CUSS GROUP HOME

special report

Evaluation of assessments carried out to measure the social competence of residents of the CUSS home before and after discharge from Ely Hospital, Cardiff.

November 1976

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About 55,000 people live in special mental subnormality hospitals: many of them have been there for most of their life. These hospitals are not very pleasant places to live in. Isolated socially and geographically, most of them are old and badly designed, with poor facilities, understaffed and with little drive to make sure that the mentally handicapped person gets the special education and training he needs to live independently in the community. In some hospitals changes are being made to make the hospitals more homely; this is not enough. It is quite clear that the problems of subnormality hospitals are not really problems of money or facilities, to be solved by the creation of 'super-institutions'. They are fundamental problems inherent in the structure and organisation of institutions. We need a system of care which will guarantee the rights of the mentally handicapped; an end to segregated, inferior services, in favour of a system which allows mentally handicapped people to live with the rest of us and to use the same services we use.

STORE 5

Cardiff Universities Social Services wants to see all subnormality hospitals closed and replaced by small homes near where mentally handicapped people were born and spent their first years. We do not pretend that mentally handicapped people will be "cured" by doing this. Although many of them will not need much help, others will need a lot, and a few will need nursing support in the home. But for all the handicapped, CUSS wants them to be able to live near their family and friends and to live in the kind of home we would want for ourselves: this is their right. CUSS is a registered charity set up by students who want to do something concrete about these ideas. Since 1968 it has been working with patients of Ely Hospital in Cardiff. It now runs a group home where students and mentally handicapped young people live together; this report has been produced to show the improvements in self-help, social and personal skills that have occurred amongst the residents of the CUSS Group Home since their discharge from hospital in July 1974.

We are grateful to the staff of the Trelai Adult Training Centre for their contribution to the training received by the Group Home residents. We should also like to thank Alan, John, Jackie, Heather and Paul for showing the interest and determination to learn new things.

The Group Home Project is funded jointly by South Glamorgan Social Services and South Glamorgan Health Authority. Reports on the Project are available from Cardiff Universities Social Services, Joint Students Union, Park Place, Cardiff.

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November 1976

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Cardiff Universities Social Services
Gwasanaethau Cymdeithasol Colegau Caerdydd
Joint Students Union, Park Place, Cardiff CF1 3QN
Telephone: 43474
(Office entrance in Senghennydd Road)
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STUDENTS SHOW THE WAY

Cardiff Universities Social Services run a group home with a difference: four students share with five mentally handicapped people of their own age. Jim Mansell describes how the home works, and the success it has achieved in just eighteen months.

In July 1974 another group home opened, and a few more mentally handicapped people got the chance to escape the constraints of an institution and to try to live like the rest of us. Some things made this home different: firstly it was set up by students, and students lived in it too; secondly the non-student residents (in their late teens) had been held to be too handicapped for discharge from hospital.

Another important difference between this project and others was the emphasis the students placed on building links with local people to break down the social isolation that often affects even the smallest group home. So, after eighteen months, what are the lessons that can be drawn from this experience, and what are the problems that face the home in its second year of operation?

An outline description of the project appeared in 'New Psychiatry' in 1974 ('Home for the handicapped', September 19). Four students live with five non-students (who are all mentally handicapped) in a house rented from University College, Cardiff. Residents either attend adult training centre or their college classes during the day: at evenings and weekends they share housework tasks and participate in a range of activities which make as much use of the neighbourhood facilities as possible. Student holidays are covered by the student residents with additional support from prospective residents. Support also comes from non-resident student volunteers who undertake some of the training programmes, and from the full-time social worker employed to develop community links and to monitor progress in the home. The home is financially self-supporting; residents get student grants or supplementary benefit, and all pay the same (economic) rent to the university and equal shares of the bills. Social work, and the administrative support for the project are financed by the student charity (Cardiff Universities Social Services) and grant aid from the South Glamorgan County Council and the AHA. A videotape of the home is available for hire or purchase from CUSS (1).

