THE KIMBERLEY PROJECT EVALUATION

THE SERVICE ONE YEAR ON.

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CONTENTS

1.0. The Kimberley Project

The Kimberley Project is an accommodation and support facility for people with learning difficulties and challenging behaviour. The majority of individuals using the service had been living in a hospital setting prior to moving to the Kimberley Project.

Established by the charity organisation *Challenge* [i], the scheme consists of both supported accommodation and off-site day care facilities. The Kimberley Project opened in Newtownards, Co. Down, in June 1995, with the majority of residents taking up residency over the next five months.

Accommodation

The accommodation element of the project, Kimberley House, has the capacity to provide accommodation and support to sixteen individuals. It is a purpose-built home, providing residency for, and offering twenty-four hour staff support to, twelve individuals. A further four accommodation places are provided in semi-independent flats (known as Kimberley Mews), situated within the Kimberley House complex. These flats were not occupied at the time of the evaluation.

Off-site day-care/work placements are available at the Work Skills Centre to those individuals living within Kimberley House. Based in Conlig, three miles outside Newtownards, the centre is located within a Church Hall which shares its facilities with other community groups (for example, a creche). At the time of this evaluation, the Works Skills Centre was specifically for the Kimberley House residents. The aim of this facility was to provide the residents of Kimberley House with a work focus, and to provide basic education and training which may lead to employment in the future.

1.1. The Evaluation

Challenge was established in October 1993. As Kimberley House was the first accommodation and support scheme set up by *Challenge*, the organisation decided that an evaluation would be a vital way of informing service development. *Challenge* commissioned the evaluation through another charity, *Praxis*[ii].

This report describes the findings of an evaluation of the Kimberley Project one year after residents had been living there (uptake of residency was staggered so data collection took place approximately twelve to fifteen months after the facility had opened). The evaluation is a snapshot of the Kimberley Project after one year of operation. The long-term aim is that this should be a longitudinal project, exploring the issues related to residents' lives over a longer period living in a community setting.

The aims of the evaluation were:

- to investigate the impact of a supported lifestyles project (Kimberley Project), which includes both accommodation and support and day care, on service-users. Three areas of outcome have been examined as part of this evaluation:
    - residents' social networks

- residents' daily activity
- residents' adaptive behaviour;

- to elicit the views of residents about their daily lives and the service they receive, with a particular focus on the autonomy and choice they are allowed in their daily lives;

- to determine the views of families and relevant statutory staff about the project;

- to examine the impact the service has on the staff working in the project through an assessment of the sources of pressure they experience in their jobs, how they cope with those pressures, and how this effects their physical and mental health well-being.

1.2. Background to the Evaluation

A large number of studies have looked at how the move from hospital to community setting impacts on the individual with learning difficulties (for example in N. Ireland, Donnelly et al 1994). This evaluation focuses on the issues which arise for individuals during their first year living in a community setting, with the aim of a long term follow-up.

Mansell & Beasley (1993) have raised the issue of decay in the activity levels achieved by individuals with learning disabilities and in associated staff performance in some of the new services they evaluated over a period of three years. This emphasizes the importance of long-term longitudinal evaluations. Although there are some U.K. studies with longer term time-scales (e.g. five years, Lowe & DePaiva), the majority of longitudinal studies have had relatively short time-scales (e.g. eighteen months, Felce et al 1986; twelve months, Kleinberg & Galligan 1983, Shah & Holmes 1987, Fleming & Stenfert-Kroese 1990). Emerson & Hatton (1994), in their recent comprehensive review of forty-six studies carried out in the U.K. since 1980, argue that the evaluation literature has failed to take a longitudinal perspective when measuring outcomes, resulting in serious omissions in our knowledge. Therefore it was felt that it was important that this evaluation would be carried out over as long a time-scale as possible. We would suggest a four year follow up.

In *Residential Care: A Positive Choice* (1988), Wagner stated that *"Living in a residential establishment should be a positive experience enjoying a better quality of life than the resident could enjoy in any other setting"*, and that the *"needs and wishes of the user must be paramount"* in residential provision. Similarly, Blunden and Allen (1987), referring to the provision of services and the Ordinary Life initiative, comment that f*undamental to the approach advocated … is an attempt to understand the person's situation from the perspective of their experiences"*. Every attempt was made to make this principle central to the methodology used in this evaluation. It was felt that an examination of outcome for residents in terms of quality of life, from the perspective of the individual, should be central to the evaluation.

1.3. Quality Of Life

Schalock & Genung (1993) have identified the increasing focus on quality of life as one of a number of changes in recent years in outcome studies of individuals with learning disabilities. Quality of life encompasses a range of issues (see Felce, 1996). These can vary from more individual matters, (for example, friendships, development, daily activity, work, emotional well-being, and physical well-being), to wider political concerns (for example, the state of the nation, benefits, housing, education, and health). This evaluation primarily focuses on a number of personal quality of life issues.

- **Residents' Views**

Emerson (1985) commented that

"the evaluation of personal satisfaction has been seriously neglected in personal outcome studies … Failure to canvass client opinion is to continue to condone the exclusion of retarded people from taking active participant roles in decisions affecting their own lives".

Eliciting the views of any population group in relation to the health care they receive presents a number of methodological difficulties. For example, social desirability, acquiescence and differences between individuals in what constitutes satisfaction (Leiper & Field, 1993). Ways of limiting the influence of these variables through, for example, appropriate phrasing of questions, particular styles of interviewing, and emphasizing the confidentiality of information given, is an ongoing issue that researchers/evaluators must address.

There are other methodological issues in eliciting service-users' views which are more specific to individuals with learning disabilities. Historically, much focus has been given to the obstacles of interviewing individuals with learning difficulties: they may have limited experiences and so have few yardsticks against which to judge services which may result in low expectations of services. They may also be reluctant to criticise the people on whom they depend for support (Simons, 1995) .

Other methodological issues which are seen to threaten the validity of the information obtained in eliciting the views of individuals with learning disabilities (Kabzems, 1985; Flynn, 1986; Heal & Sigelman, 1995, for reviews) include:

- a tendency towards acquiescence
- open-ended questions yield low responsiveness, and may lead to under-reporting of certain behaviours
- when given two or three response options, individuals with learning difficulties have a tendency to choose the last response in every instance.
- multiple choice questions are subject to memory retention problems.

Research into response bias among individuals with learning difficulties has allowed the development of guidelines relating to the design of interview schedules. Studies which have examined the views of individuals with learning disabilities have shown that many of the methodological and practical obstacles can be overcome (Brandon & Ridley, 1983;

Schalock & Genung, 1993; Legault, 1992; Brown, 1994; Atkinson, 1989).

Indeed, when given the opportunity to talk in a safe environment to someone independent whom they trust, and who will listen to them as an equal, individuals with learning difficulties often talk freely and openly about their views (Simons, 1995).

This evaluation gave the residents of Kimberley House an opportunity to have their say about the service they received. The resident interview particularly focused on the degree of autonomy and choice residents are allowed in their day-to-day lives, and their satisfaction with various aspects of the service provided.

- **Residents' Social Networks**

Kennedy, Horner & Newton (1989) identify social contacts as being at the core of community integration. Yet, in a review of forty-six studies carried out in the UK since 1980, Emerson & Hatton (1994) found that there was a *"relative dearth"* of studies examining the quality and quantity of social relationships of individuals with learning difficulties living in the community.

There is a large body of research showing a strong relationship between social support and both psychological and physical health. There is also general agreement that certain groups in society tend to be more socially isolated than others. Grant & Wegner (1993) compared the social networks of individuals with learning disabilities living with their family to an elderly group and an elderly mentally infirm group. They concluded that the networks of the learning disabilities group were much less stable than the other groups, were family embedded and the individual was insulated from the community. Similarly, Donegan & Potts (1988) found that individuals with learning disabilities, living in their own homes with minimal professional support and individuals in community based homes, had large gaps in the social support they received due to the very small social networks they experienced. The poor levels of community integration experienced by many individuals with learning disabilities living in a community setting (Maskaant et al 1993; Saxby et al 1986) is partly a reflection of these small networks.

This evaluation attempts to examine residents social networks from both a qualitative and quantitative perspective.

- **Residents' Daily Activity Patterns**

One of the key principles of community care is to help vulnerable people *"to lead as far as possible, full and independent lives"* (People First, 1990). The fullness of an individual's life is largely determined by the day-to-day activities he/she participates in. Hoge & Dattilo (1995), found that people with learning difficulties living in the community were involved in primarily solitary or family-oriented recreation. To supplement the information gathered on social networks and related issues covered in interviews with residents, there will be a focus on their day-to-day activities.

- **Residents' Development In Terms Of Adaptive Behaviour**

As stated above, one of the aims of community care is to promote the independence of the individuals using the service through the development of skills, such as daily living skills, social skills and so on. Many studies have reported that users of new services often show improvements in adaptive behaviour in the first six months of the service. These gains may reflect the increased opportunities for individuals to display the skills they already possess, rather than an actual increase in competency (Emerson & Hatton 1994). This phase of the evaluation will examine changes in adaptive behaviour over one year.

1.4. Carers' Views

In recent years carers have received an increased profile within community care. Given the central role of the carer in the provision of community care, carers are key stake-holders of the services which are developed for their family members. As such, their needs, views, and experiences of services are important in informing service development. Policy encourages services to address the needs of carers, stating that they *"should pay attention to and take account of their views"* (Carers' Recognition and Services Act, DOH 1995). Hence, eliciting the views of carers was identified as one of the key areas to be addressed in this evaluation.

1.5. Views Of Professional Stake-Holders

Statutory key-workers have frequent contact with the Kimberley Project, through both client visits, and through their involvement in the review process. As a result, statutory key-workers are also seen as key stake-holders in the service provided by the Kimberley Project. In order to produce a holistic and comprehensive evaluation, it was felt to be important that statutory professionals associated with the Kimberley House Project were canvassed for their views about the service.

1.6. Staff Issues

Kimberley House was set up specifically to meet the needs of those individuals with learning difficulties who would present a challenge to services. Challenging behaviour has been identified as one of the most common causes of the breakdown of community placement (Felce & Lowe, 1993).

Challenging behaviour brings with it certain demands which other community support services may not experience. Research indicates that high levels of staff stress within the human services for individuals with learning difficulties can lead to high staff turnover rates (Baumeister & Zaharia, 1987; Felce et al, 1993, and Emerson & Hatton 1994). This has a potential impact on continuity of care and the implementation of service principles. Hence, an *'acceptable'* level of staff stress is a prerequisite for quality care (Rose, 1995). As a result, it was felt that any study looking at the quality of life of individuals living within Kimberley House would need to examine staff turnover rates and

staff absence due to sickness. The study also aimed to examine sources of work pressure, the coping mechanisms staff use to cope with work pressures, and to determine what impact, if any, work pressures have on their physical and mental health well-being.

1.7. The Sample

During the evaluation period there were eleven individuals living within Kimberley House. At that stage, no-one had taken up residence in the semi-independent flats.

The eleven individuals living within Kimberley House were mainly in their twenties and thirties, with the exception of one resident who was aged fifty-nine (mean 30.5 years; min 23 years, max 59 years). The extent of learning disabilities ranged from mild to moderate. Residents ranged from having good verbal skills to very limited verbal skills. All individuals had challenging behaviours and/or experienced a mental health overlay.

The purpose of the evaluation was explained to the residents by either their key-worker when they were still resident in hospital, or when they moved to Kimberley House (a number of visual cues were made available in order to help them to do so). Residents were then asked to sign a written consent form which was co-signed by their key-worker, or a family member if appropriate.

All eleven residents consented to participate in the evaluation.

1.8. The Report

This is a detailed and lengthy report. To facilitate the reader, it has been presented in a series of chapters. Each chapter focuses on a particular part of the evaluation and has it's own table of contents. Details of the research tools used will be outlined at the beginning of each chapter. The discussion at the end of the report will pull together the findings reported in each section.

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[i] *Challenge* is a Northern Ireland charity for people with learning disabilities

[ii] *Praxis* is a charity promoting mental health throughout Northern Ireland

2.0. The Aim

An Ordinary Life (King's Fund Centre, 1980) has been an influential report in relation to the aims of community care for people with learning difficulties. The report states that the goal of community care is to see adults with learning difficulties *"in the mainstream of life … with the same range of choices as any citizen"*.

The overall aim of this evaluation was to look at residents' quality of life within Kimberley House, with a particular focus on the degree of autonomy and choice they were allowed in their day-to-day lives. It was felt that a complete picture of residents' quality of life could not be fully understood without speaking to the residents themselves. Therefore, one-to-one interviews with residents were carried out. These interviews aimed to allow residents the opportunity to speak about every aspect of their life within Kimberley House.

2.1. The Interview

A semi-structured interview schedule was employed. It was adapted for the purposes of this evaluation from the interview used by *People First* (1994) in their evaluation *"Outside But Not Inside … Yet!"*. Some sections of the People First interview schedule were omitted as they were assessed as being irrelevant to the lives of those individuals living in Kimberley House - for example, the section aimed at ethnic and minority groups. A number of questions were also added in order to improve the coverage of the questionnaire. In particular, these questions were aimed at finding out more about the degree of autonomy and choice residents had in their day to day lives. For example, residents were asked if they could go to bed when they wanted to, have a lie in on weekends, or have a bath/shower whenever they wanted to.

The schedule included a number of open-ended and fixed-response questions. All questions comprised short simple sentences and were followed by thorough probing where appropriate. Questions were supplemented with visual illustrations. It was felt that illustrations would be needed in relation to only one resident. However, attempts to interview this resident proved unsuccessful (see Para. 1.3.).

The interview schedule was divided into two sections. The first section, entitled "Leisure, Weekends and Evenings", asked residents about how they spent their spare time, and about their views on their day care and education. The second section, entitled "Living With Other People", asked residents about many aspects of their daily lives within Kimberley, with a focus on the degree of autonomy and choice they were allowed within their home.

Each interview lasted for approximately one hour. Several measures were taken to try and make the experience a comfortable and positive one for residents:

- Residents were thanked for taking the time out to share their views and experiences of the service;

- Before the interview commenced, residents were informed that they did not have to answer a particular question if they chose not to do so, and that they should feel free to terminate the interview at any stage if they so desired;
- Residents were assured of confidentiality.
- Residents were given the opportunity to ask the interviewer questions about the interview and/or the evaluation, both at the beginning and at the end of the interview;
- Finally, if a resident seemed restless, or unable to concentrate during the interview, they were given the option to break for a cup of tea, or to complete the interview at a later date (only one resident chose to take a break).

2.2. The Sample

At this stage in the evaluation, ten individuals had been resident at Kimberley House for approximately twelve months, and one individual had been using the service for just over eight months. It was decided that this was an adequate amount of time for this resident to form views about his/her home, and that he/she should be given the opportunity to express his/her views. Hence eleven residents were approached to participate in this part of the evaluation. The mean age of the sample was 30.5 years (min: 23; max: 59). Interviews were carried out with nine residents (seven male and two female). Attempts were made to interview the two remaining residents, but their well-being at the time of interview meant these efforts were unsuccessful.

2.3. Findings: Leisure - Weekends - Evenings

A. Going Out

All nine residents reported that they liked to get out and about, *"It's brilliant so it is"*. Residents were able to list a range of places they liked to visit (see Figure 1), many involving some kind of leisure activity.

Figure 1: Activities Residents Enjoyed

Weightlifting (x3)*
Swimming (x2)
Cycling
Horse riding
Karate
Walking around town (x2)
Going to restaurants (x2)
Visiting parents (x2)
Going on day trips (x2)
Bowling
Going for walks
Aerobics
Going to the pub, pub quizzes and music sessions (x3)
Snooker
Going to local discos (x2)
Going to the cinema
Attending local historic society
Unislim

(*Figure in brackets indicates number of residents who mention participating in the activity)

In the majority of cases, the places where residents liked to go, and the past-times they enjoyed, involved use of non-segregated community facilities. Only one reported activity reported (disco) involved attendance at an event organised solely for individuals with learning disabilities. Residents also attended other discos within the local community that were not specifically for individuals with learning difficulties.

On average, each resident reported four places they enjoyed going to, with most of the outings occurring on a weekly basis. However, five out of the nine residents interviewed expressed a wish to get out more (see Figure 2).

Figure 2: Getting Out More Often

"I'd like to go out more often".

"I'd like to visit my mum more often".

"I (would) like them things, seeing different places more often".

"I would yes, I'm feeling very confined … pent-up here all the time".

Four individuals reported that they get out and about often enough. A typical comment was: *"I go out every night. Monday night the Basement* (a disco), *Tuesday night Gateway, swimming on a Wednesday, aerobics on a Thursday, and then Friday a disco again, Saturday I go shopping with my friend".*

Due to the challenging component of many residents' behaviour, at the time of these interviews, only two individuals were allowed out alone, and one of these individuals for a limited time period only. Consequently, on the vast majority of outings, residents are accompanied by at least one member of staff.

Three residents expressed some dissatisfaction with this, stating that they would like to be able to go out independent of staff:
"I'd like to out on my own. I get out on my own on a Saturday for an hour, down the town you know … but that's not enough".

"I would like to go out more often … to be independent by myself".

"I would like to go out on my own sometime, but I have to wait".

B. Home-Based Activities

When asked how they would pass time at home, residents listed a range of activities (see Figure 3).

