1976
No Children under 16	6648	6419	6094	5277	4933	4263

Source: National Development Group (1976) Pamphlet nol DHSS

Collaboration between hospital and schools was increasingly regarded as being of cardinal importance. A working relationship between carers and teachers was not evident in many areas during the 1970s. However many of the principles underlying the liaison role between school and residence were outlined in a Government circular in 1974 (DES 5/74). One of the main principles was to recommend that children should attend school outside the hospital campus, although according to the NDG (1978) only 7.7% of children resident in hospitals in England attended outside schools in 1975. Where liaison between carers and teachers was in evidence joint programmes were often devised based on sound educational principles and continued at 'home' when school was over. Joint assessments of the child's needs were also recommended:

> 'Differences in behaviour between two settings can also be highly instructive, and can form the basis of a joint approach. Similar experiences of collaboration between teachers and careers in day special schools has shown that joint assessments of this kind can lead to well designed programmes. Indeed we believe that more nursing staff could be encouraged to work with teachers within a joint training framework. Not only are nurses working as substitute parents, but they have been increasingly successful in learning and using systematic teaching methods' (p17 NDG [1978]).

During the latter half of the 1970s, experiments began on the integration of children with mental handicaps in mainstream schools. This debate marked a radical change in public attitude and tolerance towards children with mental handicaps and opened up discussions on the relevance of improving the children's social opportunities against the relative security of the special school with its intensive teaching methods. Section 10 of the 1976 Education Act advised schools that they should attempt to integrate children with handicaps into ordinary schools unless this was considered to be 'impracticable'.

In 1978 Lady Warnock presented her report on the educational needs of handicapped people and produced a set of wide ranging topics for discussion on the range of provision that should be available. In her report she identified the need to regard children as children first and positively reacted against their segregation by 'labelling'. An agenda for action was included to meet her three main objectives and principles - practicality, efficiency and cost. She emphasised that integration was a desirable goal and that its achievement would not be a 'cheap option'. She placed responsibility for the implementation of her report on the government:

> 'Parliament having willed the ends, we would expect the government to will the means' (para 19.17).

Whilst changes in the philosophy of the education of mentally handicapped children may not appear to have a direct effect on residential care practice, they have had a considerable influence on the way in which nurses deliver their skills as recognition of the educability of handicapped children and adults is accepted. Mittler (1979) recognised its importance:

> 'It now seems obvious to us that education of the mentally handicapped is not only worthwhile on humanitarian grounds but is technically possible to a greater extent than we have previously thought. We need to convey this to the general public, to teachers and carers, and to educational administrators who determine the resources that are to be given to special education' (p102).

The coordination of child health services also received attention at this time and came in for considerable criticism from consumer groups and statutory services. Little acknowledgment had been given to the increased demands placed on the community services as family care was encouraged and identified as the model of preference. Services were still concentrated on the philosophy of hospital based care and all too often families had little choice between coping alone at home or accepting residential care as an alternative. Paediatricians, mental handicap specialists, educationalists, health visitors and social workers all contributed to meeting the needs of the handicapped child and family but there was little coordination in how services were delivered, and certainly no attempt was made to evaluate the quality of service at the point of delivery.

This general state of affairs led the government to commission a review of child health services and in 1976, Professor Court published his report on this subject. The Report recommended that paediatric services should be rationalised in order to provide comprehensive services to children wherever they lived. The role of Specialist Health Visitors was described and the concept of multidisciplinary District Handicap Teams, introduced with the specific aim of assuming responsibility for the coordination of services to all handicapped children (including mentally retarded young persons). The team made recommendations for the integration of all child services within the 'District Handicap Team':

> 'A District Handicap Team should be established in each district based on the DGH, the basic staff to compromise a consultant community paediatrician, a nursing officer for handicapped children, a specialist social worker, a principle psychologist and a teacher with wide experience of handicapped children, together with supporting administrative staff' (para14.3.). The planning and development of an integrated health service must be done in such a way as to facilitate at every level the closest possible working relationships with these other services (para5.25).

The report provided the basis for the acceptance of 'a voice for children', and urgently called for the transfer of residential services for children from mental handicap hospitals to the 'special units' in the local District general Hospital (para14.24). Health surveillance for all children in residential care was also recommended with a published 'annual statement' being made available of all children in statutory and voluntary/ private sector care. The rights of handicapped children were emphasised in this report which has since been regarded by professionals as a turning point in the history of care for children with mental handicaps within the health service.

The government confirmed its commitment to providing children with improved living environments by launching a number of initiatives to reduce the number of children in long stay hospitals. In 1978 money, in the form of central grants and bursaries, was made available for 'health authorities' to transfer children to the community. In 1980 the government launched another scheme, '**The Pound for Pound Scheme**' which aimed to match health authority finance with an identical amount as an incentive for hospitals to transfer their resident children into the community. Developments in foster care provision, expanded short term care services and local authority developments were witnessed and the population of children in long term care in hospitals fell drastically to twenty five percent of their former number in the ten years from 1975. Support for families in the community also increased as community mental handicap teams extended their services to special schools and the home. Whilst long stay admissions reduced, short stays continued to increase to a point where short term care became accepted practice in most hospitals although the range of provision is varied from long stay hospital wards to respite or alternative family placement schemes. All in all there has been general acceptance of the need for domestic style housing and for home making skills for children who required residential care, this trend which had been set for the children's services was soon to be extended to adults with a mental handicap.

Figure 1.6: Admissions and Discharges from/to Mental Handicap Hospitals (England) by age.

Admissions

	Numbers (thousands).				Percentage change change in numbers	Rates per 100,000 (mental handicap pop)			
	1980	1981	1982	1983	1982-1983	1980	1981	1982	1983
Persons									
0-4	0.8	0.8	1.0	1.0	+ 0.0	27	29	33	34
5-9	2.5	2.8	3.1	3.5	+14.9	79	94	108	128
10-14	3.9	4.5	5.2	6.1	+17.3	106	124	146	176
15-19	3.9	4.5	5.4	7.0	+30.7	104	118	138	180
20-24	2.6	3.1	3.6	4.8	+30.5	76	90	100	128
25-44	3.7	4.6	4.9	6.4	+29.9	30	37	39	51
45-64	1.2	1.3	1.5	1.8	+25.7	12	12	14	18
65 & over	0.3	0.3	0.3	0.5	+48.8	4	4	5	7

Discharges

	1980	1981	1982	1983	1982-1983	1980	1981	1982	1983
Persons									
0-4	0.7	0.8	0.9	1.0	+ 6.3	26	28	32	33
5-9	2.5	2.8	3.0	3.5	+16.2	78	94	106	128
10-14	3.9	4.5	5.2	6.1	+17.7	105	124	145	176
15-19	3.9	4.5	5.3	7.0	+31.2	103	116	136	179
20-24	2.6	3.1	3.7	4.8	+30.4	77	91	101	128
25-44	3.9	4.8	5.2	6.7	+28.2	32	39	42	53
45-64	1.7	1.8	2.0	2.4	+21.2	16	17	19	23
65 & over	0.8	0.9	0.9	1.1	+16.1	12	12	13	15

Source: Statistical Bulletin - DHSS - No2/85 p6 & 7.

KEY ISSUES ARISING FROM THIS CHAPTER.

- an appreciation of the historical and social context within which care for people with mental handicaps has developed is essential if an awareness of the role and function of mental handicap nursing is to be gained;

- societal attitudes have shaped the nature of care for this client group and these in turn have conditioned the process of nursing within an institutional model of care;

- over the period of one hundred and fifty years the economic, social, clinical and psychological determinants of mental handicap have changed and this in turn has required the nursing profession to adapt to meet changing needs; the nature of mental handicap nursing is therefore conditioned by prevailing moral, social and economic values;

- the nurse's role has been influenced by the introduction of legislation over the past one hundred years which was designed to control treatment practice and to determine models of care;

- the role of nursing with this client group is influenced by the current model of care practice prescribed at the time. Each model has required its own approach, standards and responses and these in turn were written into the nurse training syllabus. Models have moved between custodial, medical, therapeutic and psychological practices and were dependent on resource allocation and the value systems in operation at the time;

- mental handicap hospitals and asylums could be characterised as total institutions and their nature influenced both residents and the nurses who worked with them (see Chapter Four);

- people with mental handicaps are dependent on care regimes and individual staff practices in respect of the quality and type of care they receive. The hospital model tends towards custodial care whilst care in the community emphasises quality of life as a major determinant;

- following the publication of the 1946 National Health Service Act, the NHS became the primary agency providing care and support for this mentally handicapped people . This has been challenged in recent years as Social Service Departments have shared responsibility. The division of labour between statutory agencies has had a significant impact on the role of nurses and influences the boundaries of professional practice and job security;

- an awareness of the needs of this client group has led to the introduction of external validation and inspection of hospital services following a number of public enquiry reports during the 1970s. A growing body of public opinion and awareness of mental handicap and its associated care models has greatly influenced nursing practice;

- care has now extended beyond the institution to include domiciliary practice and support in community based residential facilities;

- children are no longer dependent on hospitals for their residential needs and nurses no longer hold the majority interest in their care;

- by 1979 the in-patient population of mental handicap hospitals had reduced by 40% compared to its maximum in 1938.

Chapter Two

Residential Care for People with a Mental Handicap:

The Current Policy Perspective 1979 - 1990

The Jay Report - A Charter for Change.

In 1975 the Secretary of State for social services, in a speech to Mencap, announced his proposals for the establishment of a review of service provision for children and adults with a mental handicap. The Secretary of State reviewed the implementation of the 1971 White Paper Proposals in a speech made to Mencap (July 1975):

> '...We must be disappointed that there has not been that dramatic change in attitudes nor, as a consequence, that improvement in collaboration and joint planning between health and local authorities which was, and is, central to the full success of the White Paper's strategy. The relative lack of progress with collaboration and joint planning may partly be due to the upheaval of reorganisation in both services and the uncertainties that preceded re-organisations...But public expenditure is also tight, and we shall only keep up to the targets in the future if local authorities give mental handicap a higher priority than some other pressing demands on their capital programmes' (Para19).

It was in the same speech that an announcement noted the establishment of an 'inquiry into mental handicap nursing and care':

> 'Thirdly, I propose to establish an inquiry into mental handicap nursing and care to follow up in greater detail the ideas which have been tentatively mentioned in the Briggs Report on Nursing. I am glad to say that Mrs Peggy Jay, who is member of the Central Health Services Council and who has wide experience in the National Health Service and in local government, has agreed to be the chairman of this committee' (para34.ii).

The Jay Committee considered evidence from across the country and its members made extensive visits to local services and hospitals. Its membership was drawn from nursing, education. social services, psychiatry and from university lecturers. Within the report a statement of main principles for future service delivery was presented. These were:

> 1- Mentally handicapped people should use normal services wherever possible;
> 2- Existing networks of community support should be strengthened by professional services rather than supplanted by them;
> 3- 'Specialised' services or organisations for mentally handicapped people should be provided only to the extent that they demonstrably meet or are likely to meet additional needs that cannot be met by the general services;
> 4- If we are to meet the many and diverse needs of mentally handicapped people we need maximum co-ordination of services both within and between agencies and at all levels. The concept of a 'life plan' seems to be essential if co-ordination and continuity of care is to be achieved;
> 5- Finally, if we are to establish and maintain high quality services for a group of people who cannot easily articulate and press their just claims, we need someone to intercede on behalf of mentally handicapped people in obtaining services (DHSS 1979 p36-37).

The Report achieved recognition as a major contribution in the history of mental handicap care and the principles it expounded are still used as the main foundation for community care services at the present time. Perhaps the most important elements of the report were those relating to the rights of people with a mental handicap:

- to live like others in the community;
- to live, learn and work in the least restrictive environment appropriate to that particular person;
- to use normal services wherever possible.

It was suggested by the committee that existing networks of local services should be developed by diverting additional resources to community based services rather then continuing to invest in hospital models of care. To meet the many and diverse needs of mentally handicapped people and their families, what was needed was maximum co-ordination of services between hospitals, family based care and between service agencies. The concept of 'life planning' has now been accepted as the cornerstone for service development and is currently accepted practice in all services. The need for support for the family was reinforced and foster care was recommended as a substitute for residential care. Residential care was accepted as an alternative to life at home but the report recommended that this must take place in surroundings and circumstances as close as possible to those of normal life in homelike conditions.

More specifically the report recommended that mixed sex accommodation should be provided and that service users should be given greater control over their lives and have the opportunity to take risks and to take responsibility for decisions made in respect of their lives. Research was undertaken by the committee to determine background information regarding the range of handicaps, the age of residents and where care was provided. Extensive visits were also made to local services and to hospitals and consumers and their families were consulted. In total information was collected from six hundred organisations and the committee based their final conclusions on the 'perceived life experiences' of people with mental handicaps (p4). The recommendations of the report fall into four main areas consisting of staffing ratios, staff training, residential accommodation and financial resources:

Staffing Ratios.

The report recommended the appointment of 60,000 more residential care staff and this represented a 50% increase in the workforce. Of these staff 50% should have a formal qualification and the other half should receive in-service training. The committee acknowledged the shortage of qualified nursing and social work staff and suggested that the 'bulk of extra resources must go into the recruitment of trainees (who will become qualified staff)' (p64). In order for appropriate models of care to be delivered a new caring profession was envisaged with the hope that the majority of existing staff - nurses and local authority care workers, would choose to join the new mental handicap service. The committee also called for a new training structure to attract workers was also envisaged which would be flexible enough to take in a wide range of age groups. Men and women were required in equal numbers, to maintain a family model of care.

Staff training.

One of the most dramatic changes recommended by the report was in the training of residential care staff. In order to meet the demands of a predominantly unqualified workforce the training had to be efficient and comprehensive in design if the increase in qualified staff envisaged was to be realised. The new model of care also called for the retraining of existing staff and together the authorities were set to face an expensive and marathon training exercise if the highest standards of care were to be offered to people with mental handicaps. The essence of the training was to unite the skills common to all forms of residential care irrespective of the employing agency. The committee saw that the basic human needs of people with mental handicaps were the same whether they lived in local authority or National Health Service accommodation. The concept of a common training was also introduced to develop a common career structure within a new unified care model within which staff would be free to transfer between employing agencies with ease.

The most crucial and controversial question was who was to provide the training? In considering this question four options were presented:

- To continue with separate nursing and social work training within nationally recognised curricula;
- To transfer responsibility to the General Nursing Council for all training;
- To establish a separate training authority;

- To give the Central Council for the Education and Training of Social Work (CCETSW), total responsibility for the training and education of all residential care staff.

The committee finally chose the fourth option and recommended that the Certificate in Social Service (CSS) as the appropriate qualification for all residential care staff. This course offered a practice based learning experience for students over a two year period with concentration on social and educational aspects of care. The committee rejected the other options on the basis that nursing was too medically orientated for the model of care they desired and that the concept of a new training body was too difficult and expensive to establish (and possibly dominated by medical models of care). In addition they envisaged the need for various forms of in-service training for all levels of staff in the form of induction and refresher courses.

In order for the new qualifying training to work smoothly and effectively the General Nursing Council (GNC) and CCETSW would have had to have worked in harmony and in cooperation with each other. A new syllabus of training was required which would be approved by both training bodies and formally recognised. If the proposals had been accepted it would have effectively signalled the end of nurse training.

Accommodation.

In order for the objectives of the report to be realised, a workforce was required that would have the right qualities and attitudes to enable mentally handicapped people to live fulfilled lives. Hospitals were certainly recommended for closure and the move towards community care accelerated in principle. The report acknowledged that care should ideally be provided in the family home. When residential facilities were required it was recommended that they should form an integral part of the community and as such should be small and domestic in nature. Thus the pace of change for hospitals would be determined by the number of alternative community services that the local authority and the health authorities were able to provide and manage.

Finance and implementation.

A new dynamic management structure was called for within which staff played a leadership role with their clients in shaping and managing their service and resources. Nurses were to be encouraged to accept the new proposals and to undertake conversion training and in return new conditions of service and career pathways would be provided. A major increase in government finance to implement the proposals was called for and in magnitude this was to match the major shift in professional and public attitude that the report called for.

The Jay Report - responses and minority views.

The report elicited a varied response from consumers and professionals and received a turbulent passage throughout the nursing profession. During the middle of 1979 the Nursing Mirror ran a national campaign to reject the anti-nurse aspects of the committee's recommendations and used the slogan, 'No Way Mrs. Jay!'. The report was not accepted by all members of the working committee and a minority report was sponsored by the health union COHSE. In this report the training proposals were rejected but the call for improved resources and community care were supported. In total there were three dissenters on the Jay Committee who presented various alternatives from a new separate training profession to the maintenance of the status quo.

Many felt that the proposed model of care would not meet the needs of all people with a mental handicap and that a substantial number of people would be left within hospital in without stimulation. The emphasis on the failure of hospitals to meet the needs of this client group was also challenged and reports were carried in the professional press which suggested that the committee had underestimated the skills that profoundly handicapped people would require. Certainly the committee underestimated the allegiance that mental handicap nurses had to their profession and with one voice the profession rejected the proposals. The suitability of the local authority as the lead agency was also rejected on the previous 'track record' of this agency (Nursing Times March 1979). As one senior nurse stated at the time:

> 'All in all, such a scheme can work only if it commands a consensus of approval from those concerned, and most of all from mental handicap nurses. If the majority of nurses reject the proposals for the dissolution of their profession then the new government must act quickly and decisively to shelve the report. It is the mark of a profession that it manages its own affairs, and practising nurses must speak at once with a clear voice. Only they can decide, and they have a responsibility to vote now with their pens, rather than later with their feet' (Wood 1979 unpublished).

In July of 1980 the government did respond to the report and whilst 'appreciating their appreciation for the Committee's dedicated approach and hard work' (p1) issued the following statement:

> 'The Committee's philosophy and model of care for mental handicap services envisaged a radical change from the present pattern of services to one based on smaller and more local residential units in the community. Whilst welcoming their approach, we have to accept that this shift will be gradual and will take longer than the Committee had hoped, particularly in view of the necessary restraints on public expenditure. We also take the view that most severely and multiply handicapped people will always need some form of NHS care and more experience is needed on whether this can be provided within the Committee's model of care. In these circumstances whilst we accept the principles underlying the Committee's recommendations we believe it would not be right to urge immediate fundamental changes to the present training arrangements. This is not, in our view, the time to abandon a well tried form of training for nurses - who will continue to provide the majority of mental handicap care staff for some time to come - for one which is comparatively new, and vigorously opposed by nurses and major voluntary organisations...' (DHSS (CNO 80 6).

There is little doubt that the government had sympathy with the residential care model proposed by the Committee but found the cost of implementing these proposals astronomical and the training unacceptably controversial. The report was therefore formally rejected by the government on these grounds but the recommendations were to earn recognition in the future plans for community based services.

The report of the Jay Committee was published at an opportune time. Financial constraints inhibited the development of local authority services and, although the building of adult training centres continued, the building of new hostels had virtually come to a halt. Health authorities had become increasingly perplexed about how to to promote joint planning with local authorities and, apart from an expansion in the numbers of community mental handicap nurses (Hall and Russell 1985), there had been little real progress in the initiation and development of new services since the reorganisation of the National Health Service in 1974.

By emphasising the principles around which new services might be planned, the Jay Committee facilitated the development of a number of options for people with a mental handicap and of meeting local needs. The publication of 'An Ordinary Life' (Kings Fund 1980), the 'Guy's Health District Plan', (Guy's Health District 1981) and the handbook on local services published by the British Institute of Mental Handicap (Simon 1981), provided much of the stimulus for the initiation of change in the organisation of local services.

For nurses the report served only to lower their already falling morale within the profession Martin (1984):

> 'Morale had been lowered by the publication of the Jay Report which had created a sense of insecurity which, linked with shortages of staff, made the outlook in some hospitals very unsatisfactory' (p211).

Conditions were indeed unsatisfactory and whilst the Jay Committee were concluding their report a public inquiry was published which demonstrated the quality of care for residents in one hospital with very specific problems. This was the report of the Committee of Inquiry into Normansfield Hospital (1978) and was to be the last of the Section 70 inquiries of the 1970's into allegations of poor treatment in hospitals for people with a mental handicap and for those with a mental illness.

Normansfield - the final inquiry.

Normansfield has been described as one of the most revealing and traumatic of the Section 70 inquiries of this period and is included in this chapter to illustrate the important contribution that public inquiries had in revealing and determining the patterns of care for people with mental handicaps in hospitals.

There had been a long history of conflict between the consultant psychiatrist and the nursing and other staff employed in the hospital mainly as the result of his autocratic approach and regime of restricted care practice. The nursing staff were unable to secure the support of the Area Health Authority and the Community Health Council were powerless to secure positive action and as such, in their desperation they planned a strike and called in the media to witness their protest against poor staffing conditions and the behaviour of their consultant psychiatrist. This event was significant in itself, and was the first time that nurses had taken strike action in the history of the National Health Service.

The hospital had been subjected to an autocratic regime which persisted unchallenged for five years under the direction of the consultant psychiatrist. Weak nurse management contributed to the lack of leadership required by nurses working there, and the detached position taken by the Area Health Authority provided no monitoring or positive action to rectify the many problems that were identified. Morale was particularly poor and the residents were restricted to regimented routines without the opportunity to meet their individual needs. The hospital was located in a major South London conurbation and yet its isolation from the local community was identified as being significant to the findings of the inquiry.

The Committee massed 15,000 pages of evidence over 124 days on and had the unenviable task of dissecting conflicting evidence from nurses, doctors, parents, unions and others. Attribution of responsibility for the problems at Normansfield was directed at senior members of staff and at the officials of the Area Health Authority. The nursing hierarchy was removed and all but two of the nursing officers dismissed. Five million pounds were invested and the nursing workforce increased by 30%, new bungalows were commissioned and much of the Victorian building removed from residents' use. However many problems persisted after the inquiry in respect of the of the quality of life afforded to its residents. A recent visit by the National Development Team (August 1987, unpublished), reported that the hospital should now be closed and the residents transferred to the community, 'to overcome some of the difficulties in realising high quality services which had still not been achieved despite the investment of additional financial and human resources' (p26).

The Inquiry report also demonstrated the length of time it had taken before strike action was finally agreed upon and this in itself was without the official support of the union involved. The failure of managers to take preventative action was almost inexcusable when the results of restrictive care practice were so evident. Surprisingly enough, nobody felt the situation to be so serious as to take official or effective action against the Health Authority or its managers. Ironically it was left to the nurses to demonstrate their plight to the media on the day of the strike.

The discovery and reporting of ill treatment and poor conditions has been studied by Martin in his study of the Section 70 inquires of this era. He felt that it was rare for maltreatment to be an isolated affair and suggests that:

> 'Almost always it seems to have been known at 'grass roots' level that certain wards, and indeed certain individuals, 'were bad'. ...One of the facts, therefore, which has to be explained is why people at senior levels, knowing things are wrong, still did nothing effective about them...At a lower level the problem can be even more acute. Operational units such as wards normally have a minimum of two, with a maximum of anything up to seven staff and possibly more if assistants are included. It follows therefore that any act of maltreatment by a member of staff is unlikely to be unnoticed and repeated acts are virtually certain to be known to others. The author found a consensus among experienced nurses, that repeated maltreatment could not escape the notice of the sister or charge nurse, so that, if it does occur, it must at the very least be condoned at that level' (p85-86).

The conspiracy of silence that Martin was referring to is certainly not restricted to any one long stay hospital and may be regarded as a feature of many hospitals where tacit rules and processes exist to protect the sub-culture of the organisation and the workforce. Beardshaw (1981), has discussed the reasons for the failure of nurses to 'blow the whistle' on their colleagues. She identified that staff who complain not only risk the wrath of their colleagues but may also be victimised. The victimisation process may be particularly evident in long-stay hospitals. Martin (1984) summarises this point well:

> 'Here it is sufficient to say that in badly run institutions staff who complain seem extremely likely to to be victimised to a greater or lesser degree. Apart from being unsophisticated such an instinctive defensive reaction is little more than an implicit expression of guilt. Its prevalence tells volumes about the calibre of leadership' (p88).

The concept of group loyalty has also been discussed by Beardshaw as one reason for the non reporting of mal-treatment, and was described by her as being indicative of 'a dangerously inwardlooking and protective character' (p38). The price for disclosure and of breaking the unwritten code of professional loyalty may be high and could result in ostracism or even the loss of a job. More discreet ways of dealing with dissenters might be to control the allocation of overtime, to allocate antisocial shift rotas or to transfer less popular members of staff to 'back-wards'.

The Normansfield inquiry and the reports of its contemporaries clearly had a significant role in shaping the pattern of hospital services, their management and monitoring. It is also, perhaps ironic that whilst these conditions were existing in the long stay hospitals that Peggy Jay and her Committee were forging ahead with plans for a new model of care. The government clearly accepted that the status quo should continue at that time and with the rejection of the Jay Committee's proposals so it rejected the opportunity to publicly seal the demise of the institutions who were still the main residential care providers for people with mental handicaps.

Martin (1984) considers the effectiveness of the Inquiries of this time and their role in securing radical change:

> 'Most social groups tend to conservatism in wanting to preserve their own existence, and, by implication, most of the circumstances allow them to exist. The plans of far-sighted thinkers, of politicians and administrators cannot easily be imposed; they have to permeate all manner of groups before a whole community is transformed. Moreover no one part is independent. Priorities for one tend to be losses for another, so reforming the care of deprived groups may threaten those presently successful and enjoying high status. Improving an isolated mental hospital may not appeal to the public as much as adding to the gleaming equipment of high-technology medicine. ....It is a plausible value judgement. As a means of reform, therefore, the inquiry is only a beginning. The real tests are yet to follow' (p97).

'The Reformation' - the Move to the Community.

The Kings Fund publication 'An Ordinary Life' (1980) set out plainly and convincingly how the life of the most handicapped person could be transformed by living in ordinary houses in the community. The concept of normalisation referred to earlier in this chapter was the foundation upon which these principles were developed and these are summarised below:

1- People with a mental handicap have the same human value as anyone else and the same human rights;
2- More specifically, all people with mental handicaps have a right to live like others within the community and where necessary are entitled to the extra help which will enable then to do so;
3- People with mental handicaps are developing human beings and services should assist them towards the greatest possible independence;
4- People with mental handicaps should be involved as far as possible in decisions that affect their own lives;
5- Services should therefore affirm and enhance the dignity, self respect and individuality of people with mental handicaps; they are people first and mentally handicapped second;
6- Services should support the social networks which people with mental handicaps have already established and thus contribute to continuity in personal relationships;
7- Services should be local, accessible and comprehensive;
8- Existing general services available to the rest of the community (like ordinary housing) should be used, rather than separate specialist services, wherever possible.

Technology was also changing the way in which skills were developed amongst people with mental handicaps and the use of systems such as The Bereweeke Skills Teaching System (Mansell et al 1979), were introduced into residential care practice with the intention of assisting front line staff in developing new approaches to individual teaching for residents. Accompanied by the arrival of the Individual Programme Planning System (IPP) (Blunden 1980), the focus of service delivery transferred from a management base to one which involved service users at all stages of their lives. The IPP is essentially a written programme of intervention and action drawn up by people who are regularly involved with an individual client. Specific objectives are set and ways of attaining these goals are agreed amongst all those working with the client. The plan also specifies the support and skills that will be needed by each service user and in consequence determines the way in which care and staff skills are deployed.

These principles and advances in technology were to form the framework around which community based services were to be designed. A change in attitude amongst the care team was also evident and nurses, recovering in the wake of the Jay Committee's proposals, responded reactively to redefine their training syllabus in 1982 (GNC 1982). The nurses were perhaps forced to re-examine their values and attitude to care practice following the publicity and general public acceptance of the need for major reform in hospital-based care.

The most fundamental change brought about by central government at this time was to reinforce arrangements to transfer funding between health authorities and local authorities in order to adjust the balance of care provision and funding within the statutory sector. The use of joint financing arrangements facilitated the development of new hostel and day service provision and the emergence of community mental handicap teams complimented a general increase in comprehensive service provision within many districts throughout the country.

A consultative paper was published in 1981 - 'Care in the Community' (DHSS 1981), in which the government outlined ways in which they intended that authorities might use resources to achieve more care in the community as an alternative to hospital provision. The report acknowledged that the majority of people in hospital care could benefit from a transfer to the community:

> 'Most people who need long-term care can and should be cared for in the community. This is what they need for themselves and what those responsible for their care believe to be best' (p1).

The report suggested that in order for care in the community to become a reality a transfer of funding would need to be made and that radical changes were needed if client focused services were to be accomplished. This document provided suggestions on how financial resources could be used in jointly planned projects to develop community care for long-term hospital residents among whom people with mental handicaps were included. It was estimated that 33% of all hospital residents could be discharged immediately - approximately 5000 people. The report suggested that care in the community would cost some £2,300 less per place than its equivalent cost in hospital. The improved quality of community based environments and the status of living in the community were considered to be good reasons for the balance of care to move away from an institutionalised model care.

The importance of joint planning between the two statutory authorities was emphasised by the 1974 reorganisation of the National Health Service and the 1981 paper recognised the importance of reinforcing these principles in practice. However many people were suspicious of the government's intentions and were cautious in their acceptance of the package on offer. The professional and staff organisations, for example, objected to the proposals outlined in the Green Paper. Their main concerns were that the funding proposals and estimates were inadequate and that the real costs of community care would be far in excess of current budgets for hospital and hostel/day care. Concerns were also voiced regarding management ability and commitment within the statutory sector to ensure that new projects were encouraged and recognised as a priority. These concerns appeared to be well founded and in 1982 the 'Campaign for the Mentally Handicapped' in its Autumn newsletter reported:

> 'Just over a year ago, it looked as if the government was serious about tackling the central problem of services to people with mental handicaps - the large scale transfer of resources from old institutions to new local services. But no one can suppose the government is serious now. Its decision on Care in the Community makes clear that there are to be no extra resources- and that without them, the best we can hope for is fine words and minor tinkerings with the present system' (p1).

The government was convinced that the way forward was to invest its energies in seeking greater cooperation between the statutory and voluntary sector in realising it's goal of achieving care in the community. In 1982 The Secretary of State for Social Services, in a written reply to a question in the House of Commons stated:

> 'I am convinced that it would be right despite current restraints on resources, to press ahead with a programme aimed at getting out of hospital and into community care as many as possible of those patients who do not specifically require hospital care' (House of Commons Debates Vol28 Col559/560).

In this official statement the Secretary of State made three main proposals:

1- That health authorities should be able to guarantee annual payments to local authorities and voluntary organisations for people moving into community care;
2- Joint finance from health authorities could be continued to thirteen years (previously the maximum time was seven years) with a hundred per cent joint financing for ten years;
3- A programme of pilot projects was to be introduced and a central reserve of £15 million was to be maintained for this purpose in order to develop and to assess the programme.

Flexibility was facilitated and health authorities were authorised to make payments to housing associations and to education authorities in order to speed up the passage to community care. Bridging loans were also recommended for those people who were in the process of closing large hospitals and for whom alternative provision was planned and the government advised Health Authorities that new provision could be provided in the community by accelerating the closure of hospitals. This may be achieved by investing the monies released from the closure of hospitals in order to 'meet the transitional costs involved' (House of Commons Debates Vol28 Col559/560).

In 1983 the government announced further initiatives in community care legislation and policy. An additional £11.3 million was allocated for joint finance per year both at central level for national project initiatives and at local level to encourage innovation as part of hospital closure plans. A circular was issued by the DHSS (83/56), to reduce restrictions on payments made to local authorities for those people transferring from hospital on a revenue/recurring basis with the expressed purpose of moving resources with patients to provide them with better care at or near their home.

The publicity that the government gave to these new initiatives on the movement of financial resources in England generated activity within professional and voluntary organisations alike. From 1981 onwards reports on Care in the Community, were published by the Independent Development Council (December, 1981), The Campaign for The Mentally Handicapped (September 1982), The Association of Professionals for People with Mental Handicaps (April 1983), and Mencap (June 1986), each of them calling for government commitment to providing additional funding and for the sensitive and rapid closure of hospitals. Requests were also made for the introduction of centrally monitored schemes to evaluate their success of community care provision. Naturally enough the role of consumers as advocates and of the voluntary sector was emphasised and the importance of a consumer/parent lobby dominated the responses. The elements of a comprehensive service were also identified by these groups and in summary these may be listed below:

1- The use of ordinary housing;
2- The development of respite care provision;
3- Meaningful daily activities;
4- The right of people to maintain and develop interpersonal relationships;
5- The right of people with mental handicaps to be represented when they are unable to represent themselves;
6- Interagency liaison and joint planning;
7- The right of people with mental handicaps to share in the planning and delivery of their services.

The first major hospital closure programme occurred at Darenth Park Hospital in Kent and has been well documented by Korman and Glennerster (1986). In their account of the closure they emphasis the lessons to be learnt from collaboration between statutory agencies and stress the importance of consulting with residents, their families and the staff at the very outset of the project. They also demonstrate the problems which residents face when they have to live for several years within the hospital as the closure programme is realised. For those left until the end, they felt that their lives in a 'crumbling environment' were most impoverished. Perhaps some of the greatest lessons to be learnt from Darenth Park relate to the importance that must be placed on re-educating and training existing staff to accept new skills and to participate in the process of service change:

> 'If the objective is to ensure staff stay at the hospital until it closes, then efforts must be made at the very beginning to retain them. They must know from the start that there will be a place for them in the new services if this is what they want. Districts, some of whom had no staff currently working with mentally handicapped people, failed to use the expertise available to them in the hospital to plan their services.....Staff who had worked many years in large institutions were thought to have little to offer a new style of service' (p147)

In summary the government's proposals for joint finance and for the transition to community care were clearly revolutionary but the question has to be answered, did they go far enough to provide service providers and users with the answers they needed to move from an out-dated model of care based on institutional care practice to a new, untested one?

Professor Peter Mittler, ex-Director of the National Development Group, clearly did not think so:

> 'Progress has been delayed not simply because of lack of money but also because of the absence of effective collaboration between local authority and health service staff at all levels. Although local authorities have expanded their provision for people with mental handicaps, at least for adults, the fact is that provision has been made for people already in the community rather than for those in hospital. What is

> really needed is for the wide range of alternatives, now seen to be essential components of a community service to be spelled out. This was a major flaw in the 1971 White Paper which saw community care largely in terms of hostels and adult training centres. Although these are necessary foundation facilities from which a great deal springs, we now think of community services as much broader than that. I am convinced that there has to be some form of central monitoring. It is inescapable and ministers simply cannot evade their responsibilities for ensuring implementation of the Green Paper's proposals under the banner of local autonomy for field authorities. If they do so, then the future is bleak' (Mittler 1982 p18).

Professor Mittler's forecast was to prove correct and not only was the government to underestimate the funding required to make community care a reality but they were also to fail to provide the central leadership and monitoring that he called for. Between 1979 and 1984 only thirteen hospitals had been approved for closure, involving just 500 residents - 2% of the total number of people in hospital. According to Wertheimer (1986) of these only 5% were transferred into local authority homes and hostels, 17% into NHS hostels and community hostels; and the remainder went to other hospitals! (See also Korman and Glennerster 1985).These figures cast doubt on the widespread belief that care in community was marching forward with any speed or direction. Thirteen hospital closures during five years represented slow progress at and Wertheimer's findings suggest that little was done at this time to develop alternatives to hospital. Finance was clearly one main reason for this slow transfer of people with mental handicaps to the community but others have suggested that this was a deliberate ploy to encourage health authorities to rationalise their resources by claiming to have closed hospitals, whilst merely moving residents to other spare beds in adjacent hospital provision. In summary Professor Kathleen Jones, of the University of York, states that:

> 'There will be little progress with the transfer of these patients to the community unless there is an enormous expenditure of time, money and effort. In its struggle to reduce further the mental handicap hospital population, the government's best ally is likely to remain the grim reaper' (<u>in</u> Wertheimer 1986 p25).

In Wales an opportunity arose in 1983 to introduce a mufti-agency approach to care provision through the government's proposal to launch 'The All Wales Strategy' (Welsh Office 1983). The strategy came about following an appraisal of progress in respect of the move to community care in the principality. The Secretary of State for Wales, Nicholas Edwards, believed that the lack of progress in the achievement of targets identified in the 1971 White Paper, required a concerted effort on the part of the statutory agencies who were advised that a new approach to the care of people with mental handicaps and their families should be realised:

> 'there was general agreement that too little progress had been made since the publication in 1971 of the Government White Paper 'Better Services for the Mentally Handicapped'; and that we needed to redouble our efforts to correct the historic anomaly in the development of the National Health Service and local authority provision which has left the bulk of public service provision in large, and for many, remote hospitals whilst the great majority of mentally handicapped people and their families receive little or no support in their homes where it is most needed. This inadequacy of care in the community creates a cycle of dependence on institutional care because this is often the only option open to families who can no longer cope on their own' (Welsh Office 1983 p1)

The main problem was identified as being the lack of a comprehensive and fully integrated service and the dependence on a hospital system of care. More resources were also required and the results of a working party established by the Welsh Office in 1982 advised Ministers that responsibility for the planning and coordination of care services should be transferred to County level. The Welsh Office agreed to undertake a central monitoring and leadership function for the development of a new strategy for mental handicap and identified several priorities for action:

- a coordinated system of planning and management for all services;
- the development of ordinary housing to encourage integration and implicitly the closure of long stay hospitals;
- local estimation of service need;

- the inclusion of consumers at all levels of the planning of local services;
- the creation of individual plans for people with mental handicaps against which to assess their service requirements;
- the development and extension of community mental handicap teams based on a multi-disciplinary approach to care;
- the identification and introduction of a training strategy for all staff involved in the present model of care and of those required for the future model;

The principles outlined in the Jay Committee of Inquiry (1979) were adopted as the philosophical base for the service model and an advisory panel was established at the Welsh Office to steer the strategy and to evaluate its achievements. A new approach to financing the strategy was agreed which effectively placed the responsibility for the allocation of new monies to local counties who were charged with the responsibility to ensure that all development bids were within the total context of the All Wales Strategy. The programming of the strategy was based on the 'priming' of two vanguard areas in Wales who were given advance monies to pilot the main themes of the strategy (Welsh Office 1983).

Whilst there was evidence to suggest that improved services were made available to users and their families, the projected bed reductions were not realised within the hospitals and opportunities for nurses to transfer to local authority employment were not present; their concerns were:

> 'Some nursing staff were not entirely satisfied that their profession was adequately involved in decision making. There was similar but more general concern expressed by doctors including consultant psychiatrists in mental handicap. There was general concern that staff with appropriate skills should have the opportunity of taking part in developing new services. It had to be recognised that varying conditions of service in authorities did not assist in the movement of staff from existing to new services. It was essential not to lose the expertise of skilled staff such as nurses and other health authority staff , who had a great deal to contribute....it was clear

> that some staff were unclear about their precise role in implementing new services and better communication was essential....there was also some concern that posts were advertised in such a way to attract local authority trained personnel when other skills would have been equally appropriate. There was some concern that staff working in hospitals and hostels regarded themselves as being outside of the strategy' (Welsh Office 1987 p7-8).