Perhaps the first news to be proclaimed is that the home has been operating successfully for nearly eighteen months. A widespread scepticism among more

conservative sections of the hospital staff has proved unfounded. The credibility of those who claimed that none of the handicapped people the students wanted to live with were suitable for discharge is opened to doubt, and predictions about residents returning 'within three months' from the then consultant now seem pessimistic in the extreme. The reticence of senior staff in the traditional hospital disciplines contrasted with the acceptance of the scheme by the local authority social services department. To get effective support from the health service it was necessary to involve the (now defunct) Welsh Hospital Board: in the event the board were able to overcome objections from the staff concerned. Their involvement was also important in helping the students to 'firm up' their plans in a way acceptable to administrators and policy-makers, and in providing financial support.

A particular contribution to the project came from the clinical psychologist at Ely Hospital, who assisted both in the strategy and the tactics of rehabilitating and training the handicapped residents. For four months prior to moving into the group home, a special rehabilitation programme was carried out by staff employed and directed by CUSS, and financed by a grant from the King's Fund Centre. The results of this programme were adequate, but disappointing. The institutional environment of the hospital seriously inhibited training for life outside. This experience contrasts with the substantial increase in skills and character development in the non-student residents since getting out of the hospital. Progress is documented by regular assessments using Gunzburg Progress Assessment Charts: but a more striking impression is gained from direct observation. To see a young man, who used to spend several hours a day in hospital disengaged from activities around him, go out and collect his supplementary benefit from the local post office, or iron his shirts, or buy a pint in a pub brings home some idea of the extent of untapped potential that there must be among residents in hospital.

The former residents of the hospital were among the most competent in their age group: but one particular experience soon after the group home opened illustrates the extent to which problems can be overcome. As the behaviour modification training programmes began to take effect, and inappropriate behaviour began to consistently elicit withdrawal of attention in the students, one of the young women developed a serious behaviour problem. In order to gain attention - even reprimanding or restraining attention - this resident took to disrupting activities, threatening to damage property and attacking other residents; all of which could not be ignored and so was being reinforced.

It was planned to deal with this problem by transferring the reward away from

attention and approval to a token scheme; added urgency rose when neighbours complained about the noise made by the resident concerned. This was a major test of the project: the social services officer thought it might be best to re-admit this resident and replace her with another (even though the group had been selected and trained together), the consultant was initially in favour of tranquillisers. It was agreed to pursue the revised behaviour modification programme, and in addition to use chloral hydrate to prevent the noisiest hysterics. A description of the scheme is beyond the scope of this article, but it was completely successful within a very short period (the chloral hydrate being used three times only). This conclusive demonstration of solving a serious problem within the home goes a long way to meeting criticisms that the home is a 'soft option' because of the competence of the residents.

Even the standard of health care is higher outside the hospital: two of the handicapped residents have spectacles they needed, and one has an orthopaedic appliance to assist in overcoming a hemiplegia. After a three month 'trial run' in the group home the handicapped residents were discharged from the hospital and so are now able to use normal health facilities.

Among those most concerned with the project there is an overwhelming optimism about the prospects for integrated care using group homes. Although the students live in (and this in itself is a valuable experiment) it is felt that a concentrated training input to residents of similar competence could reduce the need for support to levels within the scope of social services departments, especially if use is made of the potential of volunteers in the neighbourhood.

The second area where the experience of operating the home has been valuable is in understanding the role of students as residents in a group home like this. There is a basic ambiguity in this role; the student is part trainer, part friend. The training role requires an authoritative, manipulative, detached outlook on the part of the student; the role of co-resident and friend is one of mutuality, involvement and non-directive support. In the first few months the conflict was not really apparent because all the emphasis was on skill acquisition rather than personality development; but emphasis has shifted away from training towards friendship. There does not seem to be any problem in mixing the two kinds of relationship, and the handicapped residents seemed to have no difficulty in distinguishing between the two; but the artificiality this brings has disturbed the students and there is a move towards making training the function of non-residents.

