

## **JOINT ASSESSMENT OF COMMUNICATION SKILLS: FORMALISING THE ROLE OF THE CARER**

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### **INTRODUCTION**

Amongst the major developments in the provision of services to people with mental handicaps has been the increasing emphasis on the need for a multi-disciplinary approach. (Mittler, 1984, 1987; McBrien and Foxen, 1981; Landesman Dwyer and Knowles, 1987). The difficulties of successful collaboration have been discussed by researchers and argued by practitioners for many years. One of the root problems seems to be that of isolation. (Mittler, 1987)

Professionals (therapists, teachers, psychologists, etc) are frequently isolated from each other, in that they know very little about each other's skills. This isolation is perhaps most obvious during professional training. As Mittler (1987) says:

"despite the lip service paid to multidisciplinary teamwork, the initial training of most professionals is carried out in largely watertight compartments, with the result that few students are provided with opportunities to learn about the work of colleagues in other disciplines . . ." (p36)

The isolation is also common after qualification. Most in service training courses are exclusive to one profession, the British Institute of Mental Handicap (BIMH) courses being one major exception.

There is also a sense of isolation between professionals and carers, which can seriously affect collaboration. (Carers in this context refers to the individual who is in direct, day to day contact with the client.) Professionals may feel a sense of superiority, or they may feel threatened and unsure of their role in working with people with mental handicaps. They are therefore unwilling to work closely with carers. The carers, on the other hand, are given minimal status (MacDonald, 1981) and are not seen as the "change agents" (Mittler, 1987). They have often not had a training in working with people with mental handicaps. (DHSS, 1980)

It is important for the client that the professional should work in collaboration with the carer. This collaboration should enable the carer to learn from the professional's skills. It should also enable the professional to learn from the carer's wealth of experience of the individual client. Nowhere is collaboration of greater potential value than in the area of assessment, given the changing pattern of care for this group.

### **The Communication Assessment Profile**

The Communication Assessment Profile (CASP) (van der Gaag, 1988) is based upon the premise that the carer and professional should have equal status in the assessment procedure, and that both undertake a specific role within it. CASP provides the structure which allows this to take place.

The profile is divided into three parts. Part 1 is to be completed by the client's carer/keyworker. It consists of a questionnaire divided into two sections. The first

section contains questions on 'communicative functions' (how the client is using his/her communication skills in everyday situations). The second section contains questions about the environment (what kind of activities the client is involved in, what opportunities there are for communicating).

Part 2 is to be completed by the speech therapist. It is divided into 8 sections plus an appendix. Section 1 looks at the client's conversational skills and intelligibility. Sections 2-6 examine understanding and expression at the word and sentence level. Section 7 is a rating scale of 'communicative functions', which corresponds directly to the first section of Part 1. The final section of the therapist's assessment is a checklist of expressive skills.

When Parts 1 and 2 have been completed, Part 3 is completed jointly by both carer and professional, during which information gathered by both assessors is analysed and a list of 'Priorities for change' is drawn up. This is a list of changes which will improve the clients' communication skills; one which is immediately transferable into action.

Most communication assessments do not involve the carer until after formal assessments have been made by the professional. Carers are involved on an informal basis, but they are not an integral part of the assessment itself. CASP, however, encourages collaboration from the outset in order that:

- a. personal and professional relationships can be developed through understanding the others' perspective on assessment.
- b. objective and subjective assessments can be usefully combined.
- c. equal value is ascribed to all. This is especially important for staff who are rarely encouraged to think of themselves as responsible for any positive changes in the clients' abilities.

One of the questions raised by this model concerns the carers' ability to make reliable judgements about communication, given that she/he will not have had any specialist training in communication assessment.

The aims of the present study were therefore to determine:

1. Whether the carers were able to make reliable judgements about the clients' communication skills.
2. Whether they provided any additional information not readily accessible to the professional.

This was achieved by examining responses on Part 1 of the carers' assessment, and Section 7 of the therapists' assessment. The outcome would determine whether or not CASP was justified in the use of a formalised joint assessment approach.

## **METHOD**

Between 1985 and 1987 the CASP prototype underwent three clinical trials and was used with over 350 adults with mental handicap. Subjects were selected from 31 adult training centres and 12 hospitals throughout Scotland and England. 66 speech therapists and 384 care staff took part in the assessments during this period. (see Table I)

### **Procedure**

To assess the reliability of the carers' ratings, carers in each centre or hospital were asked to complete Part 1 of CASP. Two carers were asked to complete Part 1 questionnaire on each subject selected. One was "keyworker" for the subject, which

meant that she/he had a particular responsibility for the subject, or knew the subject well. The other carer had no particular responsibility for the subject, but did have regular contact with him/her. The number of carers involved in each centre/hospital varied according to staff/client ratio, staff availability, and shift work. A total of 384 carers completed Part 1 questionnaires in this way.

