

SOME WAYS OF SETTING, MONITORING AND ATTAINING OBJECTIVES FOR SERVICES FOR DISABLED PEOPLE⁽¹⁾

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Those of us attending this Conference represent different disciplines. Within these disciplines we work at different levels of our respective hierarchies.

We share a common concern to enable the people called "mentally or physically handicapped" to "attain their full potential." To this end, we do, or are concerned with, the procedures of "educating," "caring," "treating," "social work," "multi-disciplinary assessment" and "administration."

We share a common concern that the lot of people in hospital or other forms of residential provision needs improving especially. I also assume that we share a concern to work in teams implementing clear policies.

In this paper I will attempt to provide some answers to the following general questions:—

- A. How will we "know" that we are achieving the things we say we should be doing when we are implementing stated policies?
Can we answer the question: Are things getting better or worse?
- B. How can we identify our present strengths and build on them?
- C. How can we identify our weaknesses and reduce them? Can we do this in a way that is reasonably objective and provides clear answers to all professionals, clients and their relatives?

I will use some of the work now being undertaken by my research colleagues and our professional colleagues in Wessex, England, to illustrate how we are trying to solve some of the problems (Kushlick, 1972, 1973, 1974a, b; Blunden and Kushlick, 1975).

Policy documents, where they exist, contain descriptions of things that should be being done by many people. These people are listed as follows:

- A. At the top of the list are the **CLIENTS**.
- B. Contacting and interacting directly with the clients are the **DIRECT-CARE STAFF**. We distinguish:—
 - i. The direct-care 24 hours—these are members of the client's family (often a parent or a spouse). Their interactions with a client are likely to take place mainly in a single location every day of the week.
 - ii. Direct-care 12 hours—these include people like nurses, house parents, assistants in residential settings who interact with clients mainly in the same location on a shift basis.
 - iii. Direct-care 2—6 hours—include teachers, occupational therapists, etc., who run programmes during a morning or afternoon of the five-day working week. Their interactions with clients tend also to occur in the same location.
 - iv. Direct-care 10 minutes—this category includes people like doctors, social workers, educational or clinical psychologists, speech therapists, physio-

(1) Paper presented to the Annual Conference of the British Society for the Study of Mental Subnormality, on the 26th April, 1975.

therapists, etc. They interact with clients in many different locations throughout the day—we call them the “hit-and-runners” and include ourselves among them. Very often they interact mainly with direct-care staff 24 hours, 12 hours or 2—6 hours, who are the mediators between them and the clients.

- C. Next come the **MONITORS AND SUPERVISORS**. These include administrators or managers in social work, nursing, education, medicine, as well as professional managers or administrators. They tend to interact only with Direct-care staff and **not** with clients. They allocate resources between Direct-care staff working in different locations. They also monitor and supervise the way in which the Direct-care staff work.
- D. Finally, there are the **PROVIDERS AND PLANNERS**. Their main interaction is with Monitors and Supervisors. They produce policy documents and circulars containing rules or guidelines to be followed or implemented by the Monitors and Supervisors. They also produce building notes (also rules) which pre-determine the shape, size and components of facilities in which “direct-care” activities will take place, i.e., in which direct-care staff and clients will interact throughout the day and night. Finally, they also provide the money with which Monitors and Supervisors buy physical and personnel resources.

In our setting we classify the Government Departments and Regional Planning agencies as having the Providers and Planners. The people ensuring indirectly the implementation of existing policies (health, education, social service) are the Monitors and Supervisors. The direct-care staff, of course, must implement the policies directly.

The main aim of this presentation is to try to clarify what each of us in different situations, from different disciplines and different agencies **does** which is helpful or unhelpful to others in our joint work with regard to:—

1. The handicapped client;
2. the direct-care 24 hours, 12 hour and 2—6 hour personnel. The way in which the client and direct-care personnel interact with one another constitutes what we regard as the “quality of care.”

These processes are complex and subtle and there are dangers that any analysis will over-simplify them. However, there are also dangers of over-complicating them or of failing to try to simplify them. The interaction between client and direct-care personnel is the crucial one in the chain and tends in many discussions to be neglected.

The first task in clarification is to identify the difference between what is called (Mager, 1972) a performance and a “fuzzy.” To distinguish these from one another Mager, who introduced the term, uses the “Hey Dad” test, e.g., “Hey Dad, let me show you how I can:—

increase this child’s potential;
change his attitude;
develop his awareness;
assess him;
pass clinical judgement on him;
develop intensive care;
improve hospital morale;
provide a supporting environment;
integrate, co-ordinate services.”

These are called **fuzzies** because Dad **cannot** observe whether or not I have done what I tell him that I have done.

"Hey Dad, let me show you how I can:—

- set a goal for this person;
- record what he did yesterday between 10.15 and 10.20 a.m.;
- arrange material for his learning to walk or dress;
- graph the changes since last week;
- identify the manipulable organic variables controlling his disruptive behaviour in the evening between 5—7 p.m.;
- improve staff recruitment/attendance at work;
- increase levels of goal setting, monitoring and attaining;"

are called **performances** because Dad **can** observe whether or not I have done these things.

Implications

We all use fuzzies all of the time. If asked for detail and cross-examined we can all eventually describe detailed performances. However, often we never get to the details—we argue about fuzzies—e.g., what is a "nursing problem"? what is a "medical problem"? what is a "social problem" or an "education problem"?—but we seldom get detailed or specific enough to identify **performances**.

This is sad because at the detailed performance level there is generally much more agreement between people—if only because the performance is clearer. In addition, we all know and can agree whether or not performances are being carried out—with fuzzies we never know.

Let us look at the details of our joint fuzzy—"to allow the development of potential of handicapped people in all settings and particularly in hospital and other residential settings."

Experts state—in "grand fuzzies"—that x% or y% are in hospital because "they need constant nursing care under constant specialist medical supervision."

During the course of our research, my colleagues and I have been examining in some detail what people are doing when they are "providing care." We have been attempting to group these activities into useful categories. I will first attempt to describe the performances generally. I will then illustrate them with examples. Although our work has, until recently, been largely concerned with the mentally retarded, we find the concepts helpful in relation to all people with disability.(1)

(1) The concepts and procedures described below are fully documented in the following publications:—

Living Environments Group, University of Kansas.

Risley, T. R. and Cataldo, M. F. (1973). *Planned Activities Check: Materials for Training Observers*. Centre for Applied Behaviour Analysis, Kansas.