One of the most controversial recommendations contained within the strategy was that lead responsibility for all future provision should be vested in and taken by the local authorities. For nurses this compounded their low morale in the Principality as service plans failed to take into account the needs of those people still living in hospital. As a result of a local lobby a newly constituted Advisory Panel was established in July 1988 by the Secretary of State for Wales and on this occasion a nurse and medical practitioner were included to readjust the previously reported imbalance of the strategy. The author was appointed to represent the mental handicap nursing profession on the panel in 1988. The specific function of the panel is stated as :

> 'In order to disseminate good practice the Department will need assistance from outside sources. The main source of advice and support will come from the All Wales Advisory Panel on the development of services for people with a mental handicap. The panel will advise the Secretary of State on relevant policy trends in mental handicap and at the request of the Department will provide specific advice on specific issues' (Welsh Office 1987 p15).

The significance of the strategy for the future of residential care within the United Kingdom is considerable since its introduction as a pilot within Wales was surveyed as a potential model for the rest of the country. The extent to which the strategy embraced the complexities of a unified approach to service provision was partially successful. However the strategy failed to recognise the important position played by nurses and hospitals within the total package of care provision. Fortunately lessons have been learnt from the Welsh experience which will be corrected in the future. Perhaps the most important weakness in the strategy was the underestimation of the specialist skills and provision that a significant number of people with mental handicaps will require in the future. The task facing the newly constituted advisory panel will clearly be to readjust the skill mix and service design required to realise the objectives of the strategy if a comprehensive service is to be realised.

Towards a comprehensive service

Community care was also under review in England by the Social Services Select Committee under the chairmanship of Renee Short. The committee considered all aspects of care in the community for the adult mentally ill and for mentally handicapped people. Known more commonly as the 'Short Report' (DHSS 1985) the most obvious problem to face the Committee was how to define community care and how to judge services without reference to a common set of standards or targets:

> "The phrase 'community care' means little by itself. It is a phrase used by some descriptively and by others prescriptively; that is, by some as a shorthand way of describing certain specific services provided in certain ways and in certain places: by others as an ideal or principle in the light of which existing services are to be judged and new ones developed. It has in fact come to have such general reference as to be virtually meaningless. It has become a slogan, with all the weakness that implies. As the National Council for Voluntary Organisations (NCVO) pointed out - 'the pleasant connotations of the phrase can be misleading'" (DHSS March 1985, para 8).

The report acknowledged that there had been a real investment in additional finances for health services but questioned whether the health service was the most appropriate agency to take 'lead responsibility' for the care of long stay community care groups such as those provided for mentally handicapped people. The Committee endorsed the concept of care in the community for people with mental handicaps but recognised the need for adequate finances to be made available by the government and for careful joint planning by the statutory agencies involved in the delivery of care for this client group :

> 'Community care cannot be put into practice overnight. It cannot and must not be done on the cheap. It if were, the effects on thousands of our most vulnerable fellow-citizens could be disastrous. We must ensure that people with a wide range of mental disabilities receive care at least as good as they at present receive, and preferably better. This involves a lot more than reducing the number of hospital beds. It means the creation of a wide variety of alternative facilities...It means that the rest of the community has to be prepared to accept mentally disabled people in its midst. It means the redeployment of thousands of skilled, partly skilled and unskilled staff and a switch of capital resources. None of this is cheap. It is no good imagining that community care will save money. Nor is it easy to plan or implement. The frontiers are still relatively unexplored' (para223 pcxii-iii).

The Select Committee clearly recommended a transfer of agency responsibility for people with mental handicaps from the health service to the local authority and as such was similar in its conclusions to the Jay Committee of inquiry of 1979. The following quote from the Select Committee indicates their thinking:

> 'In the short term we accept that the NHS should not be constrained from providing residential services in the community for mentally disordered people. In the long-term however we consider that it is logically desirable and sensible to envisage all social care mental handicap services , including residential and day-care services, financed and administered by local authorities. We recommend that Ministers create the means to bring about the necessary permanent transfer of resources to local authorities so that by the end of this century they will be in a position to take over prime responsibility for non-medical services for mentally handicapped people. There is no reason to believe that local authorities given the staff and the

> finance, could not provide an adequate service for mentally handicapped people, nor that they would not' (para83 pcxvii).

The Government responded to the Select Committee report in December 1985 (DHSS Dec 1985) and whilst upholding many of its fundamental proposals did not accept that one agency should assume total responsibility for this client group:

> 'The Government shares what it believes to be the Committee's view that at present what matters is effective cooperation in the implementation of agreed policies between health and social services. At such time as it was decided that it would be appropriate to make a central transfer of further resources to local authorities that could be done- though earmarking those resources for the specific purpose for which they were intended would, under current conventions, present greater difficulties' (para 51 p14).

In respect of joint planning and preparation of service users prior to discharge into the community the Government were in full support of the proposals. Similarly they reinforced the need to strengthen the role of the Community Mental Handicap Team and to ensure that the skills of mental handicap nurses were reinforced and fully utilised in the community. As regards hospitals the Government stated:

> 'Health authorities are expected to look (with professional advice) at the whole range of possibilities for the disposal of hospital sites or part sites. Reuse for community mental health services should be determined according to suitability. Any new community facility should be non-institutional, and firmly detached from the hospital ethos....the Government confirms its view that since the hospitals were established in the first place for the benefit of mentally disabled people, this must be the primary consideration in disposing of them' (Para89 p23).

The Government's response drew together a realistic appraisal of what was currently happening in the move to community care at that time. Although this is to be commended, from a philosophical point of view, there was no commitment to provide the monitoring or financial support needed to ensure that alternative services were developed to ensure that a higher quality of life was available to consumers. The report did not provide any specific answers to some of the main problems identified in the Short Report but it did reject the idea of forming a joint management body for mental handicap services and in its place recommended cooperation at a local level between health, social services, education, employment, housing and the voluntary sector. It is also interesting to note the importance the Government placed on the involvement of consumers at all stages of the planning process. The private sector was reported as playing a significant part in the pattern of present and future services and the significance of this this will be discussed later in the chapter. The Government failed to provide central guidance for the planning of services at local level and omitted to provide a satisfactory answer on how services were to be financed or coordinated between the statutory agencies. However the Select Committee report and the Government response did provide a new agenda against which community care was to proceed, albeit at a slower rate than the Government would have liked and with many national inconsistencies in the pace of change from a hospital based model.

The significance of the Select Committee Report was also noted for the interest it generated amongst consumers and voluntary groups. Mencap, for example, published evidence to the Select Committee and explained their position in respect of future arrangements for lead agency management:

> 'Eventually, it would be for the local authorities to provide proper care because we believe this is the long term concept. I would like to say that services for the profoundly retarded and profoundly handicapped people are , as we know, woefully inadequate'
> (Sir Brian Rix _in_ DHSS May 1984 para 188 p97).

During the same session Mencap and the Spastics Society confirmed their approval of closing mental handicap hospitals in favour of adequately funded community developments. This view was also accepted by the major Nursing unions and by the Royal College of Nursing who agreed with the principles of community care although they clearly disagreed that the local authority should be the lead responsible agency. They similarly considered it appropriate for nurses to continue to be employed as a major care-force for this client group and were adamant in their prophecy that nurses were skilled and able to meet the challenge that the changing philosophy of community care would demand compared to outdated models of care in the hospital.

Some parents were concerned regarding the proposed closure of mental handicap hospitals and a new organisation, 'Rescare' (The National Society for Mentally Handicapped People in Residential Care), was formed in 1986 to apply pressure on the Government to reverse its decision to continue with hospital closures and to consider the development of new 'village communities' on a campus type model instead:

> 'This gathering is against the complete lack of adequate funding for the community care policy and the lack of facilities for those with a mental handicap and mental illness already living in the community. We believe that discharges from hospitals should only take place following the comprehensive assessment of individual needs and the provision of appropriate facilities, resources and support services in the community, This is not happening at the moment. We believe that for those people presently being cared for in hospitals, the quality of life and standard of care must not be diminished by dissipating the resources available to them at the moment'
> (Rescare April 1986 p12).

Since its inception the membership of Rescare has grown rapidly to encompass professionals, politicians and parents. Perhaps one of the most significant indicators of this anti-hospital closure lobby, has been the sponsorship that they have received in the House of Commons from M.P.s. who have included Renee Short, the previous chairman of a Social Services Select Committee referred to above who has served as a patron for the organisation. Mrs Short, in a speech to Rescare members in the House of Commons on the 24th May stated:

> 'Mrs Renee Short- former chairman of the Social Services Select Committee; Patron of RESCARE- spoke of the underfunding of the National Health Service and the concern and lack of resources......the plight of the many mentally handicapped and mentally ill people discharged from hospital and ending up in poor conditions....private care homes are a growth industry.....authorities are often too liberal in approving registration......stricter controls needed....30,000 hospital places lost and only 4,000 community placed provided....prison too often the only 'sheltered accommodation' on offer.....less money available for staff training...thank authorities for good practice but seeks publicity for the bad....hospital land should not be sold to speculators but should be used for the benefit of residents...more coordinated planning needed....should not be afraid to challenge government policies....will be delighted to help RESCARE' (RESNEWS 2, 1988 para 1 p1)).

The above quotation is reproduced from the opening paragraph of bi-monthly newsletter from Rescare and has a circulation in excess of 5,000 copies. The organisation has organised its political lobby well and argues that it has directly influenced government policy on the future of mental handicap hospitals. Their philosophy of care was published as a petition in the same newsletter:

> 'We the undersigned register our support for the proposals drawn up by RESCARE and outlined in this petition as follows:-
>
> 1- That there should be an immediate input of adequate funding and resources for people with a mental handicap already living in the community;
>
> 2- The the run-down or closure of hospital homes for mentally handicapped people and the discharge of their residents into open society be halted and an independent re-appraisal of the policy of care for all such people be undertaken;

> 3- That the potential of such hospital homes and/or their sites be realised by their transformation into well proven village communities, which, as centres of expertise, would serve their residents and those living in the surrounding community' (RESNEWS-2 1988 p3 para 2-5)

The Government were not slow to respond to the initial publicity material and statements made by Rescare and in November 1986 issued the following press release:

> 'The Government is committed to developing good quality services for mentally handicapped people according to the individual's needs'. Lady Trumpington, Parliamentary Under Secretary of State for Social Services, has told Rescare in a response to representatives from that organisation:
>
> "There are a good many important areas in which we are and ought to be seen as allies. You want good quality services in hospitals and out of them; you want individual needs recognised and catered for; you want the resources dedicated to mental handicap services increased and not reduced, and used to their best possible effect....I want all of this too, and I am working to those ends.....As you can see I do see both sides and I am conscious of the very strong, opposing views that there are. It is a great pity that so much energy is spent in this somewhat negative debate when there is so much common ground between us - especially when what we want is the best that can be provided for people with mental handicaps - because we are all convinced that Society owes them no less. But listening is a two way process, and there is a growing body of experience to share. You are not going to persuade those who have seen the better alternatives to adopt a ghetto policy, or to draw a line between those already in the community (including those who have never been in hospital) and the minority who are still stuck in large, often increasingly empty and ageing mental handicap hospitals" (DHSS November 1986).

It is hardly surprising that Rescare was so successful in its campaign when many parents of people with mental handicaps had been conditioned to become secure with the knowledge that their dependants were receiving care within a well established model of care. Care in the community posed certain threats to the more familiar and tested model of residential care found in hospitals. Some parents considered that 'ordinary living' might expose people with mental handicaps to additional risks in the community. Many nursing staff also found solace in the ideals presented by Rescare and were able to associate their own feelings regarding the closure of hospitals with those of parents. The final group to associate with the Rescare lobby were a number of psychiatrists who preferred the established model of care in hospitals.

One of the main concerns presented by Rescare was the rapid growth that had taken place in the private/independent sector, which in some areas appeared to be encouraged by statutory authorities as a 'cheaper' alternative to hospital care. Certainly developments within the independent or private sector have increased in excess of the provision made by statutory services in the community. Evidence to support this statement was provided in October 1988 in the Department of Health's Statistical Bulletin published that month. The Bulletin recorded that:

> '- In 1976 there were 11,800 residential places of which about three quarters were provided by local authorities. By 1986 there were 24,400 places but since voluntary and private sector provision had increased faster than local authority provision, the local authority share had become 65 per cent (15,800).
>
> - The voluntary sector, with 4,700 places in 1986, is still larger than the private sector which has 3,900 places. But the private sector has grown faster, with more than a three-fold increase in places since 1976' (p15).

These developments have been encouraged by the financial incentives that health and local authorities have been able to take advantage of as they discharge previous in-patients into the community. Resettlement grants from the DHSS and 'board and lodgings' allowances have reduced the cost of residential care in real terms for statutory agencies. In some cases the the total cost of care has been transferred to the private sector without the need for additional revenue from these authorities and some have become effectively self-financing. Difficulties with rate-capping within the local authority and 'cut-backs' within the health services during the mid to late 1980s, made these new developments increasingly attractive as the demands for new and additional services outstripped the financial resources of the local and health authorities.

The Government introduced new legislation in 1984 (The Registered Homes Act) which provided a definition of properties in the community that required registration under the terms of the Act:

> 'A residential care home is defined as any establishment which provides or is intended to provide, for reward or not, residential accommodation with both board and personal care for persons in need of personal care by reason of old age, disablement, past or present dependence on drugs or alcohol, or past or present mental disorder' (Registered Homes Act 1984 Part 1 para 1).

The Act was passed in response to the rapid increase in private sector developments that had been witnessed in the 1980s. It set standards against which the quality of care for clients could be assessed and monitored and gave responsibility to the local authority to ensure that each residential establishment, with three or more occupants was inspected annually in accordance with the requirements issued in the Act.

In 1987, the Royal College of Nursing, issued supplementary guidelines for the registration and monitoring of private sector developments for people with a a mental handicap. In this document aspects relating to the quality of each persons life were emphasised and a plea made for all private sector developments to be coordinated with local statutory sector services. The Act insisted that individual, daily activities were provided and that all staff working in the residential service should receive training and qualified supervision. The role of the Community Mental Handicap Team was also reinforced and extended to assume responsibility for the monitoring of standards of care in the independent sector.

The number of people transferred to the private sector from long-stay hospitals is not officially available and government statistics do not proved this information. However, general concern has been expressed that health authorities were discharging people from hospital without entering into formal contracts with the proprietors of either private or voluntary sector establishments. Some counties such as Kent, introduced formal contracts which ensured that the private/voluntary sector entered into a valued partnership with the statutory services and thereby extended the range of available choice and opportunities for service users (Kent County Council 1977).

Whilst acknowledging the need for mutual trust and partnership between the voluntary, private and statutory sectors, there were still significant difficulties in monitoring the quality of life/care for service users since the 1984 Registered Homes Act did not make provision for the qualitative assessment of each individual. The Royal College of Nursing in its guidelines (1987) made reference to wide variation in applying the Act locally:

> 'Each district is encouraged to formulate its own guidelines for the registration of private homes in order to ensure that persons applying for registration fall in line with local policies. These policies vary considerably throughout the country. This in itself may provide a loop-hole and may encourage proprietors to chose an area or district in the country where statutory services are sympathetic to encouraging the proliferation of private units. This may result in an influx of private units within a small geographical area, thus causing rapid saturation. It is essential that clear interpretation of the 1984 Registered Homes Act is provided to enable national standards to be set and maintained' (p28.3).

By the middle of the 1980s the government had positively recommended that the private and voluntary sectors had a significant part to play in the development and provision of residential care for people with a a mental handicap. In fact the voluntary sector, (defined as non-profit making organisations compared to the private or independent sector who manage residential care establishments as a business or enterprise for profit), had been playing a valued role through the provision of alternative homes for people with mental handicaps for at least two decades and the National Autistic Association had also established several residential homes for people who had additional needs. The Spastics Society and a number of smaller organisations also made their contribution to developments in the private sector which become formally accepted at this time. The most important and significant event to prove their acceptance was witnessed in 1981 when arrangements for joint finance was were extended to the voluntary sector ('Care in the Community' DHSS 1983). Legislation was passed to allow health and local authorities to transfer funding on a permanent basis for voluntary organisations to provide residential care for individuals. With an assurance of a regular income and grant aid the voluntary sector was set to escalate, which it did in response to demands for new service provision.

Mencap introduced a new scheme in 1984, 'The Homes Foundation Scheme', which invited statutory authorities to enter into contractual arrangements with them to commission residential developments as part of planned hospital closure programmes. Discharged residents were able to claim DHSS benefits and to contribute to the cost of care, and Mencap as a non-profit making organisation was able to obtain additional monies from the statutory agencies as 'top-up' grants.

As a result of developments in both the private and voluntary sectors statutory agencies began to reduce their own investment in capital planning for new residences for people with mental handicaps and concentrated their finances on making provision for the revenue consequences of staff training and redeployment into the community. In some areas health authorities began to transfer their total responsibility for this client group to local authorities, and in others to enter into joint management agreements on the basis of housing consortia with the voluntary sector. Opportunities for ordinary housing were also provided by the Housing Corporation who, in partnership with voluntary agencies were beginning to contribute extensively in the capital planning arena for disabled and sheltered housing developments (Sines 1988 p86).

For people with a mental handicap and their carers these developments offered new opportunities to live and to work in community settings. These schemes are currently subject to local and national evaluation but are making a significant contribution to the provision of comprehensive service design for this client group. One of the main safeguards that appeared to be missing was to ensure that adults with mental handicaps received appropriate services following their discharge from hospital. National consumer groups recognised this omission and as a result an all-party working party was established in the House of Commons to review the rights of disabled people.

The working party reported in the early part of 1986 under the chairmanship of Tom Clarke, M.P. and a Bill was rapidly drafted to protect the rights of disabled people in the community. The Bill was passed without opposition in July 1986 and was enacted as the '<u>Disabled Persons, (Services, Consultation and Representation) Act</u>'. The Act received the immediate acclaim and support of the voluntary sector and local authorities were charged with the responsibility to ensure that its main recommendations were put into action by April 1988. Section one of the Act gave people with mental handicaps the right to appoint an authorised and independent representative to speak on their behalf when approaching the statutory services, in the absence of an appointed relative. Section two outlined the rights and expectations of nominated representatives to have access to all documents and files concerning the individual and also gave them the right to attend any meeting or interview with their representatives. Other sections empower local authorities to assess each persons needs individually and to supply a written statement of the services that the individual is to expect. For those people leaving hospitals after a six month period of time, evidence of plans to meet their needs in quality based services is required.

Responsibility for the ongoing review and assessment of client needs is given to the local authority who, in consultation with consumers and health authorities, which is required to monitor the quality of care in all non-NHS provision.

However, as with the Chronically Sick and Disabled Persons Act 1970, which also empowered local authorities to make practical provision to meet the needs of the handicapped and disabled, the provisions in this Act are not mandatory and are dependent on the availability of finances to make the implementation of the main recommendations a reality. Local voluntary groups have been actively campaigning to ensure that the Act is enforced in accordance with its main provisions (at the time of writing four of the most important Sections have still not been implemented thus reducing the effect the Act has had in empowering disabled and handicapped persons to regulate their own lives):

> 'What of the future? People with disabilities and their organisations, most would agree, must campaign locally and nationally for the properly resource implementation of the Disabled Persons Act. If its implementation is coherently realised with a full awareness of its wider implications, the Act could be the one important contributer to the achievement of a real transfer of power' (Bingley, W 1987 p20).

The rapid advances in general awareness of the needs of people with mental handicaps accelerated the pressures that the government placed on authorities to make plans to close long-stay hospitals in favour of the development of new services in the community. Thus Regional Health Authorities were expected to publish strategies to demonstrate their commitment to realising this objective. In practice national policies varied in their acceptance or adoption of the community care policy and many authorities were confused in respect of funding policies, transfer agreements between authorities and of how to proceed with major hospital closures in the absence of clear guidance and valued alternatives. It was as a result of these concerns that the government requested The Audit Commission to review the financial arrangements used to fund and develop community based services for long-stay groups (December 1986).

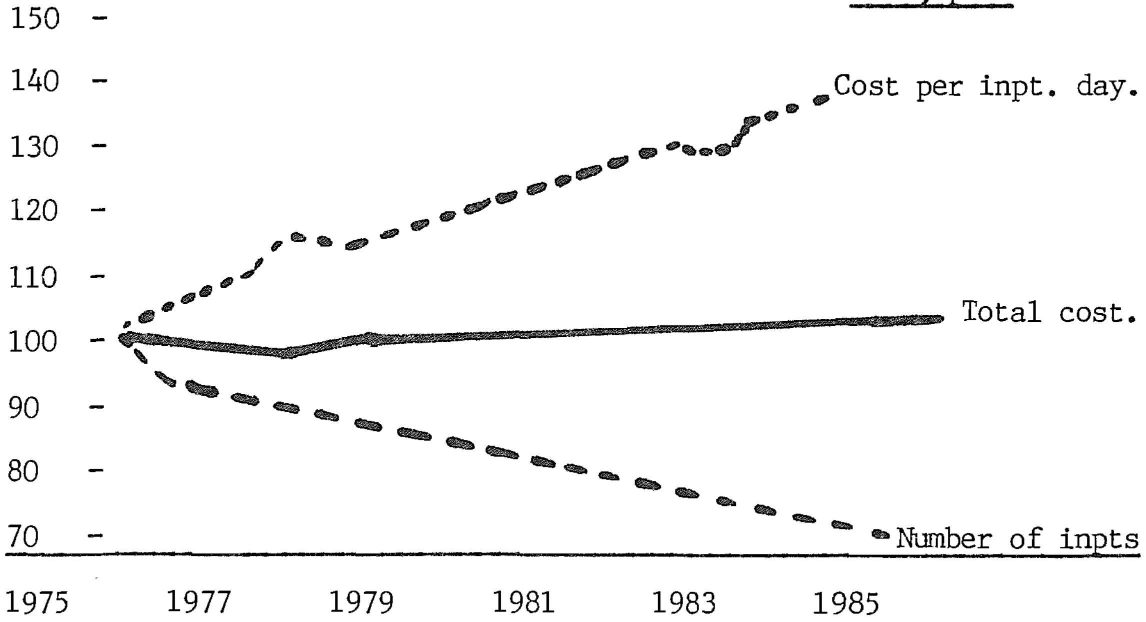
> 'Services for people with mental handicaps are undergoing a revolution. A major restructuring is underway in favour of care in the community. The range and type of services considered appropriate are changing fundamentally. This in turn is shifting the balance of responsibility between different public bodies - notably, the National Health Service, and local authorities, increasing the load both on personal social services, who must provide additional care , and on housing authorities who face increasing requests for accommodation. In addition, the private and voluntary sectors are growing as a result of social security support. Accommodation is also being provided by housing associations and the number of places in private residential homes is steadily increasing by about 20% each year. The task of combining these various considerations to the care of individuals is therefore becoming more and more complex. But the organisational and financial framework within which these changes is taking place is seriously flawed. As a result, local authorities face a herculean task to make community care a reality for people with mental handicaps and to manage the changes currently sweeping through the service' (Audit Commission Dec 1986 p2).

The report recognised the changing role of the NHS and in particular the apparent transfer of responsibility witnessed in some areas for residential care for people with mental handicaps to the local authority:

> 'the burden on local authorities is increasing as the NHS reduces its provision of long stay places in hospital. The process of change appears to be set to accelerate. Many health authorities now have plans to close long stay hospitals within the next ten years, and at least two regions are hoping to close all of their provision in that period. If these targets are to be realised there will have to be a major increase in the rate of resettlement and the people actually being resettled will inevitably be older and more dependent. Health authorities face major problems as a result....the implications of these developments need to be addressed urgently and require a coordinated approach with health authorities' (p3).

The report recommended the development of an integrated approach to care provision which should coordinate the local planning procedures and processes of all the statutory and voluntary authorities/bodies and was summarised in a newsletter produced by the Commission in November 1987. In order to achieve maximum coordination it was felt appropriate for the local authorities to assume responsibility as lead agencies for all care for people with mental handicaps. The health service would have a significant part to play in partnership with the local authority but not as a major, future care provider. They envisaged the development of a new care service based on 'trust and mutual respect between authorities. The health service would continue to train skilled staff and might have a role in the future to care for those people with mental handicaps with additional needs that required medical attention and support. The Jay Committee philosophy (1979) was adopted by the Commission as the foundation upon which to develop local services. Their achievement would depend upon a major shift in responsibility from the health service to the local authority with the NHS continuing to provide general health and psychiatric care through its primary health care services and community mental handicap teams. The following table illustrates the decrease in long stay people in hospital compared to actual increases in cost:

Figure 2.1
MENTAL HANDICAP - NHS INPATIENTS AND COSTS - Source: Audit Commission. 1987, p.3.



In order to realise the objectives of community care the report recommended that the members of community mental handicap teams should have sufficient autonomy to make decisions and to act on behalf of their clients. They saw this as a fundamental principle to providing people with mental handicaps with the right to receive a 'full and valued life and with the same rights as other citizens in the community' (p8).

> 'If community care is to operate effectively, field staff must have sufficient autonomy to make decisions : and there must be a flexible range of services to allow effective choice. At the same time, such autonomy must not be constrained by the policies of the authority, on the one hand by restrictive policies, and by resource constraints on the other. A balance must be struck between the often conflicting demands of the individual's needs and the resources available. A loose - tight arrangement may be suitable requiring a managerial balancing act with considerable autonomy within clear guidelines' (p8).

The report also recognised the importance of training staff in the private sector and of executing greater liaison and control on their methods of operation. The role of informal carers at home was also reinforced with an urgent plea that community mental handicap services should be extended to meet their needs:

> 'Support services have also been diversified although they will normally be based around core teams, such as community mental handicap teams, who will oversee assessment, Individual Programme Plans and placements. Support services also include such services as respite care, domiciliary support services, care attendants and family link schemes...of particular importance is the provision of 'care for the carers' since such support can help to keep families together and make life tolerable for people who might otherwise not be able to cope' (P9).

The Commission concluded their report by emphasising their recommendation that the local authority should assume lead responsibility for services for people with mental handicaps. They did not believe that more money was necessarily required to implement care in the community but they did emphasis the need for cost - efficiency and a reappraisal of the ways in which finance was being distributed and allocated. They recommended that greater use should be made of the housing authorities, housing associations and of the voluntary and private sectors, thus reducing the dependency of people with mental handicaps on the statutory services as landlords.

The government considered the main conclusions of the Commission's report and called for a radical reappraisal of the ways in which community care services for people with mental handicaps were planned, managed, delivered and financed. It called for action to improve community care and as a result in February of 1987, announced its intention to invite Sir Roy Griffiths to review the way in which its community care policy was provided and financed for dependent people in the community. His review built directly upon the recommendations and findings of the Audit Commission and was to be prove highly influential.

One of the questions that was to require clarification was the future role that the health service would play in community based services for this client group. In 1984 the DHSS published a study group report which identified the role of the health service with people with special needs (DHSS 1984). The report's remit was:

> 'To consider: Services for mentally handicapped people with special needs - including both residential and day services required for people with additional sensory handicaps; those who are behaviourally disturbed; and those who are elderly. Services for profoundly and multiply handicapped people will also be included in the review (pl.1).

The report considered the needs of parents and consumers and reinforced the role of nurses and specialist staff in meeting the health related needs of people with additional handicaps and special needs and challenging behaviours.

The practical advice contained in the report clarified, for many practitioners the role of the health service within the context of a multi-agency approach to care. The role of mental handicap nurses was reinforced throughout the recommendations as primary practitioners working alongside other specialists and doctors.

The long awaited review of community care arrived in March 1988 amid major speculation regarding its contents from consumer groups and statutory agencies alike (DHSS [March] 1988). The terms of reference were:

> 'To review the way in which public funds are used to support community care policy and to advise me of the options for action that would improve the use of these funds as a contribution to more effective community care.'(**Community Care: An Agenda for Action**' piii para 2).

Sir Roy used the evidence provided by the Audit Commission (Audit Commission, Dec. 1986), and highlighted the apparent duplication of effort and underfunding in the community and emphasised the need for 'cost improvement and not cost reduction' (piv.8) and rationalisation of government funding policy:

> 'The problem is further compounded by the responsibility for inputs to community care at the centre being divided between the two arms of the DHSS, the Social Security and the Health and the Personal Social Services sides and the Department of the Environment - a feeling that community care is a poor relation; everybody's distant relative but nobody's baby' (para iv.9).

Sir Roy recommended that responsibility for the coordination and design of all community care programmes should be individually tailored and transferred to the local authority, who in close liaison with the health and voluntary services would identify a range of options to meet the needs of each person requiring support. He also acknowledged the regional variations in provision and choice and highlighted the need for closer monitoring of the closure programmes for large hospitals:

> 'Dominant in our visits was the question of the closure of the large mental hospitals. Representations ranged inevitably around the desirability of this policy and problems of implementation. The policy and its implementation are matters of national concern and need to be recognised and handled as such. Each closure needs approval, monitoring and control at the highest level. No person should be discharged without a clear package of care devised and without being the responsibility of a named care worker. This is not simply an administrative or financial process: it is intended to be a thorough process of review to guarantee that there are carefully prepared plans to ensure an optimal quality of life for the individuals leaving hospital' (para v.18).

He recognised that change was required and that the present system was failing to coordinate the needs of community care programmes and of their recipients, and as such his proposals were radical:

- the appointment of a new minister, responsible for community care, its funding and promotion;

- the introduction of a new 'specific grant', to be awarded to local authorities upon their demonstration of cost effectiveness/efficiency through the provision of individual choice/care to service users;

- the insistence on the assessment/review of all people needing support by multi-disciplinary teams;

- the involvement of the private and the voluntary sector in all community care projects;

- the introduction of effective strategies for planning and collaboration between all government agencies and the voluntary bodies, shared with consumers.

- the introduction of an informal care worker or 'community carer' as new occupation with appropriate training;

- the transfer of central government resources to local authorities to finance community care in response to locally determined need;

- the publication of the government's community care objectives, policies and priorities' (para vi.20).

He proposed a new framework for coordination of service delivery between these two agencies and recommended that all monies currently held be 'ring - fenced' for community care. He identified the role of the public sector as:

> 'essentially to ensure that care is provided. How it is provided is an important, but secondary consideration and local authorities must show how they are getting and providing real value' (para vii.25).

He believed that the community itself should choose the range of provision it required and residential care should only be offered/available when all other forms of support had been exhausted:

> 'If community care means anything, it is that responsibility is placed as near to the individual and his carers as possible. I also believe that where the priorities between different client groups may differ widely according to local needs, the right and indeed obligation to determine that should be as local as possible and with the locally elected authority. It cannot be managed in detail from Whitehall, but it has to be managed' (para viii.30).

Sir Roy avoided prescribing a 'lead authority' for the priority care groups in the community and identified that the role of the health authorities in providing residential care was restricted to those people with health or medically determined needs:

> 'An individual's need for long-term care and support may stem from a medical condition that itself requires medical treatment, whether regularly or occasionally. In addition an individual's handicap, or disability may affect their normal acute health care.... The health

> contribution to community care is to respond to both sets of need....It has been Government policy for many years that long stay hospitals for the mentally ill, mentally handicapped and elderly people are not, in general, the right setting for people who do not need both medical supervision and nursing care to be available throughout twenty four hours, although there will be a continuing need for some long-stay hospital facilities' (p4.13).

Responses to the report varied from the Royal College of Nursing denouncement of its failure to acknowledge the role of nursing in community care (RCN March 1988), to the Central Council for the Education and Training of Social Workers (CCETSW) who were concerned regarding the additional resource implications that the recommendations held for social workers and their training (CCETSW March 1988).

The Kings Fund (Kings Fund Institute Sept 1987) in its evidence to Sir Roy's review, was concerned that structural aspects of change had been overemphasised and would have preferred a more concerted approach that reinforced the team approach to care in the community. They wished to see an increase in models and standards of good practice with a clear focus on the local neighbourhood.

> 'Our emphasis is on process change rather than structural change in the belief that an overriding concern with the latter could run the risk of undoing much valuable work that has already been achieved. Moreover structural change on its own will not resolve the matter of the principles and objectives which should underlie community care. We are convinced that in the development of community care there is no 'organisational quick fix' that can be universally applied. In this regard we depart somewhat from the Audit Commission's apparent preference for structural change on a grand scale. We remain sceptical about the claims made for major organisational change while having sympathy for changes which seek to build on current innovative arrangements' (p6).

The Griffiths report identified the challenges that had faced people with mental handicaps and their carers for decades and publicly exposed the complicated decision making processes that has confronted local service providers in their efforts to make community care a reality. Retrospectively there were many examples of good working practice between nurses and social workers for Sir Roy to build upon and despite the negative response that the nursing profession gave to this report for its failure to recognise its contribution to community care there was much sympathy to be found within the profession for most of his recommendations. This was summarised in a lead article in the Royal College of Nursing's Journal 'Lampada'(1988):

> 'As the inevitable debate on the structure of our community services enters its final stages, following the publication of the Wagner and Griffiths reports, one is reminded of the need for Nurses to regard their recommendations within the total context of social policy, and within the political scenario which is currently engulfing the National Health Service. There is a future beyond doubt for those mental handicap nurses who have prepared themselves to face the future with the confidence which their training and experience has provided for them, irrespective of the agency that might manage and employ them in the future' (Sines & Parrish Lampada p15)

A second report was published at the same time as the 'Griffiths Report' and has already been referred to at the beginning of this chapter - 'The Wagner Report' (March 1988). The report was a review of local authority provision for residential care and naturally included comments on the residential services provided by other agencies - statutory, private and voluntary. The second volume of the report contained a summary of research on residential care and identified the chief historical influences that had shaped the current pattern of services for the major client groups, including services for people with a mental handicap.

The main recommendations were that local authorities should take the lead in the strategic planning of accommodation and support services (para 6.10) and that all services should be planned and delivered in response to the identified needs of the client group concerned. The similarities between this report and the Griffiths review are clearly visible with the emphasis being placed on the needs of clients and their families with a full acknowledgment of their rights to contribute to a valued service.

For people with a mental handicap the local authority was identified as being the main care provider of choice, with mental handicap nurses employed in local authority services being required to obtain appropriate social work qualifications to complement their nursing expertise:

> 'Some agencies accept qualifications as relevant for residential care work, eg. with the elderly, but in doing so they ignore some very fundamental differences between social work and nursing. We recommend that people with nursing or other professional backgrounds moving into residential service work should receive relevant 'conversion training' on an in-service basis, and those appointed to senior posts should be expected to undertake professional qualifying training in social work as early as possible' (para 21).

The implication contained in this statement was widely challenged by the Royal College of Nursing in their response to Wagner (RCN May 1988):

> 'The most serious criticism that we have to make is against paragraph 88.21, where people with non-social work qualifications are expected to receive conversion training as soon as possible after entering the field. We believe that this is both devaluing and unacceptable to nurses, at a time when a pluralistic approach to residential care is required. We would suggest that 30% of local authority hostel managers are nurses (mental handicap), and work as recognised heads of home. We believe that this is a personal insult and against the principles of shared training agreed by CCETSW and the English National Board for Nursing and the current trend of shared care agreed by the government....' (p3).

The report made many acceptable and valued recommendations regarding the need for closer monitoring of private sector developments and for the closer scrutiny of all residential care placements. The governing body for social work training (CCETSW), responded in March 1988 and welcomed the report and shared the Committee's view that further work was required in order to 'formulate concrete proposals' (p2). They felt that:

> 'Each recommendation needs to be tested against the present capacities of staff and task-related training must be built into strategies for implementation and full account must be taken of this when preparing costs' (p1).

On the question of nursing and the contribution made to residential care by other professions they stated:

> 'Neither Griffiths or Wagner explicitly values the contribution of other professions - nurses, teachers, psychologists etc. - in residential care for those roles for which their qualifications are relevant. By arguing that they need 'conversion courses' Wagner perhaps inadvertently devalues their contribution. Yet residential work is self-evidently multi-purpose and multi-professional. Furthermore, a by-product of adopting a multi-professional staffing model would have been to reduce expectations of the number of qualified social workers to a more realistic scale. But the relative roles and status of the professions - a sensitive issue - must then be debated and resolved' (CCETSW p4-5).

The Confederation of Health Service Employees (1988) also published a manifesto for future care provision of people with a mental handicap and in so doing called for the creation of a new 'Caring Profession':

> 'Given that the comparison between the health and social services employee role and the qualifications/training, this working party now proposes a new care profession for the support of people who have a mental handicap; such profession to control entry qualifications, training, examination assessment and registration and set up a body

> of practice upon which professional accountability will be based. The above should be within a framework of statutory regulation and a supervisory body' (para 94).

The working party reiterated the principles of community care outlined in the Jay Report (DHSS 1979) and called upon the government to provide additional finance and leadership in taking the community care initiative forward. The role of nursing was clearly spelt out in the document and a future for the profession and its members was advocated in the new proposed model of service delivery.

A planning circular (DHSS July 1988) provided health authorities with guidelines upon which to plan and deliver services for specific client groups. Page 5 of this document related to mental handicap services and identified the following policy aims:

> 'i - To develop at local level, in collaboration with statutory and other agencies, a comprehensive and integrated range of health, social and other services for mentally handicapped people and their families, with provision for assessing and prioritising their needs.
>
> ii - To provide:
>
> a. specialist and generic health care for people with special medical or nursing needs, including small residential units in the community and specialist support for people in other settings;
>
> b. good quality care for mentally handicapped people in all settings including maintaining and, where necessary, improving standards in large hospitals as their populations reduce.
>
> 111 - As a consequence of these developments, to reduce dependence on the larger hospitals for mentally handicapped people. The closure of hospitals is not a primary aim.

> iv - Regional Health Authorities should ensure that no person who was or is mentally impaired or severely mentally impaired, who is awaiting a move from a special hospital to a regional or District facility waits for more than one year (5.2).

The objectives for the mental handicap service were also clarified in the same document;

> 'By 1991 every district should have policy statements and action plans for meeting those needs for which health authorities have the relevant skills, expertise and responsibility. These should be agreed in consultation with statutory and other agencies concerned, and with mentally handicapped people and their families, and should integrate primary and secondary care, as far as possible. They should include:
>
> i - services for people with mental handicaps and other special needs (eg. because they are also physically, sensorily or multiply handicapped). These needs were discussed in "Helping Mentally Handicapped People with Special Problems": DHSS 1984;
>
> ii - the provision of mental handicap nursing, clinical psychology, occupational therapy, physiotherapy, speech therapy and incontinence disability equipment services' (5.3).

The proposals contained in the Griffiths Report (1988) were generally accepted in their overall form and were published in two White Papers: 'Caring for People' - for England, Scotland and Wales (November 1989) & 'People First' - for Northern Ireland (April 1990).

Both White Papers recommended that 'lead responsibility' for mental handicap services should pass to the Local Authority but they also noted the priority that should be given to mental handicap services in the community and confirmed that dependence on mental handicap hospitals would be reduced in the future. The important role played by the mental handicap nursing profession was noted:

> 'The mental handicap nursing profession plays a particularly important role in providing treatment, care and support to people with a mental handicap, both in hospital and in a range of community settings. Nurses' skills and experience are highly valued and will continue to be needed as part of the new forms of service which will be increasingly the responsibility of the Local Authority. The Department of Health will be exploring with the professions, the Local Authority associations, and other interests how this can best be facilitated' (Department of Health November 1989 p12).