**Table 1.**  
**Summary of therapists and carers involved in the study**

	Therapists	Carers
Pilot	10	21
Second Trial	26	89
Third Trial	30	274
<b>TOTAL</b>	<b>66</b>	<b>384</b>

At the same time, speech therapists visiting the centre/hospital completed the rating scale of communicative function on each subject assessed by the carers. (Section 7, Part 2) These were filled in independently of the carers. 66 speech therapists completed the rating scales in this way.

To assess the unique contribution of the carer, a content analysis was carried out on Section 2 of Part 1. This involved looking at the amount and quality of the information supplied.

## **RESULTS**

### **Section 1**

#### **Agreement between carers**

The first task was to determine which variables, if any, were affecting the level of agreement between carers, and then to calculate the level of agreement itself.

Preliminary analysis of data from the pilot study showed that the level of agreement was influenced by the particular centre or hospital environment. In some environments the level of agreement between carers was much higher than in others.

These effects were examined in more depth during the second trial. (Kirkland, 1986) A total score was calculated for Section 1 by adding together the responses to questions on communicative functions. This score was looked at in relation to 4 variables: length of time carer had known client, sex of carer, sex of client, and environment. Results showed that scores were unrelated to any of these except environment. In other words, the centre/hospital that the carers were in appeared to have an effect upon how much information the carers gave, regardless of the relationship they had with the client (i.e. whether they were a "keyworker" or not).

The level of agreement between carers was then investigated using a Pearsons Product Moment correlation. A coefficient of .72  $p < .001$  was obtained, which indicated a high level of agreement between the carers.

### Agreement between Carers and Therapists

The second task was to examine the level of agreement between the therapists and the carers.

Preliminary analysis on data from the second clinical trial used percentage agreements to calculate this. (Table II). This involved comparing carers' responses on Section 1 (Part 1) with therapists' responses on Section 7 (Part 2). The mean percentage agreement between therapist and keyworker was 74. The mean percentage agreement between the therapist and the carer who was not a keyworker was 72.

Levels of agreement were investigated further during the third clinical trial using Pearsons Product Moment Correlations. A correlation of .68  $p < .001$  was obtained for therapist and keyworker. The same correlation (.68  $p < .001$ ) was obtained for the therapist and the other carer. These results confirmed the percentage agreements obtained during the second trial, which indicated a high level of agreement between carer and therapist.

**Table II**  
**Percentage Agreements between Therapists and Carers on Communicative Functions**

Communicative Functions	Therapist – therapist	Therapist – key worker	Therapist – other carer
Giving information	99	70	67
Initiating conversation	87	78	75
Responding to questions	81	78	77
Describing events	96	71	69
Describing feelings	89	75	70
Shows interest in comm.	96	80	76
Talking to self	(insufficient data)	56	50
Telling jokes	"	72	72
Maintains eye contact	94	75	77
Stands at correct distance	97	82	85
MEAN	92	74	72

### Section 2

#### Content Analysis

In general, keyworkers gave more information in this section than did the non keyworkers. This was presumably because they knew their clients better, or because they had access to the relevant information. A number of other variables were also important in determining the amount of information given in this section.

#### a. Environment

i) In the smaller centres (total number of clients below 50) the difference between the amount of information given by the keyworkers and the amount given by other carers was minimal. In these centres the staff explained that they all dealt with clients on an equal basis.

ii) Less information was provided by the hospital staff than by the staff in the centres, with few exceptions. The most likely explanation for this was high staff turnover in hospitals, and consequently less familiarity with clients.

#### **b. Staff/client relationship**

There were some instances where the relationship between the staff and client seemed to have an influence on the type as well as the amount of information given in this section. For example, one ward sister commented that "S. speaks only when spoken to"; whereas the student nurse said, "S. tends to talk quietly".

Staff attitudes and expectations were often reflected in their comments about the clients.

#### **c. Management Practices**

The amount of information given in this section was also influenced by the management practices of the centre/hospital. For example, in one centre, the management did not allow any contact between the carers and the clients' families, and therefore the carers were unable to give much information on home circumstances.

The "institutional" nature of these variables is reminiscent of the work of Goffman (1961), who suggested that the social and physical characteristics of institutions often have an influence on the quality of care and the clients' apparent skills.