The group home had a good start because it did not need planning permission - the house was already designated for multiple occupancy by students. It should be a

scandal that handicapped people can be discriminated against through objections to planning permission. The only enquiry when residents first moved in turned into relief that the house would not be occupied solely by students!

The most important contacts with local people in the time that the home has been operating have been through the use of local facilities such as shops, the launderette, the post office and the pub. Contact with handicapped people has led to a positive attitude; repeated interaction lessens the use of inappropriate stereotypes of handicap and provides new and direct opportunities for people to help. The amount of special help needed depends in part on the extent to which we are prepared to meet the handicapped part-way: for example, those residents who attend training centres are competent in using public transport to get most of the way there - but Cardiff buses are not sufficiently reliable at peak periods to be useful. In the longer term, work is being started to develop other, more organised, links with local people - initially through a local 'sitting-in' service for parents. This is very much the province of the social worker, who is in no sense a 'warden'.

Initial aims have been achieved and in many cases exceeded by this project. But as yet there is no sign of any real spin-off in terms of developments in statutory services. Of course the social services department has no money; but the health authority is embarking on expensive schemes to patch up institutional provision. The Ely Hospital has had some success in developing its Play Assistant Scheme as a training forge, but this is constrained by the same sort of limits that the students came up against in their pre-discharge programme. There are vague signs that the health authority may purchase houses in the community to replace its institutional provision; this would be welcome, and is not a moment too soon. Meanwhile, this group home in Cardiff amasses more evidence in favour of a more optimistic approach to community care.

References:

(1) Enquiries: Cardiff Universities Social Services, Students Union, Park Place, Cardiff (phone 0222 43474).

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METHODS OF ASSESSMENT

The method of assessment selected for the residents of the Group Home is Gunzburg Progress Assessment Chart. The first assessment was carried out in December 1973 to January 1974 by the psychologist at Ely Hospital, using the P.A.C.2. Subsequent assessments have taken place at intervals of approximately six months, using the same method.

The P.A.C.s covers four major areas of social competence; these are: self help, communication, socialisation and occupation. This evaluation of progress made by the five residents of the Group Home draws on the data compiled in the early assessment, whilst they were still living in Ely Hospital, and compares this with the levels of competence shown by the recent assessment, carried out in June 1976.

In the area on occupation only two subsections are discussed; this is because the remaining sections relate to skills developed in the work setting, for example the care of tools and materials. These skills could not be tested in the early assessment, and therefore no comparison can be made.

The P.A.C. Manual provides guidelines for scoring the performance of each skill. These guidelines cannot ensure a completely objective assessment; in fact, Gunzburg states that "observers have to use their judgement constantly and have to make the necessary adjustments dictated by different local conditions". This element of discretion, on the part of the assessor, means that there is a degree of variability as to how a client's performance is scored. This variability is most likely to occur when there has been a change in the client's environment and a change in the standards of social conduct applied to the client's behaviour.

An example of this effect is shown in Alan's assessment in the area of socialisation (p. 6). In the hospital setting Alan scored well on social graces and social initiative. A decline in score from 5 to 4 is shown in each area in the recent assessment. But observers who have known Alan throughout the period considered report improvement in Alan's social graces and social initiative. The lower score reflects higher expectations of what is acceptable in the context of an ordinary home, compared with hospital, where staff are more accustomed to unusual patterns of behaviour. This general raising of expectations has occurred across the range of skills assessed. The P.A.C. provides a useful and reasonably accurate assessment of social competence on an individual

basis. However, in attempting to evaluate the quality of care in the Group Home, other measures are also required, and a range of assessments is favoured. Direct observation methods have recently been used to collect data relating to the residents' evening activities (see Appendix I). Further observations will be carried out at intervals of six months. Video recording has also been used as an aid to measuring levels of interaction and engagement in the home. These levels are generally held to be a significant indicator of the quality of care provided in a residential setting. An additional assessment, recently devised and adopted in the Group Home, measures aspects of the residents' independence and integration in specific behavioural terms (see Appendix II).