Cataldo, M. F. and Risley, T. R. (in press). Evaluation of Living Environments: The Manifest Description of Ward Activities. To be published in: Clark and Hammerlynck (Eds.) *Evaluation of Social Programs in Community, Residential and School Settings*. Research Press: Champaign, Ill.

Health Care Evaluation Research Team, Winchester.

Whatmore, R., Durward, L. and Kushlick, A. (1975). Measuring the quality of residential care. *Behaviour Research and Therapy*, 13, 227-236.

Durward, L. and Whatmore, R. (1975). Testing measures of the quality of residential care: A Pilot Study. *Behaviour Research and Therapy* (in press).

First some general concepts. We find it helpful to say that clients are at any time either **approaching** learning situations or **avoiding or escaping** from them, while, at the same time, staff in either case are responding to them.

At "good" times, when the client's "potential" is likely to be developed or is being maintained, clients can be observed engaging at any time; and they do so without any conspicuous coercion, i.e., they "choose" what they do from a range of choices open to them.

For example:—

1. they participate actively with their environment;
2. they contact and interact with people and material;
3. they respond (their behaviour changes) according to the way in which the material or people do, or do not respond to them;
4. they do **not** display "emotional" behaviours—crying, running away, screaming, anxiety, e.g., their pupils are not dilated, etc.

At the same time, direct-care staff (of any discipline) can be observed:—

1. providing, arranging and displaying engaging materials;
2. contacting and interacting with the client during the periods of engagement.

In these settings, when people are **disengaged**, they tend to be ignored—i.e., they are **not** contacted or interacted with—people are too busy doing exciting things to pay much attention to the whining person who generally joins in when he or she stops whining.

This type of interaction goes on during all hours of the working day. It is likely to strengthen existing skills and abilities of clients; it avoids disengagement and disruption because these behaviours are incompatible with engaged activity. Moreover, it is likely to be attractive to staff and to relatives, including parents; in residential and school settings, staff sickness-absence will be low and Monitors and Supervisors will have been able to recruit establishments fully and to allocate them; in home settings, relatives, including parents and their children, will do things together as frequently as anyone without a handicapped relative.

Clients

On the other hand, at "bad" times—when "potential" is being lost, clients are observed to be **disengaged**.

1. They are disrupting material/people in the environment—throwing things around or pushing or biting people in a manner likely to injure them. Direct observation in even poor facilities shows that individual clients do not emit this form of behaviour often during a day.
- or 2. They are irritating—but not disrupting—to others. The behaviour which irritates another person is highly individualised to the person irritated. It is nevertheless most important to be aware of this.
- or 3. They repeat a set of responses over a long period without new responses to the material or to the people in the environment, and/or without responses from the other people in the environment, e.g., walking up and down alone or simply rocking for long periods.
- or 4. Any movements they make are passive, i.e., they occur only in response to someone else moving their limbs.
- or 5. They may also be displaying emotional behaviour—crying, screaming, etc.

Direct-Care Personnel(2)

At these times, direct-care staff (including parents or teachers) are likely to respond by:—

1. Acting as **social prostheses**—i.e., they do things for clients which clients don't do for themselves rather than prompting or aiding clients to carry out the tasks.
2. **Restricting** the clients:—
 - i. **socially**—by means of rules, threats about where they can't go; warning about what will happen if the rule is broken.
 - or ii. **mechanically**—by means of locked doors, cot sides, early bed-times; or by *removing items from the environment*—toys, books, clothes, spectacles, hearing aids, carpets, curtains, crockery, cutlery.
3. **Restraining** the client:—
 - chemically—by means of tranquillisers;
 - physically—by means of splints, webbing, chairs with trays or which slope backwards;
 - socially—by holding on to the client.
4. Responding with **positive punishers**—i.e., smacking, yelling (Dont! Stop! Come here!), or by humiliating after the offending behaviour. They may use **negative punishers**—i.e., fining or depriving the client after the misdemeanour.
5. **Reinforcing negatively**—i.e., nag, threaten, in order to achieve compliance. As a rule, after the client has complied, direct-care personnel ignore him or her.

Not only is this relationship incompatible with the positive relationship described earlier—i.e., with interaction and contact during engagement—it is virtually the opposite. Thus, direct-care staff and client are **interacting** and contacting one another when the client is **disengaged**, e.g., during social restraint, positive punishment, negative punishment, negative reinforcement; or direct-care staff **ignore** clients when they are **engaged**, i.e., during social prosthesis, restriction, restraint.

The consequences are likely to be:—

- i. The acceptable skills, abilities of the client are likely to be weakened and lost; the disruptive, avoidance and emotional skills are likely to be strengthened.
- ii. The approach behaviours of direct-care staff and parents are likely to be weakened, the restrictive practices to be strengthened, and their avoidance and escape behaviours to be strengthened.
- iii. Time during which direct-care staff or parents may behave engagingly—or arrange materials for clients—is likely to be lost.

It is at times like this and in settings like this that we say the client “needs nursing and specialist medical care,” i.e., he or she “doesn't need education or social care,” or “**wouldn't benefit**” from such care.

We all either use or are victims of all of these negative techniques of social control at some times in our own family or work situations. The problem is to

(2) The concepts and procedures described below are extensively developed in the following publications:—

Skinner, B. F. (1953). *Science and Human Behaviour*. New York: Free Press.

Lindsley, O. R. (1964a). Geriatric behavioral prosthetics. In: *New Thoughts on Old Age*. R. Kastenbaum (Ed.). New York: Springer.

Lindsley, O. R. (1964b). Direct measurement and prosthesis of retarded behavior. *J. Educ.* 147, 62-81.

monitor them in settings where clients are particularly vulnerable and in need of specially sensitive educational environments. This is particularly urgent where the client has no power to control his own environment and may be moved against, or without his wishes to a more barren and restricted environment.

Research and Development Applications

In any total population of 100,000 in England and Wales there are about 150 mentally handicapped residents in psychiatric hospitals for the retarded; of these 20 are children.

In Wessex the providers and planners of the Regional Hospital Board have built locally-based units of 20-25 places, domestic in design, sited them in the middle of population centres and equipped them according to criteria specified in our new policy documents.(3)

The clients eligible as a priority to enter the new facilities are the people who "need hospital treatment." These include:—

1. those with the worst problem behaviours;
2. those with the most behaviour deficits.

A high proportion have convulsions, are incontinent, have no speech, or have physical or sensory defects.

Since these clients have been transferred successfully to these new domestic "settings," we have observed the interactions of clients and staff, both when things are going well and when problems arise.

The following vignettes provide examples of the performance of different performers in the setting up of the new locally-based, domestic type residential facilities for the retarded in the Wessex Region. They also illustrate, with regard to clients in the new Wessex facilities, engagement and disengagement at different times of the day and staff reaction to the situations.