Figure 3:	**Home Based Activities**
Reading	
Watching television	
Listening to music	
Knitting	
Doing crosswords	
Collecting things e.g., mugs, posters.	
Compiling scrap books	
Writing letters	
Gardening	
Tidying your bedroom	

When asked if these activities were satisfactory, or if there was anything else they would like to be doing, seven out of nine residents reported that it was okay as it was. Two residents however expressed some dissatisfaction. One individual said that they would prefer not to have as much spare-time, and would rather be in full-time employment:

"I'd like to get a good job. I'm doing as best I can (at work placement) … *I'd like to get a full-time job there".*

Another individual reported that they only got to cook once a week and would like to have more opportunities to do so:
"I like cooking … that's something I don't get to do at all".

C. Holidays

The majority of residents were interviewed before any holidays had taken place. When asked if they were going on holiday in the coming months, one said 'no', two reported that they did not know, and six replied that a holiday was planned. Of the six residents who reported that a holiday was planned, one resident reported some dissatisfaction with the fact that residents had yet to be informed about the destination and dates of the holiday:
"… (staff member) *downstairs asked* (Senior Staff) *plenty of times and no answer back yet".*

The other five residents (interviewed one month after the previous resident) reported that they had been informed of the holiday destination. According to staff and resident reports, the holiday destination was discussed during residents' meetings, with the final decision being taken by the Scheme Manager. Those residents who did know the holiday destination, reported that they were satisfied with it.

D. Day-time Activity

Eight out of the nine residents interviewed reported attending the Work Skills Centre at Conlig, which is part of the Kimberley Project, at least one day a week.

- four were currently attending a local technical college at least one day a week,
- two were scheduled to start college with the start of the new academic year,
- three individuals had work placements.

i. Work Skills Centre

Clients reported participating in a wide range of activities while attending the Work Skills Centre. These ranged from participating in assertiveness groups, to bricklaying, to clay modeling (see Figure 4).

Seven out of the eight residents who reported attending the Work Skills Centre stated that they enjoyed work. When asked *what* they enjoyed most, they usually named a particular activity:

"Brick-laying".

"Just painting".

Residents reported a range of reasons *why* they liked attending the Work Skills Centre. Residents reported that they: found it interesting; preferred it to staying at home; enjoyed spending time with their friends; or found that they were learning new things which were useful in their everyday lives (see Figure 5).

Figure 4: Work Skills Activities

Botany
Knitting
Art & craft e.g., woodwork, painting, and clay modeling
Assertiveness Group
Relationships Group
Food Hygiene Group
History
Reading & writing
Mathematics
Life skills e.g., budgeting, learning how to tell the time
Computers
Gardening
Brick-laying

Figure 5: Reasons Why Residents Enjoyed Work Skills

"I find it interesting".

"It's brilliant, it gets you out like, out of the house".

"I enjoy the company with all my friends"

"*Well it* (the relationships group) *was about mens' bodies and womens' bodies … well it helped me on* (what to do) *whenever I marry my* (partner)*".*

Only one individual reported wanting a change in their activity:

"I'd like to do more art and craft and computers. But our computer is broke at the minute so we have to get a new computer".

"I would like to do woodwork … we used to do it, and then (staff member who taught it) *left".*

Despite enjoying the Work Skills Centre, one resident reported some dissatisfaction with the low wages he/she received as a result of working there. He/she reported that they would like to change to a new day centre with better pay:

"I'd like to change to a day centre outside … 'cos they'd give me more money".

Another individual reported that he/she found the centre too structured:

"I do and I don't (enjoy it) *… it's very regimental, very strict you know".*

When asked to give an example of how the centre was strict and regimented, the resident in question did not expand.

There was evidence that residents talked to day care staff about their needs and wishes, and that their views were listened to. For example, in the past, one individual who had had been taking part in history lessons told day care staff that he/she found the classes too difficult and was subsequently removed from the classes:

"I told (staff member) *I couldn't do history, so* (staff member) *let me out of history".*

ii. Education

Four individuals were currently attending a course called *Mainstream*[1] at the local technical college. Of these four individuals, two reported that they enjoyed college, one reported liking college because he/she had made friends there, and one expressed great enjoyment in learning to read. Primarily however, he/she liked college because *"…they* (classes) *give me something to do".*

Another individual reported enjoying the computer classes because they were good for improving basic skills, *"English and typing and all".* However, this individual also reported that they often did not find the classes stimulating:

"Sometimes I get fed up. They (teachers) *talk all the time".*

While reporting some benefits of attending college, he/she expressed an overall preference to be in full-time employment, or to be working towards a higher qualification in an area relevant to his/her career choice.

The third individual attending college did not consider him/herself to be suffering from a disability of any kind, and therefore did not like being grouped in a class with other disabled individuals:

[1] *Mainstream* is a basic education course for individuals with physical and learning disabilities, held in a local technical college.

"I don't like it. It's all for like you know, people in wheelchairs and stuff".

Furthermore, this individual expressed a preference to learn more practical rather than academic skills, for example, brick laying and plumbing. He/she obviously felt that these could be better learned in the day-care setting, and expressed a preference to attend the Work Skills Centre full time:

"You can pick up more things in day-care".

One individual had been attending *Mainstream*, but had chosen to leave it, reporting that he/she was dissatisfied with the attitude of staff at the college:

"I was doing Mainstream, but I packed it in … the staff down there were yuk. They were far too ignorant … they didn't give a damn, and that is a statement of fact".

Two of the individuals interviewed were due to start college at the beginning of the next academic year. Both were very positive about starting and reported having discussed their interests with the care facilitators at the Work Skills Centre. However, one was unsure as to exactly which courses he/she would be attending:
"I'm sure I will be doing (cookery classes), *I hope I will"*.

One individual was not yet scheduled to attend the Mainstream course. He/she did want to go to college and expressed an interest in taking classes in English and Computers.

iii. Work Placements

All three individuals in work placements reported that they enjoyed their part-time work. One individual had a love of botany and had been placed in a local garden centre wholesalers. This individual reported that he/she enjoyed being able to work with plants, and getting out and about:
"I love the greenhouses. I enjoy getting out and about. I enjoy tea breaks (laughs)*"*.

The second individual talked about the personal reward and sense of achievement gained since starting a work placement at a nearby crèche:
"I like the children playing with me … one child doesn't talk to the other staff and I got him/her talking".

When asked if there were any changes they would like to see at work, one individual reported that they would like better wages. With the support of a care facilitator at the Work Skills Centre, this individual was applying for a government grant that would boost his/her wages:

"Well I'm looking for a grant from the government so I am … to pay my wages. I get wages at the minute but I need a bit of money from the government to help top them up. You see they can't get you work but they can get you grants now instead (laughs)*"*.
Another individual expressed a concern that he/she was not treated like other members of staff and was forbidden from doing certain tasks. As a result he/she felt that he/she was not trusted by the other staff there:

"I'm not allowed to … 'cos I'm not a proper member of staff there. I'm only there to get assessed as well. It beats me, 'cos I don't think they trust me".

2.4. Findings: Living With Other People

A. The Surroundings

All nine residents interviewed reported that they liked their bedrooms - a typical comment

was: *"It's brilliant so it is".* Seven residents reported that they had chosen the paint colour, carpets and borders for their rooms. The Scheme Manager had visited each of them in the hospital where they had chosen from colour cards and samples:

"Me, I chose them whenever I was up in (hospital)*".*

"(Scheme Manager), *brought colour cards and I picked".*

Two residents reported that staff had chosen the furnishings for their rooms, which had been completed before their arrival at Kimberley House.

All residents reported having their own personal belongings in their rooms. A variety of objects were listed which included : a set of fitness weights; books; toys; musical instruments; ornaments, and many had their own television and/or video recorder:

"T.V., hi-fi, radio CD player, ornaments, cuddly toys".

"I have a witch and a monkey and a bull dog and a big large dog called Fred. I have a whole lot of different toys upstairs".

When asked if they wanted their bedrooms to be changed in any way, all but one resident replied that they liked their room as it was. A typical comment was, *"I like it the way it is you know".*

However, one resident said that they would like more storage space, and greater privacy:

"There's not enough room to put anything, the room is too small … and there's not enough privacy … the staff wander in and out willy nilly".

All of those interviewed expressed satisfaction with the other rooms in the house:

"They're alright, just to sit and watch TV in and stuff".

However, one resident had suggested that the existing smoking room was too small, and that the present non-smoking lounge should become the smoking room:
"I'd like this room (non-smoking lounge) *to be a smoking room because it's bigger, and let downstairs* (the smoking room) *be the sitting room. Sometimes friends come down and they smoke too and we have no room".*

B. The House Pet

At this stage of the evaluation, Kimberley House had acquired a house pet, a kitten called "Smokey". Residents reported that they had decided to acquire a house pet during a staff-resident meeting:

"It was our (decision), *at the meeting you know".*

"Staff called a wee meeting up with us all and we says what we want and so we got Smokey".

Likewise, Smokey's name was voted on during a staff-resident meeting.

Seven out of the nine residents reported that they took it in turn to look after Smokey, and that the rota system was working out okay:

"Everybody (looks after Smokey)*, I take my turn on a Monday".*

One resident had chosen not to be involved in the care of Smokey as he/she did not spend much time at home.

All of the residents seemed to enjoy having a pet. A typical comment was *"I love Smokey".*

C. House Rules

Residents were asked if they were aware of any rules regarding going into other people's bedrooms. Residents appeared to have quite a good idea about what was considered appropriate behaviour in these situations : that you should ask the permission of the person first, and that you should not go into anyone's room if they are not there (see Figure 6).

Figure 6: Going Into Other Peoples Rooms

"I just ask (the resident)*"*

"Just not to go into anyone's room if they are not there".

"I knock and (another resident) *will knock my room the same".*

"Don't go in without knocking".

However, there were two individuals who appeared to be unsure of the rules regarding going into other people's bedrooms. These individuals believed that going into other people's rooms was forbidden and as a result, they never went into other people's rooms:

"I don't think anybody is allowed … I wouldn't go into anybody's room".

"I don't go into other people's rooms, it's private".

All residents were aware of the rules on fighting:
"You're not allowed to fight here".

"You're not allowed to fight but you are allowed to argue".

"No (fighting)*. You get grounded for a week"*

One individual more specifically stated their perception of the rules regarding fighting applicable to them personally, as laid down within their contract[2].
"If you fight you are sent to (hospital) *and they give you a longer stretch. You go to the lock up straight away".*

Eight out of the nine residents interviewed reported that the house rules were okay. One resident reported that initially, he/she found the rules difficult, but that after settling in it was fine:
"It's okay. When you start you be okay".

Another resident reported that they thought it was good that they were still allowed to argue as it gave them a chance to express their anger, frustration or irritation:
"I've argued plenty of times and I wasn't told off. I suppose I had to get my temper out".

[2] **Contract** - a written agreement between Kimberley House and an individual resident detailing the care-plan which residents are expected to follow while living at Kimberley House.

One resident reported that the rules helped him/her:
"I think they are okay, they are helping me … before (I moved here) *I was a bit aggressive".*

However, one resident, who was unsure about rules regarding going into other people's bedrooms, reported that he/she found those rules difficult:
"Some of it is difficult, some of it is not difficult".

This individual believed that it was completely forbidden to go into other people's rooms and felt that this prevented them from visiting friends in their rooms:
"Cos you're not allowed to go into other people's bedrooms".

D. Cooking and Food Shopping

Residents reported that all of their main meals were cooked by staff members. Five residents reported that they cooked for themselves at supper time. This involved making simple snacks for example, toast or sandwiches:
"Well, I cook my own supper. I cook toast or sandwiches".

Two residents (interviewed some months after the other seven) replied that they had to help prepare lunch at the Work Skills Centre.

One resident reported cooking all three of his/her own meals once per week:
" … in the morning, strawberries and cornflakes. And then I like meat and roast potatoes, you know, like a Sunday dinner".

One resident reported that he/she had not yet been taught how to cook, but would like to learn:
"No, they (staff) *haven't teached me yet, but I would like to learn".*

When asked if they ever shopped for food, four residents replied that they did. One individual, who was on a weight-loss program, reported that he/she would go and buy his/her own slimming foods:
"I would buy stuff for slimming, you know like slimming soups and pot noodles".

The resident who had reported that he/she did his/her own cooking one day every week, stated that he/she would shop for his/her own food for that day.

Another resident stated that he/she sometimes helped staff shop for food:
"Sometimes I pay for stuff, staff give me the money and I pay".

Two residents reported that they never helped staff shop for food. One of them went on to point out that they would like to help out with shopping, but had never been asked:
"No, because I have never been asked, but if I was I would gladly help".

The final resident reported that he/she was always out at work or out visiting and so did not know who did the food shopping.
Residents did, however, report shopping for other items, for example, toiletries, music tapes, books, and clothes.

E. Cleaning

All residents reported that they were responsible for cleaning their own bedrooms. Each individual had what they called a "home-based" day, usually during the week, when they would be expected to clean their bedrooms and do their laundry with the supervision of a care auxiliary:
"We clean our own rooms and that".

"I get a day off to do it, Fridays".

F. Meals

Eight out of nine residents reported that dinner was generally served at around five o'clock, unless there were exceptional circumstances, for example if they were having a barbecue:
"Well it depends if we have a barbecue.".

All of these eight reported that this was satisfactory.

One individual reported that meal times varied from day-to-day, and that he/she would prefer a set time:
"Tea-time is very erratic … from half four to five, to quarter to six".

Residents were also asked if they were allowed to have a meal whenever they wanted to. All reported that they had to have their meals at the allocated time. Residents appeared to have no objections to this, and seemed to understand why it was necessary:

"No, you're not allowed to do that, it breaks the rules of the house".

"No, I don't think so, no … well everyone would want something".

One resident noted that there was one exception to this rule, you could choose when to have a meal if you had invited guests to dinner:
"If you are inviting anybody up you can have it any time, on ordinary days, no … you have to have it with all the other residents in the dining room".

Residents were asked if they were allowed to make themselves a snack when they felt like it. Five residents reported that they were allowed to make themselves snacks:
"…you can go and take an apple".

"Yeah you can because I said I was hungry a few weeks ago and I said I wanted something to eat, so someone gave me a pot noodle and I ate it".

Four individuals stated that they were not allowed to make snacks:
"No you are not allowed to do that".

Two of these individuals stated that if you wanted a snack you would have to wait until supper time, although you could make yourself a cup of tea if you wanted to.

G. Privacy

All residents reported that all bathroom and bedroom doors were equipped with locks. Residents each had a separate key to their own bedroom.

All nine residents maintained that other residents always knocked before entering their bedroom. One resident, however, complained that he/she had no privacy because the staff went in and out of his/her room *"willy nilly"*.

Another resident cited one occasion when a member of staff had left something in his/her room while he/she had been out at work:
"(Staff member) *left it in the room and told me about it when I got back like, and I didn't even know about it. If I'd known I'd of told him/her to leave it in the office 'til got back".*

Eight out of nine residents reported that they could be on their own in their room if they wanted to. One resident noted an exception to this was that staff would often sit with residents if they were ill:
"Well sometimes the staff have to be with you because they have to carry bleepers with them in case people get sick".

H. Trust

When asked if they could trust people not to take money from their rooms, all residents replied that they could because they kept their bedrooms locked at all times.

When asked what they would do if someone did take money from their rooms, eight out of nine residents stated that they would inform staff:

"I'd walk down and tell staff and they'd bring everybody up and ask"

"Go and tell staff"

Only one individual reported that he/she would not report it to staff, not because staff were not approachable, but because he/she would fear losing the friendship of the person who had stolen the money:
"If I told staff that someone took my money, the person (who stole it) *wouldn't be my friend".*

I. Getting on With Staff

Each resident is assigned two-three key staff. All residents reported that they had met their key-workers before they moved to Kimberley House. Prior to their move, residents' key staff visited them in hospital, and residents were invited to visit Kimberley House:

"They (three staff members) *come up* (to the hospital) *and saw me first and then I came* (to Kimberley House) *for a visit and then back up to hospital".*

Generally staff visited residents in hospital on one occasion, the visit lasting for approximately half an hour, *"only half an hour"*. Client visits to Kimberley House varied in duration from "*a couple of hours"* to a *"two night stay over"*.

From the time that residents had first moved to Kimberley House, several new members of staff had started work there. Residents were asked if they had been given an opportunity to meet these new staff members before they took up their posts: five replied that they had; two replied that they had not, and two could not recall.

When asked if they "got on" with staff, all residents reported that they did:

"Everybody, I get on with every staff and every resident".

"Yes, most of them".

All nine residents reported that they would normally discuss their problems with staff:

"I would … sometimes. Sometimes I bottle it up myself and just keep it in. I was told (by staff) *not to do that"*.

"I had a problem about work (and told staff member), *but he/she sorted that out for me so he/she did, about getting me a part time job"*.

All nine reported that being able to talk to staff about their problems was helpful:

"I feel bad … sometimes staff help me get it out of my head".

"It relaxes me more".

Residents were asked if there were any other ways in which staff helped them. Two residents could not think of any other ways. However, as the comments below illustrate, seven residents were able to cite a variety of ways in which staff helped them: through counseling; helping them tidy their rooms; helping with bathing; helping them to buy clothes, and taking residents out.

"They (staff) *help me in all ways … they help me with bathing and all that. They help me with my room, they take me out places"*.

"Just counseling and that".

"With tidying your room and stuff".

