PROJECT ON

CO-ORDINATION OF THE SERVICES FOR THE MENTALLY HANDICAPPED

PROGRESS REPORT JULY 1971

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THC 71/485

KING EDWARD'S HOSPITAL FUND FOR LONDON

THE HOSPITAL CENTRE

PROJECT ON CO-ORDINATION OF THE SERVICES FOR THE MENTALLY HANDICAPPED

PROGRESS REPORT

JULY, 1971

Prepared by:-

Ali Baquer

Research Officer for the Working Party
King Edward's Hospital Fund for London

THE HOSPITAL CENTRE
24 Nutford Place
London W1H 6AN

Tele: 01-262 2641

List of Contributors to this Report.

Professor R.W. Revans, Chairman, Working Party
Miss J.B. Craig, Secretary, Working Party
Dr. M. Spark, Chairman, Research Advisory Group (Community), and General Practitioner, Gateshead
Dr. R. Mein, Chairman, Research Advisory Group (Hospitals), and Consultant Psychologist, Harperbury Hospital
Mrs. D. Cortazzi, Principal Psychologist, St. Lawrence's Hospital, Caterham
Mr. Ali Baquer, Research Officer for the Working Party

Hounslow:	Dr. G.H. Curtis Jenkins, General Practitioner, Ashford, Middlesex Mr. D. Williams, Area Team Leader Mr. D. Mason, Senior Social Worker Mrs. M. Hills, Deputy Principal Nursing Officer, Health Visiting Miss J. Trigwell, Health Visitor
East Sussex:	Dr. R.G. Brims Young, Deputy County Medical Officer of Health Mrs. S. Sharrif, Social Worker Miss A. Pfister, Social Worker
Gateshead:	Dr. W. Kell, Deputy Medical Officer of Health Mr. S. Atkinson, Community Services Co-ordinator
King's Fund Researchers:	Miss V. Mills Mr. R. Fogg Mr. P. Sommerfeld Miss L. Crout

References

The following sources have been used in compiling this volume: **

1. Research papers written by Professor R.W. Revans

2. Research papers and reports written by Ali Baquer.

3. Reports and accounts of hospital meetings and a working document written by Diana Cortazzi.

4. Paper written by Janet Craig.

5. Notes of conferences and meetings of the Research Advisory Groups.

** A list of documents prepared during the development of this project can be obtained on request to the Research Officer.

ACTION AS THE SUBJECT OF RESEARCH AND STAFF DEVELOPMENT

In developing this particular methodology of research, a consistent attempt has been made, with the help of all those who have the responsibility of handling the situation, to examine and evaluate specific real-life situations.

The providers of the services for the mentally handicapped were given an opportunity to define the objectives of the service they were providing so that they might relate themselves to these definitions, or these definitions to themselves. An objective measurement of the behaviour of the providers of services in a randomly selected situation was also made.

The responsibility for undertaking research on the subject of co-ordination could have been entrusted to the hands of researchers outside the service. The temptation to do so is prompted by considerations of scientific technology, and the economy of effort and time. One of the limitations of the effectiveness of an academic type of research is that those outside a service can only offer solutions for the problems they see, but cannot solve the problems they do not see. Indeed they tend, in the first place, to turn up only those problems to which they command the technical solutions, and, not seldom, even to manipulate quite different problems so that they appear in these soluble forms. The other alternative was to give an opportunity to the providers of the services to examine and evaluate various practices. There was no clear-cut method for following this second course. There was no known precedent for the use of the second method. Even now that a methodology has developed, its success is measured largely in terms of the subjective assessment of those who have been involved in it, but it is anticipated that these will be supported by statistical findings.

This method demands a radical change in the behaviour of people. It shifts the responsibility of finding solutions, of improving services, from academic researchers to the professionals at the grass-roots level. It discriminates between taking action and merely talking about action, or between being directly involved in action and merely analysing action taken by others. This method offers techniques for identifying problems by creating a climate and a setting to search for solutions through comradeship and mutual understanding. It becomes a process in which ideas of the people who really count are turned into activity and activity leads to more ideas. It helps professionals at the cutting edge of the service to become active agents of change. Change is inevitable, but if it is based on a sound assessment of real needs and real potentials it becomes meaningful. The aim of any good research should be to achieve purposeful social action.

Brussels	Professor R.W. Revans.
July, 1971	Chairman, Working Party

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INTRODUCTION

CHAPTER I

CHAPTER 1

INTRODUCTION

This is an account of an attempt, begun in 1968, to improve co-ordination of services received by the mentally handicapped.

With the guidance of a working party set up by the King's Fund under the chairmanship of Professor R.W. Revans, and with the assistance of a research officer, Mr. Ali Baquer, the project has been designed and developed by members of a research advisory group, comprising various providers of services both in community and hospitals in seven different local authorites of the country.

From the initial stages of the project this group shared the responsibility of deciding which particular problems to investigate and which disciplines to involve in undertaking the research.

The group also decided that questionnaires would form an important part of the study. The group designed, tested and finalised questionnaires and, where possible, actually helped in the administration of questionnaires. The field work has now been completed and some members of the group are presently engaged in the analysis of data. Results and conclusions will be written up by the group by the end of 1971.

This progress report is a brief description written by some members of the group for the purpose of informing those interested in this kind of approach. This report describes why and how the project started, what philosophy guided its development, how the aims were defined, what methods were used and what results are being achieved in more effective co-ordination and communication in the field of subnormality. This report also contains the subjective assessment of the impact of this type of method of research on those who have a direct experience of it.

For those who already are familiar with this project the report will bring them up to date, by adding a condensed description of its history, aims, methods and future plans.

WHY AND HOW THE STUDY WAS DESIGNED

CHAPTER II

CHAPTER II

WHY AND HOW THE STUDY WAS DESIGNED

1. The need to undertake research

A three-day conference was held at Church House in December 1965 to discuss the circulars issued by the Ministry of Health on improving the effectiveness of services for the mentally ill and mentally handicapped. This conference was followed by a series of meetings of staff from various hospitals at the Hospital Centre. The hospital staff described their efforts to improve particular care in and out of hospitals**. In March 1968 a national conference was held at the Hospital Centre and was attended by some 60 people, representing organisations, institutions and individuals in the field of mental handicap in the United Kingdom. It was agreed at this conference that patterns of co-ordination of services for the mentally handicapped should be examined in different parts of the country.

2. The working party

Some of the audience at the March 1968 meeting volunteered to form a King's Fund working party to supervise the project. (Appendix A). A full-time research officer was appointed in June 1969 to conduct the project on "Co-ordination of the Services for the Mentally Handicapped".

3. Fundamental aims

The main aim of the project was to explore the many different methods, both formal and informal, by which services are co-ordinated. In order to seek better ways for the co-ordination of the services for the mentally handicapped, the working party defined the two fundamental aims of the project as follows:

i. to compile data about the existing services in order to present a picture of actual co-ordination in the seven areas across the country;

ii. to involve the users and providers of services in compiling and examining the data.

** The King's Fund Hospital Centre published the papers given at these meetings and the discussions that followed them in a volume entitled, "Improving the Effectiveness of Hospitals and Services for the Mentally Ill and Mentally Subnormal".

This project has been developed on the belief that through the personal involvement of the providers of the services in an examination if it, the co-ordination of services and the care of the handicapped should improve.

4. Selection of areas

Six reasonably representative local authorities of the country (Appendix B) were selected to make a comparative study of the services. A London Borough was chosen as a pilot area, to try out research methods. It was suggested at this stage that a comparison of what was actually happening in half a dozen or so areas of the country would suggest where the strong and weak points of the services are likely to be found. It was not considered feasible to generalise either at local or national levels, but if, despite the diversity of the areas selected, certain common features emerged, then they would be considered indicative of general trends.