Ex. 1. The Providers and Planners were the performers concerned in the buying of an existing house in the middle of a residential area. Predicting from prevalence data that the children eligible for admission would include a proportion who are unable to walk, they planned downstairs bedroom accommodation. Knowing the numbers who were likely to be severely incontinent, they planned the number and siting of toilets and bathrooms in the building and outside the building. These features are specified in the rules of building notes, as are the rules about the siting of the unit in the middle of the town close to public transport, shopping and recreational areas for both staff and residents.

Ex. 2. One child is non-ambulant, doubly incontinent, has a few words of speech and is regarded as severely behaviour-disordered because of the high frequency with which she screams and knocks her head on the floor unless she is lifted up by her parents or a member of staff. In addition, she is also blind. The important performance of the **D-C 12 hours** is to interact with her when she is **not** screaming and when she is interacting acceptably, for example, when she is sitting on the lap of one of the houseparents having her hair combed, or participating in getting dressed, while at the same time she vocalises. For this to occur, it is important

(3) Wessex Regional Hospital Board (1966). *Report of the Working Party on Provision of Further Education for the Mentally Subnormal*. Mimeograph.

Wessex Regional Hospital Board (1969). *Provision of Further Accommodation for the Mentally Subnormal*. Mimeograph.

Wessex Regional Hospital Board (1973). *Forward Planning of Services for the Mentally Handicapped in Wessex: Report of a Joint Planning Group*. Mimeograph.

The 10 year plans put forward in the 1973 Report of the Joint Planning Group have been prepared within the context of the Department of Health and Social Security White Paper: *Better Services for the Mentally Handicapped* (London: HMSO).

that **Monitors and Supervisors** have allocated sufficient direct-care staff with whom she can interact at any time of the day. It is also important that **Providers and Planners** have allocated sufficient resources and made rules which ensure the buying of individual clothes with which both houseparent and the child can interact during dressing. Rules limiting the number of D-C 12 hours staff which **Monitors and Supervisors** may allocate to be on duty at any time or which veto the acquisition of personal clothes or of a cupboard in which to store them, will make it unlikely that an appropriate interaction can occur between the handicapped child and the D-C 12 hours staff.

Ex. 3. The setting is early morning. An ambulant young lady, who has no speech, is getting up out of bed. She is also doubly incontinent. She is described also as having severe behaviour disorders—at getting up time these include the likelihood that if her soiled clothes are not cleared away soon enough she will smear faeces on the surrounding furnishings and fittings. She also has other difficult behaviours including being able to produce self-vomiting. When this occurs at the dining room table it is very disrupting because it is so disagreeable. She is unable to sit in her chair waiting for her food to arrive for longer than a few minutes and is likely to get up and take other people's food. It is extremely difficult for the D-C 12 hours staff to find engaging activities which are acceptable for a child like this over a period of 13 hours of the waking day. In the absence of such activities, it is likely that D-C 12 hours staff will:—

remove materials from the environment that are likely to get damaged or soiled, for example, removing the curtains from the bedroom. It is also likely that mechanical restraint will be employed at mealtime to stop her from getting up out of her chair and taking other people's food. In the hospital from which such a child was admitted to a new unit, the child was mechanically restrained to her chair by means of a bandage. Her arms were also swathed in a sheet so that she was unable to get her hand down her throat to produce self-vomiting. She learned to do it without this. In the experimental unit, given other methods of engaging activities, the child was no longer restrained at meal-times and was able to feed herself, an activity which in itself is highly engaging. This person has now reached the age of 17, has been transferred to a locally based adult unit. Here the rules require that the doors are left open and that the front gate which opens on to the road be left open. In this situation the D-C 12 hours staff must now use mechanical restraints during the day to prevent this person walking out. In the new setting the woman is also being fed at mealtimes because no other way has been found of dealing with the food stealing.

Ex. 4. A young man of 15, who is ambulant, has no speech and is severely incontinent. In addition, he appears to enjoy screwing light fittings from the ceiling and throwing objects at light fittings. For this reason, his behaviour is regarded as severely disordered. The actions taken successfully by the D-C 12 hours staff to control these problem behaviours include requesting the engineer to raise one of the light fittings so that it is beyond his reach and teaching the youngster to refrain from these activities on the command "No." Despite the fact that learning to use a toilet appropriately and to urinate and defaecate in the toilet only and not elsewhere is a key task for him to learn, it is likely that he will be found at toileting time sitting in the toilet on his own, that is, not contacting and interacting with a member of the direct-care staff during this, for him, highly appropriate and important learning situation.

Ex. 5. In the setting of mealtime, the appropriate materials for clients and D-C 12 staff are cutlery, crockery and the food contents within available on the table. Engaged activity is observable as the hands of both clients and direct-care staff contact and interact with the cutlery, crockery and food. Disengaged children are seen **not** to be contacting and interacting with cutlery, crockery and food. A young man in this setting who has severe physical deformities which make it impossible for him to feed himself at all, and who must therefore be fed, can be seen in such a situation being completely fed by a D-C 12 hours staff. This constitutes an example of social prosthesis.

Ex. 6. Mealtime setting continued. A youngster, aged 12, who is ambulant but has no speech is sitting at the table feeding himself with a spoon. He is thus contacting and interacting with the appropriate materials during mealtime. As a result, the problem behaviours which get him the label of severely behaviour disordered do not occur. These include biting his own hands and those of others, beating his head and those of others, eating inedible objects including the linoleum of the floor of the dormitory—he is said to have consumed half of the linoleum from a 26-bed dormitory in the hospital from which he was admitted. He also stole other people's food at the table—for this behaviour he had been mechanically restrained to his chair while in a traditional hospital, where he was also fed. In the experimental setting, because there are not long intervals to wait between courses, because there is a member of staff sitting eating next to him who can intervene should he behave inappro-

priately, and because there is very likely to be a sharp reaction following any attempt on his part to take someone else's food or to walk off, he has acquired appropriate eating behaviour at the table and is able to feed himself.

Ex. 7. The setting is the time just after breakfast, waiting for the school bus to take the schoolchildren to a local school. Two young ladies, aged 9 and 11, who have Down's Syndrome, are sitting in the one playroom on the carpet. One is leaning up against the legs of a houseparent who is tying a ribbon in her hair; the other child kneels on the floor next to her. She is holding a comb in her hand and is being guided in combing the hair of the other child by the houseparent. The child whose hair is being combed has her school-book in her hand. This is an example of a rich contact and interaction with materials—the book and the comb—as well as contact and interaction with people—the other child and the houseparent—during a highly engaging and acceptable sequence of activities.

