Residential and day care services for the mentally ill in Newcastle-upon- Tyne

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RESIDENTIAL AND DAY CARE SERVICES

FOR THE MENTALLY ILL IN NEWCASTLE-UPON- TYNE

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ABSTRACT

Residential and Day Care Services for the Mentally Ill in Newcastle upon Tyne

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This study examines local authority residential and day care for the mentally ill in Newcastle-upon-Tyne. Fieldwork was undertaken between 1st November 1978 and 31st December 1979.

The first part of the study traces the development of the services from the 1959 Mental Health Act to 1979. It demonstrates the way in which the Council responded rapidly to Government prescription for policy making. The Authority developed an extensive service more rapidly than did most other comparable local authorities.

The second section investigates characteristics of the staff and clients. Most basic grade staff were lacking in training and relevant work experience and came from the manual working class. Many senior staff had transferred from nursing. Most clients were over 49 and came from the unskilled working class. The sample comprised of similar numbers of male and female clients. Only half the clients had a recent history of psychiatric hospitalisation, but the majority were diagnosed as suffering from chronic mental illnesses. Clients had been referred for services primarily because of difficulties with inter-personal relationships, or in caring for themselves.

The aims of the units are examined (as understood by management, staff and clients). The process of communication of aims is analysed, thus exploring the policy making process, the extent to which the theory of *Management by Objectives* operated and providing performance yardsticks.

Communication was best effected through regular staff meetings and better educated senior staff. Aims commonly identified by staff and clients embraced enhancement of personal relationship skills improvement of self-care and preventing psychiatric hospitalisation.

The fourth section ascertains the degree to which these aims were achieved, examining opinions of staff and clients and investigating hospital admission and job acquisition. It culminates in a cost-effectiveness study and comparison of costs of hospital and social services care.

Aims which were best attained concerned personal relationships within the unit and prevention of hospitalisation. Poor attainment was acknowledged for most aims external to units. There was a positive relationship between the sharing of aims between clients and staff and *client's* perception of success. Costs were similar in like units and bore no relationship to achievement.

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J. G. Johnston

February 1984

DECLARATION AND STATEMENT OF COPYRIGHT

The material contained in this Thesis has not previously been submitted for a degree to the University of Durham or any other University.

I also verify that I am the sole author of this work.

J. G. JOHNSTON February 1984

INTRODUCTION

The Mental Health Act 1959 enacted that Local Health Authorities should provide care, or aftercare, for the mentally disordered and should engage in:

> (a) "The provision, equipment and maintenance of residential accommodation, and the care of persons for the time being resident in accommodation so provided".
>
> (b) "The provision of centres or other facilities for training or occupation and the equipment and maintenance of such centres". (1)

In spite of the aspirations of this Act, sixteen years later the White Paper "Better Services for the Mentally Ill", stated that: "day care services are at present perhaps the least developed of all mental health services". (2) In reviewing residential care it found there to be insufficient places. (3) The White Paper summarized the Government's view of the situation:

> "by and large the non-hospital community resources are still minimal, though where facilities have been developed they have, in general, proved successful". (4)

However, the White Paper, offers little evidence to substantiate this claim of success.

This study aims to make a qualitative evaluation and an enumeration of the residential and day care services for the mentally ill run by one local authority during late 1978 and 1979.

It has been prompted by concerns such as that of Hawks:

> "While Community Care (for the mentally ill) has many advocates, and moreover is official government policy, there have been few attempts to analyse its implicit assumptions and consider that evidence which bears upon these assumptions."[5]

Abrams[6] advocated that studies of social services use the evaluations of clients and staff as one of their indexes of effectiveness. This study attempts to follow his advice. Brandon has pointed out that:

> "The mental illness industry is dominated by professionals' accounts - psychiatrists, psychologists and social workers especially. It is extremely difficult for psychiatric patients to have their views taken seriously".[7]

The desire to play a part in remedying this deficiency underlies the survey of user opinion in the study. The need to do so was emphasised by Gordon et al:

> "Reliance only on professional opinion raises the possibility that the professional authors and surveyors of the service may seriously assume, albeit innocently, that what they have created will be ipso facto consistent with the needs of those whom they serve. To offset this, therefore, the opinion of the 'consumer', i.e. the patient, should be elicited systematically and evaluated."[8]

Such evaluation can only identify 'wants' within the framework of the clients' experience. But this does not negate the value of such exercises, as clients' wants and needs are probably inter-related.

Newcastle Social Services Department was chosen because it enjoyed a good reputation for the provision of social services

and because the writer, being employed there, was able to gain access to data.

The study traces the recent historical development of the services as a background to service evaluation and as a means of further highlighting the nature, quantity and quality of the services at the time of the main study and also to illuminate one theme of the study; namely the examination of the development and communication of service aims.

The work proceeds to examine who is providing the services for whom . This information has an intrinsic value and provides background information essential to a viable analysis of the services. The study sets out to establish the aims of the services - as identified by national and local politicians, departmental management, unit staff and by clients. It examines the process of communication of aims in relation to the theory of 'Management by Objectives'. The importance of effective communication of aims and of appreciation of its failure was outlined by Billis:

> "The first precondition for a move towards more effective, or at least less ineffective, organisation is the presence of high reality. Put rather differently, we must avoid creating yawning gaps between policy and implementation. Thus, those who are responsible for the provision of human services must recognise what they *believe* is being provided may be rather different from what their clients or staff actually *know* is being provided".(9)

This study seeks to ascertain the nature and extent of the communication gap described by Billis and to discover how it was being bridged.(10) "Management by Objectives' incorporates the thesis that senior managment formulate aims which are dynamic and responsive to externally dicatated change and

that these can be communicated effectively through an hierarchical (or other) organization to those who receive and implement them at basic level. In the case of personal services it is also desirable that they are understood by the recipients of the services - so that their agreement and co-operation may be secured. Finally, the study attempts to ascertain which of the identified aims had been successfully attained, how and to what extent. It also undertakes cost effectiveness and comparative cost studies to obtain some gauge of service effectiveness.

Each chapter sets out to answer certain questions and is structured as follows:

Chapter I

Provides an historical analysis of the development of Newcastle's residential and day care services for the mentally ill from the implementation of the 1959 Mental Health Act to 31st December 1979. Chapter I poses the following questions:

(a) How rapidly did Newcastle City Council respond to government prescription for social services for the mentally ill? How extensive and comprehensive were the services which they developed? In comparison did their services take shape more or less rapidly than did those set up by comparable local authorities?

(b) What effect did the Social Services Act 1970 and the 1972 Local Government Re-Organisation have upon the mental health services in Newcastle?

Did services deteriorate in any way?
Did service priorities or the professional background of those recruited as senior managers change?

Chapter II

Investigates the characteristics of middle management and staff of the units and scrutinises staff/client ratios. It examines the characteristics of those clients included in the survey. The staff profile describes age, sex, marital status and also the educational, training and work experience histories of the staff. The client characteristics investigated are: social situation, age, sex, marital status, psychiatric history and the nature and extent of social and medical services which they had received. The exercise is a necessary part of gaining a profile of the services and facilitates subsequent assessment of opinions. This chapter asks a number of questions:

(a) What sort of characteristics did unit managers and basic grade staff possess? In particular did their training and previous work experience (if any) involve a 'clinical' or a 'social' orientation? What was the nature of staff/client ratios?

(b) What were the characteristics of the users of the services? To what extent did most clients present as being 'chronic' or 'acute' in terms of age, diagnosis, treatment history and social situation?

(c) Were clients admitted to social services care primarily for 'social' or for 'clinical' reasons?

Chapter III

Attempts to ascertain which needs the services aspired to meet; how, and on the basis of which models and what knowledge.

Townsend and Davidson expressed anxiety that:

> "the quality of care provided by the different types of institution, judged by costs, manpower, amenities etc. may bear little relation to need". (11)

Culyer suggested that overall objectives of the service should be determined by the ultimate clients:

> "with help from experts whose role it would be to make suggestions, eliminate redundant dimensions, refine the dimensions and keep them relevant to the purpose for which the exercise is designed". (12)

Chapter III attempts to ascertain who determined aims and by what method they did so. It explores the *differences* in perceptions of aims between different levels of staff and the clients, and investigates the extent to which client accepted aims were shared by staff, that is: as to whether Culyer's precepts operated in practice. Culyer (13) maintained that judgements about priorities in planning resource deployments should be taken by people with public accountability. The study investigates whether priority objectives set by politicians were communicated and accepted effectively down the line to basic staff level so that they could be fully attained. The questions which are addressed in Chapter III are:

(a) What were the aims of the units as seen by managers and as perceived by basic grade staff - in respect of each client and by clients in respect of themselves? Did these aims have a predominantly 'social' or 'clinical' orientation?

Were the majority of aims related to user's functioning within the units or towards their rehabilitation into the wider community?

(b) How far did the theory of Management by Objectives operate in the social services studied? Was the communication of aims affected by such factors as the media used for that communciation, by staff training or previous work experience or by client's limitations?

Chapter IV

Chapter IV examines the attainment of aims identified in Chapter III. It looks at the hospitalisation and employment records of clients which were the subject matter of identified aims, and at evaluations by clients and staff of the degree of achievement of the additional aims. The chapter attempts to identify some factors inherent in successful achievement and in failure. In particular it examines the effect of aims being shared by staff and clients. The chapter proceeds to evaluate cost effectiveness and to undertake a comparative costs study between hospital and residential and day care services.

Chapter IV seeks to obtain answers to the following questions:

(a) Did residential and day care units succeed in preventing admission to psychiatric wards? How far was their record related to client's previous treatment histories? Did social services residential care save overall public expenditure - when

compared with the costs of hospitalisation?

(b) What role did the social services units play in helping clients under pensionable age to find employment?

(c) Which aims did staff and clients perceive to have been successfully or unsuccessfully achieved? Was greater or lesser success attributed to aims with a 'social' or 'clinical' orientation or to those internal or external to the operation of the units?

(d) How far was success in aim attainment determined by the characteristics of staff and clients and by the willingness of the wider community to accept and relate to the users?

Hawks expressed the fear that:

> "The adequate care of sick patients requires not so much a re-organisation of services as a re-ordering of society's values".(14)

The study will examine the validity of this view in relation to services in Newcastle.

(e) Did the sharing of an aim between staff and a client cause either to be more likely to consider the aim to be well achieved - as was postulated by Olsen?(15)

(f) Did those units which had the highest variable costs exhibit the greatest success in aim attainment?

(g) Was social services residential care cheaper than hospital in-patient care and, if so, by how much?

Additional Background to the Study

Before proceeding to the empirical part of the study the writer would like to include an account of some of the obstacles which impeded progress particularly in the early stages. When she registered in 1977 the writer hoped to obtain a sample of discharged psychiatric hospital patients to follow up. Owing to the concern of psychiatrists in Newcastle about release of data to non-medical researchers it took her a year to persuade the Division of Psychiatry to allow her to proceed through the good offices of her supervisor. She then recruited a sample of patients and intended to monitor the field social work services which they received after discharge. However, she was again obstructed by the Social Worker's strike - from August 1978. A change of plan became inevitable and the present study was conceived. Fieldwork commenced in November 1978.

This study originally included investigation of sources of client's satisfaction, dissatisfaction and perception of 'unmet needs'. It was also planned to use the originally recruited 'hospital sample' as a control group in examination of client's characteristics and in the monitoring of psychiatric hospitalisation. However, the first draft of this thesis was excessively long and these elements were jettisoned as not being central to the study. They did, however, produce

interesting information. Various aspects of the methodology used are described at appropriate points in the text. The clients included in the study constituted virtually the whole population of the psychiatric hostels and day centre. In the homes for the elderly mentally infirm only those clients deemed by staff to be intellectually capable of answering the questionnaire were included. This issue is discussed in the text.

Some explanations should be given of terms used in the thesis: 'basic grade staff' refers to those who were not managers or deputy managers of units and who provided a direct caring service to the clients.

The 'social model' of mental illness and its treatment percieved its causes and remedies as lying primarily in the client's social economic situation and personal relationships. The 'clinical' (medical) model views the aetiology and effective treatment of mental illness as being principally physiological and bio-chemical. This terminology is discussed in detail in Chapter III. The study proved a most illuminating and absorbing exercise .

INTRODUCTION - FOOTNOTES

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3. Ibid 37-40 paras 4.36 - 4.49.
4. Ibid p. 14s. 2.8
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13. Ibid p. 44
14. Hawks, D. "Community Care: An Analysis of Assumptions" p. 284
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CHAPTER ONE

THE IMPLEMENTATION OF MENTAL ILLNESS LEGISLATION AND POLICY IN NEWCASTLE BETWEEN 1959 and 1979

This chapter examines the response of Newcastle City Council to the three major pieces of legislation and the prescriptive white paper issued by governments, concerning social services for the Mentally Ill, during the period between the enactment of the Mental Health Act 1959[1] and 31st December 1979. This time span commences with the Act because it consolidated existing legislation on services for the mentally ill, provided for new services and was not superseded by subsequent legislation until 1982. However, 31st December 1979 marked the end of the period during which fieldwork was undertaken.

The chapter concentrates on residential and day-care services because these are the principal focus of the remainder of the study. The services were developed in a situation in which Central Government assumed few powers to secure the implementation of its recommedations. As Roberts pointed out:

> "Problems of resource allocation, of phased development related to available resources, can be considered as a logical development where a relatively strict degree of control can be exercised. Both in theory and in fact this state of affairs did not pertain in the developments within the field of mental health". [2]

A major part of this chapter compares the extent of Newcastle's services with that of other similar councils. This provides a picture of differential response to government prescription. One purpose of this chapter is to describe the development

of the services as an essential background to the study as a whole. Finally, a brief survey of unit occupancy and an enumeration of the study sample sets the scene for the rest of the study.

The names given to the individual residential/day care units are fictitious-in order to preserve confidentiality.

Section A - Service Development following the Mental Health Act 1959 (period 1959 - 1970)

Sub-Section A.1. General Development

A new era in community care was envisaged by the 1959 Act which was facilitated by the increasing use of effective new drugs for the treatment of mental illness and by the introduction of services such as: out-patient clinics, day hospitals, social clubs, hostels, therapeutic community hospital systems, psychiatric units in district general hospitals and the development of community based mental health social work.[3] The Act was foreshadowed by the Report of the Royal Commission on the Law relating to Mental Illness and Mental Deficiency.[4] This report produced what Jones described as "a blue-print for a comprehensive mental health service".[5] It recommended that:

> "after leaving hospital, community care should be available without powers of compulsory control, whether or not the patient has been subject to detention whilst in hospital".[6]

The publication proposed that community care and after care should be the responsibility of local authorities[7] and that this should include provision of hostels for the younger mentally ill,[8] residential homes for the elderly mentally infirm,[9] field social work,[10] and day centres providing industrial, sheltered workshop, occupational and social facilities.[11]

The Newcastle City Health Committee responded to the recommendations of the Royal Commission even before the Mental Health Bill was published:

> "During the year (1958) the Health Committee decided that steps should be taken to provide a complete after-care service for the cases discharged from mental hospitals and to provide, as far as possible, a service which would play its full share in the prevention of mental ill-health. It is hoped ultimately to make a recommendation to the City Council to set up a comprehensive after-care service".(12)

The Mental Health Act(13) laid down specifications for local authority personal social services for the mentally ill. Services already provided under Section 28 of the National Health Service Act 1946(14) (for prevention, care and after-care) were to continue. Whilst the Act outlined what was expected of local authorities; sections relating to service provision (other than statutory admissions to hospital) were permissive. The objectives prescribed by statute for the services were those of 'overall direction', rather than those of 'result'.(15) The drafters of the Mental Health Bill probably heeded the view of the Royal Commission:

> "the law should not attempt to prescribe in detail what these arrangements (for local authority community based services) should be and thus fix them in a pattern which advances in knowledge and methods of treatment may soon make out of date".(16)

The Act made council Health Departments responsible for the provision of residential accommodation for 'centres or other facilities for training or occupation',(17) and for supplementary services for the mentally disordered.(18) There was a mandatory duty to appoint Mental Welfare Officers, and to operate guardianship and compulsory admission procedures for some mentally disordered patients.(19)

Newcastle's Medical Officer of Health perceived the passing of the Act thus:

> "An impetus has been given to many ideas which the Committee and staff have been considering for the immediate and long-term improvement and expansion of this service, particularly in so far as prevention and aftercare are concerned".[20]

He continued that:

> "The City Council approved the Committee's scheme for the erection of hostels, training and social centres and liaison with hospital staff, the appointment of a Consultant Psychiatrist (half-time), a Psychiatric Social Worker, two Trainee Mental Welfare Officers and clerical staff".[21]

The next major policy change effected in the Council's mental health services occurred, when in 1964, they amalgamated the Health and Welfare Departments and their Committees. The joint department was under the direction of the Medical Officer of Health and was re-named the "Health and Social Services Department".[22]

A.D.[23] recalled some consequent improvement in liaison related to the admission of the elderly mentally infirm to (former Welfare Department) residential accommodation.

Similar departmental 'mergers' took place in a number of local authorities at about the same time.[24]

According to M.W.O.,[25] in a 1967 reorganisation all social workers from the separate Mental Health and Welfare Sections were integrated into unitary area teams and most took generic caseloads.

P.A.[26] thought that in the later 1960's mental health staff in Newcastle regarded their service as "one of the foremost in the country and considered that 'their' department operated

in the spirit of the 1959 Act better than did most other departments." A.D. believed that the 1967 reorganisation benefited the service, because professional knowledge and skills were then developed by the former 'welfare'staff who had generally received less training than had the mental health staff. In his opinion the social work service for the elderly mentally infirm (a group referred to hereafter as 'EMI') also improved.

A.D. and P.A.[27] believed that all clients of the newly integrated Department received a better service. In 1969 the Medical Officer of Health's report reiterated this view:

> "Administrative divisions have been bridged, old prejudices erased, and a healthy, dynamic service developed for the benefit of patients".[28]

Sub-Section A. 2 - Development of Residential and Day Care Services

The response of the Council to those provisions of the 1959 Act relating to residential and day care services for the mentally ill was positive. In 1960 the Council was initially cautious:

> "so far the true indications of the Mental Health Act for community care, its limitations and fundamental aims are not yet known,and it must, of necessity, take some time for such information to be gathered and properly assessed. In the meantime there is every danger in rushing too quickly into what is, after all, a relatively new method of treatment, and any progress made must be carefully considered on the grounds of benefit to the patient and to the community and not merely from the point of view of economic advantages". [29]

The following year saw a changed approach - in March 1961 it was stated that:

> "Hostel accommodation together with 'sheltered' workshop facilities will be required for the younger groups whilst the provision of geriatric hostels is necessary for the elderly. Plans are being made to meet this need but it will be some years before a comprehensive service can be provided!"[30]

Plans to establish a hostel materialised when, in 1961, a former commercial hotel was purchased by the Council for conversion to a hostel for 25 mentally ill women.[31]

When this hostel (Harbottle Lodge) was opened in 1963[32] it was described as:

> "a temporary home for the residents - run on informal lines with a minimum of rules and regulations, its purpose being to encourage residents to take their own decisions and so counteract the effect of prolonged hospital care".[33]

In its early years Harbottle appeared to be successful in attaining this objective:

> "Single rooms, a permissive environment, and continued efforts by the staff have resulted in 26 women being successfully discharged into the community, many of whom had spent one, or more, decades in hospital".[34]

This achievement may have been due to staff input as described by the Consultant Psychiatrist involved[35]:

> "The Senior Psychiatric Social Worker visits almost daily, the Mental Welfare Officers at least weekly, and the Consultant Psychiatrist once per week. As well as these frequent informal meetings, there is a monthly working case conference, attended by the staff and the Disablement Resettlement Officers of the Ministry of Labour".[36]

It is also noteworthy that:

> "Each resident was told at the initial interview that the hostel was a temporary and not a permanent home.[37]

In 1963 the average length of stay in Harbottle was 6.13 weeks and only five women had resided for periods from three months up to one year.[38]

A.D. suggested that during the early years of Harbottle's operation it was very successful in resettling clients because early residents had greater potential for rehabilitation - many of them were previously 'inappropriately' placed in mental

hospital. He surmised that the hostel was subsequently less successful in this respect because residents whose difficulties were more serious were admitted.(39)

Further mention of Harbottle was again made by the Medical Officer of Health in 1966, he wrote:

> "this hostel has served three main functions - prevention, rehabilitation and after-care, the success of the hostel has been due, in part, to the correct selection of residents, and the maintenance of a mixture of different residents of different ages, hospital diagnoses, and hospital experience, within the hostel".(40)

He proceeded to mention "single rooms, the absence of institution-like rules and regulations and the proximity of places of amusement in the City Centre" as being other factors related to the success of the hostel in attaining its aims.(41)

Another function of the hostel was that:

> "it has also served as a 'mother ship' in the community where ex-residents could return for support".(42)

In 1967 the Council opened Craster Lodge. This hostel, also, for younger mentally ill adults, was a former Barnardo's Home situated in east Newcastle. Initially it also housed a few mentally handicapped residents. However, they moved to the new hostel for sub-normals in 1969.

The Medical Officer of Health's Report identified the aim of Craster as being:'to supplement the work of Harbottle Lodge which has provided short term accommodation since it opened in 1963'. The report stated that:

> "both hostels appear to be meeting a definiteneed in the community for short-term and medium-stay residents".(43)

In 1968 it was reported that:

> "examination of the admissions and discharges to the psychiatric hostels shows little change over the years, although recently there has been some decrease in the annual turnover".(44)

A rise in the number of discharges from both hostels was recorded in 1969 and 1970.(45) The reason for this is unclear. It was not until 1969 that the Committee provided homes exclusively for the EMI. Prior to this such clients were accommodated in general purpose homes for the elderly. The Medical Officer wrote:

> "during the year the most important event was the opening of Warkworth House psycho-geriatric hostel. This hostel is the first of four such hostels planned for the future".(46)

A Consultant psycho-geriatrician attended the home weekly.(47)

In 1970 the aims of this unit were outlined:

> "The main objective has been to create an atmosphere in which the abnormalities of behaviour arising from psychiatric disturbances would be observed, reported, discussed, and an effort made to give staff insight and understanding, so that abnormal behaviour would not lead to rejection and further aggravation of psychiatric disabilities". (48)

Occupational therapy and social activity were introduced into the home.(49)

The provison of day care under Section 6 of the Mental Health Act 1959 was developed more slowly. The first official mention of the need for 'sheltered workshops' for the mentally ill occurred in 1961.(50) The initial day centre was provided in 1964. It opened in the 'attics' at Harbottle. According to M.W.O. it materialised because those hostel residents, who were unemployed, needed day time occupation.(51)

In his 1964 Report the Medical Officer of Health described 'the psychiatric day centre'; it had 30 clients and:

> "proved very popular with mentally ill persons living at home who would not otherwise be employed. By the end of the year it became obvious that a move to larger premises would be necessary."(52)

The report also contained the first promise of a purpose built day centre with 120 places. This centre did not materialize until 1970.(53)

The next detailed report of the day centre appeared in 1967.(54) It stated that it:

> "now has a considerable waiting list. Whilst it was thought that the people attending would require permanent sheltered work and were incapable of open employment, a small number have been rehabilitated back into the community".(55)

M.W.O. suggested that the first craft instructor was recruited because he was an engineer who could teach skills(56) and A.D. considered that the day centre was intended to train clients for work and to assist them in obtaining outside employment. However, he thought that after the first intake the centre was 'not very successful'; in attaining this aim. He attributed this to lack of employment potential in subsequent intakes.(57) This view as officially endorsed in 1968:

> "after an initial turnover of patients by placement into industry, this (the day centre) has now settled into a static population who, presumably, need sheltered work, which is the purpose of the centre".(58)

Section A.3 - Summary

The final appraisal of the Medical Officer of Health concluded that:

> "A decade has now gone by since the Mental Health Act 1959 became law and during that time considerable progress has been made in the City to implement its recommendations".(59)

Certainly a relatively extensive community care service had been set up. However, some elements of it, for instance: residential care for the EMI, had taken up to nine years to materialize.

In 1968 Newcastle's extent and scope of services was probably one of the foremost in the country, this was evidenced by the report of the Committee on Local Authority and Allied Personal Social Services in England and Wales[60] (hereafter referred to as the "Seebohm Report") which described the overall state of services. Provision of hostels was described by Jones:

> "Hostel care has increased from the very low figure of 968 places in England and Wales in 1962 to 2,755 places by the end of 1970".[61]

In 1971 a well developed service was handed over to Newcastle's Director of Social Services.

Section B - Service Development following the Social Services Act 1970 (period 1970-74)

Section B.1: General Service Development

In 1968 the Seebohm Report was published.[62] It recommended the establishment of:

> "A new Local Authority Department, providing a community-based and family orientated service which will be available to all. This new department will reach far beyond the discovery and rescue of social casualties, it will enable the greatest possible number of individuals to act reciprocally, giving and receiving service for the benefit of the whole community".[63]

The prescription of the report was to include the mental health community services in these departments:

> "Although members of Health Committees and Medical Officers of Health feel strongly that the Local Authority services for the mentally disordered should continue to be their responsibility".[64]

Their rationalewas, in part, that:

> "the nature of social problems commonly encountered by the families of mentally disordered people are such that they tend to suffer from inter-related social disabilities which are often caused or aggravated by the mental disorder ... the social worker should be concerned with the whole family ... This is more likely to happen in the kind of social service department we are proposing".(65)

The Report concluded that:

> "not to do so would further segregate the mentally disordered and would perpetuate the problems instanced elsewhere in the Report".(66)

The Document continued:

> "this conclusion also applies to hostels, clubs, day centres, training centres for adults and sheltered workshops. The Social Services Department will be running these for various groups, and to separate the mentally afflicted no longer seems sensible".(67)

Jones explained the Report's rationale by contrasting:

> "the Seebohm model in which mental illness is seen primarily as a social problem demanding skills in social diagnosis andhuman relations" with "the medical model in which hospital services are seen as being of prime importance, social work services being merely ancilliary to medicine".(68)

This 'social model' of mental illness is discussed in Chapter III.

A reorganisation in Newcastle took place before the publication of the 'Seebohm' report, this action of Medical Officer of Health suggested that perhaps he had received advance indications of its recommendations.

The Reports of the Medical Officer of Health between 1968 and 1970 indicate that he was reluctant to see the mental health services integrated into a "Seebohm Type" department, for example:

> "Unfortunately such progress (as had been achieved in Newcastle) has been far from common throughout the country. In an attempt to solve the problems the central government has decided to make radical administrative changes, which will create further divisions to be bridged - there is no doubt that an adequate service can be developed in spite of these changes, but an evolutionary process would seem to have been more satisfactory than a revolutionary one".(69)

Cooper substantiated his opinion:

> "While as a whole the (Seebohm) Committee were disillusioned about the developments since 1959 they still regarded community based services as vital to their objective".(70)

She also observed that:

> "Vested interests were not immediately convinced by the arguments for the determination of boundaries between the education, health and personal social services".(71)

The new integrated Social Services Departments commenced operating on 1st April 1971 - as was ordained by the Social Services Act 1970.(72) County and County Borough Councils were to set up a Social Services Department to encompass the services provided by their Children's and Welfare Departments and by the mental health, other social work and domicilliary services of the Health Departments.(73) These new Departments were to be managed by a Director of Social Services, and to provide personal social services as outlined above.

Jones attributed the nature of the Social Services Act to the growing power and influence of social workers at that time:

> "the advances made by social work, as a profession, in the post-Seebohm era have been so striking that it is no longer impossible that it (the social model of mental illness) should in future, become the dominant model".(74)

Between 1st April 1971 and 1st April 1974 Newcastle's Director of Social Services did not publish an annual report - which he had no statutory duty to do . The Local Government Act 1929,(75) made it a duty of Medical Officers of Health to publish

an annual report. The Director of Social Services published his first Annual Report for 1974/75.

> "The first years of the new Social Services Department were marked by an almost desperate uncertainty as to the role and functions of one service coupled with new problems facing the Committee and staff in managing and rationalising the extraordinary variety of tasks expected from them".(76)

In referring to preceding years he mentioned difficulties which had been experienced by the Social Services Department emanating from having to implement the Children and Young Persons Act 1969 and the Chronically Sick and Disabled Persons Act 1970, at the same time as managing a new and heterogeneous organisation.(77)

The Director of Social Services was a former Children's Officer. Amongst the second and third tier officers only one (the former Senior Psychiatric Social Worker from the Health and Social Services Department) had a mental health background. She had no operational responsibilities for services for the mentally ill and soon resigned.(78) This staffing situation may partly explain why the high priority given to mental health services by the former Health and Social Services Department diminished from 1971 onwards (as intimated below).

Section B.2 - Development of Residential and Day Care Services

Only two additional hostels for the EMI, out of the three planned by the Medical Officer of Health in 1969,(79) were opened between April 1971 and April 1974. These were Kielder House and Dunstanburgh House (few further residential or day care places were provided during this period).(80)

A.D. believed that some aspects of the residential and day care services for the mentally ill improved as a result of Social Services Act reorganisation in Newcastle. This was because

for the first time in the history of the City's mental health services, middle managers administered residential and day care units as their sole task. He also maintained that the value of training for residential and day care staff became recognised. However, he commented that regular liaison between field social workers and residential and day care units 'stopped almost overnight - and has not really recovered during the 1970's'. Furthermore, he considered that from this time involvement of field social workers with mentally ill clients receiving residential day care was severely reduced and only barely increased again by 1979. This, he believed, had caused most of the hostels and day centres to turn into long term institutions.(81)

P.A. thought that although field social work support for mentally ill residential/day care clients diminished after 1971 this did not have a detrimental effect on the majority.(82)

M.W.O. considered that more residential and day care units for the mentally ill ought to have been opened during this period on account of demand.(83) The Wansbeck (purpose built) 150 place day centre, though long planned, was opened in 1970.

Section B. 3 - Summary

The Department seemed to be struggling with complex problems as a consequence of the Social Services Act 1970 and other new legislation. On balance the evidence seems to show that lower priority was accorded to Newcastle's services for the mentally ill between 1971 and 1974. Shortcomings related to a dearth of Senior Management with mental health interest which, in turn, probably led to failure to plan new residential and day care units or to support the clients of existing units with appropriate field social work services. The fact that

the then most recent social services legislation did *not* provide for the mentally ill, probably also reduced priority given to them by both policy makers and managers in Newcastle.

Section C - Service Development following the Local Government Act 1972 (period 1974-75)

Section C.1 General Service Development

(84)

The Local Government Act 1972 operated from 1st April 1974. It abolished County Borough Councils and created County, Metropolitan and Non-Metropolitan District Councils in England and Wales (outside London). There were major boundary changes. County Councils and Metropolitan District Councils (hereafter referred to as M.D.C. s) were made responsible for running Social Services Departments.

Newcastle M.D.C. was allocated more extensive boundaries than had the former County Borough. The new boundaries included more affluent areas - Gosforth and several commuter villages. They also encompassed a large council estate and three former mining villages. A.D. perceived that the council became responsible for serving more mentally ill people but, did not acquire any additional facilities for doing so from the Northumberland County Council.(85)

The new social services committee appeared to be more concerned than was its predecessor to improve the personal social services; by such means as producing Annual Reports and articulating service aims.

The Social Services Department's Annual Report (1974-75) was the first of a series. The Chairman of the Committee

attributed its publication to local government reorganisation and said that its objective was:[86]

> "to chart the very substantial progress made in implementing the detailed policies set out in "Social Services for the Seventies" - the Labour Party policy document which was published in 1973 and endorsed by the Committee in July of that year.[87]

This is a rare instance of a national opposition policy document being cited as influencing council policy-making.[88]

The Annual Report of 1974 said:

> "Local government reorganisation gave the new Social Services Committee an opportunity to re-define its objectivies for local authority personal social services and to set out a programme to meet these objectives gradually but steadily".[89]

The report set down five objectives concerning the investigation of need, the provision of a wide range of social services and liaison with other agencies.

One aim was concerned entirely with residential services and another wholly with child care. Specific mention was made neither of day care nor of the mentally ill.[90]

Sub-Section C.2. - Development of Residential and Day Care Services

The mentally ill were given priority in one of the suggestions adopted from "Social Services for the Seventies". It was proposed that a specialist adviser on mental health be appointed to the department. Immediately upon local government reorganisation in April 1974 one (a qualified psychiatric social worker) was appointed. Her brief was to manage, and to advise on, residential and day care services for the mentally disordered; (in December 1976 her remit for the mentally handicapped was passed to another adviser).[91]

The state of Newcastle's residential and day care services

for the mentally ill in 1974-75 was described in the Annual Report and the objectives of the hostels and day centres were spelt out:

> "One hostel (is used) for fairly rapid recovery and short-stay patients, while the other endeavours to work with patients with long term illnesses and the (day) centre aims to foster good working attitudes, teach skills and some trades, help with the growth of independence by teaching cooking, housewifery skills and generally how to maintain individual care. It is also important that patients should be helped to enjoy life again and to take part in social activities".(92)

Section C.3 - Summary

Apart from the appointment of the adviser there was little indication that the probable diminution of priority given to the mentally ill from 1971 had been reversed. In general the committee and, by implication, Senior Management gave more attention to systematic policy development.

Section D - Service Development following Publication of the White Paper "Better Services for the Mentally Ill" (period 1975-79)

Section D.1. General Service Development

The White Paper "Better Services for the Mentally Ill"(93) (referred to hereafter as B.S.M.I.) represents an attempt, at national level, "to get to grips with shifting the emphasis to community care".(94) The Secretary of State for Health and Social Services expressed caution:

> "the policy can only be achieved if there is substantial capital investment in new facilites and if there is a significant shift in the balance of servicesbetween health and local authority. In the present state of financial stringency we have, therefore, felt bound to ask ourselves whether we should issue a White Paper at all".(95)

However, she advocated the White Paper's viability as a long-term programme and added that:

> "in a period of severe financial restraint it is even more important that there should be a clear statement of policy objectives against which financial priorities can be assessed".(96)

The White Paper indicated:

> "...the general direction in which we should move and the general background against which we should take decisions".(97)

The response of local authorities to B.S.M.I. can only be fairly assessed within the context of the time scale and broad policy objectives set by that document. One of the main overall aims was:

> "an expansion of local authority personal social services to provide residential, domiciliary, day care and social work support".(98)

B.S.M.I. acknowledged that:

> "the substantial expansion of these services, as soon as economic circumstances permit, is an essential element in the Government's strategy.(99) Services should meet two distinct, but related, needs: for social care and for rehabilitation".(100)

The publication of the White Paper was rapidly acknowledged by Newcastle Social Services Committee in its 1975-76 Annual Report.(101) Their first reaction was to set up a working party "to study the work carried out in Newcastle".(102) This working party subsequently produced the report 'Towards Good Mental Health - A Three Year Plan for Newcastle' in January 1977. This is referred to hereafter as "T.G.M.H.". In 1976 their Annual Report asserted that:

> "the White Paper whilst setting out many good objectives cannot possibly do anything to improve the lot of the mentally ill until more resources are made available".(103)

This judgement contradicted the Secretary of State's assessment of scope for shorter term action and of potential for making services more effective. The Minister said:

> ". . . there is much that can be done without necessarily using extra money - through changes of attitude and more effective use of resources".(104)

There had been a change of attitude on the part of the Newcastle Committee when they published T.G.M.H.:

> "whilst the plan (B.S.M.I.) recognised the need for additional resources and the improvement of the use of some of the existing resources - it also recommended a thorough examination of the methods employed to prevent mental illness and of the programme of treatment".(105)

Among the list of aims in T.G.M.H. is:

> "The primary need is to maximise existing resources, and better co-ordination of the local authority services with area health authority services is required.(106)

Total expenditure on residential and day care services by Newcastle's Committee in the financial year 1977-78 was £5.1 million, (on fieldwork it was £1.7 million). The total social services budget was £9.6 million for that year. The projected cost of the 'T.G.M.H.' plans represented a 3.6 per cent increase in the residential/day care services budget and 1.9 per cent increase in the departmental budget.(107)

T.G.M.H. also subscribed to a further aim of the White Paper when it stated that:

> "the first objective for improving all the services in Newcastle is for these to be seen as part of a total provision made through medical, educational and voluntary services".(108)

Describing 'the local district network envisaged in the new pattern of services' - B.S.M.I. stressed that:

> "it is fundamental that they should be seen as interdependent and as together constituting an integrated whole".(109)

The remaining objectives of T.G.M.H. were also in line with the broad aims of B.S.M.I. - they were:

> "a. The Social Services Committee acknowledges the interaction between mental health and most other social problems and therefore, sees effective development in this field as the key to the Three Year Plan.(110)
>
> b. Priority will be given to developing the skills of all staff who are involved in working with people whose mental health is impaired.(111)

c. To explore greater use of community resources particularly in developing individual accommodation and day care of patients".(112)

d. To seek more information about the numbers and needs of the mentally ill in the community".(113)

In accord with the Committee it stated:

> "the key to the Three Year Plan lies in making better use of existing resources and co-ordinating them with other interested parties".(114)

Section D. 2 - Development of Residential and Day Care Services

The precepts of B.S.M.I. are compared with residential and day care services in Newcastle at the time of its publication, and with plans for the future as outlined in "T.G.M.H.". Thereafter the implementation and development of those plans up to the end of 1979 is examined.(115)

The principal aims of the White Paper for hostels were that: institutionalisation of clients should be avoided by keeping units small and that they should cater for both sexes, be located in residential areas and encourage residents to leave the unit during daytime.(116)

Harbottle and Craster both had places for 25 residents - possibly they were too large. By 1979 Craster had divided into three units, one of which was completely self-contained and a similar development was being set up at Harbottle. Both hostels were mixed by 1975. Both had long encouraged residents to go out during the day and most who were unemployed attended the Wansbeck.

B.S.M.I. advocated a broad differentiation between hostels (designed for short-term care and rehabilitation) and staffed homes (where the main aim was to provide long term care). In staffed homes rehabilitation would remain a secondary objective.(117)

Hostels should provide a bridge between hospitalisation and return to the community, or a short respite for a client who might otherwise need to be hospitalised.(118) Participation of residents in running the hostel and freedom of choice in lifestyle were seen as essential.(119)

B.S.M.I. took stock of hostel provision at the time of its publication(120) and set broad goals for future achievement. In line with the White Paper;in 1976-76 Newcastle's Annual Report described both hostel's aims as being "to provide a bridge between hospital and complete return to the community".(121) The Report further conceded that whilst:

> "some patients are resident in these hostels for short periods of time before they return to their own families or move into the community, others with more serious problems virtually spend the whole of their adult life in one institution or another".(122)

The Report stated that one hostel aimedto;'concentrate on affording fairly rapid recovery to short-stay patients', but that even this programme had been 'thrown out of gear' by the 'increased number of people suffering from chronic mental illness and needing rehabilitation'. Plans for an additional hostel for the mentally ill were postponed until 1978/79 (through joint financing with the Area Health Authority).(123) This proposal dis appeared, from subsequent annual reports and

did not reappear in the capital programmes for the future after 1979-80.

T.G.M.H. complained of the 'blocking' of hostel places and proposed an nquiry to determine the likely numbers requiring long-stay hostel accommodation in the future.[124] A team from St. Nicholas Hospital was investigating the question and information was being sought from the Department's social workers.[125] T.G.M.H. also identified the need, as did B.S.M.I., for "some form of bridging accommodation in which confidence will be restored and social contacts and employment re-established".[126]

T.G.M.H. did not envisage any radical change in the functions of the hostels.[127] In order to promote the use of the hostels more in accordance with their aims, T.G.M.H. suggested more discerning selection of residents. Concern was expressed about previous inappropriate admissions 'often as a result of incomplete information from the social worker or to meet an emergency'.[128] T.G.M.H. proposed obtaining a psychiatrists' opinion of every potential resident. It suggested that different kinds of accommodation should be provided for the mentally ill - especially for the single and homeless.

Also recommended was the re-introduction of regular case reviews for hostel residents. The intention was to check that the unit was continuing to meet their needs and to find ways of 'moving on' those for whom the hostel was no longer serving a useful function. It was postulated that each resident should have a 'key worker' responsible for co-

ordinating his treatment.[129]

T.G.M.H. praised the informal support being offered to former residents of Harbottle. It proposed that hostel staffing be increased to allow this support to be part of the recognised workload at both hostels.[130]

By mid 1977 the review system had been re-established as had the practice of psychiatric consultation about prospective residents.[131] By December 1979 the key worker scheme had not materialised. T.G.M.H. projected the establishment of an additional(minimally staffed)hostel for 12-15 long term residents during 1978/79.[132] The Adviser sought a suitable existing building, but, up to December 1979 none had been found.[133] By mid 1978 Craster had set up a follow-up support scheme for former residents and in November that year weekly resident's discussion meetings were established.[134]

B.S.M.I. gave no clear advice to councils on the provision of homes for the elderly mentally infirm. No target number of places was set. The White Paper described "problems for investigation and resolution". These were: as to how to: improve the calibre of assessment, delineate the boundaries between Health Service and Council care, solve organisational

problems inherent in transferring people between the two and to investigate the relative benefits of segregated and integrated homes for EMI clients.[135]

In 1975-76 Newcastle M.D.C. ran three homes exclusively for the EMI - the newest was opened in the autumn of 1974.[136]

T.G.M.H. contended that:

> "Homes for the elderly mentally ill are the subject of much professional controversy, many experts believing that the gathering together of people with such problems is not always in their interests. We believe, however, that the establishment of E.M.I. homes in Newcastle has been an entirely successful venture, and this has been due to the very considerable support of local psychiatrists who assist in the assessment of residents for such care and give on-going support through weekly visiting and reviewing of cases."

It continued:

> "Newcastle plans to have more of these specialised homes, but to offer humane and sensitive care also requires that the ordinary homes for the elderly can contain a number of seriously or mildly confused patients". [137]

In March 1978 Bamburgh House, a purpose built home for the elderly mentally infirm, was opened. The Departmental annual report announced:

> "Bamburgh House reflects our changing attitude to caring for the elderly confused as it is a building designed with three wings which can each operate as a fairly self-contained unit, therefore, offering a chance for more individual care and personal support". [138]

Bamburgh increased the number of EMI Home places in Newcastle to 140.

In October 1978 Jedburgh House, formerly a 'generic' old peoples home started to become an exclusively EMI Home.[139] This home was excluded from the main part of the study because it was still in a transitional state in 1978-1979.

B.S.M.I. advocated that local authority day care should have "a broadly therapeutic role with a social orientation," and should involve "a mixture of social and work-directed activities".(140) The document continued:

> "on one level the goal of day care is to meet client's immediate needs for shelter, occupation and social activity - and in so doing relieve pressures by giving the client and his family opportunities to be apart and so relieve tensions and pressures".(141)

The White Paper recommended that key aims for day centre clients should be to improve individual functioning in personal relationships and in work situations and to enable them to lead a more satisfying life in the community.(142)

It was advocated that day centres should be accessible by public transport from the whole of their catchment area. For this reason B.S.M.I. recommended that only densely populated areas should support day centres of as many as 150 Places.(143)

In 1975-76 Newcastle Council saw the function of the day centre as being:

> "to teach working skills and trades, but, particularly to enable patients to learn or re-learn working habits and the capacity to work in the community. It is also necessary for some of them to be helped to learn how to become independent and live by themselves caring for, washing and generally maintaining themselves".(144)

By early 1977 the Wansbeck had been sub-divided into two units: one for psycho-geriatric clients, who were given social and occupational opportunities, and the training/workshop unit for younger clients. T.G.M.H. suggested that a wide variety of clients, with differing needs, should benefit from the Department's day care.(145)

In order to meet their needs the T.G.M.H. postulated the aims of: providing a safe environment, treatment, training in work

skills or sheltered occupation and relief to client's families: all to be preceded by thorough individual assessment.[146] These aims closely resemble those of the White Paper.

In 1977 an assessment unit was developed at the Wansbeck for all incoming younger mentally ill clients.[147] In January that year the Wansbeck was seen as:

> "caring effectively for a large number of people - but being subject to stresses and strains - perhaps, the biggest single problem which it faces is that of being the only formally identified day care resource which the Department has - no one institution can be expected to provide for so many different needs".[148]

A review of the organisation and structure of the Wansbeck and of its staff development needs was called for; as was an investigation of the characteristics and numbers of the mentally ill population likely to need its services in the future.[149] This review had not taken place by December 1979.[150]

T.G.M.H. proposed further development of day-care facilities at Harbottle and their extension to Craster. A pilot scheme was set up in June 1977 at Craster and by December 1979 had expanded to take 14 clients per day. A 'Local' Day Centre was established in a church hall in 1976. This was open for one half-day each week. It was run by field social workers and nurses from St. Nicholas Hospital. There was an average attendance of 10 in 1977 although 17 were on the register. This centre still existed in December 1979[151] and partly met the goals set by T.G.M.H. for 'two more localised day centres' (in year one).[152] It was closed at the time of the study by industrial action.

