

SOCIAL SKILLS ASSESSMENT AND THE RIPPLE EFFECT

Introduction

According to Siperstein (1992), "the study of social competence is now more critical than ever if we are to assist . . . individuals (with a learning disability) in their efforts to become contributing members within the social fabric of the family, school and community" (page 4). Some writers (e.g. O'Connor and Tizard, 1956; Greenspan and Granfield, 1992) go back in time to single out individuals such as Itard (1806/1962), Seguin (1847), Tredgold (1992) and Doll (1936) for their "pioneering work in this area. In fact, several nineteenth century alienists well understood the need for skills training in the case of individuals with a learning disability. For example, Mitchell (1864) said, "All efforts to develop the usefulness of such persons are and should be encouraged, when they are conducted in a humane and judicious manner. To teach them self-control, to make them able to put off and on their own clothes, to make them acquire habits of cleanliness, and to render them in some degree useful, is to diminish the burden which their defect of mind imposes on their friends, or on the public, and by so much indeed to diminish the defect itself, since that which was capable of cultivation has been cultivated. By every little thing he learns to do, by so much is he less an idiot . . ." (page 67). Outdated words and quaint phrases, perhaps, but the message is both practical and relevant today.

The biggest difference between then and now, of course, is that the concept of social competence has been subjected to extensive and detailed analysis. The research literature is vast but, fortunately, there are several

reviews. The wide range of topics includes, at one extreme, general models of social competence (e.g. Greenspan and Granfield, 1992), and attempts to determine their structure (for a comprehensive review, see Widaman et al., 1991). At the other extreme are "naturalistic" studies, such as the classic by Edgerton (1967) and a more recent account by Stumpf (1990). Topics in between these extremes include social skills of deinstitutionalised persons (Craig and McCarver, 1984), "social intelligence" (Greenspan, 1979), and the maintenance and generalisation of skills (Borkowski and Cavanaugh, 1979).

According to Meyers et al., (1979) one of the main reasons for the "burgeoning use" of appraisals of social competence (adaptive behaviour) is the increased emphasis on the provision of adequate programmes of training for large groups of individuals with a learning disability. In a recent survey, Cicchetti et al., (1991) argue that the extent of emotional disturbance amongst those with learning difficulties has not been sufficiently investigated. These were two of the main considerations underlying the present study.

McDonald and MacKay (1996, a b) reported on the prevalence of severe learning disability (IQ <50) in one of the Health and Social Services Boards in Northern Ireland. They felt that in addition to the information usually collected in this type of study (e.g. age specific rates) it would be advantageous, to planners and providers especially, if more details were obtained on (a) levels of social competence and (b) levels of challenging or maladaptive behaviour. One of the behavioural checklists or assessment instruments that covers both these major components is

the Inventory for Client and Agency Planning (ICAP; Bruininks et al., 1986, 1990), and it was selected for the study - for more details, see Method section.

Method

Subjects

The prevalence survey involved over 2000 children and adults functioning at all levels of learning disability in the Southern Health and Social Services Board in Northern Ireland. This Board is made up of three geographical areas of Management (Newry and Mourne; Armagh and Dungannon; and Craigavon and Banbridge) and has a total population of some 290,000.

Assessment

There are four adaptive behaviour domains in the ICAP: Motor Skills; Personal Living Skills; Community Living Skills; and Broad Independence. Problem behaviours are in eight categories: Hurtful to Self; Hurtful to Others; Destructive to Property; Disruptive Behaviour; Unusual or Repetitive Habits; Socially Offensive Behaviour; Withdrawal or Inattentive Behaviour; Uncooperative Behaviour. The scale is completed by someone who knows the client well (e.g. instructor, community mental handicap nurse) and takes between 15 and 30 minutes to complete.

In summarising the results a given individual is allocated to one of nine levels of adaptive behaviour and to one of five levels of maladaptive behaviour. Level 1 of the former indicates the need for "total personal care and intense supervision"; Level 5 indicates the need for "regular personal care

and/or close supervision; Level 9 calls for "infrequent or no assistance for daily living". The five levels of maladaptive behaviour range from the not serious to the very serious.

Seventy-nine adults (55 M; 24F) in one geographical area were independently assessed by two raters. Reliabilities on outcome levels for the adaptive and maladaptive scales were 87 per cent and 82 per cent respectively.

Results

TABLE I shows the findings for 1886 community-based subjects. In terms of adaptive behaviour, Level 1 - 4 inclusive accounted for 42 per cent of the total; Levels 5 and 6 accounted for another 42 per cent. (Note that no individual functioned on Level 9). Eighty per cent of the total were adjudged to display maladaptive behaviour that was not serious or was marginally serious.