When asked if there were any other ways in which they would like staff to help them, four residents replied that there were not. However, five residents listed a variety of ways in which they would like staff to help them, from assisting them with crosswords, to helping them to move back to the family home:

"I'd like them (staff) *to help me do crosswords. I'm no good at crosswords, but I can do them sometimes. I'd like to be helped with games, draughts and dominoes and different games"*.

"I would like the staff to help me get home to my mum and dad".

One individual, who had expressed concerns over privacy earlier in the interview (see Section 2.4. Paragraph A), stated that staff could help by allowing him/her more privacy in his/her bedroom:
"more privacy in my room (from staff)*"*.

Two individuals who reported that they talked to staff about their problems, explained that, while finding it helpful, still felt they had not reached any solutions, or experienced real relief. These individuals wanted staff to help them find solutions to these problems:
"I'd like them (staff) *to help me with my problems … they are still there, but I don't know what they could do for me"*.

"First (I would like staff to help me with), *peace of mind"*.

J. Other Residents

All nine residents stated that, generally speaking, all the residents got on well together:

"Everybody gets on".

"I get on well with them".

Five individuals mentioned that occasionally there were arguments between residents but that they always made friends quickly:

"This was a big one (argument). *It was a misunderstanding but it all went too far between us. It's all sorted out now"*.

"There was an argument one night between (names two other residents), *and there was an argument between me and* (names another resident), *but we made up friends in day-care"*.

Residents were then asked if they could choose who else could come and live in Kimberley House. Six residents were unsure as to whether or not they had any say regarding choice of new residents. Three residents stated that they had no say as to who can move in:

"We get told who is coming"

"Sure that is up to Challenge to choose them (new residents)*"*.

One individual went on to say that if someone came who they had known before in hospital and did not like, they would try to get on with them, and would tell staff of any difficulties they might have:

"I'd try to get on with them (new resident). *I'd mention it to staff first and just tell them, we'll try as best we can"*.

K. Residents' Meetings

i. Attendance

All residents reported that there were residents' meetings which they all attended at least occasionally. Seven residents reported attending when they chose to:
"Some of them I do, but not all".

However, two individuals believed that attendance was compulsory:

"You have to attend those meetings".

"We all have to (attend)*".*

ii. Frequency

Seven residents reported that the frequency of meetings depended primarily on the Scheme Manager, but that residents could request a meeting if they wanted one:

"Well it's up to residents or staff to decide".

"If I went to (manager) *and said 'could I have a residents' meeting?', he/she would say 'go ahead and have a meeting'".*

Two residents reported that staff decided when meetings were to take place: one reported that meetings occurred monthly, and that this had been the decision of senior staff, the other (interviewed at a much later date) reported that meetings took place every six weeks.

iii. Content

Residents were asked to describe the sorts of things they talked about in residents' meetings. They reported that a lot of what was said was confidential, but did say that they talked about: holidays; issues like mad cow disease and whether or not they wanted to stop eating beef; house rules; and any problems they might be having with the staff (see Figure 7; see also Appendix A for minutes of a meeting).

Figure 7: The Content of Residents Meetings.

"We're not allowed to say (what is discussed during meetings) … *about where you're going on holidays and stuff like that, about house rules".*

"Holidays and different things, new rules".

"Sort of staff not doing what they are supposed to … you know"

" … if you are happy with the situation here … here in Kimberley House".

One individual mentioned an issue that he/she was going to bring up at the next meeting. He/she felt that a system within the house had been changed, without resident consultation, or adequate explanation:

"We're not allowed the keys no more, up were you get the towels and stuff, we're not allowed them no more. We used to have them. I just ask a member of staff to go and get them for me now, I don't know why".

iv. Enjoyment

Seven out of nine residents reported that they enjoyed going to the residents' meetings. However, one individual stated that he/she did not always find them enjoyable. This individual felt that the meetings could be quite boring, and that sometimes they did not seem to be achieving anything:

"Not all the time no. You sit feeling bored, after five minutes you feel like you are wasting your time, you know what I mean".

This individual seemed to feel that the meetings were perhaps too informal:

"Well I'm always up on my feet all the time, messing about as usual, you know with the staff and that".

One individual did not respond to this question.

v. Changes

Residents were asked if they would like the meetings to be changed in any way. Two residents did not respond to this question. Five residents reported that the meetings were okay as they were:

"No, nothing, everything is alright".

"The meetings are alright".

One individual reported that, in the past, they did not have to have a member of staff present during the meetings, but that this had now changed. This individual expressed a preference for staff not to be present during meetings:

"One of the staff has to stay in the meeting, but we didn't have that (before). *I'd like it to be changed to normal. It started off we could say 'go away we've got a meeting, no staff is not allowed'".*

This view was shared by another resident:

"Residents meetings are for the residents, and they are private and confidential".

Moreover, what this resident wanted was for staff to listen to the residents' voice:

"I can only answer truthfully, I would like the staff to listen to the residents".

This resident felt that very little action resulted from the meetings. For example, with regard to their discussion on holidays:

"Yes, a big fat zero on that, nothing has been done about that yet".

L. Contracts

Residents were asked if they had a contract.

Six residents reported that they did have contracts, the other three were unsure. Of the six residents who reported having a contract, three were able to recall its contents. One person's contract specified that they were to take care around electrical appliances, or the television remote controls:

"Well don't mess around with the electric, I know that. Don't mess around with the remote controls, just to switch to one station and just watch, that's it. Just to stay calm and be cool".

The other resident was able to list a number of behavioural requirements that were detailed in his/her contract:

"I have a contract upstairs. It says no bad behaviour or you'll be sent straight back to (hospital) *for a long stretch. And no hitting*

out at members of staff, and your laundry is up to date, and don't leave the building without one member of staff. I know all my contract".

"I can stay at Kimberley House if my behaviour is good. I have to obey staff, if I give any cheek back or anything like that, I lose a token (as part of a behavioural program)".

M. Money

All nine residents reported that they had their own bank accounts and their own money to spend. However, one resident complained that he/she did not have enough money. In particular, he/she expressed dissatisfaction with the level of pay he/she was given at the Work Skills Centre:

"I do (have a bank account), *but the bank account that I have, it's hungry. Out of day-care I have eight pounds a week. For a forty hour week that works out at twenty pence an hour which is bloody ridiculous. Twenty pence an hour is an insult"*.

This was the second resident to raise this issue (see Section 2.3. Paragraph Di).

When asked about budgeting, one resident was unable to say whether or not he/she received staff help. However, six residents reported that they budgeted with staff help:

"Every staff at Kimberley House would help to budget the money".

"Staff in general help (with budgeting)*"*.

Two residents said they budgeted without staff help:

"No, I do it myself".

When residents were asked what kinds of things they spent their money on, they listed a wide variety of items: compact discs, tapes, toiletries, cigarettes, clothes, shoes; sweets; presents for their families; and books.

Eight out of nine residents stated that they went shopping for their own clothes, and while staff accompanied them and sometimes advised them, ultimately, they chose what to buy:

"Sometimes they (staff) *help you, and sometimes I do it myself"*.

"I chose them myself"

"They just help me with sizes and stuff".

"You just buy what you want. You don't need to be told, you just go to it".

One resident reported that all this/her clothes were bought for him/her by his/her family.

N. Visitors

Residents were asked when friends and family could visit. Two residents stated that they did not know about visiting times - their families did not come to visit them as they would go home to visit their families.

Two residents stated the times at which their families actually visited as being visiting time:

"Every month, once a month".

"Any time on Sunday".

The five remaining residents reported that visitors could come whenever they wanted to:
"Any time at all".
"Any day they want, or any night".

All nine residents stated that guests were allowed to stay for dinner:
"If they tell staff yeah".

"Well whenever my family come staff makes a supper for them".

O. Getting Up and Going to Bed

Residents were asked if they could sleep in on the weekends if they wanted to. All nine reported that they could have a "lie in" if they wanted to:
"Yes, I lie in 'til eleven".

"You can lie on. I don't lie on but the rest of the residents would lie on".

Residents were also asked if they could go to bed whenever they felt like it. Seven residents reported that they could choose when to go:

" … any time, as long as you can get up for work in the morning".

"Some of them in here stay up 'til midnight. I asked (staff member) *if I could stay up late to watch a film, he/she says 'fine'.* (Staff member) *lets* (other resident) *stay up 'til one for* (names television program)*.".*

However, one resident stated that whether or not they could stay up late depended on which members of staff were on night duty:
"It depends who's working".

Another resident reported that he/she had to go to bed at 10.30 p.m. as part of his/her behavioural program. He/she stated that they would like to be able to stay up for an extra fifteen minutes each night.

P. Bathing and/or Showering

Seven out of nine residents stated that they could have a bath or shower whenever they chose to:

"You can, any time".

"Yes, you just have to tell them (staff) *when, just in case they be looking for you".*

One individual who required staff help when bathing stated that he/she could only have a bath/shower at scheduled times. However, he/she went on to say that the scheduled days suited him/her.

Another individual reported that his/her key-worker had decided that he/she would bath every day. He she felt this was too often:
"I'd like it to be once every other day".

Q. Other Issues

At the end of each interview, residents were given the opportunity to talk about anything they felt was important which had not been covered during the interview, or to ask questions about the evaluation. Only one resident had something they wanted to ask about. A few weeks prior to the interview, a representative of the Mental Health Tribunal had been talking to residents about calming and restraint procedure. This had obviously raised a lot of questions in this individual's mind. This resident wanted to know if it was illegal to use care and restraint if it was not necessary. While he/she had been told to report any such incident to Challenge, he/she was concerned that no-one would take the word of a resident over that of a staff member:

"It hasn't happened to me, it's just reports you hear about abuse going on in homes these days, in places in Belfast … why would they (Challenge) *believe me instead of the other person* (staff member) *if they said it didn't happen?".*

R. Do You Like It Here?

Finally, residents were asked if they liked living in Kimberley House. Eight residents reported that they did like living in Kimberley House. Residents gave several reasons for this: it's location; the staff and the other people who lived there; the greater sense of freedom; being closer to family, and the house itself (see Figure 8).

As Figure 8 shows, many residents drew comparisons between Kimberley House and the hospital where they had lived before moving there.

One resident was unsure about whether or not he/she liked living in Kimberley House. This individual enjoyed living with the other residents, and appreciated that it took the pressure of care away from his/her now elderly parents:

"I do and I don't (like living at Kimberley House). *Here in Kimberley there is great camaraderie* (between residents). *That's one thing I do like. And mum and dad are*

Figure 8: Why Residents Like Living at Kimberley House.

"I like the house, it's lovely, and I like the residents and all, I like the scenery".

"I like the staff and everybody".

"I love it, it's closer to my family. I used to tell staff here about going back to (hospital), *but when I got back I didn't like it. I love it here. I'm closer to my friends and I'm closer to staff here".*

"Well, it's better than (hospital) *… cos you get out in the car for runs and stuff. It's more fun, you get a bit of crack out of it, with the residents … just messing around you know".*

"It gives me more movement, it's more relaxed (than the hospital) *and stuff like that. And the staff are good to me and they keep me right. They keep me in good behaviour".*

" (I like it) *cos it's outside* (of hospital). *You've got your own freedom down here. It's not like a hospital because there's a whole lot of things you can do down here, like going out places".*

"You have more freedom than when you were in hospital".

"I was glad to get out of it (hospital). *I was always shouted at there".*

"I didn't like hospital. You were always kept in the grounds. I'm getting friends now"

pensioners now and don't keep well. They are no longer fit to look after me you know".

However, he/she went on to say that he/she did not like the staff's attitude towards the residents:

"(I don't like) *the staff attitude to myself and the rest of the residents. You ask them to do something and it's 'not now I'm too busy. I'll get it for you later' and that's their attitude".*

S. Is There Anywhere You Would Prefer To Live?

When residents were asked if there was anywhere else they would prefer to live, three out of nine responded that there was nowhere else they would prefer to live:

"No, (there is nowhere else I would prefer), *Newtownards is the best".*

"No, I just like it here".

However, six residents (five of whom had stated that they liked living at Kimberley House) maintained that they would prefer to live either with their families, or somewhere closer to their family home:

"I'd love to stay at home, but they (staff) *say there is only two places you can live, it's either here or hospital and that is the law, and I have to go by the law".*

"I'd like to live in (names another town) *because it's close to my people".*

"Most of the time I would like to go home but there is no way … most of all I prefer (another town) *because there is more rakers there, to have a laugh with".*

"It (Kimberley House) *is too far away from my parents and the rest of my family".*

3.0. Background

The activity an individual participates in on a day-to-day basis is an important component of the quality of life of that individual (see Perry & Felce, 1995). Therefore, as part of the evaluation of the Kimberley project, an examination of how residents spend their time on a day-to-day basis was carried out. Three aspects of residents daily activity were explored:

- who they spend time with - in particular the amount of time spent with other residents, the amount of time spent interacting with staff, and whether residents can spend time alone if they want to;
- the kinds of activities residents participate in on a day-to-day basis;
- the extent to which residents' daily activities allow them the opportunity to mix with other individuals within a community setting.

Opportunities for integration are very often equated with opportunities for contact with members of the community who do not suffer from a learning disability. The residents of Kimberley House moved to the accommodation scheme from a hospital setting. It is natural for people to select friends like themselves, with whom they have things in common.

Furthermore, there is evidence to suggest that individuals with learning difficulties may make unfavourable comparisons between themselves and individuals without learning difficulties (Szivos, 1992). It is important that, in the transition between hospital and community, individuals with learning difficulties can feel positive about themselves and their abilities. Therefore, the opportunity to develop friendships with other learning disabled individuals could be argued to be important in the success of community placements. Equally, however, developing relationships with a range of individuals including those without learning disabilities, provides opportunities for community integration. Consequently, this report does not place different weightings on activity allowing opportunities to mix with individuals with learning difficulties, and opportunities to mix with individuals without learning difficulties.

3.1. The Methodology

In order to assess the three aspects of residents' daily activity identified above, we asked the residents' key workers within Kimberley House to complete activity logs on each resident over a three week period (see Appendix E). The activity logs divided the day up into fifteen minute blocks. For each fifteen minute period, staff were asked to specify what residents were doing, where they were, and who they were with.

Activity logs have a number of methodological weakness. Although intended to be prospective in nature, they rely on staff completing them as instructed and not, for example, completing them at the end of each day. Also, they are an indirect measure of resident activity, relying on staff giving a full account of how residents

spend their time. They also place an extra burden on staff on top of their care duties.

Previous research on the activity levels of individuals with learning disabilities has taken a variety of approaches. For example, studies of individuals with severe and profound learning disabilities have employed observational techniques with a time frame sampling methodology. In these instances, the particular focus has been the level of resident engagement in meaningful activities across a sample of one day periods, making observations at pre-determined intervals, for example twenty second intervals (e.g. Mansell & Beasley, 1993; Felce & Perry, 1995). Although noticeably time consuming, this approach can provide a very accurate and detailed account of the amount of time residents are engaged in meaningful activities, and the quality of interactions between staff and residents.

Some studies have explored activity patterns through the examination of individual case notes/records (e.g., Donegan & Potts, 1988). Other studies have used structured interviews, relying upon the recall of either the individual with a learning difficulty, a staff member, or a proxy in order to access activity patterns (Shah & Holmes, 1987). Some of these studies have employed very general questions, for example, "Think about how you spend your time on a typical day that you are at home, and not at your job" (Schalock & Genung, 1993). While these two methods do give some indication of the types of activities individuals with learning difficulties participate in, they do not provide information on the relative proportions of time spent on the various activities. Furthermore, these measures provide little or no information on who individuals spend their time with. This is an area which is often examined independently from activity patterns, but which can provide valuable information when examined in conjunction with data on activity patterns.

In this evaluation, the activity logs were used as a compromise between observational techniques and retrospective techniques. While activity logs may not provide the depth or accuracy of information that observational data provides, they provide an economical and efficient compromise which bridges the gap between observational methods and methods which depend on carer recall.

Activity logs were completed for each resident over a three week period, twelve months after residents had come to live at Kimberley House. Hence, data collection was staggered, depending on the date residents came to live at Kimberley House.

Two separate activity logs were recorded for each resident:

- The first activity log catalogued residents activity within the Work Skills setting in fifteen minute intervals, and was completed by the resident's key worker there. The activity logs returned from the Work Skills Centre revealed that each resident has a set time-table of activity for each week.

Given the structured nature of the activity residents participated in within the Work Skills Centre, it was decided to supplement the activity log data with general information on how the Work Skills Centre was managed, what it's aims were, how time-tables were formulated, and so on. This was done through a semi-structured interview with the Work Skills coordinator. The interview was specifically designed for the purposes of this evaluation.

- The second activity log recorded the activities residents participated in from the time they got up to the time they retired to bed, excluding any hours spent at the Work Skills Centre, at work placements, or at college. This time will be referred to as their 'leisure time'. This activity log was completed by their key worker from Kimberley House. Residents' activity patterns from Monday to Friday will be reported separately from weekend activity patterns.

A classification system, detailing what activities residents were participating in during their day, was devised upon examination of the data (see Appendix F). In order to make the classification of data more manageable, where a resident was recorded as participating in two activities (for example, talking to other residents and watching television), the former of the two activities (i.e. the least passive) was taken as being the primary activity. The activity the resident was performing at that time was classified accordingly (e.g., talking to other residents). Activity logs were completed for nine of the eleven residents.