The total number of day care places provided by the social services department in December 1979 is shown in the following table:

Table 1 - Number of Day Care Places - 31st December 1979

Centre	Number of Places available each day	Number of half day sessions available each week
Wansbeck	150	1500
Harbottle Lodge	10	100
Craster Lodge	14	140
Local Day Centre (averaged out)	2	17
ALL CENTRES	176	1757

The Government guideline was 0.6 places per 1,000 population; as applied to Newcastle, this indicates the provision of 180 places per day.(153)

T.G.M.H. (published when fewer places were provided) dismissed this failure (then) to reach the government target.

> "the comparison is not particularly informative - especially as no information is available as to how the guideline figure is derived."(154)

However, the above table shows that by 1979 the Government's precept had virtually been achieved.

Section D. 3 - Section Summary

The prescriptions, of B.S.M.I. were greeted with some initial scepticism by Newcastle Social Services Committee. However, by 1979 they had chosen to attain many of its aims. They rapidly responded to its publication with their own related policy document which adopted many of its precepts.

Section E - Quantitative Comparison between Newcastle's Service Provision and that of similar Local Authorities (period 1975-79)

Section E. 1. Rationale

A major task of this chapter is to ascertain whether, in responding to government policy precept, Newcastle M.D.C. provided a quantity of services equal to, or surpassing, that of other comparable local authorities.

For comparison, two points in time during the latter part of the study period are chosen - because only during the later 1970's did the majority of Councils begin to provide residential/day care services for the mentally ill. Section E.1 examines M.D.C. s who possessed similar powers and populations to Newcastle. Section E.2 examines other authorities in the northern region. This comparison is appropriate because of close inter-authority political and managerial links and similar economic and cultural characteristic

Section E. 2. Comparison with other Metropolitan District Councils (1975-76)

The first comparison is of Newcastle's quantity of service provision with that of other Metropolitan District Councils in the year of publication of 'B.S.M.I.', because the White Paper prescribed levels of service provision.

These tables show the level of provision made by Newcastle compared with that of other M.D.C. s:

Table 2 - Day Centres

Metropolitan District Council	Number of attendance days in 1975-76 (in 000's)	% of occupancy
Newcastle upon Tyne	22	67
Sefton	5	90
Liverpool	12	80
Kirklees	6	49
Bradford	3	56
Leeds	6	92 (est.)
Manchester	7	68
Coventry	13	76 (est.)

Note: **Only the above named eight (out of the total of 36) M.D.C. s made any day care provision for the mentally ill during the municipal year 1975-76**

Source C.I.P.F.A. Personal Social Services Statistics 1975-76 (Actuals)

In the number of attendance days in the year Newcastle was top of the 'league' of M.D.C. s - providing almost twice as many attendance days as the second and third authorities in rank order.

However, its level of place occupancy (two thirds of potential) was lower than in four other Council's units - the highest being Sefton (90 per cent occupancy).

Table 3: 1975 - 1976 Residential Care for the Mentally Ill under Retirement Age

Metropolitan District Council	Average Number in Residential Care		Average nos. of residents (Council hostels only)	Percentage occupancy
	TOTAL	Total per 100,000 population aged 18 - 64		
Tyne and Wear				
South Tyneside	18	18	17	82
North Tyneside	nil	-	-	-
Gateshead	nil	-	-	-
Newcastle upon Tyne	53	30	47	95
Sunderland	46	27	44	94
South Yorkshire				
Barnsley	1	1	-	-
Rotherham	nil	-	-	-
Doncaster	23	14	-	-
Sheffield	41	12	41	86
Merseyside				
Knowsley	1	1	-	-
ST. Helens	15	13	15	75
Sefton	nil	-	-	-
Wirral	nil	-	-	-
Liverpool	62	19	22	91
West Yorkshire				
Calderdale	8	7	7	87
Wakefield	6	3	nil	-
Kirklees	16	8	17	84
Bradford	41	16	25	96
Leeds	72	16	49	83
Greater Manchester				
Bury	nil	-	-	-
Rochdale	19	16	8	100
Tameside	10	8	10	80
Trafford	11	8	6	99
Oldham	32	24	7	7
Bolton	24	3	15	92
Salford	4	16	-	-
Stockport	38	22	20	78
Wigan	1	-	-	-
Manchester	92	31	71	98
West Midlands				
Solihull	nil	-	-	-
Wolverhampton	10	6	10	83
(actuals)		-	-	-
Walsall	nil	4	nil	-
Dudley	7	-	-	-
Sandwell	nil		16	76
Coventry	14	7	7	7
Birmingham	3	9		

Source: C.I.P.F.A. Personal Social Services Statistics 1975-76.

Newcastle was amongst the most prolific providers of hostel care in 1975-76. In total numbers of places it was surpassed only by Leeds, Manchester and Liverpool M.D.C.'s. For provision of places per 100,000 of population only the latter marginally exceeded Newcastle. In respect of hostel places directly provided in the Council's own units - Newcastle's crude number of places was similar to those furnished by Sunderland, Sheffield and Leeds M.D.C.'s. The range of occupancy rates was 75 per cent to 100 per cent. Newcastle had amongst the highest, but, it was lower than those of Liverpool, Bradford, Rochdale, Trafford and Manchester M.D.C.'s.

It is noteworthy that the B.S.M.I guideline for hostel places was five places per 100,000 population,[155] 20 of the 36 M.D.C. s thus, met the guideline in 1975-76. However, 12 others provided virtually no hostel places.

The shortcomings of these authorities and the dearth of day centre. provision probably had causes which were identified by Lapping:

> "Demand is Invisible. Reasonably enough authorities can point to short waiting lists or their complete absence when taxed with their low provisions . . .
>
> If people are forced to leave (a hostel) too soon then it is the hospital, not the council, which carries the cost of their relapse . . . spending on community care is an invisible investment until you get down to cases".[156]

Furthermore, as Roberts pointed out:

> "the posture of social policy was responsive but at the point of response significant problems arose which were not the result of dilatoriness or ill-will. The need was for a response on a legal level, in the allocation of priorities and in the development of community care".[157]

Section E 3. Comparison with other Social Services Authorities in Northern England (1978-79)

This section compares the quantity of residential and day care places for the mentally ill provided by Newcastle Council with thatfurnished by neighbouring authorities. This comparison was undertaken in July 1979 approaching the conclusion of fieldwork for this study. Comparison is made through the following tables:

Table 4 Quantity of residential/day care services for the mentally ill provided by Northern Local Authorities at 31st July 1979

a) Day Care

Authority	No. of day care (only) centres	No. of places in each day (only) centre	No. of hostels providing day care	No. of places (each day) in hostels
Newcastle M.D.C.	1	150	2	24
Cleveland C.C.	1	100	nil	-
Cumbria C.C.	-	-	2	2
Durham C.C.	-	-	nil	-
Gateshead M.D.C.[1]	-	-	nil	-
N. Tyneside M.D.C.	-	-	1	20
Northumberland C.C.	-	-	nil	-
S. Tyneside M.D.C.[2]	-	-	1	12
Sunderland M.D.C.	2	48	nil	-

b) Residential Care

Authority	No. of hostels (for clients under 60/65)	No. of hostel res. places	No. of Res. E.M.I. Homes	No. of res. places in E.M.I. Homes
Newcastle M.D.C.	2	42	4½[3]	164
Cleveland C.C.	3	58	nil	-
Cumbria C.C.[5]	2	28	nil	-
Durham C.C.	1	17	1	24
[1]Gateshead M.D.C.[4]	-	-	nil	-
N. Tyneside M.D.C.	1	15	1	15
Northumberland C.C.	-	-	nil	-
S. Tyneside M.D.C.	1	22	nil	-
Sunderland M.D.C.	2	38	nil	-

Sources: Social Services Departments concerned.

Notes to Table 4

1. Gateshead M.D.C. were opening a 15 place day centre and a 15 place hostel (for all age groups) in late 1980.
2. South Tyneside M.D.C. opened a 50 place day centre in September 1979.
3. One Newcastle home was in transition and is recorded as '½'.
4. Gateshead M.D.C.'s policy was not to provide EMI Homes because they doubted their value.
5. Cumbria C.C. had no specialised EMI Homes but, reserved 11 places for the EMI in a generic home for the elderly.

These tables demonstrate that in numbers of establishments and places provided only Newcastle and Cleveland (which encompasses a large conurbation) were major service givers. They provided over 100 day care and over 40 hostel places each. Northumberland had no services and were not planning any.

Section E. 4. Section Summary

This section demonstrates that in quantitative terms Newcastle's level of provision, at the time of the publication of B.S.M.I. and in 1979 was one of the highest amongst comparable authorities.

Section F Unit Occupancy and the Selection of the Main Study Sample (1978-79)

Section F. 1. - Rationale

Before the conclusion of this chapter tables are provided to indicate the total number of clients in each unit at the time of the fieldwork for this study (1978/79). This section also provides details of the sample of clients studied in greater depth in Chapters II, III and IV and the reasons for selecting this sample.

Section F. 2 - Adult Hostels

This table shows the number of hostel clients at the time of the study, the type of services they were receiving and the proportion of clients included in the survey.

Table 5 - Adult Hostels included in this Study (January 1979)

Hostel	Number of clients in study	Number of *resident* clients in the study	Number of 'supported' clients in the study
Harbottle	22	22	0
Craster	26	14	12

Two non-resident clients, one from each hostel, were excluded as numerous attempts to contact them failed. All resident clients were included in the study. Some other studies which are referred to in the text, for comparative purposes, have surveyed 'group home residents'. These were mentally ill clients who lived in small groups, in ordinary housing and were supported by social workers. Their postion was broadly similar to that of the twelve non-resident Craster clients, who lived in outside housing, mainly in groups, and continued to receive support from the hostel and its staff. It therefore, seems appropriate to effect some general comparisons between these Craster clients and other studies of 'group home residents'

Section F. 3. - EMI Homes

The table below shows the total number of residents in each EMI Home and the proportion included in this study.

Table 6 - EMI Home Residents included in this study January (1979)

EMI Home	Number of residents in home	Number of residents included in this study	
		Number	% of residents in home
Bamburgh	36	10	28
Dunstanburgh	36	10	28
Kielder	34	12	35
Warkworth	36	15	42

The clients of EMI Homes included in the study were those whom senior staff of the home deemed capable of answering the questionnaire.(158) All clients referred to in this table were resident.

The exclusion of those elderly clients who were too confused to answer the study questionnaire was effected in order to render the results as valid as possible. The home Superintendents identified those too confused to be able to undertake the opinion survey. This may have led to the elimination of known critical clients, but the writer has no evidence that it did so. This proved the most satisfactory available method of eliminating the substantial numbers

who were very severely confused.

There is a precedent for this methodology provided by Raphael and Peers.(159) Their study excluded certain geriatric patients, from a survey of psychiatric in-patient opinion, after it had been found, in a pilot survey, that they could not participate meaningfully.

Section F.4. - Day Centres

Wansbeck clients living in the hostels were surveyed as part of the hostel sample only. Clients of the 'Local Day Centre' were excluded because it was closed by the social worker's strike at the time of the study.

This study included clients of the Wansbeck in the numbers and proportions indicated in the table:

Table 7 - Wansbeck Centre - clients included in this study (March - July 1979)

Section of Unit	Number of clients	Number included in this study	Proportion of all clients included in this study %
Wansbeck I (younger clients)	45	40	89
Wansbeck II (elderly clients)	61	50	82

Psychiatric in-patients and those who had virtually ceased attending the centre during the material period were excluded

from the study.

Section G - Chapter Summary and Conclusion

During the 1960's, in response to the Mental Health Act 1959, Newcastle Health and Social Services Committee increased its services for the mentally ill and kept systematic records of this. In 1971 the coming of the Social Services Department and the genericisation of social work temporarily resulted in less priority being given to the mental illness services and in mental health specialists disappearing from senior management. In the mid 1970's - after the local government reorganisation and the publication of 'B.S.M.I.' - somewhat greater priority was progressively accorded to these services and attempts were made to improve services and to make better use of existing resources. The precepts of national policies were, by and large, implemented by the Newcastle Committee in the latter half of the nineteen seventies. The Committee was one of the most prolific providers (amongst comparable authorities) of residential and day care services for the mentally ill, during this period.

FOOTNOTES CHAPTER I

1. Mental Health Act 1959 (Pub. H.M.S.O.)
2. Roberts, A. "Response to Innovation: Government Policy towards the Mentally Disordered" (in Differential approaches to social work with the mentally disordered") (1976 pub. B.A.S.W.) p.106.
3. Jones K. "A History of the Mental Health Services" (1972 pub. Routledge and Kegan Paul) p.p. 291-301.
4. "Report of the Royal Commission of the Law relating to Mental Illness and Mental Deficiency" (1957 pub. H.M.S.O.)
5. Jones K. "A History of the Mental Health Services" p. 305.
6. "Report of the Royal Commission on the law relating to Mental Illness and Mental Deficiency" p. 106 s 30.
7. Ibid p.p. 229-30 ss 675-77.
8. Ibid p.p. 217-18 ss 632-6
9. Ibid p.p. 214-7 ss 626-31
10. Ibid p.p. 208-9 ss 603
11. Ibid p.p. 225-6 ss 664-7
12. "Annual Report of the Medical Officer on Health for the City of Newcastle upon Tyne 1958" p.72
13. Mental Health Act 1959
14. National Health Service Act 1946 s.28 (Pub. H.M.S.O.)
15. Brown M. "Management By Objectives" (1972) Unpublished Paper - University of Birmingham. p.1.
16. The Mental Health Act 1959 Part II s6. ss2a
17. Ibid Part II s 6 ss 2b.
18. Ibid Part II s 6 ss 2c.
19. Ibid Part IV ss22, 25-30, 33-36,43-48,54-59 and 135
20. Medical Officer of Health's Annual Report (Newcastle) 1959 p.75 (abbreviated below as "M.O.H.").
21. Ibid
22. Ibid
23. A.D. Joined Newcastle City Health Department in 1962 as a Trainee Mental Welfare Officer. He remained in the employment of the Council up to 14.12.79. When as Assistant Director (Residental and Day

Care Services) he was interviewed by the writer.

24. For example: the London Borough of Greenwich where the writer was employed at that time.

25. M.W.O.supplied this information in an interview with the writer on 12.12.1979. He joined the Newcastle Health Department as a Duly Authorised Officer in 1948 and remained with the City Council's Mental Health Services until his retirement in 1974.

26. P.A., interviewed 15.12.1979, joined the Newcastle City Health and Social Services Department as a Trainee Mental Welfare Officer in 1967 and remained in the City's social services, in 1979 he was Principal Assistant (Fieldwork).

27. Interviews with P.A. and A.D. (December 1979).

28. Annual Report of the M.O.H. for Newcastle 1969.

29. M. O. H. Report (Newcastle) 1960 p.p. 82-83

30. M. O. H. Report (Newcastle) 1961 p.78

31. M. O. H. Report (Newcastle) 1961 p.81

32. M. O. H. Report (Newcastle) 1963 p.67

33. Ibid

34. M. O. H. Report (Newcastle) 1966 p.p.89-90

35. The Consultant Psychiatrist employed on a half-time basis by the Health and Social Services Committee.

36. Morgan P. "A Local Authority Psychiatric Hostel" (1964) Pub. in Monthly Bulletin ofthe Ministry of Health and Public Health Laboratory Services No. 23 p.224.

37. Ibid p.227

38. Ibid P.229

39. Interview with A.D. (December 1979)

40. Report of the M.O.H. (Newcastle) 1966 p.p. 89-90

41. Ibid

42. Ibid

43. M.O.H. Report (Newcastle) 1967 p.85

44. M.O.H. Report (Newcastle) 1968 p.91

45. M.O.H. Reports(Newcastle) 1963-70

46. M.O.H. Report (Newcastle) 1969 p.83

47. Ibid

48. M.O.H. Report (Newcastle) 1970 p.73

49. Ibid

50. M.O.H. Report (Newcastle) 1961 p.78

51. Interview with M.W.O. (December 1979)

52. M.O.H. Report (Newcastle) 1964 p.69

53. M.O.H. Report (Newcastle) 1970 p.77

54. M.O.H. Report (Newcastle) 1967 p.86

55. Ibid

56. Interview with M.W.O. (December 1979)

57. Interview with A.D. (December 1979)

58. M.O.H. Report (Newcastle) 1968 p.90

59. M.O.H. Report (Newcastle) 1969 p.77

60. "Report of the Committee of Local Authority and Allied Personal Social Services for England and Wales" (Pub.H.M.S.O. 1968)'Seebohm Report

61. Jones K. "A History of the Mental Health Services" p.350

62. 'Seebohm Report'

63. Ibid p.11 s2

64. Ibid p.111 s351

65. Ibid p.112 s353

66. Ibid p.112 s354

67. Ibid p.112 s356

68. Jones, K. "A History of The Mental Health Services". p.350.

69. M.O.H. Report (Newcastle) 1969 p.69

70. Cooper J. "The Creation of the British Personal Social Services 1962-74" (1983) Pub. Heinemann Educational Books. p.96

71. Ibid p.99

72. Social Services Act 1970 (Pub. H.M.S.O.) ss1-2

73. Ibid

74. Jones, K. "A History of the Mental Health Services" p.350

75. Local Government Act 1929 (pub. H.M.S.O.) s58.

76. Annual Report Newcastle Social Services Department 1974-75 p.3

77. Ibid

78. Interview with P.A. (December 1979)

79. M.O.H. Report (Newcastle) 1969 p.83

80. Interview with A.D. (December 1979)

81. Ibid

82. Interview with P.A. (December 1979)

83. Interview with M.W.O. (December 1979)

84. Local Government Act 1972 (pub. H.M.S.O.)

85. Interview with A.D. (December 1979)

86. Newcastle Social Services Department Annual Report 1974-75 p.2

87. Ibid

88. The Conservatives were in government in 1973.

89. Newcastle Social Services Department Annual Report 1974-75 p.3

90. Ibid

91. "Towards Good Mental Health - A Three Year Plan for Newcastle" (1977) pub. Newcastle City Social Services Department) [referred to hereafter as 'T.G.M.H.']

92. Newcastle Socail Services Department Annual Report 1974-75 p.3

93. "Better Services for the Mentally Ill" (1975) (pub. H.M.S.O.) [referred to hereafter as B.S.M.I.]

94. Ibid Forward p.ii s6

95. Ibid p.iii s8

96. Ibid p.iii s9

97. Ibid p.iv s10

98. Ibid p.17 s2.22

99. Ibid p.33 s4.18

100. Ibid p.22 s4.19

101. Newcastle Social Services Department Annual Report 1975-76 p.10

102. Newcastle Social Services Department Annual Report 1975-76 p.10

103. Ibid

104. "Better Services for the Mentally Ill" Forward p.iv.

105. "Towards Good Mental Health" p.1 s.1

106. Ibid s4

107. Newcastle Social Services Department Annual Report 1977-78 p.p.22-24

108. T.G.M.H. s1

109. B.S.M.I. p.1 s11

110. Compare with B.S.M.I. p.75 s9.20

111. Compare with B.S.M.I. p.p.27-28 ss3.35-3.38

112. Compare with B.S.M.I. p.79 s16.2

113. T.G.M.H. s4

114. Newcastle Social Services Department Annual Report 1976-77 p.11 s43

115. On 1.10.1979 two of the three years implementation period for T.G.M.H. had expired.

116. B.S.M.I. pp37-40

117. Ibid p.p. 37-38

118. Ibid p.38

119. Ibid p.38

120. Ibid p.p. 13-14

121. Newcastle Social Services Department Annual Report 1975-76 p.11

122. Ibid

123. Newcastle Social Services Department Annual Report 1977-78 Table 4

124. T.G.M.H Appendix 2 p.p. 1-2

125. Ibid

126. Ibid

127. Ibid s.c.

128. Ibid p.8 s.d.

129. T.G.M.H. Appendix 2 p.9 s.d.

130. T.G.M.H. Appendix 2 p.9

131. Source - Interview with Departmental Professional Adviser (Mental Illness (December 1979).

132. T.G.M.H. p.6

133. Interview with Professional Adviser (Mental Illness) (December 1979)

134. Interview with Superintendent of Craster Lodge (December 1979)

135. B.S.M.I. p.p. 39-40 s4 48-9.

136. Source: Interview with Professional Adviser (December 1979)

137. T.G.M.H. Annexe 2 p.3 s 3b and p.2 s 2b.

138. Newcastle Social Services Department Annual Report 1977-78 p.10 s45

139. Source: Interview with Professional Adviser (December 1979)

140. B.S.M.I. p.34 s4.26

141. Ibid p.35 s4.28

142. Ibid s4.29

143. Ibid p.36 s4.34

144. Newcastle SocialServices Department Annual Report 1975-76 p.11

145. T.G.M.H. p.4

146. Ibid Appendix 1 p.p. 2-3

147. Source: Interview with Professional Adviser (Mental Illness) December 1979.

148. T.G.M.H. Appendix 1 p.p. 3-4

149. Ibid p.4

150. Source: Interview with Professional Adviser(Mental Illness)December 197

151. Ibid

152. T.G.M.H. p.5

153. B.S.M.I. p. 36

154. T.G.M.H. Appendix 1 p.5

155. B.S.M.I. p.37 s4.40

156. Lapping A. "Community Careless" New Society 9.4.1970 p.590

157. Roberts A. "Response to Innovation: Government Policy towards the Mentally Disordered" p. 109

158. See Appendix 4

159. Raphael , W. and Peers V. "Psychiatric Hospitals viewed by their patients"(1972) Pub. Kings Fund p.12.

Chapter Two

THE STAFF AND CLIENTS OF THE RESIDENTIAL AND DAY CARE UNITS 1978-79

The aim of this Chapter is to examine staff and client characteristics as a means of identifying *who* was providing the service for *whom*, in what numbers, and of using this data to assist with evaluation of staff and client opinion in subsequent Chapters.

Mullen and Dumpson explained the need to discover "who" was providing a service for "whom".[1]

A D.H.S.S. seminar on "Social Care Research" concluded with the summary:

> "most of the papers stressed the importance of context for social care and so brought into the discussion who is involved in the caring process".[2]

An essential adjunct to surveying client and staff opinion is understanding the characteristics of the staff - because staff views are elicited and because the clients are likely to express opinions about them and about their work. This latter point was illustrated by Mayer and Timms[3] and Butrym.[4]

The examination of client characteristics is designed to facilitate subsequent enquiry as to whether the services provided were as appropriate as possible to the needs of those clients who were receiving them. Identifying client characteristics also provides information important for analysis of their opinions and their judgements about the services.

A comparative approach involving other studies is also used in this investigation. The purpose is to ascertain whether the Newcastle services had similar staffing and clients to comparable services elsewhere in Britain. This will assist subsequently in comparison with other study's findings on the quality of services.

Section A - Staff: Client ratios

This section examines staff/client ratios. It compares these with ratios in similar units which have been the subject of other studies.

The following tables illustrate the staff/client ratios in Newcastle Units. They relate to the municipal year 1978-79.

Table 8 : Newcastle Residential and Day Care Units

Staff Numbers 1978-79

Unit		Head	Dep. Head	Seniors	Care Workers/ Craft Instructors	Domestic Cooks Gardeners etc.
Craster	Hostels	1	1	1	5	5½
Harbottle	Hostels	1	1	1	5	3
Bamburgh	EMI Homes	1	1	1	15½	5
Dunstanburgh	EMI Homes	1	1	1	15	5½
Kielder	"	1	1	1	15	5½
Warkworth	"	1	1	1	15½	5
Wansbeck (entire Centre)		1	1	2	12	6½

Table 9: Numbers of Clients and Staff/Client Ratios

	Total No. of Clients	Sen. Staff	Care Staff	Other Staff	All Care Staff	All Staff
Craster	27*	1:9	1:5	1:7½	1:3½	1:2
Harbottle	23+	1:8	1:5	1:5	1:3	1:2
Bamburgh	36	1:12	1:2	1:7	1:2	1:1½
Dunstanburgh	36	1:12	1:2	1:7	1:2	1:1½
Kielder	34	1.11	1:2	1:7	1:2	1:1½
Warkworth	36	1:12	1:2	1:7	1:2	1;1½
Wansbeck	97	1:24	1:8	1:15	1:6	1:4

Note: * Only 14 of these were resident

+ Only 22 of these were resident

Notes to tables

1. Numbers of *all* clients using the Unit at the time of the study are included in the staff/client ratio data.

2. Residential Unit staff worked a shift system so that the actual staff/client ratio at any one time was seldom more than half that recorded in the table.

3. Day Centre staff (with the exception of the caretaker) were all on duty for the whole of the time that the Centre was open (9.00 a.m. to 4.00 p.m. Monday to Friday) therefore, the actual operational staff/client ratios was as shown.

4. The ratios are complied to the nearest ½(half-time) member of staff.

It can be seen that each Unit of the *same* kind had (to the nearest 'half-time' member of staff) an equal staff/client ratio. The only exception to this was Craster where the total was increased by a gardener and an additional domestic. This was due to the size of the hostel premises.

"B.S.M.I."[5] suggested ideal ratios of psychiatric, medical and nursing staff to the general population, however, it did not make similar recommendations in respect of ratios for social services staff because it: "is not possible to isolate and hence to quantify social work staffing needs."[6]

LAMSAC[7] investigated the assessment of appropriate levels of staffing for various tasks undertaken by local authorities. They concluded[8] that where no officially recognised relationship between the task and staff requirement exists, research must be based upon comparative studies between Authorities. They sought to identify those conditions which affect staffing needs and then to make comparisons within groups of local authorities which were subject to the same conditions.

In respect of staff/client ratios in the hostel; the most relevant research is that undertaken by Ryan and Wing.[9] They studied four Hostels each run by a different London Borough. There would be some similarity of conditions-partly because these were in urban areas like Newcastle. In Ryan and Wing's four Hostels the staff/user ratios were 1:1½, 2:2½. 1:6 and 1:2 respectively with an average of 1:3. This

compared with an average of 1:3 (care staff and management only) in the two Newcastle Hostels. It is unclear which kinds of staff Ryan and Wings's data included.

In considering the staffing needs of EMI Homes the most relevant study is Davies and Judkin's[10] Bradford study, undertaken in a northern industrial city where conditions were probably similar to Newcastle. Whilst they surveyed generic homes for the elderly they did document the proportion of mentally confused residents (38 per cent in 1976).

However, they stated that staffing levels were established on the basis of crude numbers of beds in a home and which authority it belonged to prior to local government re-organisation (in 1974).

The disabilities of the residents(including mental frailty) played no part in determining staff/client ratios. This contrasted with Newcastle, where EMI Homes had higher staff/client ratios than did generic part III homes for the elderly.[11]

The National Day-Care Study[12] does not indicate whether the eight Local Authority Day Centres surveyed were run in conditions very similar to those in Newcastle. The average

ratio of staff to users in these Social Services Day Centres for the (younger) Mentally Ill was 1:9. Furthermore, it is not clear whether this ratio included all staff, solely care staff, or management and care staff. In day centres for the elderly confused the National Study found an average ratio of staff to users of 1:5 [13]. Of eleven units for the elderly confused only two out of eleven were run by social services departments. At the Wansbeck I (younger mentally ill unit) the staff/user ratio (management and care staff only) was 1:4, but, in the Wansbeck II (unit for the elderly not all of whom were confused) the staff/user ratio was only 1:9. As few elderly clients attended every day; the numbers present on any given day would have made the actual ratio higher.

Section Summary

Newcastle implemented virtually identical staff/client ratios in like units. These ratios appear to be fairly comparable with those in some similar establis elsewhere, but available data is limited and its exact nature is not clear.

Section B: Staff Characteristics

B.1. Age and Sex Distribution

All tables relate to the municipal year 1978-79 when most of the other study data was collected. The age of the staff may have had some bearing on their capacity to relate to the client age groups in their units. In so far as age is linked with emotional maturity, a pre-requisite in caring for mentally ill clients, it is pertinent. Emotional maturity is more likely to enable staff to operate with the "affective neutrality" called for by Roth [14] and which he considered to

be most difficult to attain in caring for the mentally ill.

Some clients may have a need to relate to staff of a particular sex. If the staff of a unit are all of one gender then such opportunities are denied. In the case of clients who need intimate physical care; their right to receive this from a person of the same sex is acknowledged by the Sex Discrimination Act.[15] Olsen[16] has shown how units often harmfully segregate their clients from the community by confining them to a homogeneous group. To limit clients to contact with staff of one sex or age group further restricts their scope for relationships as compared with those available outside care.

These tables indicate staff age and sex distribution in the psychiatric hostels.

Table 10 - Sex Distribution - Hostels

	Craster Management	Craster Care-Attendants	Harbottle Management	Harbottle Care Attendants
Male	1	3	-	1
Female	2	4	3	4
Total	3	7	3	5

Note: Females predominated - particularly at Harbottle - where there was only one male member of staff. However, there was a higher proportion of males at Craster where the majority of clients were men.[17]

Table 11 - Age Distribution - Hostels

	Craster Management	Craster C. Attns.	Harbottle Management	Harbottle C. Attns.
Under 20	-	-	-	1
20-29	-	3	1	1
30-39	2	2	-	2
40-49	-	-	-	-
50-59	1	1	2	1
60-64	-	-	-	-
Unknown	-	1	-	-
Total	3	7	3	5

In both hostels most staff were aged between 20 and 39 with a significant minority aged between 50 and 59 (especially at Harbottle). The majority of clients were aged between 30 and 59 with clients at Harbottle mainly at the upper end of that age range.[18] The trend in staff ages bore some similarity to that found in Ryan and Wing's[19] study where the average age of hostel staff was 30 with an age range of 23-47.

The following tables and comments illustrate EMI Home staffing trends in respect of age and sex. Data was not available for all Care Attendants at Warkworth.

Table 12 - Sex Distribution - EMI Homes

	Bamburgh		Dunstanburgh		Kielder		Warkworth	
	Mgmnt.	C. Att.	Mgmnt.	C. Att.	Mgmnt.	C. Att.	Mgmnt.	C. Att
Male	1	1	-	-	1	1	-	1
Female	2	13	2	15	3	14	3	5
Total	3	14	2	15	4	15	3	6

The high proportion of female staff must have made it difficult for many of the clients to have relationships with, or personal attention from, male staff. In view of the tendency of men in North Eastern England to share much of their social life with other men,[20] the dearth of male staff may have deprived male clients in some respects.

Table 13 - Age Distribution EMI Homes

	Bamburgh		Dunstanburgh		Kielder		Warkworth	
	Mgmnt.	C. Att.	Mgmnt.	C. Att.	Mgmnt.	C. Att.	Mgmnt.	C. Att.
Under 20	-	2	-	-	-	1	-	-
20-29	2	1	1	2	1	5	-	-
30-39	-	5	1	4	3	2	-	1
40-49	1	3	-	3	-	3	1	-
50-59	-	3	-	6	-	2	2	5
60-64	-	-	-	-	-	2	-	-
Total	3	14	2	15	4	15	3	6

If there is benefit in the ages of the staff being nearer to those of clients, the trends would seem to be advantageous. There was a tendency for care attendants at Dunstanburgh and Warkworth to be in later middle age. This may be linked with length of service.(21)

By contrast Deputy Superintendents were relatively young and most Superintendents were in earlier rather than later middle age. This detail of their ages is not shown in the table.

The tables below examine trends in gender and age amongst Wansbeck staff.

Table 14 - Sex Distribution - Wansbeck Day Centre

	Whole Unit	Wansbeck I		Wansbeck II	
	Mngmnt.	Mngmnt.	Craft Instrs.	Mngmnt.	Craft Instrs.
Male	2	-	3	1	1
Female	-	1	5	-	3
Total	2	1	8	1	4

Women predominated amongst the Craft Instructors; this trend is like that found in the National Study[22] to the extent that three quarters of 'their' sample working with the EMI were women. At Wansbeck men and women clients were virtually equal in numbers. Male Craft Instructors in the Wansbeck I worked entirely with male clients in the workshops for woodwork, metalwork and gardening. In the National Study[23] most heads of day units were women, whereas at Wansbeck both the Manager and his Deputy were male.

Table 15 - Age Distribution - Wansbeck Day Centre

	Whole Unit	Wansbeck I		Wansbeck II	
	Mngmnt.	Mngmnt.	Craft Instrs.	Mngmnt.	Craft Instrs.
Under 20	-	-	-	-	-
20-29	-	1	4	-	1
30-39	-	-	1	1	2
40-49	1	-	-	-	-
50-59	1	-	2	-	1
60-64	-	-	1	-	-
Total	2	1	8	1	4

Two thirds of the Craft Instructors were in the 20-39 age group, there were none in the 40-49 age group, but one third were in the 50-64 group. There were thus two disparate groups, it transpired, not only in terms of age, but also, in terms of education and work experience. The age range was similar to that found in the National Study[24] in respect of EMI day centres. The ages of the Manager and Deputy Manager were similar to those commonly found by Carter amongst similar officers.

Sub-Section B.2. Staff Continuity, Work Experience and Qualifications

These factors were likely to affect staff's capacity for their work and the stability of the unit's community. The following tables illustrate hostel staff's length of service, previous work experience and qualifications. A glossary of qualifications appears in footnote (25).

Table 16 - Length of time in present post - Hostels

	Craster		Harbottle	
	Mngmnt.	Care Atts.	Mngmnt.	Care Atts.
Under 1 year	1	-	1	-
Over 1 yr. under 3 yrs	1	3	-	5
Over 3 yrs under 5 yrs	1	2	1	-
Over 5 years	-	1	1	-
Unknown	-	1	-	-
Total	3	7	3	5

The majority of basic grade hostel staff had been in post for between one and three years. There was a trend towards longer service than was found in Wing and Ryan's[26] sample (whose mean length of service was 16 months). The comparison is crude because precise lengths of service were not sought in this study. The range of lengths of service of Newcastle management was wide.

Table 17- Previous Work Experience (most recent job) - Hostels

	Craster		Harbottle	
	Mngmnt.	Care Atts.	Mngmnt.	Care Atts
Skilled Manual (unrelated to present job)	-	3	-	1
Unskilled Manual/Shop Assistant (unrelated to present job)	-	1	-	1
Unemployed/Housewife	-	-	-	1
In Higher/Further Education	-	-	-	2
Care Attn. (Mentally ill)	2	-	1	-
Care Attn. (other client group)	-	2	-	-
Psychiatric Nursing Auxillary	-	-	1	-
Deputy Hostel Superintendent (Superintendents only)	1	-	1	-
Unknown	-	1	-	-
Total	3	7	3	5

Half the basic grade care staff had previously been in manual occupations unrelated to social services (or unemployed). Only two had been previously employed in care work.

Recruitment to senior posts (with one exception) had been from thosewho had gained experience on a lower grade in a similar unit.

Table 18 - Staff Qualifications - Hostels

(Categories not exclusive - except "none")

	Craster		Harbottle	
	Mngmnt.	Care Atts.	Mngmnt.	Care Atts.
I.C.S.C.	2	2	1	-
'A' Level Sociology	1	-	-	-
Teaching Certificate	-	-	1	-
B. Sc. (Psychology)	-	-	-	1
C.S.S. (still on scheme)	-	-	1	-
B.A.	1	-	-	-
S.E.N. (Psychiatric)	1	-	-	-
None	-	5	-	4
Total	5	7	3	1

Ryan and Wing, (27) interviewed eighteen psychiatric hostel staff. Six staff in their study were graduates compared with only two in Newcastle. Seven staff in this study had attended Technical or Teaching Colleges compared with an equal number in Ryan and Wing's sample. None in Newcastle held a professional qualification in social services work compared with three in their study. Only one staff member in this study held another professional qualification (compared with three in Ryan and Wing's group).

Overall the Newcastle sample were less well educated and qualified than Ryan and Wing's sample (except in the area of technical/teacher education). The proportion of Care Attendants who had received external training or education was comparatively low. In respect of senior staff the

situation was more favourable - all in Newcastle having received some further education or training.

These tables illustrate the staff qualifications, length of service and work experience profile for the E.M.I. Homes

Table 19 - Length of time in present post - EMI Homes

	Bamburgh		Dunstanburgh		Kielder		Warkworth	
	Mngmnt.	Care Att.	Mngmnt.	Care Att.	Mngmnt.	Care Att.	Mngmnt.	Care Att
Under 1 year	1	3	2	3	2	4	-	-
Over 1 year under 3 years	2	11	-	2	1	3	1	-
Over 3 years under 5 years	-	-	-	4	1	3	-	1
Over 5 years	-	-	-	6	-	5	2	5
Total	3	14	2	15	4	15	3	6

The trend in the homes, other than recently opened Bamburgh,[28] was that the majority of Care Attendants at Bamburgh had been in post since its opening.

The trend in the homes, other than recently opened Bamburgh,[28] was that the majority of Care Attendants had been in post more than three years. At Bamburgh 11 out of 14 had been employed since the home opened.

Indications provided by this study point to fairly low staff turnover (especially amongst Care Attendants) 24 out of 36 in the three older homes having been in post more than three years. The table overleaf details work experience:

Table 20 - Previous Work Experience (most recent job) - EMI Homes

	Bamburgh		Dunstanburgh		Kielder		Warkworth	
	Mngmt.	Care	Mngmt.	Care	Mngmt.	Care	Mngmt.	Care
Housewife/ unemployed	-	3	-	-	-	8	-	5
Factory Worker	-	1	-	1	-	-	-	1
Nursing auxillary	-	4	-	6	-	2	-	-
Edcn. Ancillary	-	1	-	2	-	-	-	-
Care Attendant/ Home Help	1	2	-	4	1	-	-	-
Shop Assistant	-	3	-	2	-	1	-	-
Painter/ Decorator	-	-	-	-	-	1	-	-
Dressmaker/ Caterer	-	-	-	-	-	2	-	-
Further Education Student	-	-	-	-	-	1	-	-
Psychiatric Staff Nurse	1	-	-	-	-	-	-	-
Nursing Sister (General)	-	-	-	-	-	-	1	-
Nursing Sister (Psychiatric)	1	-	2	-	3	-	2	-
Total	3	14	2	15	4	15	3	6

All four superintendents had previously been nursing sisters or charge nurses on general or psychiatric wards.

Almost one third of the care attendants were unemployed or housewives prior to taking their posts (although none at Dunstanburgh were in these categories). The second most frequent previous occupation was that of nursing auxilliary.

Only 12 per cent of the total had previously been care attendants in other homes. The remainder came from unrelated occupations, thus 68 per cent of all the Care Attendants had no previous relevant job experience.

With two exceptions (both of whom 'rose through the ranks' of care attendants) all the Managers had a background of middle management in (predominantly psychiatric) nursing. They had come directly from such a hospital post into their present job. When this is considered, together with the fact that the largest number of Care Attendants with previous recent job experience came from Auxilliary Nursing, it could be anticipated that the regime of the EMI Homes might resemble that of a hospital.

Table 21 - Qualifications held by staff - EMI Homes

(Categories *not* exclusive (except "none")

This table indicates the profile of staff qualifications:

	Bamburgh		Dunstanburgh		Kielder		Warkworth	
	Mngmnt.	Care Att.	Mngmnt.	Care Att.	Mngmnt.	Care Att.	Mngmnt.	Care Att.
I.C.S.C.	-	-	-	1	1	2	-	1
P.C.S.C.	1	-	-	-	-	1	-	-
S.E.N.	1	1	-	-	1	-	-	-
S.R.N.	-	-	-	-	-	-	2	-
R.M.N.	1	-	2	-	2	-	1	-
None	-	13	-	14	-	12	-	5
Total	3	14	2	15	4	15	3	6

The lack of qualifications amongst the Care Attendants accentuates the picture of low skill indicated by the dearth of previous relevant recent job experience. A meagre six per cent had obtained a pre-entry certificate in nursing or

residential care. A further six per cent had taken the I.C.S.C. after obtaining their post. Two thirds of these worked at Kielder.

Three quarters of the Deputy Superintendents and all Superintendents held nursing qualifications (the latter in mental nursing). This reinforces the impression indicated by job experience, of a possible nursing bias in their approach.

Two Deputies held preliminary qualification in residential work and two others (already qualified and experienced nurses) were currently on the first intake of the C.S.S.

These tables give a similar staffing profile of the Wansbeck.

Table 22 - Length of Service in Present Post - Wansbeck Day Centre

	Whole Centre	Wansbeck I		Wansbeck II	
	Mngmnt.	Mngmnt.	Craft Instr.	Mngmnt.	Craft Instr.
Under 1 year	-	-	3	-	-
Over 1 year under 3 years	-	1	2	-	3
Over 3 years under 5 years	-	-	1	-	-
Over 5 years	2	-	2	1	1
Total	2	1	8	1	4

The modal length of service of Craft Instructors was between one and three years, but many of those working with younger clients had been in post for either a relatively short time or a fairly long one. In general, the younger instructors were in the former category and the older in the latter.

Amongst the senior staff many were long serving. This would seem likely to have given continuity and stability to the Units - but, might also have led to conservatism and resistence to innovation.

Table 23 - Previous Work Experience (most recent job)- Wansbeck Day Centre

	Whole Centre	Wansbeck I		Wansbeck II	
	Mngmnt.	Mngmnt.	Craft Instr.	Mngmnt.	Craft Instr.
In Further/Higher Education	-	-	3	-	1
Skilled Crafts Person	1	-	1	-	2
Clerk/Shop Assistant	-	-	2	-	-
Occupational Therapist	-	1	-	-	1
Craft Instructor (Physically Handicapped)	-	-	1	-	-
Industrial Graphics Designer	-	-	1	1	-
Construction Manager	1	-	-	-	-
Total	2	1	8	1	4

Half the Craft Instructors and all the management had previous job experience in related fields. In the majority of cases this was practising a craft which they could, potentially, use in their work with clients. Two Craft Instructors and one Senior Craft Instructor had worked with clients in a residential/day setting using craft skills.

One third of all the Craft Instructors came directly from higher education. All had undertaken a course which bore some relevance to their job. (see Table 24). As they had not been 'mature students'-

they were likely to be lacking in life experience (especially experience of the ordinary working situation for which they were 'preparing' many clients).[29] However, those staff who had entered their jobs directly from an industrial post had recent work experience neither involving teaching nor the mentally ill. Only 15 per cent of all Wansbeck staff had relevant previous recent job experience. A comparison of qualifications held by Newcastle staff with those possessed by staff surveyed by the National Day Care Study, is appropriate, and is undertaken in the table below:

Table 24 - Staff Qualifications - A Comparison between Wansbeck and the National Study (Categories *non* exclusive)

	Wansbeck 1	Wansbeck II	Edwards & Carter's S.S.D* Sample[30]
Teaching Certificate	2	-	2
Art/Art Therapy Degree/Diploma	3	-	1
C.Q.S.W.	1	-	-
Craft Apprenticeship	1	3	3
I.C.S.C.**	2	2	-
R.M.N. (or R.M.N & S.R.N.)	-	-	2
S.R.N. only	-	-	1
S.E.N.	-	-	1
N.N.E.B.	-	-	1
Occupational Therapy Diploma	-	-	3
B. Sc. (Psychology)	-	-	1
Other University Degree	-	-	2
Other Qualifications***	-	-	2
No Qualifications	2	1	9
Unknown	-	-	4
Total	11	6	32

Notes to Table:

* Ten per cent of the National Study's social services staff had more than one qualification.

** This qualification was not specifically recorded by Edwards and Carter and *may* have appeared under their 'other qualifications' category.

*** 'Other qualifications' - this categorisation is not used for the Newcastle data.

Supplementary Table24a:Senior staff Wansbeck Day Centre

(Categories *not* exclusive)

	Senior Craft Instructors Wansbeck I	Senior Craft Instructors Wansbeck II	Deputy Manager	Manager
B.A. (Fine Arts)	1	-	-	-
I.C.S.C.	1	-	-	-
Craft Apprenticeship	-	1	1	1
D.T.M.H.A.	-	-	1	1
Total	2	1	2	2

Qualifications held by all staff of Wansbeck I had some relevance to their work whereas some of the qualifications held by staff in the National Study do not appear to be appropriate. It is also noteworthy that nearly one third of the 'National' sample had no qualifications and the qualifications of a further four were unknown. One quarter of the Wansbeck I instructors were unqualified. There was a shortage of nursing qualifications amongst Wansbeck I staff compared with those in the National Study.

Including Managers; one third of the Wansbeck I staff held a craft apprenticeship certificate compared with only one tenth of those in the National Study. Whilst all but one of the Wansbeck II staff held a qualification these were academically inferior. However, they had relevance to the jobs in question.

That both managers held the D.T.M.H.A. was due to the Departmental policy of seconding day care staff working with mentally ill to this course prior to the advent of C.S.S.

Section B.3 Summary

Newcastle's staffing ratios, age and sex distribution and qualification levels were similar to those found in recent studies of similar Units. In some job grades and some types of Unit staff modal age was higher and the proportion of graduates was lower than in similar Units studied elsewhere in Britain. Women predominated - especially in lower grades and in the EMI Homes.