5. Co-operation of the appropriate officials

The consent of all those with responsibility for providing services to the mentally handicapped in the selected areas was obtained. The support was enlisted from the appropriate

Regional hospital boards
Hospital management committees
Executive councils
Local medical committees
local health authorities.

6. Research advisory groups

In October 1969, representatives of those professions in the local authority services who had some responsibility for providing help to the mentally subnormal and their families formed themselves into a research advisory group. This group elected a general practitioner, Dr. M. Spark, as its chairman. Subsequently, in July 1970 a second group, consisting of representatives in the hospital service, was formed from those who had shown an interest in the project. This group elected a consultant psychologist, Dr. R. Mein, as its chairman. Finally the two grpups merged when it became obvious that stronger links between hospital and local authority services must be forged for the benefit of the mentally handicapped and their families. The enlarged research advisory group includes a wide variety of staff at all levels plus a few researchers who have been helping, on a part-time basis, with the field work.

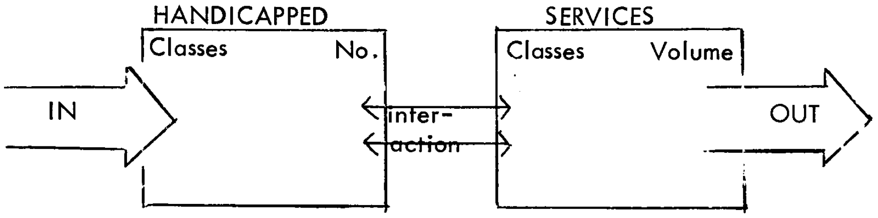
Members of the research advisory group number over a hundred. This includes a large fringe of professionals unable for various reasons to be quite so actively involved. Nevertheless they attend occasional meetings or advise on a particular aspect of the research. Active members hold meetings from time to time either in London or in the selected areas, to discuss different aspects of the research and to take decisions on its development. The research officer acts upon the advice of the group and maintains continuity of the project by circulating reports of the meetings and by supervising the field work.

7. The method of research

Since the project was expecially designed to draw on the ideas and skills of those in the field, the direction of the research, at all stages of its development, remained in the hands of the research advisory group. The use of this method transforms research into a 'learning by doing' exercise for all those who are at the cutting edge of the service.

8. The basic model

In order to clarify the purpose of the research, it was agreed by the group in October 1969 to use a simple input/output model. On one hand there is a whole set of handicapped persons who fall into various classifications. On the other hand there are a lot of services with specific functions. The group decided to examine the interactions between the two systems and also the interaction within the service.



9. The scope of the project

The research advisory group agreed that the study should attempt to find out:

(i) How do parents of the mentally handicapped and those providing the services first suspect subnormality?

(ii) What action follows the suspicion?

(iii) How do all involved perceive the needs of the handicapped and how much do they differ from each other in their respective perceptions?

(iv) How do all involved see their own roles with regard to the handicapped and that of other providers of the services?

It was hoped that through the analysis of this information the weaknesses and strengths of the services would be discovered, then suggestions could be made to improve

(a) the co-ordination of the services

(b) the quality of the care of the handicapped and his family.

10. Community and hospital studies (List of questionnaires: Appendix C)

The group agreed that it would be necessary to examine the hospital services for the handicapped as well as for those living in the community.

On the community side it was decided to interview:

the parents
general practitioners
health visitors
mental welfare officers
and teachers,

and to examine the case records kept for each client. A consultant paediatrician has designed a questionnaire for the paediatricians, but it has not been used so far.

In the hospitals - perhaps because such a wide variety of professional staff are giving a service under one roof - some fifteen different disciplines were involved, although in practice only nine questionnaires were developed, for:

- parents
- nursing staff
- medical staff
- hospital school teaching staff
- speechtherapist and physiotherapists
- voluntary organisers
- psychologists
- social workers
- occupational therapists, workshop units, industrial training units and utility departments

Not every mentally handicapped person of course has dealings with all these professions.

11. Sample

The research advisory group decided to look at a 5% sample of those under the age of 30*, living in the community and known to the local authority. For the hospital study it was agreed that the patients from the appropriate local authorities with matching dates of birth with the community sample should be included.

12. Designing of questionnaires through staff involvement

In the process of getting a lead on the sort of questions to put to these professions, opinions have been given by a fairly complete cross-section of local authority and hospital staff; for example,

- medical officers of health
- health visitors
- mental welfare officers
- general practitioners
- paediatricians
- administrative officers
- staff of staining centres
- physician superintendents
- hospital group secretaries
- nursing officers
- head teachers
- psychologists
- social workers
- physiotherapists
- records officers
- farm managers
- voluntary organisers
- laundry staff
- occupational therapists
- nursing assistants
- supervisors and trainers
- hall porters

The initial interviews were with the medical officers of health, the chief mental welfare officers, the chief nursing officers and the physician

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* The research advisory group agreed that the study of mentally handicapped under the age of 30 would cover the critical action period.

superintendents. The following account of how the questionnaires were developed and administered in community and hospital, and of the changes that were taking place even at this early stage, can best be described by quoting from two members of the research advisory group:-

"We do not go to a hospital or local authority with a list of people to interview and a list of questions to ask as in the more formal type of research. Our method is to involve the staff themselves right from the start, by asking them to advise us with whom we could usefully discuss the project. At no time have we approached anyone who had not been suggested by some member of staff, however much we wanted to. Officials say charmingly: "Yes of course I'll help, in any way They suggest. If They will just say who They think you should see ....." It was quite difficult to get across the idea that there is no "They", and that "They" is *us*.

It would have been expedient and certainly enjoyable for those of us already involved to conjure up what we felt to be appropriate questions to put to the subjects, but this would be missing an opportunity to involve a wider circle of people who were crucial to better co-ordination. So we approached, for example, numerous social workers, and asked each of them: "What questions would you, as a social worker, ask yourself about the help you give to the mentally handicapped and his family? What information do you need to do your job effectively? With whom do you think you should co-ordinate?" We repeatedly explained: "This is *your* research, *you* know what sort of questions we should be asking."[6] Based on these discussions with the professionals in the field, questionnaires were drafted, tested and finalised by all those interested in this research.

Once the need for personal commitment was understood some degree of immediate involvement occurred, and those participating began to experience a sense of creativeness instead of the more common state of frustration at not being able to get below the surface of the problems.

13. Administration of questionnaires

The research advisory group agreed that wherever possible the questionnaires must be administered by those providing the services. In trying out the research questionnaires the providers of services found that becoming engaged in a research exercise in itself improved co-ordination between the various professions. Thus, a social worker interviewing a general practitioner came to the point where the general practitioner described the role of the mental welfare officer as the person who admits the mentally handicapped to hospital After completing the questionnaire they were able to return to this point and discuss the much wider functions of the mental welfare officer. Gaining an understanding of roles in this way will no doubt improve co-ordination in the future.

The administration of parents' questionnaires proved extremely valuable to the providers of the services. This research activity resulted in the expression of their frustrations and anxieties. It also provided an opportunity for constructive criticism of the service. In other words, the questionnaire had become a therapeutic tool in the hands of the field workers. Also in shifting the focus over the whole life span of the child, the social workers were not having to deal with the acute anxiety state which so often exists when they are called in to deal with the here-and-now situation. One can only fully appreciate the value of this opportunity when remembering that in the past many parents have lacked any meaningful social work support. Under these circumstances, some would be suspicious and diffident if the social worker for any other reasons than research, suddenly took a deep interest in them.