The consultation phase commenced in March 1990 and culminated with the publication of National Health Service and Community Care Act (July 1990). This Act was passed following a stormy ride through both Houses of Parliament and represents the Government's attempt to introduce radical reforms into the way in which health and social services are delivered to all client groups in the United Kingdom (despite many requests for amendments to the original National Health Service and Community Bill few changes were accepted by the Conservative Government and the Bill was enacted almost in its 'pure' form). As far as 'Care in the Community' is concerned the following represent the major components of the new legislation (and will all be in place by April 1993 when the government expects full enactment of its legislation):

- a new system of care planning based on joint planning agreements between the local authority, health authority and the private and voluntary sectors (in consultation with housing and Family Health Service Authorities);

- a new system of assessment of care management and assessment (led and coordinated by the local authority);

- new commissioning and purchasing procedures for all statutory authorities;

- revised complaints procedures for service users;

- inspection units to monitor the quality of all services provided and purchased;

- payment of a 'Specific Grant' for community services for people with a mental illness;

- revised financial systems which will transfer responsibility for the purchase of all community services to the local authorities by April 1993 (and thus relieve the Department of Social Security of financing community care residential services).

The contribution of mental handicap nursing was also to be defined and a multi-disciplinary review of the role and contribution that mental handicap nurses could make to the new pattern of service delivery outlined in the NHS and Community Care Act was called for. This took the form of a Chief Nursing Officer review in respect of the four countries of the United Kingdom. The author is a member of this group, the remit of which is:

> 'In the light of the Community Care White Papers and mindful of the multi-professional and multi-agency shape of the future service, review the needs of the mentally handicapped person and identify the future requirement for skilled nursing care' (CNO letter 11.6.90).

After many years of uncertainty the die was cast and the Government finally came out with a statement of support for the mental handicap nursing profession. The CNO review will confirm that the skills of mental handicap nurses are and will be needed in the future but will consider their deployment in community based settings. The consequences for the nurses are many and varied and will require that they are able to demonstrate their skills and competences in the community. Some will be employed by the NHS and others by the Local Authority, the Voluntary and the Independent sector.

Political and ideological considerations

The first section of this thesis has mapped the development of services for people with mental handicaps over the past century or so. The historical and social context within which services have evolved are important considerations but political and ideological influences also have their part to play in explaining why services for this client group have changed so rapidly in recent years.

The post-war years witnessed a massive increase in social service provision which emphasised the rights of the most needy members of society to receive support from the state without charge. However the rapid expansion in state provision was designed to accompany increased productivity and sustained growth in the economy.

Macmillan writing in 1938 in The Middle Way outlined these principles in the Conservative manifesto of that year and emphasised the delicate balance that was required between the expansion of the welfare state and economic development. Clearly a motivated and contented workforce was required to provide the labour necessary to drive Britain through the war years and there-after towards full economic recovery following the crippling cost of the war effort. The provision of services to support the elderly, the sick and 'the handicapped' was therefore clearly on the agenda, thus freeing valuable female labour (which had proven its worth during the war) to support the economy.

However the provision of welfare has not been limitless and boundaries have always been necessary and imposed as McCarthy (1989) writes:

> "Little more than a decade after Macmillan had set out his own boundaries for caring Conservatism and with the modern welfare state barely out of its cradle, a Conservative manifesto warned that 'Britain can only enjoy the social services for which she is prepared to work' [This is the Road 1950]. This phrase demonstrated what has since become both a persistent feature and a continuing tension in

the Conservative Party's approach to the personal social services" (1989 p23).

Consecutive governments appear to have wrestled with the need to balance the level of state benefits and volume of service with the nation's income generation programme. In so doing each government has applied criteria to provide selective access to these services whether it be on the basis of eligibility through the personal taxation system or through the social security system. Such policies have resulted in a redistribution of services as successive governments have selected new policies and targeted new groups of eligible recipients. All of this has taken place against demographic changes and the emergence of more complex needs amongst the population (for example the rapid demand for home care services for the elderly, residential accommodation for people with physical disabilities and changes in child care policy).

Society was also making its demands known and discontentment with 'outdated' concepts of welfare contributed to the need for change. Many consumers, members of the public and practitioners saw the welfare state becoming an institution in its own right. The lack of choice between institutional care for all groups in need in society (children were dependent on 'Children's Homes; the elderly and 'handicapped' on hospitals or 'Part III' accommodation) and the growing belief amongst some that the welfare state was encouraging dependency on the state (and thus reducing personal choice and self-directed activities) provided the governments of the sixties and seventies with much food for thought.

There was no simple agreement on the direction that services should take in the community and the post-war period appears to have been characterised by a lack of consensus on the shape and pattern of community care (possibly this is why mental handicap services were left for so long without change) and in Walker's view (in McCarthy 1989) the hospital model of the day was 'held together because of the remarkable gulf between rhetoric and action and the interest of the most powerful groups involved in sustaining it' p223). As economic pressures began to make their impact in the 1970s the price to pay to sustain outdated models of care became too much to bear and hence radical reforms which reduced dependence on the state were introduced in the form of community care policy.

Hence at the end of the 1970s the economy was characterised by a growing concern for 'thrift' as economic changes at this time emphasised the realities of inflation and reduced productivity. The General Election of 1979 may be regarded as heralding a new era for the welfare state following the success of the Conservative government in gaining power from Labour in that year (McCarthy 1989 p 4). Margaret Thatcher brought with her a commitment to changing the style of the welfare state and the policy content that underpinned it.

The 1979 manifesto introduced the notion of 'self-help' and a return to the notion of personal responsibility and national success. The government, from the outset declared its intention to 'concentrate welfare services on the effective support of the old, the sick, and the disabled and those who are in real need' (Conservative manifesto 1979).

Who declared the need to invest in the mobilisation of the community and the voluntary sector to work in partnership with the statutory services and thus reaffirmed the Tory edict of ensuring that sufficient funds existed before expanding the welfare state (or to maintain it in its then most expensive form).

The 1980's proved to be a significant period of change and challenge to the post-war consensus on the way in which social care policy was to be discharged. The effective end of protected status for public expenditure was noted very early on in the new Government's life (Jenkin 1979) which has resulted in the virtual 'residualisation' of the role of social services as a major community care provider (Walker, in McCarthy 1989 p 204). Walker argues that the main thrust of Conservative welfare policy has been influenced by the following four dimensions that dominated the Thatcher governments since 1979:

'- antagonism towards public expenditure on the welfare state;
- increasing emphasis on self-help and family support;

- extension of the market and commodification of social relations;
- the general breakdown of the social demographic consensus'

(p 204)

The Thatcher government challenged the consensus view of community care and the notion of the welfare state and was able to exploit the fact that the concept of 'community care' has almost always escaped formal or agreed definition. Hence the government was able to build on the accepted statement that community care means 'care in the community' and to replace this by the statement 'care by the community' (Walker 1989 p205). This subtle but important distinction may be seen as the cornerstone to Conservative policy at this time. Similarly the government was able to take advantage of the lack of agreement about the most effective and desirable model to adopt in the provision of care for people with a mental handicap. Power struggles amongst psychiatrists, nurses, administrators, social workers, voluntary groups and politicians provided for the perfect scenario to introduce a new direction of care for this client group.

In keeping with government policy the need for radical reform and overhaul of the social security and health systems was undertaken (NHS and Community Care Act 1990). Reliance on large, expensive hospitals was seen to be not only an outdated model of care but also to be more expensive than models of family based care in the community. Success had also been witnessed in the United States through the introduction of private insurance to pay for health care and a prolific system of private enterprise was challenging the statutory services franchise on care. Thus began the promotion of the private sector in Great Britain which had doubled between 1979 and 1984 (Walker 1989 p 210).

The attraction of securing cost-effective 'packages of care' in the private sector provided many hospital managers with the incentive to embark on major hospital closure programmes between 1980 and 1985. As a result the first mental handicap hospitals this century began to close (despite several decades of decrying the standards of care to be found therein) and the social security budget used to support such people (including elderly persons and those with a mental health need) rose from £6 million in 1979 to £460 million in 1987.

A rapid decline in admissions and inpatient numbers was noted and at the end of 1984, as might be expected, the government acted to stem the flow of money from the social security coffers and froze the limits available for clients and at the same time ruled that the majority of persons who were resident in long-stay hospitals would be excluded from 'discharge benefits'. As a result the rapid exodus from hospitals slowed down and many closure programmes were, in fact, frozen in their turn.

Admissions to long stay care reduced dramatically at this time (see Table 1.6) as community care legislation, referred to earlier on in this chapter took effect. Additional support to families from Community Mental Handicap Teams and increases in social security benefits have also delayed admissions to the long-stay sector.

It may be argued that the residualisation of health authorities and social service departments as main care providers, the centralisation of government control over expenditure, the fragmentation of care provision and increased marketisation of care enterprise have all played their part in the realisation of the Government's policy of reducing dependence on the state. In its place has followed a policy of care by the community, thus reducing state sponsorship and expenditure. These factors may therefore lead to the conclusion that the main reason for the Government's interest in promoting hospital closure (although a reason it has never openly admitted too), may be cost-efficiency with the effectiveness of care received in the community taking second-place (Walker p211).

However, whatever the reason, the Conservative government ended several decades of inertia about the conditions and future of long-stay hospitals. Ministers and their civil servants overcame some of the professional defences and tactics employed by psychiatrists, nurses and social workers and formed new allegiances with consumer groups, the voluntary sector and professional carers. All in all this strategy was to prove to be effective in achieving consensus about the way forward albeit most subscribers to community care policy continue to view the future with some degree of concern and suspicion.

Discussion.

This chapter ends with reference to a new Act (and to its associated political and ideological foundation) which states that community care has set the pattern for future services for people with a mental handicap. The role of specialist nursing within the this model is also to be reaffirmed and the role of health authorities continues to be confirmed both in the provision of residential care and community support service provision. Many reports have been published regarding the future of hospitals and the mental handicap nursing profession and together they have recommended major improvements in the quality of life for this client group.

Historically the heritage of mental handicap care has caused the continuation of a dependency on the hospital model as new residential services are pioneered and tested. In Britain, the asylums were developed with two major purposes in mind. It was believed that both society and the person with a mental handicap would be better off if there was a physical and social distance between them. First, there was the desire to protect the mentally handicapped person from exploitation within society and to allow him the right to live a valued life within the institution as a protected person. Second, there was a wish to protect society from becoming saturated with retarded persons.

In 1946, with the coming of the welfare state the asylums were handed over to the National Health Service and were renamed as 'hospitals'. Henceforward mental handicap was integrated within a medical model of care and the medical and nursing professions became highly influential in service planning and determining appropriate models of care. The need to redefine the methods and philosophical base used in mental handicap care have continued to be debated. Changes in public attitude and levels of public expenditure have determined the pattern of care that has been afforded to this client group and in turn these have been embedded within social policy. For people with mental handicaps and their carers these changes have not always been presented positively or sensitively.

Nurses, for example have been socialised within a pattern of institutionalised care characterised by the long stay hospital. With the institution existed a series of rules and procedures designed to promote and to protect the interests of the organisation. As a secondary consequence these rules provided the residents and the workforce with a culture within which daily practices were prescribed and determined. These systems discouraged free-thinking and little opportunity was afforded to question or to analyse the manner in which residential care practices were delivered.

The nurses, themselves, were also ascribed negative labels associated with the people for whom they cared, mainly due to public ignorance of their skills and competences. Consequently the philosophy of normalisation introduced in the 1970s provided nurses with the opportunity to revalue their skillbase and to seriously question the way in which they delivered care. The enquiries of the 70s and the publication of the Jay Report in 1979 (DHSS 1979) accelerated the process of self-reflection which resulted in the emergence of a new approach to mental handicap nursing characterised by the application of learning theory and an individualised approach to care.

All of these changes have been superimposed on what may be described as long standing power struggles between various professionals and members of the hospital hierarchy. Consultant psychiatrists, hospital administrators, nurse managers and others have been engaged in successive 'battles' for control and their audience [and the passive recipients of the results of these struggles] have all too often been the people for whom the hospital system was purportedly established to care.

Each group of professionals has attempted to influence government thinking and not surprisingly self interest has often dominated changes in policy and social change. Hence, evidence provided to government committees by doctors and nurses may have been perceived to be biased in favour of 'perpetuating the hospital system that served the members of their professions well' rather that focussing on the real needs of people with mental handicaps. Similarly the local authorities have also played their part in directing social policy and have made claims on the 'financial resources' that this client group currently had at its disposal (these changes may not have always resulted in an improved quality of life for service users).

Policy developments have not taken place in a vacuum but have clearly been directed by different (and often conflicting) opinions from those persons charged with the care of people with mental handicaps. Some mental handicap nurses, have, given the opportunity, been able to review their own role and function and have begun to question their ideology and beliefs. A significant number have already transferred their skills to community settings (although the degree of success of this transfer is yet to be 'tested' and evaluated by service users). Leonard (1988) demonstrated in her study of thirty new services for children in the community, that mental handicap nurses were able to adapt the skills that were acquired in hospitals when they moved to community settings. She believed that nurses were, in fact, able to provide the most impressive and successful services for this client group based on their experiences of total care in less appropriate environments (p57).

Some Mental handicap nurses are currently in the process of demonstrating that they are capable of applying flexibility when translating their care practices outside of traditional hospitals. This flexibility is, however, dependent upon nurses being able to make a successful transition to unfamiliar surroundings although some may find themselves without adequate support and preparation for the move. The National Boards for nursing have identified a distinct lack of formal programmes of preparation for staff involved in hospital closure plans. This was also referred to by Korman and Glennester (1986) in their analysis of the Darenth Park Hospital closure process and they concluded that a major opportunity was likely to be missed as some nurses left the profession, disillusioned by the lack of opportunities provided for continuing education (p147).

The changes witnessed over the past hundred years in the pattern of service delivery for this client group have been well documented in respect of outcomes for service users (Health Care, Evaluation and Research Team 1977; Felce 1983). However little research has been undertaken to consider the effects that these service changes have had on the nursing profession and its staff. It might be argued that the disappearance of the institution has removed a number of discrete, but important support mechanisms for staff, who having left the hospital, may find themselves surrounded by new demands on their skills and time, despite the absence of opportunities to share their experiences with colleagues working within dispersed community settings. Some staff in the Author's service are already returning to hospital based services in order to seek the security of the subculture which exists within these institutions. Perhaps it might be suggested that community based services have not yet had sufficient time to be able to establish a culture of their own within which new rules and norms might exist to support staff in their everyday work.

Whilst nurses attempt to redefine their role contribution and to re-establish new working patterns the development of care in the community programmes continues to gain momentum. The reasons for the growth and promotion of community care have been defined by Knapp and Renshaw (1986):

> 'Thus the emphasis on community care is based on three premises:
>
> 1- normalisation (which relates to the criterion of justice or equity).
>
> 2- cost (related to the criterion of economy) and
>
> 3- the preferences and well-being of mentally retarded persons and their relatives (related to the criterion of efficiency)' (p3)

Knapp and Renshaw have, in one statement identified the driving forces behind the government's policy for care in the community for people with a mental handicap. In addition emphasis on multidisciplinary teamwork and the central role of consumers in determining their own futures has pointed the direction in which nursing for this client group must follow as the outputs of community care are set and measured in terms of the quality of life experienced and desired by service users.

However, it remains to be seen whether the power struggles that existed in the hospital have been totally eradicated in the community. Whenever people are 'paid to care' for socially dependent persons, there will always be an inherent danger that resources and relationships will be abused and impositions made on others. Consequently power relations will undoubtedly continue to undermine the quality of care and life that people experience in their new homes and nursing staff will be particularly influential in this matter (this is considered further in Chapter Five).

In conclusion the first two chapters of this thesis have presented the framework of social policy within which services for people with mental handicaps and their families have been provided. The nature of mental handicap and of its associated workforce have changed in response to changes in government policy and public attitude. The future pattern of residential care provision will hopefully be shaped by the needs of the client group as they become increasingly involved in the determination of their own services. Life for many people in the community is new and the features of their life experience are discussed later in this thesis in Chapter Seven; consequently whether the government has been successful in creating effective and valued opportunities for people with mental handicaps as they leave hospital is yet to be evaluated through the eyes of service users.

The next chapter concludes the historical analysis of care for people with mental handicaps and considers the growth of mental handicap nursing as a profession and the significance of the influences that have directed its development.

KEY ISSUES ARISING FROM THIS CHAPTER.

- the 1970s and the 1980s were characterised by major change and witnessed a proliferation of reports and recommendations associated with the future of mental handicap care and nursing;

- the publication of the Jay Report in 1979 presented an open challenge to the future of NHS care for mentally handicapped people and recommended a complete change of philosophy based on the practice of community care;

- the publication of the last section 70 enquiry report on Normansfield Hospital provided the public with insight into the conditions of care in mental handicap hospitals and provided an agenda for action in respect of the poor quality of life experienced by people with mental handicaps living in institutional care;

- staff were identified as being personally responsible for their actions and the 'conspiracy of silence' found to exist in some institutions was exposed thus highlighting the need for public accountability for patient care;

- the 1970s witnessed the introduction of 'an ordinary life' model of care based on the principles of normalisation which in turn challenged nurses to radically rethink their methods of practice and philosophy of care. The result was the publication of a new syllabus of training in 1982;

- care in the community was given full government support in the early 1980s with the introduction of legislation to move monies from hospitals to other agencies thus reinforcing the move towards plurality in agency responsibility;

- consumers and their associated voluntary groups gained power and influence and thus began to oppose outdated models of hospital care and the under-resourcing of care provision;

- the first hospital closures were witnessed and regional strategies began to publish plans to reduce the number of long-stay hospitals to a minimum. This was to have a major impact on the nursing profession who had come to depend on the hospital as their main workplace and 'refuge';

- the Welsh Office published a radical programme of reform based on the principle of identifying and delivering a comprehensive service to people and their families and agreed to transfer its total mental handicap programme to the County Councils;

- the voluntary and private sectors emerged as a contender for residential care provision and offered new opportunities (but not necessarily improvements) to clients and their nurses for residence and employment;

- people with mental handicaps gained recognition as people in their own right and achieved the right to obtain ordinary/generic services and personal advocacy;

- the government commenced a formal audit of the costs and effectiveness of hospital and community care in terms of the quality of life that they afforded their clients and as a result commissioned a series of influential reports recommending the transfer of care for people with mental handicaps to Social Services;

- the 1970s and 1980s were characterised by the prescription of a radically different model of care based on non-hospital based principles. New planning guidelines from the government have supported the need for a new charter for change which has clearly required the redefinition of the role of mental handicap nurses within the context of community based models of care;

- the reasons for these changes in agenda may have have been politically motivated and whilst we have noted that hospitals no longer dominate the lives of many people with a mental handicap the incentive for this change may have also been for economic rather than pure humanitarian reasons;

- the Conservative governments of the 1980s brought about the greatest changes to the British welfare state since the introduction of the 1946 National Health Service Act. With these changes came the introduction of a 'new mixed economy' of care and welfare which was no longer dependent on statutory sector provision. In their place as 'major share-holders' have emerged the private and voluntary sectors; as largely untested contenders for a dominant position in the 'care market', their contribution and effectiveness should be judged in the light of research and objective evidence as it emerges over the next few years.

SECTION TWO

MENTAL HANDICAP NURSING - THE DEVELOPMENT OF A PROFESSION

Chapter Three

The Development of Mental Handicap Nursing as a Profession.

Early nursing for people with a mental handicap undoubtedly had its roots within the family and in preindustrial society support was afforded to the village idiot by the extended family and by local friends and neighbours. Approaches to care were related to Christian attitudes and to a general sense of pity for 'one's fellow men' (Baly 1977). The early church believed that suffering was the will of God and as such was the passport to eternal life. Primitive beliefs were also predominant and were related to the difference between good and evil. A general relationship with witchcraft, astrology and mysticism surrounded the unknown and the unusual and responsibility for the care for the mentally defective fell to the church and its associated religious orders. According to Baly the introduction of the monasteries witnessed the end of the 'early Christian tradition of nursing in the community' (p8). As the monks withdrew from the world into monasteries so the care of people with mental handicaps withdrew with them into hospices and monastic hospitals. The birth of the Priory of St. Mary of Bethlehem (now the Bethlem Royal Hospital) in the 12th century was the first recorded institution of this nature to care for the insane. (It should be noted that no differentiation was made at this time between insanity and mental handicap).

The Tudor poor laws made provision for the sick, the old, vagabonds and for unemployed labourers and prescribed that parents and children must maintain their own relatives, thus reducing the number of dependent people who might require support from the state and the justices. Money released from the religious institutions was used to invest in the development of a number of royal hospitals, the majority of whom remained staffed by nuns and by pauper attendants whose primary purpose was to ensure that custodial care was implemented when the family was unable to care for their own dependants.

The industrial revolution heralded major changes and accentuated the role of the parish as the local unit in whom responsibility was vested for the care of paupers and dependants who were unable to contribute to the economy. The parish elected officials who were funded by the local rates and they attempted to secure paid employment for their charges in order that they could earn their parish relief. Medical care was part of the relief given under the Poor Law and physicians were appointed by the Guardians. The aged, infirm, handicapped and poor sick were traditionally accepted as being valid candidates for care and attendants were appointed to care/supervise them by an Overseer. Employment of nurses in the workhouses was rare, and if nursing was required this was usually provided by other inmates who were expected to meet the needs of the sick and handicapped as part of their duties.

The 'nurses' were an assorted group and the way in which they performed their duties was unregulated (Abel-Smith 1970 p5). The Victorian era introduced a certain degree of moral earnestness which was manifested in acts of social reform and philanthropic investment. As a result investment in new hospitals and asylums satisfied the moral conscience demanded at the time and witnessed the hospitalisation of thousands of handicapped people (see Chapter One).

According to Abel-Smith (1970), the workhouses were not designed to care for the sick or the feeble-minded who often found themselves 'all bundled together in the same mixed institution managed with the one major aim in view - to discourage the able-bodied from seeking support from public funds' (p3). Abel-Smith stated that the antecedants of the nursing profession were domestic servants and nursing 'amounted to little more than a specialised form of charring' (p4). By the second half of the nineteenth century nurses were renumerated and it was not unusual to find the nurses working without supervision, although in the London hospitals, sisters were recruited from higher social classes to oversee the work of the poorer and often illiterate nursing workforce. For those people with a mental handicap the luxury of care by 'trained nurses' was unusual and unless they had the privilege of care in a private asylum their carers were usually fellow paupers. Abel-Smith suggests that hospital nurses were not attracted to working in the workhouses:

> '..Even if the Guardians had wished to obtain experienced women to act as nurses, it would have been very hard to find them. Hospital nurses would not have chosen to look after the chronic sick patients in the workhouses and be employed in due subordination to to the matron who was totally unqualified' (p11).

The matrons of the workhouses showed little regard for the nursing aspects of the daily routine of the institution and according to Abel-Smith their duties 'were varied and multiplied' (p15). Her tasks were not totally dissimilar to the role of the sister described by John (1961), and revolved around domestic and supervisory functions. By 1849 (Abel-Smith 1970) a debate began to question the quality of nursing care offered to inmates in the workhouses and even at this early stage it was suggested that suitable paupers should be given training as nurses. It was at this stage that the famous Florence Nightingale rejected the acceptance of pauper nurses as suitable employees for the profession:

> 'Are we to expect that we shall find suitable women for an occupation which requires, perhaps above every other occupation, sobriety, honesty, trustworthiness, truthfulness, orderliness, cleanliness, good character, and good health, among those who, nearly all, at least in the workhouses of the large towns, are there because they have not been sober, not been honest, not been trustworthy or truthful, not been orderly or cleanly, not had good character or good health, because they have not been one or other of these things, because they have failed in one or all of these? Is it Likely?' (Nightingale 1867).

Despite Nightingale's attempts to reform workhouse training for attendants and nurses, a complete reform of workhouse administration failed and training schemes were restricted to a number of specific pilot projects in city areas. During the second half of the nineteenth century the Boards of Guardians became aware of the need to employ paid nurses and to provide them with some form of rudimentary instruction. Doctors were also concerned that there was a general shortage of trained nurses to meet the needs of a wide variety of people, some who were feeble minded. By 1873 probationary nurses were to be found in voluntary hospitals and a few of these found their way into the poorhouse infirmaries and undoubtedly provided care for people with mental handicaps amongst their patients. By 1900 there were still anomalies in the system:

> 'At the root of this dichotomy lay the philosophy on which the whole system of the administration of the poor laws was ostensibly based. the provision of a high standard of medical care would have been in conflict with the principle of less eligibility' (Abel-Smith 1970 p49).

The philosophical battle between discouraging pauperism and the duties of treating illness led to the gradual division of responsibility for idiots and the insane from the poor sick. The development of the victorian asylums and hospitals witnessed in the later decades of the last century encouraged the employment of a separate group of untrained staff whose primary purpose was to provide custodial care and to reinforce the rules of the asylum in an effort to ensure social control and moral reform. The medical officers responsible for the asylums at the time organised themselves in 1841 to form the Royal Medico-Psychological Association (Walk 1961). The Association developed as the result of a number of informal meetings of prominent doctors to:

- 'to meet annually to cultivate the science of insanity;
- to cooperate in the collection of statistical information (Walk p617).

Out of a total of 47 invitations to join the Association 43 replied positively and in 1841 the members had resolved to engage in reciprocal regulatory visits to member hospitals and to 'record the medical moral treatment adopted in each hospital' (p618). Annual reports were provided and a register of good practice was introduced. By 1853 the Association was publishing its own journal and was resolving to:

> 'discuss the question of cooperation between members in the engagement and discharge of 'servants and attendants' and it was resolved 'that members pledge themselves not to engage any person who had been in service in any other asylum without a character from that asylum, and to undertake to afford each other a full and faithful account of the qualifications and character of persons who may have been in their control' (RMPA 1853 in Walk 1961).

The birth of the RMPA heralded the first attempt to introduce a standardised programme of instruction and training for attendants and carers in mental illness and mental handicap hospitals. The staff, themselves were also seeking recognition and as early as 1865 attendants had organised themselves to form the National Asylum Workers' Union (Abel-Smith 1970), with a view to obtaining better conditions of service. By the turn of the century the training of attendants was the responsibility of the asylum doctors who took great pride in regulating the quality of their workforce and set the scene for the next sixty years as a medical and clinical dominance was emphasised within the profession.

By 1920 the RMPA, now the controlling body, laid down regulations for the training and examination of asylum/mental nurses and provided successful staff with a 'Certificate of Proficiency in Nursing and attending on the Insane'. After 1926 the qualification became known as the RMPA (Ramon 1985). The Association laid down the following conditions for training:

- A period of three months probation had to be completed before the attendant was considered formally to have entered training.

- A period of two years training and service was required before an attendant was allowed to become a candidate for examination,

- Study of the Red Handbook first published in 1885 by a group of psychiatrists on behalf of the Medico-Psychological Association was required. The Handbook was reprinted every three to four years with an edition showing minor changes. The 1921 edition stated:

> 'A good attendant knows his own mind: he has attained self-control; he has a grasp of hygiene, bodily and mental, and possesses those moral qualities contained in the term 'good character' (p15).

The handbook went on to state that discipline was the first duty of the attendant in order to provide the patients with a role model to follow. Attendants 'should themselves, set an example of industry, order, cleanliness and obedience' (p18). Practical instruction and exercises under the supervision of the Superintendent was required and clinical instruction by doctors in the wards, complemented by formal medical lectures made up the total course of instruction.

Specialisation in the care of the mentally handicapped was permissible within the RMPA framework, since it was self regulating within the hospitals where supervised practice/training took place. All hospitals were eligible to register for training and the majority of the larger ones provided courses of instruction of two years duration with the award of a certificate of proficiency (examinations commenced in 1887). Examinations were held twice yearly; the papers were set by members of the RMPA and the Medical Superintendent oversaw the examinations in his own hospital. Failures were rare and on passing the examination candidates received £5.00! By 1934 over 100 asylums were participating in the scheme with between 500-600 certificates being awarded each year (Jay 1979 p12-13).

Staff were recruited from a range of backgrounds but the most favoured were those with a service background and an appreciation of discipline. Probationers were mostly single and were required to live in on the wards and it was not uncommon for them to test their strength of character by sleeping in open dormitories with refractory patients (Nolan 1986 p20). The Asylum Workers Union (later known as the Mental Hospital and Institutional Workers Union) soon put a stop to this on the grounds that the nurses were unable to sleep or to work efficiently. The need to provide a skilled workforces continued to conflict with the domestic function of the nursing workforce:

> 'The need for pairs of hands on the part of the hospitals was always at variance with attempts to raise the standard. While the Council might require that each candidate spent a period of time on each ward, what it could not do was ensure the experience enriched the training of the candidate and not the ward with another domestic.' (Baly 1973 p164).

Despite the care taken by Medical Superintendents to improve the knowledge and skills of their staff many of the nurses remained poorly educated and according to Nolan the training served to:

> 'The training which many of them undertook was not designed to stimulate them into questioning the status quo, but rather to promote compliance to it' (p21).

The 1919 Regulation of Nurses Act introduced the General Nursing Council as the regulating body for the nursing profession. A separate register was kept for male nurses and for those trained to care for 'persons suffering from mental diseases' (Bowman 1967 p162). A register was formed for the nursing care of mental defectives (RNMD) which was later changed to the Registered Nurse for Mental Subnormality (RNMS) qualification in England. The Minister of Health was responsible for implementing the Act and for ensuring that the registers were maintained, examinations held, the regulation of standards of care and for the introduction of a new disciplinary code of conduct for practising nurses on all parts of the register. Nursing had been officially recognised as a profession with granting of a statutory register:

> 'It had been granted what the law and the church had never felt it necessary to seek: a statutory register. It had followed the path of the doctors, the teachers and the midwives, and achieved its objective two years before the dentists. With its military heritage showing in its language, its religious tradition conveyed in its sentiment and its humble ancestory revealed in its uniform, the profession had come of age' (Abel-Smith 1970 p99).

The GNC also aimed to provide the public with safeguards against people falsely claiming to be nurses and discharged this function through the appointment of a number of fulltime officers and elected nurse members. The medical profession were also represented on the Council, thus satisfying some doctors that their power base and influence would continue. By the mid 1920s the Council assumed full responsibility for the syllabus of nurse training although disagreements between the GNC and the RMPA meant that the two regulating bodies continued to award their own certificates in mental handicap nursing for a further twenty five years. When the NHS came into being in 1948 over half of the 6,500 nurses working in mental handicap hospitals in England and Wales were either qualified or in training for the RMPA or GNC qualifications. The majority of these held or were training for the RMPA certificate (Jay 1979 p13).

In the United States psychiatrists had a similar influence within the profession and by 1906 the annual meeting of the American Medico-Psychological Association, discussed the value of training for attendants and nurses in asylums (Church 1987). They published a number of papers and agreed that training was necessary for the workforce. The United States introduced a Committee of training schools to regulate the standards of care in the asylums and hospitals. In fact they believed that mental nurses had greater needs than their colleagues in general nursing:

> 'The amount of intelligence, tact, judgement and skill required to care properly for an insane person person is infinitely greater than that required to care properly for even a surgical patient in a general hospital. There is need of missionary work with the public to teach the importance of intelligent care of the insane' (Cowle 1906).

One other development to enhance the status of the profession of nursing was the launch of the Royal College of Nursing in 1916. The College charter identified the following principal objects:

1- to promote the better education and training of nurses and the advancement of nursing as a profession in all or any of its branches;

2- to promote uniformity of curriculum;

3- to recognise approved nursing schools;

4- to make and maintain a register of persons to whom certificates of proficiency had been granted.

5- to promote Bills in Parliament for any object connected with the interests of the nursing profession and, in particular, with nurse education, organisation, protection, or for their recognition by the state' (Bowman 1967 p34.)

Membership of the RCN was exclusive to females whose names appeared on the General Register and continued until 1957 when the Nurses Act replaced the General Register with one Register with various parts including a specialist branch for nurses for the mentally handicapped (RNMH). In 1960 the RCN extended its membership to male nurses for the first time but it was not until 1984 that it recognised the specialist needs of the mental handicap nurse and introduced a 'Society of Mental Handicap Nursing' with its own full time nurse adviser (the Society of Mental Handicap Nursing was to become a significant entity within the Royal College of Nursing by the end of the 1980s in respect of the important role played by the speciality in influencing the development of community care for 'priority client' services).

In 1937 the Society of Registered Male Nurses was founded and marked a major era of transition in mental and mental handicap nursing. According to Edgers (1989), the Society was introduced in order to address the imbalance of skilled nursing care in a profession dominated by unqualified attendants who 'regarded training as an unnecessary imposition, considering a knowledge of first aid to be all that was necessary for their job' (Edwards p51). The RMPA had, however by this time, gained the status required to regulate access to promotion and those people who held either a GNC or RMPA qualification became 'nurses' as distinct from a number of their colleagues who were unqualified attendants. The Royal College of Nursing offered its premises for the organisation's meetings and at its inaugural meeting in 1937 a proposal to extend membership to those people holding the RMPA certificate was defeated, thus restricting membership to those with a GNC award. Before the end of the year the new organisation recommended that hospitals should dispense with the RMPA training in order to attract higher salaries equal to those received by general training. The Society flourished, and by 1945 had 12,000 members working in mental and mental subnormality hospitals, (a further 3,470 members were general nurses). By this time there were 24 training schools and five affiliated training schools for male nurses. (Edwards 1989 p53). The Society continued to raise the standards of the profession and to represent its members until the RCN opened its doors to male members and thus ended the pioneering phase of the profession's development.

In 1946 a working party was established by the Minister of Health under the chairmanship of Sir Robert Wood to determine the 'proper task of the nurse' and what training they required to fulfil their responsibilities. The working party consisted of the chairman, two nurses, one doctor and a psychologist and when it reported in 1947 its results were timely for the inception of the National Health Service. The report recommended an increase in trained nurses and identified ways to reduce wastage. The committee challenged the attitudes of hospital matrons and senior staff and was, not surprisingly given a cool reception by the Association of Hospital Matrons. The committee recommended that trainee nurses should be afforded full student status and that the '33%' of their time given to domestic duties should be reduced and allocated to professional tasks and responsibilities. One of their main recommendations was that the independent training schools should amalgamate into larger schools of nursing which should be coordinated by a Regional Nurse Training Board. Responsibility for monitoring the standards of teaching, admission and examination would be delegated to this body. Its final recommendations were in respect of assistant nurses and proposed a major increase in ward orderlies and nursing assistants. The recommendations were not universally accepted and it was not to be until 1966 that formal entry qualifications were to be introduced and, indeed, 1988 until the principle of full student status was to be conferred on entrants to the profession.

In 1948 with the inception of the National Health Service the opportunity arose to distinguish between the social welfare functions and the hospital functions of the old Public Assistance institutions. For the mental deficiency services responsibility was transferred in total to the NHS hospital authorities. According to Jay (1979) this was partly due to the psychiatrists' need to be identified with their medical colleagues in the NHS and thus ensure that their patients did not receive 'a second class service' (p14). Local authority services did have some responsibilities for mental patients and these were for after care and rehabilitation.

Staff salary interests were to be represented by a new Whitely Council which was formed in 1948 and which, as a negotiating committee, was made up of staff and management interests. The Royal College of Nursing,the newly formed Confederation of Health Service Employees (COHSE) and a number of other nursing organisations made up the staff side of the Council. COHSE was the newest of the members and was inaugurated in 1946 following the amalgamation of the Hospital and Welfare Services Union and the Mental Hospital and Institutional Workers' Union. Thus began a recognised partnership between the NHS and its employees through a formally recognised negotiating body which was to strengthen and unite the various nursing groups at a time of major change in the history of nursing services.

The changing attitudes of the post war years were reflected in the nursing profession which was beginning to acknowledge the need for a revised approach to nurse training. The advent of the NHS heralded the demise of the RMPA which admitted its last candidates for training in 1951. In this year the General Nursing Councils were reconstituted and two statutory mental nursing committees were established. Only 500 mental handicap nurses were registered out of a total register of over 140,000 qualified nurses. The problem appeared to be the need to develop a new and distinct curriculum for mental handicap nursing which was not biased in favour of general nursing. This was compounded in part due to the GNC's requirement for all nurses to receive preliminary training in all parts of the register. The final solution came in 1957 when the GNC published a new syllabus for Mental Subnormality Nursing (RNMS) which was more closely related to the needs of people with mental handicaps. The syllabus was still dominated by general nursing principles but provided for adaptations to be made to meet the distinct needs of the client group.

The medical profession still retained an interest in nurses training and the medical model of care was reinforced by the doctors' involvement in nurse training and lecture presentation. The State Final examinations were set by multi-disciplinary panels, and the medical profession thus ensured its influence in the accreditation process for the RNMS register.

Meanwhile entry qualifications continued to cause concern for the nursing profession. At this time entry to training was left to the discretion of the hospital authorities, with bias usually being given to the candidate's practical experience. The RNMS was clearly regarded by the general nurses as an inferior qualification which was reinforced by old associations of mental handicap nurses being uneducated attendants. Recruitment to the speciality caused particular problems by 1960 and attempts to establish more rigid entry requirements were delayed until 1964, when legislation was passed to establish a more practically based training for mental handicap nurses. In 1944 a two year practice based training was approved by the GNC for general nurses. Successful nurses were admitted to a new 'Roll' for enrolled nurses and had to prove their proficiency by examination. It was an extension of this Roll for mental and mental handicap nursing that occurred in 1964and thus increased recruitment and the numbers of qualified nurses for the profession.

The 1964 changes also made provision for unqualified nursing assistants to enter the Roll by virtue of their experience; 16,000 nurses did so in mental handicap and mental hospitals and the award of the State Enrolled Mental Subnormality qualification was formally recognised [SEN(MS)]. By 1966 levels of recruitment were at a sufficiently high level to allow the introduction of stringent entry requirements based on proven academic performance at general education level or by proving competence through attainment tests administered by nurses training schools on behalf of the GNC. Thus a two tier training structure was introduced which with amendments to the syllabus of training was to survive to the present day. An emphasis on community care was the main change in attitude and this was reflected in the first revision of the RNMS syllabus in 1970.

The role of nurse administration was also revised in 1966 with the publication of the Salmon Report which recommended that senior nurse management in all hospitals should be less restrictive. The Report introduced a new hierarchy for nursing, divided into three tiers of First line, Middle and Top management. Hospitals were divided into managed areas and units and were encouraged to divide responsibility in accordance with specialisms. New titles of Nursing Officer were recorded for mid line managers through to Chief Nursing Officer for those nurses managing groups of hospitals within geographical boundaries. The Report recommended that mental handicap hospitals and their associated nurse training schools should be managed with other hospitals but that their control should be delegated and de-centralised. One head of nursing was to be appointed in each hospital and thus ended the tradition of hospital management with a Matron in charge of the female half of the hospital's beds and a Chief Male Nurse for the male component. Standing committees were also suggested to ensure that all grades of nurses were involved in the formulation of policy in their own areas of practice. Management courses for senior nurses were also sponsored and a new career structure emerged which resulted in the recognition of an enhanced status within the multi-disciplinary context of the hospital. Perhaps, the acceptance of this report was the first significant step in transferring partial control of the larger mental handicap hospitals to the nurses who where thereafter recognised as contributors in their own right to the decision making bodies of the institution.