The profile which emerges in Newcastle is one of lack of education, and a manual working class background, amongst the basic grade residential staff (who were graded as manual workers). The majority of qualified residential staff held nursing qualifications, at the time of the study a few senior staff were undertaking the new C.S.S. As Roberts observed:

> "The position in regard to the training of specialist residential workers remains virtually neglected".(31)

The work experience of residential staff where it had been relevant was more often in nursing than in social services work. In the Day Centre there were two groupings of staff, older ones who generally possessed craft skills and younger ones recently arrived from higher education.

There was a dearth of male staff, especially at basic grades and particularly in the EMI Homes. All these trends probably reflect low pay and manual status awarded to basic grade workers - especially in residential units.

Section C - Characteristics of the Clients

This section aspires to identify the characteristics of those Newcastle clients who were included in this study.

Several points should be noted. The first, is that the categories in all tables in this section are exclusive unless otherwise stated. Secondly, the data on Wansbeck clients is not differentiated: between Wansbeck I and Wansbeck II. Industrial action prevented data retrieval from the computer in this form. Thirdly, the data on client characteristics was supplied by Unit staff from client's files and recorded on a standard form (Appendix 5). In tables in this, and in all the following sections of the text, percentages are expressed to the nearest whole number. Therefore, percentage totals do not necessarily add up exactly to 100 per cent - although totals are expressed this way.

Sub-Section C.1 - Social Situation

In order to provide a social profile of the users, the tables below indicate social class, source of income and housing situation in accordance with the Registrar General's classification scheme.[32]

Table 25 Social Class - All Units

	All Clients		Craster	Harbottle	Wansbeck
		%			
A	2	(1)	-	-	2
B	10	(5)	1	1	5
C1	24	(13)	3	1	14
C2	24	(13)	4	2	11
D	23	(12)	4	4	11
E	74	(41)	13	13	33
Unknown	28	(15)	1	1	14
Total	185	100	26	22	90

Social Class (continued)

	Bamburgh	Dunstanburgh	Kielder	Warkworth
A	-	-	-	-
B	1	1	1	-
C1	2	1	-	3
C2	5	1	-	1
D	1	2	-	1
E	1	2	7	5
Unknown	-	3	4	5
Total	10	10	12	15

Table 26 - Principal Source of Income (by type of unit)

	All Clients in sample		Wansbeck	EMI Homes	Hostels
		%			
Wages from full-time work	8	(4)	2	-	7
Unemployment/OAP Benefit/S.Benefit	176	(95)	88	47	40
Private income	1	(1)	-	-	1
Total	185	100	90	47	48

Table 27 - Housing Situation (by type of tenure) - All Units

	All Clients		Craster (33)	Wansbeck Day Centre
		%		
Council Tenant	50	(27)	12	38
Tenant of Private Landlord	9	(5)	-	9
Living in Relative's Home (other than spouse - tenure type unknown)	28	(15)	-	28
Owner/occupier	9	(5)	-	9
In Local Authority Care (Including Homes not earmarked for the "Mentally Ill")	89	(48)	14	6
Total	185	100	26	90

Note:- Craster clients included in this table were those who were not resident.

The profile of the clients (in tables) shows a concentration in the unskilled manual working class (class E) and few members of the professional classes (A and B) in all age groups. The remainder came from the skilled or semi-skilled manual working class. There was a handful of non-professional white collar workers; these were slightly more numerous at Warkworth and the Wansbeck. The high proportion of skilled working class in the Bamburgh sample is not readily explicable. Of those who were not working, only one did not rely on state benefits as his principal source of income.

Of those *not* living in residential homes 43 per cent resided in council housing and nine per cent were the tenants of private landlords. Townsend[34] has shown that these are the housing sectors in which the poorest are concentrated.

In respect of social class, as identified by occupational status, the younger groups of clients resembledthat Wing[35] et al have described as the "new long-stay" hospital population.

All elderly clients depended on state benefits for their income. Almost three quarters of those whose class was known belonged to one of the three manual classes (C2, D and E). Jordan[36] documented the prevalence of poverty in old age. He showed that, in 1976, 23 per cent of all pensioners were claiming supplementary benefit and that in 1975, 740,000 persons of pensionable age were eligible for supplementary benefit but, did not claim. He demonstrated that in 1966 only 52 per cent of all pensioner couples, only 40 per cent of single pensioner men and 55 per cent of single pensioner women received occupational pensions. In 1975 almost one third of occupational

pensions were worth less than £3 per week.

That 43 per cent of non-resident clients in this study were council tenants indicates higher concentration in this sector than was typical of Newcastle generally. In 1978 45 per cent of all households in the City were council tenants - 34 per cent of all households in Britain rented from local authorities in 1977.[37]

Nine per cent of the non-resident clients rented in the private sector compared with 17 per cent of the City population and 13 per cent of the U.K. population.[38] The type of housing inhabited by the 31 per cent of Wansbeck clients who lived with relatives was unknown.

Sub-Section C.2 - Age, Sex and Marital Status

This section examines age, sex and marital status patterns of the sample. The age structure was largely determined by the aims of each unit.[39] Age and sex profiles for the total clientele would have been different if many EMI Home residents had not been excluded. The following tables record the relevant data:

Table 28 - Age - All Units

	All Clients		Craster	Harbottle
		%		
Under 20	1	(1)	-	1
20-29	14	(8)	4	1
30-49	28	(15)	10	2
50-64	55	(31)	10	17
65 and over	87	(47)	2	1
Total	185	100	26	22

	Wansbeck	Bamburgh	Dunstanburgh	Kielder	Warkworth
Under 20	0	-	-	-	-
20-29	9	-	-	-	-
30-49	16	-	-	-	-
50-64	26	2	-	-	-
65 and over	39	8	10	12	15
Total	90	10	10	12	15

Table 29 - Sex - All Units

	All Clients	%	Craster	Harbottle	Wansbeck
Male	79	(43)	16	10	44
Female	106	(57)	10	12	46
Total	185	100	26	22	90

	Bamburgh	Dunstanburgh	Kielder	Warkworth
Male	3	3	2	1
Female	7	7	10	14
Total	10	10	12	15

Table 30 - Marital Status - All Units

	All Clients	%	Craster	Harbottle	Wansbeck
Single	85	(46)	15	13	47
Married	28	(15)	6	-	17
Widowed	57	(31)	1	5	19
Divorced	8	(4)	2	3	3
Separated	7	(4)	2	1	4
Total	185	100	26	22	90

[Table continued overleaf]

	Bamburgh	Dunstanburgh	Kielder	Warkworth
Single	2	2	1	5
Married	-	3	2	-
Widowed	8	5	9	10
Divorced	-	-	-	-
Separated	-	-	-	-
Total	10	10	12	15

78 per cent of clients were in later middle age or old age. One was in late adolescence.

The hostels were designated for those under pensionable age and long established older residents. More than three quarters of the Harbottle residents were in later middle age, and only one fifth under 50; whereas more than half of the Craster residents were between 30 and 49.

Partly because of the under-representation of elderly women in the sample,(40) the sexes were virtually equally balanced with a slight predominance of women. In the hostels and the Wansbeck, male clients were the majority. Among the Craster clients men outnumbered women by almost two to one.

Predictably; in the EMI Homes the postion was reversed; four fifths of the sample was female.

Overall: the most common marital statuses were 'single' (almost half the sample) and 'widowed' (almost one third). The numbers of separated and divorced clients were small.

Twice as many clients were currently married as were divorced or separated.

Single clients were found predominantly in units for younger clients (58 per cent in the hostels were single). Widowhood was found mainly in units for elderly clients but encompassed nearly one quarter of Harbottle residents. The highest proportion of married clients was at Craster (23% were not resident) and in the Wansbeck (19%). Generally, it was the maritally unsupported who were most likely to avail themselves of services. There are also links between certain mental illnesses and remaining single (schizophrenia)[41] or reacting to bereavement (reactive depression)[42].

The National Day Care Study estimated that just over half the Social Services clients were "chronic" (in terms of their psychiatric hospitalisation history)[43]. It is worth comparing the age and sex structure of this residential and day care sample with those of 'chronic' patients studied by others[44]. Morgan and Johnson found that the majority of their sample of chronic hospital in-patients were over the age of 40. They found that most 'chronic' males were aged between 40 and 59 (47 per cent compared with 38 per cent of females in this age group) However, the group aged 60 and over contained the majority of chronic females in their sample (44 per cent as compared with 37 per cent of men). This offers some clarification about age and sex differences between Craster and Harbottle clients. In 1967 Magnus[45] demonstrated chronicity to be commoner in male patients at a younger age than it was in females. 75 per cent of his male sample of

chronic patients was under 65 compared with only 55 per cent of his females. This trend also throws some light on the proportion of women in the EMI Homes.

Magnus surveyed marital status and found that 65 per cent of his 'chronic' patients under 65 were single, this profile is similar to that of the Newcastle hostels. In Magnus' sample, 52 per cent of those aged over 65 were widowed.

Gore and Jones (1961)[46] found that of a sample of patients who had been in hospital continuously for five years, 63 per cent were single and another 18 per cent were separated, widowed or divorced.

In a small scale survey of mentally ill people who had become institutionalised at home over a long period Huxley[47] found the majority to be single and aged between 26 and 55. All these studies show the age and marital statuses of the Newcastle sample to be similar to those of samples of the chronically mentally ill surveyed elsewhere.

Comparing the age structure of the residential and day care sample with that of the City population; the relatively high proportion of the elderly in the residential and day care units is apparent. Only 18 per cent of the City population were over 60/65[48] compared with 47 per cent of the residential and day care sample who were over 65. Because of the different age ranges comparison is inexact.

In Ryan's[49] two surveys of short-stay hostels he noted that three quarters of all residents had never married. He also found that "most of the rest" were divorced or separated.

His 1973 study showed that:

> "the hostel residents were predominantly a middle-aged and elderly group, two thirds being over 45".[50]

Ryan's study recorded that the residents of long-stay hostels were older (three quarters aged 55-64), whereas only one quarter of the residents of 'transitional hostels' were in this age group. This connects with the difference in age structure between the client groups at Craster and Harbottle (the former had mainly younger clients and the aims of a predominantly transitional hostel,[51] the latter had mostly later middle aged clients and was used primarily as a 'long stay' hostel).[52]

Just under half of Ryan and Hewett's[53] sample of hostel residents were male. In this study just over half were men. A 1960 hostel study (Clark and Cooper), found 72 per cent of residents to be single, and a further 14 per cent to be divorced or separated. Only 14 per cent of clients in their study were aged over 50 and 61 per cent were between 30 and 49. However Clark and Cooper[54] examined a 'transitional hostel', therefore, comparison with Craster's client group seems more appropriate. The age structure at Craster would suggest greater chronicity than existed in the Clark and Cooper[55] hostel.

The National Day Care Study Team[56] found that a slight majority of men attended social services day centres (this was a similar position to that at Wansbeck I). The National Study discovered the largest group of users to be in their thirties. At Wansbeck I clients tended to be older.

The National Study showed a slight preponderance of single users in the social services day centres. This was also the case at Wansbeck.

In Hassall's (1976)[57] study of psychiatric day hospital patients, 19 per cent were under 45 years old, 37 per cent between 45 and 65 and 44 per cent aged 65 and over. This pattern bears some similarity to that at Wansbeck. Of Hassall's sample, 44 per cent were men and 57 per cent women. At the Wansbeck there were almost equal numbers, but a slight majority of men.

Sub-Section C. 3 Psychiatric History

This sub-section deals with psychiatric diagnosis and chronicity(as indicated by client's history of hospitalisation). The first table details client's psychiatric 'diagnosis'. This names the illness which the client's psychiatrist deemed to be the predominant one. These diagnostic categories were adopted on the advice of a Newcastle consultant psychiatrist

Table 31 - Psychiatric Diagnosis - All Units

	All Res. & D.C. Clients		Craster	Harbottle	Wansbeck Day Centre
		%			
Psychotic depression	23	(12)	3	5	10
Schizophrenia	53	(29)	12	13	24
Psycho-neuroses	30	(16)	2	-	26
Brain disorder	16	(9)	2	2	-
Personality disorder	29	(16)	7	1	10
Confusional state (Senile Dementia)	28	(15)	-	1	14
Unknown	6	(3)	-	-	6
Total	185	100	26	22	90

	Bamburgh	Dunstanburgh	Kielder	Warkworth
Psychotic depression	1	-	2	2
Schizophrenia	1	-	2	1
Brain disorder	5	-	2	5
Psycho-neuroses	-	1	-	1
Personality disorder	3	4	3	1
Confusional state (Senile Dementia)	-	5	3	5
Unknown	-	-	-	-
Total	10	10	12	15

The tables concerning hospitalisation refer to the four years immediately prior to the study. This is because the client's recent history is most relevant in analysing other study data.

This table indicates the number of stays in psychiatric wards (in the City) during the preceding four years.

Table 32 - Number of Psychiatric Hospitalisations during Preceding four years - All Units

No. of Hospitalisations	All Res. & D.C. Units	%	% of those admitted	Craster	Harbottle
None	105	(57)	(-)	13	11
1	48	(26)	(60)	6	7
2	10	(5)	(13)	-	2
3	14	(8)	(18)	4	2
4	1	(1)	(1)	-	-
5	2	(1)	(3)	-	-
6	2	(1)	(3)	-	-
7	-	(-)	(-)	-	-
8	1	(1)	(1)	1	-
9 or more	2	(1)	(3)	2	-
Total	185	100	100	26	22

No. of Hospitalisations	All Wansbeck	Bamburgh	Dunstanburgh	Kielder	Warkworth
None	52	3	6	8	12
1	21	5	3	4	2
2	5	1	1	-	1
3	8	-	-	-	-
4	1	-	-	-	-
5	1	1	-	-	-
6	2	-	-	-	-
7	-	-	-	-	-
8	-	-	-	-	-
9 or more	-	-	-	-	-
Total	90	10	10	12	15

Notes:
1. Recording exact numbers of hospitalisations in excess of 9 was considered unnecessary as this indicates a chronic pattern.
2. Where clients were discharged from psychiatric wards *during* the four year period, but admitted only *prior* to this period they are recorded in this table as having had one hospitalisation.
3. The above data was verifed with local hospital records.

The next table shows the duration of the most recent stay in Newcastle psychiatric wards during the four years preceding the study.

Table33 - Durations of most recent sojourn in hospital (if any)
All Units

	All Clients		% of those admitted	Craster	Harbottle
	N	%			
No admissions	105	(57)	-	13	11
Under 28 days	27	(15)	(35)	4	2
29 days - 3 months	23	(12)	(29)	2	2
3 months - 6 months	8	(4)	(10)	-	-
6 months - 1 year	9	(4)	(9)	4	1
1 year - 3 years	2	(1)	(3)	-	1
3 years - 5 years	-	(-)	(-)	-	-
Over 5 years	9	(5)	(11)	2	4
Unknown	2	(1)	(3)	1	1
Total	185	100	100	26	22

	Wansbeck		Bamburgh	Dunstanburgh	Kielder	Warkworth
	N	%				
No admissions	52	(58)	3	6	8	12
Under 28 days	15	(17)	3	2	1	-
29 days - 3 months	14	(16)	1	1	2	1
3 months - 6 months	4	(3)	2	-	1	1
6 months - 1 year	1	(1)	1	1	-	1
1 year - 3 years	1	(1)	-	-	-	-
3 years - 5 years	-	(-)	-	-	-	-
Over 5 years	3	(3)	-	-	-	-
Unknown	-	(-)	-	-	-	-
Total	90	100	10	10	12	15

Note: This table records any sojourn in hospital all, *or part*, of which occurred during the four years immediately prior to the study. Data, again, was verified with local hospital records.

Schizophrenia was the most common diagnosis in units for younger clients. Its highest incidence was in the Hostels (where it affected half the residents).

The occurrence of neuroses was large only in the Day Centre where it afflicted almost one third of the clients. Apart from the prevalence of schizophrenia; the diagnostic patterns differed between the hostels. Nearly a quarter of the Harbottle clients suffered from psychotic depression-which had only a small incidence at Craster. The trend was reversed in respect of 'personality disorders' (affecting over one quarter of Craster users).

The pattern of diagnoses in EMI Home residents was different from that in other units. There were three major diagnostic categories (each affecting about one quarter to one third of residents). These were: brain disorder, confusional states and personality disorders. The first two categories are more

common in old age.[58] The occurrence of personality (or character) disorders was more frequent than that discovered in studies cited by Bergmann.[59] The highest incidence of "character disorders" noted in seven research studies undertaken amongst elderly residents in the community was 12.6 per cent (Bremer 1951).[60]

Some trends affected single homes: at Bamburgh nearly one quarter of the sample suffered from neuroses and one client was suffering from pre-senile dementia. The Warkworth and Kielder samples included two clients suffering from schizophrenia. Day Centre clients differed from residential ones, the latter were more likely to suffer from chronic organic or psychotic illnesses.

As many as 59 per cent of clients had not been hospitalised in four years preceding the study. Hostel clients were more likely to have been hospitalised than all other groups (except Bamburgh residents). A majority of those hospitalised were admitted only once and 5% were admitted more than three times. Units designed for younger clients had one sixth of their clients admitted two or three times. Craster clients had more admissions. None of the EMI Homes sample had been admitted more than thrice.

Day Centre clients were most likely to have been hospitalised for less than three months. The range of length of hospital stay for EMI Home residents was: from under 28 days to three years with the majority of those (one quarter) having been hospitalised for less than six months.

The range of lengths of stay of Craster clients was wider but, most commonly they had been hospitalised for under 28 days or between six months and a year. The range at Harbottle was as great but the modal length of say was over five years.

This suggests that a substantial minority of Harbottle users probably belonged to the 'old long-stay' psychiatric patient group and would be likely to have become institutionalised and to have been in need of resocialisation - as described by Wing.[61] Two per cent of the residential and day care sample appear to belong to the 'new long-stay' psychiatric hospital population classification (as defined by Wing and by Mann and Cree).[62][63] That is: they had been hospitalised for between one and five years. (Only one per cent of the total sample were in 'the old long-stay' category defined by Wing). All the latter were in the hostels and the Day Centre.

It was in these units that the diagnoses of schizophrenia and manic depression most frequently occurred (44 per cent of Mann and Cree's new long-stay group were schizophrenic, and 16 per cent suffered from manic depressive disorders). Mann and Cree also found that 14 per cent were suffering from pre-senile dementia.[64] In Hailey's study of the 'new chronic psychiatric population' (hospitalised up to eight years) she found that as many were suffering from senile dementia as were schizophrenic. None of this study's EMI Home sample belonged in Hailey's 'new long-stay' classification. The prevalence of schizophrenia and psychotic depression amongst discharged patients who had been in hospital more than two years, was confirmed by an older study[65] in which 68 per cent were 'schizophrenic' and the next most common diagnosis

(11 per cent)was 'depression'.

This hostel sample can be compared with that of other hostel studies: the median length of resident's previous hospitalisation found by Clark and Cooper[66] was four years and nine months (much longer than for the Newcastle clients). However, this must be seen in the context of the release, at the time of their study, of large numbers of long hospitalised patients due to the then recent advances in drug therapy.

In Clark and Cooper's hostel 53 per cent were schizophrenic - similar to the median for the hostels in this study. Fourteen per cent of their sample were suffering from 'depression' - a trend similar to that in Newcastle hostels.

A few of the Harbottle residents had been in hospital for 5 years or more (partly during the preceding 4 years), whereas 81 per cent of the Ryan and Hewett's recent 'long stay' sample had been in hospital for five years or more - not necessarily during the past four years. Of Ryan et al's 'transitional hostel' sample 36 per cent had spent five years or more in hospital compared with few at Craster. Nearly four fifths of Ryan and Hewett's[67] total sample were "schizophrenic" a far higher proportion than the hostels' average in this study.

Day Care users in the study by Cross et al.[68] showed a pattern of diagnoses different from that at Wansbeck-where a quarter of the clients were "schizophrenic" as were 36 per cent of of Cross's sample. A few Wansbeck clients, compared with 31 per cent of Cross's sample suffered from "affective disorders". Thirteen per cent of Cross's sample manifested

senile psychoses. The most striking difference was that only five per cent of her sample were diagnosed as 'neurotic' compared with one third of Wansbeck users. The profile of Wansbeck clients is of less serious illness than was discovered by Cross's study.

The National Study[69] found that three quarters of the users of Social Services Day Centres for the younger clients could be labelled 'chronic' (based on their length of psychiatric hospitalisation). In ninety per cent of these cases hospitalisation was for a year or longer. At the Wansbeck, only 30 per cent had been hospitalised during the previous four years. During the four year period only 4 per cent had been hospitalised for one year or more. The National Study[70] did not obtain objective assessments of client's diagnoses (unlike this study), but relied on the client's own account. About 17 per cent of their Social Services clients called their disorder 'depression' and another 17 per cent said that they suffered from 'schizophrenia' or 'manic depression'.

In this study departmental records showed that two fifths of the clients suffered from schizophrenia or psychotic depression but comparison is impaired by the different survey methods used.

The National Study's two social services units for 'the elderly confused' catered for clients having "chronic brain syndrome, senile dementia, arterio-sclerotic dementia or chronic brain failure"[71]. The Wansbeck had a more heterogeneous clientèle. One third of the National Study's sample had previously stayed in psychiatric wards for three months or more and half of these had spent at least two years there.

This study examines in detail only the recent hospitalisation history of clients; unlike these other studies. Nevertheless, it seems that there was less chronicity at Wansbeck than other studies discovered. Bearing in mind the infrequency of *recent* hospitalisation of Newcastle clients their other characteristics show a high prevalence of 'chronicity'.

Sub Section C. 4 - Profile of Social Services Received

This sub-section details help given to clients by the Social Services Department and other agencies. Table 34 illustrates the use of the Residential and Day Care services by clients up to the time of the study.

Table 34 - Length of Receipt of Unit Services (up to time of the study) - All Units

	All		Craster	Harbottle	Wansbeck
	N	%			
Under 28 days	4	(2)	1	-	3
29 days to 3 months	3	(2)	1	-	1
2 months to 6 months	6	(3)	1	1	2
6 months to 1 year	33	(18)	6	4	8
1 year to 3 year	55	(30)	7	8	30
3 years to 5 years	34	(18)	2	2	17
5 years and over	50	(27)	8	7	29
Total	185	100	26	22	90

	Bamburgh	Dunstanburgh	Kielder	Warkworth
Under 28 days	-	-	-	-
29 days to 3 months	1	-	-	-
3 months to 6 months	1	1	-	-
6 months to 1 year	8	4	2	1
1 year to 3 years	-	1	4	5
3 years to 5 years	-	4	5	4
5 years and over	-	-	1	5
Total	10	10	12	15

The next table states whether clients had received services continuously since admission:

Table 35 - Continuity of Take-up of Services - All Units

	All Res. & D.C.		Craster	Harbottle	Wansbeck
	N	%			
Continuous	159	(86)	22	15	80
Non-Continuous	26	(14)	4	7	10
Total	185	100	26	22	90

	Bamburgh	Dunstanburgh	Kielder	Warkworth
Continous	6	10	12	14
Non-Continous	4	-	-	1
Total	10	10	12	15

This table shows the number of attendances per week allocated to Wansbeck clients.

Table 36 - Wansbeck Day Centre - Number of Day-Attendances Per Week (at the time of the study)

Number of days per week	Number of Clients	% of Clients
1	7	(8)
2	36	(40)
3	9	(10)
4	6	(7)
5	32	(36)
Total	90	100

The next table details the field social worker's assessment of client's problems at the time of *original* referral to the Department. Categories in this table are taken from the

standard departmental referral forms.

Table 37 - Field Social Worker's original assessment of Problems - All Units (Categories *non-exclusive* except for 'unknown')

	All Res. & D.C.	%	Craster	Harbottle	Wansbeck
Unknown	20	(11)	1	-	12
Accommodation	30	(16)	8	10	7
Rent Arrears	3	(2)	-	1	1
Fuel Debts	3	(2)	-	3	-
Social Sec. Problems	2	(1)	-	-	1
Other financial problems	7	(4)	-	1	2
Legal Difficulties	2	(1)	1	-	1
Relationship Difficulties	93	(50)	14	10	48
Self-Care Difficulties	75	(41)	10	15	12
Difficulties in Caring for others	7	(4)	1	1	1
Mobility difficulties	6	(3)	1	1	2
Delinquency	1	(1)	-	1	-
Other Problems	17	(9)	7	-	10
Total	266	-	43	43	97

	Bamburgh	Dunstanburgh	Kielder	Warkworth
Unknown	3	-	2	2
Accommodation	1	2	-	2
Rent Arrears	-	-	-	-
Fuel Debts	-	-	-	-
Social Sec. Problems	1	1	-	-
Other Financial Problems	-	3	-	-
Legal Difficulties	3	-	-	-
Relationship Difficulties	7	6	6	6
Self-Care Difficulties	1	10	9	12
Difficulties in caring for others	1	-	3	-
Mobility Difficulties	1	-	1	-
Delinquency	-	-	-	-
Other Problems	-	-	-	-
Total	18	22	21	22

The next table indicates whether a field social worker was still working with the client at the time of the study.

As social workers were on strike at the material time, respondents were asked to ignore the effect of the dispute. This table, shows which clients *would still* have been in contact with a social worker had there been no industrial action.

Table 38 - Whether clients involved with a field social worker at time of the study - All Units

	All Res. & D.C.		Craster	Harbottle	Wansbeck
	N	%			
Still involved	79	(43)	14	17	41
Not still invol.	106	(57)	12	5	49
Total	185	100	26	22	90

	Bamburgh	Dunstanburgh	Kielder	Warkworth
Still involved	1	2	3	1
Not still involved	9	8	9	14
Total	10	10	12	15

The final table in this section examines receipt by clients of assistance from social, medical and other agencies (other than the Social Services Department). It records the position at the time of the study.

Table 39 - Clients involvement with other social/medical agencies (at the time of the study) - All Units

These categories are *non-exclusive*

	All Res. Day Care N	All Res. Day Care %	Craster	Harbottle	Wansbeck
Voluntary Agency (for financial assistance)	3	(2)	2	-	1
Voluntary Agency (for social casework)	1	(1)	1	-	-
Courts/Police/Probation	5	(3)	2	-	1
Department of Employment	9	(5)	1	1	7
General Practitioner (on-going treatment)	115	(62)	14	17	58
Psychiatric Out-Patient Clinic	1	(1)	-	-	-
Awaiting local authority housing	20	(11)	6	7	6
Community Psychiatric Nursing Service	5	(3)	1	-	4
Other Agency	11	(6)	-	1	-
Total	170		27	26	77

	Bamburgh	Dunstanburgh	Kielder	Warkworth
Voluntary Agency (for financial assistance)	-	-	-	-
Voluntary Agency (for social casework)	-	-	-	-
Courts/Police/Probation	1	-	-	1
Department of Employment	-	-	-	-
General Practitioner (on-going treatment)	8	-	12	-
Psychiatric Out-Patient Clinic	1	-	-	-
Awaiting Loc. Auth. Housing	1	-	-	-
Community Psychiatric Nur. Serv.	-	-	-	-
Other Agency	-	-	4	5
Total	11	-	16	6

Three quarters of sample clients had been receiving residential/ day care for more than one year, and a quarter had been receiving the services for five years or more. At the Wansbeck the proportion of clients who had received services for one year or more was 13 per cent above the total sample average. It was below the average at Bamburgh (newly opened) and Dunstanburgh, but, above average at Kielder and well above at Warkworth.

The Newcastle sample experienced long take-up and low turnover. The hostels and day unit foryounger clients saw rehabilitation into the community as one of their aims[72]; but, there is little evidence of success in this respect. Nevertheless, twelve of the Craster clients were already being supported in the community and Harbottle, where many clients awaited rehousing, was, to a greater extent, intended as a long-term home.[73] Many younger clients remained at the Day Centre because of scarcity of employment (10 per cent of men aged 16-64 and 12 per cent of non-married women aged 16-59 in Newcastle were registered unemployed in 1978).[74] However, low turnover would probably have promoted stability and emotional security for the clients.[75] Ryan and Wing's later study of hostel residents showed 67 per cent as having lived in hostels for less than one year. This compares with much lower proportions in the Newcastle hostels.[76] Ryan and Hewett's earlier study found that 29 per cent of hostel residents had lived there for under one year. In their 1973 study 19 per cent had lived in the hostel for five years or more but, in their 1976 study none had lived in hostels for so long. Almost one third of the hostel residents / supported

clients in this study were so long resident and the proportions for both hostels were almost identical - despite their differing remits.[77] The 1960 Clark and Cooper study found no client whose stay had exceeded 45 weeks. The median length of stay was 22 weeks.

The National Study[78] showed that more than half of their sample who attended psychiatric social services day centres had been clients for one year or more. One third of their sample, who had attended for one year or more, had attended for five years or longer. The majority of the Wansbeck sample (76) had attended for one year or more and almost two fifths of these had attended for five years or over.

Hassall's[79] study showed that 12 per cent of her day patient sample had received services for one year or over, but, by 1976 this proportion had risen to 46 per cent.

Newcastle's record of long dependence on day services (for younger clients) is poorer than that of similar Centres surveyed by the National Study. On average four fifths of the clients of all Newcastle units had used services continuously. Harbottle had the lowest rate of continuity, Bamburgh also had a low incidence. Continuity of take-up was common in the other three EMI Homes - yet Bamburgh had been open for just over a year at the time of the study. Some breaks in residence at Bamburgh were due to re-admissions to psychiatric wards, this will be demonstrated subsequently in the text.[80]

Almost three quarters of clients in the Wansbeck I unit were allocated five days care each week. This was in line

(81)

with the aim of that unit to rehabilitate; or to provide a substitute for work. Few of the older clients at Wansbeck II attended five days per week, the majority went for two days a week.

Most Wansbeck I clients arranged their own transport to the Centre (usually by bus). The capacity to travel by public transport was seen as a rehabilitation aim for some of them (Appendix 8). Staff stated that for those Wansbeck II clients who could not travel independently the number of attendances per week was governed by the availability of the Centre's transport. This situation is paralleled by Edwards , Sinclair (82) and Gorbach's study of day centres for the elderly which showed that those people who used centre transport to get to the unit attended less frequently. Only five of their study's 42 users who attended five days per week used centre transport, but 55 of their 69 users who attended only day per week were dependent upon being transported. Statistically they found the difference in average days attendance between users in "transport" and "no-transport" centres was very significant (F=84.5, d.f.= 1,140 PC 0.001).

In field social worker's assessments of the problems of clients in this study; the most frequently diagnosed difficulties were "relationship difficulties" (affecting 50 per cent of the total) and "self-care difficulties" (40 per cent). The incidence of "relationship difficulties" was high in all units with the exception of Bamburgh. "Self-care difficulties" occurred most frequently in the EMI Home clients - affecting about two thirds. The greatest occurrence was at Bamburgh. Self-care difficulties were half as prevalent

again at Harbottle as they were at Craster. This reinforces the picture of greater chronicity in the former's clients.

The only other specific problem classification which frequently appeared was 'accommodation problems' (17 per cent overall). These problems were most common amongst hostel residents (median incidence for both hostels was 38 per cent). The average incidence for the EMI Homes was 11 per cent (with awide variation between Homes). The occurrence of "accommodation problems" in Day Centre clients was only eight per cent. It can therefore, be concluded that in the case of the hostels "accommodation problems" were a significant factor in determing client's admissions.

Advocates of a 'social' model of mental illness (which is discussed fully in Chapter III) have long connected with psychiatric disorders impaired inter personal relationships. For example: Heron stated that:

> "Mental Health in the community, should allow for a social intercourse between members ...".(83)

He goes on to point out that in a "sick group" there will be distorted, unrealistic expectations with limited control and anxiety-ridden and stereotyped reactions. The social worker's initial assessment of "relationship problems" of mentally ill users of the residential and day care services in this study accords with such a model of mental illness. "Self-care difficulties" are also compatible with the model described by Clare:

> "at some point in time society becomes unable to tolerate the eccentric or odd behaviour of one of its members and the psychiatrist, acting on society's behalf, designated him 'ill'." (84)

Inability to care for self in adulthood (in the absence of substantial physical or mental handicap) constitutes the sort

of 'odd' behaviour intimated. Clients were selected for Newcastle's residential and day care units by social workers who probably used a 'social' model of mental illness.

The frequency of "relationship difficulties" in hostel clients was examined by Ryan and Hewett's 1973 study. Only five per cent of their sample currently had a 'serious relationship' with a member of the opposite sex and 71 per cent either had no friends at all or experienced short-lived relationships. The high incidence of 'personal relationship difficulties' in those who become instutionalised at home was graphically described by Huxley:

> "They are content to remain at home, and happy to keep themselves away from other people - perhaps because they find contact with others over stimulating or they are insufficiently socially skilled to cope with anxiety - provoking encounters with others in the community".(85)

The other characteristics of Huxley's group resembled the younger Newcastle clients sampled and it is reasonable to suppose that such a syndrome also affected many of the latter.

A small majority of study clients (55%) were no longer involved with a field social worker at the time of the study. Most hostel clients (more than three quarters at Harbottle) were still in receipt of field social work assistance. Conversely only 16 per cent of EMI Home clients continued to have social workers. This trend did not seem to be related to newness of home.

Ryan and Hewett's 1973 hostel study[86] examines this question. In their study 47 per cent of clients were no longer in contact with a field social worker. Newcastle's hostel average of about two thirds still receiving help compares favourably .

Huxley expands on lack of involvement of social workers:

> "Figures from the pre-mental health service days of 1968 to more recent times, show that the proportion of mental health cases terminated within four weeks of referral to community social workers in Salford has doubled. It also shows that the rate of clients retained under social work community care for at least one year has not increased as one might expect given the increase in the new chronic population". (8.7)

As far as client involvement with other agencies was concerned the only significant involvement was with the general practitioner (62 per cent of all study clients). This was typical of almost all units (Warkworth and Dunstanburgh excepted). The reason for this is inexplicable. Continuing contact with the general practitioner probably gave reassurance (as well as treatment) to clients. Surprisingly Dunstanburgh clients were not involved with any outside agencies.

Over a quarter of hostel clients were awaiting rehousing. This need was keenly felt amongst the Harbottle clients - over three quarters of whom were apparently awaiting group home rehousing. The lack of availability of social work support at the time of the study was preventing such re-settlement (not the availability of Council lettings).

The writer had expected to find greater involvement with the Community Psychiatric Nursing Service than the study discovered. Only four per cent of Day Centre clients, and one other , were involved with this Service. Only four per cent of hostel residents and eight per cent of Wansbeck clients (about 40 of whom were not 'retired') were being assisted by the Department of Employment. Surprisingly

involvement with Courts, Police and the Probation Service was more common amongst EMI Home clients than amongst those in other units; but numbers involved (five) were very small.

Section C5- Summary

The overall profile of the clients which emerged showed them to be mainly middle aged in the units for 'younger' clients and, by definition, elderly in the units for that generation. Females outnumbered males in units for the elderly but the position was reversed in units for younger clients. The majority of clients were not married. A large majority of clients were from the unskilled working class and derived their incomes entirely from state benefits. The more chronic psychiatric illnesses predominated in residential units and neuroses were found frequently only at the Wansbeck. Less than half the clients had been in a psychiatric ward during the four years preceding the study. Most clients had used the units continuously since admission. Many, especially amongst elderly clients, were no longer in contact with a field social worker. The only other 'external' service still received by numerous clients was from the General Practitioner. When originally referred for social services the most common client problems identified were 'relationship' and 'self-care' difficulties followed by 'accommodation problems'. The clients were an ageing, socially depressed and isolated group, suffering from relatively serious mental illnesses. They exhibited the traits of the "new chronic" group of psychiatric patients described in many studies. That many lacked a recent history of psychiatric hospitalisation does not negate this assessment. It also

emerged that the only common reasons for admission to units were those related to social malfunctioning and social deprivation.

Section D - Chapter Summary

Staff/client ratios and staff characteristics appear to have been relatively like those found in similar units studied elsewhere. The age range was wide, women predominated and there was a lack of relevant experience and qualifications. In the management tier there were more males, younger staff and better trained or educated personnel - especially qualified nurses.

The clients generally exhibited signs of 'chronicity' in terms of age, diagnosis and social circumstances, although surprisingly few had been recently hospitalised. Most had been admitted to care for 'social' rather than 'medical' reasons. The significance of this is put into context in Section A of Chapter III.

CHAPTER II FOOTNOTES

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13. Ibid p.85
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17. See p 68
18. See p 68
19. Ryan and Wing J.K. "Patterns of Residential Care" p.p. 87-88
20. For example: See Chaplin S."Durham Mining Villages" (1978) in "Mining and Social Change" ed. Bulmer M. Pub. Croom Helm p.p. 70-72
21. See p 69
22. Carter, J. "Day Services for Adults" p. 87
23. Ibid p.p. 78 and 87
24. Ibid p.p. 87-88

25. Glossary of Staff Qualifications

'A' Level Sociology - General Certificate of Education - pass in Sociology at Advanced Level.

Art/Art Therapy Degree/Diploma

B.A. Bachelor of Arts Degree

B.Sc.. Bachelor of Science Degree

C.Q.S.W.-Certificate of Qualification in Social Work - Recognised by the Central Council for Education and Training in Social Work (C.C.E.T.S.W.)

Craft Apprenticeship - Recognised qualification for the craft in question (e.g. upholstery).
C.S.S.-Certificate of Social Services recognised by C.C.E.T.S.W.

D.T.M.H.A.-Diploma for Teachers of Mentally Handicapped Adults - recognised by C.C.E.T.S.W.

I.C.S.C.-In-Service Certificate in Social Care, A preliminary qualification recognised by C.C.E.T.S.W.

N.N.E.B. Recognised as a qualification for nursery nursing by the Nursery Nurse Examination Board.

Occupational Therapy Diploma - Recognised qualification for Occupational Therapists.

P.C.S.C. Preliminary Certificate in Social Care - A preliminary qualification recognised by C.C.E.T.S.W.

R.M.N. - Registered Mental Nursing Certificate recognised by the General Nursing Council.

S.E.N. State Enrolled Nursing Certificate recognised by the General Nursing Council

S.R.N. State Registered Nursing Certificate recognised by the General Nursing Council.

Teaching Certificate - A qualification in teaching recognised by the Department of Education and Science.

26. Ryan P. and Wing J.K. "Patterns of Residential Care" p.88

27. Ryan, P. and Wing J.K."Patterns of Residential Care" p.106

28. Bamburgh House had been open for just under one year at the time of the study.

29. See Appendix 4

30. Edwards C. and Carter J. "Day Services for the Mentally Ill" in "Community Care for the Mentally Disabled" ed. Olsen & Wing (1979) Pub. Oxford Medical Publications p.44

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32. Census Report 1971 Pub. H.M.S.O. Classification relates to last known occupation of client (or husband in the case of married women who were not employed).

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39. See Appendices 2,3 and 4

40. See p.35

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50. Ryan P. and Hewett S. "A Pilot Study of Hostels for the Mentally Ill" 1976 Social Work today No. 25 p.777

51. See Appendix 2

52. See Appendix 2A.

53. Ryan P. & Hewett S. "A Pilot Study of Hostels for the Mentally Ill" p.777

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59. Bergmann, Klaus "Psycho-geriatrics" in "An Ageing Population" (1978) ed. Carver/Liddiard p.p. 273-5

60. Ibid p.279

61. Wing J.K. "Trends in the care of the Chronically Mentally Disabled" p.5

62. Ibid

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67. Ryan P. and Hewett S. "A Pilot Study of Hostels for the Mentally Ill" pp. 776-8

68. Cross K. Hassall C and Gath D. "Psychiatric Day Care - The New Chronic Population" 1972 Brit. Journal of Preventive Social Medicine p.203

69. Carter J. "Day Services for Adults" p.79 and Edwards & Carter "Day Services for the Mentally Ill" p.41

70. Edwards & Carter Loc. Cit. p.p. 40-41

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72. See Appendices 2,2A and 4

73. See Appendix 2A

74. Source: "City Profiles" 1979 p.19

75. Ryan P and Wing J.K. "Patterns of Residential Care" p.106

76. Ryan P. & Hewett, S. "A Pilot Study of Hostels for the Mentally Ill" p777

77. Clark D and Cooper L. "Psychiatric Half-Way Hostel - A Cambridge Experiment" p. 588

78. Carter J. & Edwards C. "Day Services for the Mentally Ill" p. 42

79. Hassall C. "Psychiatric Day Hospital Care" p.118

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81. See Appendix 4

82. Edwards C. Sinclair I and Gorbach P. "Day Centres for the Elderly" (1980) Brit. Journal of Social Work Vol. 10 p.p. 423-5

83. Clare A "Psychiatry in Dissent" (1980) Pub. Tavistock p.60

84. Ryan P. and Hewett S. "A Pilot Study of Hostels for the Mentally Ill" p.777

85. Huxley P. "The Return of the Single Lunatic" p.13

86. Ryan P. and Hewett S. "A Pilot Study of Hostels for the Mentally Ill" p.777

87. Huxley P. "The Return of the Single Lunatic" p.13

Chapter Three

THE IDENTIFICATION AND COMMUNICATION OF SERVICE AIMS

Section A: Discussion of Concepts of Mental Illness and Treatment Methods

The greater part of this chapter investigates the nature, origin and communication of service aims in Newcastle. However, a pre-requisite for this process is to determine the conceptual framework upon which this investigation is built. Indeed, Chapters I and II have examined the development of the services and the characteristics of their staff and recipients without questioning their underlying rationale - except in so far as this was articulated in public policy statements and other studies of existing services. These chapters have contained references to the 'clinical/medical' and to the 'social' models of mental illness which must now be defined more closely.

Wing[1] postulates that there is a logical hierarchy of levels of social care research related to disability. He contends that there are three discrete levels. The second and third levels of research depend upon knowledge acquired at the ealier level or levels. These levels are:

(i) "Research into the nature and causes of disablement;

(ii) Research into methods of preventing, reducing or containing disablement, i.e. into methods of care or prevention ('containment': maintenance at a minimum level)

(iii) Research into the services necessary to ensure that methods of care are properly deployed".[2]

This study is principally conducted at Wing's third level of research. There is, therefore, a necessity to discuss the findings of other research which has been conducted at Wing's first and second levels and which have provided the foundations upon which this study is built.

Sub-Section A1 The Nature and Causes of Mental Illness

This subject is extremely contentious. Kennedy has argued that the concept of mental illness rests upon a "shaky intellectual basis".(3) His rationale is that:

> "... intellectually and conceptually there are no ready limits, no rationally defensible borders, to the notion of mental illness".(4)

However, he does accept that:

> "... there is some validity in the notion of mental illness. It offers us the opportunity to ascribe the status ill to someone whose thoughts or feelings, mood or behaviour we judge to be abnormal".(5)

In conclusion Kennedy decides that there are three viable classes of mental illness:

(1) Those whose thoughts *and* behaviour pose a danger to the community.

(2) Those who freely request help because they are very unhappy *and* are prepared to designate themselves as being mentally ill.

(3) Those who are so helpless (in the absence of physical disability) that they are unable to perform the basic tasks of life such as "procuring food, or practising hygiene, or finding lodging". (6)

Having accepted that mental illness exists; despite the fact that its perimeters are indefinite and that "psychiatry is in a fairly primitive stage in its development"[7], it becomes necessary to consider causal factors.

With the exception of certain mental impairments, such as organic brain disorders and senile dementia, there are no mental illnesses (viz: recognised patterns of psychiatric symptoms) of which the causes have been scientifically proven beyond all reasonable doubt.[8]

What we are left with, therefore, is four main conceptual models of mental illness as described by Clare.[9] These models ascribe causes and thence develop indications for treatment. The first such model is the organic orientation:

> "There are those who insist that all genuine psychiatric disorders rest upon a physical basis and they pin their hopes for ultimate clarification of the present confused situation on discoveries in the fields of neurochemistry, neurophysiology, and psycho-pharmacology".[10]

According to Clare those who adhere to the organic tendency are having their beliefs reinforced:

> "The biologically inclined psychiatrist takes some satisfaction in the fact that the list of conditions in which psychological disturbances appear to be symptomatic of underlying physical pathology continues to expand".[11]

The second major model of mental illness is the psychotherapeutic orientation:

> "According to this model, adult neuroses and vulnerabilities to stress are the consequence of early childhood deprivation, developmental fixations at certain crucial stages of maturation, distortions in early relationships and confused communications between parent and child".[12]

Clare continues:

> "The psychotherapeutic approach rejects many of the central features of the organic model, formulating a diagnosis is not regarded highly and a continuum of emotional disturbance, ranging from mild neurosis to severe psychosis, is preferred to a typological system made up of discrete disease states". (13)

Such a continuum is described in terms of its social consequences by Heimler as measured by his 'social function scale'. His results showed that people who scored a third or less were "not part of ordinary society" (e.g. in prison or psychiatric hospital). People who scored a half or less were "the concern of social workers in the community". Those who scored more than half "function adequately in society". (14) The yardstick for diagnosis is therefore, social performance rather than physical or psychological symptoms.