The research activities began bringing together several interested and multi-professional groups, since the questionnaires were discussed fully by everyone involved in the project before they were finalised. A new dialogue based on joint effort was beginning to develop between the various professions. This experience plus the analysis of some of the facts that are coming is helping us to see some of the gaps in our service. Some families are being seen in an entirely different light and problems in family relationships are being uncovered where they were thought not to exist.

14. The studies in the pilot areas

The community pilot study was concluded in the London Borough of Hounslow and the hospital pilot study in Leavesden and Harperbury hospitals serving Hounslow.

During the pilot study representatives of all the seven areas pooled their efforts to design, test, modify and finalise the research instruments.

15. Fieldwork

In the community, interviews were started following completion of the pilot study, in May 1970, and finished one year later - a time spread accounted for by the methodology, which presumed that the major part of the interviewing would be done by those actually involved in the services for the mentally handicapped. This naturally, as it was done in conjunction with normal work, took longer than if professional researchers had been employed.

A sample of cases was drawn for the community study. Nearly 1,100 interviews were conducted largely by mental welfare officers, health visitors and teachers, with the assistance of student social workers. In areas which were not able to do it all this way, assistance was given, financed by the King's Fund.

In the two hospitals concerned in the pilot study, the approach has been slightly different since a health visitor was seconded by her borough's Department of Health for six months, to do the interviewing. This has thus, in a very practical way, bridged one gap between hospital and community.

16. Time table

Originally it had been anticipated that the research would take three years, being completed in the Spring of 1974. It had been hoped that the Department of Health and Social Security would take over the financial responsibility in January 1971. The D.H.S.S. felt unable to provide the financial support requested, and the King's Fund agreed to continue to support the project until the end of March, 1972. This has called for substantial alterations in the research strategy. The group is making every effort to produce tangible results of this research experience by the end of 1971.

17. Analysis of information collected - case histories

Faced with something like one million possible sets of figures to analyse, and with less time than was originally allowed for, conferences of various members of the research advisory groups were held early in 1971, together with other, smaller meetings in the hospitals, to discuss the priorities.

These meetings confirmed that the essential task was not merely to collect statistics as such, but to interpret them so as to reveal strengths and failures of co-ordination. One of the approaches in the analysis of the data could be identification of incidents, episodes or examples drawn from the work arising wholly or mainly from a failure or shortcoming in the co-ordination of the services. The research advisory group agreed that by identifying such cases symptoms of poor co-ordination could be identified. Such a catalogue of stresses and strains could be prepared not to condemn any services, but to be used primarily as an instructive background to the study.

Episodes illustrating gaps in services

The following episodes are presented as a reminder that this is essentially a practical project, focussing on:

a handicapped person in an operational situation, and
the service provided.

The five episodes described below are a few examples in which members of the research advisory group have recently been involved. They may or may not have been based on experiences of the seven selected areas in the study. They were originally contributed as a means of bringing technical research down to an operational level. So it is operationally that these incidents illustrate the aims of the project.

i. Peter's leg

Peter - a patient in a subnormal hospital - was knocked down while crossing the road on his way to his first outside job. His leg was crushed. A number of responsible people had known by word of mouth, or had suspected, that Peter was unaccustomed to crossing a busy road alone. No one spoke, no report was called for, no case conference was held. Peter was unable to work for six months.

ii. The third pregnancy

A mother gave birth to one child with retinal dysplasia and multiple handicaps, and then to another in a similar condition. A London teaching hospital, which has a genetic counselling service offered the mother help by putting her on its four-year waiting list. In the meantime she became pregnant again, on the principle of third time lucky.

At a late stage in pregnancy, an emergency genetic counselling was arranged by a general practitioner new to the family. The foetus was found to be abnormal, termination was carried out, followed by hysterectomy due to complications.

The marriage has now broken up and the two children are in care.

iii. The deaf child

A beautiful baby was taken regularly by its mother to a "well baby" clinic, where a succession of doctors noted a gradual slowing down in development, but did nothing about it except make notes.

The mother became more and more upset, because of the doctors' lack of explanation to her. Eventually she changed her general practitioner and took the baby to the "developmental care" clinic. It was apparent that the child was not only developmentally retarded, but also deaf.

iv. Billy is NOT mentally handicapped

Billy was sent to a subnormal hospital at the age of six. Almost from the start it was apparent that Billy was only behaving like a severely physically handicapped child, and was not handicapped.

Billy is NOT mentally handicapped (cont'd)

The following people were helping Billy:

Medical officer of health
Consultant psychiatrist
Assistant medical officer
Clinical psychologist
Child care officer
National Deaf Children's Society
Head teacher ----- deaf school
Head teacher ----- hospital school
Peripatetic teacher for the deaf
Speech therapist
Local authority social worker
Hospital social worker
Senior nursing staff.

But two years later Billy is still in a hospital for the handicapped.

v. The pink daisies

Nursing assistants in pink uniform were working in a special unit with incontinent adult patients, teaching simple educational skills. When the patients wet their pants, they were sent to the ward to be changed. The ward returned them to the unit, still wet, with the remark: "You're dressed up as nurses, you change them."

The patients were shuttled back and forth in this way for some months. At one stage, one side took the wet pants off, and the patients went bare, in winter.

The immediate controversy was ultimately solved, but the lack of co-ordination and communication between trained and untrained staff continued for a number of years.

Typology of "Horror Stories"

From this sample of 'horror stories' it looks as if the more dramatic episodes affect one person and have an end: Peter is run over. The lack of communication and the apparently trivial clash of staff personalities however are more insidious. They are there before the story starts, even may be the cause of it, and they remain when the incident is finished. If such clashes could be recognised then it might be possible to attempt to prevent the damaging gaps all too often present in the service.

Not all the stories collected show trivial drawing apart or clash of staff personalities. Some are due to:

a) Lack of services
b) Relatives' ignorance of services available
c) Lack of perception of one's own and others' roles
d) Apathy on the part of staff members
e) Poor quality of care sometimes, in spite of good communication.

Typology of "Happy Stories"

It is proposed that some of the happier experiences will also be classified in the final report, so that analysis can also be made of the strong points in the services.

18. Suggestions for general analysis offered by the Research Advisory Group

To analyse the data we have now a sub-group of representatives of the seven areas.

The sub-group has not made any final decision, but feels:

a) that one way of dealing with the problem is to concentrate only on those items in the questionnaires dealing specifically with co-ordination leaving for the moment those which are only of interest to one or other profession;

b) another suggestion is to concentrate on those items which would throw some light on the ability of the family in the extent to which they persistently seek out the necessary services for the handicapped child;

c) analysing the types of failure in co-ordination as shown by "horror stories" and matching these gaps with relevant information from the questionnaires could be attempted;

d) examining the peak periods of stress to the family, such as the help given on ascertainment by various professions; education facilities at school age; training facilities for the young adult and the prospects for the mentally handicapped in the community on the death of their parents, also seems a promising approach.

The above interests are examples, but the final decision on the type and amount of information which can be analysed rests on the availability of time and resources.

19. Subsequent extension of research

Although the field work in the selected areas has been completed, the research has been expended in Hull, Hounslow and Gateshead. The extended surveys are being or have been carried out by local staffs.

a) Galen House Project, Hull – the project has been completed. Only the parents and teachers of the mentally handicapped above the age of 16 and attending Galen House have been interviewed. The analysis of the questionnaires is complete.

b) Isleworth Project, Hounslow – Between 20 and 30 social workers, health visitors, staff of training centres, representatives of local voluntary organisations etc. have volunteered to use the questionnaires designed for the main study on all the mentally handicapped living in an administrative division of the London Borough of Hounslow.

c) Gateshead Project – some of the social workers and health visitors in the area have extended the main survey to a 100% sample of the mentally handicapped children under the age of 10. In addition to the six questionnaires used in the main study the Gateshead team has proposed to use the questionnaire for the paediatricians, which has been designed by a local consultant.