In 1972 the Committee on Nursing, chaired by Asa Briggs published a radical report on the future of nurse education (Briggs 1972). It recommended major changes in the system of nurse training with younger entry, common basic education for all nurses and midwives and a new career pattern for the profession based on more appropriate manpower planning. He recommended that

Colleges of Nursing should be introduced (p349-351) with governing bodies similar to those in the local education field. Colleges should be under the direction of a principal and should offer a common core training to all nurses for the first eighteen months of the course without specialisation, the successful completion of which would lead to the award of the Certificate in Nursing Practice. Courses were to be planned on a modular basis providing for experience in psychiatry in both the hospital and the community. A further eighteen months would be offered to nurses possessing the Certificate which would then allow them to 'Register' on a non-specialist register.

For many the logic of the Briggs recommendations was plausible and offered the profession the leadership and coordination it so badly lacked at the time. For the mental handicap profession, now moving away from general hospital/medical domination, the report offered nothing short of a major rebuff. The time had come to challenge the future role of nursing in the care of people whose needs were often social and educational rather than physical.

Briggs recommended the introduction of a new professional group of 'care staff' to undertake all but purely physical or mental nursing functions and in so doing recommended a gradual realignment of the health and social services staff caring for this client group. The main arguments presented in the report were:

a- that large numbers of mentally handicapped people in hospital have no significant physical or psychiatric disability requiring clinical nursing;

b- that too much emphasis in nursing care has been and is devoted to medical and health aspects and too little to the social development and needs of the mentally handicapped person as an individual or as a member of a group;

c- that it is illogical to regard the social and home-making aspects of care as 'nursing' and to provide totally different training for those performing these duties in hospitals and in the community;

d- that this is also undesirable as likely to hinder the change in balance between hospital care and community care advocated in the White Paper 1971 Cmnd 4683.;

e- that division of care into 'nursing' and 'social and domestic' elements, each to be provided by separate professions, would draw on a wider field of recruitment and thus help to relieve the staff shortages which currently present a major obstacle to improvement of the service.

Briggs envisaged a role for residential care staff for the majority of people with mental handicaps similar to that carried out by social services staff. These staff would work alongside nurses in mental handicap hospitals. Briggs encouraged the further training of residential social work staff and saw their integration into hospitals over a period of time as the correct conclusion for the care of this client group. Nurse training would need to change emphasis to encompass the social and developmental needs of people with mental handicaps and thus provide nurses with the opportunity to become leaders of a new caring profession (p565).

In 1973 the Kings Fund published a discussion paper on the future role and training of subnormality nurses and critically evaluated their relationship to the residential care staff (Kings Fund 1973). The paper acknowledged the problems facing people with mental handicaps in long stay hospitals and recommended the introduction of smaller living units in the community. Fearing the demise of the specialist RNMS if Briggs were to be accepted, the paper recommended that a new specialist training should be introduced based on a common sharing with social service staff. The 'New Syllabus' (p15) would be the precursor of a unified national mental handicap service, with common salaries and training systems. They recommended that there should be a two year course of basic training with additional modules to bring the total up to three years. The course would be taught at local colleges of further education and would be open to staff working in the NHS and in social services. The course would require joint validation by the GNC and be the Central Council for the Education and Training of Social Work (CCETSW).

They envisaged that there would be two separate groups of workers following a course of study based on 'parallelism' (p.17) which would encourage the development of a new caring profession envisaged by the Briggs Committee and which still retained the specialist emphasis required by the mental handicap profession. The profession was thus posed to face a major challenge of whether to set down its roots and retain a traditional three year RNMS training or to seize the opportunity of the Briggs era to create a new caring profession with a distinctive element of specialist mental handicap nursing qualification as recommended by the Kings Fund.

The recommendation that a new caring profession should gradually emerge for this client group received a mixed reception from the professionals involved in the care of people with mental handicaps and such was the controversy that even when the government failed to accept the overall recommendations contained in the Briggs Report to reform nurse education, the debate on mental handicap care continued. Thus it was in 1975 that the Royal College of Nursing called upon the government to set up a national committee to review the future of mental handicap nurse training. As the pressure built that year, Barbara Castle, Secretary of State for Social Services announced that Peggy Jay was to chair a committee of enquiry to reappraise nursing and care for the mentally handicapped in the light of new developments and policies. Mrs Jay was also asked to study how best to provide the personal and social services the mentally handicapped person required. The review was an inevitable consequence of the debate stimulated by Briggs into the future of the nursing profession for people with mental handicaps.

The announcement that a formal review was to be undertaken took the nursing profession by storm and the nursing and professional press soon published many letters of concern from nurses who regarded their futures as less than secure. However at a time when community care was being introduced nurses had to reflect upon their role and contribution to a new pattern of care delivery that held little relevance to the hospital based services of previous decades. Nurses had good cause to worry for this committee was to make significant enquiries into the quality of care and life for this client group and would not just confine its brief to the professional status of mental handicap nursing. As one editorial in an American nursing journal (quoted in Wakely 1975) stated:

> 'it seems that mental subnormality nurses will find their futures far more concerned with the patient in the community and in helping him to achieve the best he can from life. This shift in emphasis may create what amounts to a new caring profession. Maybe the title nurse will no longer be used to describe these specialists in the care of the mentally handicapped-the health visitors have not suffered any loss of respect or status because they are not called nurses. But at least this inquiry into the future of mental subnormality nursing will take place as part of an overall scheme to improve the lot of the mentally handicapped and not as an isolated essay, rooted simply in theory' (Supervisor Nurse 1975 p4).

The Jay Committee reported in March 1979 and emphasised the importance of small group living for the majority of people with mental handicaps. Not surprisingly a new training for residential care staff from health and social services was called for; half of the workforce were formally qualified and the other half qualified only through experience and in-service training. They recommended that a new certificate in residential care should be developed in general residential care for children and adults. Local authority and hospital staff (including nurses) would have a common training irrespective of whether they lived in hospital or in the community. A common training would be the key to a new uniform career structure which would ensure that a new workforce of staff would be available to meet the diverse needs of the client group irrespective of traditional dependencies and agency control. Jay rejected the principle that the GNC should continue to approve and validate nurse training for 'the new model of care' on the basis that it would perpetuate the dogma of special services and special staff and in paragraph 237 of the report formally stated:

> 'It was thus clear to us that, whether or not the Briggs Committee's proposals were implemented, nurse training could not provide a basis for training mental handicap residential care staff' (Jay 1979).

They felt that the 1970 RNMS syllabus did not emphasise the social and educational components of residential care required in the new service, and the continued dependence on the hospital system for training and experience was incompatible with the ordinary life principle which the committee advocated and supported. The Jay Committee effectively provided the final 'nail in the coffin' for the mental handicap nursing profession which was already reeling from the recommendations contained in the Briggs report. The Committee mounted roadshows and held seminars to market the report which received a very cool response from the nurses and from the nursing unions. The profession was demoralised and dejected and whilst it accepted the need for more staffing, the nurses were unable to identify with the new model of care proposed in the report due to their lack of experience in non-hospital settings. Clearly the results for the profession were profound as was confirmed by Martin (1984):

> 'The position of staff aroused great concern for a variety of reasons. Morale had been lowered by the publication of the Jay Report which had created a sense of insecurity which, linked with shortages of staff, made the outlook in some hospitals very bleak' (p211).

The profession had to wait until July 1980 before the Government formally responded to the Jay recommendations in a letter from the Chief Nursing Officer [CNO(80)6]. In that letter she stated that the Government had not accepted the Jay proposals that 'there should be immediate and fundamental changes to provide a common training for all staff - nurses and social workers - caring for the mentally handicapped' (p1) The rationale for this decision was not so much a response to the pressure that had been exercised by the 'anti-Jay' lobby, but more an acknowledgment of the complexities and funding implications that any revision of staff training would require if the Jay principles were adopted. Not least a change of Government also played its part in determining the future direction of care services for this client group. The Government response was clear:

> 'The Committee's philosophy and model of care for mental handicap services envisaged a radical change from the present pattern of services to one based on smaller and more local residential units in the community. While welcoming the approach, we have to accept that this shift will be gradual and will take longer than the Committee had hoped, particularly in view of current necessary restraints on public expenditure. We also take the view that the most severely and multiply handicapped people will always need some form of NHS care and more experience is needed on whether this can be provided within the Committee's model of care. In these circumstances we do not believe it would be right to urge immediate fundamental changes to the present training arrangements. This is not, in our view, the time to abandon a well tried form of training for nurses- who will continue to provide the majority of mental handicap care staff for some time to come- for one which is comparatively new, and vigorously opposed by nurses and major voluntary organisations' (CNO 1980 p2-3).

Thus another decade started by offering the mental handicap nurse a reprieve, but one which was to challenge the basic principles of its philosophy and to involve a major review of its approach since in its response the government stated that they were 'inviting the General Nursing Councils and the Central Council for the Education and Training in Social Work to set up a Working Group to look urgently at ways of introducing common elements within the separate forms of training' (p3).

A joint working group was established in July 1980 (GNC, 1982a) to examine common elements for joint qualifying training under the chairmanship of Edward Sidebottom which reported in March 1982. A second group under the same chairman was established to review common elements of in-service training and this group duly reported in January 1983. Each of these reports identified common ground for shared training initiatives at both levels of training although they explicitly accepted that nursing and social work should remain as two separate entities, coming together only to share common elements of training at qualifying and post-qualifying levels and not to merge to provide joint curricula as was envisaged by Jay and Briggs. Flexibility of transfer for qualified staff between social work and nurse training was advocated and opportunities for students from each training to share common elements of the curriculum recommended. More importantly for the nurses this was the first time that the statutory social work training body (CCETSW) had published a public statement to the effect that mental handicap nurse training had a distinct skill base and that this could not be absorbed within a joint framework of training.

With a renewed vote of confidence the profession moved forward to publish a new syllabus of training and with it came a new title - The Registered Nurse for The Mentally Handicapped, (RNMH) [GNC-1982b). (The first move was by the GNC for England and Wales and this was followed by the publication of similar syllabi for Scotland and Northern Ireland in 1985). The syllabus emphasised educational and social aspects of care that Briggs and Jay had criticised the profession for having missed in its earlier curricula and set the scene for a radical change in emphasis. What was clear was that the profession had finally left its medical/clinical base and in its place had adopted a community focused approach to care. The framework of the new syllabus placed the person with a mental handicap in the centre of all care planning and nurse intervention.

One other major advance was the development of domiciliary nursing in the community for people with a mental handicap. A new branch of Community Mental Handicap Nursing made its debut in 1974 and extended the role of the specialist nurse into the community to provide support to people in their own homes and to people in local authority hostels and voluntary homes. For the first time the skills of the mental handicap nurse were exposed to public scrutiny outside the hospital. By 1988 there were some 1600 qualified community nurses in post supporting people in non-NHS settings and demonstrating the role of the mental handicap nurse in multi-disciplinary teams or Community Mental Handicap Teams. The role and function of the community mental handicap nurse was well described by Hall and Russell in a series of DHSS research reports in 1979 and 1980. In their reports they demonstrated the important role the nurses played in developing new services and forging links for people in community settings. In a summary of their work in Sines and Bicknell (1985) they stated that:

> 'In a study which we undertook of community nursing services established in a local area (Hall 1979) we identified ways in which these community nurses were changing their orientation in mental handicap care from a hospital-based perspective to one based in the community. In the early days of the development the nurses were likely to see themselves as deviants from the orthodox norms of nursing. They adopted alternative forms of support among community colleagues and from the consultants with whom they worked. Faced with the novel demands in unfamiliar settings they looked to other professionals working in the community for models of appropriate ways of working. New sets of skills were grafted on to those acquired previously. From the fusion of the two emerged a new professional person' (p39).

There is little doubt that the contribution that the domiciliary nurses made at this important time in the profession's development was significant in providing a revaluation of the skillbase of the mental handicap nurse. With their new approach came fresh challenges which required the demonstration of a range of skills without the support and backup of the traditional hospital and its associated hierarchy of multi-disciplinary consultancy. In people's homes and in local authority hostels the nurses were put to the test and not surprisingly a new audience of non-hospital based staff were able to appreciate their stamina and flexibility when presented with client focussed problems. The public demonstration of the nurse's competences provided them opportunities to gain respect from their colleagues in social services and to respond to requests for intervention from general practitioners. What is important to remember is that all these nurses acquired their skills and experiences from their hospital training although these were supplemented by post-basic training in community nursing and by new experiences and learning situations in the community:

> 'The main impetus behind recommendations for change in the training of mental handicap nurses is the desire to take care of mentally handicapped people outside of the sphere of the medical model and to put it primarily in a social context. The community nurses emerge as the vanguard of this movement, not only as the result of their training but from the need to reconstruct their professional perceptions of the caring process of which they are a necessary part' (Hall & Russell (1985) p46).

Whilst the mental handicap nursing profession was under scrutiny from the Jay Committee the rest of the profession was preoccupied by the need to reconstitute the General Nursing Council. The result of deliberations was the publication in 1979 of a new Nurses, Midwives and Health Visitors Act. Four National Boards for nursing were established (one for each country) under the umbrella of a central council - The United Kingdom Central Council for Nursing, Midwifery and Health Visiting. (UKCC). The new structure was introduced in 1983 and replaced the General Nursing Councils. It was as a result of the introduction of the new structure that the old Mental Nurses Committee of the GNC hurried through its consultation process on the 1982 RNMH syllabus to ensure that the momentum of the new package was not lost with the new legislation. The priority given to this initiative was to prove correct, for the new Boards removed the Mental Nurses Committee and thereby removed the limited statutory protection that existed at the time for the speciality. Within the operational arrangements for the new Boards non-statutory mental nursing committees were introduced which combined the interests of mental illness and mental handicap nurses. It was not until 1987 that a separate committee emerged for mental handicap nurses. (This reflected emerging trends in mental handicap in respect of shared training initiatives with social work).

In 1985 the Social Services Select Committee published its review of adult services for the mentally ill and handicapped (The Short Report) and this again questioned the role of the NHS as a continuing care agency for people with mental handicaps. They commented that mental handicap nurses in the community should 'provide long-term management, training and advice rather than primarily 'hands on' services' (para 88). A debate ensued within the nursing profession regarding the role and function of the mental handicap nurse which resulted in a number of publications to clarify the position. In April the RCN published a document on the role of the community mental handicap nurse in the community (RCN 1985) and in December the Chief Nursing Officer published a now famous statement on the role of the mental handicap nurse (CNO 1985). In a four page letter published by the DHSS a new skill base linked to the 1982 syllabus was reinforced and the transferability of nursing skills across agencies emphasised. This is confirmed in the Chief Nursing Officer's introduction to the letter:

> 'Although the contribution of the nurse towards the care of the mentally handicapped has been recognised for many years, until recently the main role and function of the nurse qualified in the field of mental handicap has been

> seen by some as providing a clinically - orientated service to people in hospital, and more recently in NHS residential units outside hospital. Gradually the role has been changing and has expanded in recent years, not only in content but also in regard to where it is exercised (p1).
>
> The attached paper discusses the developing role of the mental handicap nurse as services in the community emerge, and describes the increasing range of skills required to carry out that function. It is set in the context of government policy which encourages the replacement of services concentrated in large mental handicap hospitals with an integrated network of local domiciliary, residential and day services catering for mentally handicapped people according to their individual needs, and inter-disciplinary working in which there will be an important and continued role for mental handicap nurses' (CNO(85)5 - Introduction).

In the same year the English National Board published a statement of its policy on the education and training of nurses and confirmed that a 'hands-on' service was the priority. The government published its response to the Select Committee report in December 1985 (DHSS 1985) and disagreed with the comments made on the role of the mental handicap nurse and reaffirmed its policy on developing a pluralistic approach to care for this client group which would continue to include a health service component in all plans.

One other development to follow early in 1986 was the publication of a 'Community Nursing Review' chaired by Julia Cumberlege (DHSS 1986). In this report the specialist role of the domiciliary nurse for people with mental handicaps was reaffirmed. Clearly defined links were to be established between the specialist nurses and their general nurse colleagues:

> 'Primary care and specialist teams working in the same neighbourhoods should foster links to ensure a more coordinated approach to the planning and delivery of services' (p43).

One of the most important indications of a change in the status of the mental handicap nurse came with the publication of this review since it provided the specialist nurses with a key role to play within the context of the wider nursing team in the community. No longer was the mental handicap nurse the subject only of specialist reports limited to the speciality but it was now to be recognised as a primary force in the community services. The Royal College of Nursing accepted the recommendations with enthusiasm and immediately dissolved their long-established Primary Care Society and in its place introduced a new Community Nurses Association on whose executive committee were represented all community nursing specialities, including mental handicap.

The enthusiasm for the continued role of the mental handicap nurse expressed by the Chief Nursing Officer was not shared by her inner-council of Regional Nursing Officers in England. Following her instructions a working group was convened to identify a new strategy for nursing for the year 2000. The minutes of their meeting of the 6th January 1987 identified the thinking contained within the group of the profession's leaders:

> '.....agreed to report to the Steering Group on the Strategy for Nursing, that the RNOs did not consider that care of the mentally handicapped should be given any priority in the nursing strategy for the future' (p2).

The minutes of these meetings are limited in circulation but on this occasion a copy found its way to the Royal College of Nursing and the author met with the General Secretary, Trevor Clay to organise a response. The minutes were delivered to the nursing press and a major discussion erupted within the profession with particular support for a new statement on the role of the nurse coming from the Chief Nursing Officer and the general nursing field. The RNOs were lobbied by their local mental handicap nurses and an apology was received. As a result the RCN was invited to produce a strategy for mental handicap nursing (this was later published in February 1989). This document was accepted with enthusiasm by the profession and effectively served to repair some of the damage done by the Regional Nursing Officers in their report.

The service continued to change over the next three years with reports from hospitals undergoing closure providing new insight into the role of the mental handicap nurse in non-hospital settings (Korman and Glennerster (1986), Allen et al (1988). In the latter report by Allen and colleagues in Kent the following was quoted:

> '..there is a reservoir of feeling within the hospital which favours the current developments, but there is also concern that somehow the criticism of large institutions, which is implicit in current policies, has rubbed off onto the staff.....We are aware that there is a certain absurdity in the idea that whilst residents can be discharged into the community, their former professional caretakers may be seen as unsuitable employees because they are 'too institutionalised' (p53).

> 'Ex-hospital staff proved to be valuable employees of the community service; if any re-training was required it was in terms of acquiring a 'hands-off' approach in teaching skills to residents. The experience of staff who have moved from hospital to the community, and who have witnessed dramatic improvements in their clients, is particularly valuable. Their positive view should be shared with staff who have not seen these improvements take place' (p189).

Not only were these findings restricted to adult services. One study of thirty schemes funded from the Government's initiative to move children from hospitals, found that nurses again provided valuable contributions to the care process in the community (Leonard 1988):

> There was no doubting the commitment of most staff whether with previous hospital experience or from other backgrounds, to the aims and spirit of these schemes, and to the individual young people living in them. The most shining examples of inspiring home leadership and dynamic management were all people originally nurses trained in long-stay mental handicap hospitals. The three or four schemes with exceptionally good staff relations , with an open, non-hierarchical style of management, where staff views are welcomed and involvement in decision making nurtured, were all led by a nurse qualified Home Leader, under a nurse manager' (p58).

The Royal College of Nursing and the UKCC had been considering major changes in the system of nurse education and during the decade a number of consultation papers had been published (UKCC 1985 and 1987 and the RCN 1985). The result was the publication of a new framework for nursing based on a model of health, with less emphasis on the medical model of care. The tide was turning and the rest of the profession was considering its future, just as the mental handicap profession had been forced to do at the beginning of the decade with the 1982 syllabus. The new training proposals were published under the title 'Project 2000' (UKCC 1988). The Government accepted the UKCC proposals without amendment and offered full funding for the implementation of a a comprehensive training package which would:

- introduce a common core training for all branches of nursing for the first eighteen months of a three year training;

- witness the end of Enrolled Nurse training by creating a single register;

- provide four specialist branches of nursing (including mental handicap);

- move nurse education from schools of nursing to Colleges of Higher/Further education with student status for learner nurses;

- revise the training and academic qualifications of tutors;

- to introduce a new level of 'support worker' for the profession.

All students will follow a common foundation programme before specialising in a particular branch of nursing. Mental handicap nurses were again concerned that their integration within a common foundation would result in a diminution of their skills. The original submissions for the curriculum was seen in terms that narrowed the practice base and restricted skills to providing support and care for only those people with a severe mental handicap. At a major ENB conference of mental handicap tutors and managers in Rippon in July 1987 the skill base was debated and an amendment for the mental handicap profession proposed. The amendment was accepted by the UKCC and read:

> '....mental handicap is an actual social and educational concern rather than an illness.... We fully support the functions of the nurse for mentally handicapped person's as described in the CNO's letter CNO(85)5 DHSS. The nurse must be able to deliver across all settings specialist skills when required...the development of community nursing will increasingly allow the nurse for the mentally handicapped to provide this professional advice and practical support to clients and their families both in their own home and in group homes as appropriate....The continuing development of the syllabus for the education and training of nurses caring for mentally handicapped persons has received widespread support and has proved to be a good foundation in equipping nurses for mentally handicapped persons. It is anticipated that a substantial component of such syllabi would be incorporated within the new common foundation programme.This will give an opportunity within the branch programme for experimentation in joint or shared learning' (para 6.30).

The exact nature of the common foundation and the branch programme became known in January 1989 with the publication of an outline curriculum written by the Mental Handicap Nursing Committee of the ENB (ENB 1989). In the introduction to the document the Board stated:

> '...the nurse must adapt to need ...this branch has introduced a curriculum which has produced practitioners who are flexible and have the confidence to adapt to changing service delivery...It is a major aim that the flexibility for curriculum planning associated with this branch should assist in maintaining links with other agencies and professions who form part of the process of service delivery to the consumer groups' (p1).

The concept of joint training also regained consideration at this time and following the failure of the joint initiatives between the GNC and CCETSW in 1982 (GNC 1982/3) a new series of negotiations began in earnest in 1986 (ENB 1986) which resulted in the publication of the first joint syllabus of shared training at a post-basic qualifying level (ENB 1988). A steering group was also set up to consider methods of providing joint validation for mental handicap staff employed in social services and in the NHS, and clear guidelines were published in 1988 to pave the way for further initiatives. Both validating bodies were agreed that separate qualifying training courses should continue and that a joint syllabus would not be appropriate. However every support was offered by the ENB and by CCETSW for the continuation of shared training initiatives and plans are now being made to consider the first sharing of basic training between the two professions. New initiatives and changes in the joint approach to care delivery have now been affirmed within the training arrangements for nurses and social workers. The professions have developed in confidence since the first attempts to break down the boundaries between social work and nursing were introduced, the result has been a major shift in attitude and respect for each others contribution to the care process.

This respect is dependent on recognition of the skill and practice base for each profession. Nurses and social workers are now crossing employment boundaries and evidence is emerging to suggest that nurses are taking up a number of senior positions in local authority and voluntary services (Walton & Brown 1989). The messages are not, however clear and some misconceptions regarding the employment of nurses in social work exist. Wagner (1988) summarises the major concerns which still prevail in social work in respect of nursing qualifications:

> 'Some agencies accept nursing qualifications as relevant for residential care work, e.g. with the elderly, but in so doing they ignore some fundamental differences between social work and nursing. We recommend that people with nursing or other professional backgrounds moving into residential service work should receive relevant 'conversion training' on an in-service basis, and those appointed to senior posts should be expected to undertake professional qualifying training social work as early as possible' (p88).

The debate will continue between the agencies and professions but the ENB and CCETSW have stated that the future will be determined by a new approach to shared training initiatives (ENB 1988). A new statement was published by the Chief Executive of the ENB in November 1988 which reaffirmed commitment to mental handicap nursing and this statement was accompanied by a joint position statement with CCETSW which launched 'The First Fruits of the ENB/CCETSW Joint Training Initiatives'. The results of these new initiatives are yet to be seen but one thing is clear, the mental handicap nursing profession has changed direction and instead of accepting poor conditions of care and practice, is facing a future within a culture characterised by rapid service change and renewed optimism:

> 'Mental handicap nurses in the past have, in many ways, been their worst enemies by tolerating 'the very worst conditions of building, facilities and staffing ratios' and allowing their dedication and commitment to be exploited. This is not likely to be the case in the future (Walton/Brown 1989 9.134).

Finally, it should be noted that a significant conclusion to the debate on the future of mental handicap nursing is now awaited in the form of a Chief Nursing Officer Review [1990] (see Chapter Two) which is understood to clarify the role of the nursing profession following the publication of the National Health Service and Community Care Act (1990).

KEY ISSUES ARISING FROM THIS CHAPTER.

- an historical analysis of the development of the role of nursing in society is essential if current care practices are to be understood and evaluated;

- economic influences may be amongst those which determine the nature and number of those people for whom society chooses to label as 'deviant or dependent';

- within the workhouse and hospital structures rigid practices and hierarchies encouraged a differentiation of labour and placed nurses at the bottom end of the status hierarchy; such nurses were expected to perform their duties on the basis of task allocation;

- within the wider sphere of nursing, mental and mental handicap nursing evolved as separate entities; working with distinct client groups; nurses in these sub-group categories were given a lower status than those working in general nursing;

- the first attempt to 'professionalise' and to regulate the mental and mental handicap nurses was inspired by the psychiatrists through the introduction of the R.M.P.A.;

- as a result of regulation new divisions appeared within the profession and a formal grading structure emerged which ascribed higher status to male nurses and those with a recognised professional qualification;

- the medical/clinical model dominated mental handicap nursing until the 1970s when alternative models of care were introduced based on psychological and social models of care;

- until 1972 the nursing profession held the major interest in care provision for people with mental handicaps; their practices were unchallenged by society and by most people other than their own regulating body (The General Nursing Council) and by the psychiatrists;

- with a growing public awareness of the nature of mental handicap in the 1970s came challenges to the role of the mental handicap hospital and to the nurses working within them;

- a series of reports and recommendations on nursing administration and education polarised the mental handicap nurses towards the non-clinical end of the care spectrum and alienated them from their peers in both general and psychiatric nursing;

- as local authorities demonstrated an alternative model of care and and of education for staff caring for people with mental handicaps, civil servants challenged the medical model still practised in most hospitals and recommendations were made for the transfer of all residential care practices to the local authority (Jay 1979);

- although the government rejected the Jay proposals, the scene was set for radical change in both care practice and training; the result was the publication of the 1982 RNMH syllabus of training based on behavioural and social models and the design of joint training courses for nurses and residential social workers;

- the Royal College of Nursing recognised the professional status of RNMH nurses in 1982 through the formation of a Society of Mental Handicap Nursing, ironically marking the 'coming of age' of the specialty within the profession of nursing at a point when it was at its most vulnerable to external challenge;

- the 1980s witnessed attempts by voluntary bodies, social services and professional organisations outside of nursing to 'de-professionalise' mental handicap nursing and to replace it with a 'new caring profession';

- the future of mental handicap nursing is now awaited in the form of a Chief Nursing Officer Review (due for publication in the Spring of 1991) which is understood to clarify the role of the nursing profession following the publication of the National Health Service and Community Care Act (1990);

- one clear conclusion from this chapter is that nursing is influenced by social change and by public opinion; it is equally clear that nursing can adapt its care practices and values to meet these changes.

Chapter Four

The Mental Handicap Hospital: Its Culture and its Nurses.

The Subculture - its origins and nature.

So far we have considered those aspects of social policy which have affected the provision and the nature of care of people with mental handicaps. However, policies and models of care have to be put into practice by nurses, and how well they do this will be directly related to their feelings of job security and job satisfaction.

The majority of these nurses received their introduction to the field of mental handicap care whilst training or working in large mental handicap hospitals. The development of these establishments has been described in the two previous chapters, but the essence of how they affected the lives of those who lived there has been aptly summarised by Goffman (1961) in his essays on institutionalisation:

> 'Their total character is symbolized by the barrier to social intercourse with the outside and to departure that is often built into the actual physical plant, such as locked doors, high walls and isolated settings. A basic social arrangement is that individuals tend to sleep, work and play in different places, under different authorities and without an overall rational plan. The central feature of the total institution is that the individual carries out all of his life experiences under one roof.....the various enforced activities are brought together into a single rational plan purportedly designed to fulfil the official aims of the institution' (p17).

Goffman notes that a central characteristic of such hospitals is to generate a mortification process which denies the importance of individual possessions and behaviours which have previously supported their self image in society. Consequently the daily routine and 'gossip' associated with the establishment tends to become the main topic of conversation both within and without the institution and both 'inmates' and their carers assume uniforms and practices which set them apart from each other and ultimately from the society within which they live.

Ryan (1980) provides a vivid description of a mental handicap hospital which illustrates the paradox between the pleasant external surroundings of the wards and their interior:

> 'When you first enter the hospital it seems a peaceful place - a wide path leading to the main building, trees lining well-kept banks of grass, the majority of buildings solid and imposing two-storey blocks, built to last for ever. A few people are walking about with varying degrees of urgency, some staring ahead, some talking loudly to themselves, others cadging cigarettes, demanding your name, offering their own. Nurses in long white coats pushing wheelchairs. A strange place for the first time, in many ways much more pleasant than hospitals for the physically sick, each ward possessing its own stretch of greenery, and trees everywhere.
>
> Over there is a lot of space - but then nearly a thousand people live, eat, sleep, play and work here. Only when you go on the wards do you realise how cramped and small everything really is. This is where the patients spend most of their time - around forty patients and eight or so staff of various kinds - the walls closing in on you. From inside the ward you can see the green and the trees through the thick windows, access only to them with a key. Only the staff had keys. My first impression of the ward itself was the smell. An unpleasant mixture of urine and faeces. 'You'll get used to that,' smiles the charge nurse' (p31-32).

Moreover many of the practices of institutionalisation found within the hospitals were also applicable to the staff who worked within them. In some ways the staff were subjected to the same routines and deprivations as their charges (although the impact of these was clearly lessened by the fact that the staff were 'free' to leave at any time and had the opportunity to supplement the experiences of the institution with other activities) and a significant number chose to live in nurse's homes and housing estates adjacent to the hospital campus (see below). The physical isolation of the hospitals encouraged dependency on their own families, which were often extensive. They could include social clubs, shops, sports facilities, subsidised accommodation and transport systems, extended friendship networks not to mention their own farms and in some cases breweries and railway stations!

The Nature of the Workforce.

The antisocial nature of the hospital shift systems also encouraged dependency on the hospital for meeting the social needs of the staff. The hospital social club provided opportunities for relaxation and 'to unwind' after stressful periods on duty and the similar nature of work activities allowed for mutual sharing and information exchange. Personal associations between staff were not uncommon and a significant number resulted in marriages which in turn encouraged the development of kinship networks within the mental handicap speciality which are still evident today. The existence of kinship ties was positively encouraged by administrators in order to guarantee a consistent workforce which was 'socialised' in respect of the norms and expectations of the institution. John (1961) recognised the importance of administrative practices for the continuation of the hospital workforce. She reported that in some cases a radius ban was imposed by administrators which ensured that the recruitment of nurses was restricted to those coming from areas away from the hospital (eg 40 miles in one hospital). According to John this reduced the ties of staff to the immediate environment and encouraged dependency on the hospital campus and its facilities (p117-8).

I can recall quite vividly the importance of these kinship networks which appeared to underpin the whole workforce and its relationship to the culture of the hospital. Not only were family ties evident, the rivalries and tribulations associated within families also came to the surface. It was not uncommon, for example, for family members to refuse to work together on the same shift due to problems which might have arisen within the 'privacy' of their family unit outside of work. Others insisted on working opposite shifts to provide continuity for child care at home and thus the single members of staff on the wards would often have to take pot luck on their off-duty rotas. Whilst the rivalry was permissible within the family units, there was no way that any intrusive comments or criticisms were accepted by outsiders. Nolan (1979) had a similar experience when he started work in one such hospital:

> 'The first impression of hospital life was that the staff were mostly related to each other. This was a mixed blessing. Though it was pleasing to feel part of a small community, it was difficult to get to know people: 'One was scared to ask about members of staff and who they were, in case the person you asked was related to them' (p58).

The isolated nature of many of the larger hospitals encouraged male nurses to settle in the immediate vicinity and this attracted their family to take up similar types of work. This was reinforced by the lack of other employment opportunities in the rural areas where the hospitals were traditionally located (John p118). The low salaries paid to nurses also discouraged the purchase of independent forms of transport and hospital authorities were forced to provide free transport to and from local towns and villages, timed to meet workers' shift patterns and changes. This in itself developed further dependence on the hospital and its environment.

John also reported that reasons for choosing to work in certain hospitals was closely related to residence and kinship. She found that only 2% had selected the hospital for its reputation as a training school and that 44% had done so to join relatives or friends (p119).

The workforce was far from homogeneous in some respects and was made up of a number of subcultures of its own. Religious and cultural affiliations influenced the make up of some hospital staff groups, which in turn encouraged the emergence of secondary affiliations amongst workers. By the 1960s the nature of the workforce had become positively cosmopolitan with the arrival of significant numbers of staff from Spain, The West Indies, Mauritius, Malaya, The Philippines and Sri-Lanka. Each new arrival naturally sought employment in hospitals where relatives and friends were working. These were added to the many Southern Irish people who had migrated to England earlier and together significantly influenced the balance of the workforce and its constituent parts.

It would not be unreasonable to infer that in some cases staff regarded the primary purpose of the institution as being to meet their own social, or even academic, needs. The latter was particularly true of some people whose only means of gaining a work permit was to enter human care services and the Author has personally witnessed a number of people 'using' the hospital service as a stepping stone towards career advancement in totally different fields eg. architecture. Foreign recruitment campaigns in the 1960s, for example, extolled the virtues of working in hospitals with the associated advantage of access to the British university system for many immigrants. The nature of mental handicap care was to prove to be a major shock to some male staff who regarded the more basic tasks associated with human care as being beneath their 'caste' or more akin to female tasks and responsibilities.

For others the hospital was to provide a more positive source of employment and life experience. Nolan (1979) notes that a significant number of staff in mental and mental handicap hospitals were recruited immediately after the end of the war. He states that the regimented routines of the hospitals were particularly attractive to people who were used to the strict routines of the armed forces. In an interesting article he notes from interviews with former prisoners of war that some form of security was received after being 'de-mobbed'.

> 'The respondents had also been keenly impressed by the institutional symbols which conferred on them their membership of the hospital team - the uniform, the rule book and the belt and keys. For ex-soldiers, the wearing of the uniform was comforting: 'You could always tell those nurses who had been in the army - they looked immaculate in their uniforms and they always took great pride in their appearance'. ..Having one's own belt and keys was confirmation of one's power; patients and to ask staff permission even to go to the lavatory or have a drink of water' (p58).

Naturally, for staff in such circumstances, alternative activities were needed to survive the three year training that the majority undertook. Ironically, for many the hospital provided the means for career advancement and at the end of the training period few left to undertake other work, despite their original dissatisfaction with the work and its social acceptability. This is well illustrated by an examination of the staff establishment figures of one south London hospital (800 beds) where out of a total workforce of 580 some 75% of senior staff were of ethnic origin and had arrived in this country in the 1960s and 1970s and all gave mental handicap nursing as their first job on entry to the United Kingdom.

'Alternative activities' often centred on the social life of the hospital. Many people engaged in recreational and sports activities and inter hospital leagues became a feature of many people's lives. The competitive nature of the hospital sports activities was promoted by administrators who willingly gave staff time off from their ward duties to participate in events, and good players were openly acknowledged by senior staff on 'Rolls of Honour'. Indeed, a good sports record was, in some cases, regarded as a pre-requisite for promotion or acceptance for nurse training (interestingly enough the same applied for entry to certain London medical schools!). The most famous of the inter-hospital sports events was organised by the London Mental Hospital Sports Association, to which all hospitals contributed, some registering for up to twenty sporting activities each year.

People with mental handicaps also benefited from sports activities and were often taken along as spectators to see them perform. They had their own sports, although the reason for their existence is somewhat questionable. In host hospitals skittles became a competitive sport for the patients and was always looked upon as a highlight in the social calendar. Regular coach trips to other hospitals were arranged and there was never a shortage of staff to volunteer to accompany them. Such outings offered opportunities for staff to meet old friends or to visit hospitals where they had worked before, and perhaps more importantly offered the chance to relieve some of the monotony shared by staff and patients in the hospital. The monotony of the hospital was always broken once a year with the arrival of the annual

Sports Day. This event attracted wide support from the community and figured as the one public day in the hospital calendar. Local fairground proprietors were attracted to the event and staff and patients were attired in their best 'uniforms' to meet the public. The event always ended with late night parties and socialising for the staff, but for the patient's an early night was prescribed to balance the excitement of the day!

In order to supplement their income, some staff engaged in 'extra-mural' activities. I can recall a number of people who were engaged in a variety of enterprises ranging from 'betting circles' and car sales. One senior member of staff always ensured that he worked evenings and weekends in order to carry out car repairs at the rear of his ward, for which he received payment from other staff members. Another member of the night staff developed a major commercial enterprise by organising a mail order system which was coordinated by his wife. Other night staff would bring their ironing and laundry to work whilst one person was found selling hospital linen on the local market!

The Social Life of the Hospital.

The social club and dining room where totally out of bounds for patients and provided staff with a secure base and provided staff with a secure haven from the routines of the ward. They provided an arena for gossip and engagement in social activities. Dances and outings were held for the staff and their families and each bank holiday brought with it a package of local activities to support staff who were on duty for the major part of the time.

For the patients dances were held weekly and cinema shows were also provided. Naturally staff would accompany patients to these activities and in some cases their spouses and children would also attend to confirm the social nature of the institution on such occasions. Christmas parties were held for staff children and staff arranged pantomimes for the patients and thus relieved some of the tedium associated with long stay care. Others engaged in annual holidays with the patients which offered diversion in the summer months, and duty rotas were altered to accommodate the kinship and friendship network needs of staff who accompanied them.

The importance of religion was reinforced by the engagement of the services of a full time hospital chaplain (Church of England) and of a part time Priest (Roman Catholic). The ritual of church on Sundays demonstrated the division which existed between staff in respect of their own religious allegiances. The catholics often refused to accompany protestant patients to their services and similarly the protestants to accompany the catholics. Such was the nature of the subcultures of the hospitals, whose primary purpose was purported to be to meet the needs of patients - including their spiritual needs. However, the ritual of church on Sunday provided an opportunity for staff to display their best behaviour as row after row of neatly attired patients filed into the hospital's main hall to attend the weekly service. The staff wore clean uniforms and joined with their patients in a public display of devotion whilst maintaining the social distance required of them by controlling any behavioural outburst that occurred during the service. The managers and senior staff would also attend the service and the address was often read by staff aspiring for promotion, having been selected by the senior members of the nursing hierarchy and the chaplain. [Morris (1969) also commented on the significance of church, outings, open and sports days in her research].