Ex. 8. The setting is the same room at the same time. Another two children are sitting on the carpet. Both are unable to walk, one is doubly incontinent, non-speaking and able to take food only from a feeding bottle, despite the fact that she is 9 years old. The other is able to feed herself, is occasionally incontinent of urine and has a limited vocabulary of about 25 words. The second child is assisting the first as she drinks from a bottle on the floor as she leans up against the legs of another houseparent, who is sitting with them. In this instance, both children are contacting and interacting with moveable objects (the feeding bottle), as well as with another person (one another). In addition, one child is being contacted and interacted with by the houseparent. Once again, a rich set of interactions is occurring during engaged activity.

Ex. 9. The setting in the living unit is a playroom especially designed for the use of sand and water materials. The client is the very severely physically handicapped child of Example 5, who must be fed at mealtimes. He is sitting supported on the floor with cushions and is being presented with a handful of sand lifted out of a bowl of sand in front of him by a D-C 12 houseparent. He is responding by lifting his arms and picking up some sand between his fingers as he focusses his eyes intensely on his hand, the hand of the houseparent and the sand. He is contacting and interacting with the sand as well as with the houseparent.

Ex. 10. The setting is breakfast time. The client is a boy of 12. He is ambulant, fully continent and has an IQ score of at least 75. His general behaviour presents no difficult problems. He is seen standing at a table pouring out milk into a large number of cups—he is making cups of tea for other residents as well as himself. He had been admitted to the unit from a so-called adolescent ward of a traditional hospital for the mentally retarded. This ward had 40 people in it, their ages ranging from 12 to 69. He had been admitted to this unit from a residential school for children categorised as "educationally subnormal." The school had been closed following an inspection from the Department of Education and Science. He was moved to the locally-based experimental unit because the address of his mother was on the side of the town served by the experimental unit. The observations of levels of engagement at different times of the day and the listing of different materials which clients contact and interact with during the course of the day show that, despite the fact that the other children in this unit are much more severely retarded than this young man, his daily experience can be very rich indeed if D-C 12 hours staff make available to him an appropriately wide range of material with which he can make contact and interact. It can be further enriched by making available to him people—adults and peers of his own age with whom he can also make contact and interact during the day. Thus this young man attended a local day school for children categorised "educationally subnormal." He did very well at school and was soon transferred to a residential home for deprived children with normal intelligence scores, as a result of the joint intervention of the D-C 12 hours staff of the unit with the Social Services Department's D-C 10 minutes staff, who visit the local unit regularly.

Ex. 11. A locally-based, domestic type unit for profoundly retarded and severely behaviour-disordered adults whose parents live within a total population of 50,000 constitutes another example of the performance of **Providers and Planners**. We now have two such units, one in Southampton and one in Christchurch.

Ex. 12. In this unit, the setting is getting-up time in one of the bedrooms. The client is a young lady who is unable to walk on the level by herself, has no speech, and is doubly incontinent. The houseparent, D-C 12 hours, is dressing her. The girl is disengaged and non-participating—this can easily be seen as her eyes are focussed in the distance, i.e., she is **not** looking either at the clothes item or at the member of staff. One hand is in her lap and her other hand is being lifted and placed by the member of staff through the sleeve of her dress, that is, the client is not "helping" with the dressing process. Another resident who stands watching the interaction is not contacting or interacting with material but is obviously speculating.

Ex. 13. The setting is still getting-up time. An older man in his bedroom is dressing. He is able to walk on the level with difficulty, provided that he has a walking aid to help him maintain his balance. He has no speech but he is fully continent. His bedroom has a small wardrobe which is easily accessible from the bed. He can stretch across to this from his bed by supporting himself on a chair which is placed between the bed and the wardrobe. At this stage he already has his vest and underpants on. He has got both of his legs through his trousers, is standing up supporting himself by holding on to the chair, and is pulling his trousers up. He is thus contacting and interacting with the material appropriate to getting up in the morning. He has been busy at this for the past 40 minutes and it is clearly a highly engaging activity in which he is maintaining, if not developing, skills very relevant to controlling his own environment. In the absence of a bedroom in which he has his own clothes and in which these clothes are so situated that he has access to them himself, he would be unable to control his environment to the extent that he could not get his own clothes and dress himself in the morning. He would thus be dependent on other people. Were he to be socially prosthethised, that is, dressed by somebody else, he would be deprived of the opportunity of maintaining and developing new skills in this way.

Ex. 14. The same setting—getting up in the morning. A middle-aged man, who is ambulant and continent but unable to speak. He is sitting on the bed dressing himself. He has his underpants on already. He is attempting to put his vest on. He has got his head through the armhole and is attempting to get his arm through a hole in a very twisted vest. He is looking at, and smiling at, another non-speaking resident whose eyes are focussed on him and who is vocalising back at him. This man is contacting and interacting with material appropriate at dressing time, namely the vest. However, he is in difficulty, and although he is interacting with another resident in the unit, it is unlikely that the resident will solve his problem and allow him to continue and solve his problem of getting dressed.

Ex. 15. The setting is toileting time within the unit. A middle-aged woman, who sits in a wheelchair, is in one of the bathrooms. She has a wide range of speech but is unable to walk on the level without help because of her physical impediment, namely paralysis following a stroke. She is fully continent. Despite her right-sided stroke, she stretches across with her left hand to her toilet bag which is on the right side of the wheelchair on the bath while she washes herself at the basin in front of her. She is highly engaged, contacting and interacting with appropriate material for toileting time. She is able to do so because the wheelchair can get in through the door of the bathroom and because the basin is so placed that the wheelchair can move directly under the basin. She has her own toileting materials which she stores in her room and which she can take with her to the bathroom. Without any of these things she would be unable to contact and interact with the materials herself and again may well have been socially prosthethised, that is, washed and toiletted by somebody else.

Ex. 16. The same setting at toileting time. A very able young man, who can walk, speak in sentences and is fully continent. He has troublesome outbursts of difficult behaviour in which he can be physically aggressive. He is in a bathroom sitting on a chair. A towel has been swathed around him and he is being shaved by a D-C 12 hour houseparent. This is an example of social prosthesis. His disengagement can be seen from the position of his hands, in his lap, and his eyes looking away into the distance. In this situation he is not contacting and interacting with the appropriate material and he is therefore unlikely to be acquiring a relevant skill.