3.2. Activity Within The Work Skills Centre

- **Overview**

The aim of the Work Skills Centre is to provide residents with a work focus, and to provide basic education and training which may lead to employment in the future. For those residents who were felt to be ready for this type of activity, this was achieved through liaison with outside agencies.

The Work Skills Centre provided basic education and employment on either a full-time or part-time basis for the residents of Kimberley House

(i) Basic Education

Much of the residents' time within the centre is spent on basic education. This was reported to include literacy and numeracy, computers, typing, banking and budgeting. While much of the work is carried out on a one-to-one basis with staff, many areas are tackled within a group setting, for example, developing assertiveness skills.

(ii) Employment

The work focus within the centre is provided through both art and craft, and wood work. Any products produced within the Work Skills Centre are sold at craft fairs and open days arranged by the residents and staff. Residents are paid a weekly wage. The amount paid

reflects the amount of work the individual has done during the week.

- **The Activity**

The range of activities residents participated in within both the Work Skills Centre and the course available at the local college (Mainstream[i]), are detailed in Appendix G. The activities residents were reported to participate in matched those activities reported by the residents during their interviews.

- **Individual Time-Tables**

The activity log data and the interview with the staff member indicated that each individual had a separate work time-table at the Work Skills Centre:

- Two individuals had work placements which they attended three days a week; four individuals attended the Mainstream

  course at the local college for two days each week; One individual chose not to attend college, and two individuals were not yet felt to be ready to attend college or a work placement.

- The focus of activity within the Work Skills Centre was different for each individual. For example, one individual spent a lot of time on practical activities such as wood work and gardening, while another individual spent more time on basic education, for example, numeracy and literacy (see Appendix H for examples of Work Skills time-tables for two individuals attending the centre).

- **Opportunities For Integration**

For those individuals who did not attend the Mainstream course or who did not have a work placement outside the Work Skills Centre, opportunities for integration within this day-care setting appeared to be restricted to those individuals with whom they already have contact with in their residential setting. While some classes within Work Skills do give residents the opportunity to go out into the community in order to develop important life skills (for example banking and budgeting), these are limited. However, this may be a reflection of the focus of individual care-plans at this stage.

3.3. Weekday Leisure Time

The data presented below details how residents spend their time on an average week day (i.e., Monday through Friday) outside Work Skills hours. This will be referred to as 'leisure time'.

Any daily activity logs which were returned incomplete were not used. As a result, data presented on leisure activity during the week are based on the maximum number of days for which there was complete data for each individual. The minimum number of days for which data was available for an individual was ten and the maximum number of days was fifteen. The data are based on an average taken across the number of complete days available for each individual. The mean day length

(excluding time spent at Work Skills) was seven hours, five minutes.

3.4. Who Do Residents Spend Their Leisure Time With?

- **At Group Level**

Table 1 provides a breakdown of who residents spent their time with. The largest portion of residents' leisure time, 42%, was spent in the company of both staff and other residents together. On average residents spent: 19% of their time with members of staff only; 9% with other residents only; and 7% of their leisure time with "others", for example, family and friends. On an average day, residents spent 19% of their time
alone.

- **At The Individual Level**

There was a considerable amount of variability between residents in terms of who they spent their time with (see Figure 1 overleaf):

Table 1: Who Residents Spend Their Leisure Time With

With Whom?	Mean % of Residents' Leisure Time	Mean Length of Time
Staff & Residents	42	179 mins
Alone	23	98 mins
Staff Only	19	81 mins
Residents Only	9	38 mins
Other	7	30 mins
Total	100	7 hrs 5 mins

(i) Staff & Residents

The proportion of time spent with staff and residents ranges from 24% (1 hr 40 mins) of leisure time for resident 6, to more than double that for resident 1 (58%; 4 hrs 5 mins).

(ii) Alone

On an average day, resident 1 spent no time alone. In contrast, 5 residents (residents 2, 5, 6, 8 and 9) spent approximately 30% of their leisure time alone.

(iii) Staff

Resident 9 spent 8% of leisure time (34 mins) in the company of staff. Resident 4 spent more than three times that amount of time (28% of their leisure time) with staff.

(iv) Other Residents

On an average day, resident 2 spent just 1% of his/her leisure time with other residents only (approximately 5 mins). In contrast, resident 7 spent 17% of time (1 hr 10 mins) alone with other residents.

(v) Others

Table 2: How Residents Spend Their Day

Activity	Mean % of Day	Mean Length of Time
Routine Activity	28	119 mins
Community-Based Recreation	23	98 mins
Watching Television	13	55 mins
Home-Based Recreation	12	51 mins
Inactive	9	38 mins
Chatting With Staff &/or Residents	9	38 mins
Domestic Chores	3	13 mins
Receiving Visits/Phone Calls	3	13 mins
Total	100	7 hrs 5 mins

friends. Resident 2 spent no time with friends or family during the period over which the activity logs were recorded, whereas resident 6 spent, on average, 23% of leisure time (1 hr 40 mins) with family and/or friends.

3.5. How Do Residents Spend Their Leisure Time?

The daily activities residents participated in will be examined at both group level, and individual level.

- **At Group Level**

Table 2 (overleaf) provides a complete breakdown of how residents spend an average week. Definitions of each activity are provided in Appendix F.

Figure 1: Who Residents Spend Their Day With

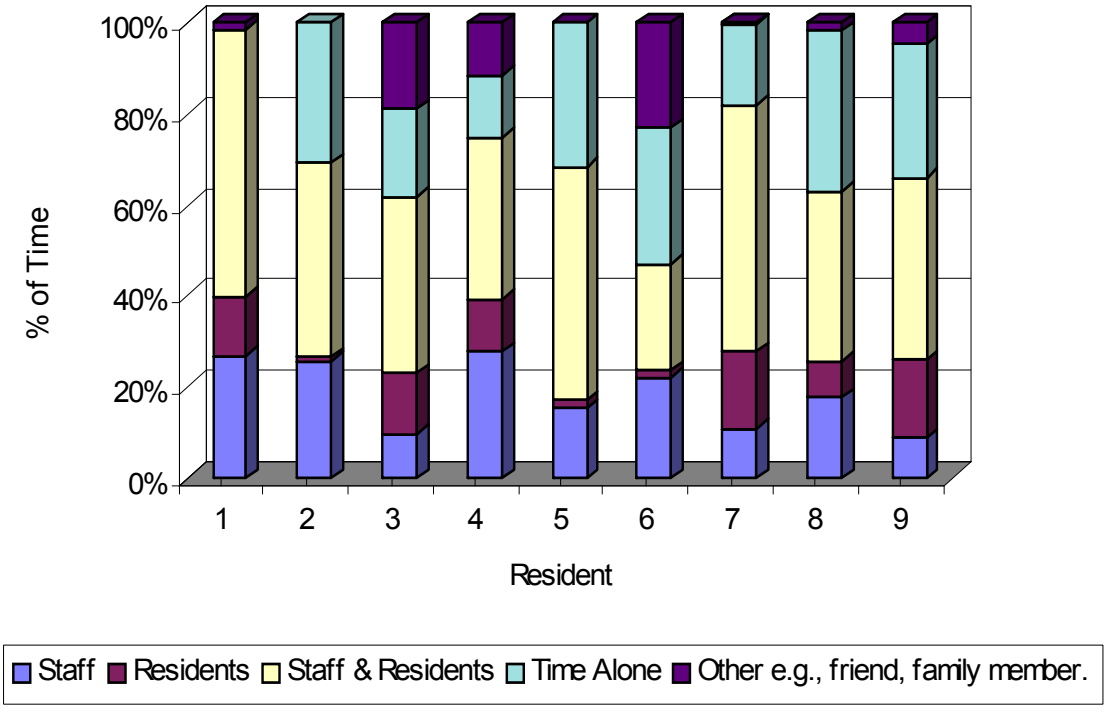


Table 4: Residents' Home-Based Activity

Activity	Number Of Residents Participating
Listening To Music	**5**
Reading	**3**
Writing Letters	**2**
Attending Residents' Meetings	**2**
Watching Videos	**2**
Cycling (within the grounds of Kimberley House)	**2**
Preparation for Parties within Kimberley House (e.g., for Halloween & Valentines Day)	**2**
Having Barbecues/Parties	**2**
Playing Board Games/Cards	**2**
Sun Bathing	**2**
Looking after a Pet	**2**
Playing an Instrument	**1**
Bicycle Maintenance	**1**
Knitting	**1**
Drawing/Painting	**1**
Singing	**1**
Story-telling	**1**

The largest proportion of residents' day (28%) was spent on routine activities - for example, having meals, taking medication, and personal hygiene. 23% of time was spent engaged in community-based recreation, while 12% was spent on home-based recreation.

On an average day, just under one hour was spent watching television (13% of their time). 9% of residents' leisure time was spent talking to staff and residents, and 9% of the time they were inactive (for example, having a nap, smoking alone). A small proportion of residents' time (3%; 13 mins) was taken up on visits or telephone calls with friends and/or family, and on domestic chores (12%).

Activity logs indicated that residents participated in a wide variety of both home-based and community-based activities (n=29). Twelve different kinds of community-based activities (see Table 3) and seventeen different kinds of home-based activities were reported during the time the data was being collected (see Table 4).

Table 3: Community-Based Activities

Activity	Number Of Residents Participating
Going Shopping	**7**
Going on Day-Trips/Outings	**7**
Going for Walks	**6**
Going to the Pub, Pub Quizzes & Music Sessions	**6**
Visiting Family/Friends	**6**
Going to Local Discos (non-integrated)	**2**
Weightlifting *	**2**
Swimming *	**2**
Playing Badminton *	**1**
Aerobics *	**1**
Surfing the Internet *	**1**
Going to Restaurants	**1**

* Activity within local leisure centre.

- **Individual Differences**

There was considerable individual variation between residents in terms of how they spent their day (see Figures 2-8 overleaf).

(i) Domestic Activity (Figure 2)

One individual (resident 3) spent no time on domestic chores during the three week period in which the activity logs were kept. In contrast, resident 9 spent almost 7% of his/her leisure time (33 mins) carrying out domestic chores

(ii) Watching Television (Figure 3)

While resident 2 spent only 6% of leisure time (26 mins) watching television, residents 4 and 7 spent 20% (1 hr 27 mins) and 28% (2 hrs) respectively.

(iii) Home-Based Recreation (Figure 4)

The amount of time residents spent on home-based recreation ranged from 26% (1 hr 44 mins; resident 1), to 3% of their day (12mins; resident 8).

There is a split in the sample between those residents who fall well below the group mean in terms of time spent on home-based recreation (residents 3, 4, 6, 7, and 8), and those residents who are well above the group mean (residents 1, 2, 5, and 9) in terms of time spent on home-based recreation.

All of those individuals falling above the group mean spent more than 15% of their day on home-based recreation (see Appendix F for a definition of home-based recreation). Those residents falling below the group mean spent less than half of that amount of time on home-based recreation.

It should be noted that four out of the five residents who spent less than 15% of their day on home-based recreation (residents 3, 4, 6, and 7), did spend a high proportion of their day on community-based activity (see below).

(iv) Community-Based Recreation (Figure 5)

Resident 1 spent 12% of leisure time (47 mins) on community-based activity, while resident 6 spent three times that amount of time, 35% (2 hrs 22 mins), on community-based recreation.

(v) Talking With Staff & Residents (Figure 6)

Resident 6 spent 21% of his/her leisure time, (1 hr 15 mins) talking to staff and/or residents (in this instance, primarily to staff). This is a particularly high proportion of time when compared to the rest of the group. Resident 4 spent the next highest percentage of leisure time talking to staff and/or residents (13%; 56 mins). Resident 5 spent the least amount of his/her day (2%; 7 mins) talking with staff and/or residents.

(vi) Receiving Visits/Phone Calls (Figure 7)

Three residents (residents 2, 4, and 6) received no visits from friends or family during the data collection period. In contrast, resident 3 spent

9% of his/her day (36 mins) receiving visits and/or phone calls from friends or family.

(vii) Inactive (Figure 8)

Four out of nine residents were inactive for less than 30 minutes of their leisure time (residents 4, 6, 7 and 9). In contrast, resident 8 appeared to be unrepresentative of the sample, spending more than one quarter of his/her leisure time (28%; 1 hour 52 minutes) inactive. This individual spent most of this time asleep.

3.6. Leisure Activity At Weekends

Insufficient data was available to perform a detailed analysis of the leisure activity residents participated in at the weekend:

- no data was available for two individuals as they went home every weekend;
- one individual spent one of the weekends in bed ill, therefore the data for that period was felt to be unrepresentative of his/her normal activities;
- data collection for three residents overlapped with their annual holiday. These residents departed for their holiday on the final weekend of data collection, causing the data for that period to be incomplete.

Complete data was available in relation to only three individuals.

One general trend did emerge from the available data: residents spent more of their day receiving family visits over the weekend period compared to during the week.

[i] Mainstream is an education programme which caters for the needs of individuals with a physical and/or learning disability.

4.4. Findings

To provide a clearer picture, both staff views and resident views will be reported separately These perspectives will then be compared at a group level. The main findings will be highlighted in the general discussion at the end of the report.

It should be noted that, within the findings, relationships that residents have with other learning disabled individuals within the community will be reported separately from relationships they have with non-learning disabled individuals within the community. There is much debate as to the potential advantages and disadvantages each type of relationship can have (Pilkington, 1991, Szivos 1992). The two groups have not been separated here in the assumption that one is somehow superior to the other. It is accepted that both types of friendships have their merits and drawbacks. The two groups have been reported separately in order to provide as detailed a picture as possible of the breakdown of tenants' networks.

4.5. Key-Worker Views

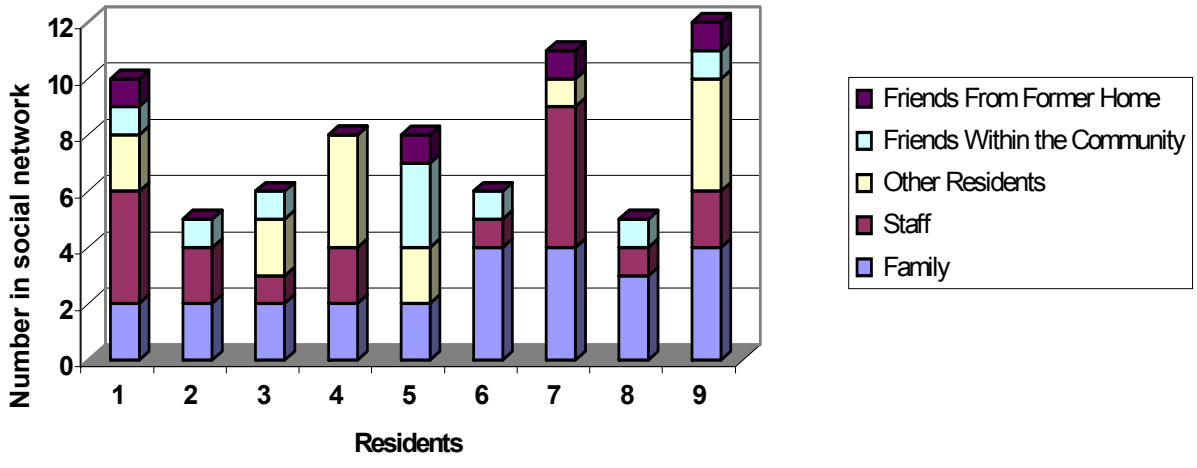
- **Total Network Size**

Staff reported that the mean size of residents' social networks was 7.9 people. The smallest total network size a resident had was five people, while the largest network was twelve. Families formed the largest section of residents' social networks.

- **Family**

At an overall group level, residents' families comprised over one third (35.2%; n=25) of their social networks. There was some individual variability (see Figure 1). For resident 1, family comprised just one fifth of his/her social network, while for resident 6, family comprised two thirds of his/her social network. However, the range in number of family members was fairly small. All residents

Figure 1: Composition of Residents Social Networks Based on Staff Reports



had at least two family members in their social network, and the maximum number was four. Most contact involved visits from family members to Kimberley House. Four residents visited their family in the family home. For three of these individuals, these visits were on a regular basis.

A. Frequency of Contact

Frequency of contact with family members varied substantially, from twice a week to once every one to two years. Four residents had family contact on a weekly basis. For a complete breakdown of the frequency of family contact, see Appendix L - Table 1.

B. Duration of Visits

Likewise, the duration of family contact varied greatly, from visits to Kimberley House lasting half an hour, to visits by residents to their family home every weekend from Friday evening to Monday morning. For a further breakdown of the duration of family visits, see Appendix L - Table 2.

- **Staff**

At a group level, staff comprised one quarter of residents' social networks (25.4%; n=18). This included staff members from both the residential facility, and the Work Skills Centre. However, there was considerable variability between residents. One individual was reported as having no staff members as part of his/her social network, while another individual had five staff members identified as being part of his/her social network.

Staff reported that 61% (n=11) of these relationships involved emotional disclosure on the part of the resident and support:

"having a laugh, chatting, everything, it would depend entirely on what mood (resident) *was in at the time, but* (resident) *would confide in them"*.

"If (resident) *had a problem he/she would actively seek out him/her* (staff member named)*"*.

22.2% (n=4), of staff relations were not felt to be a source of emotional support. All four of these relations involved the same resident, and the absence of emotional support was attributed primarily to the nature of the resident's disorder:

"Regarding discussing problems, unless they were of a tangible nature, for example, he/she (resident) *would ask for a shirt to be mended … he/she wouldn't really discuss them"*.