General observation indicates that residents now interact more frequently with one another than they did when they were in hospital. When they first moved into the home it was noted that there was little interaction between residents; most conversation was limited to student-resident exchanges, leisure activities were invariably initiated by students, and, in the absence of this, residents would sit in the living room with little evidence of purposeful activity. This is the same pattern as reported in mental handicap hospitals by Grant & Moores (1975). In comparison, the residents are now far more inclined to talk with one another and initiate leisure activities between themselves without the influence of the non-handicapped members of the household. These areas of development are not so easily measurable as progress is made in practical skills, yet they should be noted as important indications of high quality care.

An important area of progress not featured in the P.A.C. assessment, is the increased contact that the residents have with their families. This growth of contact with relatives has been noted in other projects where hospital residents have moved out to small homes in the community (for example, the West Wales hostels). It is clear that parents and other relatives find it a more rewarding and positive experience to visit someone living in an ordinary home than to visit that person on a hospital ward. Those involved in running the Group Home take the view that family contacts and bonds contribute to the quality of life of the residents; increased contact may therefore be taken as one of the indications of a higher quality of care.

In October 1976 a pilot project on the use of goal planning procedures was introduced in the Group Home, with the collaboration of the Mental Handicap Applied Research Unit. The objectives of the project are as follows:-

i) to increase the frequency of setting and attaining behaviour goals

within the Group Home, including goals relating to 'problem behaviours';

ii) to set up conditions such that this goal-related behaviour will be sustained over a period of at least six months;

iii) to document a package of training and maintenance procedures which could possibly be introduced into other settings (day, domiciliary or residential services);

iv) to specify measurement and data - analysis methods which could possibly be used in such other settings.

Two instructors employed under the Job Creation Programme from the beginning of October work with the residents on a one-to-one ratio, using goal planning procedures. Their employment will last for one year only. The purpose of this is to systematise training and provide as much opportunity for development as possible - to provide an equivalent of a high quality community support service. It is hoped that this high input of systematic training will bring a further significant increase in levels of independence.

The P.A.C.2 data usefully highlights areas of underachievement; training is aimed at developing the residents' skills in these important areas. A review procedure has been established whereby the CUSS Board of Trustees meets at regular intervals to review the goals and methods of training. Instructors, Group Home residents and social worker meet each week to review the progress that has been made and to set new goals.

The following evaluation of P.A.C.2 data shows that striking progress in skill development has been made by all five residents. This progress results from the many opportunities provided in an ordinary home for learning and maintaining new skills; it clearly indicates that the residents were underachieving in many areas in the hospital setting.

* * *

INDIVIDUAL PROGRESS

Alan, who was born on [redacted].55, suffers from Down's Syndrome. He has no additional physical handicap. In comparison with the other residents Alan has a high level of ability and is making the fastest progress in basic 'academic' skills, such as social sight reading, number work and writing. It has been suggested that Alan's comparatively high level of ability led to his adopting an authoritarian attitude towards other patients, whilst living in Ely Hospital. One of Alan's tasks has, therefore, been to learn to live cooperatively with other members of the group. The section below on socialisation skills comments further on Alan's progress in terms of 'social graces'.

Self Help

Alan scored a total of ten skills (out of a maximum of 30) for this area of social competence according to the data collected between December 1973 and January 1974. Using the same method of assessment his score in June 1976 was 15, showing an overall increase of 50%. Significant progress is shown in the 'mobility' skills; these reflect his ability to find his way around the local community, go on errands involving the crossing of roads, and to use public transport. Alan's progress in this sphere is directly related to the many opportunities for becoming familiar with the local neighbourhood and making regular use of local services and facilities available in a normal home.