20. Application of research methodology

The method of involving providers of services in a systematic examination of it is being used in the following research projects. Since none of the research activities mentioned below are directly concerned with the mentally handicapped, those involved in these projects are designing questionnaires relevant to their own requirements.

a) Project on E.S.N. Adults, Croydon.

b) Project on Aids and Services for the Disabled, Consumers' Association.

c) Project on Assessment of Nurses in Training, King's Fund.

d) Project on Assessment of Workload of Nurses, North West Metropolitan Regional Hospital Board.

e) Project on Health and Social Content of Patients' care needs, the London Hospital.

f) Project on Aims and Roles in the Social Training Unit, St. Lawrence Hospital, Caterham.

21. Report

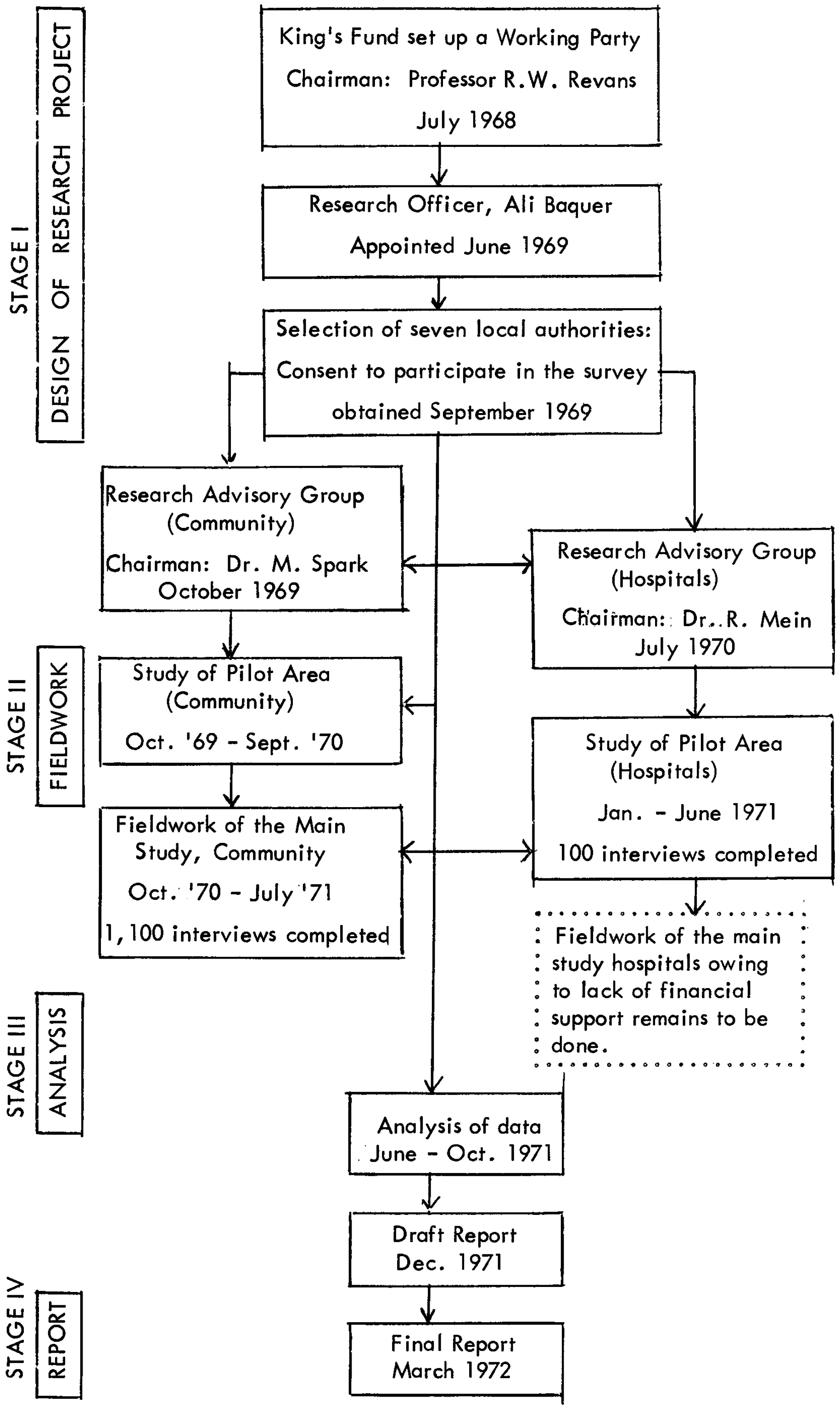
Appendix D outlines a proposed draft of the report for publication, which will be presented to the King's Fund in the Spring of 1972.

SUMMARY

Some indication has been given in this chapter of the way in which those at the "cutting edge" of the service set about designing and administering the questionnaires, deciding at each stage what professions should be involved, what sort of questions should be asked. The providers thus develop a strong sense of comradeship and carry out the research tasks taking collective decisions. They even visit each other's areas to offer help or to explain the method of research.

This is obviously no "ivory tower" research by academics, nor is it just a question of bringing together a number of enthusiastic amateurs to discuss mutual problems over lunch. Active members deliberately volunteer to be involved in this method, because in this "action research" there is a dynamic learning process involving changes in role perception and attitude, which does result in better co-ordinated service for the mentally handicapped.

CHART SHOWING EVOLUTION AND DEVELOPMENT OF THE PROJECT



INVOLVEMENT

CHAPTER III

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INVOLVEMENT

One of the fundamental aims in undertaking this research was to attempt to involve the providers of the service in a systematic examination of it. Our conviction has been that the appropriate people to restructure the services and to improve thereby the care of the clients and patients are those who work in these services. This chapter deals with some of the problems of involving professionals in a research project of this kind; it gives examples of involvement; and finally lists some of the benefits resulting from involvement once it is achieved.

The list of those who have been active in this project is a long one. The following three sections are the impressions of only a very small number of the providers of the services for the mentally handicapped. They have described, in their own words, the difficulties and advantages of this particular method of research.

A. PROBLEMS

This section is presented here to illustrate some of the problems we meet in our attempts to involve others in this field.

Conveying the method

All of us have experienced difficulties in trying to explain the method used in this research to others in the field.

Normally those conducting a research project define their methods and techniques specifically and clearly. Some hypotheses are put forward and people are given well defined tasks. The present research purposely avoided this and its start was admittedly amorphous and vague. But once this seemingly uneasy phase was over we were able to state clearly the aims and objectives of the project, at least in terms of the administration of questionnaires and collection of data. This aspect of the project is familiar. All surveys collect information of one type or another and professionals in the field are quite used to supplying such information.

Our main problem was to convince those at the grass-roots, and with the first-hand knowledge of the needs of the clients and of the strengths and weaknesses of the service they provide, to help us in designing the study, to voluntarily share the responsibility of carrying out the field work and finally to assist in analysing the collected information.

Our objective at all times is to understand better the total situation, or the integration of what is provided by different agencies to meet the clients' needs. What did we and our colleagues and other counterparts in the seven areas believe to be the needs of the handicapped and his family? What did they do about it? Could we, on the basis of this experience, suggest methods of improving the quality of the service and the care of the handicapped? We believe that such questions can best be posed and answered by those who have the responsibility for taking action, both individually and collectively.

Lack of communication vertically

We had hoped that by holding central meetings and conferences in London the method of research would be communicated to the rest of our colleagues by the participants. When we actually started the field work in some areas we discovered that it was not so. We needed to hold formal and informal meetings in the regions. The enthusiasm and interest of the professionals was always very encouraging. The maximum involvement occured in those areas where those on the higher levels of hierarchy believed that this project is a learning process connected with institutional and administrative development, and that it should be actively supported.