Ex. 17. The setting is mealtime. The young lady from Example 12 (she was being socially prosthethised, being dressed while she failed to contact or interact with either the clothes or the individual who was dressing her) is now sitting at the table. In front of her are pieces of cutlery and crockery. Her plate has food on it. She is not contacting or interacting with the cutlery, crockery or food. Her eyes are staring in front of her, her hands are at her side. There is a band around her waist restraining her to the chair, while a D-C 12 hours houseparent is giving her her medication. This is an example of social prosthesis and mechanical restraint. In this setting she is unlikely to acquire skills appropriate to the situation.

Ex. 18. The setting is mealtime. The resident is a young man. He is ambulant, has no speech and is doubly incontinent. He has a range of troublesome behaviours which include pulling his trousers down in public situations, urinating publicly on the floor, pulling the hair of residents sitting next to him, banging his head against the wall when seated in a chair against the wall, banging on the table at mealtimes with his elbow or banging on the under surface of the table with his fist at mealtime. The table is laid in front of him with crockery and cutlery. There is food on the plate. He is not contacting or interacting with the cutlery

or the crockery or the food. His eyes stare out in front of him, his right arm is being held down by a D-C 12 houseparent who is standing at his side feeding him. This is an example of social prosthesis. The client concerned is disengaged and is unlikely to be acquiring skills of self-feeding. In addition, it is likely that the client is being contacted and interacted with specifically during disruptive conduct which may therefore be strengthened and increased in frequency.

Ex. 19. The same setting. A young man who is unable to walk on the level without help and unable to speak, but is continent, is sitting at the table. In front of him is crockery and cutlery. His plate has food in it. He is holding in his hand a spoon with a specially designed handle that he can grip easily. A D-C 12 hours houseparent is standing next to him contacting and interacting with him as she helps him to lift the spoon to his mouth. His eyes are focussed on the spoon and food. This is an example of contact and interaction with a member of staff when the client is appropriately engaged at mealtimes. This man is likely to strengthen and develop relevant behaviours as a result of these interactions.

Ex. 20. The setting is mealtime. Several residents are sitting at a table eating. One, in particular, who is ambulant, fully continent, has a wide range of speech and social skills, is sitting at the table pouring herself a cup of tea from a pot. This woman clearly has a very much wider range of acceptable behaviours than most of the other residents. Nevertheless, as with the young man in Example 10, she is able to do a much wider range of activities and to maintain skills and develop them as long as she has access to a wider range of material than would be available to the people with smaller repertoires, and as long as she is encouraged to use the material.

Ex. 21. The setting is the recreation period following mealtime. The young man with the troublesome behaviours (Example 18) is now sitting on his own in the lounge. He still has his plastic bib on. In his hand he has a piece of toast which he is eating while sitting. He is engaged to the extent that he is contacting and interacting with eating material. However, if the aim was to develop the skills of eating appropriately at the mealtime in the meal room, and **not** to behave disruptively at mealtime, it is possible that he has learned how to escape from the mealtime situation to the lounge where he can eat on his own.

Ex. 22. The setting is a recreation period. An older man is sitting in an armchair. He is able to walk, has no speech, and is fully continent. He has a very small head and has a physical disability of his lip, so that when he eats it is very difficult for him to avoid food slipping out of his mouth. This man "looks" profoundly retarded. However, on looking at what he is doing in the lounge during the recreation period, it is clear that he is looking intently at a magazine and may well be reading it. From the closeness with which he holds the book to his nose, it appears that this man may be in need of a pair of spectacles. This example illustrates how the measure of engagement may lead one to spot requirements for specific clinical interventions.

Ex. 23. The situation is again recreation. The resident is a young woman who is unable to walk on the level without help because of physical deformity. She is fully continent but has no speech. She has been nursed in a spinal carriage for the whole of her life. In the lounge she can be seen disengaged, that is, there are no materials available to her. In her spinal carriage, her hands are only contacting her own clothes. Her eyes are following with some interest the activities that are going on around her. The provision of engaging activities for severely physically handicapped people who are confined to a spinal carriage or a wheelchair requires special ingenuity.

Ex. 24. The setting is pre-mealtime. A young woman with Down's Syndrome who has speech, is fully continent and able to walk, is pushing a wheelchair containing an older woman who is unable to walk on the level without help. The second woman, however, is able to speak, has a wide range of verbal behaviour and is also fully continent. Here is a situation in which the first woman is certainly contacting and interacting with a moveable object and, at the same time, interacting with another person—a very rich interaction. The woman in the wheelchair is being socially prosthethised by another client with whom she is interacting by speech and giving her directions. The second woman in the wheelchair has become organically ill as a result of cancer with secondaries to the spine. Despite this, she can remain within the residential facility, only going to a special District General Hospital when this is required because of surgical procedures to deal with the growing secondaries or to control pain.

Ex. 25. The setting is a traditional hospital where a traditionally designed day room or dining room of a traditionally designed ward has been re-modelled or "upgraded." The visitor to such a remodelled ward is necessarily and rightly impressed by the new furnishings, fittings and by the pleasant colours which contrast sharply with the stark furnishings and fittings and the unpleasant colours of parts of the building which have not been remodelled. That this alone is a poor criterion of the quality of the programme of the unit can quickly be seen by having a look at the levels of engagement of the clients in the setting. Despite the new furnishings, fittings and colours, the clients are sitting in wheelchairs or armchairs, some are asleep and others are staring straight ahead. Their hands are at their sides or they are touching themselves. They are not contacting and interacting with other manipulable objects, nor are they contacting or interacting with other clients or with members of staff; direct-care 12 hours staff are not contacting or interacting with clients but either stand supervising or contacting and interacting with health care materials like domestic materials. These are the signs of a programme in which clients may well be losing appropriate skills and possibly acquiring inappropriate ones despite the remodelling of the ward on the request of Providers and Planners.