Alan's potential ability to make use of public transport has not developed significantly; this is largely because of his home's proximity to the centre of town and easy access to shops, cinemas, parks, etc. Originally it was intended to use public transport in travelling to and from adult training centre. An intensive training programme was carried out for all residents in order to provide them with the skills required. This was completely successful. However, bus services for this route proved unreliable, and the residents had to make use of the transport provided by the Social Services Department; they continue to use this service at the present time. Alan is now learning to use buses as a general skill.

In the area of cleanliness Alan shows a loss of one skill in the recent assessment. This is because he still occasionally neglects to shave and needs to be reminded to do so. Alan also finds some difficulty in shaving within a reasonable length of time. Although the skill is well within Alan's ability, his slow pace and occasional need for a reminder have resulted in the skill not

being credited.

Communication

The P.A.C. data collected December 1973 to January 1974 credits Alan with two skills out of a maximum of 20 in this area. The recent assessment (June 1976) gives a total of 8.5 skills. Progress has been made in each of the five subsections: language, use of money, understanding time and measures, writing and reading.

No formal assessment of verbal ability is available at either point of assessment, but general observation suggests that Alan has developed a wider vocabulary and is able to express himself more clearly in his new home. This is because more opportunities are available for interacting with non-handicapped people in a variety of social settings.

Structured training by student volunteers, using systematic programmes, has helped Alan to develop his skills in using money, in telling the time, signing his name and recognising social sight vocabulary, including words such as 'push', 'pull', 'exit' and 'danger'. These kinds of skills are maintained and reinforced through living a normal pattern of life in the community.

Socialisation

The score in this area shown by the early assessment (December 1973 to January 1974) was 14 out of a possible maximum of 30 skills. The recent assessment in June 1976 shows a total of 18 skills.

Whilst in hospital Alan appears to have scored well on social graces and social initiative. The most recent assessment shows a decline in social graces from a score of 5 to a score of 4. This is due to the higher standards of social conduct that operate in a small group, where a high level of mutual cooperation and consideration is required. A large and relatively impersonal grouping of people is not so sensitive towards an individual's mood or behaviour.

Alan's recent assessment shows an increase in skills relating to home assistance, financial dealings and shopping. These increases are due to the opportunities presented in a small group home, where clients are involved in ordinary domestic activities.

Occupation

In this area only two subsections of the P.A.C.2 have been tested in the early

assessment; this is because the remaining four relate chiefly to skills developed in the work setting, such as time-keeping and the care of tools. In the two subsections tested, a total of 7 out of a possible 12 skills have been credited to Alan in the early assessment. The recent assessment gives a total of 6, showing a drop of one skill in the section on leisure occupations. Alan enjoys going out for a drink with frineds and attending the youth club, but overall he is less inclined to initiate specific leisure activities in the home. The standard expected in a normal household is higher than in hospital. This is in contrast with Paul, for example, who plays cards and usually invites others to join in. Recently, a darts board has been set up in the home and Alan has shown an active interest in playing and improving his game. This is also a means of helping him develop number concepts.

Conclusion

Alan's assessment shows an overall increase from 33 to 47.5 skills as measured in the P.A.C.2 over the period considered.

* * *

Paul, who was born on [redacted].54, suffers from Down's Syndrome. He has no additional physical disability but does have a severe language problem; this is shown in his score for the section of the P.A.C. dealing with communication skills.

In July 1976 Paul was diagnosed as diabetic, and certain health and dietary requirements must now be met. A district nurse visits each morning to give Paul his insulin injection. The staff at the A.T.C. have cooperated in arranging a modified diet and supervising urine tests. Paul has responded well to these special requirements and is gradually learning to appreciate the importance of regulating his intake of carbohydrate foods.

Self Help

The data collected between December 1973 and January 1974 whilst Paul was still in hospital show a very low score on self help skills, with a total of 4 out of a maximum of 30 skills. Data collected in June 1976 show a total score of 16 skills; scores on cleanliness, care of clothes, mobility and health go from 0 to 3, 4, 2 and 1 respectively.