There are a lot of professionals who really understand the importance of active involvement in research. They support us in a variety of ways. But there are some who either remain indifferent or become even hostile to this idea. They either do not recognise the need for an evaluation of the service because they perhaps believe in its excellence, or perhaps they have no faith in our method. They no doubt prefer to trust the skills and competence of researchers from outside the service. In such cases we feel that we have failed in conveying the essential ingredients of the nature of the active participation.

Lack of time

Some representatives of the selected areas thought that this research would make demands on the time of a limited number of staff. We have challenged this point of view over and over again. Those of us who have been very active in this research did not neglect our routine duties. This method of research does not call for any additional and time-consuming responsibilities. It provides each one of us an opportunity to evaluate our practical achievements. This method also helps us to understand the real-life situation and at the same time enables us to suggest practical ways of improving it. We start by becoming aware of what we are doing in our normal routine jobs, and gradually begin to discuss amongst ourselves what we ought to be doing. The examination of the internal dynamics of a situation leads to discussing the techniques of problem solving.

Summary

Meetings and conferences between all professionals providing services are necessary at central and regional levels. Interchange of ideas and experiences is the key to the success of a project of this nature. They help to establish the aims of the study based on general agreement and set out operational details of the administration of research. In addition to this they promote a degree of comradeship which eventually enables participants to use their common experiences to the fullest extent. In this process they also learn to abandon their attempts to impress their colleagues or to defend their practices.

There is also a need to enlist the active support of top management and policy makers in the local situation. The time spent on winning this commitment is time well spent. The involvement of such a person results in 'officially' recognising the advantages of this method of research.

B. EXAMPLES OF INVOLVEMENT

Introduction

The following three accounts are presonal, but have been included to highlight some of the points that are made elsewhere. Two of the writers are, for the first time, seeing how the other half lives in hospital or community; both are discovering these different worlds - each catering for the mentally handicapped, each in isolation - and both, as a result of their experience, have developed a change in attitude. The first writer is on her home ground, but she too finds serious gaps in the service, and develops ways of dealing with them.

1. A Health Visitor's involvement in the community

"I did not know one of the families I interviewed in order to complete the research questionnaire. The subnormal girl was an 18-year-old attending the Adult Training Centre in a London Borough. Both mother and daughter appeared at first sight to have adjusted themselves extremely well, but during the interview it became apparent that the mother had many anxieties about the future of her daughter. Her husband had died two years before my visit, and since his death she had no-one on whom to unburden her anxieties. It was all too clear that here was a woman who appeared to everybody with whom she came into contact as self-sufficient, but in fact was in need of a great deal of reassurance and support. This family was unknown to me because they had had no children born in England since arriving from Ireland when the girl in question was 2 years of age. The child was referred by her general practitioner to the local hospital where she was assessed by the paediatrician and later admitted to the Junior Training School. This is an example of lack of co-ordination between hospital, general practitioner and local authority health visitors.

General practitioner attachment schemes are now developing in our borough, so the general practitioner will in future be better informed about any mentally handicapped person on his list through his health visitor, who, because of her involvement in this project, will know the stage of mental development reached.

As the health visitor sees the families of all newly born infants and makes regular follow-up visits, she is often the first person to suspect handicap of any kind and suggest a mother takes the baby to the local authority clinic, where the child can be assessed and if necessary referred to the Mental Health Department. I used to rely on the parents to keep me informed or had to telephone the Mental Health Department to find out about decisions taken. However, since this project people in the Mental Health Department and health visitors in our area have become more aware of the other's role and now have an excellent rapport, finding it easier to approach each other over difficulties arising in a particular family and offer support between them. This is important to the clinets and much more satisfying to the field workers who have in the past tended to work in their own isolated spheres."

2. Health Visitor's involvement in two hospitals

"Things may go wrong when we forget to pass on a message, or intentionally neglect to report vital information to another department, or we feel that we can cope without the help of other professions within our branch of service to the patient. The sad thing is that we may become frustrated when we are neglected or forgotten, but the one who really suffers is the patient.

During the past few months I have been making regular visits to two hospitals for the mentally subnormal near London . At first I was shattered to find myself in a completely different world. People of all shapes and sizes with varying degrees of physical or mental handicap happily ambling around the hospital grounds and corridors: some attending industrial training units or sheltered workshops, others partaking in work on the wards. ~~When visiting~~ wards I ~~saw others~~ who were chair-bound, wholly dependent on those who cared for them.

With the word "co-ordination" uppermost in my mind, I endeavoured to talk about it to staff of these hospitals, and of course met with various reactions. Most felt that a lack of it did exist. Many felt that it could not be helped because no-one was perfect and there will always be personality conflicts and petty jealousies. Accepting this as an unalterable fact, how can non-co-ordination be overcome?

The way we are attempting it is through questionnaires answered by all the hospital departments concerned with a random sample of patients who originally came from our borough. As each person is contacted and the subject discussed, it is hoped that each one will consider his own position in regard to co-ordination.

As this idea of communicating with others comes to the forefront of our thinking, then attitudes do change. It may sound too simple to be true, but is worth considering if we want the client to have the best service possible.

Visiting two hospitals simultaneously has been very interesting and sometimes very difficult. Although each group of people are doing the same type of work, the attitudes and problems have been different.

At one hospital the social workers very kindly opened their office to me, and I soon felt at home and almost part of the hospital, which certainly helped as I endeavoured to get to various departments and to speak to people, knowing that I had a welcome base to return to.

Several members of this hospital have shown interest in this project, but no-one has been willing to take some sort of action in meeting and discussing together. At first it appeared that this was because of opposition from the top management. However, when this so-called opposition was removed, still no-one has taken any sort of initiative apart from filling in questionnaires. In fact, some have shown definite signs of withdrawing their interest.

Some people filling in questionnaires have done them grudgingly, complaining of the time they take to do it and feeling that research has been done before and nothing came of it - what can anyone else suggest?

The various departments appear to be 'worlds within a world' and as one suggested, 'empire-making'. It was also sad to see how isolated some people appeared to be although they had sincerely dedicated their lives to this common and challenging task. Because their attitudes had become very narrow and conversation topics rarely extended to the world beyond the hospital walls, they either have no co-operation from others, or as much as one can expect - how can it be changed?

There were, however, a number of people interested in the survey and they also seemed to be in contact with each other. Although still, there are many problems in co-ordination, the situation is beginning to appear more hopeful. People are becoming more willing to interview their colleagues, and to answer the questionnaires."

3. A clinical psychologist in the community

"This city in the north-east has a huge unemployment figure, so subnormal adults are a problem where finding work is concerned. The rates are very high, but there is no money available for subnormality, either for hospitals or training centres. The mental welfare officers see families breaking down because they can't get even short-term care .... but they are told that the town is very advanced in community care, and well supplied with day centres. They are cynical, and say that both parents have to be dead before a severely subnormal who is blind, deaf and spastic has a chance of being admitted to hospital. And even then, if there are relatives, hospital is out. Parents' holidays often have to be cancelled because the hospitals are full and cannot take even short-stay patients. The mental welfare officers wonder what "They"think happens after 4.30 p.m. to those attending the day centre.

Mental welfare officers could see no point in research of any kind, in this area: "We just need more money, larger hospitals, more hostels," they said, " and one mental welfare officer for the subnormal, full-time."

But when a drooping mental welfare officer came to my hospital with a patient next day, with drab apologies for being late; when he automatically sat down on a wooden chair in the corridor; when he looked shattered at being offered hospitality or participation in the assessment - I knew something new of what was behind his attitude. My job, he sees as routine and office-bound, out-of-touch with the real problems of life; whilst I see him (or used to) as just a messenger with another subnormal outpatient to be assessed as quickly as possible, because he has other calls to make.