In many ways the nature of the mental handicap hospital encouraged the development of a restricted role set for staff and their patients. Morris (1969) recognised this:

> 'The hospital is not only remote from informal contacts with the community, but to a large extent it is socially cocooned, lacking relationships even with formal organizations' (p313).

Morris found that within the hospitals there existed a certain degree of apathy amongst staff who failed to 'cross-fertilize' ideas to improve patient care, and an apparent reluctance to share good practice outside of the hospital reinforced a sense of professional isolation 'both in the outside community and in other types of hospital' (p312). She believed that the isolation found in most subnormality hospitals was virtually total and that their physical remoteness helped to maintain the barrier to communication with the outside world. Visits from patient's relatives or from visitors from the community might have relieved some of the isolation but according to Morris and John (1961) they were not really welcomed, and as for volunteers there appeared to be very little support for their services. Morris felt that contact with the outside world might have been seen by staff as disruptive and as a potential threat to the smooth running of the establishment (p313).

'The hospital is clearly a world divided in two, where the staff dominate the patients and the patients are dependent on the staff for most of their needs' (Ryan 1980). This statement typifies the state of most mental handicap hospitals that were deprived of external stimulation. The hospitals existed as segregated and self-contained communities, with rigid divisions between the in-side and the outside worlds. Whenever the opportunity arose for visitors to enter the hospital rituals were entered into the disguise the true nature of the wards. This is well illustrated by Ryan and Thomas (1980):

> 'Every time someone of importance visits the villa the whole place is turned upside down, everyone is as nice as pie to the lads, everything is hunky-dory as circumstances and the hospital budget allow. June (a nursing assistant) says the only reason as she sees it for making the lads presentable is 'if any big nobs come round to see this place'. In an ordinary hospital, doctors come round all the time, but not here.
>
> Canary, the supreme shit ward, was spruced up when the news broke that the Hospital Area Committee were due for a visit. The nurses did a great cover up job, were nice to the patients, the charge nurses answering the committee's questions with considerable competence....As with most visitors, they went away thinking what a grand job the hospital was doing, and how humanitarian the nurses were' (pp69-70).

Care or Control - Defending the System or the Nurses?

Morris considered the ways in which nurses perform their duties in terms of their exertion of forms of social control (p314). John (1961) believed that status was of great importance to the mental nurse and that it was seriously undermined by the significant numbers of untrained staff and ancillary workers who made up the main workforce in the hospitals (p137), (Morris 1969 p127). She found that much of the nurses' work was concerned with domestic and routine duties which discouraged 'thinking and proved anxiety-relieving' and served the specific function of providing the nurses with an opportunity to avoid some of the more anxiety provoking aspects of their role. She felt that it was unfortunate for the nurses that respite from their jobs was found in menial tasks which were associated with low status activities (p140).

The avoidance of thought and anxiety provoking situations appeared to be an important factor in producing apathy, which in turn was responsible for the continuation of traditional routines and programmes associated with the concept of the total institution. John found examples of staff spending hours in the 'office' copying off-duty rotas and medicine lists and whilst so occupied, leaving the tasks of direct patient care to unqualified staff and more able patients. Adherence to routine and regimentation, frequently observed in hospitals, was often rewarded by senior staff who discouraged 'genuine attempts, by nursing staff, to introduce a more permissive regime' (John p149).

John believed that poor staff relations and poor communications were responsible for much of the inefficiency and low morale noted in these hospitals. Role confusion between the skilled activities performed by qualified nurses and the more menial tasks which formed a key component of their daily work exacerbated feelings of low status which were evident in the workforce. The emergence and growth of these low status feelings may be encouraged within the mental hospital and according to Caudill (1958) the hospital may serve to operate as a separate and discrete social system in its own right (p.x). Advancement between levels of professional training are regulated by formal rules and by tacit norms reinforced by the daily functioning of the hospital. Caudill believed that status problems facing nurses were due to the presence of a 'mobility block' which discouraged interpersonal relations between different levels of staff and which restricted communication within the hospital system (Caudill and John presented their findings in respect to mental illness hospitals but it is acceptable to assume that they are equally applicable to mental handicap hospitals).

Communication structures also depend on the existence of a process of 'multiple subordination (Caudill p8), where each worker is under the authority of several independent chiefs. In the mental handicap hospital nurses are responsible to senior nurses, medical staff and in some cases to therapists as well. In such situations it might be assumed that nurses face potential conflict in their work and consequently tend to protect their activities by restricting the nature and scope of their work to more familiar tasks and routines. Morris, like John before her, found that nurses did so much domestic work that it had a serious effect on their morale and self-perceived status and this in turn encouraged their belief that other specialist staff looked down on them (Morris 1969).

In some cases nurses regarded their chances of promotion as being best determined by their ability to 'be a good yes man' and to keep the ward in a clean and orderly fashion (Morris p129). She regarded the general abasement of the nurses role as tending to 'stultify creative thinking' (p129) and the isolation of the hospital as creating barriers to changing the 'present curative/custodial ideology' of the institution (p284). Morris did however recognise that many of the nurses maintained a high level of commitment and vocation to their patients , 'despite the many frustrations from which the service suffers and which result in poor staff morale' (p290). Many of the nurses certainly did receive enormous personal rewards and job satisfaction from their patients and their progress in the acquisition of new skills and more appropriate behaviours as a result of their intervention. However:

> 'The vocational ideology which embodies the notion of personal sacrifice implies that the nurses will see some result, but the many frustrations that they suffer can well lead to a lowering of morale and a dilution of vocational enthusiasm. One method of meeting such a threat to their investment in the job is for the objectives to be lowered, in this way conserving physical and emotional energy and reducing vulnerability to criticism by superiors' (Morris p290).

Undoubtedly the quality and the nature of the services received by clients will depend greatly upon the relationships existing between staff at all levels in the organisation. Job security and freedom from major change in work patterns and styles will affect the degree to which staff feel confident to carry out their practices, and there is little doubt that the power of influence exerted by ward staff effectively determines the nature of the patient's regime. Such freedom enjoyed by the ward staff was often unchallenged by senior staff and administrators who within a rigid hierarchical system allowed each level of supervisor to delegate to those below them an area of discretion in return for acceptance of the regime above them.

In a study by Revans (1974) the communication processes used in hospitals were explored. He demonstrated that administrators controlled access to information as a means to protect certain levels of the organization from over-exposure to unnecessary responsibility which in the long term might prove to be counter-productive to what they saw as the work of the establishment;

> ' In certain forms of organization or under particular systems of authority, these limits may soon be reached, and the subordinates seen either as self-centred and rebellious or as incompetent and alienated. It is an unusual view, perhaps, that a main cause of discontent today is not that society rewards its servants with what

> they consider as too little, but that it does not know how to accept from them all that they would wish to give' (p125).

Revans has perhaps identified one of the many reasons for the with-holding of information from nursing staff in hospitals. To involve them more would be to expose them to additional responsibilities for their practice which have traditionally been shouldered by rigid hierarchical systems and rules. This balance of responsibility and personal commitment requires further exploration.

George Brown (1973) in a paper on the mental hospital as an institution suggested that high control and specification of working procedures are efficient where the environment is stable and unchanging (p410). In such situations staff are able to predict outcomes and consequences of patient behaviour since the environment and procedures have been designed to minimise disruption from routine and are directly related to the organizations need for stability. In Brown's words:

> 'Where the care of human beings is concerned the complexity of the task depends on how the organization chooses to define the nature of the work' (p410).

The outputs of mental handicap hospitals might be defined in terms of the extent to which they maintain social order and provide administrators with the minimum of problems. If this is the case then the work patterns prescribed for the nurses by their managers will encourage adherence to established routines. John (1961) and Morris (1969) considered that the more routine tasks provided some nurses with a significant degree of job satisfaction and reward. Brown identified that whilst some basic tasks may be 'intrinsically neutral' or even 'negative' in the rewards they bring nurses they can, nevertheless, provide them with an overall sense of satisfaction when their whole workload is considered (p410). Many of the tasks performed by nurses are of a routine nature (Goffman 1961, Morris 1969) and as such may, in time, be undertaken automatically:

> 'Routine tasks undoubtedly give less 'intrinsic reward'. This is a persistent human predicament. Tomkins refers to the ideo-affective density consequent on the attainment of a skill: by which he means the degree to which an activity concerns and engages the awareness, feelings and the ideation as well as the action of the individual. As a person becomes more proficient in a skill, such as a morning shave, his awareness, his affect and thought about it declines, so that he is hardly aware that he is shaving' (Brown p410).

The process of routinization may become an integral part of the nurse's work and this in turn may force the nurse to seek satisfaction from external activities. Brown noted that nurses may use coffee breaks and time out of the ward area for this purpose and thus relieve some of the boredom that the nature of their work creates. Certainly my own experience would confirm that ward based nurses were expected to carry out routine tasks without becoming involved in the development of new procedures to regulate their work. Responsibility for the latter was clearly left to senior staff who were usually non-ward based. The introduction of the clinical grading structure (1988) further clarified this division of responsibility between grades of staff, demarcating the 'formulation of policy' to senior staff, the lowest grades of whom would usually hold responsibility as 'Senior Nurses' or 'Nursing officers'. Ward based staff would, however be expected to take responsibility for all aspects of care relating to individual patients, although staff would be expected to plan and deliver all care within the prescribed parameters of care practice prescribed by the management of the hospital (usually the consultant and senior nurse managers). Such routine programming may leave little scope for staff to use their creative abilities and may encourage their disengagement from patient centred activities.

Staff are under strong peer group pressures to work to agreed standards and to show loyalty to the group. The existence of explicit rules of performance may benefit the workforce as well as the managers that set them:

> 'Conformity is not a two sided process. Subordinates will bargain with their own conformity and use it as a toll with which to bind management. This is another aspect of the fight for control. Subordinates tacitly agree to play the management game, but they try to turn it to their own advantage and to prevent management from interfering with their independence. When this double pressure is stabilised and leaves very little freedom for adjusting difficulties, then an organization has become deeply rigid' (Crozier p412).

One characteristic of many mental handicap hospitals is the degree to which a 'closed system' is encouraged to operate in respect of the amount of information that is shared outside the ward. The degree to which surveillance practices operate will vary from hospital to hospital as indeed will the precise nature of daily routines and practices. Martin (1984) considers some of the reasons for the poor practice found in some hospitals following public enquiries. He asks two questions:

> 1- 'How is it that individuals who have either been trained in a caring profession, or at least have chosen to work in an institution dedicated to healing or caring, come to behave in ways which are explicitly contrary to the standards of their profession or the aims of the institution?'
>
> 2- 'How is it that the hospital has been so organized that such behaviour has not been prevented?' (Martin p80).

Martin attributed some of the reasons to the isolation of the hospital, the lack of support perceived by staff, failures of leadership, inadequacies of training, union influence and personal failings (p80-97). He also noted the private nature of ward activities which were often considered by staff as their personal responsibility, 'to be protected from outside (or senior) influences' (p83). The ward may be regarded as a small community 'theoretically subject to inspection and supervision, but liable not to be much influenced by inspection as such' (Martin p83) and like King et al

(1971) and Caudill (1958) he found that nurses were encouraged by the seniors to concentrate their time on mundane administrative matters rather than concerning themselves with matters relating to the quality of life for their charges.

'Silencing the System'.

There is, of course, an inherent danger in such closed communities that patients may become disenfranchised in respect of their rights as citizens and may not have access to the outside world to express grievances regarding their treatment or care. Virginia Beardshaw, in her study 'Conscientious Objectors at Work' (1981), identifies the fundamental responsibilities of all nurses working in human care services to maintain the optimum health and well being of their patients. However, as the lessons from the 1970 enquiries proved (Martin 1984), nurses may not always be best placed or able to represent the interests of their patients due to the potential conflicts that this may cause between their loyalty to their peers and the organisation and to their public conscience.

Staff who have 'blown the whistle' on their colleagues following poor practice may be scapegoated or labelled as trouble makers (Beardshaw). In some cases when staff allow their sense of public duty to report incidents of poor practice they have been regarded as being awkward whenever they challenge the status quo of the hospital. Beardshaw associated the problems faced by patients in mental hospitals with the nature of the routines of the ward environment. Where custodial practices predominate patient centred approaches are discouraged or impossible to implement. The stress on conformity and obedience by staff demonstrated by the hierarchical relationships that existed in the hospitals and which in themselves encouraged solidarity amongst the workforce.

Beardshaw catalogued some conclusions from her study of the types of abuses that may occur:

'There is clear evidence to suggest that the number of reported incidents of abuse confirm that 'things can go very badly wrong in mental hospitals';

- Malpractice may reoccur and be seen in similar forms in different hospital and at different times;

- Some of the abuses can be explained 'but never justified' in terms of 'an overstrained, undertrained staff doing a difficult job with limited resources and inadequate support'. Other more serious abuse cases such as manslaughter cannot be explained;

- Abuses rarely follow a simple pattern and may be better explained in terms of a series of 'inter-related malpractices and abuses, many which have continued for years' (p16).

Staff may find that they are silenced when they attempt to complain on behalf of a patient. Intimidation may result and career pathways may be blocked by managers for staff who are regarded as being 'disloyal'. Beardshaw and Martin found that the trade unions also experienced difficulties when asked to investigate complaints reported by their members (Beardshaw p51). In her conclusion, Beardshaw believed that nurses should receive support from their managers and colleagues to expose problems of mal-practice in their hospitals. However she noted:

> 'Nurses have good reasons for keeping quiet about abuse in mental hospitals: silence is a normal, human response to intimidation and fear. Their silence is enforced by vested interests within the hospital organisation: interests which have something to hide or which prefer not to face embarrassing, painful and difficult truths.'
>
> This enforced silence involves a denial of basic human rights. Through it patients suffer within a 'caring' environment. Through it caring nurses are deprived of free speech and are effectively prevented from following their profession's basic tenets' (p81).

Martin (1984 p13) noted that at Ely Hospital and at Farleigh senior nurses protected the status quo to the point where their efforts were successful in suppressing action by student nurses to do something about the ill treatment of patients on certain wards (p13). Martin also explored the concept of group loyalty referred to earlier by Beardshaw. He reported that there was a 'darker side of group loyalty' which took the form of angry and destructive reactions on the part of peers and managers against staff who were tempted to 'blow the whistle' (p245). He believed that one reason for these reactions was a basic fear that 'people who had come to neglect the standards of the outside world suddenly felt vulnerable when criticised at a professional level' (p245.). He went on to suggest that a combination of anger and guilt was experienced by staff working under 'impossible conditions' which in turn reinforced their hostility towards complainants. For the staff some sympathy might be felt for the conditions under which they had to work. Some had worked for so long in a climate characterised by inadequate resources and poor support that they had long left behind them any personal frame of reference against which to judge their personal performance and professional standards. Many had complained in the past but to no avail. Perhaps, what was witnessed was the continuation of a self-perpetuating spiral of disillusionment and apathy which had been conditioned over many years of working within the systems of the hospital.

When such conditions prevail there is however a danger that staff will learn to exploit the situation to their own ends. Brown (1973) recognised that the rewards staff can expect to receive for their often thankless, routine tasks, may not be adequate to meet their needs. For many of the qualified staff alternative employment may not have been a possibility due to the dependency that the hospital regime had presented them with in respect of job security, subsidised housing and a restricted skill base. Consequently many staff remained in the service with a growing sense of disillusionment and yet many managed to gain satisfaction from their jobs in other ways.

Whilst some staff were obviously victims of an uncaring and under-resourced system, others were clearly uncaring in their attitudes as the following example suggests:

> 'I was put on another ward - Canary - for an hour. The guy working there, who had started the same day as I did, said, 'You've got to shout at these bastards or they don't take any notice of you. If you're quiet with them they take the piss out of you and make things difficult. They need shouting at and a bit of pasting to keep them down, know what I mean? See that guy over there, he had a go at me yesterday so I put one on him. Said he'd report me to the Heath (the Chief Nursing Officer) but they all say that, don't they? You've got to defend yourself, be fair.'..He abuses everyone he can, to show me I'm on his villa and he knows the score and they know him' (pp50-51).

Some, according to Brown, become so used to familiar tasks and procedures that they distance themselves from the actual nature and reality of their work (p417). He suggests that nurses actively seek to engage in 'means-orientated and goal-orientated' attitudes and behaviour at work. For many of the nurses this involved the maintenance of a common belief that they were engaged in the 'moral treatment' of their patients and that they maintained a certain continuity of interest and a degree of hope and optimism in their work and for their patients (Brown p417).

In a famous study by Isobel Menzies (1970) the problems facing nursing staff in under-resourced and under-staffed hospitals were explained in terms of the anxiety they experience as a result of their work. In order to cope with some of the more depressing and less rewarding aspects of their job, some may bring defensive techniques into their work in an effort to disguise and assist them in externalising work pressures. Menzies saw these defence mechanisms as being socially structured and developing over time following reinforcement by managers and staff:

> ' A social defence system develops over time as the result of collusive interaction and agreement, often unconscious, between members of the organization as to what form it should take. The socially structured defence mechanisms then tend to become an aspect of external reality with which old and new members of the institution must come to terms' (p51).

The following are examples of some of the social defence mechanisms identified by Menzies which she suggests assist staff in the accomplishment and achievement of their tasks under difficult and personally threatening conditions;

- splitting up the nurse-patient relationship (distancing);

- depersonalisation, categorisation and denial of the significance of the individual;

- detachment and denial of personal feelings;

- the attempt to eliminate the need to make decisions by ritual task-performance;

- reducing the weight of responsibility in decision-making by checks and counter-checks by senior staff;

- collusive social redistribution of responsibility and irresponsibility;

- purposeful obscurity in the formal distribution of responsibility;

- the reduction of the impact of responsibility by delegation to superiors;

- avoidance of change (Menzies pp50 - 63)

Individuals vary in the extent to which they use these mechanisms and the personal agendas they develop to cope with their work will be influenced by their past experiences and learning behaviours. Some of these behaviours will undoubtedly result in a detachment from the primary purpose of the nurse's role, to provide an individually based service to each patient. In some cases the defence mechanisms may work to the positive disadvantage of the patient and may cause them to become the subject of ridicule and distraction. Stockwell(1972) indicated the significance of joking behaviour in long term care. In some cases such jokes may become personalised and whilst introducing humour into very tense situations may cause personal embarrassment and humiliation for the patient. As Martin points out (p84) 'mildly poking fun can be acceptable amongst friends , but it always involves a social risk, and it is not surprising that sometimes jokes misfire and take a cruel or hurtful form. it represents a slippery slope and can easily lead to bullying and totally unprofessional behaviour' (p84).

Staff clearly have the upper hand in mental handicap hospitals and there is little doubt that this statement is true. The following statement from Ryan typifies my own experiences:

> 'That the staff's authority is unassailable comes across clearly when hospital patients talk about their lives: 'If you speak your mind, you're called cheeky. If you keep quiet, they tread on your toes.'; 'It was terrible you could not go out, you could not do this, you could not walk about as you liked, had to stop in the ward' (p54).

Possible Explanations.

The hospitals social structure serves to reinforce the dependence and incapacity of patients. In such circumstances it becomes easy to objectify people. Ryan (1980) identify that mental handicap hospitals encourage staff to regard their charges as objects rather than people. The authors suggest that the main reasons for this process are:

-the absence of any equality or similarity between people;

- the absence of the possibility that people can be anything other than prescribed by their social roles or definitions;

- the absence of the acknowledgement of subjectivity, of people's own consciousness of themselves (Ryan and Thomas p47).

Brown (1973) and John (1961) point out that individual nurses are responsible for their own actions, even within highly bureaucratic systems.

It is this aspect of personal responsibility and self-discipline that cannot be abdicated:

> 'In the end the individual is of critical importance even within a highly bureaucratic organization. In the final analysis men think, feel, choose and act. Responsibility in these unique forms of human behaviour cannot be abdicated in the name of organisations and institutions' (Brown p422).

> 'There comes a point in every normal person's life when responsibility for his actions and behaviour must depend on himself. If a man is considered mature enough to, hold the emotional well-being of his patients in his hands, it is reasonable to assume that he can also run his own life. Certainly in no other profession are outside sanctions expected to reinforce a man's personal self-discipline' (John pp113-114).

John (1961) found that 40% of staff were concerned with the 'laxity which existed', in hospitals and demonstrated that in striving for improved status, a number of nurses publicly demonstrated that were both 'willing and eager to adopt the sterner discipline and more exciting ethics consistent with professional standards of behaviour' (p112). A nucleus of professionals were found in each of the four hospitals studied who were ready to introduce reforms. However,when such positive attitudes were put to the test a typical staff response to queries relating to why tasks were performed in certain ways was, 'We have always done it' (John 1961).

Such potential conflict between the caring attitudes that existed amongst staff for their patients and the abuses that came to light in the 1970s is shared by Beardshaw (1981) in a quote from a psychiatric nurse she interviewed in 1980:

> 'There is something wrong with a system that chokes people, isn't there? These people haven't stopped caring, they've just been coerced by the system not to care or not to appear to care as much' (p83).

Conformity to the social customs of the organisation is understandable if one considers the pressures exerted by established staff and their allegiance to the social systems operating in long stay hospitals. Beardshaw, Martin and John described the penalties for non-conformity and as such many staff found it easier to follow the same course of action as their colleagues. Martin believed that it did not necessarily imply personal failure to succumb to such pressures and used the concept of 'delinquency and drift' (Martin 1984 p96) originated by Matza (1964):

> 'It may just be, as Matza pointed out in 'Delinquency and Drift, that deviant norms are strengthened simply because no one in a group wants to appear different - each thinks the others are more committed than he or she is, and thus unsuitable customs grow by accretion and repetition. It becomes, in his terms, a sub-culture of delinquency, as opposed to a delinquent subculture - one in which delinquency is made possible but not deliberately encouraged' (Martin 1984 p96).

According to Matza, the concept of deviant behaviour is very simple and uncomplicated and is explained in terms of straying from a path or standard. In many cases standards are not easily defined and within a mental handicap hospital there may be several, and potentially conflicting, sub-cultures and rules in operation. This plurality may present different rewards to different groups of staff and may result in differences of opinion. Box (1975) suggests that subscribers to any one culture will normally try to have its major precepts legitimised and accepted within the dominant culture of the organisation (p7). Many of the practices and routines employed by nurses in hospitals are not publicly visible and may therefore escape scrutiny by the official policy makers and by those responsible for monitoring the quality of life and care for patients. In such situations it might be that staff seek not to legitimise their activities formally but to seek their endorsement more subtly by enshrining them within the tacit norms or rules which exist within the workforce.

Box also notes that conflicts or controversies may not be clearly obvious within organisations and may be influenced by 'institutional expectations', 'expectations which are shared', 'norms which are socially defined as appropriate and morally binding', and the 'tolerance limit of the community' (p8). The origins of many of the rules and sanctions which exist and are applied in organisations may be unknown to the majority of the workforce and yet staff may still follow them without question:

> 'any concrete social structure that persists for any length of time must therefore be institutionalised or legitimised into a system of consensual authority. However, there is a very wide gap between large-scale participative, voluntary, informed consent to the role demands....and overt opposition to them' (p196).

As one might imagine, following patterns of activity which mean little to the individual might occasionally encourage the development of a repressive sub-culture. Martin (1984) suggests that this might attract people 'whose personalities are more in tune with cruelty and harshness' (p96). The mental handicap profession presents staff with more than enough opportunities to meet frustrations in their everyday work and these, when accompanied with boredom and a feeling of purposeless activity, may lead to the display of violent forms of expression. Martin believed that such situations may not indicate the presence of 'sadists' in the profession but warns that when unacceptable behaviours are allowed to develop unchecked that they might eventually lead to violence and assaults against the patients they were employed to protect from exploitation. Martin found many examples of alleged 'ill-treatment' in mental handicap hospitals during his study 'Hospitals in Trouble' which illustrates this point further (p97). Martin further suggests that the low popularity associated with the job encourages managers to be less selective in their appointment procedures and this may lead them to 'take on dubious recruits' (p97). Sadly there was little evidence that managers assumed responsibility for training these staff or for encouraging the development of more appropriate and positive care practices.

Nolan (1989) suggests that the personalities of some of the male nurses employed after the end of the second world war lent themselves to the institutionalised practices of the hospitals:

> 'the accounts offered by the retired nurses interviewed in this study suggest that all experienced a long period of post-war readjustment to normal social life. Their natural human sympathies had been numbed by what they had been through. They were attracted to hospital work, not out of concern for their patients, but by the military aspects of institutional life. It seems to have taken years for these men to work through a state of mind which made them treat patients as the enemy or as junior recruits, to one which enabled them to sympathise with their suffering by relating it to their own' (p59).

At this point we should consider why seemingly caring staff are able to behave in such unacceptable ways. Deviant forms of behaviour may well clarify social rules of behaviour and may legitimise those latent social processes which are present within the sub-culture of the mental handicap hospital. Such practices may be accepted as everyday practice and thus disguise the irregularity of their actions when judged against the legitimate business of the organisation. Clearly care practices which are allowed to continue without checking, may benefit some staff by making their jobs less stressful or intensive. However, this may be at the expense of their patients or of some of their colleagues who may be pursuing the professional aims of the organisation. When such situations prevail staff may remain free to engage in whatever forms of behaviour they feel are appropriate or with which they feel most comfortable. The latter forms of behaviour have usually been encouraged by the social climate of the organisation and may become an integral part of the sub-culture socialisation process which exists in each hospital.

Engaging in seemingly deviant forms of behaviour may be associated with the concept of group loyalty or conformity as explained above or it may be that staff receive personal reward by minimising the amount of personal effort or work outputs expected of them. Take for example a busy ward of thirty people with physical and severe mental handicaps who require total care and support with all bodily functions. The four staff who may be on duty with them face a major dilemma in choosing how best to meet their needs. The staff may aspire to provide individual care but will need to accommodate work schedules based on task allocation. The result will be a depersonalised approach to care which will distance the staff from the core purpose of their job and will relegate them to the position of technicians. The sheer physical efforts involved day after day combined with little diversity in work patters may encourage staff to look for short cuts in performance and to disassociate themselves from conventional forms of practice or recognition of human rights and morality.

The lack of respite from impoverished routines may lead staff to 'neutralize' their behaviours and to 'drift' towards a patterns of practice which may be associated with the deviant sub-culture of the organisation. The theory of neutralization and drift was developed by Sykes and Matza (1957) and according to Martin (1984) provides 'a helpful starting point' in the understanding of the ways in which staff rationalise their behaviours(p99). Sykes and Matza suggest that a typology of rationalisations exist consisting of five techniques of neutralization. One of these is identified as the 'denial of injury' which implies that staff fail to accept that their actions actually cause injury or distress to their patients.

Many people with mental handicaps do not possess the necessary skills to articulate their needs or to present their own grievances. Some people may not demonstrate their emotions or reactions to the routines of the wards, which may encourage the denial of patient feelings and may lead some staff to suggest that 'patients do not feel in the same way as ordinary people do'. The denial of certain basic rights to hospitalised people may also be significant for patients who rely on the integrity of their staff or 'carers' to represent their interests and to protect them from harm or exploitation.

It is as a result of the acknowledgement of the needs of hospitalised people that we are now witnessing the development of advocacy movements within the United kingdom. Such schemes aims to provide an independent source of support and representation for dependent people. [The Conservative government has also demonstrated a partial commitment to the concept of citizen rights through the enactment of the 'Disabled Persons (Services, Representation and Consultation) Act (1986). However, it should be noted that four of the most important Sections of the Act are still awaiting 'enactment and funding' and in their absence the concept of citizen advocacy is regarded by some as tokenism (Mencap and Values into Action 1989)].

For many of the patients the experience of routine and sometimes harsh treatment becomes an accepted part of everyday life in the institution. The apathy and response to such dehumanising treatment may in turn condition some of them to fail to recognise genuine attempts of kindness and support that staff might be trying to make to make. In such circumstances a vicious circle might be created whereby staff are confronted with negative or neutral responses to their attempts to engage patients in valued or meaningful activities, and these in turn may encourage them to adopt less personally demanding interactions in the future.

The way in which nurses address their patients also does much to reinforce the theory of neutralization and denial of individual feelings. The culture of the hospital encourages staff to call each other by their surnames and not to use familiar titles. However within staff groups and wards first names are used but in public conversations a reversion to formal titles is witnessed. This apparent conflict of approach is similarly witnessed when addressing patients who may secretly be called by nicknames or first names by individual staff but who receive formal address in public. Consequently a discrete pat on the head and a 'cuddle' when bathing 'Johnny' by nurses might be replaced by a mechanistic approach to bathing 'Smith' (or in general hospitals, Mr. Smith), when the nurse in question is accompanied by other patients or by staff.

The dependency needs of people with mental handicaps may encourage staff to treat and to regard them as children, thereby denying them the right to considerations and treatment more appropriate to their chronological age. Many may be treated as children and unintentionally humiliated. Kathleen Jones (1974) considers this in her study of 25 subnormality hospitals:

> 'found that the severely subnormal were often called 'the babies; the 'Boy's ward might contain 50 patients 50 years old; and a ward for mature women patients might be divided into 'big girls' and 'little girls'. For many staff, this was the best model of staff-patient interaction they had. Often it brought out a kind of protectiveness and tenderness which was valuable in patient care; but it also had less desirable implications.....these children were static and consequently exasperating.... when staff failed to elicit some response from patients to their care, they tended to feel that they were 'ungrateful' for what was being done for them. Above all, many ward staff came from family backgrounds where the normal reaction to unruliness or disobedience was 'a clip around the ear'. As one of the staff said, 'The doctors say we should treat them as our own kids, so that's what we do. If my son does something wrong, I give him a slap. It's the same with the patients' (p249).

During the course of my work I have witnessed many occasions when the needs of people with mental handicaps have been subjected to infantile interpretation by their carers. A significant number of unmarried female carers were employed in the hospitals who treated their patients as their own children. If you were to ask them the age of their charges they would take several moments before responding. Their initial response would be to recall the age of each child when they first met them, failing to recognise that many years may have passed since that time. Others would buy child-like clothes for them and toy cars or dolls for people who were closer to adulthood. The use of childish language and a denial of the sexual needs of patients was also common. Staff would regard any expression of sexuality as 'filthy' or 'dirty' and thus denied that the physical and emotional development of their charges had far surpassed their actual mental development. Staff were, thus, fixed in time and their practices were characterised by a basic denial of the rights and responsibilities of their patients.

The denial of responsibility for what staff do has also been recorded by Menzies (1970) and basically means that the staff believe that they are unable to change a system of accepted practice which has been determined by others. Buck passing of responsibility may also occur with staff passing responsibility up the line to their superiors in the ward hierarchy. Others may hide behind a cloak of collective responsibility whereby the rules governing what is right or wrong become blurred within a web of bureaucratic convenience spun by staff to minimise responsibility for individual decision making. In some cases staff may judge their actions against the behaviour of their patients and may believe that violent acts on their part warrant firm management. Guidelines are often provided for the management of individual patients for which responsibility officially rests with the doctor or consultant psychiatrist. However in practice treatment programmes are often devised by the senior ward based nurses who, on behalf of the doctors and the hospital managers, ensure that behaviour problems are appropriately controlled. Decisions will often be made in terms of the calculation of risk if less forceful intervention were taken. Nurses are constantly working under orders to balance the well-being of all the patients in their care with that of their staff. By stating that they 'acted in good faith' to prevent danger to others they are often able to deny responsibility for their actions when dealing with a violent attack.

Guidelines for the management of violent behaviour usually include a standard phrase to advise staff on how to deal with these situations, 'the minimum required amount of force should be used to bring a violent situation under control.' In practice this might mean that nurses have to balance the treatment needs of one patient against the well-being of others. One other problem for patients is that they often develop a reputation for violence which, entered in their official records reinforces a negative label for future encounters. New staff are automatically introduced to the patient, not just by name but also by the degree to which their behaviour is judged to be antisocial or disruptive. The anticipated appearance of disturbed behaviour may encourage staff to use firm methods of handling residents which in turn are supported by the hospital managers based on the persons previous history. Perhaps a personal example would illustrate this further:

> 'Robert, a 35 year old man lived with twenty other adult males in a 'locked ward' in a long-stay hospital in the south of England. Ten years previously he had been admitted to the hospital and was noted to be aggressive and potentially violent. He had a history of biting people and kicking. After six months his behaviour was assumed to be so disturbed that he was sent to the locked ward for the safety of others. The reputation of this ward was well known in the hospital and had the overt function of providing a high staff ratio to assist in the mediation and reduction of violent behaviours. The therapeutic milieu was balanced against a more sinister acceptance that the ward existed as the 'punishment ward' from which staff and patients rarely returned. After ten years, Robert found himself treated as an isolatee within the ward and was locked in a side-room away from the other patients at night. During the day he would be the last to receive care and would be 'fed' in a corner of the room by cautious staff who keep a discreet distance form him. However a community based service was opened nearer to his home and an assessment of his needs recommended that he should be transferred to the new unit where new staff treated him as an individual without paying too much attention to his previous behaviours. After three years Robert was fully integrated in the unit, with his behaviour under full control.'

This recollection illustrates the powerful way in which preconceived ideas about patient behaviour can influence how staff behave. In many ways this scenario operated in locked wards and was typical of a specific sub-culture within the hospital which can be compared to the 'glass house' or isolation block in prisons or concentration camps. Responsibility for the regimes rested clearly with the hospital managers and the individual staff who could, understandably, be said to be acting under the instruction or orders of their superiors. Failure to follow these instructions could result in disciplinary action which might be defended in that 'it put other patients at risk when the rules were relaxed'. As one might expect the rules existed to enforce a moral code of behaviour within the wards which were typified by the presence of 'heavily built' staff and a profusion of keys and uniforms which further distanced the staff from their patients and emphasised the power base of the staff group.

Martin suggests that one other technique of neutralization identified by Sykes and Matza may also be relevant here. That is the 'condemnation of the condemners' (Martin 1984 p 104). Martin suggests that the work of 'do-gooders' is discouraged on the basis that an expert store of knowledge is possessed by the experienced carers thus legitimising their status and right to control the care situation. In other words it may be likened to a 'we know best' syndrome. Martin suggests that a process of 'professional mystification' might be in operation to protect the franchise which the nurses believe that they have on the care process(p105). The final Sykes and Matza defence is that of 'appeal to higher loyalties' and operates when staff become concerned when any of their number become over involved with their patients. Towell (1975) suggests that staff may apply sanctions to nurses who deviate from the accepted care process partly in order 'to protect individual nurses from stressful emotional experiences' and partly to ensure conformity and solidarity within the staff group. Over involvement may also be regarded by the staff hierarchy as 'weakening staff control over patients. More generally in meeting unusual requests from one patient might make it more difficult not to meet similar demands from all patients (Towell 1975 pp 93-4).

Miller and Gwynne (1974) introduce the concept of 'the distortion of the primary task' (p173) in their study of care practices in services for the physically handicapped. They suggest that the primary aim of some institutions may be to provide support for staff:

> 'Indeed, far from providing support for individual inmates, some institutions appear to be set up in such a way that their primary task is to provide support for staff. The inmates are a means to this end' (p173).

They found that a significant number of staff working in such establishments had social handicaps of their own. They found that the proportion of staff who were divorced or separated was higher than in the general population and that another group had a history of mental illness. They suggest that a close relationship of mutual support develops between the helper and the helped and whilst this has some advantages in the care process the authors warn that there are some dangers inherent when 'these collusive processes' exist. Such processes may become a major feature of the hospital culture and, in my experience, serve to provide staff and residents with a means to avoid certain routines and to receive certain privileges. 'Useful' patients might keep a watchful eye open for senior ward visitors and act as a 'lookout' for staff who might be relaxing or watching television rather than working with patients; in return additional food portions, drinks and later bedtimes might be given. A system of mutual dependency emerges which eases the problems which ward life and routine presents.

Miller and Gwynne believe that for the more vulnerable people in society the appointment of staff who are dependent on the institution to meet their own needs may encourage collusive processes to develop:

> 'These residential institutions, however, as recipients of individuals whom society has already rejected, are less amenable to the processes of wider social control and there is thus a greater opportunity for collusive processes to develop that are more destructive of the inmates's individuality than supportive to him....One form of insurance that an institution can adopt to prevent such distortion of its primary task is to recruit to its staff people who have an established role in in the wider society - and who do not depend for their personal identity and social status on maintaining superiority over the people in their care' (p174).

People with mental handicaps are 'labelled' by society as being different and it is this concept of being different which might imply that they require a set of care standards of their own. Erikson (1957) suggests that society defines mental illness and handicap as a form of 'secondary deviance'. In order to differentiate between members of the dominant culture and those who have been labelled as deviant, ceremonies exist to confirm their shift in status:

> 'The community's decision to bring deviant sanctions against the individual....is a sharp rite of transition at once moving him out of his normal position in society and transferring him into a distinctive deviant role. The ceremonies which accomplish this change of status, ordinarily have three related phases. They provide a formal confrontation between the deviant suspect and the representatives of his community (as in the criminal trial or psychiatric conference), they announce some judgement about the nature of his deviancy (a verdict or diagnosis for example) and they perform an act of social placement, assigning him to a special role (like that of a prisoner or patient) which redefines his position in society' (p263).

Erikson regards these ceremonies as being almost 'irreversible' and once a person is admitted to hospital, exposure to new systems of social control commence. Townsend, in the preface to Morris (1969), takes this further and suggests that since people with mental handicaps may be unaware of what is expected of them, they may adopt deviant roles of their own which require management and corrective treatment (pxxi).

Miller and Gwynne (1974) attributed this to the fact that:

> 'They have for the most part been rejected as individuals, in that their families are no longer willing or able to look after them. More importantly, by crossing the boundary into the institution, whether voluntarily or not, they fall into a rejected category of non-contributors to and non-participants in society, and indeed are virtually non-members of society' (p73).

The most visible sign of distance is the wearing of uniform and the importance attached to it. This visual symbol of control and order serves as a constant reminder of the power ascribed to the staff over their charges. Systems to control social behaviour may therefore emerge which provide staff with the opportunity to exert their influence and to display status symbols to reinforce and to publicise their superior role in the organisation. Hartman (1969) suggested that nurses demonstrate considerable power in a manner which may be debilitating to the patient. He introduced the concept of the 'key jingler' who may be characterised by his adherence to bureaucratic procedures, his ability to exert his influence on persons with less power (in some cases in a way more associated with confidence men), and his intent to pass the buck to superiors for any decisions that need to be made outside of the routine work of the ward. He found that staff adopt the established norms and practices of the institution and thereby become part of the conditioned culture, often without question or challenge. Staff may use symbols to display their power and status eg. keys, uniforms and by their access to personal information and knowledge relating to patients.