There were numerous examples of carers providing information not readily available to anyone who did not know the client on a day to day basis, such as a visiting speech therapist or psychologist.

##### **1. Mood changes.**

"Her moods can affect her speech."

"Sometimes violent when unable to express herself."

"His outbursts are his biggest drawback to communication."

##### **2. Variability.**

"Shy and withdrawn with strangers."

"Pleasant so long as things go her own way."

"Domineering if allowed to be that way."

##### **3. Home circumstances.**

"Lives at home with his father who has hearing difficulties."

"An only child. Takes care of her elderly mother, who is wheelchair bound."

##### **4. Personality.**

"Very helpful. Enjoys certain jobs e.g. washing up, helping wheelchair bound residents."

"Very withdrawn person who prefers to be alone."

"Talkative when relaxed."

"I think that much of I's communication difficulties arise from his unusually nervous condition; I'm not convinced that when asked questions he knows what he actually wants to say."

##### **5. Interests, responsibilities, activities.**

"Loves housework, music and dancing."

"Goes to the pub every week."

"Very bright lady, with positive attitudes towards her disabilities."

"Sets the tables for lunch every day."

"Washes her own clothes."

"Enjoys being part of the group, but rarely offers conversation unless prompted."  
This kind of information, readily available to the carer, but not to the professional, demonstrates the value of a truly multidisciplinary approach.

## DISCUSSION

There can be little doubt that carers do make a significant contribution to the assessment of communication skills if they are provided with the right framework in which to work closely with the professional. They provide information which is reliable, and which would not otherwise be available at the assessment stage. Variables such as environment, staff/client relationships and management practices appear to influence the quantity and quality of this information. What then are the implications of using a joint assessment approach?

Working together can be a demanding and a threatening experience. For the carer, there will inevitably be more need for accountability, and more personal responsibility for implementing changes. For the professional, there is a sense in which sharing information and roles with untrained people can be a threat to professional status. For example, if the untrained person can assess communication skills, where is the speech therapist's role?

There is a more positive way of approaching this experience, however. For the carer, joint assessment represents an acknowledgement of the importance of the client/carer relationship to the client's quality of life and learning opportunities. (Landesman Dwyer and Knowles, 1987). For the professional, joint assessment does not mean "de-skilling". It is simply a more effective use of time and resources, given the shortage of speech therapists and psychologists who work with this population (Cottam 1986, Mittler 1987). Joint assessment is advocating nothing more or less than a mutual respect for knowledge and experience.

This mutual respect leads to greater understanding of the others' perspective. For example, carers will learn more about communication in this context than they would from formal teaching. Many of the carers involved in the CASP study commented that they had learnt something new about communication through completing the questionnaire and filling in Part 3 with therapists. Therapists commented on the importance of having the carers involved "from the beginning" if practical ways of developing the client's communication skills were to emerge from the assessment. In other words, the carers gained new insights into the nature of communication, and the therapists discovered how best to implement changes for the client in practical and realistic ways.

It is worth considering the application of this model to other areas of assessment, as well as other client groups. Formalising the role of the carer could be relevant to work with dysphasics, the elderly, and with children who have a mental or physical handicap. Mary Warnock (1979) wrote:

"The most valuable form of integration comes from conscious attempts to help people share experiences and learn from one another, and to make use of what they have learned."

These "conscious attempts" to share knowledge and experience are essentially what CASP is trying to achieve between carers and professionals.

Some procedures are based on the assumption that professionals have all the knowledge, and that their role is to pass that knowledge on to the carers. CASP emphasises the strengths of both carer and professional. It is a truly multidisciplinary approach to assessment, and in the end, it will mean better service

provision for people with mental handicaps. Working with people with mental handicaps requires a multi-disciplinary approach (Mittler 1987). This should start with assessment, and not with teaching/intervention. There must be more recognition of the role of the carer in assessment procedures in order that a more accurate picture of the client's communication in relation to his/her environment is obtained. This approach does not constitute a deskilling of the professional. Instead it is an acknowledgement of the carer's contribution and of the importance of developing closer working relationships.

### SUMMARY

This paper discusses the involvement of carers in the assessment of communication skills in adults with a mental handicap. An analysis of joint assessments made by 384 carers and 66 speech therapists using the Communication Assessment Profile (CASP) revealed that carers were able to make reliable judgements concerning clients' functional communication and were providing important additional information on environmental influences. Giving the carer a formal role in the assessment was an integral part of the procedure. The joint assessment approach used in CASP may have application to other populations who experience difficulty in communicating.

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