Communication

The early assessment does not credit Paul with any skills in communication. The

later assessment (June 1976) gives a total of 3 skills. Paul's language deficit affects both his comprehension and verbal ability. This problem may have resulted from the fact that he was admitted to hospital at a very early age (2 years 5 months) and consequently lacked the stimulus of a normal home environment at a critical age in the development of language. Paul's problem with language constitutes a serious disadvantage in the acquisition of other skills such as the use of money, and understanding time and measures, where the training involves a high level of verbal communication. P.A.C.1 data collected in August 1974 and November 1975 show an increase in communication skills from 14 to 21. In a small group home there are many opportunities for sharing in tasks and other activities which promote the development of speech by relating sounds to concrete everyday objects. This has helped to expand Paul's comprehension of words and his verbal ability.

The P.A.C.2 data show that Paul is now able to sign his name. This important social skill is maintained through the regular need for Paul to sign for social security payments, and to sign forms relating to his Post Office account.

Socialisation

The early assessment (December 1973 to January 1974) shows that Paul has acquired no skills in this area. A later assessment in January 1975 shows a total of 9 skills credited, and the recent data collected in June 1976 show a total of 17 skills credited. The greatest increases come in the areas of social graces, home assistance and shopping. In general Paul's social behaviour reflects a more mature and confident approach developed through wider experience of meeting people in different social situations. Although Paul is not able to understand complex verbal instructions he has a great capacity for imitation and can quickly acquire practical skills through observing the actions of others. Opportunities for learning and maintaining domestic skills are provided by the daily pattern of life in the group home. Progress is also shown in financial dealings, as Paul makes regular use of the local Post Office which handles his savings.

Occupation

In the area of manual activities and leisure occupations Paul scored a total of 2 skills out of a possible 12 in the P.A.C. completed January 1974. The assessment carried out a year later shows an increase to 7 skills and the recent data collected in June 1976 credit Paul with 11 skills. Paul's high score in leisure occupations reflects his enjoyment in playing cards and badminton, going to the local pub and youth club.

Conclusion

Paul shows an overall increase from 6 skills to 47 skills over the period considered.

* * *

Heather was born on [redacted]58. There is no known cause for her mental handicap. At the age of 9 years Heather was misdiagnosed and sent to a school for deaf children. Subsequent investigation by a speech therapist revealed that her speech defect was due to dispraxia, a neurological defect which impedes voluntary control over the sounds made and also their intonation. Heather's speech problem is discussed in the section on communication skills.

Self Help

Heather's score on the early assessment was 8 out of a maximum of 30 skills. In June 1976 the data show a total of 19 skills. Progress in each area of 'self help' has been made. This reflects Heather's facility for learning and carrying out practical tasks independently. Her potential in this area has been significantly developed by the wide range of opportunities for incidental learning presented in an ordinary domestic environment. Heather takes an active interest in her appearance and enjoys shopping for new clothes. Basic knitting and sewing are amongst the skills that Heather has developed since leaving hospital.

Heather's progress in mobility skills is not so marked as that in other areas. Although she is growing more confident in finding hew way around the local neighbourhood, she is not yet thought to be sufficiently competent to cross roads without some supervision. Heather's problem with this skill seems to be one of judging the distance and speed of approaching cars, and keeping a watchful eye on the road as she crosses. In practice, her lack of complete competence in this skill does not restrict her mobility, since there is invariably a member of the household willing to accompany her to the local shops, launderette, Post Office, etc.

Communication

Heather seems to have no difficulty in understanding complex verbal instructions; it seems evident that her comprehension of language is far in advance of her expressive ability. Her lack of verbal ability creates problems in learning

other skills in this area of social competence, such as using money or telling the time. Whereas she is enthusiastic about learning practical skills, Heather is often reluctant to work on social skills which require verbal responses. This may well be due to the frustration she experiences in trying to articulate words correctly. In addition, since the sounds she makes seem very similar, it can be difficult for the person teaching to tell what progress is being made and to give appropriate praise and reinforcement. The advice of speech therapists has been requested, but so far no concrete help has been offered because of the extreme pressure on this service.