Implications

We believe that attaining high levels of engagement throughout the waking day is the most important and urgent priority for the handicapped person. Thus, if direct-care 12 or 24-hours staff **cannot** attain high levels of client engagement during the working day, serious consequences follow:—

- (a) Minimum criteria of client self-esteem will not be met.
- (b) Much of the additional work undertaken by skilled specialists (Direct-care 10 mins.) will be wasted or appear irrelevant—e.g., as client skills are lost and as avoidance behaviour and disruptive conduct takes its place, specialist educational programmes will appear irrelevant to direct-care 12 and 24-hours staff. (Department. Health and Soc. Sec. 1974.)
- (c) Skilled effective intervention by medical direct-care staff will **not** take place—and if it does, direct-care 12 hours staff may not implement instructions, e.g., see to the wearing of spectacles, hearing aids, dentures, etc. The medical direct-care staff role will be largely that of transferring and excluding or disciplining clients. They will also authorise the use of restriction and restraint by direct-care 12 hours staff. They will also provide unscientific mystifying explanations to people who ask why the procedures which are being employed have been chosen. (They may refuse any explanations at all.) (See Appendix 1.)
- (d) Parents and volunteers will be regarded as unwelcome participants in these procedures—it will be said by direct-care 12 hours staff that they don't "understand."
- (e) Debates on fuzzies will continue between direct-care 10 minutes staff themselves or between direct-care 10 minutes staff and direct-care 12 hours staff.
- (f) Direct-care 10 minutes staff will continue to speak derogatorily of "feeding, washing and dressing" routines which take up much of the time of direct-care 12 hours staff. Direct-care 12 hours staff carrying out "health care routines" will continue to be written off as mere "guardians of the orifices" rather than as contributors to the education and social development of clients.
- (g) The clients will develop avoidance and escape behaviour, etc., and will increasingly be excluded from unrestricted environments, i.e., they will be transferred to more restricted environments. Direct-care 10 minute medical, educational or social work staff will sometimes rationalise these exclusions as transfers to facilities offering "skilled specialist treatment facilities" on the basis of their "clinical judgement."

How are we likely to improve levels of engagement?

What consequences might follow any successes?

1. With a few hours of training in techniques of collecting data on levels of client engagement, monitors and supervisors, direct-care 12 hours and direct-care 2—6 hours or direct-care 10 minutes staff can rate levels of engagement in any environment. (See Footnote 1.) With additional training they can learn to implement and evaluate changes in their own performances on the basis of the data collected.(4)
 - (a) Where levels of engagement and staff-client contact are high at all times:—
 - i. Public recognition can be made of the manner in which staff have attained their goals.
 - ii. Direct-care 12 hour staff providing this high quality care could well teach others, either by acting as models or directly by undertaking staff teaching.
 - (b) Where low levels of engagement are found, monitors or direct-care staff can identify and remedy conditions, which, if neglected, could deteriorate into scandal proportions.
 - i. Where there are few materials contacted by clients, and where the monitor finds no suitable material in the situation, appropriate material must be ordered and made available in the living unit by the monitors and supervisors.
 - ii. Similarly, where there are at any time of the day, insufficient direct-care 12 hours staff to contact and interact with clients at specified criterion rates, monitors and supervisors must remedy the situation.(5)

It is likely that in the past front-line direct-care 12 hour staff have been unjustifiably criticised for failing to deliver high quality services; in fact, their problems have reflected a failure of monitors and supervisors to take note either of the quality of care or of the extent to which it was limited by the material and staff resources made available by monitors.

For example, in England and Wales, a Department of Health and Social Security report published at the end of last year shows that direct-care 10 minute specialist medical officers and monitors and supervisors (administrative officers) in hospitals for the retarded report annually to the Department that very large numbers of their clients are **not** receiving training or education. The reason which they give for this is that these clients are “too severely handicapped” or “too disruptive” or “senile.” According to their returns to the Department of Health and Social Security, virtually no handicapped people are **not** receiving training because of “lack of facilities”—presumably **staff, material or buildings.** (Dept. Health and Soc. Security, 1974.) Thus materials and personnel are **not**

(4) For methods of monitoring such environments objectively and for developing skills and abilities of staff and clients to improve the quality of life in these environments, see:

May, J. G., McAllister, J., Risley, T., Twardosz, S., Cox, G. H., *et al* (1974). *Florida Guidelines for the use of Behavioral Procedures in State Programs for the Retarded*. Florida Division of Retardation and Department of Psychology, Florida State University.

Accreditation Council for Facilities for the Retarded (1973). *Standards for Community Agencies serving Persons with Mental Retardation and other Developmental Disabilities*. Chicago, Illinois: Joint Commission on Accreditation of Hospitals.

(5) The writers of the Florida Guidelines (see Footnote 4) recommend that front-line direct-care 12 hours staff must reinforce clients' appropriate (engaged) behaviour and must ignore inappropriate behaviour so that the error rate (contacting clients during inappropriate behaviour) does not exceed 10% of all contacts. This must be attained with an interaction rate of one per minute. Appropriate procedures for weakening disruptive behaviour do not count as erroneous.

being requested to assist direct-care 12 hours staff to engage the clients presenting the most difficult problems.

2. Reports on levels of engagement in any unit could be made routinely available to members of the consumer groups and political representatives whose constituents are in the units, and to special consumer groups (e.g., National Society for Mentally Handicapped Children) maintaining particular interests in clients from an area.
3. (a) Where new allocation of staff or material is followed by increased levels of engagement, these effects are quickly noticed by all people receiving the data.
(b) There are, however, situations where staffing increases are not possible because monitors and supervisors are simply unable to find and recruit additional staff, and where, as a result of this, levels of engagement cannot be improved. Where this arises, providers and planners must seriously consider the necessity, if harm is not to be done to clients, of closing facilities and redeveloping them in areas where staff can be recruited, and increased levels of engagement attained.
(c) Where increases in direct-care 12 hours staff are **still not** followed by increases in levels of engagement:—
 - i. Staff-client contact and interaction may not have increased, or
 - ii. It may be taking place at the wrong time. Monitors and supervisors must correct this by counselling. (See Footnote 4.)
4. **As staff detect increases in levels of engagement among their clients:—**
 - (a) It is likely that the use of restriction and restraint and other forms of negative social control will decrease.
 - (b) Similarly, transfers and exclusions of difficult clients (or “buck-passing”) may also decrease.
 - (c) With the need recognised for more hands to assist in arranging suitable material, and in contacting and interacting with clients, direct-care 12 hours staff might invite help and assistance from relatives and volunteers. It should be feasible to arrange this in the form of acceptable contracts between residential staff and clients’ relatives.(6)
5. Other consequences might follow from this **spelling out of tasks** to be undertaken by all of the personnel concerned, as well as from the **specification of standards of excellence** for staff practices:—
 - i. This exercise should reveal the large number of complex tasks being neglected at present. In England and Wales there is still a lot of talk about which professional groups have the sole right to care for the retarded.(7) Given the long list of tasks now being neglected, talk

(6) For detailed descriptions of interventions involving contacts between professionals and clients or their relatives, see:

Carter, R. D. (1973). *Outline for Procedural Guide to Behavioral Case Management* (unpublished).

(7) Shapiro, A. (1974). Fact and Fiction in the Care of the Mentally Handicapped. *Brit. J. Psychiat.*, 125, 286-292.