Szasz (15) *does* not deny the presence of organically caused conditions in some people commonly diagnosed as 'mentally ill', he simply believes that such patients should be deemed 'physically ill' instead.

The third significant model of mental illness is the socio-therapeutic approach. Of the four main models this is the only one which perceives the causes of disability to be primarily external to the individual and to his close inter-personal relationships. This orientation:

> "... causally relates the presence of mental illness to the general malfunctioning of society. ... illnesses are seen as evolving processes, reactions to these environmental factors, such as poverty, overcrowding, stress, pollution, competitiveness, acquisitiveness, which so significantly determine the individual's personal success or failure and the degree to which he approximates to society's ideal of the 'mentally healthy' individual". (16)

This approach tends to:

> "Pay more attention to the way in which society responds to the behaviour of the deviant than to the quality of the deviance itself". (17)

The fourth important model of mental illness is a new and hybrid 'organic/behavioural model' postulated by Eysenck et al.(18) This orientation concedes the validity of the organic model for the aetiology (and treatment) of biologically caused and major psychotic disorders but advocates a behavioural interpretation of neurotic illnesses. The theory is that in the latter category inappropriate behaviours have been developed in the patient because they have been reinforced by some form of reward, or lack of punishment, for the subject. It is thus social relationships and not physiological factors which are seen to have precipitated neuroses whereas, whether the cause has yet been scientifically proven or not, other mental disorders are deemed to have probable biological causes.

In this study concept of a 'clinical/medical model' of mental illness is used to approximate, in terms of causation, to the "organic" model as described above. It must also be borne in mind that many clients of the Newcastle units, especially the elderly, were also suffering from physical illnesses and handicaps which were, in no sense, 'psychiatric' and that this also had implications for the totality of their treatment needs.

Sub-Section A2 Methods of Preventing, Reducing or Containing Mental Illness

Each of the models of mental illness discussed in Section A.1 also carries with it carollary of certain indications for treatment methods. However, it would be wrong to assume

that professionals who adhere primarily to one model will necessarily use only the treatment methods commonly associated with that orientation. For example: a psychotherapeutically inclined psychiatrist might prescribe a tranquillising drug to tide a neurotic patient over an acute situational crisis, recognising that only the symptoms, but not the underlying problem, would be effectively treated.

Such pragmatism of approach aside; the treatment methods indicated by each aetiological model are distinct.

The organic orientation is associated with physical methods of treatment, chemotherapy, brain surgery (leucotomy and lobotomy) and other physical intervention-notably electro-convulsive therapy (E.C.T). The biochemical processes induced by most forms of drug therapy are understood and scientifically verifiable. The process of psychiatric brain surgery is at last partly understood - although the known side effects render it morally questionable and its practice in the United Kingdom decreasingly frequent.[19] E.C.T. however, has been clinically demonstrated to be effective in the alleviation of 'manic depressive psychosis' and sometimes of 'schizophrenia'. But it is known to have undesirable side effects, especially memory loss. Furthermore, it has never been discovered as to exactly how and why this treatment method works.[20] The therapeutic orientation can be described as follows:-

> "Therapy consists in clarifying the meaning of events, feelings, impulses and behaviour in the context of past and often forgotten or repressed events and experiences. A crucial aspect of this model is the doctor-patient relationship, the therapeutic alliance, which enables the patient to work through the disturbance and abandon familiar but destructive methods of coping with reality".[21]

Szasz[22] has maintained that psychotherapy consists in a human relationship characterized by given aims and rules and by an insight giving process. He believes that its medical value is negligible. Indeed, psychotherapists undergo a specialist form of training and many are not medically qualified although they are usually trained in other professions such as psychology or social work. The efficacy of psychotherapy has never been medically verified.

The sociotherapeutic orientation carries indications for treatment methods which re-order the patient's relationships with individuals and with society beyond his closest personal relationships. As Heron says:

> "... the sufferer lives in a social milieu which, in varying degrees, reinforces or ameliorates his illness. Mental health, in any community, should allow for a satisfactory social intercourse between members".[23]

In concrete terms the methods of treatment deployed range from group therapy to social casework directed at improving the client's wider social relationships, both with individuals and with groups and public agencies such as the Department of Employment or the Local Health Centre. The worker may seek to accomplish these changes through the 'client system' - that is the client:

> "... being helped by the worker. Based on a contract, or working agreement which clarifies the goals of the change effort and the methods to be used in the change activity".[24]

However, the sociotherapeutic orientation also emphasises direct action in the target system by the worker i.e. with individuals and agencies whose changed behaviour is deemed a necessary ingredient of the client's improved mental

health:

> "The Target System - the people the change agent (worker) needs to change or influence in order to accomplish goals directy or indirectly".

This classification of systems is taken from the unitary approach to social work. The overall efficacy of sociotherapeutic intervention is also not conclusively proven in medical terms.

Behavouristic theoryhas been developed from the outset in association with experimental verification of treatment methods. Originally it derived from the work of Pavlov and Skinner and uses reward or punishment for selected behaviours (generally) through the process of operant conditioning.

Behaviour therapy, which can be given by suitably trained psychologists and social workers as well as by psychiatrists, focuses narrowly on behaviour and its consequences. The treatment is directed purely and simply at symptom removal and not at the underlying causes of the disability and uses the client's conscious rather than their unconscious processes (which psychotherapy attempts to do).[26]

Social Services workers do not engage in organic treatment, and are not legally empowered to do so, except in so far as they may intervene to persuade, or remind, a client to take prescribed medication or attend psychiatric hospital (occasionally by the use of compulsion).

Direct intervention by social services workers usually involves a psychotherapeutic, sociotherapeutic, or behaviouristic orientation, or frequently a combination of two or more of these methods. The unitary approach to social work is conducive to a hybrid practice[27] and such an eclectic[28] method is also advocated by Heimler.

It is such a non-organic orientation which is described by the writer when she refers elsewhere in the text to the "social" model of mental illness and to its "social treatment". This also carries the implication of treatment outside hospital by social workers (of some kind) who are trained or *at least* supervised in accordance with social work theory and practice skills.

Throughout the study the terms 'clinical/medical' model are used to denote treatment in hospital or a clinical setting administered by medically qualified workers(psychiatrists, mental nurses, clinical psychologists etc.) Whilst treatment in these settings is most likely to be in accordance with the organic model there is also some use of the other three models of intervention in these settings.

The medical/social distinction is therefore, somewhat blurred at the perimeters. However, it is an important one in the study of a service, the aims of which, at policy making and senior management levels are constructed primarily on a 'social' model (as is demonstrated in Chapter I and in the remainder of Chapter III).

However, it is also significant that many of the managers of the units studied and appreciable numbers of their staff were trained and/or experienced in hospital-based nursing (as is described in Chapter II). The potential for conflict of orientations and treatment methods inherent in this situation is an interesting dimension in this study.

A major objective of the exercise is, therefore, to examine in the light of the orientation discussed above, the nature, quality and effect of treatment offered to the clients of Newcastle's 'mentally ill' residential and day-care clients in 1978-79. Thus, it is now logical to proceed at Wing's third level of social care research.[29]

Section B.

The remaining purposes of this chapter are twofold. The first is to identify the aims set for the Newcastle Residential and Day-Care Services for the mentally ill at the time of the study. This has an intrinsic value, but, is also an essential pre-requisite for ascertaining the effectiveness of the service in terms of aim attainment.

The aims of the Professional Adviser and of the Managers for each unit, as a whole, were investigated. The aims of each unit for individual clients were then identified by unit staff and by clients themselves. Collectively these provide a profile of aims acknowledged by unit staff and clients. It was anticipated that the aims of social services units would reflect social needs rather than those of a clinical nature.(30) This chapter discusses the aims adopted and compares them with aims identified in similar studies. Chapter IV examines how effectively these aims were achieved.

The other purpose of the chapter is to ascertain using a 'Management by Objectives' model, how and to what extent service aims were communicated, interpreted and understood along the line of communication from Government via Newcastle Social Services Committee to the Professional Adviser, Unit managers staff and clients.

The key role which should be played by middle management in the communication of a framework of aims, thereby securing the implementation of policy, was described by Billis:

> "For effectiveness at departmental level . . . requires an awareness and ability to construct appropriate settings within which heads and senior staff of establishments can contribute to middle-range policy making in a constructive atmosphere. It is they who stand between client impact and departmental policy". (31)

The process of aim communication and its effectiveness will also be examined.

Section B.1 - Conceptual Framework and Methodology for Aim Identification

The study is based upon the premise that organisations seek to identify their aims and objectives. The theory of 'Management by Objectives' was first developed in 1957 by Drucker in the context of industrial management. He described the concept of objective:

> "Objectives must be derived from 'what our business is, what it will be and what it should be'. They are the action commitments through which the mission of a business is to be carried out, and the standards against which performance is to be measured". (32)

In recent years some authorities have applied this concept to public service agencies. For example: Gunn pointed out that policy analysis focuses upon (inter alia)

> "defining objectives and performance indicators (what are we trying to do and how will we know when we have done it?)". (33)

'Management by Objectives' involves setting objectives for the organisation. In the case of local authorities

this is for a hiearchy of organisations through which a governmentally initiated service is delivered to its intended recipients. By setting these objectives the management of organisations can identify the end result which they aspire to achieve, and thence measure the degree of attainment of their aims.

This study identifies the development and interpretation of objectives as it occurred during the communication process. In a single organisation the process of 'Management by Objectives' according to Brown follows a clear progression:

> "(a) Top management formulates a strategic plan by defining the corporate aims and objectives in the short, medium and long terms in key areas of its operations.
>
> (b) A course of action and the resources to meet these objectives are incorporated in a tactical plan.
>
> (c) Unit objectives, the roles of individual managers and the desired outputs are agreed.
>
> (d) Improvement possibilities are identified and incorporated in individual and corporate improvement plans.
>
> (e) (After allowing time for action) systematic reviews are carried out to assess performance results.
>
> (f) Objectives and output expectations are updated". (35)

The corporate aims and objectives of local authority Social Services Department are affected by Government policy documents for example, Statutes, White Papers, Memoranda and Guide Lines. To some degree, the method and extent of implementation of policy proposals is the prerogative of individual local authorities.

Once the local authority has defined its aims, subject to legislative and other governmental constraints, the process, in theory, continues as set out by Brown.

Sub-Section B.2 - The Methodology of Opinion Survey

During the 1970's research into social services increasingly used the methodology of opinion survey. One of the most well-known of such studies was by Mayer and Timms.[35] They contended that :

> "clients appraisals will, or at least should, be an important determinant of the kinds of services offered and their disposition".[36]

In the process of discussing the appropriate methodology for studies evaluating care services Abrams advocated cost benefit studies which assess benefits by taking:

> "into account, and assigning a meaningful value to, the subjects own view of what benefits them as well as those of various caring agents. Such studies would be especially useful in the field of mental illness where it is clear that client's views of the objects of care can differ drastically from those of therapists, and where the tendency of policy has been to accept the therapists's account of need very easily".[37]

Abram's precept summarises one rationale underlying this study. This research method was utilized in the National Day Care Study where the researcher asserted that:

> "the value of taking a user's view must relate to the recent growth of the consumer movement which has altered in the recent past - the structure of relationships between staff and users. If the user is viewed as 'consumer' ahead of 'patient' or 'client' this gives his view a legitimacy quite different to the position of a recipient of a service defined as a 'patient' or 'client'".[38]

This approach is also similar to that adopted by the present study. However, opinion survey methods of social care research have been criticised.[39] Platt stressed that the decision to use

this method is based on value judgements of the researcher which must be openly acknowledged so that the reader is aware of the probable effect of survey data on analysis and upon consequent policy recommendations. The writer has been mindful of this warning.

Platt issued caveats concerning the value to be assigned to client opinions. She stressed that their opinions have no greater value than being a comment on the current state of affairs which is within the client's own recent experience and frame of reference. Respondents views should not be treated as though they were informed judgements about possible future states. They cannot constitute a prescription for future policies although they offer some evaluation of present states.

This study has avoided pitfalls such as that succumbed to by Butrym,[40] who asked clients what sort of training they considered that social workers should receive (a question outside the frame of reference of respondents and relating to a future state). The writer does not infer that client, or staff, opinion on the present state of services implies policy prescription for the future.

This danger is illustrated by the National Day Care Study[41] in which 'predominantly satisfied' clients and staff, nevertheless, instanced numerous improvements in services which they would like to see effected. Satisfaction with the status quo can not be equated with a desire for its continuation unaltered.

Platt[42] stressed the need to obtain the opinions of 'significant others' involved in the situation, in order to give another perspective of the service; and also to provide information about clients concerning areas where they lack credibility. The writer has sought such information from unit staff and has also obtained their opinion about each client included in the opinion survey and about the unit's aims for them.

Shaw made the point that, in consumer opinion survey related to social policy research, there should be virtually no users whose viewpoints are not sampled.

> "Other things being equal, if there are such groups (of users) an equally good case can be made for acting on their opinions."[43]

By this study, in his comparative survey of two day centres for the elderly, Kaim-Caudle[44] was also careful to interview all users who attended regularly and this study, all those deemed capable of holding relevant opinions were interviewed unless they were hospitalised or long absent.[45]

Shaw's second pre-condition for the use of opinion in social policy research was that: 'consumer opinions should be relatively

permanent".[46] Opinions may change with time, external factors and client circumstances. The writer would have undertaken a follow-up study if time had permitted.

Shaw and Platt[47] suggest that consumer attitudes and behaviour may not be objectively chosen. They may be subconsciously based - or derive from a frame of reference different from that understood by the interviewer, for instance from a difference of social class or professional perspective as was highlighted by Cohen's study.[48]

The writer verifed client (and staff) comprehension by asking an open-ended question *followed* by fixed (leading) questions on aims covering the subjects.[49] Not surprisingly staff gave more frequent and prolific answers to the open-ended question than did clients, but, in respect of fixed questions the trend was reversed.[50] This questionnaire format was also used by Goldberg[51] and by Raphael and Peers.[52]

Instead of using opinion survey the writer could,[53] like Apte, have used methods such as detailed observation and analysis of client and staff behaviour. But as Sheldon observed:

> "There is little point in knowing whether Fred spends more time in conversation with people than previously if we fail to look equally carefully at how he *feels* about the change".[54]

Having discussed the methodology used overall-it is necessary to describe the specific method used to collect data analysed in this chapter.

Sub-Section B.3 - Method of Data Collection

The question arises as to the probability of honest and accurate answers having been given to this opinion survey by staff and users. Staff could have had a vested interest in presenting their achievements in a favourable way. There is also the opposite possibility that staff under-valued their service for fear of being accused of complacency. Staff were given assurances of anonymity for themselves and (outside the Department) for their unit, but the fact that the writer is a senior officer of the department (although *without* management responsibility for these services) possibly influenced respondents. However, staff expressed great interest in the collated study data which suggests that they responded in good faith; believing the collected responses to be credible.

It is possible, but unsubstantiated, that clients told the writer what they thought she would wish to hear. It is feasible that if clients could have been interviewed more than once their inhibitions, if any, might have been overcome.

The writer explained her position in the organisation to clients and that the survey was being conducted for the University of Durham. Furthermore, clients and staff were given assurances of absolute personal confidentiality. All this was stated before questioning commenced.

The purpose of asking open-ended and *then* direct (fixed) questions on aims was to identify suggestibility. It also enabled clients who had difficulty in conceptualisation to formulate more complex ideas about aims. The questions were composed by the writer after consultation with the Professional Adviser and with reference to relevant sections of "Better Services for the Mentally Ill" (see Appendices 5,6 and 7)

The following table shows trends in frequency of responses to the questionnaire:

This table charts the relative frequency of client and staff identification of (all) goals in the 'open-ended' aims section. All responses are quantified.

Table 40 Total frequency of 'open-ended aims identified (Numbers)

UNITS(S) N = Number of study clients in each group	Total [1] Numbers Client Aims	Average [2] Number of aims per client	Total [3] Numbers Staff Aims	Average [4] Number of aims per staff per client	Concurrence [5] as % of client aims	Concurrence [6] as % of staff aims
Craster Lodge N = 26	52	2.0	75	2.9	23	16
Harbottle Lodge N = 22	57	2.6	69	3.1	19	16
Both Hostels N = 48	109	2.3	144	3.0	23	16
Bamburgh House N = 10	13	1.3	23	2.3	13	9
Dunstanburgh House N = 10	15	1.5	29	2.9	24	14
Kielder House N = 12	16	1.3	35	2.9	19	9
Warkworth House N = 15	28	1.9	43	2.9	25	16
All EMI Homes N = 47	72	1.5	130	2.8	21	12
Wansbeck I Day Centre N = 40	105	2.6	169	4.2	31	19
Wansbeck 2 Day Centre N = 50	71	1.4	119	2.4	29	18
All Wansbeck Day Centres N = 90	176	2.0	288	3.2	30	18
All Units in Study N = 185	357	1.9	562	3.0	25	16

Explanation notes to table

1. Column 1 shows the total number of open-ended aims identified by all clients studied in each Unit.
2. Column 2 shows the average number of open-ended aims identified by each client in each Unit.
3. Column 3 shows the total number of open-ended aims identified by staff on behalf of study clients in their Unit.
4. Column 4 shows the average number of aims for each client in 'their' Unit indicated by staff.
5. Column 5 shows the percentage of client-identified open-ended aim categories which staff also indicated for the same clients.
6. Column 6 shows the percentage of staff-identified open-ended aim categories which were acknowledged as relevant by clients in respect of themselves - in each Unit.

In response to the open-ended questions staff proved more likely to identify aims than did clients-approximately in the ratio of 3:2 (staff/clients). This may have been due to greater self-confidence or ability to conceptualise. Elderly clients in all types of unit identified an average of 1.5 aims each compared with 2.4 perceived by younger ones. At Wansbeck I, staff indicated a high median number of aims per client (4.2) In the other units (Bamburgh House and Wansbeck II excepted) the approximate average number of 'staff aims' per client was three compared with the average number of clients' own aims (two).

In the units for younger users, clients were about four times as likely, as were staff, to identify aims in response to the fixed questions. With elderly clients, there was a slightly lower frequency of acknowledgement.

Harbottle clients responded most often(average 2.6 and 17.7 aims per head). Trends as between types of unit and client (age) groups were relatively consistent in response to the two different formats of 'aims' questions. Many clients in the study were suggestible and/or unable to conceptualise without prompting through fixed aim questions. It was only in respect of questions on alcohol and drug abuse that suggestion was consistently resisted by clients. Gordon et al[55], who conducted an opinion survey amongst psychiatric patients, also found that only a small proportion of their sample reported themselves as having problems related to the abuse of alcohol or drugs.

Staff, also were readier to give affirmative answers to fixed questions than they were to open-ended ones. However, the margin of difference was not very great, an overall ratio 3:2 ('fixed' responses/'open-ended"responses). An exceptionally high frequency of staff responses to fixed questions occurred at Kielder House.

Section C - Aims Identified by Management

This section examines and analyses the aims for the units identified by the Professional Adviser and by unit managers. She was accountable to a Principal Assistant who reported to the Assistant Director (Residential and Day Care). He reported in turn (via the Deputy Director) to the Director. The Director was responsible to the Committee for the implementation of policy. In practice, this chain of communication was often short-circuited.

The Managers of units were directly responsible to the Professional Adviser. Her responsibility was to ensure the implementation and professional interpretation of the Committee's policy within the units. Both the Adviser and Managers of the units were asked, without any prompting as to content, to list their aims for each unit. These aims are set out in Appendices 2,3 and 4.

Sub-Section C. I. Hostels

In their statements of aims for *Harbottle*, both Superintendent and Adviser emphasised:

(a) offering clients support to improve their self-valuation.

(b) improvement of client capacity for self-care- in both domestic and personal spheres.

(c) the intention to enhance client ability to take personal initiative, and to overcome, or prevent, institutionalised behaviour, or tendencies to become emotionally dependent (Adviser only).

(d) the improvement of client performance in making and retaining personal relationships and in socialising (including mixing outside the hostel group)- Superintendent only.

The Adviser, alone, cited 'improving communication between other agencies in the interests of the client'.

The Superintendent solely identified the need for residents to make constructive use of their day. This links with the precepts of 'T.G.M.H.'.[56] This aim *was* being realised; to the extent that all those residents who were not working at the time of the study attended the Day Centre. Day-time occupation was more common than that found by Ryan and Hewett, almost half of whose hostel resident sample neither attended day centre nor worked.[57]

The Superintendent, alone, mentioned persuading clients of 'the importance of non-abuse of prescribed medication'. This suggests clinical orientation and the assumption of a function often undertaken by the Community Psychiatric Nursing Service.[58] At the time of the study the opening of the rehabilitation wing was imminent and four Harbottle residents were about to be rehoused in a group home. Both

Adviser and Superintendent stressed the need for 'rehabilitation' Despite this the aim of Harbottle, for the majority of residents, was to provide a long-term home. Harbottle fell predominantly into the 'long stay' hostel category as described by Ryan.[59] Their description of one voluntary association hostel of which the Warden said: "we're all growing old together, in ten years time this will be an old people's home", was largely true of Harbottle in 1979 (see Chapter II p. 68). In other respects, such as psychiatric diagnosis, isolation and previous long-term hospitalisation history,[60] there were similarities between Harbottle residents and Ryan and Hewett's 'long stay' hostel group.[61]

Some aims of *Craster* were shared by Superintendent and Adviser. These related to the improvement of client capacity for personal relationships, increasing self-valuation, improving personal functioning and, to a greater extent, to enhancing the client's capacity for domestic self-care.

However, the remainder of Craster's aims indicate that whilst Harbottle was primarily a long-stay hostel, (but was a transitional hostel for a few residents) the converse was true of Craster. The main emphases at Craster were on preparation for re-settlement in the community and on supporting and maintaining that re-settlement once effected.

In line with this was the aim of diagnosis and treatment of client problems through insight-giving groups.

The Superintendent added: the need to improve client quality of life and to: "encourage creative interests and constructive

skills".

In respect of its aims, Craster was more akin to the 'short stay hostels' whose objectives were described by Ryan's study.[62] A difference was that the unemployment level in Newcastle in 1979 did not make job acquistion and retention a universally feasible aim.

As for Ryan's group home sample, one aim of Craster was to maximise the independence of residents.[63]

In summary the management aims for the hostels showed them to fall into four out of five of Whitehouses' hostel categories viz: assessment, supportive, therapeutic and resettlement. However, neither aimed to fulfil her fifth category of providing direct access for clients. Broadly, Harbottle was primarily a hostel with internal supportive aims and Craster predominantly one with resettlement goals. Whitehouse suggests that hostels aims invariably indicate a role in one of her categories only, but this study shows the functions to have been less specialised in Newcastle.[64]

Sub-Section C.2 - EMI Homes

For Warkworth both Adviser and Superintendent stressed enhancing the quality of life of residents - the former added that it should be in-line with their previous lifestyle.

Both identified the prevention of deterioration and preservation and maintenance of skills. This is a negative approach, in view of the potential for clinical improvement of clients with certain illnesses - such as toxic confusional states and reactive depression.[65]

Both Managers also emphasised motivating and stimulating the clients (the Acting Superintendent did not say to what end). The Adviser related this to problem-solving capacity and general personal functioning. She suggested the aim of providing a permanent home for most clients.

The Adviser foresaw the need to strengthen and maintain links with outside relations and friends. Another of her aims was the improvement of the client's senseof personal worth and preservation of personal integrity. The aim of strengthening and enhancing problem-solving capacities is one of Olsen's 'four main purposes' for services for the elderly mentally infirm.(66)

The Adviser's aims for Dunstanburgh were identical to those for Warkworth and Kielder. Dunstanburgh's Superintendent also emphasised the need for improved quality of life for residents. Furthermore, the Superintendent recognised the need to give residents a sense of security and to provide leisure and social activities. She was explicit about the provision of physical care where necessary and stressed the need for individualisation and to give maximal freedom of movement to residents. Newly in post at the time of the study, she seemed to be unhappy about the limitations upon resident's movements caused by the units's situation in an area of high delinquency. Her precepts accorded with those of Goldsmith:

> "there is still a great deal of pride and satisfaction about being able to organise ones own life. This entails having as much freedom of choice open to the elderly as possible. It is often the element of choice which is lacking in an old people's home".(67)

At *Kielder* the Adviser's aims coincided with those of the Acting Superintendent in respect of: providing a homely atmosphere

and seeking to foster involvement with the community (this latter point was not mentioned by Superintendents of Warkworth or Dunstanburgh).

The main emphasis in the Acting Superintendent's aims for Kielder was on privacy, independence, initiative-taking capacity, and prevention of institutionalisation. He thus, echoed the aspirations of Goldsmith[68] and also those of Whitton:

> "The aim is to prevent institutionalisation and to encourage satisfaction in community life".[69]

The precepts of the Adviser for *Bamburgh* were more numerous than for the other EMI Homes. In addition to their aims she included: promoting greater independence , freedom of movement and decision making opportunities for residents . These additional aims were echoed in the perception of the Superintendent to the extent that the latter mentioned the need for trying to maintain residents' independence and involving them in the running of the home . The Superintendent replicated the Adviser's aspirations in respect of creating a homely environment, providing social outlets and involving the community with residents.

A feature of the Superintendent's aims, unique amongst the units studied, was to establish 'good working relationships between residents and staff'. In respect of none of the EMI Homes did Adviser or Superintendent stress the need to review clients. Sharp and Sharp have shown this process to be essential to rendering discharge practicable.[70]

Sub-Section C.3 - Wansbeck Day Centre

The Adviser's and Manager's aims were identical for Wansbeck I and Wansbeck II units. This was despite differences in age

and actual activities between the units. The only difference in aim was that rehabilitation for work was seen by the Adviser as being appropriate for clients under 60.

Both Adviser and Manager mentioned aims in the following areas: work rehabilitation, relief of relatives, provision of occupation, leisure activities, returning the client to independent living in the community (commonly mentioned in the National Study[71]) and the provision of support and increase of self-esteem. Both implied an intention to improve the client's capacity for satisfactory inter-personal relationships.

Aims cited by the Adviser, alone, were: prevention of re-admission to psychiatric in-patient care (this was also often instanced in the National Project[72]) and 'improvement of the quality of life'.

Two aims were identified by the Manager which were not indicated by the Adviser. The first was 'assessment', and the second was help in acquiring domestic, budgeting and safety awareness skills. Finally, some of the Manager's aims are so brief and vague that their precise meaning can only be conjectured.

Section D - Unit Staff and Client Aim Recognition

This section details how unit aims for individual clients were perceived by staff and by clients themselves. The questionnaires appear in Appendices 6 and 7 and the actual *texts* of responses to the open-ended aims questions in Appendix 8. Tables in Appendix 9 quantify responses of clients and staff in the different aim areas in answer to 'open-ended' and 'fixed' questions. These tables record *only* frequency of acknowledgement

of the various aims. Detailed tables showing aim recognition are set out in Appendix 9.

Section D.1. - Hostels

The table on the identification of open-ended aims in the hostels indicates four aims commonly acknowledged by staff and clients. These were; preparation for autonomy outside care, enhancement of client capacity for domestic self-care and improvement of client's self valuation. Staff recognised these for between 15 and 19 of the 48 clients, but only for the latter did clients concur in similar numbers.

In respect of fixed aims, frequent staff and client endorsement of: enabling the client to cope better with life in general, preventing admission to psychiatric ward, enabling the client to live in a greater state of equilibrium, improving client capacity for self-care, increasing involvement with the community and enabling the client to survive outside residential care occurred (these last two related only to non-resident clients). The major different 'fixed' aim was prevention of admission to psychiatric wards. Of the above aims for resident clients, at least 37 clients assented as did staff in respect of at least 16 of them. The 'open-ended' aims more frequently recognised by clients (nine clients) than by staff were: the provision of excursions and holidays, the provision of a home, the improvement of relationships with staff, and 'everything' (eight clients each).

This was true of both hostels - except for the 'everything' category; which was exclusive to Harbottle.

Fixed goals; where there was frequent client identification but, low staff instancing were: helping clients to cope with thought disorder , coping better with mental illness , improving relationships' with friends and staff' and with their families , improving concentration on work or occupation , preparing the client for a job , resettlement outside the hostel , and de-institutionalisation . All were recognised by between 29 and 44 clients, but by staff in respect of between one and eight users. The primarily client-identified fixed goals fall into three groups: improvement of personal relationships , improvement of clinical symptoms , and rehabilitation . Staff were relatively cautious in indicating these aims. Three open-ended aims were recognised more frequently be staff than by users. They were: 'improvement of capacity for personal self-care improvement of ability to socialise, and facilitation of recovery from mental illness. These were postulated on behalf of 15-18 clients but by only 1-4 clients. The only significant difference between hostels was that personal self care was twice as frequently mentioned at Craster as at Harbottle. The only fixed-aim more frequently recognised by staff than by clients was cutting down on drinking .

Apte questioned heads and deputies of thirteen local authority hostels (including Harbottle) in the 1960's, together with the 'administrator' and mental welfare officers who liaised with the units.

Collectively they identified ten rehabilitation aims for these designated 'transitional' hostels. Aims are listed in order of respondent's judgement of their importance: Residents were to be enabled to learn new behaviour and attain greater independence through work and socialisation. The

hostel's intention was to diagnose resident's capacities and to prevent hospitalisation. Residents behaviour and medication was to be supervised and they were to be protected from unsatisfactory family environments. Improvements achieved by residents, whilst hospitalised, were to be maintained. Residents should be protected from community stresses and provided with housing when ready for resettlement.(73)

Apte worked only in 'transitional hostels' - Craster and especially Harbottle were 'transitional' to a limited extent in 1979.

Aims identified by Apte imply the intention to change behaviour which is also present in the self-care goals endorsed by hostel staff in this study; the improvement of self- valuation of capacity for socialising and for relationships with a variety of people could also be classified as intended behaviour change. Aims similar to Apte's were more often recognised at the more 'transitional' Craster.

Apte's goal of increasing independence, through work and socialising, was scarcely evidenced in Newcastle staff's aims vis-a-vis work. However, all aspects of socialising were favoured by staff in both hostels.

The hostel's role as a unit which would diagnose and then prepare the client for independent living was widely recognised by Newcastle staff. Their emphasis on the diagnostic aspect of such work was not as great as Apte's. They deemed

'diagnosis' appropriate in 38 per cent of cases. Preventing psychiatric hospital admission, was judged pertinent by staff especially in response to fixed questions and at Harbottle. 'Supervision' did not appear significantly in staff responses.

Apte's staff mentioned supervising the patient's medication. In 'open-ended' aims this was incorporated under the 'medical care' heading. At Harbottle it was more frequently cited by staff (in almost one fifth of cases).

Protecting the resident from stresses in the community, as described by Apte, was not directly reflected in this study. Leff demonstrated that many schizophrenic patients (those where there is a high degree of 'expressed emotion'(E.E.) in family relationships) function better if separated from their relatives. He contended that:

> "high E.E. relatives and patients in high social contact need to be separated. In the case of a patient living with parents the obvious strategy is to attempt to remove him from the home to supervised accommodation".(74)

Consequently, it is interesting that 77 per cent of Newcastle clients (but no staff) saw the improvement of relationships with relatives as an important 'fixed-aim'.

Apte's staff spoke of the need to provide a home. This was recognised for six clients and by five of them - Apte's study was replicated later by Hewett who, inter alia, affirmed that:

> "provision of long term care for some people may itself be thought of as long term treatment, rather than failed rehabilitation. If there is no other way to maximise the potential and minimise the handicaps of those with long-lasting mental illness, provision of social environments truly becomes treatment, albeit palliative rather than curative".(75)

However, such a concept did not materialise in practitioner staff aims at either hostel - *except* when generalised as

provision of a home. Hewett and Ryan found that half the hostels in their sample were attempting to carry out policies of short-term rehabilitation. In Newcastle, of course, one hostel aimed to a greater extent, to be short-stay and the other the converse.[76] Hewett and Ryan found that in 'short-stay hostels' aims focused on work (or day centre) or on eventual resettlement in the community. In their 'long stay' hostels the aim of providing a permanent home was accepted, but, inducing residents to work or attend day centre was not envisaged, although light domestic chores were expected, This differed from expectations in Newcastle - orientation to work rehabilitation was scarcely recognised by staff (in respect of five clients). However, the reduced availability of employment between 1973 and the time of this study made 'work rehabilitation' less realistic by then. As Patmore observed of the period since 1975:

> "To-days legacy is a concentration of officially short-term services and a growing army of vulnerable unemployed former patients for whom there is little appropriate long-term provision."[77]

Many Newcastle hostel clients were receiving long term care. Preparation for autonomy outside care was an open-ended aim favoured by staff for only two more clients at Craster than at Harbottle.

Ryan undertook a follow up study in 1976 and collated data on hostel aims from the two studies. Aims of 'short-stay' hostels studied by him included: creating a community whose relationships did not exacerbate disorders, enabling clients to lead an independent life (unhampered by regulations) which would prepare them adequately for eventual resettlement outside.[78]

In Long stay hostels: Ryan found aims to be more limited and to emphasise light domestic self-care and social activity rather than work. He found that in these hostels there was a stronger focus on mitigating the symptoms of mental illness.

The need to improve domestic self care was considered less important to Harbottle than Craster (where staff applied it to thirteen clients and six clients to themselves). The emphasis upon facilitation of recovery from 'mental illness' was numerically identical (22 clients each and three staff on their behalf) in both hostels.

That less emphasis was placed (at Harbottle) on domestic self-care is comparable with Ryan's findings. Greater self-sufficiency would be required by those who were destined for fuller independence.

Sub-Section D. 2. - EMI Homes

Overall the EMI Homes; only one open-ended aim was indicated very frequently by both staff and clients - this was the improvement of self-valuation. At Warkworth both staff and clients were most strongly aware of this aim. At Bamburgh and Kielder there was greater staff acknowledgement but, at Dunstanburgh more clients identified it. Staff saw it as pertinent for 26 clients (out of 47) and 15 clients identified it for themselves.

Frequent staff and client identifications of fixed aims occurred for the following categories: ability to cope with life in general (only two clients dissented) prevention of admission to psychiatric wards,

improved capacity to handle personal finances, prevention of deterioration of confusion, improved capacity to cope with both physical and mental illness, improvement of equilibrium, (identified by all clients at Kielder and Warkworth), improvement of general self-care capacity, and improvement of relationships with other clients (acknowledged by all clients except one). This list is similar to that for the hostels, with additional emphasis on the treatment of physical illness. Aims relating to coping with life, mental illness, self-care, equilibrium and relationships with client's were each recognised by 41 or more residents. Twenty-two or more staff recognitions concerned avoidance of hospitalisation, self-care and relationships with peers.

Several 'open-ended' aims were recognised much more frequently by clients than staff. These were: provision or improvement of medical care (nine clients, one staff), meeting of material wants (five clients, no staff) provision of a home (seven clients no staff) 'everything' (three clients, no staff) and 'nothing' (which was cited by one EMI client in nine and was found at Bamburgh and Dunstanburgh). The medical care aim was instanced by clients only at Kielder and Warkworth, the material wants aim was identified at Dunstanburgh and Kielder. 'Everything' was cited only at Bamburgh- which also produced the highest proportion (three out of ten) of 'nothing' responses.

Open-end aims often described by staff, but, infrequently by clients were improvement of client capacity for domestic self-care (10 staff, one client), improvement of capacity for personal self-care (17 staff, one client), improvement of socialisation skills (12 staff, one client) increasing client independence (Kielder) and prevention of admission to psychiatric wards (Dunstanburgh and Warkworth). The open-ended aim of facilitating

recovery from mental illness was frequently identified (by 43 per cent of staff in all units) but, by three clients. The occurrence of staff identification of this goal was above average at Bamburgh but, below the norm at Dunstanburgh.

Fixed aims much more frequently indicated by clients than by staff were: prevention of serious depression (14 clients mainly at Bamburgh and Dunstanburgh, improvement of thought disorders (41 clients) prevention of deterioration of physical illness (21 clients), increase of tenacity, and enhancement of relationships with friends outside the residential unit (41 clients in each case). As in other categoriesof unit studied; the fixed aim of: improving relationships with staff was frequently perceived by clients. (All clients except one subscribed to this) Staff endorsed these aims for less than ten clients.

Opportunities for participation in 'occupation' were also instanced (to a lesser extent at Bamburgh). De-institutionalising the client was mentioned by over 70 per cent of EMI Home clients. In all, 81 per cent of EMI Home clients saw resettlement in outside housing as a valid aim for themselves. This was not accepted by staff in the case of *any* EMI Home client (staff were specifically questioned about this point). The clinical focus of client perception of fixed aims replicates staff emphases in their identification of open-ended ones.

Only one fixed aim was more frequently mentioned by staff than by clients; namely inducing the client to cut down on drinking (in respect of four clients). This trend was also found in the other categories of unit studied.

A prescription for the aims of residential care for the elderly mentally infirm is given by Gray and Isaacs. They suggest that the aims should be: to provide for group living, physical support and as much scope for self-determination as possible. Social and emotional needs should be met and domestic self-care encouraged. Institutionalisation should be avoided and, where feasible, residents should be prepared for a return

to independent living. Satisfaction in community life must be encouraged. All clients should be assessed on admission.[79]

In respect of the first of these aims: interaction in groups was recognised as an 'open-ended' aim by four staff. The (related) provision of companionship was mentioned by staff and clients in three homes - for no more than three clients, in any one home. The 'fixed aims' schedule inquired about improving relationships with peers. Of all the fixed questions this elicited the most frequent affirmative response (from both staff and clients). All clients, save one, considered this appropriate and staff cited it on behalf of 32 residents.
There is evidence of attempts to meet Newcastle clients' social and emotional needs in various staff and client-recognised categories. Encouragement of greater client responsibility for self-care was acknowledged by staff in two homes (domestic) and in three (personal). Clients recognised the fixed aim of improving self-care in 91 per cent of cases.

Gray and Isaacs envisaged rehabilitation of clients to their own home, This was, it will be recalled, not deemed viable by staff in respect of any clients, although 81 per cent of clients saw it as realistic for themselves. Diminishing institutionalisation was endorsed by one third of Newcastle clients, but by staff in respect of one resident only.

Finally, 'assessment' was identified as valid in only one home, and solely by staff-in respect of two clients. Such infrequent recognition appears was regrettable when Gray and Isaacs saw initial assessment as essential.But it is probable that initial assessment had previously been undertaken for the majority of clients. Olsen and Brearley[80] both expressed

scepticism about residential care. They contended that it should be the last resort for the elderly, whether mentally infirm or not, for instance:

> "if support in a residential setting is required, careful thought should be given to the possibility of placement in less restrictive environments such as sheltered housing and substitute family care". (81)

The writer found Newcastle homes to be 'restrictive environments' as indicated by their having locked external doors, and their aims being deficient on independence (especially at Bamburgh and Warkworth where staff failed to indicate it), and links with the outside community. Brearley, suggests that a vital requirement for the elderly *is* that they should have freely chosen to enter care. He continues:

> "if admission to residential care is inevitable - then as far as possible the elderly person should be fully involved in discussion of the reasons for the inevitability - sometimes this will not be possible because of the inability of the older person to understand, intellectually, the reasons." (82)

His warning, which echoes the precepts of Sharp and Sharp, (83) has relevance for this study. That so many EMI clients anticipated personal resettlement in the community, unlike staff, suggests that realistic discussions had *not* taken place. In the case of the Newcastle clients surveyed the point concerning intellectual grasp was invalid.

Olsen's aims for residential care for the elderly mentally infirm included: outside community involvement and continuation of external relationships. All client's human needs should be met in the home. Privacy and independence must be maintained. Aims for clients should be agreed with staff and attained using 'contracts'. Residents should participate in running the home which should provide a congenial physical environment. Client-self determination should be implemented during the admission process (this echoes Brearley). (84) (85)

The first of Olsen's goals was not commonly being adopted by staff in Newcastle EMI Homes (it was seen as valid for two clients but the second of his precepts was widely understood in Newcastle. There was doubt as to how often the need for independence was incorporated into staff aims for clients there (as it was cited for only six residents).

Regrettably there was no organisation for residents to participate in the running of Newcastle's EMI Homes in 1978-79.

Sub-Section D.3 - Wansbeck Day Centre

Throughout the Wansbeck two open'ended' aims were relatively frequently acknowledged by staff and clients. These were: the enhancement of self-valuation (33 clients and staff on behalf of 16 of them) and providing occupation/hobbies (39 clients and staff on behalf of 35 users).

The facilitation of recovery from mental illness was recognised by significant proportions of clients and staff in both units (by 15 clients and by staff in respect of 20 of them) although this was less strongly emphasised at Wansbeck II. Two open-ended aims were commonly identified by clients and staff at Wansbeck I, which they related to the needs of people below retirement age, (job acquisition and work rehabilitation by 18 per cent and 36 per cent of clients and *for* 23 per cent and 58 per cent of users respectively).

The two frequently instanced open-ended aims at Wansbeck II were: improvement of functioning related to physical handicap (by 14 per cent clients and on behalf of 32 per cent of them) and improvement of peer group interaction(by 36 per cent of users and in respect of 14 per cent of them).'Fixed aims' which were commonly identified by Wansbeck I clients and staff were: preparation for outside and sheltered jobs (over 90 per cent of users and 23 per cent of staff

responses). Two, often reiterated, 'fixed aims' exclusive to the Wansbeck II were: preventing deterioration of confusional states (about one third of clients and staff responses) and preventing admission to residential care (46 per cent of clients and on behalf of 32 per cent of them).

Five open-ended aims frequently indicated by staff of both units but infrequently by clients were: improvement of capacity for self-care - domestic and personal (especially at Wansbeck I (where one third of clients were involved), development of work related skills, improvement of socialisation skills, and the improvement of interaction in groups (between one fifth and two thirds of clients were nominated for each of these aims).

Open-ended aims more often cited by clients than by staff at both units were: improvement of inter-personal relationships with the client's family and with the unit staff (the latter was mentioned by only two clients - but family relationships were mentioned by more than one tenth of users). Fixed aims more often identified by clients than by staff were: prevention of serious depression (41 clients) improvement of thought disorder (61 clients) contributing more fully to the outside community (76 clients) improved relationships with staff(80 clients) and family (64 clients), ability to cope better with physical illness (43 clients) and prevention of physical ailment deterioration (40 clients). Primarily at Wansbeck I, clients cited frequently one 'fixed aim': improvement of relationships with other helping agencies (23 clients) there were, of course, 90 Wansbeck Clients in all.

As in other categories of unit, clients were more likely than staff to perceive fixed aims relating to functioning outside the centre. Like this study, the National Day Care Study, in examining units for the mentally ill, sought staff and client perceptions of goals. Staff, at a variety of levels, saw aims as encompassing provision of social and recreational facilities and of (physical) medical care. Arts and crafts and occupational/work-related skills should be taught along

with personal and domestic self-care. Group therapy and opportunities to participate in unit management should be provided. Personal attention is essential to improving self-valuation.(86)

Related to the first of these were the social and recreational opportunities, like community singing, music appreciation and keep fit sessions which were conducted at Wansbeck. At Wansbeck II: staff saw the provision of excursions and holidays as valid for half of the clients - but, these were not deemed appropriate by staff for any Wansbeck I clients. Improved capacity for socialising was considered viable for almost two thirds of Wansbeck I clients and nearly one third of Wansbeck II users.

The provision/improvement of (physical) medical care was perceived by staff to be appropriate for almost half of the elderly clientéle. The availability of leisure occupation was deemed necessary for 28 per cent of Wansbeck II clients.

Enhancement of domestic self-care capacity was thought by staff to be an aim for approximately one third of Wansbeck I clients. The provision of work related skills was seen by staff to be an appropriate goal for about one quarter of all centre clients. Some of these skills also had a social purpose (see Appendix 8).

Therapy groups were not specifically mentioned, however, improving interaction in groups was believed by staff to be a suitable aim for about a fifth of clients. Wansbeck clients did not participate in unit management meetings. Work rehabilitation activities , applicable only to Wansbeck I clients were thought appropriateby staff, to the needs of 58 per cent

of them.

Some clients in the National Study mentioned aims (or achievements) in various areas. These were: improvement of client's peer group relationships, improvement of self-valuation and happiness. Providing the client with somewhere to go and with a pastime were also recommended.(87)

The first of these were recognised by 38 per cent of Wansbeck II clients and eight per cent at Wansbeck I. In response to the open-ended question (similar to that in the National Study). 'Improvement of socialisation capacity' was mentioned by only 8 per cent of clients at Wansbeck II. 'Enhancement of self-valuation' was an aim supported by both National Study and Wansbeck clients (43 per cent at Wansbeck 1 and 34 per cent at Wansbeck II).