In general it has been observed that Heather's articulation has improved over the past two years. This is more noticeable to those who visit her at infrequent intervals, than to those who have close contact with the residents. Emphasis in the home has been on encouraging Heather to name objects rather than point to them, and to relate events using words instead of signs.

Socialisation

Heather's score on the early assessment was 6 out of a maximum of 30 skills. The score on the recent assessment is 14. Heather's progress is significant in the areas of shopping and home assistance, where scores go from 0 to 4, and 2 to 5 respectively. Progress is also shown in social initiative and financial dealings. Heather shows a decline in score for those skills grouped under the heading of social graces. This can be attributed to the higher expectations of social conduct operating in the Group Home compared with hospital. Behaviours that are accepted within the context of a hospital ward are considered unacceptable amongst a close-knit group of people living together in an ordinary home. Heather's low score reflects her inconsistency in achieving the standards of social conduct expected by those who live with her.

Occupation

Heather's score on manual activities in the early assessment was 2. The recent data show that Heather now scores on all 6 skills in this area. The scores on leisure occupation give an increase from 0 to 3. Although this shows significant progress, it should be noted that Heather is generally reluctant to join in group leisure activities. This can be explained partly by her inability to express herself as clearly as the other residents, and the frustration that this brings. Heather prefers to occupy herself with practical tasks such as knitting and sewing.

Conclusion

Heather's overall score has increased from 17 to 39 skills over the period considered.

* * *

Jackie, born on ██.55, has made progress in all the areas of social competence recorded by P.A.C. Her overall score in the early assessment December 1973 to January 1974 was 17; the recent assessment shows a score of 35, giving over a 100% increase. In addition to the skills listed in the P.A.C., Jackie has shown a general maturing of behaviour, and a growing capacity for dealing calmly with everyday problems or frustrations. Jackie had been labelled as 'over-active' and although she is still very much inclined to be boisterous and excitable, she has gradually developed patterns of behaviour and ways of relating to people that are more socially acceptable.

Self Help

According to the early assessment Jackie's score on skills relating to this area of social competence was 5. The recent assessment shows a score of 9, with increases in skills relating to 'cleanliness' and 'care of clothes'. Jackie still needs some guidance in choosing what to wear - in terms of what items go well together and what clothing is suitable for the weather. She shows great interest in her appearance and likes to go shopping for new clothes. Like the other residents, she is competent at using the local launderette on her own, as well as doing her laundry by hand.

No marked improvement is evident from the P.A.C.2 in terms of mobility skills. This is largely because the P.A.C.2 emphasises the use of public transport and this is an area in which Jackie has had little practice. However, Jackie has made important progress in getting to know the local neighbourhood, including the location of particular shops and services.

Communication

Jackie scored 1 in this section of the early assessment. Her score in June 1976 was 4. Progress is significant in language development. Jackie can answer the phone, and give appropriate replies, relate simple events and deliver messages. Jackie's speech has grown increasingly more coherent and intelligible; and she is able to understand relatively complex instructions. Progress in developing

clear speech and wider vocabulary is encouraged by the frequent opportunities for conversation with her friends and visitors. Sharing in daily domestic and leisure activities with the non-handicapped members of the home also generates a high level of verbal communication, compared with the opportunities in a hospital setting.

Jackie is presently becoming more competent at recognising written numbers; she is also able to identify coins; more work is needed in order to help her understand the abstract relationship between number values. Jackie enjoys learning on a one-to-one basis and can maintain her concentration on a task for relatively long periods, providing that other distractions are kept to a minimum.

Socialisation

Jackie's score on the early assessment was 8 out of a maximum of 30 skills. In June 1976 18 skills were credited. Progress is most significant in skills relating to shopping, where the score increases from 2 to 5, and in home assistance where the score goes from 1 to 4. Frequent use of local shops and services has helped to build up skills in this area. The emphasis placed on the client's independence means that a high level of competence is maintained in ordinary home activities, such as cooking, cleaning, washing up, etc.