Kushlick, A. and Blunden, R. Letter. *Brit. J. Psychiat.*, 126, 187.

Shapiro, A. Letter. *Brit. J. Psychiat.*, 126, 487-8.

Spencer, D. A. Letter. *Brit. J. Psychiat.*, 127, 189.

Forrest, A. Letter. *Brit. J. Psychiat.*, 127, 190.

about professional rights might usefully be replaced by requests to other non-professional and professional groups for **assistance** with these tasks.

- ii. The more clearly the tasks are spelled out, the **less** likely it is that fuzzies will survive.
 - iii. Explanatory fictions, such as that "He cannot do things because he is retarded or disturbed," will cease to appear so impressive when it becomes clear that we can only neglect and deprive people on the basis of such "so-called" information. (See Appendix 1.)
6. If the professionals of different disciplines can produce and publicise general guidelines of acceptable professional conduct in performance terms (i.e., in terms which were comprehensible to one another), it is likely that clients' relatives, clients and providers and planners of services might also respond more effectively to what was needed of them.

Interesting work along these lines is already under way in the United States:—

- i. The Hospital Accreditation Commission has comprehensive lists of standards required in facilities which they accredit. (See Footnote 4.)
 - ii. Also, distinguished experimental analysts of behaviour, together with legal experts concerned with civil rights of clients, are producing most helpful and comprehensive sets of guidelines. The Division of Retardation in the State of Florida has been presented with a report on the development of its own facilities. This report incorporates performance standards of staff arising from actions brought by parents against providers and planners where unsatisfactory care was being provided. (See Footnote 5.) (8)
 - iii. It is now accepted that the clinical record is the client's property. It must contain the individual treatment or training objectives written in clear behavioural terms. Glossaries must be provided to enable the client or his relatives to comprehend any abbreviations used in the record. Staff performances not recorded in the records are regarded, for legal purposes, as not having occurred at all. (See Footnote 4.)
7. The clients who are rightly regarded as the main responsibility of specialist direct-care staff are those who:—
- (a) have very limited repertoires and who are also physically handicapped, and
 - (b) those with particularly disruptive behaviour.
 - i. The techniques for monitoring the contact and interaction of clients with materials and staff throughout the working day are particularly helpful with respect to these clients.
 - ii. Particular attention can be directed to the **health care routines** employed in their management. These clients often receive 90% or more of any contact with people or moveable objects during the activities of feeding, washing, toiletry and dressing (Felce, D. *et al*, 1974).
 - iii. Given the evidence that disruptive behaviour occurs when there is no other way of controlling the environment, the guidelines prepared for the State of Florida propose that all clients have a right to an environment which they can change without having to behave disruptively.

(8) See also the criteria for individual treatment plans described in Appendix D of the Florida Guidelines (May, J. G. *et al*, Footnote 3).

8. The extent of disruptive or non-engaged conduct of clients can be taken as an index of inadequacy of the available environment, i.e., of materials and direct-care 12 hours staff contact.(9)

These data should set the occasion for some interventions by monitoring personnel.

They should also inform the design and siting of new facilities by providers and planners and the operational policies for the staff in the units.

- (a) For example, it is now clear that a current specialist medical practice of grouping in a special unit clients with what are called similar "clinical conditions" necessarily results in units containing large groups of people with very severe physical defects.

This presents direct-care 12 hours staff with extremely difficult tasks of arranging sufficiently engaging materials, and of contacting and interacting sufficiently often with clients to maintain high levels of engagement.

It also presents hard-pressed direct-care 12 hours staff in other settings with the opportunity to "buck-pass" their difficult clients elsewhere rather than solve the problems. This buck-pass is legitimised by the fuzzy statement, "The client needs special intensive care."

- (b) The new England and Wales policy on retardates (Dept. Health and Soc. Security, 1973) requires that providers, monitors and direct-care 10 minute medical and social work staff implement the policy of "sectorisation" of living units. That is, clients must be located in particular units because the staff in the unit serve clients from that geographical area and from no other area. This ensures that staff are accountable for delivering care to **all geographically** eligible people, both inside and outside of residential facilities. It also avoids the problems caused by segregating in one setting the most disruptive clients.

This policy, however, is still resisted in principle by some specialist direct-care 10 minute staff as an infringement of "clinical or professional freedom."

9. The increases in levels of engaged activity of clients may also decrease a tendency of direct-care 10 minute specialists to undertake, in the name of research, expensive medical interventions which are irrelevant to the clients' treatment, and which may also be dangerous.

In a recent monograph published by the English Spastic Society a Finnish specialist describes how he conducted 7,000 exploratory procedures on 338 mentally retarded children and adults in a 1,000-bedded institution which appeared, from the description, to have low levels of client engagement (Iivanainen, 1974). In addition to doing 123 examinations for chromosomes, he also did 334 air encephalograms and 90 cerebral angiograms under general anaesthesia. The results are irrelevant to science. They are also irrelevant to clinical management. Only one client was found to have a cerebral tumour. This was removed and his fits were controlled. The study illustrates well that in an environment which encouraged engaged activities, the client's uncontrolled fits would have been fully investigated simply because the fits presented an obstacle to his engagement in a rich programme of daily activities.

(9) Much of this effort is informed by data assembled from sensitive, humane and ingenious experiments in the design of human environments undertaken by members of the Living Environments Group of the Department of Human Development, University of Kansas.

In England, our Royal Medico-Psychological Association Mental Deficiency Section is on record as recommending that all hospitals for the mentally handicapped be equipped with special laboratories for biochemical, neuroradiological, cytogenetic and other investigations.⁽¹⁰⁾ Indeed, the need for large groups of over 1,000 clients in such facilities is recommended because it would be uneconomic to provide laboratory facilities for smaller numbers of clients.

Concentration on client engagement and the setting of client-oriented objectives in well-designed problem-oriented individual records should limit this tendency and enhance good clinical practices (Weed, 1969; Grant and Maletsky, 1972). For example, medical intervention by orthopaedic surgeons, ophthalmologists, audiologists, are very important because they lead to client engagement (Griffiths, 1973). Without engagement, spectacles and hearing aids cannot be worn and walking aids cannot be used.

Recent advances in clinical goal setting are one of the most exciting developments now taking place. They are likely, aided by the developments made in the Problem-oriented Medical Record, to make monitoring of team activities feasible, and to lead the way toward both humane and scientifically effective practices.

Their development is important if we are to achieve the detailed collaboration between people from different disciplines as well as from people working in different parts of the hierarchies of our complex organisations (Kushlick, 1974b, 1975).