The open-ended promotion of independence was recognised by two clients but work rehabilitation was acknowledged by 36 per cent of Wansbeck I clients but *not* by mentally ill users in the National Study. The "somewhere to go" aim did not appear in responses to this study. Crine studied a Leeds Day Centre, similar to the Wansbeck, and found comparable aims:

> "The aim is to create a friendly, therapeutic environment in which people can learn both practical skills and the understanding of themselves and their situation which can enable them to cope better with their lives".(88)

Perhaps one of the most important aims of day-care for the mentally ill is 'relief of relatives'. Wansbeck clients were readier to see the Centre having the fixed aim of improvement of relationships with friends and relatives than were staff - (64 clients compared with staff in respect of 30 of them). That a day centre should offer such relief and assistance

has been suggested by Creer[89] in respect of schizophrenics (a diagnosis attached to 27 per cent of Wansbeck clients). Elderly mentally ill people and their families also have these needs[90] according to Wheatley and Flew.[91]

Section E.

The effective communciation of aims is essential to the operation of a system of Management by Objectives as postulated by Drucker and Brown (see pp. 111 - 113). It is also the intention of Governments that their aims, as stated in permissive legislation, white papers and so forth should be adopted as closely as possible by local authorities and implemented by their staff.

It now remains to examine how and to what extent council policy and managements own aims were communicated to practitioner staff and clients in response to the White Paper 'Better Services for the Mentally Ill'. The Adviser undertook a supervision session with the Head of each unit once per fortnight. The purpose of this session was to communciate aims and to monitor their attainment. At Craster and Kielder the Superintendents held fortnightly staff meetings to the same end. At Kielder, alone, staff had had regular individual supervision sessions but this practice had lapsed somewhat under the then Acting Head. The Wansbeck Manager held a supervision and monitoring meeting once per week. At Harbottle and Bamburgh there were ad hoc staff meetings about once per month - whenever issues arose. Dunstanburgh and Warkworth had virtually no staff meetings or supervision sessions. The following section examines to what extent aims had been

communicated through these media. As some of the fixed aims were either taken from B.S.M.I. or suggested by the Adviser (see Appendixes 6 and 7), it would not be surprising if clients (who proved more suggestible than did staff) were not more likely than the latter to concur with White Paper and Adviser's aims.

Sub-Section E. 1 - Hostels

The following precepts for residential care for the younger mentally ill are taken from the White Paper;[92] To help clients to attain relative stability and to cope with stress, to give more permanent support to those in need, to endow capacity for greater independence through links with the outside community, to provide, according to need, intensive care/ rehabilitation or gradual return to ordinary living (after hospitalisation), to permit participation in hostel management and maximum freedom of choice. Staffed hostels should aim primarily to provide a home.[93]

Over 40 hostel residents recognised the first 2 White Paper (fixed) aims; staff acknowledged them in 16 and 3 cases respectively.

The provision of more permanent support for some clients was indicated in the Adviser's aims (especially for Harbottle). Four Craster users and and four Harbottle clients saw provision of a home as being valid. This connects

with another White Paper aim.

B.S.M.I speaks of "enabling clients to manage their own lives in outward looking hostels" - this links with the aim of increasing independence - seen as relevant by one resident and by staff in respect of only five of them.

The White Paper mentions "intensive care and rehabilitatio This relates to self-care capacity and preparation for aut outside care. The latter was recognised by 17 per cent of clients and by staff in respect of 38 per cent of them. Improving domestic self-care capacity' was considered rel by 15 per cent of hostel clients (more at Craster) and by staff in respect of 42 per cent of users. Improvement of personal self-care capacity was scarcely recognised by clients, but, was mentioned by staff in respect of 38 per of users. Improving capacity for financial management , was recognised by few clients, but, by staff in respect of 16 per cent of users.

At *Harbottle* the following Heads and/or Adviser's aims were appreciably recognised by staff and clients: preparation fo autonomy outside care (five clients, eight staff) improveme of self-valuation (six clients, four staff) and provision o a home (four clients, five staff). Recognised mainly by staff were improvement of capacity for personal and domesti self-care (six cases) and for financial management (four ca improvement of ability to socialise and facilitation of recovery from mental illness (six cases each). Aims linked with those of Management, but which were identified by clients alone, were: provision of outings and holidays (by three users) and of material care (two users).

Clients solely, recognised aims not specifically included in

management prescriptions, which were: the meeting of material wants (five users), the improvement of relationships with staff (four users) and 'everything" (eight residents).

Of the two 'open-ended' aims which, at Harbottle,were recognised by some staff but not clients: enabling the client to find a job (validated for three clients) was affirmed in the Manager's aims, but, preventing psychiatric hospitalisation (endorsed for six users) - was not. At Harbottle the majority of aims frequently recognised by both groups were in line with Management precept. Some Management aims were *not* so reflected. These responses indicated that at Harbottle the head of home's aims and objectives had been absorbed (only one of them was not stated specifically in responses). This is surprising, considering the unsystematic nature of staff supervision at the hostel.

The Adviser's aims were less well appreciated. Two of them, relating to support of former residents in the community and to holiday placement, were not investigated by this study. Her aim of giving intensive and long-term care was not reflected in staff and client responses.

At Craster open-ended aims replicating the Manager's list which were recognised by both clients and staff were: preparation for resettlement outside the hostels (three clients and on behalf of 10 of them), improvement of capacity for domestic self-care (six users and on behalf of 13), and for financial management (three clients and on behalf of four) improvement of self-valuation (14 clients and on behalf of 11), provision of a home (by four clients and in respect of one and facilitation of recovery from mental illness (by three users and in respect of 9). In this context it must be remembered that only 14 Craster clients were resident . 'Open-ended' aims within management expectations and recognised significantly by staff, but not clients, were: improvement of capacity for personal self-care (on behalf of 10 users) and of ability to socialize (for nine clients).

One open-ened aim was recognised by four clients but by no staff and was not directly within the ambit of management aims but related to them; this was improvement of relatioships with staff. Provision of companionship was the only aim recognised appreciably by clients and staff (four cases each) which did not appear in Management precepts.

Relatively frequent staff and client recognition occurred in respect of the following management supported fixed aims: coping better with life in general, (25 clients, 15 staff responses) handling finances (13 clients, 9 staff), coping better with aspects of mental illness (22 users, three staff), improving self-care (16 clients, 11 staff) improved relationships with-peers (23 clients, 3 staff)-and staff (23 clients, 4 staff) preparation for settlement outside residential care (13 clients and five staff).

Often mentioned by staff and clients, but, not in Management prescriptions, were: preventing admission to psychiatric wards (23clients, 11 staff), de-institutionalising clients (17 clients, 3 staff responses) and less frequently, prevention of law breaking (five clients, two staff). Clients were more likely than staff to mention certain management - indicated goals: improving relationships with the client's family (19 clients, one staff response) and facilitating concentration on work or leisure/ occupation (22 users, three staff acknowledgments).

Trends in the extent to which Management goals were not appreciated by staff and clients were similar to those at Harbottle, but were less extreme. All the Head's aims were perceived by clients and/or staff (mainly both), whereas seven out of nine of the Adviser's aims were so recognised. The reasons for the greater approximation between Adviser's and staff's aims at Craster than at Harbottle probably lie in the types of regime instituted by each Manager, in differences in age and educational background between the supervisors of

the two units, and possibly in the frequency and organisation of staff meetings.

Sub-Section E.2 - EMI Homes

"B.S.M.I" declines to set out aims for homes for the elderly mentally infirm.[94] Comparison with aims indicated by this study is therefore, impossible.

At *Bamburgh* two open-ended aims were in accord with those of Management and were recognised by both clients and staff - these were: improvement of self-valuation (one client, seven staff) and enhancement of relationships with staff (two clients, one worker). One aim, which was not within management precepts, was recognised by one client and one worker. This was: improvement of functioning in relation to physical handicap. One aim was recognised by over a third of Bamburgh clients, by none of the staff in respect of clients, but was aligned with Management prescription. This was provision of a home.

Two aims, both in accordance with Management intentions, were indicated by Bamburgh staff in respect of one third or more of clients. These were: improvement of capacity for socialisation and facilitation of recovery from mental illness. Many fixed aims were recognised by significant numbers of clients and staff which were in harmony with Management precepts. Aims recognised significantly by both staff and clients, but, not in the Manager's lists were: preventing psychiatric hospitalisation (five clients, three staff) and improving financial management (three residents, one worker). Aims recognised solely by clients, and within the scope of those of management, were: preventing depression (eight clients out of ten) and deterioration of physical illness (six residents), facilitating coping with mental illness (all residents), improvement of tenancity (seven clients) and of relationships with outside friends (nine users). Two

fixed aims not shared by Managers or staff were indicated by at least three fifths of the clients. They were: preparation of clients for resettlement in the community and de-institutionalising (previously hospitalised) clients . Seven out of twelve of the Adviser's aims were recognised by staff and clients.

Aims acknowledged by staff and clients gave no intimation of the need to maintain links with the client's past or to preserve relationships with friends and relatives in the outside community.

Both Adviser and Superintendent indicated these and an intention to foster independence. This was not reflected in client and staff responses at all. One third of the Heads' aims did not appear in their responses. They were: encouraging and improving social life and involving residents and staff in running the home'.

Management aims which had been poorly communicated covered fostering of independence and maintaining links with the outside community'.

At *Dunstanburgh*, two open-ended aims which were in line with Management prescription were recognised by some clients and staff. They were: providing material care (two clients, one worker response) improving family relationship (one each). Recognised by similar numbers of clients and staff, but not directly included in the management list was: improving capacity for personal self-care (one user, four staff).

In accord with management aims and recognised by four out of ten clients, was increasing independence. Meeting material wants and 'nothing' were aims recognised by one fifth of clients, but, not aligned with Management precepts.

Three aims, recognised mainly by staff, and in harmony with Management were: helping clients to adjust to being in care (two staff responses each), providing a home and improving self-valuation (seven staff acknowledgements). Mentioned by by staff alone, but not in accordance with Management intentions were: improving functioning related to physical handicap (twice), improving capacity for personal self-care (once and preventing psychiatric hospitalisation (thrice).

Virtually all fixed aims relating to the improvement of mental illness were well recognised by staff and clients. These were in accordance with management aspiration. Recognised by both groups, but not by Management, were: preventing psychiatric hospitalisation (by four clients and for three of them) and improved handling of personal finances (one client, seven staff responses). Fixed aims in accord with Management and recognised exclusively by clients were: helping with coping with life in general (all clients) preventing physical illness deteriorating (half the residents), making life smoother (eight users), improving tenacity (all clients), improving relationships with outside friends (nine residents) and with staff (all clients) and facilitating concentration on occupation (all residents).

Six out of the ten Adviser's objectives were, to some extent, acknowledged by clients and staff. Perceived by clients, but not staff, were three aims relating to previous lifestyles and to the outside community. The aim specifying relationship of quality of life to past experiences was barely recognised.

Three out of the five Head's aims were clearly communicated to clients and staff. Two others, relating to hobbies and outings and promoting independence, were poorly appreciated by staff (in the cases of one and four clients respectively and not at all by residents).

At *Kielder*, open-ended aims in accordance with management precept recognised by clients and staff were: improving physical/medical care (three clients and one worker) not identified at all at Bamburgh and Dunstanburgh - the improvement of self-valuation (five client., two staff responses) and facilitating recovery from mental illness (two users, five staff) - mostly 'clinical' objectives.

Not specifically within Management prescriptions, but acknowledged by two staff responses and two clients was: improvement of functioning related to physical handicap. There were 12 residents in the Kielder sample.

Two aims recognised often by staff, but, not by clients, and designated by Management, were: provision of outings and holidays (four responses) and improvement of capacity for socialising (six responses). Also, frequently acknowledged by staff, but not in accord with Management or clients, were: improvement of aptitude for 'domestic' (9 responses) and 'personal' self-care (seven responses). Clients, alone, recognised three Management specified aims ; meeting material wants, providing material care (three responses each) and improving relationships with their families (two clients).

Fixed aims appreciated by management, clients and staff, were numerous. Widely recognised by staff and clients, but not by management were preventing psychiatric hospitalisation (by four of each) and handling finances better (seven resident and three staff responses).

Management held 'fixed' objectives accepted by numerous clients, but, not by staff, were: improvement of tenacity (10 clients) and of relationships with outside friends (nine clients), facilitation of occupational activities (11 clients) and de-instituionalsation of clients (four clients). All Kielder clients (but neither staff nor management) endorsed the aim of resettling the client in their own home.

Three fifths of the Adviser's aims were widely acknowledged by clients and staff. The validity of provision of a permanent home was recognised by only one resident. Staff failed to recognise the need for links with outside friends and family. Neither group appreciated the aim of 'fostering links with the outside community' and they barely linked present personal functioning with clients' immediate past.

Only one out of six of the Acting Head's precepts was widely recognised (creation of a friendly and homely atmosphere within the home-and this by implication). Four clients, alone, recognised the need not to be institutionalised, and two of each-the desirability of maintaining clients' independence. The general advisability of community involvement was not understood at all, nor was giving residents greater powers of self-determination . These trends may have been due to the deployment of a temporary, inexperienced, Superintendent.

At *Warkworth* a larger number of managment identified 'open-ended' aims were acknowledged by some clients and staff. They were: provision of outings and holidays (five client and two staff responses), improvement of capacity for socialising (one client, two staff), improvement of

self-valuation (nine client, thirteen staff responses) and provision of companionship (one resident, two staff), - these suggested a 'social' rather than 'clinical' emphasis. There were 15 clients in the Warkworth sample.

Two Management indicated aims were acknowledged solely by clients alone - enhancement of medical (six times) and 'increasing independence' (once). Management aims cited by staff only were - facilitating recovery from mental illness and improvement of personal self-care (seven and six cases resepctively)

Preventing psychiatric hospitalisation (which was implied by the Acting Head) was a fixed aim well recognised by staff and clients (in 12 and 10 cases resepectively); so were: enabling coping with physical and mental illness, with life in general, improving self-care capacity, and relationships with clients and staff. All these were identified in at least eight client and 33 staff responses. Not in accord with Management aims, but, widely acknowledged by both groups was improving financial management (by 12 clients and in seven staff responses). Outside Management aspirations, but recognised almost wholly by clients, were: preparation for resettlement in ordinary housing (13 clients) and de-institutionalisation (six residents).

The pattern of comprehension of, and response to, the Adviser's aims at Warkworth was similar to the other EMI Homes. Uniquely amongst these homes the Acting Superintendent of Warkworth named only three aims but all seemed to have been understood by staff and clients.

Overall about half the Superintendent's aims were recognised by one or the other. There was more recognition at Warkworth and less at Kielder. The poorly communicated objectives were concerned with community involvement and with promoting resident's independence.

Sub-Section E . 3 - Wansbeck Day Centre

According to B.S.M.I.[95] aims for Social Services Day Centres for the mentally ill should encompass: meeting clients immediate needs for shelter, occupation and social activity, enabling them to live at home, and providing long-term support or rapid rehabilitation. According to need, increasing reliance and enhancing quality of life. Further aims were: helping with relationship difficulties and with adjustment to work. Individuals should be assisted in contributing more to the community. Centres should provide a balanced programme of work, social and self-care activities and should have a broadly therapeutic role.

B.S.M.I. states that whilst these aims were constructed primarily for day centres for the younger mentally ill they are also suitable for centres elderly clients.[96]

The first White Paper aim is general and is difficult to compare usefully with the study data. Nowhere in this survey was the aim of providing shelter instanced. There were, however, frequent references to social activities, work and occupation. Seventy six clients saw concentration on occupation as being pertinent, and there was staff agreement in 29 cases.

The White Paper recommendation concerning assisting the client to continue living at home was considered appropriate by half of all Wansbeck clients. Staff at Wansbeck II applied the aim to approximately one third of users, but it was thought by staff to be appropriate for only one tenth of clients of Wansbeck I. B.S.M.I. emphasised that this aim would not be appropriate for all clients.

The White Paper goal of giving clients an increasing degree of self-reliance is echoed in many aims described in this study, but primarily in preparing for autonomy outside care , improving self-valuation , promoting independence and de-institutionalising after hospitalisation . At Wansbeck I the sample consisted of 40 users and at Wansbeck II of 50. The first mentioned of these was subscribed to by three per cent of Wansbeck I staff and five per cent of clients, but, by none at Wansbeck II. Improving self valuation was frequently endorsed by staff(in 16 cases) in both Wansbeck units and also, by users (in 33 instances).

The fixed aim of de-institutionalising after hospitalisation was recognised by neither clients, nor staff, in either unit. This must be viewed in the context of the hospitalisation history of Wansbeck II clients (See Chapter IV p.167)

The White Paper goal of 'giving clients a deeper enjoyment of their lives' was exceptional - almost all clients in both Wansbeck units perceived it as valid. Staff considered it relevant in more than a half of all cases.

Helping clients improve personal relationships, as suggested by the White Paper, was reflected in both 'open-ended' and 'fixed' question responses. However, of relationships with staff, clients, family and peer group, only the latter was relatively frequently acknowledged - only five Wansbeck clients did not acknowledge this and staff saw it as relevant in 22 cases. B.S.M.I. prescribed help with adjusting to the demands of work . This was only appropriate for Wansbeck I. The

open-ended work rehabilitation aim was indicated by just over one third of Wansbeck I clients and by staff in respect of three fifths of them. However, when confronted with fixed question , over 90 per cent of clients acknowledged the aim.

The intention of 'improving the quality of the individual's contribution to the life of the outside community' was not reflected in responses to open-ended questions. When asked specifically, staff saw it as being relevant to none of the clients in either Wansbeck Unit although over 80 per cent of users accepted the aim. This intimates an inward-looking orientation at the Day Centre, especially from the staff perspective.

The provision of excursions and holidays was acknowledged by less than 10 per cent of clients, unlike those in other Newcastle units, but, this is surprising as frequent outings and holidays were *actually* organised for Wansbeck users. Perhaps these benefits were taken for granted. However, these were seen as relevant by staff at Wansbeck II for 44 per cent of users. The improvement of capacity for socialising was primarily recognised by staff (in respect of 39 clients) - but only three clients (all at Wansbeck II) were in accord.
The White Paper promulgated a therapeutic and social role for day centres. Overall, this was the function which was adopted at Wansbeck. Most responses to the open-ended question dealt with aims connected with social functioning.

There was, however, some emphasis on: facilitating recovery from mental illness (15 clients and by staff on behalf of 20 of them) and at Wansbeck II the age and infirmity of

clients seems to have precipitated concentration on physical and clinical factors.

At Wansbeck I, the following open-ended goals were co-extensive with Management aims and were mentioned by appreciable numbers of both staff and clients: improving capacity for 'personal' (2 clients, 13 staff) and 'domestic' self-care (5 clients, 14 staff) job acquistion (7 clients, 9 staff) work rehabilitation (14 clients 23 staff), development of work-related skills (3 clients, 11 staff) and improvement of self-valuation (17 clients, 9 staff). In line with management and recognised by staff was: improvement of interaction in groups (18 per cent of cases). Preparation for autonomy outside care was a Management - endorsed aim understood by two clients. A Management prescribed aim identified by staff for 64 per cent of users, but not by any clients, was improvement of capacity for socialisation.

The following aims were not in line with Management precepts, but were commonly postulated by staff and by a few elderly clients: the improvement of (physical) medical care (re: 21 clients) and of functioning related to physical handicap (concerning 16 users).

Many 'fixed' aims were recognised by both staff and clients and were in accordance with Management aspirations. Management held fixed aims more frequently acknowledged by clients than by staff were: improved handling of finances (48 clients), prevention of depression (42 clients), improvement of thought disorder (61 clients) improved relationships with outside friends (sixty seven clients) improving relationships -

with their family (64 clients) contributing more to society/ the community (76 users) and remaining in their own home(48 users). Cutting down upon/or giving up drinking was also mentioned by almost one fifth of clients - but by staff in respect of less than 10 per cent of them.

Two 'fixed aims' excluded from management guidelines, were identified by over one third of clients. They were: providing medical care and improving relationships with other helping agencies .

At Wansbeck I, a higher proportion of Manager's aims seemed to have been understood by clients and staff than in the residential units studied. Nine out of ten Adviser's aims had been conveyed to many clients and staff. The remaining one - helping clients to survive in the community had been appreciated by 63 per cent of clients but by *no* staff. Seven out of nine Manager's aims had been assimilated by appreciable numbers of staff and clients. The two other Manager's aims were acknowledged by a some clients. These were 'assessment' (2 clients) and provision of hobbies (43 per cent of all users).

At the Wansbeck II there were seven open-ended aims, which were in line with management precepts, and frequently acknowledged by both clients and staff. Other management aims were recognised mainly by staff and by a few clients. They were: improvement of capacity for domestic (2 clients, 8 staff) and personal self-care (1 user, 3 staff) and improvement of interaction in groups (one client, 10 staff responses).

Three aims, not shared by Management, were intimated by some

clients and staff. These related to: care for physical illness (4 users 21 staff) and handicap (7 clients 16 staff) and facilitation of recovery from mental illness (9 clients, 6 staff).

There were numerous Management approved 'fixed aims' signified by substantial proportions of clients and staff at Wansbeck II.

In summary, in the *hostels* most of the aims of the White Paper were understood, to some extent, by clients and staff. Clients were less ready to acknowledge aims concerning behavioural change.

Aims of the Adviser had been well communicated at Craster in relation to objectives internal to the unit, but less so at Harbottle. As in the other units studied, it was the Adviser's more complex aims relating to rehabilitation and resettlement which were least understood. Clients' most common aim expectations related to improvement of inter-personal relationships within the unit and to aims related to the general improvement of mental illness. At Harbottle, the Manager, had succeeded in conveying her own apparent medical orientation of aims to numerous clients and staff. Whereas, the Adviser appeared to be using a more 'social' model of mental illness.

In the *EMI Homes* the issue of White Paper aims did not arise. Just over half of the Adviser's aims had been effectively communicated to staff. Her prescriptions for involvement with the outside community were not accepted by staff although they were appreciated by clients. Conversely, staff, unlike clients, understood the Adviser's aim that the home was to provide permanence for most clients. Communication of Advisers aims was moderately effective in all EMI Homes. The two homes which had more systematic communciation methods seem to have

had no better communication in practice.

About half of the Superintendent's aims were acknowledged by staff and clients. At Warkworth, there was greater recognition. The aims most widely recognised by EMI Home clients and staff were very similar to those commonly identified in the hostels and EMI clients also stressed their needs for material and medical care. Staff generally shared these aims; but, placed less emphasis on providing care and more on clients learning to care for themselves.

The White Paper used social and clinical categorisations to distinguish between the functions of Health Authority ('clinical') and Social Services ('social') Day Centres like Wansbeck. The National Study[97] found this distinction seldom to operate in practice. Evidence from Wansbeck does not support a hypothesis that it eschewed involvement in clinical matters and left associated tasks to the local N.H.S. day hospital.

Many of the aims incorporated in B.S.M.I. had been recognised by staff and clients at Wansbeck. The centre placed less emphasis on 'community involvement' and on 'avoidance of a clinical orientation' than the White Paper had prescribed. The National Study asserted that:

> "it is quite clear that heads and staff interviewed had absorbed at least some of the distinctive aims outlined by the White Paper". [98]

Management objectives, particularly those of the Adviser, were more effectively communicated at Wansbeck than in the other units. As in the residential units, it was Adviser's aims related to relationships in, and links with, the outside community which were understood by clients but, not by staff.

A possible reason for this is that the aims seemed unattainable to staff. At the Wansbeck, the Adviser's aims had a more 'social' emphasis (in line with those of the White Paper) whereas staff and clients had a more medical/clinical orientation. The 'improved' communciation here was, therefore, relative. Unlike other units, there was strong emphasis on work rehabilitation and occupation at the Day Centre especially at Wansbeck I.

Section F - Chapter Summary

In summary aims for the residential and day care units, seen at government and departmental middle management level, as being primarily social, were understood at staff and client level to have a more clinical character. Staff, unlike all other respondents, saw most aims as being internal to the units and having a minimal community orientation. The improvement of self-valuation and of inter-personal relationships within units were the aims most frequently recognised by staff and clients. Staff often desired improvement of self-care capacity whereas, clients saw themselves as appropriately being the passive recipients of care.

The communication of management aims down the line operated well for about half of all aims. In units with more conservative and less well educated superintendents and few formal staff meetings, Manager's aim predominated over those of the Advisers and of Government prescription. Better communication with staff and clients occurred where the Superintendents were more highly educated, where there were regular staff meetings and fewer long serving basic grade staff.

The clinical orientation of aims was injected at unit management level, probably because many managers were qualified and experienced nurses. The trend was probably compounded by some of the basic grade staff having auxilliary nursing backgrounds.

In conclusion, in the context of the services studied, the theory of'Management by Objectives'- in terms of the understanding of,and attempt to implement, aims operated in part. As far as the implementation of client perception of need was concerned; clients were frequently more attuned to governmental and Adviser's aims than were staff intermediaries.

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Chapter Four

THE ATTAINMENT OF SERVICE AIMS

Introduction

The last chapter examined the identification and communication of aims for the units studied. This chapter investigates the degree of success with which these aims were attained, considers some factors which may have contributed to success or failure, and undertakes comparative costs and cost effectiveness analyses on the basis of the findings.

In the case of two aims, a more objective analysis of attainment has been undertaken. Secondly staff and client perceptions of success are analysed - related to the aims which were identified in Chapter III. Some of the factors underlying success and particularly the factor of the sharing of aims between clients and staff, are scrutinised.

Finally, the benefits as indicated by aim achievement are offset against the costs for each unit; and viable inter-unit comparisons are made. The comparative costs of hospital and residential/day care are then examined.

Section A - Prevention of Admission to Psychiatric Wards

It will be recalled, from Chapter III,[1] that in response to

'fixed questions', relatively large percentages of clients (88 per cent in hostels, 49 per cent in EMI homes, 88 per cent in Wansbeck I, and 60 per cent in Wansbeck II) and of staff in respect of clients (re 44 per cent of hostel clients, re 47 per cent of EMI home clients, re 50 per cent of Wansbeck I and re 49 per cent Wansbeck II clients) thought that a valid aim was to prevent psychiatric hospitalisation. This aim also appeared in "Better Services for the Mentally Ill".(2)

Over a twelve month period the writer traced the history of residential and day care clients and monitored the number and duration of admissions or re-admissions to psychiatric wards. She decided to survey the twelve months immediately preceding the study's main data collection in each unit - thus, to provide recent data.

The tables below show the number and duration of psychiatric admissions. Because it was possible that clients *with* a previous hospitalisation history were more likely to be re-admitted than those without, the two categories were examined separately. As this is a study of the performance of social services units, the writer ascertained whether hospitalisation occurred before or after admission to the unit (where appropriate). The tables provide information relating to admission to psychiatric wards in Newcastle. The writer was granted access to N.H.S. records only by Newcastle Area Health Authority.
The data on 'previous hospitalisation' history indicates whether clients had *ever* been hospitalised in Newcastle

- and does not relate only to the previous four years.

Table 41 - Admission to Psychiatric Wards

Numbers of client admissions to psychiatric wards during one year prior to the study (and *after* admission to the unit).*

Unit	Clients who had no admissions	Clients who had one admission	Clients who had two admissions
Craster N = 26			
a. Clients with a hospitalisation history	15	1	1
b. Clients without a hospitalisation history	9	-	-
Harbottle N = 22			
a. Clients with a hospitalisation history	10	3	-
b. Clients without a hospitalisation history	9	-	-
EMI Homes N = 47			
a. Clients with a hospitalisation history	18	4**	-
b. Clients without a hospitalisation history	25	-	-
Wansbeck I N = 40			
a. Clients with a hospitalisation history	23	4	-
b. Clients without a hospitalisation history	13	-	-
Wansbeck II N = 50			
a. Clients with a hospitalisation history	26	5	1
b. Clients without a hospitalisation history	18	-	-
TOTAL	166	17	2

* More clients were hospitalised but this is not recorded as their hospitalisations took place prior to admission to social services units - although *during* the monitored year.

** All clients at Bamburgh House

Table 42 - Duration of Sojourns in Hospital - Where Clients were Admitted from Social Services Units

Unit	Number of sojourns lasting:				
	Under 7 days	7 days - 28 days	29 days - 3 months	Over 3 months under 6 months	Over 6 months under 1 year
Craster	1	1	-	1	-
Harbottle	-	-	3	-	-
EMI Homes	-	1	3	-	-
Wansbeck I	-	3	1	-	-
Wansbeck II	-	3	4	-	1
TOTAL	1	8	11	1	1

Notes:

1. This table notes the numbers of stays of each duration and *not* the numbers of clients involved.
2. As in the previous table only sojourns commencing *after* admission to a social services unit are recorded.
3. All E.M.I. home admissions were from Bamburgh House.

The most interesting finding is that *all* clients admitted to hospital during this monitored period had a previous history of some psychiatric hospitalisation.

Hostels

A majority of hostel clients (63 per cent) had experienced previous psychiatric hospitalisation. Psychiatric hospital

admission during the monitored year affected five hostel residents. Most were admitted on only one occasion. There was a mixture of lengths of hospitalisation; but, the mode was a sojourn of between seven days and three months.

A lower proportion of Craster (58%) than of Harbottle (45%) clients had a psychiatric hospitalisation history. However, two Craster and three Harbottle clients in the sample were admitted to psychiatric wards during the monitored year. Four of those who were admitted had one admission. A significant factor in the Harbottle admissions could have been relative chronicity of that Hostel's population compared with the greater incidence of acute conditions suffered by Craster clients. Those Harbottle residents who were hospitalised were admitted only once (all for a period of between 29 days and three months). All Harbottle clients in the sample were resident whereas only half of Craster's sample lived in. This should have made the former less prone to psychiatric admission.

EMI Homes

A narrow majority of EMI clients (53 per cent) had not been hospitalised. In three of the homes there were no psychiatric admissions throughout the monitored year - this contrasted with Bamburgh where one third of the sample had been hospitalised. The modal lengths of stay in hospital were similar to those experienced by the hostel clients.

At Bamburgh two thirds of the clients surveyed had a previous history of hospitalisation (compared with an average of about two fifths of clients for the EMI homes overall). Therefore, Bamburgh clients could have been expected to be more vulnerable. Secondly, this home was newly established and may have taken in more disturbed clients - than for instance, some of the original (sub-normal) Warkworth clients who were still in residence.

The Wansbeck I Day Unit

About two thirds of clients (compared with 63 per cent in the hostels), - had a previous hospitalisation history. The age groups involved were similar in both Wansbeck I and the hostels. The hospitalisation rate during that monitored year (one in ten) was identical with the hostels average. All Wansbeck I clients were admitted only once during that year and all admissions lasted between 7 days and 3 months. This was also true for the hostels. Under half of these admissions had a duration of between seven and twenty eight days - shorter than the mode for Harbottle clients.

Wansbeck II Day Unit

Of the clients 64 per cent had a previous psychiatric hospitalisation history. This rate was higher than that at the EMI homes (Bamburgh excepted) but, was slightly lower than the level at Wansbeck I. Most sojourns in hospital lasted between seven days and three months. This was typical of almost all units. The admissions

rate for Wansbeck II clients was 12 per cent-which was greater than the 'nil' admissions for three of the EMI homes.

That the residential and day care units made a real achievement in keeping most of their (predominantly chronic) clientele out of psychiatric hospital has been highlighted by other studies. Morgan and Johnson[3] found that of a psychiatric in-patient sample who had been hospitalised over 2 years, two thirds were 'schizophrenic'. The average ages were: males 53 years and females 57 years. Three quarters of the residential and day care sample were aged 50 years and over and one third were between 50 and 65. Only one fifth of Morgan and Johnson's males and one third of their females were married - 16 per cent of the residential and day care sample were espoused. Despite comparable characteristics the Newcastle sample were surviving with 'community care'.

The proportion of unmarried clients is pertinent. A number of studies, notably those of Ødegard[4] and Norris[5] showed that hospital admission rates are greater for the single person than for married people and that once in hospital the single stay longer than the married. This phenomenon exists for all age and diagnostic groups, but is particularly marked for schizophrenics and manic depressives (34 per cent of the residential and day care sample possessed these diagnoses). This relationship between marital status and hospitalisation is also similar for non-psychiatric patients.[6]

Cross, Hassall and Gath[7] followed up a sample of psychiatric day patients in Birmingham. After a 12 month period they found that 9.5 per cent of these had become psychiatric in-patients. However, their result is not directly comparable with data in this study which involved monitoring admisssions for a different sample *during*, and not after, 12 months.

Two hostel studies which examined hospitalisation were those by Ryan and Hewett[8] and by the City of Stoke-upon-Trent Social Services Department[9]. Ryan and Hewett did not monitor hospital admissions but discovered that 87 per cent of the clients of their long-term hostels had been resident consistently for over two years and were, therefore, not admitted to psychiatric wards during that time. They concluded:

> "prevention of the continued accumulation of new long-stay (patients) in the mental hospitals would appear to be a primary target of any thorough-going policy of community care." [10]

In the study of the Stoke-on-Trent hostel, 71 per cent of residents were admitted to the hostel from psychiatric wards. In this study 63 per cent of hostel residents had some history of hospitalisation (but were not necessarily admitted directly from hospital).

In the Stoke study the investigator asked the hostel manager for an estimate of degree of success attained with clients who left the hostel. The significant trends were: that there was apparently no relationship between having

been admitted from psychiatric wards and 'failure' as perceived by the Warden. Clients admitted from elsewhere were as likely to "fail", but, hostel 'failures and partial failures' were more likely to go into psychiatric wards or police custody within six months of discharge. An index of hostel success was therefore, keeping people out of mental hospital.

Perhaps, most relevant to this study, was the parallel finding in the Stoke study that those *not* admitted *from* mental hospital were less likely to be discharged to mental hospital.

The prevention of hospitalisation, mainly of chronic patients, on the part of the residential and day care units, was quite successful and a measure of aim attainment.

Section B Job Acquisition - Units for Clients of Working Age

Aims statements for units for younger clients mentioned this goal. It was also shown by Crine to be a key factor in successful rehabilitation.(11)

In respect of residential units job aquisition was only important in units for clients under pensionable age. The adviser's aims suggested that some Wansbeck II clients might seek jobs - although very few were under 60. However, none did acquire employment during the study period.

Wansbeck I clients, once they obtained a job, were discharged from the day centre. This study included only current clients.

Hostel clients could commence work and remain clients, consequently their job acquisition profiles could be surveyed more comprehensively. Furthermore, almost all hostel clients had, in theory, potential for working.

During the four month unit study period, two Wansbeck I clients (out of 40) obtained jobs and one former client, who had been in outside employment, became unemployed and returned to the Centre. Amongst the open-ended aims for Wansbeck I: 'helping the client to obtain a job' was seen as valid by staff in respect of almost one quarter of the clients, but only 18 per cent of clients perceived this aim as being pertinent for themselves. The fixed aims questionnaire asked about *preparation* for work and 94 per cent of clients saw this aim as appropriate.

Staff described 'work rehabilitation' as being desirable for 23 per cent of clients. Therefore, only about one in five Wansbeck I clients, for whom a job was sought by staff, actually obtained one during this four month study period.

In the hostels, data was collected concerning job acquistion since admission to the hostel. Length of residence or unit contact varied but all clients were receiving

services when the jobs were obtained.

'Assisting the client to get a job' was perceived as a valid 'open ended' aim only by staff and only at Harbottle - there only in respect of 14 per cent of clients. In response to fixed questions, 63 per cent of all hostel clients recognised this aim, but staff acknowledged it only in respect of about one fifth of Harbottle clients. It also appeared in the Superintendent's aims at Harbottle but not at Craster.

The following tables show the numbers of jobs held since admission to the hostels and how jobs were obtained.

Table 43 Number of Jobs Held since Admission to the Hostel

Number of jobs held	Number of clients at Craster Lodge N = 26	Number of clients at Harbottle Lodge N = 22
0	18	16
1	7	4
2	1	-
3	-	1
9	-	1
TOTAL	26	22

Table 44 Method of Job Acquisition

How most recent job was obtained	Craster Lodge N = 26	Harbottle Lodge N = 22
Not applicable	18	16
Unknown	1	1
Via hospital social worker	-	1
Department of Employment Services	2	-
Through hostel staff	1	1
Through client's friends or relations	-	1
Through client's own efforts and initiative	3	2
TOTAL	26	22

Note:

1. Three hostel clients were aged over 65 and therefore, were not likely to obtain jobs. Possibly they had been under 65 during their period of residence.

2. All subsequent jobs after the first were obtained through the client's own efforts.

These tables show that 31 per cent of Craster clients and under 27 per cent of Harbottle clients had worked at some time since admission. The majority of these had held one job.

The different record of each hostel was partly accounted for by the younger ages of Craster clients, (four fifths of Harbottle clients were aged 50 or over) and by the greater chronicity of the latter's residents.

The principal source of jobs and the only one for jobs obtained after the first was client's own effort. This trend should be seen as a success for the hostel - in motivating and organising clients-rather than as unit failure to acquire jobs directly. The second largest (equal) job source was the efforts of social services staff.

That the Department of Employment proved an equal but, insignificant provider shows a negation of its raison d'être In view of job acquisition having been a minor aim of the hostels, their record for clients obtaining work was creditable.

Whilst 65 per cent of those hostel residents who were under 65 at the time of the study, were unemployed during the whole of their involvement with the hostel, 56 per cent of the total hostel population were 50 or over at the time of the study and 69 per cent of the hostel sample were diagnosed as psychotic, thus diminishing their chances of employment. The unemployment level in Newcastle in 1978 was 10 per cent for men and 12 per cent for non-married women.[12] But, in the 'Inner City Partnership Area', in which both hostels were situated, it was 16 per cent for men and 12 per cent for non-married women (in which category most female clients fell). In 1975, when

two fifths of the study clients were already being helped by the hostels, the City unemployment rate was 9 per cent for men and 8 per cent for non-married women.

Data from "City Profiles"[13] showed 15 per cent of men aged 45-65 in the 'Inner City Partnership Area' to be out of work in 1978 and 25 per cent of non-married women in this age group. Against the background of the extent and nature of local unemployment at the material time, the record of the hostels was comprehensible.

Other studies show that when many short stay hostels were set up in the late 1950s and the 1960s there was an expectation that clients would work and, through working, would be rapidly rehabilitated to independence in the community. In the Cambridge hostel described by Clark and Cooper,[14] clients were not admitted unless they had jobs; or the potential to find work immediately. When Apte,[15] undertook his survey of psychiatric hostels in 1968 he found that short-stay hostels were twice as likely as long-stay hostels to require residents to be employed. As Durkin pointed out in 1971:

> "this policy emerged when the demand for unskilled low-paid labour was at its maximum and it was hoped that rehabilitated patients trained in such work would become employable within the community."[16]

Clearly the expectation of paid outside employment as a pre-condition of hostel residence would have been unrealistic in Newcastle's hostels in 1978-79.

As Wing contended:

> "rational provision must be based on knowledge of the way that social, as well as clinical, factors can act to precipitate and maintain disablement. This means that social disadvantages and secondary reactions need to be taken into account as well as clinical impairments."(17)

Ryan,(18) in the 1973 hostel survey, found that four fifths of the residents of short-stay hostels were working full time but, by 1976 only 14 per cent of his hostel sample held full-time jobs as did only one tenth of his group home sample. This renders the Newcastle hostel's record comparatively good. The studies are not directly comparable, however, as Newcastle data relates to jobs acquired over a period of hostel residence during which level of unemployment varied. The Newcastle hostel employment record also appears creditable in the light of Vaughn and Leff's(19) study. They found that 43 per cent of a sample of schizophrenics living in the community were 'impaired for work' - using Brown's impairment criteria. Just over half of this study's hostel sample were diagnosed as 'schizophrenic'.

Durkin(20) advocated a division between 'rehabilitative' and 'compensatory' hostels- the latter being, inter alia, for thoseunable to work. She thus, overlooked the point made by Hewett(21) that it is possible that some clients who are able to work may continue to need a 'compensatory environment'. This was the type of need which Harbottle, in particular, was seeking to meet.

The Hewett, Ryan and Wing[22] study of 1976 compared occupations of group home and hostel residents. They found that 45 per cent of hostel residents and 62 per cent of group home residents had no daily occupation (only 23 per cent and 3 per cent respectively attended day centre). In Newcastle all resident hostel clients attended day centre if they did not have jobs.

Section C - Staff and Client Evaluations of the Attainment of Aims

The aims identified by clients for themselves, and by staff on their behalf, have been described in Chapter III. This section aims to examine perceived attainment of these aims.

Responses to both open-ended and fixed questions ranked the degree of success in attainment on a five point scale-from one signifying total or substantial success, through two to three indicating mediocre success, through four to five signifying little, or no, success. A sixth point was added to the scale for the "don't know" response. The same methodology and five point scale were used by Gordon et al[23] in their opinion survey of psychiatric patients.

Clients proved most likely to respond at one extreme of the scale or the other; and occasionally 'not to know'. Staff usually had a positive answer and tended to estimate degrees of success in the middle ranges of the scale. A five point scale was adopted as being likely to provide adequate scope for the probable range of responses.

It was thought that a seven point scale would probably be too confusing, or daunting, for client respondents: whose limitations have been demonstrated elsewhere (see Chapters II and III). The estimations of success are set out in Appendix 10, the tables use a similar format to those in Appendix 9.

Sub-Section C. 1 - Comments on Evaluation Tables - by Unit Type

In respect of open-ended aims in the hostels: those which both staff and clients considered to have been attained most successfully were: (scale point one and two evaluations) preparation of clients for living outside residential care (19/25), the provision of a home (13/14), the improvement of self-evaluation (23/34), provision of hobbies or occupation (4/5) and providing companionship (5/8). The 'fixed aims' responses added to this list: preventing psychiatric hospitalisation (47/62) enabling the client to cope better with mental illness (39/46), facilitating the client to function in a more stable way (43/60), and de-institutionalising the client (39/45)- linked with the first aim. The figures in this section express the number of scale point one and two evaluations as a fraction of the total number of responses in each aim category.

Ten Craster clients thought that the aim of 'improving self-valuation' had been particularly well attained. One

open-ended aim was frequently considered by Craster clients and staff to have been well achieved - although this was not so at Harbottle. This was: the improvement of capacity for domestic self-care. There were 12 good evaluations out of 17 in the former hostel.

Open-ended aims which clients, unlike staff, considered to have been successfully realisedwere: the provision of material care (2/2), the arrangement of excursions and holidays (8/8), the improvement of relationships with staff (8/8), and "everything" (8/8) (Harbottle only). One reason for lack of staff agreement about these was that they infrequently recognised these goals. To this list responses to fixed questions added: enabling the client to concentrate better on work/leisure activities, (35/43), improving tenacity (36/42), preparation for sheltered work (19/28), improving relationships with staff (41/44), improvement of capacity for general self-care (34/37) and enabling the client to manage their personal finances (22/27). Staff responses were sparse rather than pessimistic. In the cases of the last two categories responses were more numerous; but indicated failure. The totals expressed in this paragraph are of client evaluations only.

One open-ended aim frequently identified by staff with evaluations of poor success (scale points four and five), but, infrequently cited by clients was: improvement of capacity for personal self-care (10/17).

There were no open-ended aims for which hostel clients judged success to have been predominantly poor. Hostel users rarely identified aims spontaneously when they considered attainment to have been minimal. Clients were marginally more likely to sense failure than they were to indicate success in respect of the 'fixed' aims: improving relationships with friends outside the hostel , prevention of deterioration of physical illness , fostering involvement with the community , and preparation of the client to live outside hostel in ordinary housing (primarily Harbottle clients).

There were a number of open-ended aims which both clients and staff of the EMI Homes considered to have been successfully attained (scale points one and two). These were; the provision of medical care (7/9), improvement of functioning in respect of physical handicap (10/11), improvement of capacity for personal self-care (9/16), the provision of material care (13/14), improvement of self valuation (27/35), improvement of relationships with staff (6/8), improvement of mental illness (18/24) provision of companionship (7/8) and of 'a home'(6/6).

Dunstanburgh respondents reflected the EMI Home pattern-except in respect of the improvement of capacity for socialising . At Kielder the pattern was similar, except that there were staff reservations about success in respect

of provision of companionship , improvement of relationships with staff and increase in capacity for personal self-care .

Fixed aims which in the EMI Homes were, mainly, considered to have been successfully achieved (on scale points one and two) by both clients and staff, were: enabling management of personal finances (16/31) enabling the client to function in a more stable manner (42/59) and improving tenacity (31/40).

These response patterns were true for all EMI Homes except that at Warkworth there were some reservations, especially from clients, about improved handling of personal finances.

The EMI Home clients were reluctant to suggest poor success for fixed goal acknowledgement, but, in respect of 'improvement and maintenance of relationships with outside friends (21/38) and 'preparation of the client to live in outside housing (29/40) clients were sceptical about attainment. Again, the response pattern was similar across the EMI Homes, but, at Dunstanburgh and Kielder clients indicated limited success in: enabling them to cope better with life , and recovering from physical illness . 'Poor success' in this paragraph is scale points four and five.