The way in which staff maintain their position within the organisation and display their loyalty to the predominant culture of the hospital will undoubtedly affect the quality of life and care offered to their patients. The techniques of neutralization and rationalisation referred to above serve to provide one set of explanations for the way in which staff behave when confronted with demanding and sometimes conflicting responsibilities. These defences do not, however protect the individual entirely as Sykes and Matza (1957) indicate:

> 'Techniques of neutralization may not be powerful enough to fully shield the individual from the force of his own internalised values and the reactions of conforming others....Nonetheless we would argue that the techniques of neutralization are critical in lessening the effectiveness of social controls and that they lie behind a large share of delinquent behaviour' (p669).

Staff and residents do however share equality in resect of the deprivation of the institution. For staff scarce resources and low numbers provided them little opportunity to engage in therapeutic practices even if they wanted to. The residents for their part displayed a series of emotions and behaviours, some of which were calculated to achieve responses from staff to meet their own needs. Not all were passive recipients of an uncaring regime. Staff were, in some ways, as much victims of the system as their charges:

> 'Many hospital staff deliberately chose to enter this kind of work because they want to deal with people rather than machines or commodities. Many of them struggle to maintain this sense of their work, despite all the pressures that separate them from the patients as human beings. Yet given that the hospital system does tend to make them simply into managers of the institution's 'raw material', is it surprising that so many either leave disheartened or else are forced to abandon their idealism?' (Ryan & Thomas 1980 p68).

From my own experience staff in such situations often feel that inadequate guidance and support is provided by managers and nurse administrators. As a result many nurses feel undervalued and unable to use their skills and training in wards characterised by the need for task orientated practices. Many staff were clearly aware that the hospitals failed to provide the correct environment for their patients and were critical of the conditions within which they had to work. The reports of the 70s and 80s gave advice on more appropriate care models but all failed to provide staff with the advice necessary to sustain good care practises in deprived situations:

> 'The question, 'Who cares for the carers?' is unasked and unanswered. We have seen in this book that it is often the staff who are in closest daily contact with the mentally handicapped who most have a need to distance and differentiate themselves from them, to see them as abnormal and unlike themselves. We have to come to grips with the personal needs and fears involved in this as well as the institutional and professional pressures that militate in the same direction. If we do not, we are in danger of planning for a future that will not be realized, and for a failure that will once again be blamed on the supposed incapacity of mentally handicapped people to 'move forward'' (Ryan 1980 p147).

This chapter has considered the ways in which staff are affected by the culture and environment of the institution and various theories have been expounded to account for the reason why staff adopt various strategies during the course of their everyday work. Townsend (1973) suggests that any move to change the current pattern of care provision would require a major restructuring of our social value system:

> '..the act of isolating mentally handicapped people, usually in large institutions, is also a political act. It confers greater power than perhaps we suspect on certain people but also on certain ideas and values. The staff determine every detail of life of patients to an extent which is unrivalled in, say, the most paternalistic firm. This creates special problems for staff as well as for patients. But this conferment of power has other effects....as a consequence the system of political authority is much more oppressive for the patients...It is important for us to understand that the very existence of the long stay hospital shapes our concepts of mental handicap itself, our values, our fears and even our willingness to assume that the problem is one primarily for medicine and nursing' (p199).

SUMMARY

THE CHARACTERISTICS OF THE MENTAL HANDICAP HOSPITAL.

- the hospitals were characterised by their geographical and social isolation from the communities which they served; physical and social barriers existed preventing the cross-fertilisation of hospital and non-hospital ideals and values existed;

- all aspects of daily living for the residents and for many of the staff occurred within the four walls of the hospital estate;

- the hospital 'team' worked with the explicit and corporate aim of maintaining the status quo of the organisation rather than to promote the well-being of the resident group;

- a sub-culture existed within the hospital for both residents and staff which was characterised by uniform practices and daily routines, tacit rules and enforced conformity;

- symbols of power existed to differentiate between staff and residents and different grades of staff such as keys, uniforms, rule-books and access to information;

- hospitals existed as communities in their own right with on-site facilities such as cinemas, shops, social clubs, housing estates and sports clubs;

- kinship ties and religious affiliations amongst staff were common and encouraged the development of a closed subgroup within the hospital community;

- staff were recruited from family groups and were often attracted from similar backgrounds which encouraged conformity to the aims of the institution;

- the hospital year was characterised by a festive calendar which included sports days, pantomimes and pageants; these all served to reinforce dependency upon the hospital culture;

- staff facilities were provided on-site with the effect of encouraging dependency on the hospital. e.g. subsidised housing, single staff accommodation, social clubs, dining rooms, sports clubs and subsidised transport services;

- contacts with relatives, members of the local community and volunteers appear to have been discouraged in the hospitals; the hospitals were therefore socially cocooned;

- decision making processes were discouraged at ward level and were deflected 'up the line' to senior managers;

- career progression was clearly defined and limited to those whose achievements were evaluated in terms of ability to conform to the status hierarchy of the institution rather than through demonstrated abilities to improve therapeutic approaches to patient care;

- staff jobs were relatively secure and free from external influence or change;

- a system of controlled access to information existed;

- strong peer-group pressures existed which encouraged new staff to adjust to the prevalent values of the hospital sub-culture which existed to operate as a closed social system to protect the status quo of the organisation;

- within the hospital the wards and departments existed as discrete social systems of their own , initiating their own staff and preserving the limited resources and routine practises therein;

- staff develop social defence systems which existed to protect them from the reality of the impoverishment of their daily routines; these were conditioned and passed on to new staff through initiation ceremonies;

- within the institution existed a self perpetuating system of disillusionment and apathy which encouraged staff to develop escapist routines and regimes to avoid exposure to to their client's lack of progress;

- many staff had second jobs and learnt to exploit the hospital system for their own ends;

- work was organised on the basis of task allocation and was goal directed to minimise the work effort for staff;

- responsibility for personal actions was discouraged and passed up the line to senior staff; staff detached themselves from personal involvement with patients and tended to objectify their association with them;

- in times of stress staff occasionally engaged in ridiculing their patients and by joking at their expense in an effort to relieve the boredom of the ward routines;

- staff may have sought to legitimise their daily practises and behaviours by defining a code of conduct to which all staff were encouraged to collude; tacit rules and norms existed to this end;

- work is characterised in terms of sheer physical effort rather than through analytical or problem solving approaches to care; work was crisis orientated rather than preventative;

- the lack of public involvement or exposure encouraged the development of a closed system which did not lend itself to external criticism or comment; consequently malpractice, the degree to which it occurred being hard to define, was rarely reported since staff may have hidden behind a cloak of collective responsibility;

- guidelines and procedures existed for most tasks and routine operations;

- staff organisations and unions were commonplace;

- sanctions existed for staff and patients who did not conform to the rules of the organisation;

- staff and residents existed in a state of mutual dependency; each was dependent on the other for survival in extreme conditions;

- within the organisation existed a distorted hierarchy of social control and power which was controlled by the staff members;

- within the institution existed a false belief that 'the problem' and responsibility when things 'went wrong' existed only with the nurses and the doctors.

Chapter Five

The Issues Involved in Creating a New Culture for Mental Handicap Nursing in the Community.

Characteristics of the Old Hospital Culture - Key Issues.

The last chapter considered many of the features of the large mental handicap hospital and described the nature of the culture that existed therein. As hospitals close there will be several key issues to address in respect of the effect that the dissolution of the sub-culture of these institutions will have for staff. This section considers the key issues involved in this process and poses the main questions for further investigation.

INTEGRATION vs SEGREGATION

Since the hospitals were characterised by their isolation from the local community internal systems of self-support were generated by staff. Many staff spent years of their lives working within these isolated hospitals and some had little contact with the out-side world. As the hospitals close and integrate within local neighbourhood networks staff will be expected to share aspects of their daily work with their neighbours.

As a result they will be forced to reduce their dependency on the hospital which in turn will require a major change of attitude from one of reliance on the hospital and peers with value systems similar to their own to sanction their behaviours, to one of public exposure.

THE DISSOLUTION OF A SUB-CULTURE

Within the hospital existed a series of rules and sanctions which encouraged behaviour according to the ideals and standards of the institution. It may be assumed that some staff found a degree of security in the provision of rigid and hierarchical management systems and structures which demanded little of them in respect of personal decision making skills.

The provision of uniform practices and daily routines further determined role expectations and reduced the possibility of role conflict. The presence of explicit organisational goals helped to initiate staff into the sub-culture which was characterised by the preservation of institutional goals.

In the community opportunities for the continuation or transfer of similar staff/organisational sub-cultures may be restricted as different values and role expectations are introduced. If this is so then it will be necessary for staff to depend on the adaptation of their own personal value systems to set the parameters of their working lives. Personal accountability may also require that staff self-evaluate their performance at work in terms of the impact their personal contribution has on the quality of life for their residents.

The erosion of institutional practices will mean that staff will be expected to plan their working day on the basis of spontaneous decision making in response to the expressed needs of their clients and to their own need to get through the day with the minimum of external interference and stress. This will demand a new approach characterised by autonomous decision making, flexible shift patterns and individual choices which will make them personally accountable for their actions.

CHANGES IN THE BALANCE OF POWER

Changes in the philosophy of care in the community have demanded a review of the way in which decisions are made in residential care. The hospitals defended and reinforced management systems that were characterised by central bureaucratic procedures and rigid interpretations of rules. The power of the organisation was invested in professional hierarchical structures which were closely controlled by nurses, doctors and administrators.

In the community such structures are replaced by a transfer of 'empowerment' to people with mental handicaps. Staff will be expected to respond to the expressed needs of their clients and the role distance between nurses and the people they work for is reduced and blurred. This is different from the traditional hierarchical communication system of the hospital. In the community new management structures will be needed which should encourage the erosion of former patterns of management control. Such a system will provide opportunities for service users to gain access to planning systems, to their own case files and to participate in the review and evaluation of their service, thus reducing the status of nurses as 'guardians of their future and welfare'.

The move towards a client focus of care clearly influences the power base of professionals. Whilst in theory the degree of control that staff have over their clients is reduced in the community, staff will be confronted with a potential conflict of interest as they need to adapt to this new approach whilst retaining their interest in the advancement of their professional careers. In so doing there is an inherent danger that power relations will continue to operate in the new service and thus reduce the control that people with mental handicaps now appear to be enjoying in their lives (one safeguard against this would be to introduce a system of independent advocacy for service users).

THE LOSS OF AMENITIES AND 'FRINGE BENEFITS'

Hospitals existed as communities in their own right with on-site facilities such as cinemas, shops, social clubs, housing estates and sports clubs. Ties of kinship and religious affiliation amongst staff were common and encouraged the development of closed subgroups within the hospital community;

As institutions disperse into the wider community, so dependence upon the special nature of the hospital campus lessens. For some staff the transfer to small houses may mean the loss of social support networks which have formed a major part of their working and social lives.

Opportunities for meeting friends may also be reduced since the number of staff employed in each house is obviously less than in the hospital. In some cases the change of workforce may weaken long-standing friendships and kinship ties as opportunities for informal meetings at work reduce.

Similarly the dispersal of staff may reduce opportunities for managerial and personal support. Staff facilities such as social clubs, subsidised housing and sports facilities may also be missed and may have a profound effect on the morale and well-being of staff members, who for many years may have depended on their existence as a way of life.

Staff may also feel restricted in their new workplaces as opportunities to disengage from intensive client activities are removed. In small houses staff are expected to work for the whole of their shifts, without respite, in the same environment, whereas in the hospital 'escape' was possible by visiting others areas of the hospital or its departments. The removal of this 'defence mechanism' may create particular stress for staff.

Finally staff may find that the guaranteed overtime that many of them had in the hospital may not be available in the community. Instead staff may have to adapt their duty rotas to meet the needs of their clients and in addition may have to work twenty four hour shifts including sleep-in duties. These changes in conditions of duty may place additional demands on staff and may influence the degree of job satisfaction and reward that they receive from their work.

DE-or RE-PROFESSIONALISATION?

Working in the community requires all staff to share their skills so that their clients develop to the maximum level of ability. Similarly the rigid divisions that previously existed between different professions are blurred as multi-disciplinary teamwork requires all staff to unite on an equal basis to meet the needs of their clients.

The number of qualified nurses in the community may also be smaller as opportunities are created for untrained staff to acquire new skills as an emergent auxiliary workforce. Additional unqualified support workers may be employed to work directly with clients as 'key workers' (UKCC 1986). These staff will require training and nurses will be the obvious group to lead and demonstrate desirable and appropriate skills. This will demand a new approach to skill sharing and may require the acquisition of teaching skills.

The concept of transfer of responsibility to the lowest point in the organisation is a feature of the new service. Traditionally the responsibility for making decisions about clients has rested with senior nurses and doctors. In the new service this responsibility is shared with keyworkers and their clients in liaison with senior staff. In some areas nurses may find that they are in competition with social workers for certain jobs which were previously restricted to nurse applicants. Staff jobs were relatively secure in the old system and free from external influence or change:

> 'Progress of some staff through assessment in training from unqualified grade and middle range posts to qualifications for posts with greater personal responsibility is likely to be stimulated by the development of new types of work in response to community care policies. These may well open up clusters of knowledge, tasks and skills new to the traditional professional which may ultimately cut across boundaries which seem sacrosanct in 1987' (CCETSW C/87 p4-5).

Nurses, in these services, may find that their skills are publicly scrutinised in terms of their suitability for a particular job, rather than receiving an automatic right to employment in all mental handicap services. Similarly, managers may, on the grounds of cost-effectiveness, be forced to review the skill mix in new and existing services and to judge workforce demands and requirements in terms of measured outcomes and productivity.

The changes outlined above refer to the imposition of new conditions within the Health Service following the introduction of general management and employment led training and represent major challenges and, in some cases, may present threats to nurses. For others they may result in role conflict and ambiguity as the expectations of their performance change.

Finally, the old routes of career progress, which depended on complying with the rules and fitting into the hierarchy of the institution, may well be swept away in favour of rewarding those who show a positive commitment to the new service and its client-centred ideals.

STAFF DEFENCE MECHANISMS

Within the hospitals opportunities existed for staff to disengage from intensive client contact and to distance themselves from responsibility for decisions about their clients. In the community staff are encouraged to assume personal responsibility for their clients and as the focus for decision making is so close to the residents, staff may find that they have to account for their own actions.

In many cases no guidelines or procedures exist to direct staff during their daily work and much of its nature is directed by the spontaneous needs of the clients. The absence of these procedures may threaten staff who may have been used to the hospital system which was characterised by rules and procedures for all activities. The removal of these 'safeguards' may expose staff to risks in their daily work and this may increase their stress levels.

In the hospital systems existed to remove responsibility for decisions by passing 'the buck up the line' to senior managers. In some services managers may have little influence on the operation of the local service and thus responsibility once again falls on individual staff members.

In the hospital staff were able to develop social defence systems to protect themselves from the reality of the impoverishment of their daily routines. These may have taken various forms but they were often characterised by distancing staff from their clients through a process of 'de-personalisation' (see **Menzies** 1970 in chapter 4). In the community service staff may require new coping skills to deal with exposure to client behaviours and presence.

The absence of staff rooms and uniforms may also 'blur' the concept of social distance between staff and clients and may offer some people no opportunity to 'escape' from intensive client work. Some staff may find the degree of exposure to their clients to be so intense that it is difficult for them to 'unwind' at the end of the day and they may have problems in adjusting to 'home life' after work.

Finally in such services the role of staff organisations diminishes as staff lose their status and transfer their loyalties from the organisation to the individuals they work with. The consequences of these changes in approach may be to expose staff to greater stress and to increase the demands made upon them as individually responsible practitioners working in new environments without rigid rules, procedures and sanctions.

THE MANAGEMENT OF CHANGE

The management of change will clearly be significant for staff transferring to the community. The way in which they are involved in the preparation programmes for the move and the degree to which they subscribe to the new philosophy of care will influence the success of the transfer.

> 'Indeed in all the changes resulting from restructuring, - within the project areas, as elsewhere - there has at times been scant evidence of the respect for staff as valued individuals so sacrosanct in current philosophies of client care. Ryan and Thomas have expressed sentiments simply and eloquently: "No amount of new buildings or new

> training programmes will produce the changes we desire if the people involved in these changes are not given adequate consideration and support themselves"'
> (Walton & Brown 1989b p150).

Staff may perceive the closure of hospitals in either negative or positive terms. Some may not have experienced any alternatives to the institution and inadequate retraining programmes may be their total introduction to the new system.

The pace of change will also be significant in securing staff commitment to community care. Some may feel 'bereaved' at the loss of familiar environments and friends, others may face the challenge of the community with mixed feelings, combining excitement with cautious optimism in respect of how 'their' residents will adapt and benefit from the change.

Some may be influenced by strong union or staff organisational opposition to the hospital closure programme whilst others may feel totally devalued by failing to acquire senior positions in the new service.

Clearly staff will require individual support, training and education if they are to perceive the transition as a positive experience. The degree to which they believe that they were able to influence the transfer programme and the extent to which their skills will be valued in the new service will also be important. The manner in which managers maintain morale and exercise their 'management style' during the crucial stages of transition may also be significant:

> 'While morale is a vague and nebulous term, which is difficult to quantify, it is, nonetheless, a vital ingredient in determining the climate in which services are delivered and changes considered.....Often it is not so much the decisions that are made that produce the difficulties but the way in which the decisions are arrived at and subsequently introduced - what could loosely be called 'management style'. As with 'morale', 'management style' can be difficult to gauge but its impact can be just as significant' (Walton & Brown 1989b p35).

Perhaps one overriding question will be whether staff perceive the move as being worthwhile and beneficial to all concerned. Individual experiences during the transfer period may well determine future work practices and personal commitment to the new model.

The process of change and its management may be described as a cycle. Adams (1976) in his analysis of staff responses to change in human services in this country, poses one model for change characterised by seven stages:

First stage: Immobilisation - a sense of shock, being overwhelmed and unable to make plans or to organise constitutes the first stage;

Second stage: Minimisation - with a reluctance to acknowledge the change, characterised by a temporary retreat from reality and a denial that anything different is happening;

Third stage: Depression is the next stage in the process, when an awareness of the change dawns; there may be sporadic outbursts of anger and a sense of frustration at not knowing how to change;

Fourth stage: 'Letting go' when there is some optimism and confidence and no longer a constant reference to the way things used to be done;

Fifth stage: 'Testing' when new behaviours are tried out;

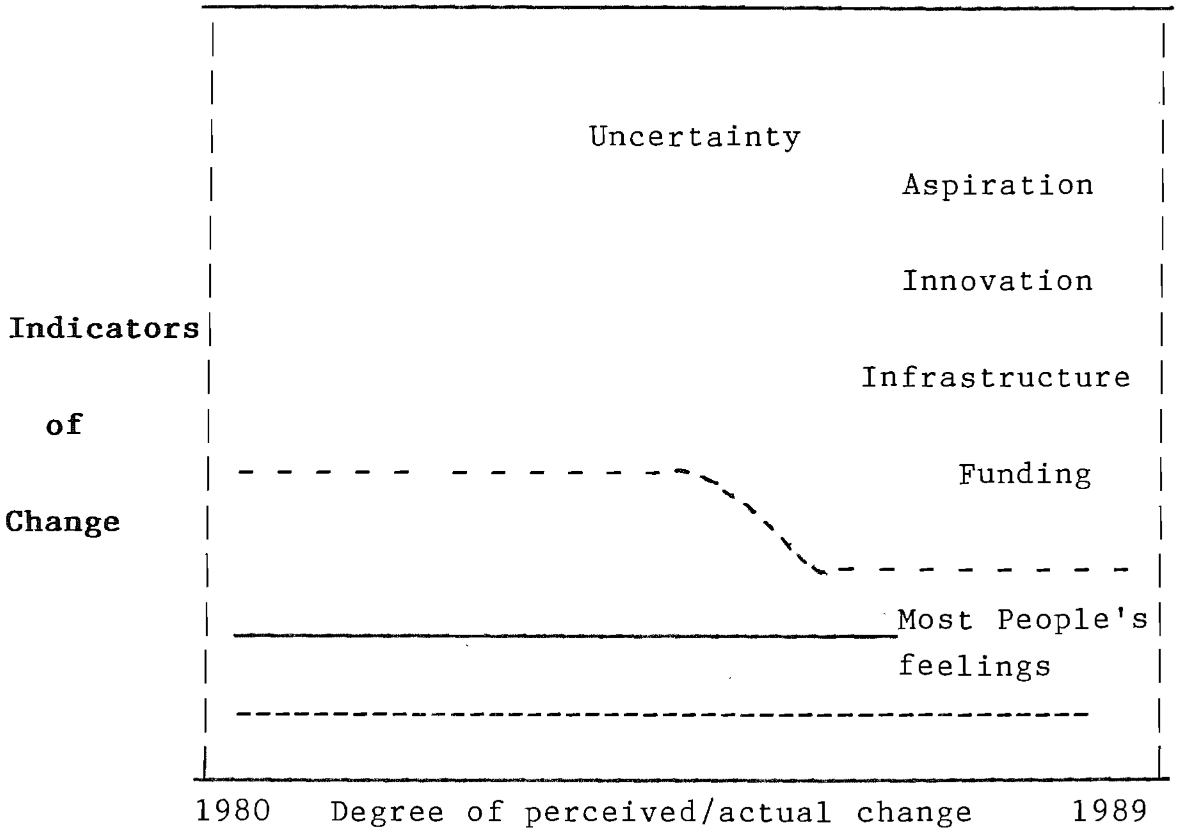
Sixth stage: 'Searching for Meaning', recognised by a gradual shift towards understanding with positive talking but with a need to step back and reflect on the meaning of the change and an acceptance that change is there to stay;

Seventh stage: Finally there is 'internalisation' when the new behaviour is automatic and feels comfortable; the old way is mentioned less often and then only in sentimental terms.

Much of management theory depends upon managers knowing what to do in almost every circumstance and as things change rapidly in the community, staff and their superiors will need to learn together with their clients, what to do when there are no clear guidelines. This may result in a tension between the practical politics of working on everyday issues with the resources that are currently provided and honouring the moral and philosophical claims that define necessary changes. This tension may be productive if attention is given to understanding the process of change and its impact on the workforce, but may be counterproductive to the philosophy of community care if no opportunities are provided to assist staff and their managers to gain a clear sense of how services will be provided in the future. Equally important is the need for staff to feel that the changes will result in a more appropriate form of care and lifestyle for people with mental handicaps.

In summary to this section, service users and their carers are now faced with what might be described as a complex and fragile situation as the move to the community accelerates. The following diagram presents some of the trends of the past fifteen or so years which shape the current pattern of services for this client group. The model presented is the result of a workshop, to which the author contributed with the National Development Team and symbolizes impressions on the rate and general direction of change. Whilst no quantitative units of measurement are implied the model provides some indication of the current situation within which many nursing staff now find themselves:

Figure 5.1



(From: National Development Team Sept 1989 p13)

The Model aims to describe the main indicators associated with the development of services for people with mental handicaps in the community and relates these to the progress made during the 1980s as perceived by service users and their carers. The following statements are provided to assist in identifying progress to date:

Funds: relative to increasing demand and rising inflation, funding has decreased in real terms, thus reducing quality of care and life;

The **Infrastructure**: the 'infrastructure' of decision making structures, methods of expenditure, methods of planning, methods of regulation and fiscal control have changed very slowly and often changes have been shaped by concerns other than ours;

Innovation: innovative ways to understand and respond to to people have expanded very rapidly both in the areas of everyday improvements in people's lives and in the longer term means to reallocate substantial funds. Innovation has developed in advance of changes in the infrastructure as the result of pioneering ventures by ambitious health and local authorities who have attempted to build new services ahead of awaited changes in national and bureaucratic policy. However, relatively few people are yet directly affected;

People's feelings: despite innovation, many people's experience has not improved much, and some people and their carers may feel that they are worse off outside of the institution;

Aspirations: these have risen very rapidly, based on a strong capacity to influence people's thinking by disseminating a new philosophy of care about real advances in care technology involving small numbers of people;

The complexity of the situation makes it difficult to assess whether the move to the community will result in success or failure. For staff faced with the realities of each of the changes indicated in the above diagram, one might assume that the process of change will demand particular strengths of character, energy and commitment.

The Transferability of Skills,Experiences and Commitment.

So far consideration has been given to the process of change involved in the move to the community and the key features and characteristics of the institution and its routines have been presented. Many of the skills and experiences acquired within the context of the hospital provide the starting point for both people with mental handicaps and their carers and it is to an examination of the transferability of these that this chapter now moves.

The 1982 syllabus of training for mental handicap nursing (GNC 1982) was intended to prepare RNMH nurses to work with people of all degrees of disability and in all service settings. This was, of course the explicit intention of the curriculum planners, following the harrowing experiences of the outcome of the Jay Committee of enquiry into the profession in 1979 (DHSS 1979). Some nurses have been disillusioned by the negative stereotyping that they have encountered from other agencies when they have applied for jobs outside of hospitals involved in the process of closure. Despite all of the evidence of ex-hospital nurses' pioneering and imaginative work in the community (Leonard 1980, Korman and Glennerster 1985, Allen 1988), the assumption that hospital trained staff are not suitable to work in the community still exists in some areas. Moreover as Allen et al argue:

> 'there is a certain absurdity in the idea that whilst residents from an institution are de-institutionalised for life in the community, their former professional caretakers may be seen as unsuitable employees because they are 'too institutionalised' (Allen et al 1988 p173).

Korman and Glennerster in their analysis of the closure of Darenth Park Hospital also note the tendency, during the closure period, to paint the institution and what is done in it, in the worst possible light - 'as part of the attempt to show how much better the new service will be' (1985 p146).

The government have repeatedly stated their allegiance to the transfer of mental handicap nursing skills to the new service and this was highlighted in the Griffiths Report (DHSS 1988 p27). Clearly to assume that nurses will automatically be unable to transfer their skills to the new service is counter-productive and risks inciting or increasing resistance to new approaches and services.

Walton and Brown (1989b) offer some support to nurses undergoing transition by comparing their need for sensitive support with that of parents of handicapped children:

> 'Institution-bred task-orientated approaches have also served as 'coping-mechanisms' both psychological and practical for nurses who were often struggling against impossible odds in their day-to-day work. Great sensitivity is required of nurses working in the community now in respecting the confused and guilt-ridden feelings of parents, who, not that long ago, were often told by professionals to put their mentally handicapped child into hospital. The same kind of sensitivity is required in considering the feelings and orientation needs of hospital staff, trained under a very different ethos, whose years of service in often appalling conditions are now being implicitly - or explicitly- denigrated' (p147-148).

In the same report Walton and Brown identify a reservoir of expertise which exists within the hospitals in the area of challenging behaviour which could also be drawn upon more to help provide the specialist input and support for which there is such a demand from staff and families in the community' (p148). It is these skills which enhance the possibility of 'employability' within multi-agency services and which provide RNMH nurses with a unique skill-base from which to bargain for their rightful place in the new service.

The extension of these skills through the development of community based teams during the past ten years has been well received and acknowledged by families and other professionals. The idea of extending these skills into the community offers a valuable teaching and specialist resource to new services in the early stages of evolution. It might, therefore, be argued that there will be sufficient jobs in the new service to meet the work requirements of the total population of trained mental handicap nurses when the move to the community is complete.

Walton and Brown (1989b) consider that this optimistic forecast is founded on a realistic appraisal of the needs of mentally handicapped people as they leave hospitals. Consequently to extend the nurse's role into the community might:

> 'reduce the isolationist factor of the institution..... and encourage recruitment by counteracting what Allen et al (1988, p. 53) have termed "an institutional myopia" which "focusses people's minds on a supposed reduction of opportunities rather than what is, in effect, an expansion of services"' (Walton & Brown 1989b p149).

The role of mental handicap nurses in the community may be regarded as a discrete specialism as the nurses follow their residents 'out of hospital' and as their skills are exposed to public scrutiny. There is already evidence to suggest that nurses are being regarded as a valuable resource with much to contribute to community based services by virtue of their long years of experience.

One of the most important contributions that nurses can make will be the ability to share transitional experiences with residents. New wider roles will be built upon the foundation of previously acquired skills and experiences which were developed in hospital. Similarly relationships, built with residents in hospital will continue if staff are enabled to transfer with their charges. Many parents have expressed relief and have received reassurance when long term relationships continue, proving the fact that friendships and personal trust which transcend traditional service structures, may be of greater significance than the stereotyped image of the caretakers.

Community care has been regarded by many nurses as a necessary and long overdue development. Exposure to inadequate, and in some cases inappropriate, resources and work conditions has equipped nurses with a certain resilience and tolerance which may be a positive strength as new models of care are introduced and tested. The implementation of the 1982 syllabus of RNMH training has meant that a wide range of contemporary skills can now be deployed in a wide variety of settings in the community as well as in the hospital. In recognition of this managers are beginning to plan their services to support initiatives developed by mental handicap nurses in recognition of the need:

- 'to ensure that scarce professional skills are used for the most cost effective benefit to the consumer; and

- to identify and evaluate varying patterns of skill mix with reference to consumer satisfaction, cost effectiveness, and quality of care' (Walton & Brown 1989b p163).

With the transfer to the community will come the need to accurately assess the skills required by a new workforce. This task will be made less easy since the needs of the client group have been identified in the past in relation to an institutionalised frame of reference. As people move to the community so new patterns of behaviour emerge and new skills and opportunities for development may be witnessed. Managers will be faced with a dilemma as they set about determining the skill and grade mix for their new services and will be forced to draw upon a local and available pool of labour.

In most cases the skills that they require will only be present in mental handicap nurses who have worked previously in mental handicap hospitals. Social workers may be attracted to new services but they will only be available in finite numbers since there is limited scope for specialist skills in mental handicap within the local authority.

National changes and influences will also limit the labour market. Demographic changes have presented the nursing profession with a reduction in entrants to nurse training and over the past two years the English National Board for Nursing, Midwifery and Health Visiting has witnessed a reduction of 15% of people entering RNMH training. The social work profession is similarly affected and with nursing will be in competition to attract newcomers to the caring professions.

Reductions in the employment market and an acceptance and awareness of the transferability of mental handicap nursing skills to the community have enhanced opportunities for the 12,000 mental handicap nurses in the United Kingdom to gain confidence to acknowledge that they possess a highly marketable product in respect of their skills, competences and experience.

Care in the community is therefore a very complex business and manpower planning will need to manage in the absence of sophisticated tools to determine client needs and staffing competences. However the reality is that there are very few well developed community schemes for this scheme that lend themselves to evaluation (the six schemes that do exist in 1989 will form the sample for this current study). Renshaw acknowledges the gaps which exist in current service planning:

> 'Finally. perhaps the most important resources of all for the effective implementation of community care are the staff. Sound manpower planning and and effective training are, therefore, essential. But unfortunately, both appear to be conspicuous by their absence' (Renshaw et al 1988 p30).

Whilst there is evidence that nurses are able to make the necessary adjustment from hospital life to the community, some nurses may develop negative attitudes to new service plans and this may give cause for concern in some areas. Renshaw explores this further:

> 'Nursing staff and ancillary staff in particular can feel resentment and fear towards a community project which they may regard as a threat to their future livelihood, as indeed in many cases it really is. This may be exacerbated by the difference between hospital and field agency cultures, and their different models of care. Nurses' reactions stem from a combination of genuine concern - they may assume that project staff are untrained and ignorant - and the perceived threat to their professional identity. Nurse training schools will also have to move to the community. Disbelief in the strategic plans can exacerbate feelings of insecurity' (1988 p178).

Renshaw and colleagues in their study of DHSS sponsored projects acknowledge that work in community services can create high levels of stress for staff:

> 'High levels of stress are almost universal. Work in these projects seems to be demanding in a special way which is difficult to explain, but is probably to do with the many different kinds of stress which are encountered in the same day. Managers still face the demands (and, of course, rewards) of regular client contact, but must also exercise line-management responsibility for staff coming from a variety of backgrounds and with whom they are in constant close contact (a new skill for many). They additionally have to undertake budgetary planning (also new to many) and take responsibility for the success or otherwise of the whole venture. Multiple lines of accountability are the norm. All of this takes place within tight financial and time constraints, so managers need to have enough double vision to see all the steps in a project both in tactical and strategic lights (p180).

The experience of work in the community may present nursing staff with different experiences, work practices and expectations. It is within the changing nature of these services that nurses will be expected to adjust and adapt their day to day work and to develop new coping strategies. In the place of shared responsibility and shorter shifts may come personal accountability and long hours which may often extend into the nurse's personal time. Rigid shift systems may succumb to erosion and flexible patterns of work emerge in response to the needs of residents and their social lives.

Questions relating to job security and satisfaction may figure on many nurses' agendas during such periods of intense service change. Front line staff may be exposed to a range of new responsibilities and duties which were previously executed within the context of the protective umbrella of the institution. Such responsibilities range from managing shifts alone as accountable practitioners to undertaking housekeeping duties and meeting the dietary needs of residents. Many of these functions will be undertaken by support workers (unqualified care assistants) under the supervision of qualified nursing staff. It is in this respect that hospital based nurses may demonstrate another set of skills relating to staff management and deployment.

It may be stated that the management of small houses in the community presents a range of complex tasks. These include the management of physical resources, human resources, estate maintenance and the supervision of care practice. Budgetary skills are also required and expenditure will be expected to be contained within strict financial limits. Nurses, having worked in hospitals with meagre resources, are well suited to extend their supervisory skills and practices to the community. However there may be potential for conflict between the time available for the management of 'the household', the staff and the care process.

The community also provides new opportunities for nurses to demonstrate their ability and willingness to work with members of other professions as services cross traditional agency boundaries. Multidisciplinary teamwork may offer new challenges to nurses to demonstrate their leadership potential and to publicly declare the more positive aspects of their skill base. Teamwork also has the advantage of facilitating the sharing of different perspectives in response to individual problems and for many nurses this may be a positive improvement following years of dependency on the intra-professional support systems that they depended upon within the institution. Teamwork may, therefore, offer staff new incentives to work together and to share the responsibilities that are necessary in the community. Conversely some nurses may regard the expectations of shared service ownership with contempt, having struggled for many years without support. Some might be expected to respond with suspicion and caution during the initial phase of the transfer as competing groups vie for control and leadership. This process is described in a similar way by Marshall:

> 'Throughout the health Service dissatisfaction is often expressed about the way in which teams operate. People talk about their difficulty in retaining their professional identity or a sense of perspective. They worry that their skills are being eroded, or feel undermined or confused. On occasions people may suspect that they are being set up to fail....By holding on to the belief that we do have something worthwhile to give and that we ourselves are capable and worthy of respect, and indeed affection it may be possible to survive within harsh systems' (1989 p115.).

Clearly new work patterns will take time to accept and to internalise and questions may be asked about staff responses to sharing management and client focussed decisions in new services.

This section has considered those skills, experiences and competences which mental handicap nurses may transfer to new service models in the community. The transferability of these skills has already been demonstrated but there may be a number of differences in the manner in which they are employed in the community. These changes may present staff with new challenges and new stresses.

Adjusting to Service Change.

This section will examine some of the important issues relating to the Nurse's willingness and acceptance of change in human care services. Central Government, in attempting to implement ideas and service models successfully will disturb the equilibrium of the culture. Each person can be expected to evaluate the change in terms of the potential benefits or disadvantages that may arise in terms of acquisition of benefits, changes in work practice or sphere of authority. It might be suggested that those nurses who look forward to enlargement of their domain will welcome the change and vice versa.

Allison writes that, 'Most organisations define the central goal of 'health' in terms of budget, manpower and territory ' (1971 p93). These factors may not arise merely from self-interest but during periods of radical social change, such as the closure of hospitals, staff may find it difficult to separate their own feelings of insecurity from those relating to possible advantages to the client group or to the social system as a whole.

Schon argues that a threat to the social system arising from an attempt to change the theory, values and related technology may be interpreted as a threat to the framework of the lives of those involved and may be resisted. This resistance he describes as dynamic conservatism - 'a tendency to fight to remain the same' (1971 p51). Schon suggests that the more radical the change the greater will be the potential for resistance.

Some staff may regard change as a potential attack on their routine and role performance. There are many ways in which staff might respond to these changes and the following list of strategies described by Schon (1971) provides a useful framework for considering the options that nurses might employ to repel threats to their system of work:

- selective inattention; appear not to recognise the threat by ignoring it;

- counter-attack; when the threat can no longer be avoided a counter attack or pre-emptive strike is launched even before the threat has materialised;

- containment and isolation; when the threat cannot be totally repulsed the change is allowed a limited scope of activity which will give rise to compartmentalisation;

- co-option; the threat is absorbed by taking on board the change and turning its energies towards the ends of the previous social system (p48-49).

In order to attempt to predict the reaction of nurses to organisational change it will be necessary to identify those features of the system which are most highly valued by the profession. It is suggested that authority, autonomy to practise, the retention of a professional identity, financial resources and the well-being of the client group will be amongst the most important indicators of job security and satisfaction. The transfer to the community may be seen in terms and gains and losses for nurses who will be the key actors in the system.

The analysis of a threat of change in an interorganisational network serves to illustrate the presence of latent conflict and the interdependence and power balance which exists between agencies and professional groups in a social system. It is suggested that those staff and agencies that stand to gain most from the change will participate and adapt with enthusiasm, those who stand neither to gain or to lose will assess the situation objectively in terms of what it is likely to achieve for the system as a whole, and those who stand to lose most may resist in order that there might be no change in the equilibrium in the social system. The impact of the change may be assessed by judging the impact of the change on an agency's authority, independence and resources. Whenever an agency's interests are threatened, negative judgements of other agencies in the social system may be in evidence.

If this model is to be applied to mental handicap nurses then it is suggested that nurses transferring to the community under the continued management of the Health Authority should be in a position to control some of the variables involved in the change process. However, it should be noted that where this model might apply to many community based services at the present time, there still exists the overall threat of a central government plan to transfer the entire mental handicap service in the longer term. It could also be argued that the nature and design of community based services lends themselves more to local authority transfer than hospital services because of their similarity in structure to social service models of care.

For mental handicap nurses their day to day expectations and functions may not match with changes in philosophy and care practice. In addition new systems may challenge opportunities and routines that staff have developed over the years to satisfy their personal needs. Menzies (1986) describes the balance that needs to be struck between personal needs fulfilment and the need to accomplish tasks prescribed by the organisation:

> 'The chosen social system is likely to reflect strongly the psychological and social satisfactions that members of an institution seek in their membership and work in the institution. These needs are of different kinds and are both positively task-orientated and potentially anti-task. In so far as they are task-orientated, they include

> the satisfactions arising from being able to deploy oneself positively and fully in relation to task, cooperating effectively with others and experiencing both personal and institutional success in task-performance. People require such satisfactions and their realization is an essential aspect of staff support....Unfortunately for task-performance, members of institutions are also likely to seek satisfaction of personal needs that are anti-task; very often they need to mitigate the stresses and strains of the task itself and of confrontation with the human material on which the task is focussed' (p228).

Menzies suggests that the customs and conventions that exist to protect staff from over-exposure to difficult client behaviours and contact, may be necessary determinants of staff performance. In the community many of the opportunities for distance and for the emergence and maintenance of social defence systems are reduced. Constant exposure to client contact, personal accountability and responsibility and longer hours of work will all contribute to this change.