These developments are vital for another reason: Unless the general levels of engagement are increased, conditions in individuals' homes or on wards will not allow the introduction of individual medical, education and social work programmes. When this occurs, direct-care 12 hours staff may claim that the clients are "hopeless," "low grade," "irremediable," "not responsive" and "psychotic," to use only a few of the terms used. The development of individual goals for clients are then seen as irrelevant.

We can now identify when this occurs. Hopefully, we should now be able also to arrange things so that clients, direct-care 24 hours, and direct-care 12 hours staff can change things in their environments when they need to.

Appendix 1

Examples abound in most traditional texts on mental retardation. The characteristic features of explanatory fictions are that one unobservable phenomenon is used to explain the presence of another phenomenon—sometimes also unobservable. The following examples are taken from:

MacGillivray, R. C. (1972). *Accommodation for the Mentally Defective*. Scottish Hospital Centre: Conference on Accommodation for the Mentally Defective.

"Their mental state is, in the large majority of cases, the result of illness, either genetically determined or the result of pathological processes, which as a rule occur in the inter-uterine state, although a small number are caused by severe brain damage post-natally." (Page 2, para. 2.)

(10) The Mental Deficiency Sub-Committee of the Psychiatric Advisory Committee of the North-West Metropolitan Regional Hospital Board. *Memorandum on the Size of Mental Deficiency Hospitals. Appendix A*. Pages 1-3. Mimeograph.

Illustrates:—

- i. The use of the term “mental state” instead of the term “behaviour.”
- ii. The attribution of the cause of the client’s day-to-day or minute-to-minute behaviour to “genes” or “pathological processes” which cannot be altered. Scientific evidence supports the commonsense proposition that minute-to-minute behaviour is controlled and can be altered by the way in which the environment (physical or social) responds to it.

“In the idiot, mental defect is frequently associated with bodily malformations. These bodily findings are—inability to walk in some 10% of cases, epilepsy in some 20% of cases, congenital heart disease, blindness, deafness and spasticity, while some 10% have severe behavioural problems. Most idiots never acquire either speech or the ability to understand any but the simplest commands. Some only know their names. Bladder and bowel control are rarely established and the profound idiot does not react to this environment; many having a diminished perception of pain and occasionally even of hunger.” (Page 2, para. 3.)

Illustrates:—

- i. The use of the term “**malformation of the body**” (as opposed to **mental defect**) to include such diverse problems as:
 - (a) congenital malformations of an organ—“congenital heart disease”;
 - (b) observed limb stiffness with paralysis accompanied by defined responses to tests—“spasticity”;
 - (c) episodic loss of consciousness—“epilepsy”;
 - (d) locomotor deficit of walking responses—“inability to walk”;
 - (e) deficit of discriminative responses to visual or auditory stimuli—“blindness” or “deafness”;
 - (f) behaviours regarded by D-C 24 hours or others as excessive with unpleasant consequences for others—“severe behaviour problems.”
- ii. How, given the term or label “profound idiot,” the user states publicly dogmatic predictions of the future failures of the client and others attempting to help the client, e.g.:
 - (a) “will rarely or never . . .” That bowel and bladder control can be rapidly established and maintained has now been demonstrated (Foxy and Azrin, 1973).
 - (b) “does not react to his environment”—has “diminished perception of pain and occasionally even of hunger.”

“Most idiots indulge in repetitive movements (rocking, head banging, waving limbs about) which are volitional, and the patients derive a considerable amount of gratification from these. Idiots in the lowest groups fall into two types. One is hyperkinetic and possess good motor control. He does things to things, but never **with** things. The other is lethargic, lying curled up in bed or in a chair and developing disuse-atrophy of the limb muscles, even in the absence of neurological changes. Neurological damage, indeed, is very common in idiots, while echolalia and echopraxia are marked in a small number of cases. These added physical handicaps often render it impossible for the patient to be nursed or looked after at home, for example, he may suffer from severe hydrocephalus or spasticity or have epileptic attacks which are difficult to control or in which he is liable to self-injury.” (Page 2, para. 4.)

Illustrates:—

- i. The listing of unpleasant topographies of behaviour as **characterising** clients without giving some information on:
 - (a) the precise behaviour of individuals in situations;
 - (b) the range and frequency of these separate responses in individuals, e.g., every minute of a 12 hour day, only 5 minutes in the hour, etc.;
 - (c) the frequency with which more than one difficult response occurs in the same individual;
 - (d) what happens to all of these responses when there is something exciting to do, e.g., eat a meal, play in a bath, etc., etc.
- ii. The characteristic “**never** does things with things” obscures the observation of doing the **wrong** thing with things or changing objects frequently.

“An occasional child shows a surprisingly rapid advance, suggesting that, prior to admission, it had been retarded probably more by over-protection than by neglect. It is difficult to assess the intelligence of a deprived child and the Developmental Quotient had probably been higher than was thought.” (Page 5, para. 4.)

Illustrates:—

Clients transferred to facilities designed for therapeutic activities by their staff might reasonably be expected to improve as a result of the staff’s therapeutic interventions. This paragraph suggests that, given the label imbecile, improvement on entering the therapeutic facility is the rare or occasional exception. In addition, rather than collecting baseline clinical data before transfer and measuring changes after admission, this change must be gross enough to constitute a “surprise” to staff. Finally, so surprising is the advance, so lacking is the data on the environment at home and the change since moving to the therapeutic facilities that the clinician must **infer** retrospectively other non-observable, fuzzy phenomena like “overprotection” and “neglect.”

“Not all patients obligingly lie in bed or sit quietly in a chair. Many are in constant violent movement, rushing about, hitting the nurses or other patients, stripping their clothes and masturbating.” (Page 3, para. 2.)

Illustrates the same error as page 2, para. 4(i).

“This ties in with that new fashionable catchphrase, ‘normalisation.’ In essence, it suggests simply that mental defectives who are given ‘normal’ opportunities for living, for experiencing, for choosing, for working, for shouldering responsibilities, will be encouraged and stimulated to function at a higher level of competence than if they were deprived of such opportunities.

Nirje and Grunewald believe that this concept applies even to the severely subnormal, and it is nice to see the design team has not succumbed to this trendy speculation.” (Page 6, paras. 2 and 3.)

Illustrates:—

- i. Dogmatic rejection of the proposition that people categorised as imbeciles, given normal opportunities for “living, experiencing, choosing, working, shouldering responsibilities,” will do more things more competently than “if they were deprived of such opportunities.”
- ii. Punishment by humiliation of any administrator or member of a design team who might be so bold as to ask for evidence or “succumb to this trendy speculation.”

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