Open-ended aims which staff, but not clients, considered successfully realised were: adjustment to being in care (2/2) (the indications were that clients had not so adjusted; as many thought that they ought to be returned to their

own homes) and preventing psychiatric admissions (3/3) (which clients recognised only when prompted by fixed-aim questions). There were no fixed aims which staff, but not users, judged to have been predominantly well achieved.

There were two open-ended aims which staff alone considered to have been less well attained: persuading clients to avail themselves of opportunities for excursions and holidays (8/14), improvement of interaction in groups (2/2) The latter was recognised only at Bamburgh and Kielder, and the former in all homes except Bamburgh. In response to the 'fixed aims' questions there were none which staff considered to have been poorly achieved.

A striking phenomenon occurred in relation to evaluations of success of open-ended aims at Wansbeck I. This was that in the case of only one aim did *both* staff and clients judge successful achievement in the majority of cases. This category was: improvement of relationships with the client's relatives - an aim primarily external to the unit. Seven out of eight responses were on points one or two of the scale

The response pattern was similar in answers to fixed aims questions. The only exception was that clients and staff perceived a predominance of success in : preventing psychiatric ward admission (40/52).

Conversely;for those open-ended aims which were positively identified by Wansbeck I clients, in all but one case, clients were more likely to indicate success than otherwise. The evaluations were inconclusive - for 'preparation for autonomy outside day care'. To the majority of fixed aims clients usually attributed success.

However, there were five 'fixed aims' where scale four and five points were attributed. These aims were; cutting down or giving up alcohol or drugs(4/7), improving relationships with outside friends (14/26) and preventing physical illness from deteriorating (7/13).

There were no 'open-ended aims' in respect of which Wansbeck I staff judged there to have been a predominance of success. Particularly poor attainment was suggested in respect of: facilitating recovery from mental illness (11/14).

Staff responses to 'fixed aims' questions mainly suggested poor, or indifferent, attainment levels. Particularly frequent 'four' and 'five' evaluations were perceived for enabling the client to cope better with life in general (17/29) and enabling the client to cope better with mental illness (15/22).

Perhaps staff perceptions of failure may have been due to low morale. The high turnover amongst the younger staff gives credance to this theory. Many young Wansbeck I

staff were trained teachers who had been unable to obtain posts in schools. This may have affected their motivation. Staff morale in this unit, which aimed to rehabilitate for work, may have been impaired by the shortage of jobs for clients. (see p. 177)

What is certain is that these staff evaluations of failure cannot have been caused by faulty communication of aims because (in Chapter III) communications were demonstrated to have been excellent (see pp 137-141)

At Wansbeck II there was a higher proportion of aims which clients and staff considered to have been successfully achieved. These were: the provision of outings and holidays (20/27), improvement of physical/medical care (16/25) improvement of self-valuation (15/22), and improving family relationships (10/12). There were more 'fixed aims' which Wansbeck II staff and clients considered to have been successfully achieved than there were at Wansbeck I. In addition on the two aims 'successfully achieved' at Wansbeck I, at Wansbeck II the following 'fixed aims' were stated to have been well attained by a majority of staff and clients: enabling the client to cope better with life in general (53/76) improving ability to handle own money (10/17), helping the client to cut down alco hol or drug abuse (5/5) enabling the client to cope better with mental illness (56/66), getting the client to enjoy life more (63/76), improving relationships with staff (49/49), improving relationships with the client's family (15/26).

There were no open-ended aims which staff, alone, considered to have been well attained, but several which they believed often to have been achieved on scale points four and five. These were: improvement of functioning related to physical handicap (10/16), work rehabilitation (4/5), development of work related skills (9/11), improvement of capacity for socialisation (9/15), and facilitation of recovery from mental illness (3/5).

Some fixed aims were deemed, solely be staff, to have been indifferently achieved; improvement of thought disorders, prevention of deterioration of confusion and improving concentration on occupational activities.

Most 'open-ended' aims which staff considered to have been poorly attained were thought by a majority of clients to have been well achieved. The exception was development of work-related skills which no clients identified. In all these categories, except improving functioning related to physical handicap and enabling recovery from mental illness, client identification was infrequent.

In evaluation of fixed aim attainment, Wansbeck II clients, unlike staff indicated mostly scale point one and two evaluations — in the following categories: prevention of serious depression (17/21) improvement of thought-disorder (27/31), improvement of concentration/capacity in relation to occupational activity (30/37) and prevention of deterioration of confusion (13/17). No fixed aims were deemed by clients to have been predominantly poorly attained.

Success of aim attainment was frequently identified by staff

and clients of all units in the study. The exception was staff perception of widespread failure at Wansbeck I.

Clients considered that most aims *internal* to the units had been well achieved. The reasons for extreme client evaluations may have been connected with personality disorder or emotional immaturity. Conversely, staff were (presumably) more emotionally stable, and through supervision or, occasionally, training, would have learned social work skills of caution in assessment. It is interesting that a majority of negative evaluations were given by clients *only* in response to fixed (leading) questions.

Staff, most commonly, indicated failure in mitigating specific symptoms of mental illnesses or physical handicaps. They tended to see moderate success in most areas and units - other than in Wansbeck I. In all units, staff saw success most often in preventing psychiatric hospitalisation and in improving self-valuation.

Overall, this represents a positive achievement. Lack of staff training and relevant job experience must also have inhibited success. Sophisticated techniques designed to alter behaviour demand a high level of staff training and education. Furthermore, the chronicity of the clients in terms of age, diagnosis, social isolation and social deprivation, must have limited their potential for behavioural improvement. (see Chapter II pp. 65-6, 69 and 74-7.

There may have been difficulties in establishing or maintaining links with friends and relatives outside the unit because of the lack of continuing field social work - especially for the EMI clients (see Chapter II p. 85). Building bridges

between clients and the wider local community may have been hindered by public attitudes to the mentally ill. These were illustrated in a 1979 M.O.R.I poll[24] in which 89 per cent of a representative sample of the British population agreed with the statement: "Most people are embarassed by mentally ill people", and 24 per cent expressed the belief that: "People cannot recover from mental breakdowns". The survey asked "If you had to look after a friend or relative who was ill, which of those illnesses listed would you find it most difficlt to deal with"? 40 per cent of respondents cited mental illness, second in rank order were cancer and multiple sclerosis (each selected by 21 per cent of respondents). Hawks made the point that:

> "It is clear from the various official statements on the development of community care ... that they assume the existence of favourable attitudes toward the mentally ill." [25]

This view together with the M.O.R.I. poll results demonstrate why it was difficult to achieve aims requiring community co-operation.

Sub-Section C2 - Comparisons with other Studies

Some other recent studies of aim achievement in social services for the mentally ill used different methodologies, and general comparisons are still valuable. Direct methodological parallels with this work are to be found in Goldberg's[26] study and in the National Day Care Study[27] to name two examples.

Apte examined, on a comparative basis, rules and practices in hostels and hospitals. He sought signs of restrictive and institutional regimes.

He concluded:

> "It is difficult to determine what social, rehabilitative, or therapeutic advantage was gained by residents of the halfway house; apart from the fact that they were not physically accommodated in the community. When they became ready to leave the hostel, they still had to accept the same types of challenges that (they) would be required to accept in moving directly from an open hospital into the community. It is fairly evident in this situation that the halfway house operates mainly for the economic and administrative advantage of the hospital." (28)

When Hewett replicated Apte's study, she found the situation of her hostel sample to be 'improved' upon Apte's. She concluded:

> "The hostels we saw contained very few institutional characteristics. Those retained by the majority of hostels could be seen as having positive value for the residents as well as administrative convenience for the staff. Looked at from another point of view they can be seen as providing the kind of interest and concern that family members give to one another."(29)

This last point is significant to this study; because it was this kind of care which both staff and clients of Newcastle hostels considered successfully provided. Preparation for autonomy outside care - the main objective on which Apte's investigation focused - was relatively frequently recognised by this study's hostel staff and clients - in response to open-ended questions. A small majority of clients and staff (four) deemed it to have been well attained. Equally, preparation for re-settlement in outside housing was seen as being well achieved in the majority of cases. The findings of this study are closer to those of Hewett than to those of Apte.

Ryan and Wing(30) looked at 'social performance' in Local Authority hostel and group home residents (using the M.R.C. Social Performance Scale). They found that there was little difference in the incedence of socially withdrawn behaviour as between hostel and group home residents. One third of

their hostel residents named four or more friends amongst other residents. Staff judged friendships to be less numerous than did clients. As an index of attainment, it transpired that in the week prior to the study 84 per cent of the sample had gone out on their own, but, only 38 per cent had done so in the company of another resident. Three 'open-ended' aims in this study covered the area of the improvement of capacity for socialising. Newcastle staff and clients tended to perceive poor attainment. However, the provision of peer group companionship was thought by five out of eight Craster clients and staff to have been well-attained. Improving interaction in groups was recognised only at Craster and was considered to have been successfully achieved in two out of three cases.

Ryan and Wing found that only 20 per cent of their sample had visited an (outside) friend or relative during the past week and the 23 per cent had had no such contact for the past six months. That finding partly accords with this study - as clients were divided equally about whether they had improved relationships with outside friends. Staff views were also divided.

Ryan and Wing used the Moos Perceived Environment Scale. Inter alia, they examined the extent to which residents were encouraged to improve domestic self-care. They found that only 7 per cent of hostel residents and 25 per cent of group home residents were given responsibilities in this sphere. *If* similar patters were repeated in Newcastle's units it was not surprising that staff perceived poor, or indifferent, success in achievement. [This study emulates the Moos methodology by

asking both open-ended and fixed choice questions about the same subject areas].

Discussing quality of life, Ryan asserted:

> "quality can be assessed in terms of participation in community affairs, richness of interpersonal contact, degree of autonomy and degree of satisfaction".(31)

The first two were clearly perceived to have been well attained within Newcastle hostels. Participating in the outside community was seen to have been less satisfactorily achieved - particularly by clients.

Relevant to the findings in the EMI Homes are several studies. In discussing the appropriateness of residential care for the elderly, Brearley points out that:

> "research has shown that the majority of old people are integrated into their local communities by the services they receive and give in return to others".(32)

From this perspective, client evaluations of poor achievement of aims like: improving relationships with outside friends are unfortunate. The value of freedom of choice in residential care for the EMIs was emphasised by Gray and Isaacs.(33) They stressed the need to encourage residents to participate in domestic self care. This latter aim was identified by 4 per cent clients and in respect of 21 per cent of clients (by staff). Clients perceived success here, but, staff were most likely to cite mediocre attainment.

Goldberg's(34) study was relevant to the clientèle of the Wansbeck II Unit. Goldberg found some improvement of illness and handicap amongst her sample of elderly social work clients - especially in those receiving help from a skilled worker. This concurs with findings at Wansbeck II. For example improved functioning in relation to physical handicap was seen by clients to have been achieved in

general, but, staff were more critical - deeming it to have been poorly attained in 10 out of 16 cases.

Improvement of peer group interaction was generally thought to have been well attained. 37 Newcastle clients and 14 of the 32 staff citations of the aim attributed scale point one or two evaluations.

Improvement of capacity for socialisation was thought by staff but, not clients, to have been indifferently achieved. This was also true of improving interaction in groups . In comparison with Goldberg's client opinion survey, 10 per cent of Wansbeck II clients mentioned the provision of external excursions and 14 per cent the improvement of functioning related to physical handicap - compared with about one fifth of Goldberg's sample.

The National Day Care Study[35] did not inquire about attainment of aims but about: 'room for improvement' which suggests failure to achieve objectives completely. Some users and staff stated that the work programme was not invested with ''enough significance and meaning''. Some complained of the the limited variety, scope and monotony of the work, and of periods of inactivity.

Some National Study users complained of feeling themselves to be exploited by the nature of the work and low payments, others of the lack of provision of training. The extent of these complaints was not quantified.

National study users wanted to be more actively involved in social activities and desired a livelier atmosphere. Allied

to this (in units for the mentally ill) they requested more outings, a greater range of social activities and facilities for physical recreation. The three Wansbeck I users who mentioned provision of external excursions considered them to have been well provided. At Wansbeck II this aim was thought by staff to have been successfully attained, twice as often, as it was poorly attained. The National Study did not distinguish between treatment of physical and psychiatric disabilities. Users and staff expressed the view that not enough "Doctor's time" was available. Better supervision of drugs and more information about user's illnesses were also sought. Clients of both Wansbeck units who mentioned 'improvement of physical/medical care' considered it to have been attained so, generally, did staff of Wansbeck II. At Wansbeck II, (5/7) clients considered that success had predominantly been achieved in improving functioning related to physical handicap, the converse was true for staff respondents. (mainly pessimistic). Enabling recovery from mental illness was considered by all clients to have been well-achieved but, the opposite pertained to staff responses. This pattern was repeated in respect of the similar fixed aim: except that Wansbeck II staff considered attainment to have been, mainly, successful - 'enabling the client to cope better with physical medical illness' was thought to have been poorly achieved by half of the citing Wansbeck I users - and was well attained according to 13 out of 25 Wansbeck II clients. Staf of both units suggested mixed success.

The National Study users commented on the value of the provision of arts and crafts , comparison in this area

is only fully relevant at Wansbeck II - although some sewing and pottery was undertaken at Wansbeck I. National Study users complained of a limited range and lack of choice of arts and crafts. 56 out of 76 Wansbeck clients suggested good achievement in improving concentration on work or occupation. But; only five staff in both units indicated success (in respect of 29 clients).

A minority of mentally ill clients in the National Study called for changes in staff attitudes which they considered to be 'adverse' or 'uninterested'. This problem was also mentioned by three Wansbeck clients. Enhanced staff relationships was an aim recognised by a few Wansbeck clients in response to the 'open question' and was seen to have been well achieved. In answer to fixed questions exceptionally frequent acknowledgement occurred and in most cases positive attainment was indicated. In the few cases in which staff considered this goal to be relevant, they indicated mixed outcomes.

There are some parallels in perceptions of aim attainment between the National Study and this one. However, close parallels cannot be drawn: as goal achievement was ascertained by very different methods in the National Study.

Sub Section C.3 - The Relationship between Shared Aims and Perceptions of Attainment

Up to now this Chapter has examined degrees of success in aim achievement and has briefly considered possible factors contributing to these outcomes.

This section looks at the role of co-extensiveness of staff and client perceptions in contributing to perceived success.

Olsen[36] found, in his study of social work with former psychiatric patients, that although the social worker was able to identify his or her aims in all cases, 48 per cent of clients could not identify any aims with certainty. This contrasts with only 3 per cent of clients in this study who were unable to identify any aims at all in response to the open-ended question. A further 4 per cent of client respondents in this study said that the unit had no positive aims for them. Almost all 'uncertain' clients were in either EMI Homes or hostels, (two thirds of these were in the EMI Homes). In discussing the results of his study, Olsen continued:

> "However, whilst is is recognised that the concept of contract based upon mutual agreement concerning the social worker's objectives is an important one, this recognition does not imply evidence that such an agreement will result in a more successful outcome. As pointed out by Macarov[37] this area awaits further research".[38]

This study has undertaken some investigation in whether the sharing of goals resulted in a more successful perceived outcome. The following table and Table 60 in Appendix 11 set out the incidence of 'concurrence' in aim recognition and indicate the degree of achievement as assessed by staff and clients in each case. The tables compare the degree of success perceived in respect of the same aims as between cases where clients and staff concurred about the significance of the aim for a client and those where they did not so agree.

Interpretation of this data must be affected by the knowledge of a close relationship between the numbers of concurrences and the numbers of positive responses.

This exercise is undertaken only in respect of open-ended

aims, because of the suggestibility discovered in client recognition of fixed aims (see Chapter III p.118)

The following table analyses the degree of perceived success in those nine categories of open-ended aim where five or more cases of concurrence occurred. Taking the five point scale; it explores whether there was a positive relationship between perceived success of aim attainment and concurrence. The trends for clients and for staff are recorded and analysed separately.

Table 45 Concurrence and Success - All Newcastle Units-Numbers and percentage of responses in each grade

Categories of perceived success on 5-point scale	Staff Responses			Client Responses		
	Conc. Higher	Conc. Lower	Conc. Equal	Conc. Higher	Conc. Lower	Conc. Equal
1 (Great success)	4 (44%)	5 (56%)	0 (0%)	7 (78)	2 (22%)	0 (0%)
2	3 (33%)	3 (33%)	3 (33%)	5 (56%)	3 (33%)	1 (11%)
3 (Mediocre success)	5 (56%)	1 (11%)	3 (33%)	2 (22%)	2 (22%)	5 (56%)
4	4 (44%)	5 (56%)	0 (0%)	3 (33%)	2 (22%)	4 (44%)
5 (Poor success)	4 (44%)	4 (44%)	1 (11%)	1 (11%)	3 (33%)	5 (56%)

Notes; 1. This table is summarised from Table 60 in Appendix 11.

2. The table indicates the number and percentage of cases where concurrent responses were more frequently (or infrequently) found in each scale point classification than were responses in the same aim category which were not concurrent; it seeks to answer the question: "is perceived success more commonly found where concurrence of aim identification exists between staff and clients?"

3. There were four cases of "don't know" responses in these nine aim categories. They are not recorded in this table. Two occurred in non-concurrent responses and two in concurrent ones.

4. 'Concurrent Higher' means that concurrent cases scored higher on the scale than did non-current ones.

5. "Concurrent Lower" signifies that the converse situation pertained.

The nine categories of open-ended aims, where there was a high degree of concurrence, covered a wide spectrum. Three of them related to work/occupation (and were primarily recognised in the day centre). Three encompassed the improvement of personal functioning in terms of mental health and good inter-personal relationships. The three remaining aims dealt with preparation for rehabilitation into the community. Several aspects of some of these aims related to the need for a good quality of life within the unit. Some open-ended aims which were often identified both by staff and clients were concurrent infrequently. These aims related to medical care, functioning related to physical handicap and to the provision of a home. All were found primarily in the residential units (especially the EMI Homes).

There were two aims where, in the assessment of both staff and clients, great success was achieved and where concurrence occurred. These were preparation for autonomy outside care and facilitation of recovery from mental illness . For only one aim was failure (marginally) more likely to be indicated by both staff and clients in concurrent than in non-concurrent cases. This aim was: the improvement of peer group interaction .

Otherwise trends clearly differed between the client and staff groups. *Client's perceptions of considerable success (scale point 1) were more common in concurrent, than in non-concurrent cases for all but two of the nine aims.* These two were: rehabilitation for work and the provision of satisfying occupation (both relevant mainly at Wansbeck). Staff were slightly less likely to perceive great success in concurrent than in non-concurrent

cases. Concurrent aims where staff did not make predominantly scale point one evaluations were: provision of outings/ holidays , improvement of domestic self-care', 'facilitation of job acquisition', improvement of self valuation' and of peer group interaction'.

Aims in respect of which staff were more likely to judge failure (scale point five) where concurrence predominated than where it did not were: improvement of domestic self-care and 'of mental illness' , and (marginally) of 'improvement of peer group interaction' and of 'self-valuation'. Clients on the whole, were reluctant to identify scale point five - (failure) in respect of these nine aims; whether concurrence existed or not. However, in the case of three aims clients allocated a 'five' scale point rating more frequently in non-current cases. These were provision of external excursions , facilitation of job acquisition and improvement of self-valuation. Overall, where clients suggested poor, or relatively poor, attainment (scale points four and five), this was as frequent in concurrent as in non-concurrent evaluations.

Most commonly in cases of concurrence, as for other aims, staff indicated the achievement of mediocre success. The scale points for which concurrence proved to be immaterial were: point two(moderately good success) and point five(failure). In the cases of great success (point one) and relatively poor success - (point four); these were more likely to be instanced by staff in non-concurrent cases than they were when aims were shared.

There was apparently no positive relationship between staff perception of marked success or failure and concurrence.

Section D. - Cost Effectiveness Analysis, Costs and Benefits

The writer considered undertaking a full cost benefit analysis, but, was dissuaded by the difficulties of expressing these benefits in money terms.

One factor was that real cost is equivalent to opportunity foregone: as demonstrated by Culyer.[41] However, in this study, because of the social deprivation and lack of employment prospects of the majority of clients,[42] it would have been difficult to demonstrate that they were relinquishing worthwhile opportunities through using social services. The writer has, therefore, undertaken a more pertinent comparative cost-effectiveness analysis of the units studied and a most relevant comparative costs analysis in respect of hospital and residential day care.

Sub-Section D.1 - Comparison of cost effectiveness of the residential and day care units

In cost-effectiveness analysis, it is essential to be able to quantify costs and benefits numerically, although the latter not necessarily in money terms.[43] This sub-section quantifies the benefits perceived by staff and users as described on the five point scale. It examines the proportion of all aggregated valuations, on each of the scale points, for each unit in the study. A numerical expression of aggregate of

benefits as seen by staff and users is thus produced. This is compared with per capita costs for each unit. The relationship between costs and benefits for each establishment are thus identified and a comparison between the units is effected.

Valuation by clients and by staff running a social service is seen as a valid index of effectiveness by Williams and Anderson. They also point out the need, ideally, to take into account the benefit evaluations of other groups. However, it is difficult to undertake valid output measurement studies with these important groups:

> "The interests of politicians as such are considered to be identified with the "efficiency" of services in general rather than with output measurement in particular, the same is true of citizens as taxpayers.
>
> This will leave us with rival perceptions of what the valuation process is about. The client-originating values are based on the assumption that the clients are the best judges of their own welfare and that it is their valuation that the system should reflect. The professional originating values are based on the assumption that experts know best, and it is their valuations the system should reflect".(42)

Culyer[43] has pointed out that it is essential to ensure that the that the outputs measured are of exactly the same thing. Consequently, cost effectiveness comparisons are only be drawn between units of the same kind.

The writer is mindful of Williams and Anderson's[44] advice that all costs, and not simply those which fell upon the Departmental residential and day care budget, should be accounted for in a costs analysis. The costs of field social work and of overall departmental administration, as well as of assistance

received by clients from other agencies are not taken into account because it was not possible to measure the quantum of each service provided to clients. Furthermore, many received less services than normal because of the strike. Similarly, Kaim-Caudle[45] ignored the overall administrative costs of the agency (the Old People's Council) in his investigation of the costs of a mobile day centre. The costings are averages. The study examines marginal costs as betweenunits of one type. This study also ensures that differential timing of cost streams does not occur and thus invalidate analysis.

The ensuing table showsthe weekly costs per client per unit. It sets these alongside the benefits (extrapolated from tables in Appendix 10) as viewed by clients and staff and quantified by the degree of aim realisation attributed on the five point scale. The table is compiled on a, per capita, averaged basis.

Table 46 Costs and Benefits - Residential and Day Care Units

Financial Year 1978 -79 (Continued Overleaf)

Unit	Cost per client * per week 1978-79 (estimated) (46)	Average number of open-ended aims per client in each unit, evaluated in each of the five degrees of attainment on the scale				
		Points				
		1	2	3	4	5
	£					
Craster	72.26 (58.10)	1.5	0.4	0.1	0.1	0.2
Harbottle	45.15 (52.64)	1.7	0.5	0.0	0.1	0.1
Bamburgh	67.60	1.0	0.2	0.1	0.1	0.1
Dunstanburgh	68.51	0.5	0.4	0.2	0.1	0.2
Kielder	64.19	0.8	0.6	0.0	0.3	1.1
Warkworth	63.01	1.0	0.6	0.0	0.1	0.0
Wansbeck I Unit +	40.56 (Actual costs)	1.1	0.9	0.1	0.1	0.1
Wansbeck II Unit +	"	1.0	0.7	0.1	0.1	0.0
Average	£59.23	1.1	0.5	0.1	0.1	0.4

Notes: * Exclusive of capital debt charges.
+ Estimates for the Wansbeck Day Centre were not available.

1. The figures given in brackets for the hostels were the *original* estimates - on the basis of 27 residents at Harbottle Lodge (instead of the actual 22) and 22 residents at Craster Lodge (instead of 14 actually resident and 12 non-resident). The estimates are adjusted accordingly.

2. The trends in estimated and actual hostel costs were due to: a) Craster actually need to be fully staffed all days and evenings to care for 14 residents and 12 day clients (thus increasing the overtime bill) At Harbottle food/fuel savings (because of fewer residents) appear in actual costs because that hostel was not staffed for day care.

3. Resident clients made financial contributions towards their maintenance which are not accounted for in this table.

4. Average numbers of aims correct to two decimal points.

TABLE 46 Continued

Unit	Average number of open-ended aims acknowledged by staff on behalf of clients in each unit and evaluated in each of the five degrees of attainment on the scale					Average number of fixed aims acknowledged by clients in each unit and evaluated in each of the five degrees of attainment on the scale					Average number of fixed aims acknowledged by staff on behalf of clients in each unit and evaluated in each of the five degrees of attainment on the scale				
	Scale Point					Scale Point					Scale Point				
	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
Craster	0.6	0.8	0.5	0.6	0.3	6.7	3.3	0.8	0.4	1.8	0.7	1.2	1.2	0.6	0.2
Harbottle	0.5	1.0	0.7	0.7	0.3	8.8	4.0	0.7	0.9	1.9	0.7	0.9	0.8	0.8	0.5
Bamburgh	0.3	0.9	0.4	0.3	0.1	5.2	4.0	1.3	0.7	2.6	0.2	0.8	2.0	0.0	0.0
Dunstanburgh	1.1	1.1	0.3	0.3	0.1	5.7	4.8	0.7	1.2	2.1	0.9	1.2	1.0	0.0	0.0
Kielder	0.3	1.0	1.3	0.6	0.3	5.0	3.7	1.4	1.0	2.5	1.1	1.9	1.5	1.0	0.2
Warkworth	1.1	1.1	0.1	0.1	0.2	5.1	4.9	1.6	0.5	1.7	1.8	1.6	1.0	0.4	0.3
Wansbeck I DC	0.2	0.4	1.2	1.2	1.4	5.8	4.5	1.1	1.6	1.4	0.5	0.4	1.1	1.3	1.2
Wansbeck II DC	0.7	0.6	0.8	0.5	1.0	4.4	3.9	1.0	1.0	0.7	0.8	1.3	1.0	0.3	0.5
Average over all clients in study	0.6	0.9	0.7	0.5	0.5	5.8	4.1	1.1	0.9	1.8	0.8	1.2	1.2	0.7	0.4

Because the Wansbeck had no peer comparison, although not a strictly viable one, is made with the other units - otherwise only like units are compared.

When averaged out over the actual number of clients using the *hostels*, running Craster proved more expensive than did operating Harbottle. Detailed estimates showed that the main causes of the differential were: the larger number of staff at Craster - thirteen and a half full-time equivalents compared with only eleven at Harbottle; and the higher "premises" costs for the former.

Staffing costs at Craster were estimated at £53,340 for the financial year 1978-79 compared with £41,277 for Harbottle for the same period. The additional staff at Craster were provided to allow for day care and group home support. Twelve Craster clients were not resident and so were costing less for food, clothing and energy. All twenty-two clients studied at Harbottle *were* resident.

Capital debt charges are excluded from cost calculations in this Chapter. In order to make a fair comparison between the cost of the two hostels it is preferable to exclude fixed premises costs. Premises costs in 1978-79 were approximately double at Craster what they were at Harbottle. The writer has therefore, deducted these, on a per capita basis, from the weekly per capita costs. At Craster the weekly premises cost was £11.76 per client, deducted from the total weekly per capita cost of £58.10 this left £46.34. At Harbottle the weekly

per capita premises cost was £6.24. When deducted from the total weekly per capita cost of £52.64, this left £46.40. The weekly per capita variable costs in each unit were therefore, virtually identical. However, higher food and clothing costs would have had to be met at Harbottle (for 22 as compared with 14 resident clients). All resident clients were compelled to pay towards the cost of their maintenance on a means tested basis - so that actual contributions varied. An average actual contribution of £15.84 per week was made towards upkeep by clients in 1978-79.

Having established a marginal difference in variable costs, the study next examines evaluated benefits on a comparative basis. In client evaluations of aim attainment, Harbottle clients more frequently indicated excellent achievement than did their Craster peers. However, in proportional terms, the differences were marginal - and the different per capita totals were affected by different response rates in the two units. Staff views of aim attainment were more optimistic at Craster than at Harbottle. The proportion of clients admitted to psychiatric hospital was slightly greater at Harbottle than it was at Craster (see p. 167).

Furthermore, performance in assisting job acquisition (see p 175) was slightly worse at Harbottle than at Craster.

In the *EMI Homes,* fixed premises costs varied. Staffing levels were almost identical in each home (twenty-three and a half full-time equivalents - except at Dunstanburgh which had twenty-four). The per capita, per week, premises costs were: Bamburgh £6.21; Dunstanburgh £6.06; Kielder £6.00;

and Warkworth £4.82.

The adjusted weekly per capita costs (with premises costs deducted) were: Bamburgh £61.39; Dunstanburgh £62.45; Kielder £58.19; and Warkworth £58.19. These figures ignore means-tested contributions from residents. These contributions averaged £17.97 across all Newcastle M.D.C.'s homes for the elderly.

In the client's open-ended evaluations of aims, Bamburgh emerged most favourably, followed by Warkworth. In client responses to fixed questions, the results were fairly even (with Dunstanburgh the marginal leader followed, in rank order, by Kielder, Bamburgh and then Warkworth).

In staff evaluations of success in open-ended aims, Dunstanburgh and Warkworth came well above the other two homes (with averages of 1.1 scale point one evaluations per client). As between homes; 'failure' rates were similar - but marginally higher at Kielder (0.3 scale point five evaluations per client (average)). Success in fixed aims was often perceived by Warkworth staff and infrequently at Bamburgh - with the other homes ranked between. Poor attainment was rarely cited by staff in any of the EMI Homes. The differing client evaluations at Dunstanburgh are not readily explicable.

Benefits did seem to accrue to one of the costlier homes Dunstanburgh - but less certainly to the other - Bamburgh (where hospital admissions were exceptionally numerous). The latter was a newly opened home at the time of the study and was perhaps suffering 'teething problems'. Warkworth, a less costly home, also emerged from the analysis with credit.

The costs for the *Wansbeck*[47] are actual and not estimates. They are not broken down between the two units - the City Treasurer was unable to do so. This presents a problem because staffing numbers were different in each unit. Separate premises costs were not available either. Crude comparisons with the other units are illuminating. The comparative weekly costs of day care seemed high compared with those of the residential units. Per capita costs were almost two-thirds of the actual costs of residential unit costs (which included full board and lodging and around-the-clock staffing on a shift-with-overtime payments system). The Wansbeck unit was open only 48 weeks in the year, five days per week and from 9.00 am to 4.00 pm. Residential units were open 52 weeks per year.

Client evaluations of successful aim attainment in both Wansbeck units were similar. Hostel clients were more likely to suggest great success in aim attainment than were those at Wansbeck (hostel clients identified an average of six to nine scale 'one ' attainments compared with an average of four to six at Wansbeck in respect of fixed aims) but were also more likely to indicate poor success. Less marked success and more failure was perceived by EMI Home clients than was judged in the hostels or the Wansbeck.

Staff evaluations of success in aim achievement at Wansbeck I were far worse than in any other unit in the study. Evaluations at Wansbeck II were broadly similar to those in the EMI Homes.

As Myers[48] and Winnicott[49] have pointed out, depression is not uncommon in those who work with the mentally ill, particularly if they are not fully trained and/or are new to the work. If this was the cause of the phenomenon at Wansbeck I; it was not found in the other units studied. This trend renders

the Wansbeck I more cost ineffective.

Sub-Section D.2 - Comparison of Hospital and Social Services Establishments Costs

The scope of this study has not permitted examination of benefits to be derived from sojourn in a psychiatric ward; rather, it has accepted the assumptions of 'B.S.M.I.'[50] and the Mental Health Act 1959[51], that a valid objective of Social Services for the mentally ill is to prevent admission to psychiatric wards - in order to enhance quality of life.

The study has not replicated that of Apte[52] which compared the quality of residential care with hospital care. A cost effectiveness analysis cannot be undertaken as the benefits of hospital care have not been investigated. However, other studies have conducted opinion surveys with psychiatric in-patients in an attempt to gauge the effectiveness of services. Although direct comparisons should not be made; it is illuminating to compare their findings with those of this study of social services units.

Raphael and Peers[53] found that just over half of their sample were 'mainly satisfied' with their stay in hospital, the principal sources of complaint was inadequate medical attention (this parallels many units in this study).

Gorden et al[54] found that their in-patient sample considered that most of their emotional and physical needs had been adequately met but cited two areas requiring improvement: the maintenance of the individual's identity (one of the most successful achievements in Newcastle units) and the development of better staff/patient relationships (again an area where

this study identified success).

Brandon[55] interviewed ten former long-stay patients. They complained of lack of privacy, about food, of loss of possessions and of the remote situation of the hospital - problems which were not apparent in Newcastle. They appreciated occupational activities and staff relationships-in parallel with Newcastle clients. Furthermore, they complained of inadequate medical attention, and also about the hospital regime.

These studies show some aspects of the in-patient's quality of life to be inferior to that found in Newcastle's social services units, but, some shortcomings were common to both. Because an objective of Social Services for the mentally ill in Newcastle was: to prevent psychiatric ward admission[56] a pertinent *comparative costs* analysis is now undertaken.

The following table illustrates the comparative costs of hospital in-patient and social services care for the mentally ill in Newcastle in 1978-79.

Table 47 Comparative Costs of Psychiatric Hospitalisation and Residential and Day Care in Newcastle - Financial Year 1978-79 (Actual costs - exclusive of capital debt charges)

Unit	St. Nicholas Hospital (Psychiatric)	Claremont House Psychiatric Unit	Newcastle Psychiatric hostels (per *resident*) (Actual)	Wansbeck Day Centre (Actual)	EMI Homes (Actual)
	£	£	£	£	£
Average cost per user per week	114.03	77.49	69.48	40.56	58.79
Average cost per user per week less income from charges	114.03	77.49	53.64	36.16	40.82
Average cost per user per day (excluding payments)	16.29	11.07	9.93	8.11	8.40
Average cost per user per day less income from charges (if applicable)	16.29	11.07	7.66	7.23	5.83

Notes: 1. The 'actual' costs for the EMI Homes do not reflect their real cost as the figures are aggregates for all homes for the elderly run by Newcastle Council at that time. A more accurate guide is the estimated costs per client per week for the EMI Homes for that year. These were: Bamburgh £67.60, Kielder £64.19, Dunstanburgh £68.51 and Warkworth £63.01 - per client per week. Staff/client ratios were higher in EMI Homes than they were in ordinary Part III homes for the elderly, hence much of the additional cost.

2. In addition to the psychiatric in-patient facilities in Claremont House and St. Nicholas hospital, Newcastle General Hospital provided two in-patient psychiatric units. However, patient costs were available only in aggregate form for the whole hospital

and were inflated by the costs of surgery, radiotheraphy and so forth. They have, therefore, been omitted from the table.

3. The daily costs of the day centre are averaged over a five day week, whereas those for all other units are averaged over a seven day week.

4. A contribution would also have been made towards the cost of their 'keep' whilst in hospital by those in-patients whose income was derived wholly from state benefits or to some extent from retirement pension. Consequently, some part of hospital costs was recovered by the State.

5. The source of data for Newcatle's Social Services is "Personal Social Services Statistics (1978-79 Actuals)" published by the Chartered Institute for Public Finance and Accountancy. The remaining data in this table was supplied by the Sector Administrator, Newcastle Area Health Authority and the City Treasurer's Department.

6. The day centre costs are averaged over all the clients attending the centre at the time of the study. Many clients did *not* attend five days per week. These costs are attributed equally to all clients regardless of the number of days of attendance per week. The costs for full-time clients were, therefore, greater than this table indicates.

7. Hostel and EMI Home costs relate only to *resident* clients. The cost of extra staff at Craster to support day care and group home clients is added to the average per capita cost per resident.

As Claremont House is a psychiatric unit which at the time of the study provided mainly for non-Newcastle residents, the principal cost comparisons are made with St. Nicholas Psychiatric Hospital- in which many study clients had been in-patients.

The differential in weekly costs between St. Nicholas' and the hostels was £44.55 per week. This is a good comparison as both include full board and lodging and those on Supplementary Benefit or Unemployment Benefit would contribute a similar amount towards their keep in either. The majority of hostel clients were dependent upon state benefits (see Chapter II p.66). The same was true in the EMI Homes; where the differential with hospital care at St. Nicholas was £48.20 per week (using the median of the estimated costs

for the four EMI Homes(£65.83 per week).

Comparison is affected, however, by the fact that hospital costs include medical and pharmaceutical services which are borne for social services clients by the N.H.S. Family Practitioner Committee and do not appear in Social Services costings. It is also possible that many hospital patients required more intensive and,therefore, expensive care than did social services unit users. Comparisons with the day centre are of more tenuous value as there were no residential costs there and other costs such as housing subsidies, which also tap the public purse, would need to be examined.

Both hospital and residential or day-care costs used public funds but, in one case debited the Area Health Authority and the other the City Council. There was potential scope for transfer payments through the Joint Funding Scheme. Both hospital and residential and day-care users may also have received additional services - for instance, field or hospital social work. However, this , and similar services,could not be included in either costing. Investigation proved them impracticable to cost, because of the problems of apportioning administrative backup costs and the differing amounts of time which social workers spent with different clients.

Residential care was thus, much cheaper than hospital care, but, this study does not probe their comparative benefits.

Section E - Chapter Summary

The first task of the chapter was to examine psychiatric hospitalisation records of unit clients. It transpired that admission rates during the monitored preceding year were low from all units except one EMI Home. Only clients who had received in-patient care previously were hospitalised. Those who were hospitalised remained there for relatively long periods.

Amongst younger clients disappointing job acquisition records must be appraised against the background of high current local unemployment. Primarily through their own efforts rather than those of enabling agencies. Staff and client evaluations of aim attainment indicated reasonable success in all units except Wansbeck I (where staff dissented).

There was general agreement concerning positive attainment of aims related to improvement of client self -valuation, relationships within the unit and provision of material care. Poor attainment was perceived, especially in units for elderly clients, in the achievement of goals external to the units involving relationships and re-settlement.

Staff suggested indifferent attainment of aims relating to the modification of behaviour of younger clients and all clients perceived shortcomings in medical care. Failure to attain aims fully was possibly due to lack of staff skills in behaviour modification and medical care. Poor staff

evaluation at Wansbeck I probably reflected low staff morale. Major constraints on the realisation of external goals may have lain in discontinuation of field social work support and in public attitudes. Clients proved more likely to adjudge success where aims were shared with staff (concurrence). But staff assessments were largely unaffected by goal sharing.

The costs and benefits comparison between social services units showed no pronounced links between costs and benefits in units of the same kind, or for the same client age group.

A comparative costs survey as between social services and hospital in-patient care showed hostels to cost little more than half of hospital care and day care costed only one third as much.

In summary a relatively high quality social service was being provided at a reasonable cost.

NOTES TO CHAPTER IV

1. See Chapter III, p.p.

2. "Better Services for the Mentally Ill" p.p. 31-40 (1975) Pub. H.M.S.O.

3. Morgan N. and Johnson, N. "Failures in Psychiatry", p.p. 824-830

4. Odegard, O. "Marriage and Mental Disease", 1946, Journal of Mental Science, No. 92 p.p. 35-39

5. Norris, V. "A Statistical Study of the Influence of Marriage on the Hospital Care of the Mentally Ill", 1956. Journal of Mental Science Vol. 103. No. 430 p.p. 146-169

6. "The Hospital In-Patient Enquiry 1979 Pub.Govt.Stat.Service(1983)Table 25 p.p. 1-33.

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FINAL SUMMARY

1. Chapter I

(a) From 1959 onwards, the City of Newcastle upon Tyne Committees responsible for mental health social services responded promptly, and ahead of the majority of comparable English Local Authorities, to Government prescription for policies for the mentally ill. Newcastle's quantity of service provision was considerable - in comparative terms.

(b) Social Services for the mentally ill developed apace in Newcastle during the 1960's, but, the implementation of the 1970 Social Services Act led to the temporary elimination of people with mental health expertise from departmental senior management, and to a slowing down of the instigation capital projects for the mentally ill. The pace of progress gradually increased after local government reorganisation in 1974.

2. Chapter 2

(a) Basic grade staff of the residential and day care units studied were mainly female, of manual working class origin and, when appointed, most had little relevant education, training or work experience. The exception was the younger craft instructors in the day centre who were mostly school teachers unable to obtain a more appropriate post.

Most residential unit managers had received nurse training and much of their previous work experience was in hospitals. In the day centre, management had received somewhat inappropriate training and had originally entered the work from industry.

The staff age range was wide. Overall staffing ratios and characteristics were quite similar to those discovered by other studies of like services.

(b) The clients in the sample were mainly in later middle age or old age. Surprisingly, the ratio of men to women was about the same. But, if the entire clientèle of the EMI Homes had been included, women would have greatly outnumbered men. A very high proportion of clients were single, most elderly clients were widowed.

The psychiatric diagnoses which predominated were schizophrenia and brain disorders. An appreciable number of neurotics was found only at the Day Centre.

Three quarters of the users had received services for over a year, and many for far longer. Surprisingly, 41 per cent of the total sample had never been admitted

(b) The theory of Management by Objectives, seemed within the service, to operate in part. Some Objectives were clearly conveyed through two or three tiers of staff to the client. Others did not percolate through. The most effective communication of aims seemed to be in units where there were frequent and regular staff meetings and where heads of units were better educated. Communication was poorest where the converse was true.

The greatest misperception of aims occurred in the EMI Homes between staff and clients, for instance, the former considered that they were providing a permanent home for virtually all clients, most of whom indicated, for themselves, the aim of rehabiliitation into outside housing.

Failure to understand this and other aims, in the EMI Homes may have been exacerbated by the low skill of basic grade staff. - Clients seemed to have a better appreciation of politician's and senior manager's aims, especially those external to the unit, than did staff. This may have been due to their suggestibility when answering 'fixed' questions.

4. Chapter IV

(a) The record of the residential and day care units in preventing psychiatric hospitalisation over a twelve month monitored period, was excellent. Only 10 per cent of the clients were admitted to hospital after reception into the units. All those who were admitted had been hospitalised during the preceding four years. Once admitted to hospital most clients had a relatively long sojourn there.

(b) A few hostel clients and two Wansbeck I clients succeeded in obtaining employment, mainly through their own efforts.

(c) Aims in which staff and client opinion most frequently indicated success related to self-valuation and to personal relationships within the unit. Clients appreciated the quality of material care provided.

Users considered that most goals internal to the units had been well attained, but they, together with staff suggested mixed attainment in self-care goals and other behaviour modification. The worst attainment, according to EMI Home clients, was in preparing them to live outside care and in helping them to establish/maintain links with the outside community, younger clients applauded rehabilitation goal achievements. Staff disagreed. Residential clients were also somewhat dissatisfied with their physical/ medical care.

to a psychiatric ward in Newcastle. Few had been hospitalised for long periods or on multiple occasions in the four years preceding the study.

A handful of working aged clients were employed, most came from the unskilled working class and the majority who were not in residential care, lived in council housing.

(c) The main reasons for clients being referred for social services lay in difficulties with inter-personal relationships (mainly younger clients) and in inability to care for themselves (principally older clients). They received little support from outside agencies other than the general practitioner and a large proportion, especially of the elderly, no longer had field social workers.

3. Chapter III

(a) Overall most aims were seen by politicians and by senior managers as social, but basic grade staff and clients demonstrated a more clinical orientation. The service aims which were most readily recognised by staff and clients of the hostels related to re-habilitation in living skills, to improving capacity for autonomy outside care , and enhancing self-valuation generally. Preventing admission to psychiatric wards, and facilitating recovery from mental illness were also acknowledged.

In the EMI Homes, staff and clients also concurred with aims of improving relationships and self-valuation. Staff emphasised clinical aims related to mental illness and the improvment of self-care capacity. Clients were more pre-occupied with their (physical) medical needs.

At the Wansbeck I unit, staff and clients endorsed aims concerning relationships and self-valuation also improvement of mental illness, and were concerned with work-related aims. Staff focused, more than did users, upon self-care goals.

In the Wansbeck II unit for elderly clients, staff and users aimed for satisfying occupation, to improve functioning related to mental illness and to prevent admission to psychiatric wards. Staff were more pre-occupied with the provision of outings and medical care whereas clients concentrated on improving personal relationships inside and outside the unit.

Overall, these aims had a greater medical orientation tha the writer had anticipated. This was probably partly linked with the nursing background of most senior staff.

Staff were more pessimistic about having improved functioning related to mental illness and (in older clients) to physical handicap.

(d) The attainment of some aims, particularly those which required a sophisticated approach to treatment methods, for instance, behaviour modification, was probably hampered by lack of staff training and education. That staff sometimes saw clients as having poorly achieved aims must be seen against the background of the 'chronic' characteristics of many clients. Exceptionally poor staff evaluations of aim attainment at Wansbeck I were probably due to low staff morale.

(e) The writer set out to test Olsen's theory (see pp 196-200) that: aims are more effectively attained when they are shared between careworker and client. This hypothesis had not previously been tested through opinion survey - so far as the writer is aware. The evidence was that in the case of shared aims, clients were more likely to perceive success where the aim was shared than where it was not. However, the factor of aim sharing made virtually no difference to staff evaluations.