This was another side of life to me, and a far cry from the petty bickering and backbiting of our hospital world. We seem by comparison like spoiled children with too many toys."

Summary

These three personal accounts show a growing awareness of gaps in the service, in both hospital and community. There is the isolation, the poor communication and the inadequate perception of each other's roles; there is the inability to initiate action and the apathy that leads to inadequate service. To balance this, there are indications of action taken and of changes in attitude in all three accounts, illustrating the soundness of one of the two fundamental aims of the research.

C. BENEFITS OF INVOLVEMENT

This section gives seven descriptions by different professionals of changes in the approach to work with the mentally handicapped and their families on a wider basis, contributed by some of the members of the research advisory groups. All the changes described have been a direct result of this research project.

1. Changes in procedure - a medical officer of health and a senior social worker in the North

There is little doubt that as in the other areas involved in the research, the staff involved in this part of the country have experienced an enrichment of their insight and knowledge of the needs of the mentally handicapped and their families that no lecture or text book could ever hope to provide. In the health visitor field both newly qualified and more mature staff have benefitted greatly. This fits in with the national pattern but other changes or benefits relate to our local situation only because they are changes in the organisational procedures adopted as a matter of policy.

It is well known that in any system there is room for improvement, none is perfect and we are no exception to this. It was known that the record system was not all that it could be and also communications could be improved. Change can be slow and a major overhaul of record keeping and referred procedures can be postponed again and again because of the need for service to continue during the changes. The research provided the necessary impetus for change to be brought about.

Referrals to an assessment centre were usually made verbally by telephone or by written memorandum. The research showed that the clinic record cards, although printed to contain a full family social and medical history, often had little more than the name, date of birth and address of the child. Referrals are still to be made in the same manner but on referral the health visitor is now required to complete the clinic record card from her own records. Should the referral be made by someone other than the health visitor, she will be informed of this by the clinic clerk and will complete the card accordingly. This ensures that the examining doctor has a comprehensive factual record of the child's development available and if further information is required, this can be asked of the parent at interview. It also eliminates for the mother the tedious task of having to repeat the history from memory, thus saving clinic time.

In addition to this important aspect of procedure the research also went some way in providing guidance and information in the re-organisation of the Department's records of handicapped children, which was being carried out at the same time. Communication has been isolated as the major problem. It has been very revealing to the communicators to see what impression has been made on parents by their efforts at communication, and procedures are being studied to improve matters. We are studying plans to have a central record for every child, which could bring in computer help in the future, but this is very much in the planning stage.

The co-operation between the paediatric and the local health authority services in the town has been improved upon over the years, but what is hoped will be a major contribution is the appointment of a senior health visitor to be responsible for the co-ordination of services for handicapped children.

2. Bringing people together - researchers in one of the areas

The first meeting to discuss the research in this town served to bring people together, which was obviously not a common occurrence. The Mental Health Department had not had any previous contact with the new Deputy medical officer of health for instance, and the representative of the local associations for the mentally handicapped, herself a parent of a mentally handicapped child, was able to get together with the staff member from the Junior Training Centre and discuss the possibilities of further contact and action.

The Health Department representatives, the deputy medical officer of health and the two nursing officers were interested in the project, both in concept and in application, as were some of the mental welfare officers. To them, an important realisation was of the project as a form of training, and as such was welcome, since they felt this was something which was lacking in the department.

The progress has come, we feel, where people have faced up to the implications for themselves.

3. Team building - social worker in the pilot area

In view of the impending re-organisation of the social work services in April, 1971, many social workers who lacked previous contact with the mentally handicapped and their families would in future be likely to be involved with them. The 'action research' technique used in this project seemed a useful method of introducing them to this area of social work.

In the Autumn of 1970, it was decided therefore to call an initial meeting to discuss this.

Those involved included hostel staff and mental health social workers, staff from the adult training centre and a social worker from the National Society for Mentally Handicapped Children who was based in this London borough.

The curiosity of other departments was aroused by this meeting, and when there was contact over a particular client, an invitation was given to participate in the project. In this way, one social worker who was involved with a family who were fostering a mentally handicapped child, felt that here was an opportunity for learning about an aspect of her work which was new to her. Another was concerned with a mentally handicapped child who also had a physical disability, and welcomes the opportunity to learn of this 'action research' approach.

Soon after these discussions, the Children's Department asked for a talk about the research and the senior staff, impressed by the methodology, encouraged their department to participate. Eventually, all the social workers in one area undertook to complete questionnaires, taking one family each.

Next, as a result of contact with the Welfare Department, two more social workers asked to be included in this project, and some health visitors followed. This was important because there was a need to establish a relationship between health visitors and social workers on a firm basis, before the Seebohm reorganisation put them into separate departments.

Although the first meeting at which this new form of training was discussed went off very quietly - in fact, those present seemed rather stunned by the implications and expectations of 'action research' - the second meeting, one month later, engendered a greater degree of enthusiasm. At this stage, arrangements for completing the parents' questionnaires were finalised.

The activities of this study group are not yet complete, but one benefit can already be see: there is little or no resistance to taking on work with the mentally handicapped and their families. The opportunity given by the use of the questionnaires for a survey of the area, has helped those new to the field to enter into the casework situation in possession of some knowledge they would not have had without the research. It has also helped them to meet other workers serving the mentally handicapped in both hospital and community - an opportunity they would not otherwise have had.

4. <u>Establishment of a clinic</u> - a general practitioner in the North

One tends to enter general practice knowing about pneumonia, bronchitis and sore throats, and not about the problems of the family which has a mentally handicapped child. This attitude springs from general practitioners' undergraduate years in medical school. The general practitioner's awareness of the problems connected with mental handicap and his knowledge of the existing services directly affects the quality of care a mentally handicapped patient receives from him.

As a general practitioner my involvement in this project has resulted in identifying the need for a training programme for the providers of services, i.e. general practitioners, health visitors, social workers etc., relevant to the needs of the mentally handicapped.

I have been able to establish a weekly clinic with an attachment of a health visitor to look at the growth and development of children. To equip myself better I am attending a course in developmental paediatrics at the local university, and am encouraging my other colleagues to do the same.

5. <u>Changes in management</u> - a clinical psychologist in a London region.

The hospital built on the villa system in open parkland, has both geographical and psychological reasons for the perennial communications problem. Within the hospital the physical distances between units underlines the need for a professional meeting point at some central point in the hospital where informal intercommunication could take place.

The King's Fund study has underlined the need for closer communication in the minds of those members of staff who have been actively concerned with this study, but has not yet led to administrative action on the part of those who could, if they so felt, do something concrete. This lack of involvement of senior administrative and medical staff would seem, at this stage, to be a weakness in the study, at least in this hospital, although it has only been actively concerned in the project for less than one year.

On the other hand, one outcome of the involvement of many middle management members of staff in the King's Fund study has been a powerful drive towards creating a middle management co-ordinating committee which would serve several functions. The two most important would seem to be inter-departmental communication and the provision of a forum at which ideas generated by hospital staff could be presented and refined through discussion. Members of this committee would be permanent and, therefore, would have the invaluable experience of learning to work together over a period of time. Communication would be directly to the Senior Co-ordinating Committee, which has the power to put ideas into practice. This middle management committee accepted by the senior committee is now in being.

The children's side of the hospital has, since participating in the research, commenced clinical team working, and is already pointing the advantages of this method of approach to problems of treatment and ward management.

6(a) Changes in teaching - a clinical psychologist near London, who has used her involvement in the project in the seven areas to improve teaching methods in her own work situation.