TABLE II provides corresponding information for 183 institutionalised adults. In terms of adaptive behaviour, Levels 1 - 4 inclusive accounted for just three quarters (76 per cent) of the total; Levels 5 and 6 accounted for a further 21 per cent. (Note that no individual functioned on Levels 8 and 9). As regards maladaptive behaviour, 62 per cent were adjudged to be not serious or marginally serious.

Clearly, the hospital population is not representative of the population of individuals with a learning disability at large. Numbers in dependency levels 1 - 7, maladaptive categories combined, were significantly different ($X^2 = 122.75$, $df = 6$, $p < 0.001$). The distributions in three maladaptive categories (normal and marginally serious; moderately serious; serious and very serious)

TABLE I
Adaptive and Maladaptive Behaviour Levels of Community-Based Clients in Southern Health and Social Services Board

DEPENDENCY LEVELS	Not Serious	Marginally Serious	Moderately Serious	Serious	Very Serious	TOTAL (PER CENT)	
1	122	13	7	11	3	156	(8.3)
2	69	14	9	6	9	107	(5.7)
3	141	22	20	11	4	198	(10.5)
4	258	32	21	14	5	330	(17.5)
5	298	30	31	10	1	370	(19.6)
6	346	32	27	7	1	413	(21.9)
7	216	13	5	2	-	236	(12.5)
8	71	3	1	1	-	76	(4.0)
9	-	-	-	-	-	-	-
Total (Per cent)	1,521 (80.0)	159 (8.4)	121 (6.4)	62 (3.3)	23 (1.2)	1,886	

TABLE II
Adaptive and Maladaptive Behaviour Levels of Hospitalised Adults in Southern Health and Social Services Board

DEPENDENCY LEVELS	Not Serious	Marginally Serious	Moderately Serious	Serious	Very Serious	TOTAL (PER CENT)	
1	14	11	6	6	9	46	(25.1)
2	11	8	5	2	4	30	(16.4)
3	13	8	5	8	4	38	(20.8)
4	3	9	4	6	4	26	(14.2)
5	8	9	3	2	-	22	(12.0)
6	9	7	1	-	-	17	(9.3)
7	3	1	-	-	-	4	(2.2)
8	-	-	-	-	-	-	-
9	-	-	-	-	-	-	-
Total (Per cent)	61 (33.3)	53 (29.0)	24 (13.1)	24 (13.1)	21 (11.5)	183	(100.0)

dependency levels combined were also significantly different ($X^2 = 124.6$, $df = 2$, $p < 0.001$).

Discussion

McDonald and Mackay (1996a) noted that, of the 2000 community-based children

and adults, just over two-thirds (68 per cent) lived at home with parents or relatives, or lived alone. The rest were in community residential facilities (CRF's), for example, private and statutory homes. Although a good proportion of the 263 highly dependant clients (Levels 1 and 2 of the adaptive index) are in these CRFs, a large number are living at home. It is important for planners and

providers to know how problems faced by parents can be alleviated. Many individual families will, of course, be known to social workers, community mental handicap nurses and other professionals who call regularly at the homes. However, it is difficult to see how such information held by these professionals can be used as a reliable data source by planners and providers for an identified population of children and adults with a learning disability. What is clearly needed is a systematic survey of all families and households in the Southern Board which seeks specific information on several fronts. For example, in how many households would structural alterations help ease the burden of caring for a highly dependent child or adult? In a two-story house, if the only toilet is upstairs, would the addition of another toilet downstairs be of significant help? Another example: how many parents who have until the present time insisted on looking after their child without a break (and with possible detriment to their health) be persuaded to consider respite care? Only when such basic, comprehensive information is available on all families can planners and providers make realistic assessments of need.

At the other end of the adaptive scale, some 16 per cent of the clients are functioning at Levels 7 and 8. All 106 adults who live alone are in this category. Many are doing very well indeed. For example, there is one gentleman who has Down's Syndrome and is in his forties. He lived with his mother in the family home until she died some five or six years ago. He then moved to a nursing home for a short while before returning home once more. He is "highly proficient" in self-help, home-care and social skills. He travels each day to a centre by public transport. Affable and kind, he is well liked in the neighbourhood. A professional calls each weekday evening for an hour to help him plan the next day's business.

Statistically, the number of community-based clients who present with serious or very serious maladaptive behaviour is small - some 4 per cent. But this, of course, is not much comfort to the parents who have to look after a highly disturbed son or daughter. As might be expected, self-injurious behaviour is one of the more typical problems at the higher-dependency levels (1 - 3). However, the example we have chosen is a man in his early twenties who lives in a remote rural area with mother, father and a sister. He has "marked autistic features" but the main presenting problem is sudden, seemingly unprovoked physical aggression. Both clients and staff at the day centre he attended (until his recent suspension) have been injured, some needing hospital treatment. He can also become distressed: he cries bitterly, slaps his face and pulls hair out of his head. His parent's coping strategy is to give him free rein in the house and garden, and to stay out of his way.