(f) The services were relatively successful in preventing psychiatric hospitalisation therefore, cost comparison (with hospital) is pertinent. It showed that residential social services were cheaper (per week) than in-patient care in the local psychiatric hospital by the following approximate margins: Hostels £44.55, EMI Homes £48.20; drugs and medical treatment costs are reflected in the hospital, but not in the social services costings. No comparative survey of benefits was undertaken between hospital and social services in Newcastle.

(g) The variable costs between the units did not differ greatly and there was no apparent relationship between higher costs and perceived benefits. Day-care costing just under two thirds of the price of hostel care per client, per week (averaged out) was relatively expensive.

(h) By a small margin greater success in aim attainment was found in the longer established, more traditionally run units, where politicians and the Advisers aims were less readily understood.

Finally

The writer is loath to make recommendations on the basis of opinion survey concerning present states and the respondent's existing frames of reference. Despite a few shortcomings the relatively extensive Residential and Day Care services provided by Newcastle upon Tyne Social Services Committee in 1978-79 were operating effectively.

APPENDIX 1

LIST OF RESIDENTIAL AND DAY-CARE UNITS FOR THE MENTALLY ILL PROVIDED BY THE CITY OF NEWCASTLE UPON TYNE COUNCIL SOCIAL SERVICES DEPARTMENT IN 1979

A. Residential hostels for the mentally ill under retirement age - these also provided day-care and support for former residents living in the neighbourhood:

Harbottle Lodge
Craster Lodge

B. Residential homes for the Elderly Mentally Infirm (EMI Homes). These provided residential care on both a long-term and a holiday relief basis:

Bamburgh House
Dunstanburgh House
Jedburgh House (not fully converted to an EMI Home in 1978-79)
Kielder House
Warkworth House

C. Day-centre for the mentally ill:

The Wansbeck Day Centre

subdivided into two units for clients below pensionable age (Wansbeck I) and those above it (Wansbeck II)

The Local Day Centre - open one half day per week

Notes:

1a. Jedburgh House was excluded from the study as it was in the process of being changed from being a 'Generic' Home for the elderly to an EMI Home at the time of the study.

b. The local day centre was excluded from the study as it was closed at the material time (a consequence of the Social Workers' strike).

2. The unit names used throught the study are fictitious - in order to preserve confidentiality and to prevent invidious comparisons being made as between units (outside Newcastle Social Services Department) Identifying data will be available for information within the Department. The fictitious names were chosen because they are the names of places in or near Northumbria.

APPENDIX 2

Craster Lodge

Aims and objectives of unit (verbatim statements)

(a) Professional Adviser's statement

1. To Provided a supportive home in the community for those recovering from mental illness (but not active psychotically).
2. To improve personal functioning in self management (cleanliness, feeding, clothing, etc.) and in financial affairs.
3. To improve capacity for inter-personal relationships and making initial contact with other people.
4. To develop the personal initiative of the client.
5. To offer some counselling and support to ex-residents living in the community.
6. To offer social contact and leisure interests/hobbies to ex-psychiatric hospital patients (through day care).
7. To involve the local neighbours in the functioning of the hostel and form a better understanding amongst them of mentally ill people.
8. To offer short term residential support and help to the mentally ill (holiday placements).
9. To improve communication between other agencies in the interest of the client.
10. To diagnose clients' problems and help clients solve these via insight giving groups.

(b) Head of Home's statement

1. To increase self-motivation towards an independent life in the community.
2. To improve self confidence by giving a sense of security and belonging to an 'accepting' group.
3. To help clients enjoy themselves more and to think less of their problems.
4. To help clients to think and behave more rationally and see the consequences of actions and reactions.
5. To improve interpersonal relations and consideration and acceptance of others.
6. To increase self-confidence by encouraging creative interests and constructive skills.
7. To stimulate interest in activities in the local area, and the world at large, to use leisure time better.
8. To teach cooking, shopping and budgeting skills.
9. To improve basic self-care and hygiene
10. To help find suitable accommodation and maintain it.

APPENDIX 2a

Harbottle Lodge

Aims and objectives of unit (verbatim statements)

(a) Professional Adviser's statement

1. To provide an authoritative and supportive home in the community for those recovering from mental illness (not active psychotically).
2. To give long term and more intensive care to clients.
3. To improve personal functioning in self-management, cleanliness, feeding, clothing, etc. and with financial affairs.
4. To improve capacity for inter-personal relationships and making initial contacts with other people.
5. To develop the personal initiative of clients.
6. To offer some counselling and support to ex-residents living in the community.
7. To offer short term residential support and help to the mentally ill by holiday placements.
8. To improve communciations between other agencies in the interest of the client.
9. To support residents in setting themselves up and maintaining themselves in group homes.
10. To enable clients to mature emotionally and become less dependent.

(b) Head of Home's statement

1. To help residents to develop confidence in themselves.
2. To test abilities and limitations of residents.
3. To develop integrity in residents and insight into their particular illness and help them to come to terms with it.
4. To reduce institutionalisation.
5. To encourage socialisation within and without the hostel.
6. To motivate self-care and care of own room.
7. To help residents to learn to cope with the emotional stresses of everyday life and encourage self-control of behavioural problems.
8. To teach residents to budget.
9. To encourage residents to structure their day, e.g. attending day centre or seeking employment, etc.
10. To stress the importance of non-abuse of prescribed medication.

APPENDIX 3

Bamburgh House

Aims and objectives of home (verbatim statements)

(a) Professional Adviser's statement

1. To offer a supportive, homely and flexible environment to elderly mentally disabled people.
2. To preserve an individual's skills and assets.
3. To improve the quality of on-going life experiences in line with their immediate past.
4. To introduce clients to compensatory social outlets and activities.
5. To improve client's ability to communicate.
6. To enhance client's sense of personal worth in old age.
7. To provide a permanent home and refuge for life - for the vast majority of clients.
8. To stimulate decision-making and problem-solving capacity and to enhance general personal functioning.
9. To maintain and strengthen existing links with friends and relatives in the outside community.
10. To foster involvement with the outside community.
11. To identify potential for greater independence and to enhance it.
12. To increase freedom of movement and decision-taking opportunities.
13. To provide some holiday and day care for the elderly mentally infirm.

(b) Superintendent's statement

1. To create a homely environment.
2. To try and maintain resident's independence.
3. To establish good working relationships between residents and staff.
4. To encourage and improve social life.
5. To involve residents and staff in the total running of the home.
6. To involve the community with residents.

APPENDIX 3a

Dunstanburgh House

Aims and objectives of home (verbatim statements)

(a) Professional Adviser's statement

1. To offer a supportive, homely and flexible environment to elderly mentally disabled people.
2. To preserve and maintain individual skills and assets.
3. To improve the quality of life experience (on-going)in line with the immediate past.
4. To introduce clients to compensatory social activities and outlets.
5. To improve client's ability to communicate.
6. To enforce client's sense of personal worth in retirement.
7. To provide a permanent home and refuge for life - for the vast majority of clients.
8. To stimulate decision-making and problem-solving capacity and to improve general personal functioning.
9. To maintain and strengthen previous links with outside relations and friends.
10. To foster involvement with the outside community.
11. Some holiday relief and day care for the EMI's.

(b) Superintendent's statement

1. To try to maintain and improve, where possible, the quality of life of the residents.
2. To make life as pleasant as possible, and give the residents a feeling of security.
3. To make the home as much like resident's own home as regards freedom of movement, with as many personal possessions with them as is practical.
4. To look after, and care for, those unable to do so adequately for themselves.
5. To provide residents with hobbies and social activities.

APPENDIX 3b

Kielder House

Aims and objectives of home (verbatim statements)

(a) Professional Adviser's statement

1. To offer a supportive, homely and flexible environment to elderly mentally disabled people.
2. To preserve and maintain individual skills and assets.
3. To improve the quality of life experiences (on-going) in line with the immediate past.
4. To introduce clients to compensatory social activities and outlets.
5. To improve client's ability to communicate.
6. To enforce client's sense of personal worth in retirement.
7. To provide a permanent home and refuge for life - for the vast majority of clients.
8. To stimulate decision-making and problem-solving capacity and to improve general personal functioning.
9. To maintain and strengthen previous links with outside relations and friends.
10. To foster involvement with the outside community.
11. To provide some holiday relief and day care for the EMI.

(b) Acting Superintendent's statement

1. To prevent the residents, and the home, from becoming an institution.
2. To maintain and resident's independence.
3. To maintain and encourage involvement within the community.
4. To respect the resident's wishes regarding: (a) privacy, (b) handling of own affairs, (c) selection, e.g. meals, clothing, entertainment.
5. To participate in the running of the home.
6. To create a friendly, homely, atmosphere within the home.

APPENDIX 3c

Warkworth House

Aims and objectives of unit (verbatim statements)

(a) Professional Adviser's statement

1. To offer a supportive ,homely and flexible environment to elderly mentally disabled people.
2. To preserve and maintain individual skills and assets.
3. To improve the quality of life experiences (on-going)
4. To introduce clients to compensatory social activities
5. To improve client's ability to communicate.
6. To enforce client's sense of personal worth in retirement
7. To provide a permanent home and refuge for life for the vast majority of clients.
8. To stimulate decision-making and problem-solving capacity and to improve general personal functioning.
9. To maintain and strengthen previous links with outside relations and friends.
10. To foster involvement with the outside community.
11. To provide some holiday relief and day care for the EMI's.

(b) Acting Superintendent's statement

1. To help maintain and improve their quality of life.
2. To motivate and stimulate, also general care.
3. To prevent deterioration within their mental capacity.

APPENDIX 4

Wansbeck Day Centre

Aims and objectives of units (verbatim statements)

(a) Wansbeck I (adult clients)

Professional Adviser's Statement

1. To support people recovering from mental illness (through social contact).
2. To help them to survive in the community.
3. To prevent re-admission to psychiatric in-patient unit.
4. To relieve pressures on families of clients.
5. To enable clients to feel accepted as people.
6. To provide occupation, interest and stimulus.
7. Development of self-confidence, self esteem and capacity in inter-personal and practical areas.
8. Re-shaping and developing positive attitudes to others.
9. Working towards 'normal' functioning in the community, including work (clients under 60).
10. To improve the quality of life of clients.

Manager's statement

1. Social rehabilitiation
2. Work rehabilitation.
3. Occupation
4. Motivation
5. Monitoring and support of clients.
6. Assessment
7. Home relief (relatives).
8. Home planning, economics, health and safety.
9. Leisure activities.

Wansbeck II (elderly clients)

Professional Adviser's statement

1. To support people recovering from mental illness (through social contact).
2. To help them to survive in the community.
3. To prevent readmission to psychiatric in-patient unit.
4. To relieve pressures on families of clients.
5. To enable clients to feel accepted as people.
6. To provide occupation, interest and stimulus.
7. Development of self-confidence, self-esteem and capacity in inter-personal and practical areas.
8. Re-shaping and developing positive attitudes to others.
9. Working towards 'normal functioning in the community including work clients under 60).
10. To improve the quality of life of clients.

Managers statement.

1. Social rehabilitation
2. Work rehabilititation
3. Occupation
4. Movitation
5. Monitoring and support of clients
6. Assessment
7. Home relief (relatives)
8. Home planning, economics, health and safety.
9. Leisure activities.

APPENDIX 5

RESIDENTIAL/DAY CARE CLIENT RECORD (TO BE COMPLETED BY UNIT STAFF WITH GUIDANCE)

SURNAME FIRST NAME(S) CODE NUMBER

Address Address Code

Present/former occupational level

Client Spouse

Duration of attendance at unit

Whether currently employed (Hostel residents)

Age

Duration of last hospitalisation

Number and dates of admissions to psychiatric ward(s) (ever)

Marital status

Sex

Primary diagnosis (psychiatric)

Known to social/medical agencies (outside Social Services Department)

Social Worker's assessment of problem(s) (pre-admission)

Source of income

Other L.A.S.S.D. services actually received since referral

Housing Situation

(a) (b)

(c) (d)

Outside employment since admission (number of jobs)

How was each job obtained?

Current involvement with voluntary organisations (state which)

Whether still involved with field social worker (L.A.S.S.D.)

APPENDIX 5 (2)

Date of admission to unit

Has take-up of residential/day care been continuous since admission?

Day care clients - number of attendances each week

Date discharged from residential unit (if applicable)

Date discharged from day care unit (if applicable)

If discharged, whether receiving on-going support from unit

Date of completion of client data

APPENDIX 6(1)

STAFF GOAL IDENTIFICATION QUESTIONNAIRE

Client Name

Address (for day clients only)

Client code

Address code

Length of unit attendance/residence Diagnosis

(a) Before proceeding to fixed goal identification, please list briefly the aims of unit for this client. (Open-ended Aims)

1. _____

2. _____

3. _____

4. _____

5. _____

(b) To what extent have these objectives been attained (appropriate to time of response)? Please use the six point evaluation scale described overleaf.

Aim Number

1. 2. 3. 4. 5.

N.B. Please number and then assess degree of attainment of 'fixed' aims overleaf.

APPENDIX 6 (2)

CODE FOR STAFF GOAL ATTAINMENT QUESTIONNAIRE

Open-ended aims

Part (a) List each aim of unit for named clients in not more than 15 words.

Part (b) Extent of goal attainment - this must be related to the time which was intended for goal attainment and the proportion of the alloted time which has expired, viz. if a client is making appropriate progress towards a long-term goal not due for attainment for some time, then a favourable response is indicated.

Full attainment	1
Good attainment	2
Moderate attainment	3
Little attainment	4
No attainment	5
Don't know	6

Fixed-aims

Possible aims for clients are listed below and staff are asked to select those which are appropriate for the client in question and put the aim number alongside a number on the above five point scale to indicate degree of success in attainment:

1. To improve adjustment to coping with the ordinary demands that 'life' makes on the individual.
2. To improve ability to handle personal finances appropriately.
3. To prevent client from needing re-admission to psychiatric (in-patient) hospital care.
4. To dissuade from suicide attempts.
5. To reduce alcohol consumption or drug abuse.
6. To terminate alcohol consumption or drug abuse.
7. To improve thought disorders (including symptoms of senile dementia).
8. To prevent deterioration of thought disorder/senile dementia.
9. To improve adjustment to medical/physical disability/illness.

APPENDIX 6 (3)

10. To prevent deterioration of medical or physical illness or disability.

11. To improve symptoms of psychiatric illness.

12. (Day care only)- to improve clients general level of satisfaction with life.

13. (Residential clients only) to induce greater emotional/social stability.

14. (Residential clients only) to improve self care.

15. (Residential clients only) to improve ability to cope with adversity/crisis.

16. Improve relationships with family.

17. Improve relationships with friends.

18. Improve relationships with other clients.

19. To improve relationships with staff.

20. (Day care clients only) - to enable clients to make a more positive contribution to society and to the outside community in general.

21. To improve relationships with other social/welfare/health agencies (e.g. G.P., Housing, D.H.S.S., etc.)

22. To improve concentration span and application in relation to work/leisure activities (including craft-work and reading).

23. To foster ability to gain and retain outside employment.

24. To foster ability to gain and retain sheltered employment.

25. (Residential clients only)-to induce capacity to live in ordinary housing.

26. To induce capacity to live in sheltered/supported housing.

27. To prevent clients from engaging in criminal activity.

28. (Day care clients only) to maintain client in their own home and to prevent admission to residential care.

29. (Residential clients only) to improve instutionalised behaviour patterns.

APPENDIX 7 (1)

CLIENT QUESTIONNAIRE

Name

Address

Client Code

Address code (day care clients only)

Diagnosis

Diagnosis code

Client Code | Address code | Diagnosis Code | Discharged?

N.B. PART B to be answered AFTER completing PART A

Part A - Open ended Question

(a) What do you think the unit has been doing in its efforts to help you (list up to four things)? Elaboration: "What are they trying to do for you here?"

1. _____

2. _____

3. _____

4. _____

(b)

To what extent has each of these things helped you?

1. 2. 3. 4.

Notes: 1. Elaboration was added if client did not appear to understand the initial question.

2. Codes were used to preserve confidentiality in the computerisation of the data.

3. The five point scale, used for staff responses (plus point 6 for 'don't know') - was also used in this questionnaire.

APPENDIX 7 (2)

CLIENT QUESTIONNAIRE Part B

Has the unit helped you with any ofthe following - if so, to what degree(on the five point scale): 6= Don't Know:

Section 1 - SELF CARE	Relevant or Not	Scale Poi
1. Coping better with life in general?		
2. Helping you to keep out of (Psychiatric) Hospital(as an in-patient)?		
3. Helping you to handle your own money better?		
4. Preventing you from trying to kill yourself?		
5. Helping you to cut down on drinking/drug taking?		
6. Helping you to give up drinking/drug taking?		
7. Helping you to think straighter and to see things more clearly and realistically?		
8. Stopping you becoming more confused?		
9. Helping you to cope better with physical/ medical illness/disability?		
10. Preventing any physical/medical illness/ disability, which you had when you entered the unit, from getting worse?		
11. Helping you to cope better with emotional/ mental illness?		
FOR DAY CARE CLIENTS ONLY		
12. Helping you to enjoy life more since starting at the day centre?		
FOR RESIDENTIAL CLIENTS ONLY		
13. Making your life on moreof an 'even keel' since you came to live in the home/hostel?		
13a. Making your life on more of an 'even keel' since you left residence in the hostel?		
13. Helping you to look after yourself better since you came to live here?		
14a. Helping you to look after yourself better since you stopped living in the home/hostel?		

APPENDIX 7 (3)

	Whether Relevant	Scale Point
15. Helping you to feel better able to 'face up' to life since you came to live here?		
15a. Helping you to feel better able to 'face up' to life since you stopped living in the home/hostel?		
SECTION 2 - SOCIAL/PERSONAL RELATIONSHIPS		
Has attending/living in the unit helped you with the following, and if so to what degree on the scale?		
16. Getting on better with members of your family?		
17. Getting on better with your friends?		
18. Getting on better with other residents/attenders at the unit?		
19. Getting on better with the unit's staff?		
FOR DAY CARE CLIENTS ONLY		
20. Has coming to the unit helped you to contribute more to the community and to other people in general?		
21. (Also for former residential clients) Enabled you to have better relationships with other helping agencies, e.g. doctors, social security and housing officers?		
SECTION 3 - RESETTLEMENT		
Has attending or living in this unit helped you with the following, and if so, to what extent on the points scale?		
22. Concentrating on work, and/or, leisure activities (including craftwork and reading)?		
23. Preparing you for a sheltered job (e.g. at Remploy or Carr Gomm Workshops)?		
24. Preparing you for an ordinary outside job?		
25. Preparing you to live in a supported group living scheme.		
26. Preparing you to live outside the home/hostel in ordinary housing?		
27. Keeping you out of trouble with the law?		
FOR DAY-CARE CLIENTS AND EX-RESIDENTIAL CLIENTS ONLY		
28. Enabling you to live at home rather than going into a residential Home or Hostel?		
FOR RESIDENTIAL CLIENTS ONLY		
29*. Helping you to get used to living outside hospital?		

Note: * signifies goals taken directly from the White Paper "Better Services for the Mentally Ill" Pub. 1975 H.M.S.O.

APPENDIX 8 (1) Responses to the Open Ended Aims Question

This appendix sets out the descriptions of aims given by clients and staff in response to the open-ended question. These are recorded verbatim - but, some prepositions/verbs etc. are ommitted in the interest of brevity.

Client perception	Staff Perception
1. Prepare for autonomy outside care	
Help me to live on my own/settle in flat/group home /find outside accommodation, return to normal life.	Enable client to live outside hostel or without day care and to meet demands of ordinary life - outside.
2. De-institutionalise	
Recover from being in hospital, get used to living outside hospital, "adjust to civilian life". Get me out of hospital.	De-institutionalise (a previously hospitalised) patient. Maintain client outside hospital setting.
3. Provide outings/holidays	
To provide us with social activities, e.g. holidays and outings (also discos, parties sport and walks).	To persuade client to go out (of hostel/day centre) more - to go on outings and/or to take holidays, social activities.
4. Improve physical/medical care	
Keep me alive, improve my medical care, keep my bowels moving, provide (free) chiropody.	To improve/to enable client to improve the quality of their own medical care (re physical illnesses) control incontinence, prevent general deterioration. Provide new false teeth
5. Improve functioning related to physical handicap	
Keep me moving, help me cope with bad legs/deafness/bad eyesight.	To improve assistance with/improvement of or prevention of deterioration of physical handicaps, obtain new glasses.
6. Personal adjustment to being in care	
Get me to fit in with the system here. Tell me what to do and what not to do.	Enable client to adjust personally to being in care. Provide supervised environment, accept authority/ make client more co-operative at day centre/secure more regular attendance.

APPENDIX 8 (2)

Clients	Staff
7. Self care (domestic)	
Help me to look after myself better, to do chores for myself to cook, be tidier.	Encouragement to do more domestic chores for self/others (including cookery) also to take better care of own possessions.
8. Improve self-care (personal)	
Improve my personal appearance/ tidiness, cleanliness.	Get client to keep self tidy. Improve client's personal appearance/ hygiene/self'presentation, get client to lose weight.
9. Improve financial management	
Help me manage my money.	Improve client's handling of own finances.
10. Provide Finance	
Give me pocket money.	-
11. Provide material care	
Help me to get dressed, bath me, look after me.	Provide physical care for clients.
12. Meet material wants	
Provide clothing/cigarettes/ new mattress/food/paint my bedroom. Give me a Christmas present.	-
13. Provide a home	
Provide me with a home/place to live. Pleasant home environment.	Provide a secure home for client/ help with accommodation problems.
14. Job acquisition	
Get me a job, help me to get a job.	Help client to find a suitable job and keep it.
15. Work rehabilitation	
Give me a rehabilitation course to get me ready for work. Co-operate with day centre, motivate me to work.	Prepare client for work so that client will be able to keep a job as well as getting one - regular attendance, punctuality, enable client to work co-operatively with others. Move to different kind of day centre.
16. Develop work-related skills	
Help me to use public transport better. Help me to read	Enhance clients work-related skills - use of pub. transport, phone boxes, improve numeracy/literacy.

APPENDIX 8 (3)

	Clients	Staff
17.	Improve client's self-valuation	
	They show interest in me. Everyone is kind. Help me make progress. Give me a break. They took me back when I left. Make me more sure of things Get rid of inferiority complex. My opinion is valued, they make life more interesting for me. they give me advice/help with personal problems, they help me to cope with getting old/living on my own. They help me to get over my husband's death, they make me happy/more cheerful, they help me to help others, they help me to understand myself, they make me feel useful. They make me realise that others are worse off than me, they improve my temper/ personality, keep an eye on me.	Improve client's personal functioning. Improve client's sense of security/of their own worth/individuality/self confidence. Improveclient's quality of life, provide emotional support. Give them more enthusiasm for life.
18.	Improved socialisation	
	Mix with others.	Improve/retain social skills/social style, improve manners, stop anti-social behaviour, make client a more acceptable member of society. Discourage attention-seeking behaviour Improve client's relationships generally
19.	Good relationships with unit staff	
	Staff very good/very kind/helpful/ offer friendship to me. Stop people bothering me/don't bother me.	Improve client's relationships with unit staff/get him to co-operate with staff.
20.	Foster relationships with client's family	
	Help me to get on better with my relations, get me out of home (my own), keep me in touch with relations, protect me from my wife/parents.	To improve client's relationships with own family/relieve home situation/co-operate with spouse.
21.	Provide occupation	
	Keep me occupied, give me hobbies, crafts, provide recreation, let me practice the piano. Keep my mind occupied, pass the day, it breaks the week, gives job satisfaction.	Provide sheltered work/occupation/ hobbies/varied crafts. Simulating occupation/directional occupation/ (how to use time constructively).

APPENDIX 8 (4)

Clients	Staff
Peer Group interaction (general)	
22. Provide company/friends, stop me being lonely, help me to mix socially.	Provide the client with companionship, alleviate loneliness. Help them mix more with fellow clients. Make clients more friendly.
23. Interaction in groups	
Group sessions work to help me get better. Groups bring me out of my shell	To improve client's interaction in groups, make clients less withdrawn.
24. Recovery from mental illness/ behaviour improvement	
Help me feel/get better. Help me get over my (nervous/mental) illness, help me get better through day centre/hostel, stop me being depressed.	Cut down excessive smoking/drinking. Improve/prevent deterioration of personality/behaviour problems (including symptoms of mental illness) e.g. self-damaging/violent aggressive behaviour, promote greater emotional maturity.
25. Assessment	
Assess me, try me at different kinds of work.	Observation and assessment of clients.
26. Everything	
Everything/all sorts of things. They do a lot for me/help in general.	-
27. Don't know	
Don't know	-
28. Nothing	
None/nothing/very little.	-
29. Prevent re-hospitalisation (psychiatric)	
Keep me out of mental hospital.	Prevent client's return/admission to psychiatric in-patient treatment.
30. Independence	
Get you to go out on own. They don't trouble you/ interfere with you/you can make your own decisions they try to make you more independent.	To improve/maintain client self help, independence/ability to take initiative/decisions/ reduce client's dependence on unit/SSD.

Note: In the tables which enumerate these responses (see Appendixes 9 and 10) only the abbreviated titles for each category of open-ended aim response are use These titles are set out in this appendix in the 'client' columns and are underlined.

APPENDIXES 9(1) and 9 (2)

The Identification of Aims by Operational Staff and by Clients

The following tables show - according to category of units aims indicated by clients and staff in response to open-ended questions and aims indicated by clients and staff in response to 'fixed' questions.

The full text of answers in each category in the open-ended group is detailed in Appendix 8 and the fixed questions are described in the questionnaires in Appendixes 6 and 7.

The 'client' columns indicate affirmation by a client that a particular category of aim was appropriate for him. The 'staff' columns show instances where staff have signified an aim in a particular category to be appropriate for a client. The 'concurrence' columns indicate cases where both client and staff member deemed an aim to be appropriate for an individual client.

These tables record frequency of the acknowledgement of aims but not the degreee of success with which aims were considered by staff and clients to have been attained (the latter data is set out in Appendix 10).

Key to the following tables for other units on aim recognition:

* Aim is co-extensive with Professional Adviser's and/or Manager's aim for the unit in question.

/ Aim is *not* co-extensive with these management aims.

All aims coming within the ambit of the collected Management aims for the home were incorporated in tables for the appropriate unit regardless of the percentage of clients or staff who identified them. However, where an aim did *not* come within the scope of those identified by management for the unit in question, it is recorded in the tables *only* if it was deemed by clients, or staff, or a combination of both, to have been a relevant aim for 20 per cent or more of the clients in any *one* unit. Non-management supported aims, therefore, only appear in collected tables if they meet the 20 per cent criterion in each unit. This device was adopted for the sake of brevity and of recording only really significant data.

It is appreciated that not all potential aims could be appropriately applied to all clients in one unit. One client's personal, social and clinical needs differ from those of others.

APPENDIX 9(3)

Table 48. Open-ended aims and objectives - psychiatric hostels (frequency of acknowledgement)

Category of Aim	Craster Lodge N = 26			Harbottle Lodge N = 22		
	Clients N	Staff N	Conc. N	Clients N	Staff N	Conc. N
1 Prepare for autonomy outside care	3	10	3	5	8	3
3 Provide external excursions (including holidays)	6	-	-	3	-	-
4 Improve medical care	3	1	-	5	4	1
7 Improve domestic self-care capacity	6	13	2	1	6	-
8 Improve personal self-care capacity	-	10	-	1	8	1
9 Improve capacity for financial management	3	4	2	1	4	-
11 Provide material care	-	-	-	2	-	-
12 Meet material wants	-	-	-	5	-	-
13 Provide a home	4	1	1	4	5	1
14 Job acquisition	-	-	-	-	3	-
15 Work preparation / rehabilitation	-	-	-	1	1	-
16 Develop work-related skills	-	-	-	1	1	1
17 Improve self valuation	14	11	3	6	4	-
18. Improve capacity for socialising	-	9	-	1	6	-
19. Improve relationships with staff	4	-	-	4	-	-
21. Provide occupation/ hobbies	2	2	-	-	1	-
22. Provide companionship	4	4	2	-	-	-

cont'd ..

APPENDIX 9(4)

Table 48. Open-ended aims and objectives - psychiatric hostels (cont'd)

Category of Aim	Craster Lodge N = 26			Harbottle Lodge N = 22		
	Clients N	Staff N	Conc. N	Clients N	Staff N	Conc. N
23. Improve (in-groups) interaction	1	2	–	–	–	–
24. Facilitate recovery from mental illness	3	9	1	1	6	1
26. "Everything"	–	–	–	8	–	–
29. Prevent psychiatric admission	–	–	–	–	6	–
30. Increase independence/ autonomy	–	2	–	1	3	1

APPENDIX 9(5)

Table 49. Fixed aims - psychiatric hostels
(frequency of acknowledgement)

Category of Aim	Craster Lodge N = 26			Harbottle Lodge N = 22		
	Clients N	Staff N	Conc. N	Clients N	Staff N	Conc. N
1 Coping better with life in general	25*	15	16	22*	14	14
2 Keep out of psychiatric wards	23/	11	9	19/	10	10
3 Handle own money better	13*	9	7	16*	6	6
4 Prevent serious depression	8*	2	-	8*	1	1
5 Cut down drinking, etc.	2*	2	1	1*	3	2
6 Give up drinking, etc.	2*	-	-	2*	-	-
7 Minimise thought disorder, etc.	19*	4	4	20*	1	1
9 Cope with physical illness	5/	2	1	7/	3	2
10 Prevent deterioration of physical illness	3/	2	-	7/	2	2
11 Cope better with mental illness	22*	3	3	22*	3	3
13 Make life smoother	22*	7	7	22*	9	9
14 Improve self-care	16*	11	8	21*	10	9
15 Improve tenacity	20*	1	1	22*	2	2
17 Improve relationships with peers	23*	3	2	21*	2	2
19 More community involvement (day care only) N = 12	13*	7	-	Not applicable		
20 Improve relationships with staff	23*	4	4	21*	3	3

cont'd .....

APPENDIX 9(6)

Table 49 Fixed Aims - Psychiatric Hostels (continued)

Category of Aim	Craster Lodge N = 26			Harbottle Lodge N = 22		
	Clients N	Staff N	Conc. N	Clients N	Staff N	Conc. N
21 Improve family relationships	19*	1	1	18*	1	1
22 Concentrate on work/ occupation	22*	3	2	21*	-	-
23 Prepare client for outside job	13/	-	-	16*	4	4
24 Prepare client for sheltered job	11/	1	1	18*	-	-
25 Prepare client to live outside hostel in ordinary housing	13*	5	4	21/	3	3
26 Prepare client for living in group home	18*	5	5	17*	3	3
27 Prevent client breaking the law	5/	2	1	-	-	-
28 Enable client to live outside residential care (where already out) N = 12	9*	6	1	Not applicable		
29 De-institutionalise client outside hospital	17/	3	3	20*	5	4

APPENDIX 9(7)

Table 50 E.M.I. homes - "Open-ended" aims (frequency of acknowledgement)

Category of Aim	Bamburgh House N = 10			Dunstanburgh House N = 10			Kielder House N = 12			Warkworth House N = 15		
	Cl. N	St. N	Con. N	Cl. N	St. N	Con. N	Cl. N	St. N	Con. N	Cl. N	St. N	Con. N
3 Provide external excursions (including holidays)	-	-	-	-	1	-		4	-	5	2	2
4 Improve medical care	-	-	-	-	-	-	3	1	-	6	-	-
5 Improve functioning re physical handicap	1	1	-	-	2	-	2	2	-	2	1	-
6 Adjust client to being in care	-	-	-	-	2	-	-	-	-	-	-	-
7 Improve domestic self-care capacity	-	-	-	1	1	-	-	9	-	-	-	-
8 Improve personal self-care capacity	-	-	-	1	4	1	-	7	-	-	6	-
11 Provide material care	2	-	-	2	1	-	3	-	-	3	3	1
12 Meet material wants	-	-	-	2	-	-	3	-	-	-	-	-
13 Provide a home	3	-	-	-	2	-	1	-	-	1	-	-
17 Improve self-valuation	1	7	1	-	3	-	5	2	2	9	13	9
18. Improve capacity for socialising	-	3	-	-	1	-	-	6	-	1	2	-
19. Improve relationships with staff	2	1	1	2	2	-	-	1	-	1	-	-
20. Improve relationships with family	-	-	-	1	1	-	2	-	-	-	-	-

cont'd ...

APPENDIX 9(8)

Table 50 E.M.I. homes - "Open-ended" aims (cont'd)

Category of Aim	Bamburgh House N = 10			Dunstanburgh House N = 10			Kielder House N = 12			Warkworth House N = 15		
	Cl. N	St. N	Con. N	Cl. N	St. N	Con. N	Cl. N	St. N	Con.	Cl.	St.	Con.
21. Provide occupation/ hobbies	-	-	-	1	1	-	-	2	-	1	2	-
22. Provide companionship	1	-	-	1	2	-	-	1	-	1	2	-
23. Improve interaction in groups	-	1	-	-	-	-	-	1	-	-	-	-
24. Facilitate recovery from mental illness	-	8	-	1	-	-	2	5	2	-	7	-
25. Assess client	-	-	-	-	-	-	-	2	-	-	-	-
26. "Everything"	3	-	-	-	-	-	-	-	-	-	-	-
27. "Nothing"	3	-	-	2	-	-	-	-	-	-	-	-
29 Prevent psychiatric admission	-	-	-	-	3	-	-	-	-	-	-	-
30. Increase independence/ autonomy	-	-	-	1	4	1	2	2	-	1	-	-

APPENDIX 9(9)

Table 51 E.M.I. homes - "Fixed" aims (frequency of acknowledgement)

Category of Aim	Bamburgh House N = 10			Dunstanburgh House N = 10			Kielder House N = 12			Warkworth House N = 15		
	Cl. N	St. N	Con. N	Cl. N	St. N	Con. N	Cl. N	St. N	Con. N	Cl. N	St. N	Con. N
1 Cope with life in general	10*	6	6	10*	-	-	9*	3	3	14*	4	4
2 Keep out psychiatric wards	5/	3	2	4/	3	3	4/	4	2	10/	12	9
3 Handle own money better	3/	1	1	7/	1	-	7/	3	1	12/	7	6
4 Prevent serious depression	8*	-	-	5*	1	-	1*	-	-	-	1	-
5 Cut down drinking	-	3	-	-	-	-	1*	1	1	-	1	-
6 Give up drink	-	-	-	-	-	-	1*	-	-	-	-	-
7 Improve thought disorder	10*	3	3	8*	1	1	10*	5	4	13*	1	1
8 Stop confusional state deteriorating	9*	4	4	9*	6	6	8*	5	4	5*	3	2
9 Cope better with physical illness	6*	1	1	6*	2	2	6*	5	2	8*	6	3
10 Prevent deterioration of physical illness	6*	-	-	5*	-	-	6*	6	4	4*	2	1
11 Cope better with mental illness	10*	-	-	10*	3	3	11*	7	7	10*	3	3
13 Make life smoother	8*	2	2	8*	-	-	12*	5	5	15*	13	13
14 Improve self-care	7*	2	2	10*	6	5	11*	8	8	14	6	6
15 Improve tenacity	7*	-	-	10*	-	-	10*	-	-	14*	2	2
17 Improve relationships with friends (outside)	9*	1	1	9*	-	-	9*	-	-	14*	1	1

cont'd ....

APPENDIX 9(10)

Table 51 E.M.I. homes - "Fixed" aims (cont'd)

Category of Aim	Bamburgh House N = 10			Dunstanburgh House N = 10			Kielder House N = 12			Warkworth House N = 15		
	Cl. N	St. N	Con. N	Cl. N	St. N	Con. N	Cl. N	St. N	Con. N	Cl. N	St. N	Con. N
18 Improve relationships with other clients	9*	4	4	10*	6	6	12*	11	11	15*	11	9
20 Improve relationships with staff	9*	2	1	10*	-	-	12*	6	6	15*	3	3
21 Improve relationships with family	7	-	-	7	2	-	12	2	-	15	2	-
22 Concentrate on occupation/ activity	3*	-	-	10*	-	-	11*	-	-	15*	-	-
25 Prepare client to live outside (in ordinary housing)	7/	-	-	8/	-	-	12	-	-	13/	-	-
29 De-institutionalise client (outside hospital)	6/	-	-	2/	-	-	4*	-	-	6/	1	1

APPENDIX 9(11)

Table 52 Wansbeck Day Centre - "Open-ended" Aims (frequency of acknowledgement)

Category of Aim	Wansbeck I Unit N = 40			Wansbeck II Unit N = 50		
	Clients N(%)	Staff N(%)	Conc. N(%)	Clients N(%)	Staff N(%)	Conc. N(%)
1 Prepare for autonomy outside care	2 (5)	1 (3)	-	-	-	-
3 Provide external excursions (including holidays)	3 (8)	-	-	5 (10)	22 (44)	3 (6)
4 Improve physical/ medical care	1 (3)	8 (20)	-	4 (8)	21 (42)	2 (4)
5 Improve functioning re physical handicap	-	-	-	7 (14)	16 (32)	0
7 Improve capacity for domestic self-care	5 (13)	14 (36)	3 (8)	2 (4)	8 (16)	1 (2)
8 Improve capacity for personal self-care	2 (5)	13 (32)	-	1 (2)	3 (6)	1 (2)
9 Improve capacity for financial management	-	-	-	-	4 (8)	-
14 Job acquisition	7 (18)	9 (23)	5 (13)	-	-	-
15 Work rehabilitation	14 (36)	23 (58)	11 (28)	1 (2)	-	-
16 Develop "work - related skills" (e.g. phone and bus use)	3 (8)	11 (28)	1 (3)	-	11 (22)	-
17 Improve self valuation	17 (43)	9 (23)	5 (13)	16 (32)	7 (14)	5 (10)
18 Improve socialisation capacity	-	24 (60)	-	3 (6)	15 (30)	-
19. Improve relationships with staff	1 (3)	-	-	1 (2)	1 (2)	-

cont'd ....

APPENDIX 9(12)

Table 52 Wansbeck Day Centre - "Open-ended" aims (cont'd)

Category of Aim	Wansbeck I Unit N = 40			Wansbeck II Unit N = 50		
	Clients N(%)	Staff N(%)	Conc. N(%)	Clients N(%)	Staff N(%)	Conc. N(%)
20. Improve relationships with family	4 (10)	3 (8)	-	6 (12)	5 (10)	1 (2)
21. Provide occupation/ hobbies	18 (45)	11 (28)	2 (5)	21 (42)	24 (48)	21 (22)
22. Improve peer group interaction (generally)	3 (8)	5 (13)	1 (3)	18 (36)	7 (14)	3 (6)
23. Improve interaction in groups	1 (3)	7 (18)	1 (3)	1 (2)	10 (20)	1 (2)
24. Enable recovery from mental illness	6 (15)	14 (35)	3 (8)	9 (18)	6 (12)	1 (2)
25. Assess client	2 (5)	-	-	-	-	-
29. Prevent psychiatric admission	6 (15)	10 (25)	3 (8)	2 (4)	7 (14)	1 (2)
30. Increase independence/ autonomy	-	6 (15)	-	2 (4)	9 (18)	1 (2)

Note: Percentages of N are in brackets, numbers appear without parentheses. These are supplied only for the Wansbeck as the numbers of clients sampled in other units were too small to render percentages appropriate.

APPENDIX 9(13)

Table 53 Wansbeck Day Centre - "Fixed" aims (frequency of acknowledgement)

Category of Aim	Wansbeck I Unit N = 40			Wansbeck II Unit N = 50		
	Clients N(%)	Staff N(%)	Conc. N(%)	Clients N(%)	Staff N(%)	Conc. N(%)
1 Cope better with life in general	38* (95)	29 (73)	29 (73)	44* (88)	32 (64)	30 (60)
2 Keep out of psychiatric wards	35* (88)	20 (50)	19 (48)	29* (58)	23 (46)	17 (34)
3 Handle own money better	38* (35)	4 (10)	2 (5)	10* (20)	7 (14)	2 (4)
4 Prevent serious depression	20* (50)	3 (8)	3 (8)	21* (42)	1 (2)	1 (2)
5 Cut down drinking/ drug abuse	7* (18)	2 (5)	1 (3)	1* (2)	4 (8)	1 (2)
6 Give up drink/drugs	7* (18)	-	-	1*	-	-
7 Improve thought disorder	30* (75)	5 (13)	5 (13)	31* (62)	3 (6)	3 (6)
8 Prevent confusional state deteriorating	-	-	-	17* (34)	18 (36)	7 (14)
9 Cope better with physical/medical illness	18/ (45)	3 (8)	2 (5)	25/ (50)	7 (14)	6 (12)
10 Prevent deterioration of physical/medical illness	13/ (33)	-	-	27/ (54)	1 (2)	1 (2)
11 Cope better - with mental illness	40*/ (100)	23 (58)	23 (58)	43*/ (86)	23 (46)	21 (42)
12 Enjoy life more	40* (100)	30 (75)	30 (75)	43* (86)	33 (66)	33 (66)
16 Improve relationships with other helping agencies	23/ (58)	-	-	-	-	-

cont'd ...

APPENDIX 9(14)

Table 53 Wansbeck Day Centre - "Fixed" aims (cont'd)

Category of Aim	Wansbeck I Unit N = 40			Wansbeck II Unit N = 50		
	Clients N(%)	Staff N(%)	Conc. N(%)	Clients N(%)	Staff N(%)	Conc. N(%)
17 Improve relationships with friends (outside)	27 (68)	-	-	40 (80)	4 (8)	4 (8)
18 Improve relationships with clients (peers)	40* (100)	12 (30)	12 (30)	45* (90)	10 (20)	10 (20)
19 Contribute more to the community/society	35* (88)	-	-	41* (82)	-	-
20 Improve relationships with staff	33* (83)	5 (13)	5 (13)	47* (94)	2 (4)	2 (4)
21 Improve family relationships	35* (88)	7 (18)	6 (15)	29* (58)	6 (12)	5 (10)
22 Concentrate better on work/occupation	35* (88)	16 (40)	15 38	41* (82)	13 (26)	12 (24)
23 Prepare for outside job	37* (93)	9 (23)	9 (23)	-	-	-
24 Prepare for sheltered job	38* (95)	9 (23)	9 (23)	-	-	-
28 Remain in own home and outside residential care	25* (63)	4 (10)	3 (8)	23* (46)	16 (32)	7 (14)
29 De-institutionalise client - outside hospital	-	-	-	-	-	-

Note: Percentages of N are in brackets, numbers appear without parentheses.

EVALUATION OF AIM ATTAINMENT — Appendix 10 (1)

This appendix records staff and client evaluation of the attainment of aims (whose frequency of acknowledgement is set out in Appendix 9). The evaluations are expressed on a five point scale (see below).

NOTES TO THE FOLLOWING TABLES:

N = Number of Clients Studied.

1. The aims recognised in response to questions are indicated by abbreviated titles - as used in Appendix 9 - and 'open-ended aim' and 'fixed aim' responses are set out in the same way as in the tables in Appendix 9.

2. The columns detailing staff and client evaluations are sub-divided into five sections. Each section indicates a point on the 5 point evaluation scale (discussed in Chapter IV). Point 1 = Great success, Point 2 = Fair success, Point 3 = Moderate attainment, Point 4 = Relatively poor attainment, Point 5 = Failure. The numbers appearing below each scale point indicate the number of such responses. Point 6 signifies a response of 'Don't Know'. These appear only in the concurrence column.

3. The concurrence columns show the evaluation of staff and clients in cases where both agreed that the aim in question was appropriate for that client. "S" followed by a number indicates the Point of Evaluation scale awarded by the staff member, "C" followed by a number indicates the corresponding client evaluation. "Conc" - relates to concurrent responses.

4. As space was at a premium in completing the following tables and because there were relatively few "Don't Know" responses; these are noted only at the base of each table *except* in cases where concurrence involved a "Don't Know" reply.