Since the stage late in 1970 of analysing 'horror stories' and roles, and discovering the gaps in communication and role perception, it has seemed more important to make an attempt to improve these aspects of the service than to give a straight lecture or demonstration on a particular topic to student nurses. It seemed important too to help the younger generation of professionals to acquire the sort of attitude to themselves and their colleagues which will result in an analysis of any situation which might threaten the well-being of the patient or the smooth relationships of those around him.

'Horror stories' are told to the students and illustrated with diagrams or cartoons. The typology suggested in a previous chapter is discussed. The attitude of assigning blame is strongly discouraged and an attempt made to replace it by one of trying to stand in the other person's shoes, and by getting constructive suggestions from the students themselves. The students are asked to bring their own examples and attempt their own sort of diagram.

Arising out of the analysis of these incidents, another aspect of teaching has appeared: the misunderstanding of roles:

a) Nurse sees herself as concerned with NURSING DUTIES.
Others see nurse as a central information bureau for all knowledge of patients.

b) Nurse sees herself as an EDUCATOR
Others see nurse as concerned with nursing duties.

c) Nurse sees herself as CO-ORDINATOR
Others see her as a parent-figure.

It is intended to illustrate two points: first how the nurse's perception of her own role can cut her off from the other professions concerned with 'Tommy' and second, how others can unwittingly cut the nurse off from communication by their own attitude and perception of her role. The others can, it appears, cocoon the nurse in a role which perhaps she herself does not desire, but the wall of others' opinion is strong and high.

The tutors are in favour of this method of teaching, seeing it as a priority to develop attitudes - and preferably in an operational setting. So far as the lecturer is concerned, this is an excellent way of stimulating discussion which can be taken broadly or in depth, according to the maturity of the students and consistent with the syllabus.

6(b) Supportive conference

We are attempting a different form of case conference with one particular patient, Margaret. The object is to help each member of the team involved with her to feel at the same time supported and responsible. Each is centred on Margaret and responsible in some way for her welfare; each is also responsible to the ward sister; each is also in contact with at least two other members of the team of twelve, so that each may be encouraged when the going is difficult. Information about Margaret, however trivial, is centred on the psychology department and much of it is given in passing on the corridor, taking a matter of minutes only. A monthly conference is held, attended by all the team and anyone else interested in Margaret: we try to include student nurses when possible.

This is, we hope, not just a monthly routine conference, but a dynamic, developing relationship between seven different disciplines and twelve different individuals at all levels of the hierarchy. Relatives too, although they have not yet attended a conference, usually meet more than one member of the team when they visit.

This attempt was a direct result of analysing the 'Pink Daisies horror story' in the course of this project.

Summary

These seven accounts have given at first-hand a picture of changes in both hospital and community that have taken place as a direct consequence of involvement in the project.

Bringing people together, developing new attitudes and teaching better understanding of roles is perhaps a small, unmeasurable change, though it has important benefits; creating a new system of records is something we see a need for, but it took an involvement in 'action research' to achieve it; and finally, developing team-work, whether in management or closer to client and patient, is vital if the services to the mentally handicapped are to be improved.

These were some of the gaps in the service uncovered by this project, and these were some of the ways in which we have dealt with them.

FURTHER EXPLORATION

CHAPTER IV

CHAPTER IV

FURTHER EXPLORATION

The programme for the researchers, up to March 1972.

1. To complete the community interviews in the seven areas.
2. To complete the pilot hospital study.
3. To encourage local hospitals and authorities to continue the study with their own resources.
4. To analyse the community study.
5. To analyse the hospital pilot study and obtain general agreement on the size and number of questionnaires to be used in any future study in hospitals.
6. To prepare a 'profile' of the seven areas.
7. To prepare a draft report by the end of 1971.

This programme will finish with the hospital side of the project incomplete, and this will leave the study in six out of seven areas unfinished.

There is a need to explore more deeply a number of fundamental aspects which we have so far only exposed.

1. How to improve the methodology, and how to develop more effective ways of communicating it. How to ensure that the project-without-us will not become just another text-book, but will continue dynamically. How to release - or redirect - the 'hidden energy' in the system.
2. How to find an effective means of predicting the ingredients of a potential'horror-story'. It is not enough just to change attitudes, we need some sort of pattern for easy reference.
3. A more careful analysis, in operational settings, of what actually motivates a person to become involved in action research; what produces that apparently rare commodity - professionalism; what group of events ultimately activates 'officialdom'?

CONCLUSION

CHAPTER V

CHAPTER V

CONCLUSION

We set out in this series of papers to demonstrate in practical settings the sort of changes we have found as a consequence of involving and becoming involved in 'action research' in the subnormality services. Our knowledge of change implies that we are becoming aware of gaps in the services, not only statistically, but operationally, at 'the place where the client meets the professional, the patient meets the nurse'. The demonstration will, however, be sterile if we are not capable of dissemination.

All systems change. Each change results in problems of adjustment. Adjustment can be effectively achieved if all those running a system understand what the change is about, or in operational terms, who should do what, and why? Those working within a system must learn their way into a new situation. In this project this learning has been achieved through a careful examination of the system. Those with responsibility for taking action have been involved in looking at the system they serve. This involvement has been positive. The participants have felt that they were able to contribute ideas and to identify strengths and weaknesses of the system. At no stage of the development of the project did they feel that they were being manipulated into agreeing with schemes worked out by others. This project is therefore a learning by doing exercise.

The main consequences of this research activity have been that firstly, we have designed useful and relevant survey instruments and have profitably used them in seven local authorities and two hospitals. Secondly, the set of matching interviews with parents, general practitioners, health visitors, medical officers of health, teachers, have produced an interesting and instructive cross section of narrative and attitudes. Much of this has already led to action. Thirdly, the involvement of the various staffs from diverse areas has in itself demonstrated the validity of the main hypothesis supporting the whole project. The staff have shown that when requested to help in discovering how the services in their areas are in fact conducted, they not only provide with an adequate description, but themselves undergo constructive changes in their own attitude towards their work and are themselves moved to change the organisation of their own services and become instrumental in actually improving the quality of care of their clients. The staff involved in this project have shown, on the one hand, an improved ability to perceive their own roles from the viewpoint of the families with whom they are concerned, and, on the other hand, they start restructuring their daily work in order that a high priority is given to those of their activities that most benefit their cases. The project has thus become a process of social learning for those engaged in it.

This progress report verifies the original hypothesis that organised attempts to define the problem of co-ordination not only improve the co-ordination, but also develop the staff involved. This implication of the study - which is distinct from the factual information on the experiences of the handicapped, his family and the agents providing services to both - may open up new lines of research policy.

This method could be applied to other fields where services of one kind or another are provided, and where priorities have not been seriously questioned for some time, and policy makers want a sound basis for reallocation of resources.

APPENDICES

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APPENDIX A

LIST OF MEMBERS OF THE WORKING PARTY

Professor R.W. Revans	Chairman	Research Fellow, European Association of Management, Brussels
Dr. R.D. Fidler	Member	Principal Medical Officer, Mental Health, London Borough of Harrow
Dr. J.A. Gillet	Member	Medical Officer of Health, London Borough of Barking (until October 1969)
Miss M.F. Hodge	Member	Administrative Assistant, Education Department, Hertfordshire County Council.
Dr. W.V.E. McKee	Member	Liverpool Regional Hospital Board
Dr. R. Wilkins	Members Department of Health	Senior Medical Officer, Department of Health
Dr. J.M. Hodgson		Medical Officer, Department of Health
Dr. A. Sippert		Regional Psychiatrist, Leeds RHB (until end of May 1969); Medical Officer, Department of Health (9th June 1969)
Dr. E. Birchwood	Co-opted	Retired Principal Medical Officer in charge of Maternity and Child Welfare in the London Borough of Harrow
Dr. A.R. Worters	Member	Physician Superintendent, The Manor Hospital, Epsom, Surrey
Miss J.B. Craig	Secretary	Assistant Director, The Hospital Centre.