The remaining staff relationships (16.6%; n=3), were largely based on a resident having a preference for one member of staff over the others.

- **Other Residents**

Other residents were the next most commonly cited contributors to residents' social networks (21.1%; n=15). It was felt that while four residents were generally friendly to all the other residents, they could not be classified as having friendships with any of the people they lived with. Of those friendships that did exist,

only one was described as "close". In other words, only one friendship involved mutual self-disclosure and was felt to be a source of emotional and practical support for both parties involved:

" … they knew each other before they even came here, and they moved in here at the same time. They've always been very close".

Staff felt that all other friendships within Kimberley House itself were quite casual in nature. In other words, the majority of relationships involved residents sitting together during meals, or sitting and having a cigarette together. It was reported that generally, conversation would not progress beyond small talk:

" (resident) *would sit at the dinner table with him/her* (fellow resident)*, and share a joke, but that would be about the height of it".*

- **Friends Within The Community**

A. Learning Disabled Friends Within The Community

Two individuals had a learning disabled friend whom they had met at a local disco organised for people with learning disabilities. The first friendship was progressing slowly with active encouragement from staff. The resident would invite his/her friend to Kimberley House for tea, or for a meal. These visits took place approximately once every two months and lasted between one and two hours. Visits usually only took place when staff prompted the resident to issue an invite. There was no real contact in the interim periods, and the invitation has never been reciprocated. While the visits were enjoyed by the resident, the key-worker felt that the friendship to be *"still at a very basic level, it is not a deep friendship".*

The second relationship involved frequent contact: they saw each other twice a week for three to four hours each time. They also exchanged frequent telephone calls throughout the week, sometimes for as long as fifteen minutes. It was felt that this relationship did act as a source of emotional support for the resident concerned.

B. Non-Learning Disabled Friends Within The Community

Non-learning disabled friends comprised 8.5% of residents' social networks (n=6). These friendships were formed while residents were out socialising in the local community and through work placements.

(i) Out & About in The Community …

Three individuals had formed friendships with non-learning disabled individuals as a result of socialising outside the Kimberley House setting. One individual in particular was felt to have a very strong relationship with a person he/she had met while socialising in a local pub. The non-learning disabled individual was described as having *"taken a shine"* to the resident involved. Accompanied by a staff member, they saw each other at least once a week at the pub, and often they would exchange visits to each others homes, for a meal or just for a chat. When they could see

each other only once a week, contact was continued throughout the week with phone calls. The friendship was felt to be a source of both emotional and practical support. This resident's friend had spoken to staff about becoming an official befriender for the resident in question. It was felt that one other resident regarded this same individual as a friend. This resident would also stop and chat with him/her in the local pub and would see them when they came to visit their fellow resident. The friendship was based largely on this mutual acquaintance, no visits were exchanged and it was reported that it was unlikely to act as a source of emotional support.

One resident had several acquaintances he/she had made through socialising with his/her sibling, but only one was reported to be noteworthy. Again the relationship was difficult for staff to characterise because they met up at the family home. The resident saw their friend at least once a week while out socialising with his/her sibling. He/she had never made a visit specifically to see this friend, and his/her friend had never been to Kimberley House to visit him/her. However, on one occasion, when the resident's sibling was unable to facilitate his/her usual visit, the resident's friend did call to invite him/her to come and spend the evening with him/her instead.

(ii) Through Work …

For the seven residents whose day-time activity took place at the Kimberley Work Skills Centre, there were no additional friendships reported[1]. This finding is not surprising given that the only people attending this centre were residents from Kimberley House.

As indicated earlier, three individuals also attended a course called *Mainstream* on a part-time basis. (This a course is held at a local technical college and is specifically designed for individuals with physical and learning disabilities.) One individual had only just started the course at the time of interview and, as a result, had not sufficient time to develop any friendships. However, the other two residents had been attending the course for some time. According to staff reports, no friendships had developed for these individuals.

Two residents had work placements. Both of these residents had formed friendships through their work placements. As the relationships were work-based, it was very difficult for the key-worker to comment on the nature of the relationship. However, for one resident who had made two friends while at work, the friendships had extended beyond the work setting. In the two-three months preceding the interview, this individual had been invited into the homes of work friends for a meal, and out for a picnic. The visits occurred approximately once a month and lasted between three-four hours. The visits had been returned on one occasion when the resident invited his/her work-mates to

[1]The only additional friendships noted were with staff members based at the centre (these numbers are included under the general category "staff").

Kimberley House for a meal. For the second resident who had also developed a work friendship, the relationship did not extend beyond the work setting. The relationship was described as *"good"*, based primarily around conversations on a common interest. It was felt to be unlikely that the relationship involved any level of emotional disclosure or support.

- **Friends From Former Home.**

One individual had an ongoing relationship with an individual he/she had known while living in hospital. The Kimberley House resident would visit their friend once every three-four months for approximately one-two hours. These visits were not reciprocated: the key-worker felt the relationship to be *"very one-sided"*.

One other resident was reported as having an ongoing friendship with an individual they had known in the hospital he/she had lived in before coming to Kimberley House. Contact, however, had fallen quite sharply and the Kimberley House resident had visited his/her friend only once in the preceding six months. There had, however, been sporadic telephone calls during this period.

Finally, one individual had had a period of contact with an old school friend. This friend has since moved out of the area and all contact had ceased.

- **Quality of relationships**

Staff reported a number of individuals as being part of residents' social networks where the relationship was antagonistic or negative in its effect. For example, there were four family relationships which were felt to have a negative impact. In three of these cases family contact was often erratic and the quality of interaction was poor. This was particularly the case for one individual who was described as being "very upset" following family visits.

One family relationship was described as a co-dependency. It was reported that, in this instance, the relative was reluctant for the resident to progress and, as a result, often hindered rather than facilitated progress. It was felt that increased independence for the resident would marginalise and undermine the relative's responsibility for the resident. While the resident looked forward to visits from the family member, they were aware of this restrictive influence and so visits were accompanied by a certain amount of tension: *"*(relative*) would kind of put* (resident) *down and think* (resident) *is a lot less able than he/she is …* (relative) *doesn't like the idea of* (resident*) developing new skills at all"*

4.6. Resident Views

- **Total Network Size**

Based on resident reports, the mean size of their social network was fourteen. The smallest reported network size was six, the largest was twenty-five. It is interesting to note that the

individual who reported that moving into the community meant you had to try and make new friends (Friends from Former Home, page) reported the largest number of friends/acquaintances.

- **Family**

Family were the largest overall contributor to residents' social networks (25.8%; n=25). There were considerable individual differences within this (see Figure 2). The number of family members reported as being part of individual social networks ranged from one to seven. Family comprised just one eighth of resident 2's social network, while family comprised almost one half of resident 5's social network.

Four out of seven residents stated that they would like to see more of their family:

"I'd like to see them the whole of the time".

"I would like to see more of all of my family".

The majority of residents interviewed talked about their family relations in quite positive terms, and obviously viewed relations as close in that they loved their families:

"Me and (sibling) *have always been close".*

"He/she is my (sibling) *and I love him/her".*

However, just 28% (n=7), of family relations were described in terms of being able to talk to family members about problems.

- **Staff**

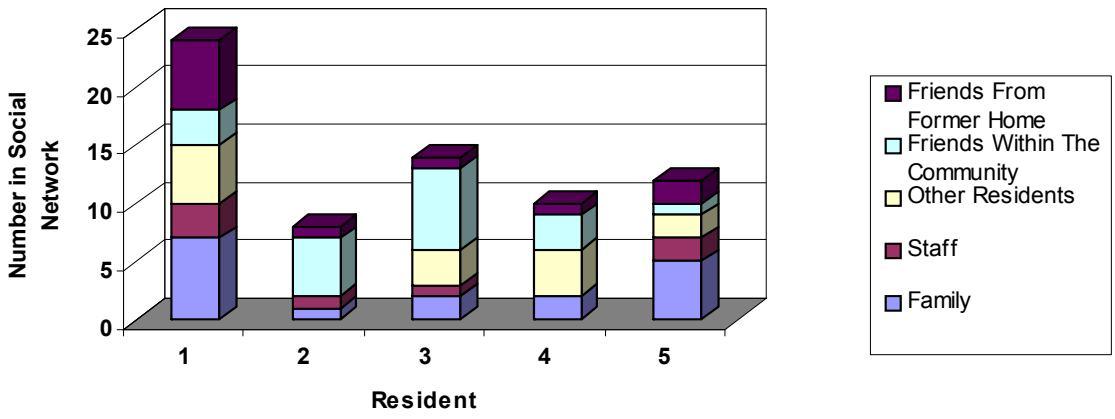
Staff were the next most common contributors to residents social networks, comprising 20.6% of residents' social networks (n=20). Again, there were considerable individual differences, for example, resident 4 named no staff members as being friends, while staff comprised over half of resident 6's social network. Of the staff relationships identified, 40% (n=8) were described by residents as close: One resident stated, *"In here I only have three people I can talk to"* - all three of these people were staff.

One resident, while stating that he/she would not discuss problems with family members, stated that if he/she had a problem he/she would go to a member of staff he/she had named as a friend:

"I could tell it to (staff member), *he/she is very good now … if you have a problem he/she sorts it out right away".*

- **Other Residents**

Figrure 2: Composition of Residents Social Networks Based on resident Reports



According to resident reports, friendships with other residents comprised 18.6% (n=18) of their social networks. Of these friendships, 33.3% (n=6) could be described as close:
"We sit and pour our hearts out to each other ... I'm talking about my problems here (at Kimberley House)*".*

"We're like brother and sister".

More usually, though, relations with other residents were described in quite casual terms:
"We talk about the good weather and going away on holidays and stuff like that".

Two out of the seven residents interviewed stated that they were friends *"Just to say hello"*, with the other residents, but had no real friendships with any of the residents at Kimberley House. One resident indicated that while he/she spent evenings in the television lounge, the rest of the residents, and most of the staff, would spend their evenings in the smoking lounge and ,as a result, he/she was left feeling isolated and in need of more contact:
"There's a smoking room downstairs, and they all go down there (residents and staff) … *nobody comes up here".*

- **Friends From Former Home**

Friends from residents' former homes comprised 13.4% (n=13) of their social networks. However, it should be noted that four of these relationships were with hospital staff, and were based largely on a professional-client relationship.

Only one out seven residents interviewed reported having no contact with friends from their former home. Interestingly, this was the only resident who had not previously been living in a hospital setting. Of the remaining six residents who had maintained contact with friends they had known in hospital, three reported visiting their friends there, one resident telephoned his/her friend every month or so, one resident wrote letters to two friends, and one resident would see a friend occasionally *"just if I happen to bump into him"*, when the friend was visiting his/her family. When asked if they would like to visit their friends in hospital they replied: *"No … you see when you come out of* (hospital)*, you have to make more friends in different places".*

"I wouldn't want to".

"No, it's okay".

Nine out of the thirteen relationships reported involved face-to-face visits, and only in these instances, did residents express a wish for more contact. Of the nine relationships involving visits, four were with members of hospital staff. Only two residents returned to hospital to visit friends (n=5) who were not staff. Of these five non-staff relationships, only two were described as close:
"He/she is my best mucker".

"My (partner)*, he/she is my friend as well, me and him/her are in love, I love him/her".*

All visits to friends in hospital were infrequent (e.g., two-three times a year). Three residents had had visits reciprocated, but each on only one occasion during the twelve month period they had been resident at Kimberley. Two reciprocated visits were from hospital staff, and both were for primarily professional purposes.

- **Friends Within The Community**

A. Learning Disabled Friends Within the Community

Only one individual reported having a friendship/relationship with another individual with learning disabilities within the community. He/she had met his/her girl/boyfriend at the local disco organised for individuals with learning difficulties. The resident involved stated that he/she did talk to his/her partner about his/her feelings or any problems he/she might be having, and indicated that he/she would like to see more of them.

B. Non-Learning Disabled Friends Within the Community

Five out of seven respondents reported (20.6%; n=20) people they would stop and chat to when they were out and about: This category made up 20.6% of the total social network. Twenty individuals were named in total. Two of these individuals were friends of family members; three were health professionals; two worked in local shops or banks; six were met while out socially, two were neighbours, and five were met through work placements.

(i) Out & About In The Community

Only one individual had what could be described as a close relationship with a non-learning disabled individual within the community. He/she had met this individual while out socialising in the local pub. The relationship involved frequent visits to each others homes and did appear to be a source of social and emotional support:.

"We talk about … just messing around you know, stuff about getting on with your lives and not worrying and stuff, relax, good time".

This resident indicated that he/she would like to see more of his/her friend.

Most of the relationships would probably be better described as acquaintances: they were reported in very casual terms, and did not involve planned visits to each others homes. For example:

"Well I know a friend in the bank now you know, getting to know him/her, like just friendly chat and stuff when I'm out getting my bank book and stuff when I'm out".

"I know their faces from (the pub) … *they all know me from running about, you know, from around the shops".*

Only one of the seven residents interviewed reported knowing any of the neighbours (n=2). Again, the contact was described as casual, and neither party had ever visited the others home:

"Just 'what about you' and all, and 'are you out for a walk?' and stuff like that".

The quotes below illustrate the views of the other residents in relation to neighbours:
"Sometimes they're very funny, they don't speak to you".

"I don't know them".

More generally, when asked how they were treated when out and about, six out of seven respondents indicated that they were treated fine:
"Alright".

"They treat me fine"

"Just treat me well".

One resident, however, felt that because he/she was always accompanied by staff, that people sometimes viewed him/her differently:

"I think when people see me with staff they think there is something wrong with me. Sometimes".

(ii) Through Work …

For five of the seven residents, who attended the Kimberley Work Skills Project, the only additional friends named at work were staff members (these are included in the overall staff figures).

Two residents, who had work placements at the time of twelve month follow-up, said that they had friends at work. One individual named all three members of staff at his/her place of work as friends. Probing revealed, that this resident did not talk to any of them about his/her feelings or any problems he/she might be having. These relationships appeared to be quite casual in nature, and did not extend beyond the work setting.

In relation to the other resident who had named two friends within his/her work place, the relationships had extended beyond the work setting in the two-three months preceding the interview. The resident had been invited out by work colleagues on two occasions, and had invited them to Kimberley House for lunch on one occasion. When asked if he/she would describe him/herself as close to any of his/her work friends, he/she replied:

"No, I just treat them all the same".

- **Quality of Relationships**

Although staff and non-learning disabled individuals outside the Kimberley Project setting made up similar proportions of the total network size, there were qualitative differences in these two sets of relationships. Not surprisingly, relationships with staff involved more frequent contact and 40% of these relationships were characterised as close. In comparison, only one relationship with a non-learning disabled individual from the community was described as close.

Relationships with other residents in Kimberley House comprised almost one fifth

of residents' networks. However, just one third of these were described in terms of emotional closeness. Of the thirteen relationships reported from their previous home, only two were described as close. One individual had a friendship with another learning disabled individual within the community and this relationship involved frequent contact and was described as close.

4.7. Staff and Resident Reports Compared.

Based on resident reports, the average social network size was fourteen, compared to just 7.9 based on staff reports.

Staff and resident reports are similar in relation to friendships with staff, other residents, and learning disabled individuals within the community (see Table 1).

The largest discrepancies between staff and resident reports occur in relation to: non-learning disabled friends within the community, and friends from residents' former homes: residents report much higher instances of both (see Table 1).

Table 1: Social Networks - Staff and Resident Reports Compared.

	Staff Reports	Resident Reports
Family	35.2% (n=25)	25.8% (n=25)
Staff	25.4% (n=18)	20.6% (n=20)
Other Residents	21.1% (n=15)	18.6% (n=18)
Learning Disabled Friends Within The Community	4.2% (n=3)	1% (n=1)
Non-Learning Disabled Friends Within The Community	8.5% (n=6)	20.6% (n=20)
Friends From Former Home	5.6% (n=4)	13.4% (n=13)
Total In Network	100% (n=71)	100% (n=97)

5.0. Background

It is argued that the move from a hospital to community setting will lead to an improved quality of life for individuals with learning disability. One of the primary aims of the service provided at Kimberley House is to allow its residents the opportunity to develop new skills which will promote independence and allow them to lead normal lives. Hence, it is important that any measures of service outcome includes a measure of skills development (Felce, 1996).

5.1. The Outcome Measure

The methodology for assessing change in both adaptive behaviours and challenging behaviours has been criticised by several researchers (e.g. Felce et al 1986; Harris et al 1992), particularly in terms of poor inter-rater reliability. A wide range of instruments are currently used to measure behaviour (Wright et al 1994; Emerson & Hatton 1994). Wright et al (1994), reporting Leedham's review of over fifty instruments, identify the Adaptive Behaviour Scale as the instrument that "scored best - or least badly" on a range of criteria. Emerson & Hatton (1994), in their review of studies examining the impact of the relocation from hospital to community, identify two methodological problems that occur across measures of both adaptive and challenging behaviour. They argue that change in scores on these scales may be a reflection of differences in staff expectations rather than differences in individual abilities. They identify this as being particularly problematic where baseline questionnaires are completed by staff in the hospital setting, and follow-up questionnaires by staff working in a community setting. A second major methodological problem highlighted by Emerson and Hatton (1994) is that increases in competencies in a move from a hospital to a community setting may actually reflect increased opportunities for individuals to display the competencies they already possess. Unfortunately, the authors do not identify ways to counteract these problems. However, they must be kept to the fore when interpreting changes in behaviour over time.