TABLE 54 - Hostels 'Open-ended' aim evaluations

Appendix 10 (2)

Abbreviated Response	CRASTER N=26											HARBOTTLE N=22										
	Clients					Staff					Conc.	Clients					Staff					Conc.
	1	2	3	4	5	1	2	3	4	5	S=Staff C=Client	1	2	3	4	5	1	2	3	4	5	S=Staff C=Client
1. Prepare for Autonomy outside 'Care'.	3	-	-	-	-	7	-	-	-	3	S1/C1 S1/C1 S1/C1	2	2	-	1	-	2	3	2	1	-	S1/C2 S3/C2 S4/C1
3. Provide outings/holidays	5	-	-	-	1	-	-	-	-	-	-	2	1	-	-	-	-	-	-	-	-	-
4. Improve Medical Care	-	2	-	-	-	1	-	-	-	-	-	4	1	-	-	-	1	3	-	-	-	S2/C1
7. Improve Domestic Self-care	4	2	-	-	-	-	6	2	3	-	S3/C1 S3/C2	-	1	-	-	-	-	-	5	-	1	-
8. Improve Personal Self-care	-	-	-	-	-	-	3	1	3	2	-	-	1	-	-	-	-	1	2	4	1	S4/C2
9. Improve Financial Management	2	-	-	-	1	-	2	-	-	2	S5/C1 S5/C5	-	1	-	-	-	-	2	-	1	1	-
11. Provide Material Care	-	-	-	-	-	-	-	-	-	-	-	1	1	-	-	-	-	-	-	-	-	-
12. Meet Material Wants	4	-	-	-	-	-	-	-	-	-	-	4	1	-	-	-	-	-	-	-	-	-
13. Provide a Home	1	3	-	-	-	1	-	-	-	-	S1/C2	3	1	-	-	-	2	2	-	-	1	S1/C1
14. Acquire a Job	1	-	-	-	-	1	-	1	-	-	S3/C1	-	-	-	-	-	1	-	-	2	-	-
15. Rehabilitate for Work	-	-	-	-	-	-	-	-	-	-	-	-	1	-	-	-	1	-	-	-	-	-
16. Develop Work related Skills	1	-	-	-	-	-	-	-	-	-	-	1	-	-	-	-	1	-	-	-	-	S1/C1
17. Improve self valuation	10	2	1	4	-	2	1	4	3	-	S1/C2 S3/C1 S4/C1	4	1	-	-	1	-	3	1	-	-	-
18. Improve Socialising skills	-	-	-	-	-	-	2	3	4	-	-	-	-	-	1	-	-	1	3	1	1	-
19. Improve Relationships with Staff	4	-	-	-	-	-	-	-	-	-	-	4	-	-	-	-	-	-	-	-	-	-
22. Provide Companionship	2	1	-	-	1	1	2	-	1	-	S2/C2 S4/C5	-	-	-	-	-	-	-	-	-	-	-
23. Improve Interaction in Groups	-	1	-	-	-	1	-	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-
24. Recover Mental Illness	-	1	-	-	-	-	4	2	2	1	S2/C1	2	-	-	-	-	1	3	2	3	1	S1/C1
21. Provide occupation/Hobbies	2	-	-	-	-	-	-	1	1	-	-	-	-	-	-	-	-	1	-	-	-	-

TABLE 54 - (continued)

10(3)

Abbreviated Response	CRASTER N=26											HARBOTTLE N=22										
	Clients					Staff					Conc.	Clients					Staff					Conc.
	1	2	3	4	5	1	2	3	4	5	S=Staff C=Client	1	2	3	4	5	1	2	3	4	5	S=Staff C=Client
26. "Everything"	-	-	-	-	-	-	-	-	-	-	-	8	-	-	-	-	-	-	-	-	-	-
29. Prevent Psychiatric Admission	-	-	-	-	-	1	-	-	-	-	-	-	-	-	-	-	3	2	-	1	-	-
30. Increase independence/ autonomy	-	-	-	-	-	-	-	1	-	1	-	-	1	-	-	-	-	2	1	-	-	S3/c2

TABLE 55 - Hostels 'Fixed' Aim Evaluations

Appendix 10(4)

Abbreviated Response	CRASTER N=26										HARBOTTLE N=22									
	Clients					Staff				Conc.	Clients					Staff				Conc.
	1	2	3	4	5	1	2	3	4	5		1	2	3	4	5	1	2	3	4	5	
1. Cope Better Life in General	15	6	2	-	2	2	5	4	4	-	S1/C2x2 S3/C1x3 S2/C1x4 S4/C1x2 S2/C2x1 S1/C1x1	15	5	2	-	-	1	1	3	6	3	S3/C2x1 S2/C1x1 S3/C1x2 S5/C3x1 S5/C1x2 S1/C2x1 S4/C1x6
2. Prevent psychiatric admission	15	4	1	-	2	5	1	3	1	1	S3/C2x1 S4/C5x1 S4/C3x1	9	5	3	1	1	3	5	1	1	-	S2/C1x2 S2/C2x3 S1/C5x1 S1/C1x2 S3/C1x1 S4/C4x1
3. Handle own money better	6	2	1	1	1	1	3	2	1	2	S2/C1x2 S2/C5x1 S5/C5x1 S4/C5x1 S3/C3x1 S5/C1x1	8	6	-	2	-	-	-	1	2	3	S5/C1x2 S4/C1x1 S4/C2x1 S5/C2x1 S3/C4x1
4. Prevent serious depression	4	3	-	-	-	1	-	1	-	-	-	1	4	1	1	1	-	-	-	-	1	S4/C5x1
5. Cut down drinking/drug abuse	2	-	-	-	-	-	1	1	-	-	S3/C1x1	2	-	-	-	-	1	1	-	1	-	S1/C1x1 S4/C1x1
6. Give up drink/drugs	-	1	-	-	1	-	-	-	-	-	-	1	-	-	1	-	-	-	-	-	-	-
7. Alleviate thought disorder etc.	5	11	1	-	1	-	1	2	1	-	S3/C2x2 S4/C6x1 S2/C1x1	13	4	1	-	1	-	-	-	-	1	S5/C1x1
9. Cope with physical illness	2	-	1	-	2	-	-	1	1	-	S3/C1x1	3	3	-	1	-	-	3	-	-	-	S3/C1x1 S3/C2x1
10. Prevent deterioration of physical illness	-	-	1	-	2	-	1	1	-	-	-	2	2	1	1	1	2	-	-	-	-	S1/C1x1 S1/C3x1
11. Cope with mental illness	11	7	-	1	2	-	1	1	1	-	S2/C5x1 S3/C1x1 S4/C2x1	15	5	-	2	-	3	-	-	-	-	S1/C1x3
13. Make life smoother	14	2	1	1	4	1	3	3	-	-	S3/C1x2 S3/C5x2 S2/C5x1 S1/C1x1 S2/C1x1	10	10	1	-	1	1	2	4	2	-	S3/C2x3 S1/C1x1 S2/C2x2 S4/C1x1 S4/C5x1 S3/C3x1
14. Improve self-care	9	5	1	1	-	-	3	7	1	-	S3/C2x3 S3/C1x2 S1/C1x1 S2/C1x1 S2/C1x1	14	6	1	-	-	1	1	6	2	-	S3/C2x3 S2/C1x1 S4/C1x1 S4/C2x1 S3/C1x2 S1/C1x1
15. Improve tenacity	9	7	1	1	2	-	-	-	1	-	S4/C1x1	19	1	-	1	1	-	1	-	-	1	S5/C1x1 S2/C1x1
17. Improve relationships with friends	4	5	2	1	2	-	2	1	-	-	S2/C1x1 S3/C5x1	7	3	-	2	9	-	-	-	1	1	S5/C5x1 S4/C5x1

TABLE 55 - continued

Appendix 10 (5)

Abbreviated Response	CRASTER N=26											HARBOTTLE N=22										
	Clients					Staff					Conc.	Clients					Staff					Conc.
	1	2	3	4	5	1	2	3	4	5		1	2	3	4	5	1	2	3	4	5	
19. Increas community involvement (non-resident clients) N=12	1	1	-	-	2	-	2	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-
20. Improve relationship with Staff	15	6	2	-	-	-	1	1	1	1	S2/C2x1 S4/C2x1 S5/C2x1 S3/C1x1	16	4	-	1	-	-	1	-	2	-	S4/C1x1 S2/C4x1 S4/C2x1
21. Improve relationship with family	5	6	3	1	2	-	-	-	1	-	S4/C5x1	7	6	-	1	4	-	1	-	-	-	S2/C2x1
22. Concentrate on work/ occupation	14	4	1	1	2	-	1	-	2	-	S2/C1x1	17	-	4	-	-	-	-	-	-	-	-
23. Prepare for outside job	4	4	3	-	2	-	-	-	-	-	-	3	2	-	2	9	3	-	-	1	-	S1/C1x3 S4/C5x1
24. Prepare for sheltered job	1	2	1	1	5	-	-	-	1	-	-	10	6	-	-	2	-	-	-	-	-	-
25. Prepare for living outside Hostel	5	2	-	-	6	4	1	-	-	-	S1/C1x3 S2/C1x1	1	9	-	1	10	-	1	-	1	1	S4/C2x1 S5/C2x1 S2/C2x1
27. Prevent law breaking	3	2	-	-	-	1	2	-	-	-	S1/C1x1	-	-	-	-	-	-	-	-	-	-	-
28. Support clients living in Community N=12	6	1	-	-	2	1	1	-	-	-	S1/C1x1	-	-	-	-	-	-	-	-	-	-	-
29. De-instutionalise client (outside Hospital)	14	3	-	-	-	-	1	2	-	-	S3/C1x2 S2/C1x1	14	5	1	-	-	-	2	2	1	-	S2/C1x2 S4/C1x1 S3/C1x1

'Don't Know' responses were recorded by staff of Craster in respect of one client in the following aim categories - Aim Numbers 2, 4, 7, 11 and 19.

One don't know response was recorded by a Harbottle client in relation to aim number 7.

Abbreviated Response	BAMBURGH N=10											DUNSTANBURGH N=10										
	Clients					Staff					Conc	Clients					Staff					Conc
	1	2	3	4	5	1	2	3	4	5		1	2	3	4	5	1	2	3	4	5	
3. Provide outings etc.	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1	-	-
4. Provide medical care	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
5. Improve functioning re physical handicap.	1	-	-	-	-	1	-	-	-	-	-	-	-	-	-	-	-	2	-	-	-	-
6. Adjust to being in care	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1	1	-	-	-	-
7. Improve domestic self care	-	-	-	-	-	-	-	-	-	-	-	-	1	-	-	-	-	1	-	-	-	-
8. Improve personal self-care	-	-	-	-	-	-	-	-	-	-	-	1	-	-	-	-	1	2	-	-	1	S2/C1
11. Provide material care	2	-	-	-	-	-	-	-	-	-	-	-	-	2	-	-	-	1	-	-	-	-
12. Meet material wants	-	-	-	-	-	-	-	-	-	-	-	1	1	-	-	-	-	-	-	-	-	-
13. Provide a Home	2	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	2	-	-	-	-	-
17. Improve self-valuation	-	1	-	-	-	2	1	1	1	1	S3/C2	-	-	-	-	-	-	2	-	1	-	-
18. Improve socialising capacity	-	-	-	-	-	-	2	1	-	-	-	-	-	-	-	-	-	-	1	-	-	-
19. Improve relationsh. with staff	2	-	-	-	-	-	-	-	1	-	S4/C1	1	-	-	-	-	2	-	-	-	-	-
20. Improve family relationships.	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1	-	-	-	-	1	-	S4/C4

Abbreviated Response	KIELDER N=12											WARKWORTH N=15										
	Clients					Staff					Conc	Clients					Staff					Conc
	1	2	3	4	5	1	2	3	4	5		1	2	3	4	5	1	2	3	4	5	
3. Provide outings etc.	-	-	-	-	-	1	-	1	-	2	-	2	2	-	-	-	-	1	-	-	1	S2/C1 S5/C2
4. Provide medical care	2	-	-	1	-	-	1	-	-	-	-	1	4	-	1	-	-	-	-	-	-	-
5. Improve functioning re physical handicap.	1	1	-	-	-	-	1	1	-	-	-	-	2	-	-	-	-	1	-	-	-	-
6. Adjust to being in care	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
7. Improve domestic self care	-	-	-	-	-	2	1	5	1	-	-	-	-	-	-	-	-	-	-	-	-	-
8. Improve personal self-care	-	-	-	-	-	-	2	5	-	-	-	-	-	-	-	-	3	2	-	-	1	-
11. Provide material care	2	-	-	1	-	-	-	-	-	-	-	3	-	-	-	-	2	1	-	-	-	S1/C1
12. Meet material wants	1	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
13. Provide a Home	-	1	-	-	-	-	-	-	-	-	-	1	-	-	-	-	-	-	-	-	-	-
17. Improve self-valuation	1	3	-	1	-	-	2	-	-	-	S2/C2 S2/C4	4	2	-	1	-	5	6	1	1	-	S2/C1x3
18. Improve socialising capacity	-	-	-	-	-	2	1	3	-	-	-	1	-	-	-	-	2	-	-	-	-	-
19. Improve relationsh. with staff	-	-	-	-	-	-	-	-	1	-	-	1	-	-	-	-	-	-	-	-	-	-
20. Improve family relationships.	-	1	-	-	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-

Abbreviated Response	BAMBURGH N=10										DUNSTANBURGH N=10										KIELDER N=12										WARKWORTH N=15									
	Clients					Staff					Conc	Clients					Staff					Conc	Clients					Staff					Conc	Clients					Staff					Conc
	1	2	3	4	5	1	2	3	4	5		1	2	3	4	5	1	2	3	4	5		1	2	3	4	5	1	2	3	4	5		1	2	3	4	5	1	2	3	4	5	
21 Provide occupation/ Hobbies	-	-	-	-	-	-	-	-	-	-		1	-	-	-	-	-	1	-	-	-	-	-	-	-	-	-	-	1	-	-	-	-	-	1	-	1	-	-	-
22 Provide Companion-ship/improve peer relationships	1	-	-	-	-	-	-	-	-	-	-	-	1	-	-	-	2	-	-	-	-	-	-	-	-	1	-	-	-	1	-	-	-	-	1	1	-	-	-	-
23. Improve Group Interaction.	-	-	-	-	-	-	-	-	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-
24 Improve mental illness	-	-	-	-	-	-	6	2	-	-	-	1	-	-	-	-	-	-	-	-	-	-	2	-	-	-	-	-	2	-	2	1	S2/C1x2	-	-	-	-	-	2	4	-	1	-	-
26 "Everything"	2	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
28 "Nothing"	-	-	1	1	1	-	-	-	-	-	-	-	-	-	-	2	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
29 Prevent psychiatric Admission	-	-	-	-	-	-	-	-	-	-	-	3	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
30 Increase independ-ence/autonomy	-	-	-	-	-	-	-	-	-	-	-	1	-	-	-	-	2	1	-	-	-	S2/c1	2	-	-	-	-	-	-	2	-	-	-	-	1	-	-	-	-	-	-	-

A "don't know" response was given by staff at Warkworth to categories 1 and 2 at Kielder to category 26 and also at Bamburgh. Once such client reply occurred at Dunstanburgh to category 20.

TABLE 57 - E.M.I. Homes Fixed Aim Evaluations

Abbreviated Response	BAMBURGH N=10										DUNSTANBURGH N=10										KIELDER N=12										WARKWORTH N=15									
	Clients					Staff					Conc	Clients					Staff					Conc	Clients					Staff					Conc	Clients					Staff					Conc
	1	2	3	4	5	1	2	3	4	5		1	2	3	4	5	1	2	3	4	5		1	2	3	4	5	1	2	3	4	5		1	2	3	4	5	1	2	3	4	5	
1.Cope better life in general	4	3	-	1	2	-	1	5	-	-	S3/C1x1 S3/C2x2 S3/C5x1 S2/C1x1	6	4	-	1	-	-	-	-	-	-	-	5	4	-	-	-	1	-	-	2	-	S2/C2x1 S4/C1x1 S4/C2x1	9	3	1	-	1	1	2	-	1	-	S2/C1x2 S4/C2x1 S1/C1x1
2.Prevent psychiatric admission	3	-	-	-	2	-	-	3	-	-	S3/C1x2	3	1	-	-	-	2	1	-	-	-	S1/C1x2 S2/C1x1	3	-	1	-	-	3	1	-	-	-	-	6	4	-	-	-	11	-	-	-	1	S1/C2x4 S1/C1x4 S5/C2x1
3.Handle own money better	1	-	1	-	1	-	-	-	1	-	S4/C3x1	-	3	-	-	2	1	-	-	-	-	-	2	1	1	-	3	1	1	1	-	-	-	1	3	5	1	2	1	4	2	-	-	S2/C2x2 S1/C3x1 S3/C2x1 S3/C5x1 S2/C3x1
4.Prevent serious depression	1	4	2	1	-	-	-	-	-	-	-	1	2	-	2	-	1	-	-	-	-	-	-	-	-	1	-	-	-	-	-	-	-	-	-	-	-	-	1	-	-	-	-	-
5.Cut down drinking /drug abuse	-	-	-	-	-	2	-	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1	-	-	-	1	-	1	-	-	-	S2/C1x1	-	-	-	-	-	1	-	-	-	-	-
6.Give up drink/ drugs	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
7.Alleviate thought disorder	4	3	1	-	2	-	1	2	-	-	S3/C1x1 S3/C5x1 S2/C1x1	3	4	1	-	-	-	1	-	-	-	S2/C2x1	3	4	3	-	-	-	-	3	1	1	S3/C2x2 S4/C1x1 S5/C2x1	2	8	2	-	-	-	-	-	-	1	S5/C3x1
8.Stop confusion deteriorating	1	5	1	-	2	-	1	3	-	-	S3/C1x1 S3/C3x1 S3/C5x1 S2/C2x1	1	4	2	-	2	-	4	2	-	-	S2/C3x2 S2/C2x1 S3/C5x2 S2/C1x1	-	3	4	1	-	3	-	1	1	-	S4/C3x1 S1/C2x2 S3/C3x1	1	2	-	1	-	2	1	-	-	-	S2/C2x1 S1/C6x1
9.Cope with physical illness	1	3	-	-	2	-	1	-	-	-	S2/C5x1	-	1	-	1	1	1	1	-	-	-	S2/C5x1 S1/C5x1	-	2	-	2	2	2	1	1	1	-	S4/C4x1 S2/C4x1	1	4	1	-	1	1	3	1	1	-	S2/C5x1 S2/C3x1 S2/C2x1
10.Prevent deterioration of physical illness	1	3	-	-	2	-	-	-	-	-	- -	-	1	1	1	-	-	-	-	-	-	- -	-	2	-	1	3	1	3	2	-	-	S3/C5x2 S2/C5x1 S2/C4x1	1	1	1	-	-	-	1	1	-	-	S3/C5

Abbreviated Response	BAMBURGH N=10										DUNSTANBURGH N=10										KIELDER N=12										WARKWORTH N=15									
	Clients					Staff					Conc	Clients					Staff					Conc	Clients					Staff					Conc	Clients					Staff					Conc
	1	2	3	4	5	1	2	3	4	5		1	2	3	4	5	1	2	3	4	5		1	2	3	4	5	1	2	3	4	5		1	2	3	4	5	1	2	3	4	5	
11.Cope with mental illness	6	2	1	-	1	-	-	-	-	-	-	6	3	-	1	-	1	1	1	-	-	S2/C1x1 S1/C1x1 S3/C2x1	5	4	-	-	-	-	1	-	2	-	S3/C4x1 S3/C3x1 S4/C3x1 S2/C1x2 S3/C1x1 S4/C1x1	6	3	1	-	-	1	1	1	-	-	S3/C1x1 S1/C1x1 S2/C2x1
13.Make life smoother	3	3	1	1	-	-	1	1	-	-	S3/C2x1 S2/C2x1	5	3	-	-	-	-	-	-	-	-	-	3	5	2	1	1	1	1	1	-	-	S2/C3x1 S2/C1x1 S1/C1x1 S2/C2x1 S3/C2x1	7	4	2	1	1	3	5	3	2	-	S3/C3x2 S2/C2c2 S1/C2x1 S1/C1x2 S2/C5x1 S3/C1x1 S4/C1x1 S4/C2x1 S2/C1x2
14.Improve self-care	4	-	-	-	2	-	-	2	-	-	S3/C1x1 S3/C2x1	4	2	-	1	2	1	3	2	-	-	S1/C1x1 S3/C5x1 S2/C1x2	6	2	2	1	-	1	3	2	2	-	S4/C2x1 S2/C2x1 S2/C1x2 S1/C1x1 S3/C4x1 S4/C1x1 S3/C2x1	8	5	1	-	-	1	2	-	2	1	S1/C1x1 S5/C2x1 S3/C2x1 S4/C2x1 S4/C1x1 S2/C2x1
15.Improve Tenacity	3	1	1	1	1	-	-	-	-	-	-	6	3	-	1	-	-	-	-	-	-	-	5	-	4	-	1	-	-	-	-	-	-	6	5	2	1	-	-	1	1	-	-	S5/C3x1 S1/C2
16.Improve relationship with friends outside	1	2	2	1	3	-	-	1	-	-	-	1	4	-	-	4	-	-	-	-	-	-	1	1	-	1	6	-	-	-	-	-	-	2	4	2	-	6	-	-	1	-	-	S3/C3x1
18.Improve relationship with other clients	5	1	2	-	1	-	2	2	-	-	S2/C5x1 S3/C2x1 S3/C3x1 S2/C1x1	8	1	-	-	1	2	1	3	-	-	S3/C1x3 S1/C1x2 S2/C1x1	5	5	-	1	1	1	4	4	2	-	S2/C2x1 S4/C2x1 S3/C2x2 S2/C1x2 S3/C4x1 S2/C2x1 S2/C5x1 S3/C1x1 S4/C1x1	5	7	2	-	1	3	1	3	-	2	S2/C1x1 S5/C5x1 S1/C1x2 S3/C1x1 S3/C2x1 S3/C3x1 S5/C2x1 S1/C2x1

TABLE 57 - continued

Abbreviated Response	BAMBURGH N=10			DUNSTANBURGH N=10			KIELDER N=12			WARKWORTH N=15		
	Clients	Staff	Conc	Clients	Staff	Conc	Clients	Staff	Conc	Clients	Staff	Conc
	1 2 3 4 5	1 2 3 4 5		1 2 3 4 5	1 2 3 4 5		1 2 3 4 5	1 2 3 4 5		1 2 3 4 5	1 2 3 4 5	
20. Improve relationship with Staff	4 5 - - -	- 1 - 1 -	S4/C x1	7 2 1 - -	- - - - -	-	9 3 - - -	- 3 2 - -	S3/C2x1 S4/C2x1 S3/C1x1 S2/C1x3	10 3 2 - -	1 2 - - -	S2/C1x2 S1/C2x1
21. Improve relationship with family	3 1 1 1 1	- - - - -	S3/C1x1	2 2 - - 3	- - 2 - -	S2/C1x1 S5/C2x1 S3/C2x1	5 4 1 - 2	- 1 1 - 1	S2/C1x1 S3/C2x1 S5/C2x1	3 5 2 1 4	- 1 3 - -	S2/C2x1 S3/C4x1
22. Concentrate on occupation/activity	1 2 - - -	- - - - -	-	4 5 - 1 -	- - - - -	-	2 4 3 2 -	- - - - -	-	4 10 1 - -	- - - - -	-
25. Prepare Client to live outside residential care	3 - - 1 3	- - - - -	-	- 2 2 1 3	- - - - -	-	2 - - 1 9	- - - - -	-	2 - - 1 10	- - - - -	-
29. De-instutionalise client (outside Hospital)	2 2 - - 1	- - - - -	-	1 1 - - -	- - - - -	-	3 - - - -	- - - - -	-	2 3 - - 1	- - 1 - -	S3/C1x1

'Dont't Know' responses were given by one client in respect of each of the following responses - numbers 7, 8, 9, 10, 14 and 29 - all these were at Bamburgh or Warkworth. There were no staff don't know responses.

TABLE 58 - Wansbeck Day Centre open-ended aim evaluation. Appendix 10 (11)

Abbreviated Response	WANSBECK I N=40											WANSBECK II N=50										
	Clients					Staff					Conc	Clients					Staff					Conc
	1	2	3	4	5	1	2	3	4	5		1	2	3	4	5	1	2	3	4	5	
1.Prepare for autonomy outside care	-	1	-	1	-	-	-	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-
2.Provide outings/ Holidays	3	-	-	-	-	-	-	-	-	-	-	4	1	-	-	-	15	-	2	-	5	S1/C1x1 S1/C2x1 S5/C1x1
4.Improve medical care	1	-	-	-	-	1	1	1	2	3	-	3	1	-	-	-	11	1	3	-	6	S3/C1x1 S1/C2x1
5.Improve functioning re physical Handicap	-	-	-	-	-	-	-	-	-	-	-	1	4	1	1	-	2	1	3	2	8	-
7.Improve Domestic self-care	2	2	-	1	-	-	2	4	7	4	S2/C1x1 S4/C1x1 S5/C4x1	-	2	-	-	-	-	1	4	1	2	S3/C2x1
8.Improve personal self-care	1	1	-	-	-	-	1	6	6	2	-	1	-	-	-	-	-	2	3	-	2	S3/C1x1
9.Improve financial management	-	-	-	-	-	-	-	1	2	3	-	-	-	-	-	-	-	2	-	-	2	-
14.Aquire a job	1	3	1	1	1	1	-	1	2	5	S1/C2x1 S3/C1x1 S4/C1x1 S5/C4x1 S5/C3x1	-	-	-	-	-	-	-	-	-	-	-
15.Rehabilitate for work	5	7	1	-	1	1	3	5	7	7	S4/C2x4 S3/C1x2 S1/C2x1 S3/C5x1 S4/C1x1 S5/C2x1 S5/C3x1	1	-	-	-	-	-	-	1	3	1	-
16.Develop work-related skills	1	2	-	-	-	1	-	3	1	6	S5/C1	-	-	-	-	-	-	-	2	2	7	-
17.Improve self valuation	8	7	-	2	-	-	2	2	4	1	S4/C1x2 S4/C2x1 S3/C2x1 S5/C4x1	6	7	1	2	-	-	2	2	1	1	S2/C1x1 S2/C2x1 S3/C2x1 S4/C1x1 S5/C2x1
18.Improve socialising capacity (peer group)	-	-	-	-	-	1	4	6	1	3	-	2	2	1	-	-	-	3	3	3	6	-

TABLE 58 (continued)

Abbreviated Response	WANSBECK I N=40										WANSBECK II N=50									
	Clients					Staff				Conc	Clients					Staff				Conc
	1	2	3	4	5	1	2	3	4	5		1	2	3	4	5	1	2	3	4	5	
19. Improve relationships with staff	1	-	-	-	-	-	-	-	-	-	-	-	1	-	-	-	-	-	-	1	-	-
20. Improve relationships with family	2	2	-	-	-	-	3	1	-	-	-	3	2	1	-	-	-	4	-	1	-	S2/C1
21. Provide hobbies/occupations																						
22. Provide companionship	1	2	-	-	1	-	-	2	1	2	S3/C2x1	1	3	-	1	-	1	2	3	-	1	S2/C1x1 S3/C1x1 S5/C1x1
23. Improve interaction in groups	-	1	-	-	-	-	-	3	3	1	S4/C2x1	-	1	-	-	-	-	2	4	2	2	S5/C2x1
24. Recover from mental illness	4	2	-	-	-	1	-	2	5	6	S4/C1x1 S3/C1x1 S5/C2x1	5	4	-	-	-	-	-	2	1	2	S5/C2x1
25. Assess Client	2	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
29. Prevent psychiatric admission	4	1	-	-	1	-	2	1	4	3	S2/C1x2 S4/C5x1	1	-	-	-	1	2	1	-	-	4	S1/C1
30. Increase independence/Autonomy	-	-	-	-	-	-	-	1	4	1	-	1	1	-	-	-	-	4	2	1	2	S3/C2

A 'Don't Know' evaluation was made by staff in one case at Wansbeck II re "Assisting recovery from Mental Illness'. This was the only such response.

TABLE 59 - Wansbeck Day-centre Fixed Aims Evaluation

APPENDIX 10(13)

Abbreviated Response	WANSBECK I N=40											WANSBECK II N=50										
	Clients					Staff					Conc	Clients					Staff					Conc
	1	2	3	4	5	1	2	3	4	5		1	2	3	4	5	1	2	3	4	5	
1. Cope with life in General	16	18	2	2	-	-	3	9	5	12	S4/C1x2 S5/C2x5 S3/C1x5 S2/C1x2 S5/C3x2 S3/C2x2 S2/C2x1 S5/C4x2 S4/C2x3 S5/C1x3	18	22	2	2	-	2	11	11	3	5	S5/C2x2 S2/C1x5 S2/C2x4 S3/C1x1 S3/C2x9 S4/C1x3 S1/C2x1 S2/C4x1 S5/C1x3 S1/C1x1
2. Prevent psychiatric admission	17	12	1	4	1	11	2	1	3	2	S3/C1x1 S1/C1x5 S2/C1x1 S4/C1x1 S6/C2x1 S5/C2x1 S5/C4x1 S1/C2x4 S4/C2x1 S1/C5x1 S1/C4x1 S2/C2x1	9	16	3	-	1	16	2	1	3	1	S1/C2x6 S4/C2x1 S5/C2x1 S4/C1x1 S1/C1x5 S4/C4x1 S1/C3x1 S3/C2x1
3. Handle own money better	5	5		3	1	-	-	-	2	2	S5/C1x1 S4/C4x1	1	5	3	-	1	-	4	-	1	2	S2/C2x1 S5/C5x1
4. Prevent serious depression	9	6	3	2	-	2	-	1	-	-	S3/C2x1 S1/C1x1 S1/C2x1	9	8	-	2	2	-	-	-	-	1	S5/C2x1
5. Cut down drink /drugs	1	-	2	2	2	-	1	-	1	-	S3/C2x1	1	-	-	-	-	-	4	-	-	-	S2/C1x1
6. Give up drink/ drugs	-	2	2	1	2	-	-	-	-	-	-	1	-	-	-	-	-	-	-	-	-	-
7. Alleviate thought disorder	16	6	4	4	-	-	-	1	-	4	S3/C2x1 S5/C3x2 S5/C4x1 S5/C2x1	14	13	1	3	-	-	-	2	-	1	S5/C1x1 S3/C1x1 S3/C4x1
8. Stop confusion deteriorating	-	-	-	-	-	-	-	-	-	-	-	5	8	1	3	-	1	4	8	2	3	S3/C2x1 S5/C2x1 S5/C1x1 S3/C1x1 S2/C3x1 S4/C1x1 S4/C2x1

TABLE 59 (continued)

APPENDIX 10(14)

Abbreviated Response	WANSBECK I N=40											WANSBECK II N=50										
	Clients					Staff					Conc	Clients					Staff					Conc
	1	2	3	4	5	1	2	3	4	5		1	2	3	4	5	1	2	3	4	5	
9. Cope with physical illness	5	3	1	3	6	-	1	1	1	-	S3/C4x1 S2/C2x1	6	7	7	3	2	-	3	3	-	1	S5/C5x1 S3/C1x1 S2/C3x1 S2/C5x1 S2/C1x1 S3/C2x1
10. Prevent deterioration of physical illness	3	2	1	2	5	-	1	-	1	-	-	6	7	7	5	2	-	1	-	-	-	S2/C3x1
11. Cope with mental illness	20	16	3	-	2	1	1	6	9	6	S5/C2x2 S4/C3x1 S3/C2x4 S4/C2x3 S2/C2x1 S4/C1x5 S5/C5x2 S3/C1x2 S5/C1x2 S1/C1x1	25	17	1	-	-	3	9	6	1	2	S1/C2x1 S3/C1x6 S3/C1x5 S5/C1x2 S2/C3x1 S4/C2x1 S1/C1x2 S2/C2x2 S3/C2x1
12. Enjoy life more	17	15	4	3	1	1	3	13	7	4	S3/C1x7 S3/C2x4 S1/C2x1 S6/C1x2 S2/C1x1 S4/C2x3 S3/C2x1 S5/C2x2 S4/C1x3 S4/C4x1 S2/C2x2 S5/C3x1 S5/C1x1 S2/C5x1	21	16	3	2	1	14	12	-	5	1	S2/C1x6 S2/C2x5 S3/C1x7 S3/C2x5 S5/C1x1 S3/C3x1 S2/C3x2 S4/C1x2 S4/C2x1 S4/C4x1 S4/C5x1 S2/C4x1
17. Improve relationship outside friends	6	6	-	8	6	-	-	-	-	-	-	5	6	6	9	14	-	3	-	-	1	S5/C5x1 S2/C4x2 S2/C1x1
18. Improve relationships with other clients	13	21	-	5	-	-	1	2	5	4	S3/C1x1 S5/C4x1 S5/C2x2 S4/C2x3 S2/C1x1 S4/C1x1 S5/C1x1 S3/C6x1 S4/C4x1	23	20	-	2	-	1	6	2	-	1	S3/C2x1 S5/C2x1 S2/C2x5 S3/C1x1 S1/C1x1 S2/C1x1

TABLE 59 (continued)

APPENDIX 10 (15)

Abbreviated Response	WANSBECK I N=40											WANSBECK II N=50										
	Clients					Staff					Conc	Clients					Staff					Conc
	1	2	3	4	5	1	2	3	4	5		1	2	3	4	5	1	2	3	4	5	
19. Contribute more to Community	12	12	3	6	2	-	-	-	-	-	-	9	11	7	7	6	-	-	-	-	-	-
20. Improve relationship with Staff	20	10	-	2	-	-	-	1	2	2	S4/C4x1 S5/C2x1 S3/C2x1 S5/C1x1 S4/C1x1	41	6	-	-	-	-	2	-	-	-	S2/C1x2
21. Improve relationship with family	11	7	5	5	7	-	1	1	4	1	S3C2x1 S4/C5x1 S4/C2x1 S5/C4x1 S4/C1x1 S4/C4x1	5	7	7	-	3	-	3	-	-	3	S5/C4x2 S5/C2x1 S2/C5x1 S2/C3x1
22. Concentrate on work/occupation	18	8	5	3	4	-	1	8	4	3	S5/C3x1 S5/C1x5 S4/C4x1 S3/C2x1 S4/C2x2 S5/C5x1 S2/C2x1 S3/C4x1 S5/C2x1 S4/C1x1	15	15	-	6	2	-	4	3	1	5	S2/C2x4 S3/C2x1 S4/C4x1 S5/C3x2 S3/C1x2 S5/C2x2
23. Prepare for outside job	8	6	5	7	11	1	-	-	4	4	S4/C2x2 S5/C2x1 S5/C4x1 S4/C1x2 S5/C1x1 S4/C3x1 S1/C1x1	-	-	-	-	-	-	-	-	-	-	-
24. Prepare for sheltered job	21	13	1	1	2	1	-	1	3	4	S3/C2x1 S5/C1x3 S4/C2x1 S4/C5x1 S4/C1x1 S5/C3x1 S1/C1x1	-	-	-	-	-	-	-	-	-	-	-
28. Support clients living in Community	12	11	1	-	1	2	1	-	-	-	S6/C2x1 S2/C1x1 S1/C2x1	4	9	3	2	3	16	-	-	-	-	S1/C1x2 S1/C2x3 S1/C5x1 S1/C3x1
29. De-institutionalise outside Hosp.	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-

One client at Wansbeck I gave a 'Don't Know' answer in response categories numbers 17,18 and 20. Staff at Wansbeck 1 gave 'Don't Know' responses in respect of one client re categories 2,10 and 28 and in respect of two clients in response category 12.

At Wansbeck 11, one client gave a 'Don't Know' response in respect of aim 19, two clients in respect of aim 28 and three clients in respect of aim 22. Wansbeck 11 staff did not give any 'Don't Know' responses in respect of clients.

This Appendix illustrates, by means of the following table, the relationship between concurrence of response between staff and clients and their perceptions of success or failure. These details are provided only in respect of the nine most commonly concurrent open-ended aims. The rationale for this appears in Chapter IV p.p.196-8. This table is collated for the whole client sample in all units. Table 45 on p.198 is extrapolated from it.

Table 60: Overall Concurrence - Where five or more instances of concurrence occurred in any one aim category

Open-ended aims

Aim	Perceived success rates where there was no concurrence				Perceived success rates where concurrence existed			
	Total cases of Non-concurrence				Total cases of concurrence			
	Clients		Staff		Staff		Clients	
	Number & grade total client respondents	% of total clients responding in each scale point	Number & grade total staff responses re clients	% of total staff responding in each scale point	Number & grade total client respondents	% of total clients responding in each scale point	Number & grade total staff responses re clients	% of total staff responding in each scale point
1 Prepare for autonomy outside 'care'	1 x 1 1 x 2 2 x 4	25 25 50 100	5 x 1 3 x 2 2 x 3 3 x 5	38 23 15 23 100	4 x 1 1 x 3 1 x 4	(67%) (17%) (17%) 100	4 x 1 2 x 2 2 x 2	(67%) (33%) 100
3 Provide external excursions	14 x 1 2 x 2 1 x 5 1 x 6	78 11 5 5 100	14 x 1 3 x 3 1 x 4 6 x 5	58 13 4 25 100	2 x 1 1 x 2 2 x 5	(40%) (20%) (40%) 100	3 x 1 2 x 2	(60%) (40%) 100
7 Improve domestic self-care	4 x 1 7 x 2	36 64 100	2 x 1 8 x 2 8 x 3 11 x 4 6 x 5 1 x 6	4 17 39 23 13 2 100	2 x 2 2 x 3 1 x 4 1 x 5	(33%) (33%) (17%) (17%) 100	3 x 1 2 x 2 1 x 4	(50%) (33%) (17%) 100

Table 60 Overall Concurrence - Where five or more instances of concurrence occurred in any one aim category (cont'd)
Open-ended aims

Aim	Perceived success rates where there was no concurrence				Perceived success rates where concurrence existed			
	Total cases of Non-concurrence				Total cases of concurrence			
	Clients		Staff		Staff		Clients	
	Number & grade total client respondents	% of total clients responding in each scale point	Number & grade total staff responses re clients	% of total staff responding in each scale point	Number & grade total client respondents	% of total clients responding in each scale point	Number & grade total staff responses re clients	% of total staff responding in each scale point
14 Facilitate job acquisition	1 x 1 1 x 5	50 50 100	2 x 1 3 x 4 3 x 5	25 38 38 101	1 x 1 2 x 3 1 x 4 2 x 5	(17%) (33%) (17%) (33%) 100	2 x 1 2 x 2 1 x 3 1 x 6	(33%) (33%) (17%) (17%) 100
15 Rehabilitate for work	6 x 1 3 x 2 1 x 3	60 30 10 100	1 x 1 3 x 2 3 x 3 5 x 4 6 x 5	5 17 17 28 33 100	1 x 1 4 x 3 5 x 4 1 x 5	(9%) (36%) (45%) (9%) 100	5 x 1 5 x 2 1 x 5	(45%) (45%) (9%) 100

Table 60 Overall Concurrence - Where five or more instances of concurrence occurred in any one aim category (cont'd)
Open-ended aims Percentages to nearest decimal point and therefore do not necessarily add up to 100

Aim	Perceived success rates where there was no concurrence				Perceived success rates where concurrence existed			
	Total cases of Non-concurrence				Total cases of concurrence			
	Clients		Staff		Staff		Clients	
	Number & grade total client respondents	% of total clients responding in each scale point	Number & grade total staff responses re clients	% of total staff responding in each scale point	Number & grade total client respondents	% of total clients responding in each scale point	Number & grade total staff responses re clients	% of total staff responding in each scale point
17 Improve self-valuation	23 x 1 15 x 2 2 x 3 5 x 4 1 x 5	50 33 4 11 2 100	7 x 1 12 x 2 7 x 3 6 x 4 2 x 5	21 35 21 18 6 100	2 x 1 7 x 2 4 x 3 5 x 4 2 x 5	(10%) (35%) (20%) (25%) (10%) 100	10 x 1 8 x 2 2 x 4	(50%) (40%) (10%) 100
22 Provide satisfying occupation	19 x 1 8 x 2 1 x 3	68 29 4 100	3 x 1 14 x 2 5 x 3 2 x 4 5 x 5	10 48 17 7 17 100	2 x 1 2 x 2 5 x 3 4 x 4	(15%) (15%) (38%) (31%)	6 x 1 4 x 2 1 x 3 1 x 4 1 x 6	(46%) (31%) (8%) (8%) (8%) 100

Table 60 Overall Concurrence - Where five or more instances of concurrence occurred in any one aim category

Open-ended aims

Aim	Perceived success rates where there was no concurrence				Perceived success rates where concurrence existed			
	Total cases of Non-concurrence				Total cases of concurrence			
	Clients		Staff		Staff		Clients	
	Number & grade total client respondents	% of total clients responding in each scale point	Number & grade total staff responses re clients	% of total staff responding in each scale point	Number & grade total client respondents	% of total clients responding in each scale point	Number & grade total staff responses re clients	% of total staff responding in each scale point
23 Improve peer group interaction	15 x 1 7 x 2 1 x 4 1 x 5	63 29 4 4 100	5 x 1 3 x 2 4 x 3 1 x 4 2 x 5	33 20 27 7 13 100	2 x 2 2 x 3 1 x 4 1 x 5	(33%) (33%) (17%) (17%) 100	3 x 1 2 x 2 1 x 5	(50%) (33%) (17%) 100
25 Facilitate recovery from mental illness	3 x 1 5 x 2	62 38 100	3 x 1 13 x 2 9 x 3 13 x 4 8 x 5	7 28 20 28 17 100	1 x 1 3 x 2 1 x 3 1 x 4 2 x 5	(33%) (38%) (13%) (13%) (25%) 100	6 x 1 2 x 2	(75%) (25%) 100

A55 APPENDIX 11(5)

Notes to Table 61

1. In all columns the first digit signifies the number of responses, and the second the grade on the five point scale to which it refers - viz. 7 x 2 indicates 7 responses o scale point 2 (relatively good) attainment in this classification category.

2. Columns relating to client respondents record client evaluations of degree (on the five point scale) of success in attaining aims related to them. In each aim category.

3. Percentage columns show the proportion of responses from each group in each scale point classification for the category of aim in question.

4. Columns referring to staff respondents record staff evaluation of success in respect of clients in attaining aims in each aim category.

5. Concurrence existed where both a client and a staff member (in respect of him/her) deemed a particular aim to be appropriate.

6. Totals of percentages are expressed as 100 - even where they do not, in aggregate, add up exactly to 100.

APPENDIX 12 Overall Aim Evaluations By Unit

APPENDIX 12 (1)

Table 61: All Units - Collated Aim Evaluations in all aim Categories

N = The number of clients studied in each unit.

Unit and method of eliciting response	Clients						Staff					
	Scale Point						Scale Point					
	1	2	3	4	5	6	1	2	3	4	5	6
1a. CRASTER N=26 Open-ended aim Responses	38	11	1	1	3	1	16	20	14	16	8	2
1b. CRASTER N=26 Fixed Aim Responses	175	85	21	10	46	6	18	32	32	15	4	-
2a. HARBOTTLE N=22 Open-ended aim responses.	37	12	-	2	1	-	12	22	16	15	6	-
2b. HARBOTTLE N=22 Fixed Aim Responses	193	89	15	19	42	1	15	20	17	18	11	-
3a. BAMBURGH N = 10 Open-ended Responses	10	2	1	1	1	1	3	9	4	3	1	-
3b. BAMBURGH N = 10 Fixed aim responses	52	40	13	7	26	2	2	8	20	2	-	-
4a. DUNSTANBURGH N=10 Open-ended aim responses	5	4	2	1	2	1	11	11	3	3	1	-
4b. DUNSTANBURGH N=10 Fixed aim responses	57	48	7	12	21	-	9	12	10	-	-	-
5a. KIELDER N = 12 Open ended aim responses	10	7	-	3	1	-	34	12	16	7	3	2
5b. KIELDER N = 12 Fixed aim responses	60	44	17	12	30	-	13	23	18	12	2	-
6a. WARKWORTH N = 15 Open-ended aim responses	15	9	-	2	-	1	17	17	1	2	3	-
6b. WARKWORTH N = 15 Fixed aim responses	76	74	24	7	26	4	27	24	15	6	5	-
7a. WANSBECK I N=40 Open-ended aim responses	45	34	2	5	3	1	9	14	46	49	54	-
7b. WANSBECK I N=40 Fixed aim responses	230	180	43	63	56	3	19	16	45	50	49	5

APPENDIX 12 (2)

TABLE 61 (continued)

Unit and method of eliciting response	Clients						Staff					
	Scale Point						Scale Point					
	1	2	3	4	5	6	1	2	3	4	5	6
8a. WANSBECK II N=50 Open-ended aims	50	34	4	5	-	1	35	28	38	23	50	1
8b. WANSBECK II N=50 Fixed aims	218	193	52	48	37	3	39	67	48	16	27	-
TOTALS (All Units)	1271	866	202	198	2 5	25	279	335	343	237	224	10
% of the responses	44.5	30.3	7.1	6.9	10.3	1	19.5	23.5	24	16.6	15.7	0.7

Notes:

1. The success scale points are those used throughout the aims analysis and evaluation exercises (as in Appendix 9). A five point scale is used (columns 1-5) and column 6 is used for "don't know" responses.

2. This table is an extrapolation from those contained in Appendix 10.

3. Evaluations given in response to *all* questions on attainment of *all* aims in *all* units are collected together in this table. It therefore charts overall client and practitioner staff evaluation of success and failure.

4. The percentages in the totals column indicate the percentage of total client, *or* staff responses *of each* scale point.

5. This table should be read in conjunction with the cost effectiveness excercise in Chapter IV.

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