APPENDIX B

LIST OF SELECTED AREAS

1.	A regional 'capital'	City of Nottingham Population: 305,050
2.	An industrial county borough	Hull Population: 294,720
3.	A traditional city	Oxford Population, 110,050
4.	A rural county	West Suffolk Population: 155,240
5.	An expanding area	East Sussex Population: 428,250
6.	A mirror city	Gateshead Population: 100,780
7.	A local check area	London Borough of Hounslow Population: 206,870

Hospitals

1. Leavesden Hospital
2. Harperbury Hospital

APPENDIX C

LIST OF QUESTIONNAIRES

Copies of the questionnaires listed below can be obtained on request to Ali Baquer, The Hospital Centre, 24 Nutford Place, London W1H 6AN, Phone 01-262 2641.

Questionnaires used in community study

1.	for	Parents	THC 70/387
2.		Mental Welfare Officers	THC 70/405
3.		Health Visitors	THC 70/403
4.		General Practitioners	THC 70/404
5.		Staff of school and training centres	THC 71/97
6.		Files kept at Mental Health Department	THC 70/406
7.		Paediatricians (first draft)	THC 71/112

Questionnaires used in hospital study

8.	for	Parents	THC 70/823
9.		Nursing staff	THC 71/56
10.		Medical staff	THC 71/57
11.		Hospital school teaching staff	THC 71/60
12.		Speech therapist and physiotherapist	THC 70/636
13.		Voluntary organisers	THC 70/637
14.		Psychologist	THC 71/96
15.		Social workers	THC 71/99
16.		Occupational therapists, workshop units, industrial training units and utility departments.	THC 70/638

APPENDIX D

PROPOSAL FOR WRITING UP REPORT.

It is proposed that the entire experience of this project should be written up for publication in a book form.

The volume is intended principally for policy-makers, top managers, social workers and all staff engaged in providing services to the mentally handicapped in community and hospitals.

The aim of the volume will be to demonstrate that new understanding of the services through active involvement in this type of research provides a basis for improvement in identifying the needs of the clients and other fellow workers and the exercise itself suggests ways and means to meet the requirements.

An appendix to this volume will present a summary of classified data collected through the use of questionnaires and will be available on request to researchers and any others interested.

REPORT

1. Foreword by Professor R.W. Revans - containing the philosophy that involvement in examination of a system leads to an overall improvement.
2. Evolution of the project - describing its history and development.
3. Profile of the seven areas in the sample - to describe formally the structure and form of the services in diverse settings.
4. Description of the methodology used in the project including an account of its development and guidelines for its use and application by others.
5. Summary and analysis of data
6. Impact of research on those involved in this research.
7. Conclusions and recommendations.

LIST OF SOME OF THE ACTIVE MEMBERS RESPONSIBLE FOR CURRENT RESEARCH ACTIVITY IN THE 7 AREAS

1. City of Nottingham

Mr. J.E. Westmoreland, MBE, MSMO, Adviser to Mental Health,
Social Services Department, 136 Mansfield Road, Nottingham NG1.

Miss Morton, Chief Nursing Officer, Department of Health, Nottingham
County Council, Huntingdon Street, Nottingham.

2. Hull

Mr. E. Elliott, RMPA, RMN, Senior Mental Welfare Officer, Health
Department, Guildhall, Kingston upon Hull.

Mr. V.L. Wilson, Social Worker, Social Services Department,
Municipal Offices, George Street, Kingston upon Hull, HU1 3BT.

3. Oxford

Mr. D. Macintosh, Senior Social Worker, City Chambers, Queen
Street, Oxford.

Mr. I. Price, Manager, City of Oxford Training Unit, Brasenose
Driftway, Cowley, Oxford, OX4 2QY.

Miss Forshaw, Headmistress, Mable Pritchard School, St. Nicholas
Road, Littlemore, Oxford.

4. West Suffolk

Mr. R. Lloyd Jones, Director of Social Services, Social Services
Department, 3 Honey Hill, Bury St. Edmunds, W.S.

Mr. D. Watkins, Area Director of Welfare Services, Social Services
Department, 3 Honey Hill, Bury St. Edmunds, W.S.

5. East Sussex

Dr. R.G. Brims Young, MB, CHB, DPH, Deputy County Medical
Officer of Health and Principal School Medical Officer,
P.O. Box 5, County Hall, St. Anne's Crescent, Lewes, Sussex.

Miss A. Pfister, Social Worker, Mental Health Service, Hayward's
Heath Area Office, "Oaklands", Oaklands Road, Haywards Heath,
Sussex.

.........cont'd

5. East Sussex cont'd

Mrs. S. Sharrif, Social Worker, Mental Health Service, Hayward's Heath Area Office, "Oaklands", Oaklands Road, Haywards Heath, Sussex.

6. Gateshead

Mr. S. Atkinson, Community Services Co-ordinator, c/- Director of Social Services, Prince Consort Road, Gateshead NE8 1LU.

Dr. D.F. Henley, Medical Officer of Health, Public Health Department, Greenesfield House, Mulgrave Terrace, Gateshead, NE8 2BX, Co. Durham.

Dr. W. Kell, Deputy Medical Officer of Health, Gateshead.

Dr. M. Spark, Chairman, Gateshead Local Medical Committee, Newlands, The Drive, Low Fell, Gateshead NE9 5BL.

Dr. R.H. Jackson, Consultant Paediatrician, c/- Gateshead Children's Hospital, Dryden Road, Gateshead 8.

7. London Borough of Hounslow

Dr. R.L. Lindon, MRCS, LRCP, DCH, Medical Officer of Health, Department of Health, 92 Bath Road, Hounslow, Middlesex.

Dr. P. Bennett, Principal Medical Officer, London Borough of Hounslow, 92 Bath Road, Hounslow, Middlesex.

Mr. D. Williams, Area Team Leader, Department of Social Services, Great West Road, Brentford, Hounslow, Middlesex.

Mr. D. Mason, Senior Social Worker, Department of Social Services, Great West Road, Brentford, Hounslow, Middlesex.

Mrs. M. Hill, Deputy Principal Nursing Officer, (Health Visiting), London Borough of Hounslow, 92 Bath Road, Hounslow, Middlesex.

Miss J. Trigwell, Health Visitor, London Borough of Hounslow, 92 Bath Road, Hounslow, Middlesex.

Mr. Seeford, Supervisor, Adult Training Centre, 84 London Road, London Borough of Hounslow, Hounslow, Middlesex.

Mr. Vincent, Warden, Woodlane Hostel, Hounslow, Middlesex.

Mrs. Cox, Welfare Worker, Twickenham Voluntary Organisation, 54 Tangier Road, Richmond, (private address).

APPENDIX E cont'd

HOSPITALS

1. Leavesden Hospital

Miss D. Roswell, Principal Psychologist, Leavesden Hospital,
Abbots Langley, Watford, Herts.

2. Harperbury Hospital

Dr. R. Mein, Chairman, Research Advisory Group (Hospitals),
Consultant Psychologist, Harperbury Hospital, Harper Lane,
Nr. St. Albans, Herts.

Miss F. Levinson, Senior Psychologist, Harperbury Hospital,
Harper Lane, Nr. St. Albans, Herts.

OTHERS

1. Mrs. D. Cortazzi, Senior Clinical Psychologist, St. Lawrence's Hospital, Coulsdon Road, Caterham, Surrey CR3 5YA.
2. Mr. P. Sommerfeld, Organisation Development Unit, University of Leeds, Leeds 2.
3. Miss E. Crout, Rutherford College, University of Kent, Canterbury.