Staff may find themselves in a state of potential conflict between the therapeutic gains that the new model of care might provide for clients and the absence of systems to support their personal needs to fulfil their role expectations and responsibilities. Consequently mental handicap nurses, used to a number of 'fringe benefits' and impersonal routines, may find the move to the community potentially stressful.

Menzies also suggests that the equilibrium of the new service must take account of changes in management systems and structures which need to redefine roles, responsibilities and relationships. These were likely to have been well defined in the hospital but there appears to be some general feeling that bureaucratic management structures may be unnecessary in the community due to the decentralised and more spontaneous nature of the work. Staff need to know as far as possible where they stand in the organisation and what is expected of them. The management structures, systems and styles adopted may promote or interfere with the adaptation process. Menzies believes that there is a distinct possibility that excessive exposure to clients may enhance stress and encourage maladaptive processes:

> 'The effects on staff of the human 'material' they work with are specially great in institutions whose clients are people in trouble. The clients are likely to evoke powerful and primitive feelings and fantasies in staff who suffer painful though not always acknowledged identifications with clients, intense reactions both positive and negative to them, pity for their plight, fear, possibly exaggerated, about their violence, or harsh, primitive, moral reactions to their delinquency. The working through and acknowledgement of such feelings is an important part of staff support and primary-task performance' (p232-233).

Failure to acknowledge these feelings and needs may influence the success of social care programmes. Management systems need to be in place before the commissioning of community based projects if staff are to be effective in the performance of their roles. Staff, once familiar with their new roles, will require support to develop adaptive and mature coping mechanisms to replace the more destructive defences characteristic of the institution. Failure to address these issues may adversely affect the success of individual acceptance of the new service and may result in the rejection of the primary aim and goals of the organisation in respect of benefits for clients.

This section has considered the key issues relating to service change and has identified some of the possible stages of transition that mental handicap nurses might be expected to pass through if they are successfully adapt to the new service. Of equal importance will be how important nurses regard the need for change. This will be considered in the next section.

Perceiving the Need for Service Change - the nurses view.

During the past three years I have had the opportunity to meet and to work with nurses in many services throughout the United Kingdom and to discuss their perceptions regarding the transition to the community. As a result of chairing a research group I have also been able to gain some insight into the main concerns, hopes and aspirations of the workforce. A (summary of these concerns and the expressed needs of nurses involved in the process of change is presented in Appendix One).

The Royal College of Nursing (RCN 1989) sponsored the research on behalf of the Society of Mental Handicap Nursing and undertook a survey of the way in which Health Authorities and Boards were aiming to develop services for people with mental handicaps in the community. The project group analysed local and Regional mental handicap strategies against forty seven variables which were considered to be important within each implementation plan.

As a result of this survey it was concluded that nursing staff appeared to be favour of the transfer to the community in respect of the advantages that they perceived would be received by service users. However, there were obviously a number of concerns that could be potentially transferred with them to the new service. Their main concerns may be summarised as the need for:

* clear information;
* guidance and support during the transition period;
* reassurance that their skills and competences will be valued in the new service;
* a clear definition of their role and expectations;
* processes to be introduced to monitor and to evaluate the quality of the service;
* assurance that adequate financial resources will be made available to support care in the community initiatives;
* more training;
* better and more responsive managers;
* regular feedback on their performance;
* the introduction of coping strategies to reduce the potential incidence of stress following transfer to the community.

[**Adapted from two main sources**: South East Thames Regional Health Authority Policy for People with Learning Difficulties (1989) & Royal College of Nursing Survey on the Implementation of Care in the Community Initiatives (1989)].

Concluding Comments

The assumption that community services for people with mental handicaps can be developed simply by transferring existing human and physical resources is both simplistic and inaccurate. Community care is a most complex business, requiring the redirection of previous allegiances, attitudes and commitments (including a review of previous power relationships between employed staff and service users which be redirected from a hospital focus to the community).

The pattern of new services will rely upon the cooperation of a number of service agencies of which the health service will be a key partner. However, the necessary partnerships with the local authority , consumer groups and the independent sector that this will involve will require a major change in health service philosophy and control. The development of local strategies will result in making it particularly difficult to implement a national policy in a consistent manner. The success of new projects will also depend on the goodwill and adaptability of the existing workforce and there is a possibility that some staff may find the transition to be difficult. Many staff are likely to lose some of their existing or previous territory and changes in their role and function will be expected as new care polices are enacted. In addition new conditions of service and uncertainty over job security and appropriate training programmes for the future professional workforce may exacerbate the situation.

For many staff concern will not only be restricted to their own well being or future job security. The well-being of their client group will also be of primary interest and at time the two concerns of meeting personal needs and those of people with mental handicaps might create tension as staff views are expressed about future models of care.

New coping strategies will be needed if nurses are to adjust to the demands of the new service and its routines. Coping strategies should help to diminish stress but will not suppress it. Different people will adjust to change and stress in different ways and it is suggested that a variety of staff support networks and systems will be required if the organisation is to succeed in facilitating the positive transfer of its mental handicap population and their staff from hospitals to the community.

This chapter has considered the transferability of skills from the hospital to new services in the community. A number of issues have been explored and variables involved in the process of change have been identified. The chapter has omitted to provide a description of the new services and has been restricted to raising a number of questions that are considered to be important for staff moving from hospitals as they close; Chapter seven contains detailed profiles of six community based services. The next chapter outlines the methods employed in a research study designed to consider the key factors identified within this chapter that will have an impact on staff involved in the transition process with the aim of making recommendations for their alleviation.

SECTION THREE

MENTAL HANDICAP NURSING - A STUDY OF DEVELOPMENTS IN THE COMMUNITY

Chapter Six

Methodology- Description of the Study and the Methods Used.

This chapter will describe the way in which this study was developed and undertaken. It will be divided into the following sections:

* a discussion of the overall design of the study, presenting the aims and objectives of the research and the way in which it was decided to obtain the data;

* the presentation and discussion of the research techniques used within the study;

* a description on the methods and processes used to collect the data;

* a description of how the data was prepared for analysis.

* a description of the process employed to analysis the data.

The aims and objectives of the study & Identifying the Problem

The changes in social policy considered within this thesis have accelerated the transition from institutionalised care to the community. In its turn, this has demanded that provision be made for new personnel, management and training systems to ensure that the Government's objective of providing high quality services for this client group in the community might be achieved.

At present very few Districts have introduced comprehensive services in the community and the vast majority are engaged at the preliminary stages of their implementation. There is no one blueprint for the introduction and commissioning of such projects, although the majority follow the principles of 'normalisation' and ordinary living in supported neighbourhoods.

It was decided to choose six community based services that had been in the forefront of hospital contraction/closure programmes and to:

- identify the support systems that would be required by mental handicap nurses who had transferred from mental handicap hospitals to work in community based residential facilities;

- examine the way in which nurses adjusted to the transfer and to make recommendations to assist in the transfer of the remaining workforce from hospital based care provision.

No other study relating to the needs of mental handicap nurses engaged in the process of transition has been undertaken in this country and the opportunity to cross reference with an acknowledged sample was not possible. In order to pursue the aims identified above, it was therefore necessary to select a representative sample.

Identifying the key elements of the task

Access to the official plans and strategies for each Health Authority/Board was facilitated by the research programme sponsored by the Royal College of Nursing and through the author's membership of a number of national bodies concerned with the monitoring of the quality of care for people with mental handicaps.

The author had the opportunity to chair a working group at the Royal College of Nursing to consider the implementation of community care programmes in the United Kingdom (Royal College of Nursing 1989). The working group undertook a research programme to survey all District Health Authority/Board strategic plans and policies. One of the main questions asked during this exercise related to the number of hospitals that were involved in closure and which authorities had introduced comprehensive community based programmes.

The literature search and the review of relevant documentation from the Department of Health and other primary sources confirmed the number of services that demonstrated criteria for inclusion in the study. Having regard to the fact that the majority of those services declaring an interest in hospital closure were involved in the early stages of contraction, it is not surprising to note that only six services were identified for inclusion in the study. All six hospitals/community services demonstrated the following common elements:

* they all employed qualified mental handicap nurses;

* they were all involved in advanced stages of hospital closure programmes;

* they were able to demonstrate a comprehensive community based service, the major elements of which had been in existence for at least one year;

* most of the nurses involved in the new service had had previous hospital employment experience;

Clearly the use of documentary evidence as a primary source to assess quality of service provision and staff attitudes to hospital closure is not ideal. As Stacey writes (1969):

> '- official statistics only exist where some area of social life is controlled;
>
> - it is essential to know the conditions under which the figures were collected and the definitions which were used. In particular in examining statistics over time it is important to notice whether the definitions have changed in that period or the boundaries of the area to which they refer been altered;
>
> - the reorganization of government departments leads to certain changes: thus the annual report of the Board of Education became that of the Ministry of Education and now of the Department of Education and Science. More seriously, for studies of comparison over time, the results of departmental changes may include new methods of data presentation and breaks in a statistical series. In times of government reorganization difficulty may therefore be experienced in tracing data, and care should always be taken in this matter' (p43).

Documentary sources proved to be particularly useful in the exploratory stages of the study. However, on their own, they failed to provide evidence of all of the relevant factors to be considered in the design of the questionnaire. As Stacey (1969) suggests :

> 'In all cases when using documents, whether those already existing or those especially called for, it is wise to cross-check the data from other sources by whatever means possible....Different sources leading in the same direction encourage one to believe that reliable data are being used even though such tendencies cannot constitute conclusive proof of accuracy or reliability'(p46).

One other method employed was to identify a number of key informants within the mental handicap specialty with whom to share ideas and to cross-reference information regarding the design stage of the study. In discussion with them the gaps which were apparent in the literature search were identified and new information obtained which was later used in the construction of a research questionnaire.

Needless to say several of the informants were able to facilitate access to other research studies and to other people more knowledgeable than themselves. In summary the involvement of key informants served to define and to help the author to understand the problems involved in the proposed study at an early stage in the investigation. However, exclusive reliance on this method was avoided in order to remove the possibility of introducing observer/informant bias.

According to Abdellah (1987) it may be more difficult to define the fundamental causes of a problem in nursing research:

> ' In nursing research, much emphasis has been placed on finding solutions to operational problems rather than to discover the fundamental cause(s) of a problem. It is often more difficult to find and to formulate a problem than to find its solution. One difficulty in putting

> nursing research on a scientific basis lies in posing appropriate questions that can be answered by a formal research study' (p50).

In mental handicap care much has been written on the apparent nature of the sub-culture that exists within mental handicap hospitals but there has been no actual scientific attempt to identify the key variables that affect the way in which nurses work and how they maintain their interest and motivation to work in the profession. This may be partly due to the difficulties that researchers may have in negotiating access to the inner culture that exists in most hospitals. The author of this study had one clear advantage in that he had worked amongst such nurses over a period of twenty years and had gained invaluable insight into the day to day routines and 'secrets' of the organisation. Consequently personal experiences as a 'participant observer' assisted in defining the nature of the problem.

Abdellah (1987) maintains that a problem solving approach should be adopted in research design and advises would be researchers to take care when reviewing current nursing routines:

> 'One might also begin by examining the facts to see if their application in current situations is still relevant. Examples can be found by examining current nursing practices that have become ritualistic rather than being based on sound physiological principles. Such practices may have served useful purposes in the past, but situations change, and current practices must be examined in light of changing situations' (p51-52).

Her warning applies particularly to mental handicap nursing which has certainly been shown to be characterised by ritualistic routines (Morris 1969, Martin 1984) which related more to the custodial models of care in hospital than to the community. In the design phase of the study, therefore, a cautious approach was adopted, which later resulted in the redesign of number of questions following the pilot phase of the study.

Formulating the Hypothesis and Defining the Variables

A variable can be defined as a quality, property or characteristic of the person or things being studied that can be quantitatively measured or enumerated (Abdellah p78).

Hypotheses are outline statements of principles on how the researcher might expect the variables to behave. In this study a number of hypotheses were postulated:

* that as nurses leave the institution, their motivation and job satisfaction will increase;

* that this increase is because they find they are able to assist people with mental handicaps to improve the quality of their lives;

* that as nurses move to the community that they will leave behind them a number of systems that were personally supportive to them in their work;

* that it will be difficult to replicate or replace these support systems in the community, the absence of which increase job stress;

* that managers may not, yet have identified or provided those components of the infrastructure that will be required to sustain community care and that as a result nurses may be frustrated and less content in their jobs;

- that the community may reduce opportunities for career advancement and expose nurses to working conditions associated more with Local Authority employment status than with the National Health Service, the result of which may contribute to feelings of job insecurity.

Following the formulation of these hypotheses it was possible to identify a number of concepts that required consideration. A number of these concepts related to personal characteristics such as previous work/occupational experience and professional qualifications. The others are presented below:

Work Characteristics

- job characteristics
- personal responsibility
- job satisfaction
- job security
- career characteristics
- payment/rewards
- job performance
- morale
- accountability
- decision making
- organisational stress
- role conflict
- role ambiguity
- role effectiveness
- shift rotation
- resident outcomes
- management style
- staffing levels
- resources
- staff turnover
- propensity to leave
- individual capacity to cope.

Issues of Staff Support and Service Change

* perception and ability to cope with change
* staff supervision
* opportunities for staff development
* self assessment/appraisal
* staff training
* peer support
* communication systems
* work overload
* ability to cope with stress
* personal coping mechanisms
* staff perception of community care vs hospital care
* staff motivation

The definition of variables has to be completed before any data can be collected and consideration must be given to refining the variables in unambiguous terms to make them meaningful and concrete. The variables listed above were accepted as the components for objective study and formed the basis for the questions to be considered and measured within the study.

However, there were a number of other questions and factors which required investigation and analysis which did not lend themselves easily to quantification as variables. These might be defined as complex phenomena relating to staff perceptions of the new service. They were better considered by the inclusion of a series of open questions which may be summarised as follows:

* How well did staff believe that they were prepared for the change?
* Were there any changes that staff felt would enhance their new role and their ability to fulfil the expectations of their managers?
* What features of the old culture were missed the most?

* What features of the old culture were least missed?
* What features of the old culture have been transferred to the new service?
* What ideas do staff have to assist people with mental handicaps and their staff to move to the community?

For many of the variables scales of measurement already existed which were incorporated into the study and these will be explained in a later section of this chapter. For others new scales were devised and a series of open questions designed to measure the more complex variables identified above.

Research Design

When the variables had been defined as precisely as possible the next stage as to consider the research design to be employed in the study. Determination of the research design involves choosing the method by which the study subjects will be selected and how the concepts will be measured and compared.

In view of the nature of the study it was agreed that the researcher should meet informants in their natural setting within which a number of variables would be held constant within the framework of a specifically designed questionnaire. ie. in the sense of limiting the sample to nurses now working in the community, who had had several years experience in hospital previously.

It was decided to approach the problem by designing a structured questionnaire which would include several open-ended questions to provide respondents with the opportunity to comment on their experiences during the move to the community. The design of the questionnaire took into account the information obtained during the problem identification phase of the study, the results of the literature study and guidance received from experts in the field.

Pilot work also assisted in the formulation of the actual wording of the questions asked. In order to test the relevance and suitability of the questions a series of question booklets were devised consisting of subsections of the final questionnaire. This approach enabled a number of questions to be piloted with staff from the author's own service and as a result useful feedback was received which proved to be invaluable when the research was undertaken in the field.

In all, the questions were revised five times following the pre-pilot phase and the following list of changes serves to illustrate the main reasons for changes:

* ensuring that ambiguous instructions for the completion of the questions were minimised;
* adjusting the balance and order of the presentation of questions, thus leaving more sensitive questions to later in the questionnaire;
* rewording a number of questions to facilitate pre-coding;
* rewording questions to clarify their meaning;
* removing 'jargon' from questions;
* rewording questions to avoid repetition;
* revising scales in order to rationalise them into five point scales in order to avoid confusion for respondents and to assist in the analysis of results;
* building into the questionnaire assurances about the confidentiality of the information provided;
* adding questions to assist in validity checks;
* confirming differences between certain response categories;
* adjusting the length of the questionnaire to maintain respondent interest and make the exercise manageable.

The pilot phase was particularly important when questions and scales were adapted from other surveys and as a result of this exercise revisions were made which assisted in the production of a coordinated and comprehensive questionnaire.

The final questionnaire was piloted with twenty staff working in a community based service in Winchester. The results were most favourable with all respondents finding the instructions for the completion of the questionnaire to be easy to follow and the questions relevant to their own experience. There were, as one might imagine, a number of recommendations to simplify and to clarify the wording of specific questions. These were noted and the questionnaire amended accordingly. It was then considered by my Advisory Group and, following their approval, was discussed with colleagues from the Department of Social Statistics to ensure that its design lent itself to coding and computer analysis. Oppenheim (1986) recommends this:

> 'In the process, due attention should be given to the methods of statistical analysis to be used. A well-phrased question emerging from careful pilot work may produce responses that are difficult to quantify. The calculation of an index or scale score may produce computational difficulties. The introduction of probes and multiple answers to the same question each produce problems of quantification, to which attention should be paid during the pilot stages. Altogether, there is a limit in any survey to the number of free-answer questions that can be coded' (p28).

As a result 'open' or semi-structured questions were limited to those areas that required in-depth consideration, and where the author required respondents to reflect and elaborate on their past experiences. Responses to the open or 'free-response' questions were considered to be more difficult to analyse and code and to assist in this process categories were identified within which to analyse each respondent's answer in the form of a coding frame. This process was undertaken manually and was extremely time consuming, hence the decision to restrict the number of such questions in the questionnaire. These questions also served to back up a number of the questions asked in the structured part of the questionnaire when more spontaneous answers were required. Belson (1962) has shown that when it comes to an enumeration of items of behaviour that the open question produces a lower yield than the spontaneous structured kind. By using both kinds of questions in the questionnaire, it might be argued that the author had attempted to reduce the possibility of respondent error as far as was possible.

Attention was also given to the question sequence within the questionnaire. It felt most appropriate to start with a series of factual questions followed by several series of structured attitudinal ones, and finally ending with a battery of semi-structured questions. The author also attempted to make the questionnaire attractive and interesting to the respondents in order to maintain their motivation and commitment to the subject area. The 'open' questions were also included to attempt to find out more about the respondent's views on the subject and to determine how strongly they were held.

A decision had to be made whether to administer the questionnaires by post or by personal contact. The chances of obtaining a high response rate from a postal survey were regarded as slim by the author and the experience of other researchers working with mental handicap nurses in recent years confirmed this (Walton 1989, Allen, 1988 & Korman 1985). The possibility of misinterpretation of instructions for completing the questionnaire would also be greater with the postal method, while opportunities for the researcher to meet the respondents and to visit their workplaces would be correspondingly reduced. Consequently it was decided that the schedules would be completed by respondents in the presence of the researcher.

During the pilot phase the author presented the questionnaires in two ways. The first was to meet individual staff, to introduce the schedule and then to leave them alone to complete it. The second was to meet the staff and their managers as a group, to explain the nature and instructions for the completion of the questionnaire and then to remain with the staff whilst they completed the schedules individually but in the same room. The latter was the preferred option for staff during the pilot phase and was the method adopted for the duration of the research study.

The self-completion questionnaire was therefore presented to six invited audiences consisting of six staff members and two of their managers. Each member of the group completed their questionnaire independently of their colleagues although each respondent chose to do so in the same room as their peers. Oppenheim (1986) suggests that this approach ensures:

> 'a high response rate, accurate sampling and a minimum of interviewer bias, while permitting interviewer assessments, providing necessary explanations (but not the interpretation of questions), and giving the benefit of a high degree of contact' (p36).

Negotiating Access to and Identifying the Sampling Frame

Six services were identified that met the criteria for inclusion in the sample. Each was engaged in an advanced stage of a hospital closure programme and had a range of comprehensive community services in place.

The author was in the fortunate position of having access to each of these services following personal contact with their managers during the course of his everyday work. An outline of the study was presented and a request was made to visit the service to clarify eligibility for inclusion in the sample.

During the preliminary meetings I outlined the main proposals for the study and requested access to six nurses and two managers who were currently involved in the community service. A copy of the questionnaire was left with the service manager to consider with his/her nurse managers.

The initial meetings demonstrated positive outcomes with the promise of an early response to my request for confirmation of acceptance for the district to become involved in the research study. Five of the services responded within three weeks with a formal agreement to participate in the study and the sixth followed two weeks later following a telephone call/prompt.

The information gathered during the preliminary meetings confirmed the following:

- the nature of the hospital service prior to full or partial closure;
- the nature of the new community based service;
- the nature of the workforce in the community service;
- the philosophy of the service and its aims and objectives.

A second meeting was held with each manager when agreement was reached on the method to be employed to administer the questionnaire and issues relating to confidentiality and feedback were explored and negotiated. There were no problems encountered apart from a request for confirmation from two authorities that anonymity would be preserved. This was agreed and will be discussed later when consideration is given to the construction of the questionnaire. Cooperation and support for the study was given by all persons involved during the negotiation phase of the project, and more so each district confirmed their interest in the project which they felt might be valuable in supporting them and other services in the introduction of support systems for their staff in the new service.

In total forty eight staff were identified for inclusion in the sample. The six samples were selected by asking all qualified nursing staff who were on duty on the day of the intended visit to each of the services whether they would be willing to cooperate in the study. In practice this proved to be most convenient since the majority of services had an average of six staff on duty at any one time and hence the sample included these on the day in question. The selection of the two manager representatives in each group was limited to those on duty on the day of the interviews in much the same way that the staff were selected.

The criteria used for the inclusion of senior staff in the 'manager' category of the sample was determined by the key components of their role and function. In the community qualified nursing staff are often required to work as day to day managers of the houses within which they work. They are also required to work directly with their clients and to spend the majority of their time in direct contact with them and to supervise the daily work of their unqualified support staff.

These staff will usually be managed by external managers who have managerial and professional responsibility for one or more houses and who have designated positions within the management structure of the organisation. A number of titles are awarded to such posts which differ between districts and services. An analysis of the titles used by staff involved in this study created some confusion when determining which staff were designated as 'managers' compared to those qualified nurses who were designated in the sample as 'staff'.

In order to resolve this, managers were asked to provide an outline of their role description during the preliminary visits to the six services. As a result the following criteria were determined for their inclusion in the 'managers' sample:

* that they occupied a designated management position in the organisational structure of the service;

* that 60% or more of their time was spent in managerial activities outside of the houses that they managed;

* that nurses included in the 'staff' sample reported directly to them as their line managers.

Consequently these potential difficulties proved to be linguistic in respect of the range of titles awarded to posts characterised by different levels of responsibility rather than substantive in respect of their influence on the study.

The sample was also selected in terms of geographical representation. Each of the five services included in the sample from England was from a different NHS Regional Health Authority and the sixth was from Wales. No hospitals were considering closure in Scotland or Northern Ireland and as such were not eligible for inclusion in the sample. There are fourteen NHS Regions and whilst ten of these are planning hospital closures only six had developed associated comprehensive community services at the time of the study. It was therefore considered acceptable to limit the sample to six districts, although had time and opportunity permitted, other districts would have been considered for inclusion in the study.

Following the completion and return of each series of questionnaires the author stayed on for about two hours to discuss their experiences with respondents. This gave further insight into their feelings, and helped to contribute to the formation of a 'rich picture' of their services. Finally visits were made to each of the community services and a profile obtained of their key features. Opportunity was also taken to meet a number of people with mental handicaps and to share their experiences of their new homes. The items covered in the completion of each service profile were:

* a description of the geographical location of the service;
* a description of the general characteristics of the new service;
* a description of the size of the service and a description of the nature of the client group provided for;
* confirmation of when the service was commissioned;
* a description of the service that the new facilities have replaced;
* a description of the nature and size of the workforce;
* a description of the management structure operating within the new service;
* a statement of the philosophy operating within the new service;
* a statement regarding the success the project has had in integration within the local community;
* account from service users on their perception of the new service.

Service managers were also asked to prepare a 'package' of written materials relating to the nature, design and philosophy of their service. Of particular assistance in understanding the nature of the services were operational policies and strategic plans. These enabled comparisons to be made between the anticipated nature of the services and that actually observed by the author during field visits and with the views expressed by staff during interviews.

The final proposals for the selection of the sample and of the research design were presented to an advisory group at the University of Southampton and were subsequently approved with recommendations for minor adjustment which were incorporated into the final research design and questionnaire.

Classification of Respondent

A sample number was assigned to each respondent with a prefixed identification code exclusively allocated to the geographical location of the cohort group to which each person belonged. This was partly for reference purposes but also served to facilitate checks between cohort groups during the analysis stage. The sample was also differentiated between managers and staff members and reference numbers reflected this. Each questionnaire was also dated. The differentiation between staff and manager responses allowed cross tabulation to be made later in the study between responses made by staff and by their managers.

When the data was edited codes were assigned to record length of previous experience, posts held, nursing status and current position.

The Questionnaire

It was finally agreed that two questionnaires should be used in the survey. Both followed a common format for staff and managers with the inclusion of specific questions for each group in respect of the client focussed priorities for the staff and management responsibilities for the managers. Copies of the questionnaires for staff and managers may be found in appendices two and three respectively. A copy of the code book used in the analysis of the results obtained from both samples is also to be found in appendix four.

Introductory Section - Employment History, Training & Appraisal

The questionnaire begins with an introduction setting out the aim of the survey in simple terms and reaffirming the pledge of confidentiality. Since the questionnaire was to be presented to respondents personally it was felt that a brief introductory statement would suffice. Any queries regarding the completion of the questionnaire were dealt with verbally at this stage of the meeting.

The first section of the questionnaire is concerned with the collection of personal information relating to past work experience, present position within the organisation and other information concerned with employment history.

Questions one to seven relate specifically to employment history and are included with the aim of comparing length of previous hospital experience with that of employment in the community. Similarly differences between present grades and previous positions were requested within the context of this series of questions. Since a rigid differentiation exists within the Health Service the range of responses could be anticipated and this proved to be true. Question eight asked respondents to consider whether they would seek employment in a community based service if they were to lose their jobs and this was regarded as an important indicator of job satisfaction which would be cross-checked later in the questionnaire.

Questions nine to fifteen refer to qualified and in-service training, staff development (staff development & performance review) and appraisal. Concern had been expressed by staff during the pilot phase that insufficient attention had been given to identifying the personal and training needs of staff undergoing change. The importance of regular supervision and feedback has already been noted and the inclusion of questions referring to staff development and their frequency served to test the extent to which training needs were being met.

The section ends with two questions relating to the number, if any, of additional hours staff worked in the new service. These were included to assess the degree to which community services demand additional commitment from staff beyond their contracted hours of employment.

The preliminary section served to 'set the scene' and to solicit the attention and motivation of the respondents. The questions provide the opportunity to identify key variables which could be used to cross tabulate with others which appear later in the questionnaire.

The Nature of Work in the Community and the Client Group

Section B requested information about the nature of work in the community. The five point scale which appears on page three of the questionnaire is adapted from the work of Peter Allen and colleagues (1988) and appears on page 7 of the Staff Interview Schedule used in their research at the University of Canterbury to consider staff experiences as they moved from hospital to the community in Kent.

Eight questions are included to seek the views from staff and managers in respect of the amount of variety, autonomy and support that occurs during their work in the community. Questions are also included in this section which relate to resident contact and peer support, both of which have been suggested to have a direct influence on job satisfaction and morale.

Decision Making, Autonomy and Authority

The same authors include scales in the staff opinion survey which relate to staff responsibility and decision making and the scale which appears on page 8 of the Staff Interview Schedule (1988) has been adapted on page 4 of the interview schedule. These questions assist in the identification of staff perceptions of their new role, their participation in and the limits of decision making and autonomy that they believe the new job offers. The results may be compared to their perceptions of their role and status within the hospital, comparisons which were often made in the informal group discussions following the administration of the questionnaire. The questions also provided information regarding role conflict and ambiguity and the degree to which staff believed that their contribution of the service was regarded and valued.

Staff Support

Four questions are included on page five to identify staff perceptions of how well they work together with colleagues and who actually provides them with the most support in the workplace. These questions were addressed in respect of peers in the first instance and subordinates in the second. Deductions regarding the 'friendliness' of the organisation were also expected to be made from these questions.

Staff Attitudes to Resident Care in the Community

The attitude of staff and managers to community based projects also requires consideration. It was suggested that staff attitudes may be conditioned, not only by their own perceptions of community care, but by the outcome that it might have for their clients. Consequently two series of questions were included to consider this. Allen and colleagues included a series of excellent questions in their survey (referenced above pp11&12) and these have been adapted and appear in the two resident orientated series on pages five and six of the questionnaire.

Role Effectiveness

The way in which staff perceive that they have a valuable role to play in the organisation will undoubtedly contribute to their job satisfaction. This phenomena is assessed in pages seven and eight under the heading of 'staff effectiveness'. Seven questions are included which have been adapted from 'The Role Effectiveness Profile (Plant 1987 p87). This series tests a number of areas which range from the way in which staff are encouraged to use their skills creatively to questions relating to their perception of whether they enjoy their job and whether there is enough freedom within it to function and to learn new ideas and competences. These questions appear on pages eight and nine of the questionnaire.

Managing Stress

One of the hypotheses postulated earlier in this chapter relates to the fact that work in the community might appear to be more stressful than work in the hospital due to the fact that inadequate attention may have been given by managers to the need to introduce support systems in the new service. It is expected that staff will respond to stressful situations in different ways according to previous experience and conditioned coping mechanisms. A series of questions appear on page eight of the questionnaire which aim to identify the way in which staff members respond to stressful situations. These questions are taken from a stress assessment which appeared in an article published by Billings & Moos (1981 p139-157).

Seven questions appear on page nine which provide respondents with the opportunity to present and to expand on their own feelings about what might be done to relieve stress in the work environment. Such open questions attempt to probe further into the thoughts of staff members and their managers to assist in the identification of relevant support systems that might be missed in their present jobs.

Job Satisfaction

Allen (1988) included a series of questions in his Staff Opinion Survey (p6) relating to the assessment of job satisfaction amongst his sample population. These questions are reproduced on page ten of the questionnaire and serve to test a number of intrinsic and extrinsic rewards that might contribute to job satisfaction amongst respondents. Job satisfaction has been suggested as an important indicator of staff adjustment and acceptance of work in the community and as such these questions are regarded to be of particular importance in the study.

Six questions are included after this series to identify the elements of the job that staff find most and least satisfying. A further question asks the proportion of the job that staff find satisfying and two others request that staff should identify issues of their work that they would rather see changed.

Interpersonal Support Networks

It is suggested that support systems at work will be different in the community when compared to work in hospital. Hugh Firth (1986) undertook extensive research to identify the interpersonal support networks for staff employed in human services based in hospital. Firth used a personal interview technique with his sample and a number of questions relating to staff support are reproduced from his schedule on pages eleven and twelve, (questions eight to thirteen and question sixteen). These questions consider staff preoccupation with work, career aspirations and those elements of staff support that are most appreciated by respondents.

The Nature and Effectiveness of the Organisation

A series of questions appear in the staff questionnaire which request staff to consider their perception of the 'health' or effectiveness of the organisation in which they work. This schedule is produced from a checklist entitled Checking the Organisation's Health (Turrell 1986) and provides the opportunity to assess staff perceptions of how the new service operates (appears on page fourteen of the staff questionnaire).

Management Skills and Performance.

An alternative approach is used for the managers on page thirteen of their questionnaire The managers were asked to rate their perception of the importance of a number of management tasks in rank order on a scale of one to five. These questions are adapted from The Management Skills Checklist published by Kotter & Lawrence (1974). One final question is included in this section to identify the importance that managers place on receiving feedback on their performance from staff.

General Questions Relating to the 'Old and New Cultures'

The final section of the questionnaire offers an opportunity for respondents to express their own views in the form of a semi-structured questionnaire. The questions contained in this section refer to respondents' experiences of working in hospitals for people with mental handicaps and requests them to explore their feelings about the old and new 'cultures'. It was anticipated that these questions would shed some light on their feelings about leaving the hospital culture and that new areas might be considered which had not been reviewed adequately by my structured questions.

Within this section a list of facilities provided by hospitals was included and staff were asked to state whether these were still available in the new service. Thus an opportunity was created to compare the nature of the support in the community and to identify if any had been transferred to the new service.

The section also provided opportunity for any other relevant information to be presented and ended with a request for information that might assist people with mental handicaps and other staff to make the transition to the community more effective and comfortable. (The results arising from these 'commentary type' questions are presented in Appendix Five).

The Interviews

Discussion of the interviews will be undertaken under the following main headings:

* the attitudes of the respondents to the research project;
* the application of the questionnaire in the interview;
* description of the interview situation;
* the researcher's role in the interview.

The attitudes of the respondents to the research project.

The project was well received by the respondents who appeared to be genuinely interested in the research area. Many of the respondents expressed a personal commitment to the study and tended to draw upon their own personal experiences of moving to the community. Many had not had the opportunity to discuss their feelings about moving from hospital and I found that time had to be given to enable people to share their experiences and to reminisce of past situations and feelings.

Consequently the majority appeared to be more than willing to cooperate and to become involved and some appeared to welcome the opportunity to 'revisit' and to share a part of their lives that they had left behind. The initial briefing session with the cohort groups was therefore eased by feelings of mutual trust between the researcher and respondents on the basis that we shared a common professional background and had worked in both hospitals and in the community.

The managers were particularly pleased to become involved in the research project and surprisingly none of the cohort groups appeared to regard the project as threatening to their own management style despite the sensitivity of some of the questions that were to appear in the questionnaire. The managers appeared to appreciate the chance of demonstrating their services and all seemed to be genuinely proud that they had been selected to participate. This is not surprising since few had had the opportunity to share their success and difficulties with others and most had been too involved with the commissioning of their services to reflect on their progress.

The staff also welcomed the chance to demonstrate their positive attitudes to community care, although they were less united in their enthusiasm to have left the hospital. They regarded the interview session as an opportunity to explore their feelings and to ventilate some of the difficulties that they had found during the course of their work in the community. Approximately ten percent asked whether their responses would be treated in confidence and whether they could be frank in their responses without fear of disclosure to their senior managers. Approximately thirty percent showed interest in receiving feedback from the research when it was concluded and requested follow up meetings for this purpose.

None of the respondents refused to participate in the exercise and the majority co-operated with enthusiasm. The degree of interest was reflected in the overall consistency of responses received to the structured questions and to the elaborated responses given by some of the respondents to the commentary type questions.

Whilst aiming to reciprocate the interest shown by the respondents, I took particular care to avoid introducing my own perceptions of work experiences in the hospital and in the community. Discussions on these subjects was reserved until after the questionnaire were completed when time was provided for informal discussion on topics related to the research study.

The application of the questionnaire in the interview.

The interviews were preceded by discussion with each group group. Two separate groups were seen on each occasion, two managers and six qualified nursing staff. During each discussion the aims and objectives of the study were presented and respondents were reassured in respect of the scope of the study and that confidentiality would be assured. This was followed by an introduction the the questionnaire, section by section, and questions were answered regarding technical aspects relating to its design and completion. Respondents were also offered the opportunity to complete the questionnaire individually or as a group. On each occasion the latter option was chosen and respondents completed their questionnaires individually within their cohort group.

One indication of the success of the method was that in all cases it facilitated the completion of the questionnaire and assisted in developing a relaxed atmosphere. A number of the respondents stated that they had found the questionnaire to be comprehensive and that they were able to associate with the key themes identified therein.

The questionnaire was designed to avoid technical difficulties and as far as possible similar scales were used to avoid complication. The majority of the questions were standardised and structured and required simple responses in pre-coded boxes or tables. The semi-structured questions required more time and consideration and provided an opportunity for free thought and personal reflection.

Respondents had few difficulties with the questionnaire and any that developed were answered individually by the researcher who remained in the interview room whilst the questionnaires were completed. The questions raised related to the interpretation of two questions (relating to staff development and performance review) and whether these were equally applicable to the more formal system of staff appraisal. One respondent asked how much time should be given to the completion of the structured questions and was advised to respond with the first answer that she considered. One final question was raised by managers in respect of the series of questions which appears on page fourteen of their questionnaire relating to the importance of management tasks. Clarification was sought in respect of the rank order of responses and thereafter the researcher ensured that this question was addressed during the briefing session for each cohort group.

The open questions provided a great deal of information and permitted insight into the personal feelings of respondents. The selected method of self-recording provided the researcher with the opportunity to avoid complicated editorial work which would have been necessary if responses had been recorded verbatim on tape or from longer transcripts. Certainly, the respondents appeared to be satisfied with the methods employed in the study for the collection of data and did not appear to be restricted in their presentation. (The results from the semi-structured questions appear in appendix five). I also believe that the absence of recording equipment facilitated open disclosure of feelings.

The time taken for the completion of the questionnaires also proved to be consistent. Each took between sixty and seventy five minutes to complete with an average of seventy minutes. The length appeared to be just right to maintain interest and motivation and the position of the semi-structured questions at the end of the questionnaire appeared to encourage a natural progression of self expression as respondents worked through the questionnaire. I therefore concluded that the design of the questionnaire enabled respondents to present their feelings and experiences accurately and that whilst not wishing to judge the design of the questionnaire in isolation from the results, it remains true that no real problems were encountered during the research programme.

The follow up meetings with respondents took place immediately after the questionnaires were completed. A relaxed atmosphere prevailed during each meeting and despite work pressures eighty percent of respondents remained for this part of the interview. General discussion on topics relating to staff transfer to the community provided additional information against which specific responses were compared and related. Comments were noted and anecdotes recorded in a notebook for illustration in the results section of the study.

The pace of the informal follow-up sessions was set by the respondents in order to reduce the possibility of introducing observer bias. Thus respondents appeared to be disinhibited in expressing their views which on occasions were particularly sensitive and personally related to their past experiences. On two occasions respondents became emotionally involved when presenting accounts of their experiences and by way of reassurance they received support from their peers. When this occurred the researcher remained passive and allowed the group to resolve the situation. As an interviewer I adopted a non-committal role in order to encourage free and reflective debate amongst the respondent group.

Description of the interview situation.

The research was undertaken at a central location within each local mental handicap service. On each occasion the questionnaires were completed at community resource base offices or at neighbouring hospitals where facilities were available which permitted uninterrupted discussion.

At no time were more people than those directly involved in the completion of the questionnaires in the situation present and arrangements were made to ensure that for the duration of the exercise that no interruptions would be made by service personnel or managers. Secretaries, where appropriate, agreed to answer telephone calls and to take messages.

The questionnaires were completed on familiar territory for the respondents and were conducted informally in comfortable surroundings. Refreshments were provided and where necessary the costs were met by the researcher.

The opportunity to control the number of interruptions clearly enabled the exercise to proceed without distraction and thus the possibility of loss of concentration was minimised. This possibly contributed to the accuracy of responses received from each of the cohort groups, the results of which led to no identified errors or missed questions being found from the total sample.

Whilst the questionnaire completion session was controlled this was not true of the informal visits that followed to the community based services. These were social visits to the homes of service users and usually took place over tea or coffee. The number of persons present varied but always included one or two service users and a member of staff who had been involved in the completion of the research questionnaire. Some of the staff were concerned regarding the degree to which service users appeared to distract the flow of information but with care it was possible to involve them purposefully within the context of the conversations. As a result the service users provided valuable information about their experiences of living in the community and on occasions they reinforced the views of their support staff. What was particularly pleasing was the fact that no staff members appeared to be inhibited by the presence of their clients.