The learning disability hospital in the Southern Board at one time cared for over 400 adults. As a result of the deinstitutionalisation movement, the bed complement at the time of the survey was 183. As noted earlier, there is a bias in it towards serious or very serious maladaptive behaviour (approximately 25 per cent as compared with 4 per cent in the community). There is a dilemma here which will be familiar to many (see Craig and McCarver, 1984). There are 85 children and adults in the community with serious behavioural problems. All need some kind of intervention, even if a few parents are reluctant to seek help. What can planners and providers do? Much depends on their philosophy of care. Professionals in favour of the institution may argue that it provides essential back-up services and should therefore be retained and used for the rehabilitation training of individuals with severely challenging

behaviours. Critics of the institution may point to the findings of the present survey (and other studies, e.g. Schroeder, 1991) and argue that if 45 adults who have been in hospital for many years still display serious maladaptive behaviour, then the care and treatment they have undergone add up to little more than benevolent containment. Therefore, to admit individuals from the community may relieve pressure on the parents but may not do much for the new residents.

CRFs seemed the ideal solution at one time: small home-like buildings convenient to the parental home. Assume that the hospital is close and that all 183 residents are to be relocated in the community. In that case, those without problem behaviours can be moved to units in the public or private sector in the usual way. But what of the 45 with serious maladaptive behaviours? They will continue to require long-term care and treatment. If we assume a CRF bed complement of say, 6 places, then 7 or 8 CRFs will be required, together with staff:resident ratios of about 1:2. Further assume that a quarter (22) of the clients with problematic behaviours living at home will require medium to long-term residential care and that the remaining 63 children and adults will frequently need short-term or respite care. Three CRFs will cope with the former, and possibly 6 or 7 with the latter.

The deinstitutionalisation movement in the USA has been under way for many years now, and professionals there have more experience of it than we do (for reviews see Willer and Intagliata, 1984; Okolo and Guskin, 1984; Craig and McCarver, 1984; Jacobson and Schwartz, 1991). Rather reluctantly, perhaps, these professionals are coming to the conclusion that whilst most children and adults can be cared for in the community, some will require hospital care. In the epilogue to their influential book,

Matson and Mulick (1991) conclude: "Many advocates of community placement were calling for the abolition of institutions a few years ago. A few professionals and advocates still make this proposal, but their numbers are dropping quickly. In fact, national statistics seem to suggest a shift back to the placement of more mentally retarded persons in institutions . . . there are special cases, such as the emotionally disturbed, severely medically impaired, and other refractory patients, who are not easily served in group homes. Rather, small institutions . . . are required for approximately 1 per cent to 5 per cent of mentally retarded individuals. Group homes in general and their staffs have not proven to be either capable to deal with clients exhibiting such problems. This concern is probably due to the lack of awareness of some professionals that such extreme problem clients exist . . ." (p. 623).

It is interesting to note that the 130 children and adults identified in this present survey as having serious or very serious maladaptive behaviours make up 6 per cent of the total, an estimate close enough to that suggested by Matson and Mulick. We should add here that a small number of high-ability clients presenting with marked maladaptive behaviours have not been included in the survey - they are in residential care outside the Southern Board.

This survey has added to new information to the prevalence data (McDonald and Mackay, 1995a, b). Suggestions for future research have been made. The report has also identified those children and adults who present with severely challenging behaviours. Planners and providers have an unenviable task: these clients and their families need special help and support. The main issue is whether that help and support should be provided in small homes in the community or in a specialist institution.

Abstract

Approximately 2000 children and adults with a learning disability in a Health and Social Services Board in Northern Ireland were assessed in terms of social competence and degrees of maladaptive behaviour. Of special concern was the community-based population who require total personal care and intense supervision (14 per cent of the total). Hospitalised adults differed significantly in terms of both adaptive and maladaptive behaviours from the community-based population. Amongst community-based clients, 85 children and adults were identified as presenting with "serious" or "very serious" maladaptive behaviours. Their future and that of hospital residents was discussed in the context of the deinstitutionalisation movement. The information collected in this survey should be a useful data source for planners and providers.

Acknowledgements

We would like to thank all the professionals in the Southern Health and Social Services Board who helped to complete the ICAP assessment booklets. We are grateful to Mary Drain of the Psychology Department at Muckamore Abbey Hospital for typing the script.

***G. McDonald**

Department of Clinical Psychology
Newry and Mourne Health and Social Services Trust,
Daisy Hill Hospital, Newry, Co. Down,
Northern Ireland.