The American Association of Mental Retardations Adaptive Behaviour Scale - Residential and Community: Second Edition (AAMR ABR - RC:2; Nihira et al, 1993) was used for this evaluation. The ABS-RC:2 is divided into two parts:

- Part One is concerned with personal independence, and evaluates coping skills considered to be important to personal independence and responsibility in daily life. This is divided into ten behaviour domains relating to several aspects of daily life. These domains are: independent functioning; physical development; economic activity; language development; numbers and time; domestic activity; prevocational/vocational activity; self-direction; responsibility, and socialisation.

- Part Two focuses on social behaviour. It is divided into eight behaviour domains which measure those adaptive behaviours that relate to the manifestation of personality and behaviour disorders.

These are: social behaviour; conformity; trustworthiness; stereotyped and hyperactive behaviour; sexual behaviour; self-abusive behaviour; social engagement, and disturbing interpersonal behaviour.

5.2. Methodology

Baseline ABS-RC:2 forms were completed for each resident by a professional within the hospital setting who had worked with them on a daily basis, and who had closely observed the resident's behaviour over time. This occurred before residents had left the hospital setting (in a few instances, due to delays in receiving service-user consent, baseline ABS was completed a short time after the individual had left the hospital).

ABS-RC:2 forms were then completed by Kimberley House staff for each resident at three data collection points: two months, six months, and twelve months after moving to Kimberley House.

5.3. The Analysis

The data were analysed in order to examine three areas:

- the inter-rater reliability of the ABS-RC:2 (See Appendix S);
- resident's level of baseline functioning in comparison to norms;
- how residents have progressed in their adaptive behaviour after twelve months at Kimberley House.

5.4. Baseline Functioning

Baseline data was available for eight residents [1]. As Table 1 indicates, the mean overall ABS score was 307 (min 179; max 367), the mean Part One (Personal Independence) score was 222, and the mean Part Two (Social Behaviour) score was 84.

Table 1: Baseline ABS-RC:2 Scores

Score	Mean	Min	Max
Total ABS	307	179	367
Part One (Personal Independence)	221	137	278
Part Two (Social Behaviour)	85	20	172

Kimberley House resident scores on the individual domains making up Part 1 and 2 of the ABS were compared to the norms for the scale (note: these are American norms). Raw scores were converted into percentile ranks.

A percentile represents "the percentage of a distribution (from a representative sample of same age individuals) that is equal to or below a particular score" (Nihira et al, 1993). For example a score at the 75th percentile means that 75% of the comparison sample scored the same as or below the person being evaluated. A score at the 25th percentile indicates that only 25% of the comparison sample had poorer functioning than the person being evaluated.

[1] Baseline data was not returned in relation to three individuals.

Therefore, a score at the 75th percentile or above indicates much better functioning than a score at the 25th percentile or below.

For each behaviour domain in Part 1 and 2 of the ABS, a count was made of the number of individuals scoring on or above the 75th percentile (referred to as *upper quadrant*); on or below the 25th percentile (referred to as *lower quadrant*); and those falling in between (referred to as *middle quadrant*).

Personal Independence

For the majority of the domains, most of the Kimberley House residents fell within the upper percentile quadrant (Table 2). This indicates above average independent living skills compared to the norms for a learning disabilities population.

Table 2: Number Of Individuals Falling Within Each Percentile Quadrant For Personal Independence Domains

	Lower Quadrant	**Middle Quadrants**	**Upper Quadrant**
Independent Functioning	1	2	5
Physical Development	0	2	6
Economic Activity	2	2	4
Language Development	0	1	7
Numbers & Time	0	1	7
Domestic Activity	1	1	6
Prevoc/Vocational Activity	5	2	1
Self-Direction	1	3	4
Responsibility	2	2	4
Socialisation	1	4	3

Table 3: Number Of Individuals Falling Within Each Percentile Quadrant For Social Behaviour Domains

	Lower Quadrant	Middle Quadrants	Upper Quadrant
Social Behaviour	6	1	1
Conformity	7	1	0
Trustworthiness	6	3	0
Stereotyped and Hyperactive Behaviour	3	1	4
Sexual Behaviour	3	2	3
Self-Abusive Behaviour	2	1	5
Social Engagement	1	5	2
Disturbing Interpersonal Behaviour	6	1	1

There was only one domain where the majority of Kimberley House residents fell below the 25th percentile (i.e. the lower quadrant) - pre-vocational and vocational activity.

Social Behaviour

A similar comparison was made for each of the domains making up Part Two of the ABS (see Table 3). On this part of the scale, there was only one domain where the majority of individuals fell within the upper quadrant - self-abusive behaviour. On four domains the majority of individuals fell within the lower quadrant (i.e. they scored below the 25th percentile). These were social behaviour, conformity, trustworthiness and disturbing interpersonal behaviour. On social engagement, the majority of individuals fell within the middle quadrants and on stereotypical/hyperactive behaviour and sexual behaviour, individuals were more evenly spread between the quadrants.

5.5. Resident Progress Over Time

Complete data from baseline to twelve month follow-up (excluding two month follow-up) was available for seven out of eleven residents. Friedman nonparametric analysis of variance was carried out to assess changes in the ABS-RC:2 scores across time.

- **AT GROUP LEVEL**

(1) Part One ABS Scores

Analysis indicated a significant change in Part One ABS scores between baseline and twelve months (p=.001). As Figure 1 (overleaf) illustrates, Part One mean score increased between baseline and the six month follow-up. The mean score decreased slightly between the six month and twelve month follow-up, but

Graphs Illustrating Overall Resident Progress on Part One and Part Two ABS-RC:2 Scores

Figure 1:Overall Resident Progress on Part One of the ABS-RC:2 from Baseline to 12 Month Follow-up.

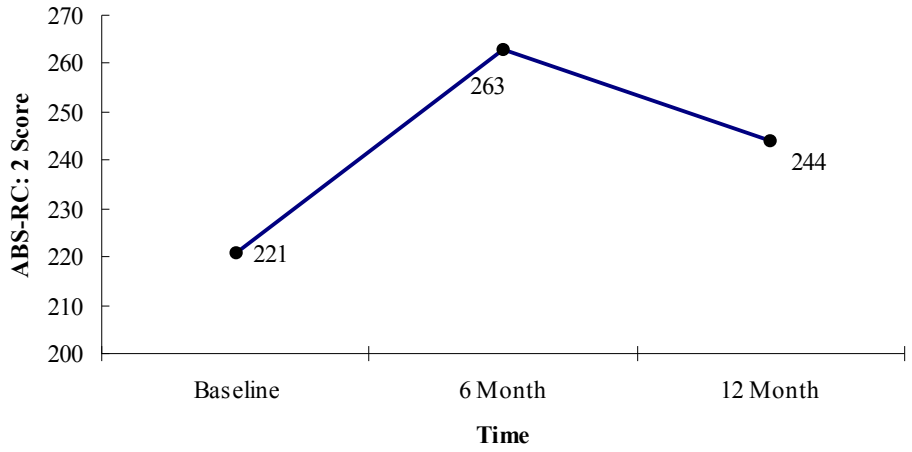
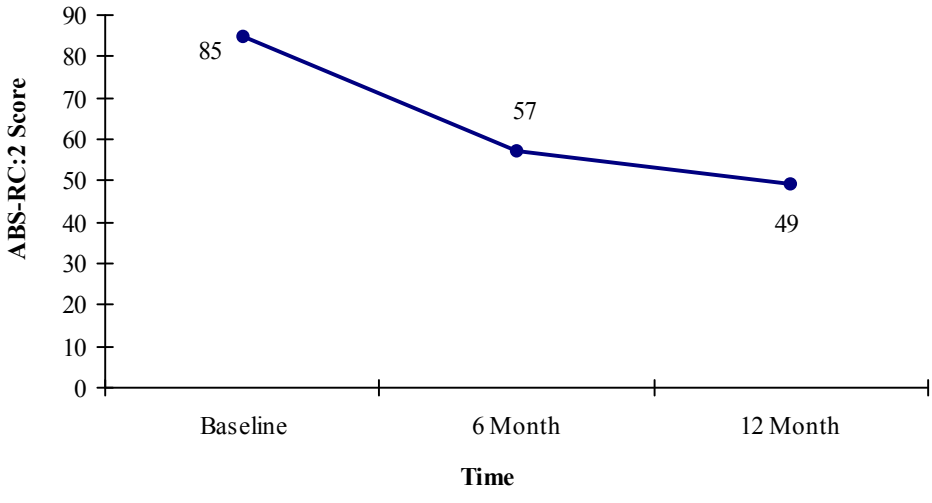


Figure 2: Overall Resident Progress on Part Two of the ABS-RC:2 from Baseline to 12 Month Follow-up



Note: Lower score indicates better performance

still remained higher than the mean baseline score. Post-hoc tests indicated that the statistically significant change occurred between baseline and six months. The change between six and twelve months was non-significant.

(2) Part Two ABS Scores

Note that on Part Two of the ABS, lower scores indicate better functioning. As Figure 2 illustrates, there was a decrease in mean scores from baseline to six months and from six months to twelve months indicating a trend towards improved functioning. However statistical analysis indicated that this change was non-significant (p=.059), although the test almost reached significance.

- **AT THE INDIVIDUAL LEVEL**

When the data were examined at the level of the individual they revealed individual variation in terms of resident progress on Part One and Part Two of the ABS-RC:2 (see Figure 3 overleaf).

(1) Part One ABS Scores

On part one of the ABS, five residents showed some improvement in skills associated with personal independence (residents 1, 2, 3, 4, and 7) across the twelve months. This increase in scores was more pronounced for some individuals than for others, i.e. it was more pronounced for residents 3 and 7. For both of these individuals the most pronounced

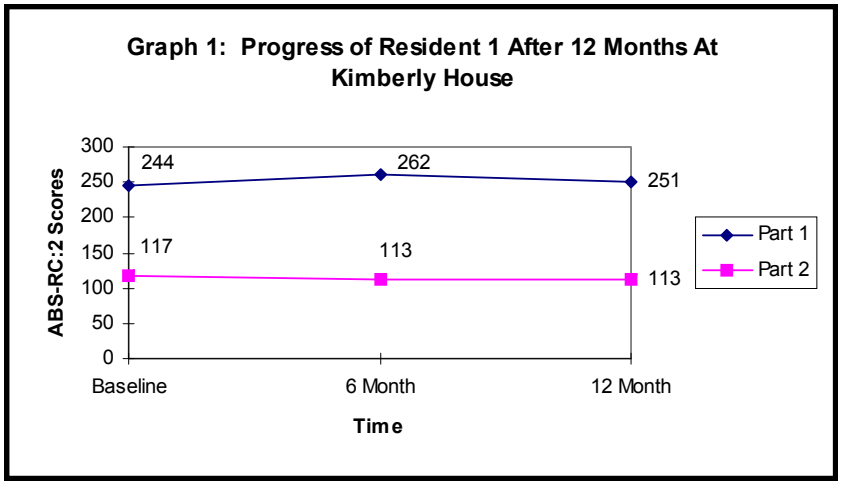
improvement took place between baseline and six months: for one individual this improvement was sustained at the same level by twelve months, for the other it dropped back, though their score remained above baseline level. One individual (Resident 5) showed considerable improvement between baseline and six months - however his/her score dropped back to just below baseline level by twelve months.

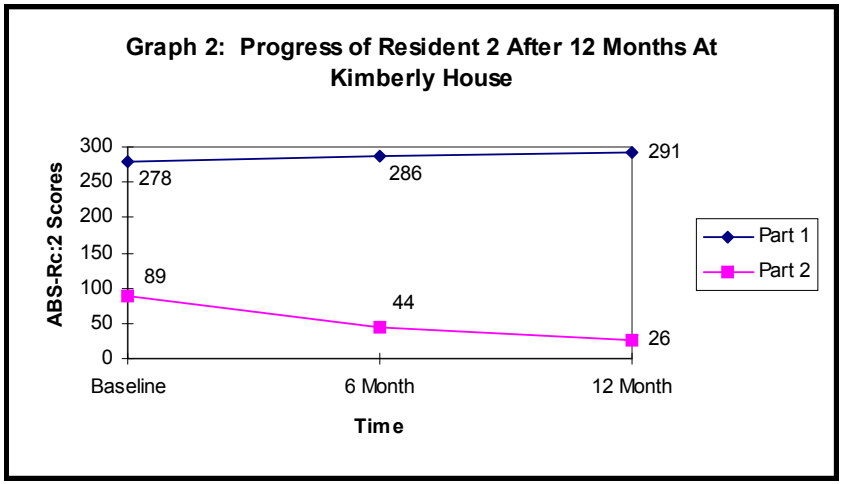
(2) Part Two ABS Scores

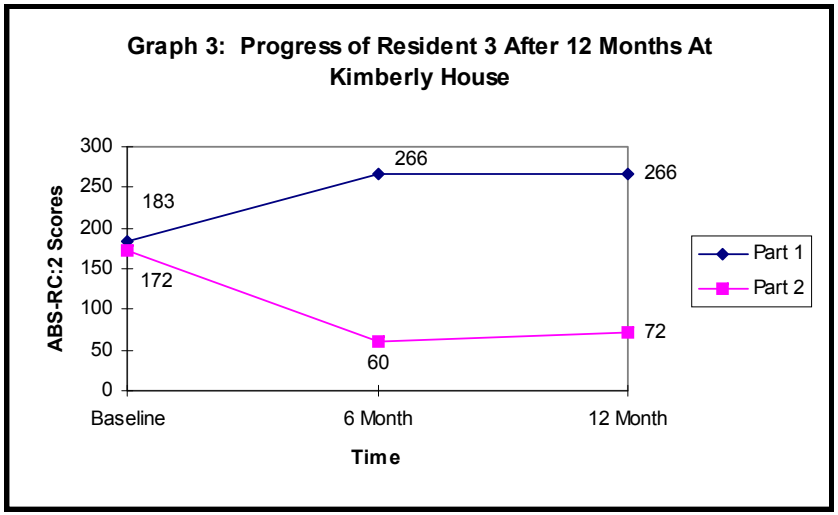
Five residents (residents 2, 3, 4, 5, and 7) showed an overall improvement in skills associated with social behaviour over the twelve month period. For Residents 4 and 5 this change was fairly small. For the other three residents, this change was much more pronounced: for two of these individuals, improvement in functioning occurred between baseline and six months and they continued to improve between six months and twelve months. For the third individual, there was very pronounced improvement between baseline and six months. This dropped back slightly between six months and twelve months.

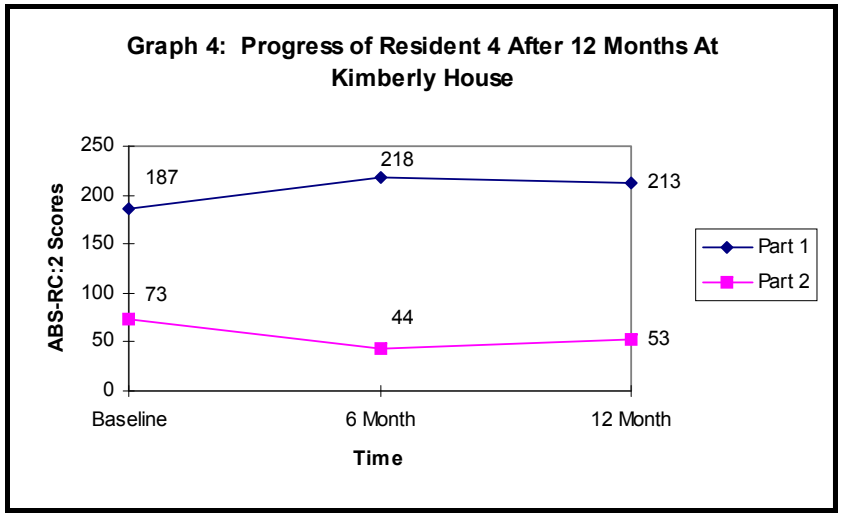
One resident (Resident 1) showed no change in skills associated with social behaviour. Resident 6 showed a decrease in skills associated with social behaviour from baseline to six months, continuing to decrease at twelve months.