The presence of service users assisted in focussing discussion on practical matters and issues relating to work in the community. Generally when more than one member of staff was present agreement was reached in respect of issues under discussion relating to service provision and client needs. These visits provided the researcher with insight into the environments within which people lived and worked in the community and the results of these visits are presented in the next chapter.

I encountered no difficulties in understanding the views expressed by respondents and this was partly due to my own experiences of working in similar services. In order to avoid observer bias I recorded the main topics of discussion in detail in a notebook and avoided any over reaction to the responses or emotions presented during the visits.

In summary I found that the respondents were more than willing to participate in the completion of the questionnaires and that they appeared to cooperate with interest and enthusiasm at each stage of the process. I had full regard for the possible introduction of contextual and observer bias and took steps to avoid this. As a result each appeared to run smoothly and without major incident. Of practical importance were the informal follow-up sessions and the informal visits to the community houses which together provided the opportunity to understand and to gain personal insight into the life and work experiences of people with mental handicaps and their support staff.

The researcher's understanding of the fieldwork exercise.

In order to complete the description of the research process an account of the researcher's perception and experience of the fieldwork is necessary.

Throughout the exercise the researcher was welcomed with genuine interest and apparent warmth. The researcher's national interest in mental handicap nursing assisted in this process and on most occasions I believe facilitated introduction to the respondents. Familiarity with the key issues affecting staff interests and client related needs enabled a rapport to develop between respondents and the researcher which I believe assisted in encouraging staff to engage in free expression of their feelings and experiences of both work and life in hospital and in the community.

I found some difficulty in restraining my instinctive desire to respond to some of the questions raised by staff during the follow-up discussion sessions which I believe would have introduced bias into the situation. One example of this was the familiar question of my perception of how community based services should be funded and managed and to which a personal response might have implied criticism of the way in which their local service was managed.

A small number of respondents seemed to regard me as a counsellor or 'an expert' in the field who would answer some of their problems and reinforce the positive aspects of their service delivery. Whilst I was willing to provide advice outside of the research situation I was particularly careful to do so with the full knowledge of their managers and often in their presence. One way of dealing with such requests for information was to offer to visit the service at a later date or to extend invitations through their managers to visit my own service or to send written comments, policies and procedures on return to my own service. This had the result of distancing myself from my more accustomed role of 'service adviser' and permitting me to concentrate on my research role.

My familiarity with the nursing profession also enabled me to feel that I was 'amongst equals' and as such I did not experience some of the difficulties reported by social researchers of having to acclimatise myself to the sub-culture and its language of my research group. In fact I immediately enjoyed a feeling of companionship which I had continually to remind myself had to be kept under control if I was to avoid losing the professional distance necessary to avoid bias in my role as researcher. I believe that I managed to fulfil this role reasonably well, and without major compromise to my position (however it was necessary to acknowledge that as a 'well-known' figure in mental handicap nursing that respondents may have provided 'researcher-elicited' answers to my questions). In summary I firmly believe that without demonstrating primary interest in the needs, experiences and values of the six groups, that I would not have been able to develop the intimacy that resulted from and during the research exercise.

The interview is a complex social process involving the interviewer and the respondents in an interactive encounter. It will always be difficult to assess the degree to which the researcher is able to maintaining an objective bias-free role in this relationship. Moser and Kalton (1971) refer to these difficulties and emphasis the importance of introducing some uniformity into the research situation. Uniformity was certainly achieved in this study in so far that the conditions for the questionnaire completion sessions were controlled as far as possible but this was not entirely true of the informal discussion meetings or the field visits which supported them. This research study was designed to be basically exploratory in nature and is concerned with sensitive issues surrounding intimate experiences and feelings as expressed by nurses involved in the process of change. In this respect it is questionable whether one could have achieved a higher degree of standardisation during the fieldwork phase of the study. To do so might have restricted the free flow of information provided and served to control the sessions within rigid parameters with the resultant loss of expression of spontaneous anecdotes and experiences.

This section ends with a short discussion of some of the practical difficulties which faced the researcher during the course of the fieldwork.

The most important difficulty was that of time! The researcher was involved in a fulltime job at a time of major social and political change in the field of mental handicap, so the work agenda was particularly full. Consequently time had to be identified in advance and visits to local services programmed into a tight schedule over a four week period. Little room was available for manoeuvre and fortunately five of the six cohort groups visited required no adjustment to the work schedule and the fieldwork was conducted within the time allotted. The sixth service presented some difficulties in agreeing and setting dates and this resulted in a later date being fixed outside of the main work programme.

Despite these practical difficulties all of the respondents who had declared an interest in the project were seen at the allotted time and appeared to enjoy the role that they played in completing the questionnaires. Generally I thoroughly enjoyed the sessions and the opportunity to meet so many interesting people with mental handicaps and their support staff.

Finally and without prejudice to the research findings, I felt at the end of the fieldwork visits that I had obtained some excellent and interesting information which would be of particular importance when the results of the study were analysed. I felt generally very satisfied with the planning and with the operation of the data collection process.

Processing of the Data, Analysis and Presentation of Results.

The last section of this chapter will describe how the information collected from the survey was processed, analysed and prepared for presentation in the following chapters where the results are discussed.

There were two types of data to be processed; basic factual data received from the structured questions included in the questionnaire and the more descriptive data provided as responses to the commentary type questions included in the questionnaire.

Editing the data.

The first stage of the process involved the checking of each of the completed questionnaires for accuracy and completeness. The questionnaires were cross checked against a master copy of the questionnaire and any omissions or confusing answers were noted. Each questionnaire was checked after completion, before the researcher left the site. This provided an opportunity for any identified errors or omissions to be discussed with the relevant respondent and mistakes were consequently reduced to a minimum.

The range of responses to the structured questions were designed to facilitate easy analysis by computer. Consequently the second task was to code individual responses to each question in accordance with the code book which appears in Appendix Four.

Responses to the semi-structured questions were less easy to categorise and were structured according to the key themes arising from the range of answers provided by respondents to each question. The results of the analysis of these commentary type questions are presented in Appendix Five. The answers to these questions proved to be most informative and several valuable anecdotes and quotations received from respondents appear in the next chapters to illustrate the feelings and perceptions of respondents to their new roles in the community. These descriptive accounts provide insight and graphic illustration of the key issues/themes arising from the results of the questionnaire completion exercise.

Coding the data for computer analysis.

Each question in the questionnaire was ascribed a value name and identified as a specific variable in the study. Against each question the range of possible responses for the structured questions was listed and codes assigned to enable simple analysis and recording. Fortunately I had taken the opportunity to discuss the questionnaire with colleagues in the Social Statistics Department of the University which resulted in valuable advice on how to standardise the questions within the context of a series of scales and ranges. No difficulties were experienced in fitting the range of responses received into the selected coding frame (see Appendix Four).

Coding the responses to the semi-structured questions was more complex and whilst key information was prepared for storage on computer, it was not possible to code these responses in the same was as was possible for the structured questions. This was to impair the possibility to undertake a computerised programme to cross-reference the structured variables with those responses received from the commentary type questions. However, this did not prove to be too much of a problem since the responses to the commentary type questions were analysed manually and the responses received were later used to illustrate the results received from the structured questions.

In analysing the data from the semi-structured questions a range of categories were identified and the frequency with which individual responses appeared in the sample were recorded. Whilst the manual analysis involved in this procedure proved to be laborious, the results received provided the researcher with much interest and encouragement as responses were analysed and recorded. It was at this stage of the project that the researcher was rewarded with a range of responses which were later to assist in the development and isolation of a series of variables which were to lead to the formulation of recommendations to assist staff during the transition from hospitals to the community.

The final stage of the process was to record my own reactions and responses to each fieldwork visit and to complete a profile record of each field visit to the community based services. A record was also made of anecdotes and comments related by service users in relation to their experiences of living in the community.

The analysis of the data.

Files were set up using the Direct Data Entry version of the Statistical Package for the Social Sciences (SPSS) on a personal computer. SPSS (Nie et al 1975) is an integrated system of computer programmes designed for the analysis of social science data. According to Nie:

> 'The system provides a unified and comprehensive package that enables the user to perform many different types of data analysis in a simple and convenient manner. SPSS allows a great deal of flexibility in the format of data. It provides the user with a comprehensive set of procedures for data transformation and file manipulation, and it offers the researcher a large number of statistical routines commonly used in the social sciences' (p1)

Through the use of the SPSS system the data contained in the structured and semi-structured sections of the questionnaire were computerised. Once the data had been coded by the researcher it was entered onto computer with range checks being built into to reduce the possibility of error during the input stage.

The SPSS package provides the opportunity for data analysis by main frame computer through the use of a specific SPSS package - SPSSX. Thus it was possible to provide simple frequency distributions and to identify possible relationships between variables and clusters of variables. Cross-tabulations by manager and staff against each variable/concept were also undertaken. This analysis was undertaken using a series of natural language control statements. (Full details of the operation of the SPSS system may be found in the SPSS Operators Manual or details may be obtained from Nie 1975).

The size of the sample, identified from a highly selective sample of specialist staff working with people with mental handicaps in the National Health Service, was necessarily small. The size of the sample and its selective nature led the researcher to consider validity checks to be impossible. For the same reasons a problem was also considered to exist in respect of reliability. However, despite the fact that field visits did not allow sufficient time to retest findings consistent patterns of results were obtained both at the pilot stage of the interviews and between the six services involved in the study. Tierney (1988) confirms a view that not all social research lends itself easily to quantification:

> 'There are some nurse researchers, as well as some anthropologists and sociologists, who claim that measurement is inappropriate for their purposes on the ground of its preoccupation with quantification and objectivity. This is hardly surprising given the origins of measurement in the mathematical and natural sciences. This is not to say that quantification and objectivity are not relevant in social sciences research, but simply a statement of the view that measurement has less relevance in certain kinds of investigation' (p58).

The results obtained as a result of computer analysis for the structured questions were linked to the responses received from the commentary type questions on the basis of 'intuitive' links and guesses.

The frequency distributions provided a preliminary overview to the results arising from the study and provided an additional opportunity to survey the data for errors in respect of double recording of data from individual respondents and other apparent anomalies. A number of arithmetical checks were also possible to determine the total number of responses in respect of the constituent parts of each question. The sum of all of responses in relation to present, specific job categories should correspond to the the development of career advancement trends reported by respondents.

As a result of the preliminary analysis of data, minor errors were isolated on a few occasions but overall I felt that these were distributed so widely throughout the sample that there was only a negligible risk of systematic bias.

The analysis of the survey data was restricted to a simple cross-tabulation of selected variables. In this way it was possible to identify any apparent relationship or association between dependent and independent variables, and a selection of these results are presented in the text in tabular form and more fully in Appendix Eight. (However, the small number of people included in each sample provided few results that proved to be significant when subjected to statistical testing and analysis).

Statements based on sample results are always probability statements. Decisions to identify responses from a selected few rather than from the total potential population of respondents, involves inference rather than certainly. Consequently the degree to which the results received from this sample represent a true reflection of the feelings of nurses involved in transition to the community will ultimately remain an unknown quantity. Cicourel (1984) summarised the difficulties facing the social researcher in this context:

> 'The problems of measurement, therefore, can be viewed from the perspective of the sociology of knowledge: the world of observables is simply not 'out there' to be described and measured with the measurement system of modern science, but the course of historical events and the ideologies of a given era can influence what is 'out there' and how these objects and events are to be perceived, evaluated, described and measured' (p38).

The findings of the study are presented in the chapters that follow and commence with a description of the nature and profile of the community services visited.

Chapter Seven

The Nature of Community Based Residential Services.

This chapter considers the nature of community based residential services for people with mental handicaps. It commences with a description of the six services involved in the study. In order to preserve confidentiality the name of each Health Authority has been changed and a pseudonym substituted.

Service One - Southern England

Five years ago four hundred people with a range of mental handicaps were resident in a large mental handicap hospital which was situated in a semi-rural area, approximately ten miles from a large city complex. The hospital was built in the 1930s on the basis of a villa-link system.

Plans were published in 1985 to close the hospital and, in partnership with a voluntary organisation, thirty houses were planned to replace the hospital accommodation. At the time of the study fifteen houses had been provided, dispersed throughout the local catchment area, ranging from four to eight occupants. Each house was selected to 'fit' in with the local neighbourhood and as a result the service was characterised by a range of accommodation which was not dependent on any one style of house. Despite the progress that had been made with the relocation programme, a significant number of people still remained in hospital at the time of the study.

Thirty eight per cent of the workforce in the community service is made up of qualified mental handicap nurses who had previously worked in the hospital. The service is managed by the local Health Authority, which has been able to provide most of its accommodation through the development of a partnership with Housing Associations and voluntary groups.

The philosophy of care practised is one of 'normalisation' and wherever possible staff suggest that work in partnership with their residents to support them towards integration within their local communities. The service is planned in such a way as to encourage a joint agency/professional responsibility by providing care in a variety of settings. The ultimate aim will be to provide a co-ordinated team of staff who will be appointed through a joint planning team consisting of health and social service staff representatives. (At the time of the study no plans had been made to transfer management for 'health houses' to the Local Authority).

Documents Referred to: Profile of Local Services (1989), Operational Policy for Residential Services (1987) - ('Southern Health Authority').

Service Two - South West England

Services in the County visited in the South West of England had been provided in two mental handicap hospitals. One was a large County Asylum caring for four hundred people and the other was a local workhouse with one hundred beds which had been adapted to care for people with mental handicaps.

A replacement service was planned by a forward thinking Health Authority in 1983 and the first houses in the community opened in 1986. The community based service now consists of twenty houses dispersed throughout the catchment area in local towns and villages. The average number of people in each house is four. The service is managed by the Health Authority who have made use of a number of Housing Associations and council properties to complement their strategy. As a result of this partnership a voluntary trust was developed in which the Health authority held a major stake.

The aims of the service are to provide a comprehensive local service to people with mental handicaps which is integrated within local communities. Qualified nurses form 33% of the workforce and the majority were relocated from the hospitals.

Documents Referred to: Community Mental Handicap Team Operational Policy 1987 Services for People with Special Needs 1988, Parent Newsletters 1988-1989, General Philosophy 1987 - ('Cornavon Health Authority').

Service Three - **North West England**

Services for people with mental handicaps were traditionally provided in the North West in two very large mental handicap hospitals situated some twenty miles from many of the areas that they served. The North Western Regional Health Authority published a strategy in 1985 which described the elements of a model district service with the intention of decentralising services to local neighbourhoods. As a result one of the two large hospitals will close in 1991 and the other will follow by the end of the next decade.

The service visited had no local services of its own before 1985 and now has a young person's unit for fourteen people and twelve houses in the community for between two and four people with varying degrees of handicap. Twenty six per cent of the workforce are qualified nurses and the total workforce consists of one hundred and fifty people.

The houses are managed by the Health Authority in partnership with the local authority and a voluntary organisation. All of the houses are council houses and are located in local neighbourhoods. The philosophy of care is stated to provide people with ordinary life experiences and to promote independence as close to the former homes of resident's themselves. The philosophy is described as 'home support' rather than a staffed housing project.

Documents referred to: Operational Policy for Home Support team Services (1986), A Plan for Settlement (1986) & A Comprehensive Local Service, (1984) - ('Lancashire Health Authority').

Service Four - Wales

Services for people with mental handicaps in Wales have historically been provided by large mental handicap hospitals which for the most part were located many miles from the populations they served. In 1984 the Welsh Office published a strategy (Welsh Office 1983) which determined the provision of community based services throughout the Principality in the community.

The study was concentrated in one Health District which was located in one of the larger Counties. Services were traditional in that a large hospital of four hundred provided the locus for provision. In 1987 new houses were opened and a large scale relocation programme in now underway to transfer people to live in the local community. The result has been to provide a total of seven houses to date in a range of ordinary housing accommodation. Each house is small, with two to three people in each.

Community Living Development Officers assist people in moving to their new homes which are provided as part of a Housing

Trust. Forty per cent of the workforce are qualified nurses and the skill mix of the residential care team is determined by the needs of the residents.

The result has been the provision of very homely surroundings which are integrated into local housing estates and neighbourhoods.

Documents Referred to: Schedule of Hospital Residents Resettled Through the Resettlement Team (1989), Relocation Newsletters (1988-1989), Operational Policy (1988), - ('Welshpool Health Authority').

Service Five - London.

Historically, services for London were provided by a number of very large hospitals situated around the perimeter of the capital. The hospital associated with the study was one of the larger ones, with a total of twelve hundred people living there in 1983. The people came from a very wide catchment area and despite the fact that it was located centrally within a large town, there was a long standing history of isolation and deprivation for residents. (The hospital was acknowledged at one time as being the largest mental handicap hospitals in Europe).

In 1985 the Health Authority commenced a programme of relocation of the majority of its residents and announced its intention to close the hospital by the mid 1990s. At the time of the study some 300 people remained on site in the hospital wards although a number of others lived in ex staff-houses on the perimeter. The number of people resident in each house ranges from three to twelve.

Fifty percent of the workforce were qualified nurses and twenty six houses have now been opened as part of the relocation programme. The new services cater specifically for people with challenging behaviours or who have special needs and the result will be to provide a dispersed service for approximately two hundred people. The relocation programme has been accelerated by the return of a number of people to their districts of origin and these parallel developments have supported the closure. The new services are managed by the Health Authority and by a Housing Trust.

The philosophy is similar to that described of the services above although the formidable task of relocating so many people has resulted in a significant number of people living in community based houses, adjacent to the hospital campus and this has resulted in a more segregated service than would have been preferred. The high costs of housing in London have also reduced opportunities for more dispersed housing purchases.

Documents Referred to: A Strategy for Mental Handicap Services (1988), Operational Policy - Neighbourhood Houses (1989), - ('Borough Health Authority').

Service Six - Eastern England

The district involved in the study was a recipient of residents from a large mental handicap hospital on the outer fringe of London. The hospital of four hundred beds is engaged in a closure programme which should be complete in six years time.

At the present time seven houses have opened, each with between four and seven residents. The houses are dispersed throughout the local community and have been provided by the local council. The relocation programme commenced in 1987 and concentrates on making provision for severely handicapped people with special needs. The houses are managed by the Health Authority and a Housing Trust and employ sixty five staff of whom twenty percent are qualified nurses.

The philosophy of the service is based on the principle of normalisation.

Documents referred to: Operational Policy for Residential Services (1988), Relocation Programme(1989), - ('Eastern Health Authority').

General Features of Community Residential Services

What is meant by 'community'?

There are as many definitions of the term community as there are examples of sub-cultures and minority groups in society and it is not surprising that professionals planning services for others so often vary in their attempts to match the needs and expectations of service users with new services.

A familiar definition of the term 'community', shared by the six services, referred to the local amenities which existed in a locality. These appeared to be evaluated in respect of the number of shops, public houses, leisure facilities and opportunities provided to the public. Access to day service facilities and health centres also figured high during informal discussions with staff and their managers as did proximity of access to main public transport routes. The presence of community centres and local community groups also influenced local perception of the community and its inhabitants.

The Oxford and Chambers dictionaries provide the following definitions of the term 'community':

> 'Joint ownership or liability; state of being held in common fellowship. Organizational social body; body of people living in the same locality; body of people with the same needs and interests in common' (Oxford concise).

> 'Common agreement; people having common rights; a body of people living in the same locality' (Chambers Concise).

Each of the services confirmed that their published definition of community care was based on the key principles presented above. These can be best summarised in the following statement on community care policy for people with mental handicaps, which appeared in a letter to members of the National Development Team for People with a Mental Handicap:

> 'community care should be planned as good local services, capable of responding flexibly to differing needs and circumstances and provided by a variety of agencies working together both in the planning and delivery of services. They should be able to identify and to meet both the general and specific needs of people with mental handicaps and their families. We are talking about our relatives, friends and next door neighbours; but the better we know people the more keenly we are aware that they are all different and that standard packages will not do. The only right answers are the relevant ones,flexible enough to change with changing needs-and when necessary to promote change' (Hansard November 23rd 1986).

General Principles

Each of the services had published a set of general principles which underpinned the philosophy and values of their community provision. Most appeared to share a common philosophy and this was expressed in working principles which can be summarised as follows:

1- People with a mental handicap are entitled both to the same range and quality of services as are available to other citizens and to services designed to meet their special needs.

2- Services for younger people should recognise their distinctive needs.

3- In order to be effective the services must be readily available and acceptable to individuals and the families who need to use them.

4- Services should be able to adapt to meet the needs of each individual.

5- The philosophy must be to provide maximum opportunity for the residents to experience an ordinary lifestyle.

6- Emphasis must be to encourage the development of new skills and staff are expected to allow or assist residents to experience life for themselves rather than to 'do things for them'.

7- Residents are encouraged to integrate within their local communities and neighbourhoods; every opportunity is taken to encourage the use of local facilities for recreation, leisure, education, shopping and employment; people will therefore be supported to contribute to the local community.

8- Individuals are encouraged to define their own lifestyle, individuality.

9- People will be encouraged to develop friendships and to form personal relationships of their choice in order to enhance the quality of their lives.

In order to achieve these aims staff and client relationships are developed to maximise the concept of 'life sharing' to:

- diminish rather than accentuate distinctions between staff and residents [as fellow human beings];

- ensure that staff and residents share space, activities, toilets, meals, recreation, holidays and interests;

- encourage staff to demonstrate appropriate behaviours and attitudes that will promote social acceptance and community integration.

Maintaining Valued and Integrated Lifestyles

Each of the services suggested that their basic planning principle was to develop ordinary services which were as fully integrated into local neighbourhoods as possible. They all stressed the importance of involving service users in the planning of their services lives and encouraged their participation in determining how they might spend their day.

Essentially most people's lives appeared to revolve around their homes ,friends, work and families and the ways in which they chose to spend their time depended on their personal choices and the demands made on their "free time" by others. The demands made on their free time were often associated with the need for each person to share the household chores associated with ordinary living e.g. shopping, preparing food, household cleaning and gardening. The amount of money that people had to spend was also regarded as an important influence on the way in which people spent their lives.

People with mental handicaps have for many years been regarded as being incapable of handling their own financial affairs and in some cases people have not considered it necessary to give them access to their own money. Rules have been imposed by the DSS and statutory agencies which positively discriminate against them and reduce their disposable incomes to a minimum. This inevitably limits their choices in respect of choice and purchasing power and may impose restrictions which require dependence upon the use of inferior or segregated services and "charity" in order to gain any fulfilment in their lives.

Many staff stated that in the past a significant number of people with mental handicaps had been encouraged to engage in leisure pursuits with others with similar needs. The segregation that such activities imposed served to set them further apart from their peers in the neighbourhood. A variety of "special" clubs and social functions were provided by well meaning staff and in the absence of more valued alternatives they certainly provided residents with a welcome break from the boredom and routine of their lives. Several reasons were given for the provision of segregated resources:

-they were often more accessible
-they were cheaper
-attitudes amongst organisers considered them to be relevant to the needs of the client group "who preferred their own company"
-there were often considered to be few alternatives.

Wherever possible there was evidence that such segregated activities were being discouraged in the new services in favour of integrating and sharing leisure time with friends and neighbours. Use had been made of the local swimming pool, riding clubs and visits to the local pub and restaurant to celebrate birthdays or to entertain friends were common features of the range of opportunities offered to clients. As a result staff in the six services reported that they were beginning to receive positive feedback from neighbours and members of the community regarding people with mental handicaps. Through the use of shops, cafes and public houses a high profile in the local community was maintained. At least three staff mentioned the importance of the 'purchasing power' that their clients had in the community. Equipped with real money to spend on goods in local shops and facilities, shopkeepers soon came to accept them as valued customers and thus assisted in their integration in the community as their businesses benefited.

In each of the six services gallant and genuine attempts had been made to provide people with maximum control over their finances, and although many still appeared to have less money than the average unemployed person, integrated social and leisure activities were much in evidence. One particularly important contribution made by the services to encourage integration, was that more staff were employed in the small houses, (compared to the resident staff ratio in hospitals) which enabled many residents to experience a range of leisure or work pursuits. This in turn required a commitment from their carers to give time, energy and imagination in the design and realisation of local opportunities.

Staff time and resource allocation was, in most cases, planned flexibly to facilitate the use of leisure activities which did not always fit neatly into ordinary staff shift patterns. Managers had taken this into account and had amended staff contracts of employment to require that they work flexible shift patterns to meet their individual needs. The majority of staff appeared to accept this commitment to enhancing the quality of life for the people they worked with. This change in attitude from the more traditional approach of task allocation, so often seen in the past, required staff to adopt flexible shift patterns and to plan their working day in accordance with the needs and wishes of their clients. This presented staff with a real challenge <u>and</u> encouraged them to receive personal credit and reinforcement for the results of their work.

One other important feature of the new services was the recognition that people with mental handicaps had the right to form relationships with others and to have the opportunity to feel valued and needed. Staff appeared to note the need to provide opportunities to form friendships and relationships with people of their choice both from within older friendship networks and from within the wider community within which they now lived.

The rapid extension of Adult Education programmes to people with mental handicaps has assisted in the acquisition of new social skills and leisure opportunities. Service users attended a range a classes in photography, cookery, literacy and design. In some cases the projects have enabled people to form new and varied friendships with members of the local community and the advantages of such activities are obvious to staff. New skills are acquired, new friends made, ordinary members of the local community are demonstrating their willingness to share learning with people with handicaps. Support is provided without undue attention being drawn to the 'special learning needs of the individual'.

Taking risks have formed a central part of the debate and it should be acknowledged that an environment which allows an appropriate degree of personal choice and privacy can never be risk-free. Staff suggested that this was one of the most difficult challenges for them to accept. The hospital offered protection from 'risks' and opportunities were restricted to avoid accusations being made against staff. In each of the services 'risk taking' polices had been written to assist staff in calculating the risks that naturally appear to accompany life in the community. Examples of some of the principal risks were given as:

- fear of pregnancy;
- 'bullying' by the 'caring' community;
- 'getting lost';
- accidents when encouraging people to acquire new skills eg. crossing the road.

Each service noted the following rights of their clients in their policy statements:

The right to choose

People were offered the opportunity to receive individually tailored services to meet their needs based on the principle of providing real choices eg where to live, work or where to go on holiday. The right to choose also implies the right to refuse to accept the offer of some or all of the facilities on offer.

The right to dignity and respect

Each service aimed to present a positive image for their clients by ensuring that the responses offered to them were appropriate and valued. Staff appeared to make efforts to signal the respect and dignity that they gave their clients to members of the general public in order to encourage the transfer of a valued image to the community.

The right to a home of their own

Each service aspired towards the offer of a tenancy agreement to their clients. Homes were often selected in partnership between staff and residents. All of the houses were ordinary dwellings, in ordinary streets, as close to the resident's family homes as possible. It was noted that each person had the right to have a room of their own and and to have their right to privacy respected.

The right to a meaningful occupation

There was evidence of a range of opportunities for daily occupation and leisure. Some people were in paid employment, some participated in voluntary activities - thus serving the local community, and others attended more traditional day centres. It seemed that wherever possible people were offered choice from a range of available opportunities.

The right to personal and sexual relationships

Each service had published a statement on interpersonal relationships. Some degree of privacy was afforded to develop personal friendships and practical assistance and counselling was stated to be available to support people to form and to maintain relationships of their choice. (Safeguards were provided to avoid unwanted pregnancy and health related risks).

The right to independence

The right to self assertion and direction was in evidence in each service. Staff appeared to encourage people to participate in all decisions affecting their lives and assisted residents to become more autonomous in their everyday lives.

The right to advocacy and representation

Services appeared to encourage and provided opportunities for people to have a right to speak and to have their point of view taken seriously. It was stated that this was evident at all levels of the service from planning decisions to specific domestic decisions about daily life, work or leisure.

Each service had recognised the possibility that conflicts might occur between the expressed wishes of service users, their families and their carers. On such occasions it was reported that provision had either been made, or was being made, to acquire the services of an independent advocate or representative to provide an objective opinion of the needs of each person.

The right to make mistakes

Rather than adopt a punitive approach when service users made mistakes or exhibited antisocial behaviour, service staff were urged to provide support and encouragement in order to demonstrate appropriate behaviours for clients to learn new ways of dealing with situations. Staff appeared to respond to such situations as learning opportunities for service users and offered support to each person 'try again'. This approach was markedly different from the punishment models used in hospitals where residents were rarely given the opportunity to apologise for their mistakes or encouraged to try again. Rather they were labelled as difficult and either ignored or rejected.

Facilitating Access to Generic Services.

In accordance with the principles of 'the ordinary life model', service users seemed to be encouraged to make use of generic services wherever possible and the development of specialist services was discouraged.

In the past a 'comprehensive' service boasted the provision of all services on one hospital site with all specialist support being available within one campus. Visits to generic services were extremely limited. Even spiritual needs were not neglected in this model and each hospital had the privilege of its own chaplain. Sick wards were provided and clinics established to meet the needs of people living in the hospital.

The managers of the six services had attempted to ensure that specialist support and advice was readily available to all people with mental handicaps and their families whilst having regard for the way in which the services were delivered. One way of overcoming the obvious difficulties was to provide specialist services in ordinary settings in health centres and in people's homes in an unobtrusive manner. Another approach was for specialist staff to advise generic workers of the specific needs of people with mental handicaps by transferring their specialist knowledge to other staff. This approach appeared to be increasingly popular as an efficient means of 'treating' a larger number of people.

The first step in realising this aim was to ensure that comprehensive assessment facilities were available to all people with mental handicaps and their families. Such facilities were provided locally in the community and encouraged the full involvement of consumers and their families in determining their own needs and services. Multidisciplinary teamwork was provided from a variety of agencies to contribute to the assessment process, especially for those people with additional or 'special needs'. These groups might be defined as:

* people with profound mental handicaps;

* people who are blind or partially sighted;

* people with a mental handicap, unable to communicate or who have severe communication difficulties;

* people with a mental handicap who are also profoundly physically handicapped;

* people who are behaviourally disturbed as a result of their mental handicap;

* people suffering from a severe progressive disability;

* people with mental handicap who have an additional mental illness.

It is interesting to note that the majority of people living in the six services had a variety of these 'special needs' and despite the obvious severity of their handicaps they had all been offered the opportunity to live in ordinary houses in the community. The service managers expressed a united view that the one (of several) reasons given for their success in small houses was the direct result of the attention given to providing adequate numbers of skilled, experienced, committed nursing and support staff.

The Feelings and Views of Residents

During the course of the visits to the six services the opportunity was taken to meet with a number of service users and their representatives. The following accounts are taken from field notes and from local magazine articles published by the services concerned. Together they provide some insight into consumers' views of their new services.

* 'Peggy and I moved into our new house in Albert Street on September 19th and its hardly stopped blinkin' raining. Me and the washing are dizzy going in and out as I like to wash my smalls every day and put them outside on the washing line. We have a lovely washing machine and a blinkin' lovely fire and central heating but I'm still blinkin' cold, in fact so cold I have all my blinkin' clothes on in bed with me. I don't wander at night now as I'm so worn out with all the house-work. Peggy and I share the household chores and when she had her accident I looked after her and took her breakfast in bed two mornings, but now she is O.K. again she can start doing the bathroom. They make me leave a towel in the blinkin' bathroom, but I'm winning the race to close the windows. I have my own bedroom and like to keep it tidy. I help to do the shopping and I help to prepare and to cook my own meals which I find very interesting, it's hard work but we have some really interesting, it's hard work but we have some really nice things to eat, which means I don't waste a lot of food because I have to pay my share of all the blinkin' household bills. I love my house and I'm really glad I've moved in, I need another pair of new boots then I wouldn't be so blinkin' cold, and everything would be perfect!' [magazine item].

* 'I now live in a house with three friends in ******. When I first moved in I enjoyed going out with my staff friends to get the carpets and the T.V. My dad provided the furniture for my bedroom and we got some furniture from an old house in the next town. I was really excited when I first moved in. I enjoyed going out shopping and to the launderette and I go to Scrabble classes once a week. On Saturdays I go into town and I have a bus rover ticket for £1.75. On Tuesday nights we go to the local club where I can draw, play darts or enjoy a disco. On Fridays we have a raffle and I won this basket of fruit for the house. I went on holiday to Germany on a coach with my friends and staff, it was great fun. On Sunday I go to church in the town and on Saturdays i have lunch at the British Home Stores. I visit my friend's house sometimes and I also spend some weekends with my parents. It is much better than the hospital. here people make me feel wanted and I can share things with them ' [magazine article].

* 'Let me introduce the 'family'. There is John, Mary, Peter, Paul, Sharon and me (and the dog). We are proud because we have something to be proud of. We have had our problems, like other people do when they move into a new house. They were not terrible problems, but we got over them and now we are all going along the same path. What have we achieved?

Well! We are all a bit older and wiser, we have all got a bank account at LLoyds bank and we are learning to understand and to appreciate what it costs to buy things and that sometimes we have to wait for things. We all choose our own clothes with our staff; we have learnt to mix with ordinary people and to be part of crowds of people without fearing them. The luxury of having a bath when we want one and to linger in it if we wish.

We know that we have the right to go to our own rooms if we so wish and to be on our own when we want. We know our possessions are kept safe and respected, as are our views. We are all going to Greece for our holidays next year. We have passports and this summer we voted!

We go out a lot and we are all members of hobby clubs and we go to adult education classes in town. We had a 'Tuppereware' party in the house last week. I go to sewing and embroidery and two of the men go to pottery and photography. We also have a residents association that we go to. Life has been good to us and for us; some people, not many seem frightened of us, but they have to, learn as we had to learn. There is nothing to be frightened of! There is some rain but there is an awful lot of sunshine!' [extract from field notes].

* 'It is not just the physical surroundings that are different, for example having your own bedroom instead of a dormitory is great, but it is even better to be able to do what you want to. I have my own guinea pig in the garden, I call him 'Toby'. I used to be locked in a ward because I got angry sometimes. Now I only get cross if they upset me. The staff are O.K. here, they only make me do things I don't want to sometimes, but not often. I peel the potatoes and weed the garden, I don't like the washing up. The front room's nice, we can all use it you know? We had one at home before I came into hospital, we were only allowed in it on Sundays. People no longer rush in or out of the house for meetings and the telephone is quieter. There are no real routines here, just some orders for the house. The neighbours are friendly, the man next door cuts the grass. I used to wet the bed, I don't now.

I like Janet, she is my girlfriend. She and I want to get married, John (a member of staff) said maybe one day!' [extract from fieldnotes].

Summary

People with mental handicaps in the six services appeared to have had the opportunity (at least to some extent) to participate as individuals in the lives of their local communities. Each of the services was designed on the basis of integration with local houses and was characterised by small houses in local towns and villages.

The philosophy of care was based on the principle of 'normalisation' and efforts had been taken to provide opportunities to enable service users to enjoy ordinary lives. This aim required some degree of commitment from staff to enter into contracts with service users to provide specific services in respect of their individual needs. A partnership in care was beginning to emerge in the services based on a genuine concern for the interests of the welfare of individuals.

There was also evidence to suggest that people with mental handicaps were becoming increasingly involved in decisions that affected their lives and there was evidence of processes in each service to support and to facilitate this (although this was not evaluated in the present study).

The rate of service change witnessed was truly remarkable for both residents and their staff. The dismantling of old service structures had to be undertaken whilst new ones were developed to take their place, and together staff and residents had to endure many difficult months of waiting and preparation for new homes to 'appear'. Despite the obvious concerns expressed and experienced during this time, the results were encouraging as both groups began to provide new services in the community.

There are a number of obvious myths that may be beginning to be dispelled by these successes:

* people with mental handicaps need to live in purpose built buildings in order to have their needs met; people with mental handicaps require doctors and nurses to 'own them', irrespective of their need for such specialist services;

* people with mental handicaps are unable to participate in deciding how to manage their lives and to choose the things that they want to, even when they are given the necessary support and opportunities;

* mental handicap nurses, like their clients, are unable to adjust to working in the community and may be unable to make a contribution to assisting people with mental handicaps to enjoy their lives;

* such projects are incapable of fitting into local communities without undue or lasting hostility from neighbours;

The provision of specialist support, is however needed for many people:

> 'The Government's overall objectives are to develop a comprehensive range of coordinated health and social services for mentally handicapped people and their families, including assessment, day services and long-term and respite care in each locality; and to achieve a major shift from institutional care for mentally handicapped people to a range of community care according to individual needs, with a corresponded shift of resources. This will go along with a continued run-down of large mental handicaps, but specialised residential health provision, which may be in small units in the community, will continue to be needed for people with special medical of nursing needs, as well as specialist support for those in other settings' (Hansard Session 1986-7 Vol 108 Col 530).

In order to sustain the high quality services envisaged by their managers, staff expressed their need for a systematic approach to in-service training, personal support and staff development/appraisal interviews. Feedback on their performance and clear guidance in respect of job expectations was also required and the degree to which these were provided will be considered in the following chapters.

The six services appear to have invested in training programmes for their staff and had given staff development a high priority in respect of resource allocation. They had made some effort to introduce safeguards to assure and to monitor the quality of their services.

Each service had identified the key stake holders for each component of their service and had introduced written policies and procedures which allowed for some degree of consumer and local involvement in their formulation and implementation. Sound and accepted systems to monitor the outcomes of the service were also evident (although caution is called for in respect of the success of the new service without an objective evaluation of user's views if the claims of service providers are to be assessed properly).

The measurement of quality required the combination and use of a variety of qualitative and quantitative tools. Whilst no one service boasted a comprehensive evaluation system, some attempts had been made to evaluate the quality of their provision. These included staff self-appraisal systems, quality action groups and an analysis of performance data such as the number of complaints received in the service from consumers and cost statements identifying the relationship between consumer experience and financial investment.

The way in which service changes were introduced and managed appear to be significant in determining the success of these new services. These changes required the introduction of challenging and innovative management structures and support systems. In their turn staff were required to work longer hours and to assume additional responsibilities, the most important of which was to account for their activities to their clients and to the local community.

Overall the services had adopted similar approaches to service management and development, some of which have been outlined in this chapter. These have had the aim of identifying various strategies which have been employed (to some degree) in the move towards the realisation of client-led services. Operational managers appear to be beginning to manage their services in accordance with the expressed needs of their consumers and local staff and within the resources available. Operational policies have been introduced and were reported to be reviewed regularly; operational guidelines provided for local managers have specified the limits of local decision making, which in turn have outlined the processes which determine the efficient management of the services.

What has been achieved in each of the services has been different and clearly no one of the six services demonstrated 'the perfect model' for providing high quality services in the community. There were obvious gaps in provision and in quality, but this was only to be expected in newly emerging services. What appears to be clear is that what is required to realise a valued service is initiative, interest and commitment and of course, a management (and financial system) that reinforces the aims and objectives of the service in practice. [**Quite clearly the extent to which the six services claimed success must be circumspect until they are subjected to an evaluation of service users views** (it is hoped that this may follow later)].

The results arising from the study are presented in the following chapters.