D. N. Mackay

Department of Clinical Psychology
North and West Belfast Health and Social
Services Trust

Muckamore Abbey Hospital,
Muckamore, Antrim,
Northern Ireland

* For Correspondence

References

- Borkowski, J. G. and Cavanaugh, J. C. (1979). Maintenance and Generalisation of Skills and Strategies of the retarded. In: Ellis, N. R. (Ed.). *Handbook of Mental Deficiency*. New Jersey: Lawrence Erlbaum Associates.
- Bruininks, R. H., Hill, B. K., Weatherman, R. F. and Woodcock, R. W. (1986). *Inventory for Client and Agency Planning*. Allen, TX: DLM Teaching Resources.
- Bruininks, R. H., Thurlow, M. L., McGrew, K. S. and Lewis, D. R. (1990). Dimensions of Community Adjustment among Young Adults with Intellectual Disabilities. In: Fraser, W. I. (Ed.). *Key Issues in Mental Retardation*. London: Routledge.
- Cicchetti, D. V., Sparrow, S. S. and Rourke, B. P. (1991). Adaptive Behaviour Profiles of Psychologically Disturbed and Developmentally Disabled Children. In: Matson, J. L. and Mulick, J. A. (Eds.). *Handbook of Mental Retardation*. Oxford: Pergamon.
- Craig, E. M. and McCarver, R. B. (1984). Community placement and adjustment of deinstitutionalised clients: Issues and findings. In: Ellis, N. R. and Bray, N. W. (Eds.). *International Review of Research in Mental Retardation*, 12, 95-122. London: Academic Press.
- Doll, E. A. (1936). President's address: Current thoughts on mental deficiency. *Journal of Psycho-Aesthetics*, 18, 40-41.
- Edgerton, R. (1969). *The Cloak of Competence*. Berkeley: University of California Press.
- Greenspan, S. (1979). Social Intelligence in the Retarded. In: Ellis, N. R. (Ed.). *Handbook of Mental Deficiency*. New Jersey: Lawrence Erlbaum Associates.
- Greenspan, S. and Granfield, J. M. (1992). Reconsidering the construct of mental retardation: Implications of a model of social competence. *American Journal on Mental Retardation*, 96, 442-453.

- Hard, J.** (1962). *The Wild Boy of Aveyron*. (Translators: Humphrey, G. and Humphrey, M.). New York: Appleton-Crofts.
- Jacobson, J. W. and Schwartz, A. A.** (1991). Evaluating Living Situations of People with Developmental Disabilities. In: Matson, J. L. and Mulick, J. A. (Eds.). *Handbook of Mental Retardation*, Oxford: Pergamon.
- McDonald, G. and MacKay, D. N.** (1996a). The Prevalence of Down's Syndrome in a Health and Social Services Board, Northern Ireland. Submitted for publication.
- McDonald, G. and MacKay, D. N.** (1996b). The Prevalence of Down's Syndrome in a Health and Social Services Board, Northern Ireland. Submitted for publication.
- Matson, J. L. and Mulick, J. A.** (1991). *Handbook of Mental Retardation*. Oxford: Pergamon.
- Meyers, C. E., Nihira, K. and Zetlin, A.** (1979). The Measurement of Adaptive Behaviour. In: Ellis, N. R. (Ed.). *Handbook of Mental Deficiency*. New Jersey: Lawrence Erlbaum Associates.
- Mitchell, A.** (1864). *The Insane in Private Dwellings*. Edinburgh: Edmonston and Douglas.
- O'Connor, N. and Tizard, J.** (1956). *The Social Problem of Mental Deficiency*. London: Pergamon Press.
- Okolo, C. and Guskin, S.** (1984). Community attitudes towards community placement of mentally retarded persons. In: Ellis, N. R. and Bray, N. W. (Eds.). *International Review of Research in Mental Retardation*. London: Academic Press.
- Schroeder, S. R.** (1991). Self-injury and Stereotyping. In: Matson, J. L. and Mulick, J. A. (Eds.). *Handbook of Mental Retardation*. Oxford: Pergamon Press.
- Seguin, E.** (1846). *Traitement Morale, Hygiène et Education des Idiots*. London: Bailliere.
- Siperstein, G. N.** (1992). Social competence: An important construct in mental retardation. *American Journal on Mental Retardation*, 96, iii-vi.
- Stumpf, S. H.** (1990). *Pathways to Success: Training for Independent Living*. Washington, DC: AAMR Monographs.
- Tredgold, A. F.** (1992). *A Textbook of Mental Deficiency*. Baltimore: William Wood.
- Widaman, K. F., Borthwick-Duffy, and Little.** (1991). The structure and development of adaptive behaviours. In: Bray, N. W. (Ed.). *International Review of Research in Mental Retardation*, 17, 1-54. London: Academic Press.
- Willer, B. and Intagliata, J.** (1984). An overview of the social policy of deinstitutionalisation. In: Ellis, N. R. and Bray, N. W. (Eds.). *International Review of Research in Mental Retardation*, 12, 123-147. London: Academic Press.