Figure 3: Graphs Illustrating Individual Resident Progress on Part One and Part Two ABS-RC:2 Scores

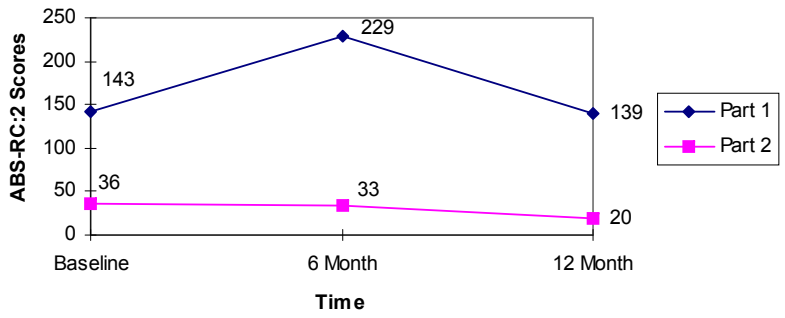




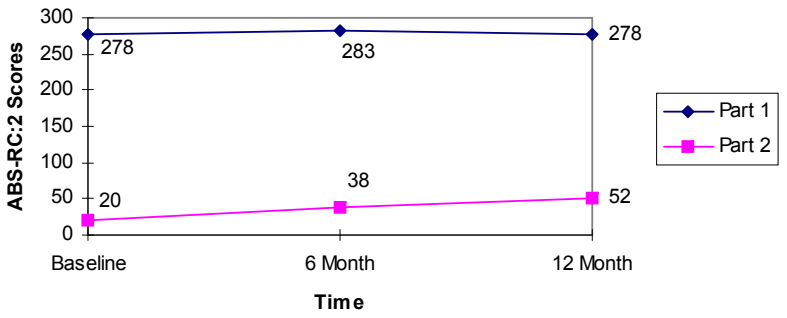




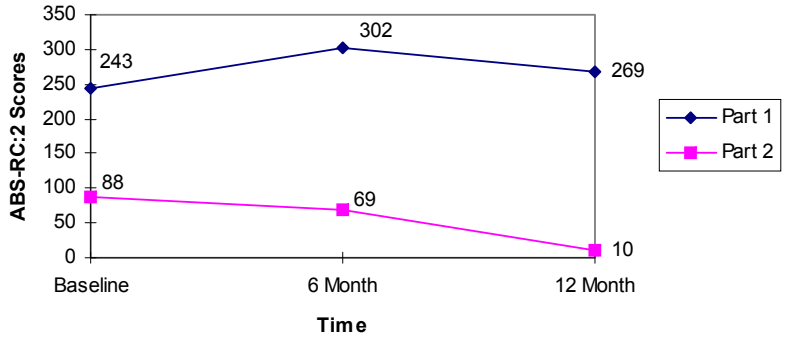
Graph 5: Progress of Resident 5 After 12 Months At Kimberly House



Graph 6: Progress of Resident 6 After 12 Months At Kimberly House



Graph 7: Progress of Resident 7 After 12 Months In Kimberly House



6.0. The Background

In recent years, carers have been given an increased profile within community care (Twigg & Atkin, 1994). Carers are now seen as key stakeholders of the services which are developed for their family members. Legislation states that services should aim to address the needs of carers, and should *"pay attention to and take account of their views"* (Carers Recognition and Services Act, 1995). Hence, it was important that in any evaluation embarked upon, one of the key areas to be addressed is that of carers' views of the service provided at the Kimberley Project.

6.1. The Methodology

The views of carers were elicited during a semi-structured interview. The interview was purposely designed for this evaluation and covered a wide range of care issues:

- the importance carers give to certain aspects of their relatives' care (for example, social needs, emotional needs, the need for community integration and so on), and the extent to which they feel those needs are addressed at Kimberley House.

- their views on the location of the scheme, the furnishings, the atmosphere of the building, the food, and staffing levels.

- their satisfaction with how the move from the hospital setting into the community was handled.
- their satisfaction with their level of involvement in the move to Kimberley House, and in the care their relative receives at Kimberley House.

- how they feel about the move one year on.

- what they like most/least about the service and suggestions for change.

6.2. The Sample

Nine out of eleven residents had family members with whom they were in frequent contact. The family members of all nine of these residents were approached to take part in the interview. The parents of four residents consented to take part. Two residents had little or no contact with their families, and had an appointed legal guardian. In both instances, the guardian was a Social Worker working within the community. Both guardians agreed to speak on the residents' behalf.

Therefore, six interviews were conducted in relation to six residents: four with parents of the residents of Kimberley House, and two with legal guardians.

6.3. Results

- **Domestic Skills**

Respondents were asked *"How important do you see the development of domestic skills (for example, cleaning, laundry, cooking) as being for your relative?"*. *Five* out of the six respondents indicated that they saw the development of domestic skills as being *"very important"* or *"important"* in the care that their relative/ward received. One individual

saw the development of domestic skills as being *"very unimportant"* for their relative/ward. This individual expressed concern that if their relative/ward developed such skills, he/she might reach a level of independence which would mean they would be considered suitable to live independently:

"No, I don't think it's important at all. I never would die happy if (X) *went into a flat, for he/she is not capable of it"*.

When asked how much importance they felt had been placed on the development of domestic skills within Kimberley House, three individuals stated that it was given *"a lot of importance"*:

"It's the only place that has asked him/her to take and do it (housework)*"*.

"He/she has one day off during the week, and that is what his/her day off is for, laundry and that sort of thing".

Three respondents were unsure as to how much importance the development of domestic skills had been given within Kimberley House. One of these respondents reported that their relative/ward had never been asked to do any domestic tasks while he/she had been visiting:

"As far as what happens when we are not there, you would need to ask the staff. I think they leave all his clothes in when they are washed, and he has to sort them out and put them into colours himself/herself".

Respondents were asked if their relative/ward had shown any improvement in domestic skills since moving to Kimberley House. Three respondents indicated that their relative had shown improvement:

"I have noticed when (resident) comes home at weekends, that instead of saying 'would you get me a drink, will you do this, will you help me take off my clothes, help me to get dressed' … he/she doesn't do that anymore, so it is obvious Kimberley House is helping … (resident) would straighten up his/her bed in the morning and things like that, there's a vast difference".

"He/she does more here in the house now (when at family home)*"*.

"He/she does more for himself/herself".

Two respondents felt that they were unable to comment as to whether or not there had been any improvement in domestic skills.

One individual stated that there had been no improvement in domestic skills of their relatives. However, from comments made, it would appear that this resident was not encouraged to take part in domestic chores while on home visits. Hence any improvement in domestic skills might not have been apparent to the carer:

"(resident) *knows no more about housework. I wouldn't even let him/her near a kettle. I wouldn't let him/her near anything in the kitchen"*.

This respondent indicated that he/she would prefer it if their relative/ward was not asked to participate in domestic tasks within Kimberley House. This seemed to be related to the respondent's perception that his/her relative was not capable of carrying out domestic chores:

"It's ridiculous, he/she shouldn't be asked to take and do that sort of thing. He/she is not capable".

- **Education**

Respondents were asked *"How important do you see education as being in the care your relative/ward receives?"*. All respondents felt that development of their relative's basic skills, for example, reading and writing, were *"very important".*

When asked to rate how much importance was placed on education within the Kimberley Project, four respondents stated that it was given *"a lot of importance"*, one stated that it was given *"quite a lot of importance"*, and one stated that it was given *"some importance".*

Four respondents highlighted improvements they had noticed in their relative/ward since their move to Kimberley House (see Figure 1).

One respondent stated that the Work Skills Centre did it's best in terms of basic education but felt that the their relative/ward had difficulties in relation to their attention span and memory capacity which meant that there was very little improvement in their educational ability:

Figure 1: Educational Improvement

"He/she learns quite a bit at college, and even going out shopping is an education in itself, and using the telephone, those are the everyday skills that are necessary for him/her … he/she never got the chance before, I suppose he/she was never out. I think he/she has improved well in those too".

"They (Kimberley staff) *have had him/her out at a computer course, and his/her writing has improved an awful lot".*

"In hospital he/she wouldn't have had the opportunities that he/she has in Kimberley House, so some things fell by the way side. But now he/she is doing all those things he/she likes, and he/she is doing them on a regular basis, and there has been an improvement certainly in his/her confidence".

"He/she is more practiced in his/her reading and writing and numeracy skills, and he/she has been trying to put them to practical use".

"His/her concentration span is not good, but I still think it is important that he/she is kept at it. He/she would jump from one thing to another and the staff at Kimberley and at Work Skills deal really well with that, they do their best".

One individual was unable to comment as to whether or not their relative/ward had shown any improvement in educational ability, as he/she did not read or write while at home:
"He/she doesn't do it (read & write) *here".*

- **Training**

Four respondents stated that training (for example, attending vocational courses, or developing skills which might prepare their relative for employment) was *"very important"* in the care that their relative/ward received:

"I would be keen for that, something to give him/her an interest … if he/she likes it".

"Everybody needs to feel like they have a purpose in life, and a job actually gives you that. I don't mean just a time passing job, a proper job".

One respondent stated that they would love to see their relative/ward in a job of some kind, but felt that it would never be possible:

"I don't see him/her ever doing a part-time job, much as I would love it to happen … because of his/her attention span, and the frustration. He/she gets terribly frustrated when he/she should be able to do something and can't do it".

One respondent felt that training was of *"very little importance"*. His/her relative had already had several work placements, all of which had failed after a very short period of time:

"I don't think he/she will ever be employed with anybody. We have had him/her out in factories before, and he/she only lasted two days in each job. He/she would just never make it in a job".

Four respondents felt that they were unable to comment on how much importance training was given within the Kimberley Project as they were not sure what their relatives did at the Work Skills Centre. The two remaining respondents felt that training was given *"a lot of importance"* within Kimberley House, but that the training was well paced, and *"very sensitive"* to the needs of the individual.

The four respondents who felt unable to comment on the importance given to training within Kimberley House, also felt unable to comment as to the progress of their relative/ward with regard to work skills. Two respondents noticed *"some improvement"* in the work skills of their relative/ward, one in terms of their willingness to work, and the other in terms of the variety of work activities their relative/ward was involved in:

"I would say he/she has improved in terms of his/her application. I think his/her motivation has probably improved (since going to live at Kimberley House)*"*.

"(resident) *has a lot more content in the range of activities that he/she does there* (at the Work Skills Centre)*"*.

- **Community Integration**

Respondents were asked *"How important do you see community integration (e.g., opportunities to get out and about and to develop friendships within the community) as being in the care your relative/ward receives?"*. Five respondents rated community integration as being *"very important"* in the

care received. One rated it as being *"important"*.

All six respondents felt that community integration was given *"a lot of importance"* within Kimberley House. All six reported that, since going to Kimberley House their relative/ward had shown *"very much improvement"* in terms of their community integration. They were able to give several examples of opportunities for community integration which Kimberley House offered (see figure 2).

Respondents often made reference to the fact that Kimberley House offered their relative/ward opportunities for integration which they could not provide:

"(resident*) gets far more stimulation at Kimberley House, at the end of the day, we're pensioners. He/she got very bored living at home"*.

Figure 2: Opportunities For Integration

"Well the staff take him/her out regularly out to different places, wee clubs and they go to the pub, they do the karaoke there. It's important, it means he/she is not stuck in the one place , and he/she is out enjoying himself/herself like everyone else".

"It's very important (relative/ward) *loves people. I know he/she goes down to the sauna once a week, and I know he/she goes to a car boot sale on a Sunday, and they have outings"*.

"It's very important. He/she goes to the library, and the leisure centre. That would be for everyone, so that is integrating. They get away on days out, and I know he/she enjoyed the panto, and he/she was at another one in the Arts Theatre. He/ she has been out to a few films. The others go to the pub on a Friday but I think (relative/ward) *went and found it a bit noisy and thought different about going"*.

"Everything before was done in the context of the hospital, now he/she is actually out in the community, and part of the community".

"He/she makes his/her own way around town, and is going to the local tech, and the pub and those sorts of things".

"(When at home), *he/she was just sitting about doing nothing, and he/she could see the difference* (between resident and other people of same age). *He/she was very cross about that and now he/she has gone to Kimberley, he/she is doing all sorts of things and is enjoying doing all those things, and enjoys talking about them"*.

"They (Kimberley House staff) *are able to take* (relative) *to places we can't go"*.

- **Behaviour Management**

Respondents were asked *"How important do you see behaviour management as being in the care that your relative/ward receives at Kimberley House?"*. Five respondents rated behaviour management as being *"very important"* in the care that their relative received while living at Kimberley House.

The sixth respondent rated behavioural

management as being *"unimportant"* in the care that their relative/ward received. This respondent reported that his/her behavioural problems had largely resulted from the frustrations of living at home. When he/she had moved out of the family home into a hospital setting there had been a great improvement in his/her behaviour:

"Whenever he/she went up to (hospital), *it was a real breakthrough, he/she really changed dramatically"*.

This behavioural improvement was reported to have been maintained since he/she had moved from the hospital setting to Kimberley House. As a result, the respondent felt that behavioural management was no longer an important issue for his/her relative/ward. He/she did, however, acknowledge that it was an important issue for some of the other residents living at Kimberley House.

All six respondents reported that behavioural management was given *"a lot of importance"* within Kimberley House. Five of these respondents spoke about the improvements they had noticed in the behaviour of their relative/ward since they had gone to live at Kimberley House (see Figure 3 overleaf).

- **Emotional Needs**

Respondents were asked *"How important do you see your relative's/ward's emotional needs as being in the care that he/she receives?"*. Five respondents rated their relative's/ward's emotional needs as being *"very important"* in the care that they received, one respondent rated them as being *"important"*.

All six respondents stated that *"a lot of importance"* was given to their relative's/ward's emotional needs within Kimberley House. All six reported that the emotional stability of their relative had *" very much"* improved since going to live at Kimberley House. Respondents reported seeing a variety of changes in their relatives emotional state (see figure 4 overleaf). These ranged from feeling respected, to being made to feel that they were experiencing a normal life, to being more emotionally aware.

- **Visiting Times**

All six respondents indicated that they could visit Kimberley House at any-time, and that they were made to feel welcome by staff and residents alike.

Figure 3: Behavioural Improvements

"I think the staff manage him/her very well. They don't argue with him/her, they don't put him/her down, and the fact that they don't put him/her down would make him/her more amenable to them. They treat him/her with respect. I think they do a great job. He/she might have a tantrum but nothing on the scale that it used to be. His/her temperament has settled a lot since he/she went to Kimberley".

"He/she is an awful lot better since he/she came down here (to live at Kimberley House). *I couldn't handle him/her myself. He/she would have went out the back screaming and kicking the gate and all. He/she never bothers*

with anything like that now. He/she is quite content. He/she is a lot calmer".

"His/her behaviour is quite good now, he/she has quietened down (since moving to Kimberley House), *he/she is quite content".*

"He/she is very motivated to be in Kimberley, very motivated, not to return to the hospital, , and I think that has a good effect on his/her behaviour".

"I measure success by the length of time he/she has been there. I mean if I look at the length of time to date, it has been a success, it has been an improvement on other placements"

Figure 4Emotional Changes

" (Staff) *treat him/her with respect … they have given him/her dignity. He/she has found his/her niche and is as happy and content as he/she can be".*

"He/she feels that he/she is living a normal life, whereas before, he/she was just sitting around doing nothing".

"We took him/her anywhere he/she wanted to go, but it was just us and he/she needed people of his own kind to get on with. That is his/her family over there (in Kimberley House) *now".*

"He/she is more stable now".

"He/she is getting able to recognise what he/she is feeling, and instead of reacting to things through his/her behaviour, he/she is learning appropriate responses to it".

"They (the staff) *give him/her respect, and he/she likes that. He/she is encouraged, and gently lead, not ordered. He/she obviously gets the attention he/she needs"*

Two respondents made reference to the fact that circumstances often meant that they could not visit their relative at Kimberley House as often as they would like. Both of these respondents reported that Kimberley House had been very helpful and flexible, and had made arrangements for their relative to visit them at their home on several occasions:
"This past year, we haven't been able to get down (to Kimberley House), *but they* (the Kimberley House staff) *bring him/her up and down to see us".*

One respondent made reference to the fact that Kimberley House is always locked yet there was often no-one around to answer the door bell:

"Sometimes there doesn't seem to be anybody around, so actually getting in can sometimes be a problem. And the door bell doesn't actually seem to be a doorbell, it seems to set some buzzer off".

- **Kimberley House**

Respondents were asked for their views about Kimberley House itself.

(i) The Building And Furnishings.

Respondents were asked for their views on the building and the furnishings. All six respondents were very positive about both the building and the furnishings:

"We like the way the rooms are, and they (the residents) *all had their choice of colours. The whole place is very nice".*

"Oh, it's lovely now it's first class, it's really beautiful. (resident's) *room is lovely, and lovely and warm too. Everything about it is lovely".*

One respondent commented on how homely the furnishings were:

"It's not like a home, it's like home, that is the best way I can describe it".

(ii) The Location

Respondents were asked for their views on the location of Kimberley House. Three respondents reported that they liked the fact that Kimberley House was central to the town, where the residents could be part of the community:

"It's close to the town centre, so they (the residents) *can actually walk places. It's nice that it* (Kimberley House) *is in among other houses and things, and are not sort of stuck away as if they* (the residents) *were people who had to be hidden".*

"I think it is important that it (Kimberley House) *is close to the town centre. People, like (relative/ward) used to be locked away, and handicapped or not, they need to be in the community".*

Respondents reported that they liked the fact that Kimberley House was convenient for visits:

"It is as central as anything. I can get a bus to it if I need to. Whereas, when (relative) *was in hospital, you just couldn't afford it … we would never have seen him/her".*

"Oh, I like it where it is, any further away, and (relative), *couldn't come to see me. I would never see him/her if he/she was still in hospital".*

Two respondents (one of whom had reported liking the fact that Kimberley House was central), stated that their one criticism of Kimberley House was that it did not have a garden:

"The only thing ever said was wrong with Kimberley House was that there wasn't more grounds to it. It would be lovely if they had a bit of garden".

(iii) The Atmosphere

Five respondents were very positive about the atmosphere within Kimberley House. These respondents reported that they found Kimberley House to have a friendly and welcoming atmosphere:

"I think it is really homely. I'm sure you've gone into a house yourself where you felt you weren't welcome, just the atmosphere. Well the atmosphere in Kimberley House is good, always was from the first day we went into it".