Jackie's skills in social initiative have increased due to the frequent opportunities for meeting people in different social contexts. Skills relating to financial dealings have also improved.

Occupation

For the two subsections tested in this area of social competence, Jackie scored 3 out of a possible 12 skills in the early assessment, and 5 in the recent assessment. Jackie does not yet score on being able to organise her leisure time adequately. This is because she often needs suggestions as to how she can use her spare time constructively. However, if a choice of possible activities is presented, she will generally settle to a particular activity and give it her attention. Amongst the interests she has developed since leaving hospital are listening to her own collection of records (which she saves for), knitting, going to the youth club, and writing letters to her mother - with help from the non-handicapped members of the home.

Conclusion

Jackie's overall score for the period considered increased from 17 skills to 36 skills.

* * *

John, born [redacted] 53, is the oldest handicapped member of the Group Home. He suffers from hemiplegia of the right side. John has suffered in the past from rare nocturnal epileptic seizures, and uses medication to control this.

The lack of training opportunities in the hospital setting had created a high level of dependence and passivity. It has taken much effort on John's part and much encouragement from those around him to help him become more confident in taking initiative and acting more independently.

Self Help

John scored a total of 5 skills out of a possible 30 on this section of the P.A.C.2, completed December 1973 to January 1974. Data collected in June 1976 show a total of 9 skills, with progress being made in those skills related to 'cleanliness' and 'care of clothes'. John is able to make use of the local launderette.

So far as mobility is concerned, John has become familiar with the local neighbourhood through frequent use of shops and services. However, he is not yet fully competent in crossing roads by himself. Although he has a clear idea of what is required, he is inclined to become unsteady and anxious while stepping off pavements, because of his physical disability. This undermines his confidence and affects his general performance.

John has recently undergone an operation to release the tendons at the back of his right leg. It is hoped that this will make him more steady and confident in moving about.

John's score on table habits shows a decline of one skill from the early assessment. This reflects John's difficulty in handling a knife and fork correctly, according to the criteria listed in the P.A.C. Manual. In addition, John's difficulty in eating with his mouth closed makes his table manners less acceptable than those of the other residents.

Communication

The early assessment showed a score of 2 in this area of social competence; in January 1975 the score was the same, and in June 1976 John's score is also 2.

John can recognise coins of different denominations and understands their relative value. Adding and subtracting amounts of money have not been mastered as yet. John's attempts at signing his name have improved noticeably, but his performance is not yet of a high enough standard to be credited in the P.A.C.2.

John's verbal ability is of a relatively high standard compared with Paul, Heather and Jackie. He has grown increasingly confident in expressing himself and enjoys relating events to other people. John responds very positively to encouragement and praise, and he likes to work on new goals on a one-to-one ratio; these strengths are important in helping him to develop his communication skills.

Socialisation

John's score for this section of skills was 10 in the early assessment. In June 1976 15 skills were credited. John scored well in the hospital setting in social graces and social initiative, but skills relating to home assistance, shopping and financial dealings were completely lacking. This reflects the lack of opportunities in an institutional environment, where centralised services remove the possibilities for patients to engage in ordinary home activities and develop their dependence. Progress can therefore be seen in these particular areas; John's competence in daily living skills such as cooking, cleaning, washing up, etc. has developed steadily. Like the other residents, John is able to cook a meal for himself and the other residents with little guidance. He needs some advice in deciding what wuantities of food should be cooked, and casual supervision is needed in lighting the gas. John has also grown more competent in locating shops and asking for the items he requires. Good relationships with local shopkeepers through frequent contact has helped to develop his confidence in this sphere.

John's score on social initiative drops by one in the recent assessment; this is because he is not presently credited with being able to order a meal independently at a cafe. The comparative drop in score reflects a more stringent set of criteria applied by assessors in the recent assessment, rather than an actual loss of skill on John's part.