"It's very bright, and very heartsome".

"The atmosphere (in Kimberley House) *is not oppressive … we went to various places* (other homes) *, and they themselves were grim, but the atmosphere was even more grim. There's a good mix, and everybody seems happy enough, all the residents. That comes across because you see them all chatting and talking. It's just more homely".*

One respondent reported that while Kimberley House was a lovely building they were still very aware that they were going into *"some kind of institution".* This individual could not pin point why the building did not feel like *"coming into a person's home",* and so could not think of any suggestions for changes which would enhance the atmosphere of the building, or make it more homely.

(iv) The Level Of Cleanliness

Five respondents stated that they were very happy with the level of cleanliness maintained within Kimberley House. A typical quote was:

"Fantastic, I wish I could keep it up!".

One respondent stated that there had been a period when they had been concerned about the cleanliness of their relative's bedroom, but that this situation had been resolved.

(v) The Food

Five respondents reported that the food at Kimberley House was good**:**

"He/she (resident) *enjoys the food, he/she loves the menus".*

"I don't know, but if the food wasn't good I would have heard about it".

However, one individual stated that he/she would like the residents to be given less processed foods:

"Food that is wholesome, and not too many additives … not as many oven chips and I'd prefer if they didn't have beef burgers at all because of this mad cow disease".

Another respondent stated that the portions could be increased:

"He/she is big, and it would take more grub for him/her than the rest of them".

(vi) Staffing Levels

Respondents were asked, *"Do you think that there are enough staff on duty at any given time?".* Three respondents felt unable to comment on staffing levels. Three respondents reported that as far as they could see, staffing levels appeared to be adequate. However, one of these respondents went on to say that news reports about cut backs in the National Health Service generally did give them cause for concern. He/she emphasized that any such cut backs within Kimberley House would be detrimental to the care provided there:

"It is essential to keep the staff level they have".

- **Level of Involvement**

Six respondents reported that they found the staff at Kimberley House to be approachable, and could speak to staff at Kimberley House about their relative's progress as often as they wanted to, either by telephone, or when they visited there:

"They (staff) *do talk, they don't dash about and say they haven't time, and they have always been extra sympathetic with relative when he/she needed a bit of sympathy, and when he/she needed a bit of extra care, he/she got that too".*

"They (staff) *always have plenty of time for me, and they would always ring me if there was anything* (I needed to know)".

One respondent reported that he/she had little contact with the staff at the scheme. When asked if they would like to have more contact with staff, he/she stated that he/she was happy with things as they were:

"It's alright the way it is".

Another respondent reported that while they could approach staff at any time, he/she would like to have more formal meetings where they could get together with the Scheme Manager, and other parents, to discuss any current issues, or maybe to become involved in fundraising:

"It would be nice to have a meeting, maybe every three months, with the manager of the place, and maybe meet some of the other parents if they can come".

This individual reported that their relative did not speak very much about life within Kimberley House and so they felt that such meetings would be a good way of keeping them informed. For example, they had only a very vague idea of what their relative did at the Work Skills Centre.

Both guardians reported that they were happy that they were regularly consulted as to the care and progress of their ward.

- **Management Changes**

Kimberley House had three different Scheme Managers within the first eighteen months of its operation. Respondents were asked whether or not they felt these changes had impacted on the care that their relative had received. Four respondents reported that these changes in management had not impacted on the care that their relative/ward received as the same direct care staff had been there throughout, so some continuity of care had been maintained:

"I don't think the manager makes an awful lot of difference to a place like that … the staff either make or break a place like that".

Two respondents stated that their relative had found the management changes unsettling:

"(Relative/ward) *makes friends with them* (Scheme Managers), *and then they go away,*

and that upsets him/her for a while".

One of these respondents felt that they could have been informed about imminent changes in management in advance of the actual change over:

"I had no idea there was a management change coming, one day (the Scheme Manager) *was there, and the next, he/she wasn't".*

- **The Move**

All four family members interviewed reported that they had been asked about the kind of care that they wanted for their relative by both the Consultant Psychiatrists within the hospital, and by the Programme Manager of Challenge or the Scheme Manager. This consultation occurred even before Kimberley House had been built. All four reported that they were happy that their views had been taken into consideration. A typical quote was:

"(Programme Manager of Challenge) *came out to see us before the place was really built and talked to us about what we would like to see in a residential home that* (relative) *was living in, and we told him/her what we had told the consultant psychiatrist in the hospital … and it has all come to pass in Kimberley".*

All family members interviewed reported that the move from the hospital or family home, to Kimberley House had been handled well. All residents had been introduced to Kimberley House gradually, and had been made to feel welcome during those introductory visits. A typical quote was:

"It (the move) *was handled brilliantly.* (Scheme Manager) *came down and talked to* (relative), *and brought colour charts down, and he/she picked the colours he/she wanted for his/her room. He/she went up for a couple of days, then a weekend, and when he/she did go there to stay, there was a present for him/her. I thought their* (the residents) *pictures in the hall, and the fact that there was a gift for everybody when they arrived was great".*

As well as being consulted by Challenge about their views, parents reported receiving a lot of information and support from the Consultant Psychiatrists within the hospital, Care Managers, and Social Workers. All parents interviewed indicated that any fears they might have had about the move were allayed when they saw the building itself:

" We went down to see it (Kimberley House) *while the builders were still at it, and we walked around and looked at some of the rooms, and looked all around, and we knew it wasn't going to be a big place, and that there wasn't going to be four to a room as some places are".*

"I used to be worried about the other places (other homes he/she had viewed), *but see once Kimberley House came up, I had a different feeling about it completely … the atmosphere was so different there".*

Two respondents went on to say that Kimberley House had been the first place their

relative had lived, which they looked forward to going back to following a visit home:

"(In other places) *it would have been a fighting match to get him/her to go back* (after a home visit)*, but not now".*

Parents were also more relaxed because they already knew some of the other residents who would be living there, and also some of the staff who would be working there:

"We knew (names two other residents) *so we were pleased about that, and then* (names two staff members whom they had known from the hospital) *got jobs there, so we were delighted about that".*

Similarly, it was reported that the residents themselves appeared to have been very positive about the move to Kimberley House. The initial visits before the move seemed to have been an important factor in this:

"He/she (relative) *was a wee bit apprehensive* (about the move)*, but the first time he/she went* (to visit Kimberley House), *he/she was as happy".*

"Oh, (relative) *liked it well* (after he/she had visited)*, and still likes it. No, he/she was looking forward to it* (the move)*".*

- **Problems/Complaints**

None of the respondents could recall ever being given any information about the complaints procedure for the Kimberley Project. All four parents interviewed indicated that they would feel okay about making a complaint if they had one. Three respondents reported that they would discuss any complaints with the Programme Manager, the Scheme Manager or their relative's key-worker. A typical quote was:

"If I was really worried I would ring (the Programme Manager)*, I would go straight to the horse's mouth. She is a very approachable person, so I would ring her".*

However, one respondent reported that they did not really know the Scheme Manager, and did not know the telephone number of the Programme Manager. As a result, this individual reported that they would probably direct any complaints to the Social Services Inspectorate.

Where respondents felt that Kimberley House placed less emphasis on a particular area of care (this only occurred on two occasions in relation to one respondent), the family member or guardian was asked if he/she had discussed this discrepancy with the staff at Kimberley House. In both instances, he/she had not discussed it with staff. The respondent reported that he/she would talk to staff if he/she had a serious complaint or a worry regarding his/her relatives well-being or safety:

"If there was something we really didn't like, something we were worried about, like if he/she (relative) *was put in some danger, or that he/she was bullied by another resident or something we would certainly hang back and talk about it".*

However, where they had a more general concern or query about the care their relative received, or a suggestion for improvement (for example with regard to the quality of food within Kimberley House), this respondent seemed reluctant to speak out:

"We don't raise anything because we wouldn't want to rock the boat, and we don't want to get on the wrong side of staff because we are happy enough with the whole thing, so we are not going to go looking for trouble".

- **Variety In Daily Activity**

Respondents were asked *"Generally, do you feel your relative/ward has enough variety in his/her daily activity?"*. All six respondents felt that there was enough variety in the day-to-day activities of their relative/ward. A typical quote was:

"Yes, he/she has life now, that he/she never had before".

- **Feelings One Year On**

Respondents were asked *"How does your relative feel about living in Kimberley House now that he/she has been living there for one year?"*. All six respondents reported that their relative/ward enjoyed living at Kimberley House, and while it was reported that some residents wanted to progress onto more independent living in future years, at present, they were very content to stay at Kimberley House. A typical quote was:

"He/she loves Kimberley House. Kimberley House is home. He/she is definitely happy and content there".

One respondent went on to say that their relative/ward's liking for Kimberley House was not merely based on the fact that life there compared well to the hospital where he/she had previously lived:

"Initially I think it was the contrast to the hospital (that relative liked), *but I think he/she has moved on from there now, and it is now a positive thing that he/she likes Kimberley, as opposed to it just being better than the hospital".*

- **Like Most About The Service**

Respondents were asked *"What would you say you like most about the service provided at Kimberley House?"*. Respondents reported a variety of aspects of the service which they particularly valued: the fact that their relative/ward was treated with respect within Kimberley House; that Kimberley House was homely rather than institutional; the quality of care provided by the staff, and their ability to deal with challenging behaviour; the staff to resident ratio; the flexibility in arranging visits; and the individual care and attention provided (see figure 5).

- **Like Least About The Service**

Respondents were asked *"Is there anything about the service you are not so keen on or are unhappy about?"*. Five respondents could not think of anything about the service that they did not like. A typical comment was:

"(There is) *nothing* (I don't like). *I honestly don't think so, they cover everything".*

Figure 5: Like Most About The Service

"The fact that challenging behaviour doesn't put them off, and I like the high ratio of staff, then people don't feel left out. They (the staff) *seem motivated to enhance residents' quality of life, not just to maintain it".*

"They (the staff) *respect* (relative), *and the other residents there. As I said before, it's not a home, it is home … and you couldn't speak highly enough of the staff".*

"They (the staff) *are willing to bring* (relative) *over here* (to visit), *so it's flexible both ways … and they would ring me if* (relative) *had an off time, they would keep me informed".*

"Any time he/she needed that wee bit of extra care and attention, he/she was pampered".

"The attention that they (the staff) *give … individually".*

One respondent commented on the high cost of providing the service, but went on to say that they felt it gave *"value for money".*

- **Suggestions For Improvements**

Two respondents made suggestions as to how Kimberley House could be improved:

- the first suggestion related to food provided at Kimberley House

- another suggestion was that a daily newspaper could be bought for the residents to read:

"One wee thing would be to buy a newspaper every day and leave it sitting so that those who want to read one can. It is a part of normal life".

- One respondent reported that they had ordered some craft goods at one of the fairs held by the Work Skills Centre, and that this order had not been filled six months later. He/she felt that if existing orders were filled, and new ones were created, it would make residents' work more meaningful, and would be a way of raising funds:

"It is important that if they get orders, they fulfill them … they need the money, it is a charity, and I'm sure that place (Kimberley House) *is expensive to run. If they were to seek out orders and make them in Work Skills, then that's a proper job for everyone".*

- Another suggestion was that outings should not always be planned, and that more activity should be done on the spur of the moment:

"They (staff & residents of Kimberley House) *don't seem to do very much on the spur of the moment … you know if it is a nice day 'I think we'll all go here' and they could all jump in the people carrier and off they go. There is nothing to stop them doing that".*

- Finally, it was suggested that a new doorbell with a normal ring might be less intimidating for visitors to Kimberley House.

- **Other Comments**

Finally, respondents were asked *"Is there anything else you would like to say about the service?"*. Three respondents talked about the difficulties they had in trying to find a suitable place for their relative to live, the relief that finding Kimberley House had brought, and how this had impacted on their own quality of life:

"I can go to my bed and sleep now, I know (relative) *is being looked after, and I don't have to worry. That is his/her wee family over there now"*.

"(Relative) *was in respite in a few places. He/she was in a place in* (X), *and it was a disaster, and in another place in* (Y), *and it was a disaster, he/she only stayed there five days … but he/she seems happy at Kimberley House. He/she wouldn't like to have to go out of it"*.

"I feel so much happier than I have done for years because I was always worried about the future. It has improved all our lives really".

The remaining three respondents had nothing further to add other than that they were generally very happy with the service provided. A typical quote was:

"I am very happy with the way it is going, the staff are approachable, they always have time, and they take a great interest in (relative)".

7.0. Background

As stated in the general introduction, this evaluation aimed to provide a holistic and comprehensive view of the service provided at the Kimberley Project. As key stakeholders in the Kimberley Project it was important to obtain the views of statutory professional, involved in the care of residents, regarding several aspects of the service provided.

7.1. The Methodology

The views of professionals associated with the service were obtained via a postal questionnaire. The questionnaire was designed specifically for the purposes of this evaluation, and consisted primarily of closed response questions. There were also a number of open-ended questions where respondents were invited to give specific comments, and they were encouraged to be as detailed in their responses as they could be. The respondents were asked to rate their level of satisfaction with several aspects of the service provided: the quality of the building itself; the location of the building; the support provided to clients in relation to their needs, the location of the Work Skills Centre; the resources and activities available at the Work Skills Centre, and communication with staff at the project.

7.2. The Sample

Two statutory professionals were approached in relation to each resident, a Consultant Psychiatrist and a Care Manager. Where a resident did not have either a Consultant Psychiatrist or a Care Manager, their Social Worker was approached. Only one professional was approached in relation to two residents as their Social Workers had already been approached, as legal guardians, to participate in the *Carer Interview.*

Due to some overlap in terms of the professionals associated with each resident, a total of eight professionals were approached for information: three Consultant Psychiatrists, three Social Workers, and two Care Managers.

Questionnaires were returned by five of the professionals approached, providing information in relation to eleven residents. One of the professionals approached returned comments in a letter format and these are also incorporated into the findings.

7.3. The Results

- **The Exterior Of Kimberley House**

Respondents were asked to rate their level of satisfaction with the quality of the exterior of Kimberley House. Two respondents stated that the exterior of Kimberley House was *"excellent":*

"It is always clean and tidy, and the exterior windows and doors are in good condition".

"Attractive building in very good state of repair".

Three rated it as *"good"*. One of these individuals stated that, while Kimberley House was well built, it had no *"surrounding grounds"*.

- **The Interior Of Kimberley House**

Respondents were asked to rate their level of satisfaction with the quality of the interior of Kimberley House. Three respondents rated the interior as *"excellent"*. A typical comment was:

"It is tastefully decorated and clean".

Two respondents rated it as *"good"*. However, while one of these individuals felt that Kimberley House was *"in good decorative order"*, he/she found the architecture of the building to be *"a little hotel-like"*.

- **Location In Terms Of Accessibility**

Respondents were asked to rate their level of satisfaction with the location of Kimberley House in terms of accessibility to local amenities. One respondent rated the accessibility of Kimberley House to be *"excellent":*

"Location is 5 minutes from town centre , pubs, clubs, shops, leisure centre, technical school".

Three respondents rated the accessibility to local amenities as *"good"*. One respondent rated accessibility to local amenities as *"fair"*. He/she stated that:

"The physical distance of the residential unit for all local amenities is greater than would be ideal for any person who requires some degree of supervision".

- **The Surrounding Environment**

Respondents were asked to rate their level of satisfaction with the location of Kimberley House in terms of the surrounding environment. Two respondents rated the surroundings as *"good"*. One of these individuals felt that Kimberley House being located amidst ordinary housing, and near a school was a good way of *"trying to integrate residents"*. The other respondent did not give a reason for his/her rating.

Three respondents felt that the surroundings were *"fair"*. Two respondents stated that they felt that Kimberley House could be further away from the local school, and could *"have a lot more ground around the building"*. The other did not give a reason for his/her rating.

- **Support**

Respondents were asked to rate their level of satisfaction with the support offered to their client in relation to their: physical needs, mental health needs, behaviour management, and their social needs.

As Table 1 shows, respondents were generally *"very satisfied"* or *"satisfied"* in relation to the support provided in all areas of client need. Reasons for satisfaction included: the individual programme planning allowed by the key-worker system in operation at the project; the good working relationship between staff and residents, and an observed improvement in the resident's behaviour or general well-being since going to live at the project (see Figure 1 overleaf).

Table 1: Respondent's Satisfaction with the Support Provided to their Clients in Relation to Four Areas of Need.

Client Need	Very Satisfied	Satisfied	Somewhat Dissatisfied	Very Dissatisfied
Physical Needs	**6**	**5**	**0**	**0**
Mental Health Needs	**5**	**5**	**1**	**0**
Behaviour Management	**6**	**4**	**1**	**0**
Social Needs	**6**	**4**	**1**	**0**

One respondent reported that they were *"somewhat dissatisfied"* with the support provided to their client in relation to their mental health needs, behaviour management, and social needs. This respondent reported that it had taken *"a rather longer time than might have been hoped to secure agreement from Challenge staff that the assessment of the clients needs made by those who had previously cared for him/her* (in hospital) *was correct, and thus to be confident that the agreed package* (of care) *would be delivered in all its aspects"*.

Four out of five respondents reported there were no changes needed in relation to the support provided to their client. One respondent reported that the support provided to their client was the *"subject of ongoing negotiation and review"*.

- **The Work Skills Centre**

i. The Location

Respondents were asked to rate their level of satisfaction with the location of the Work Skills Centre. One respondent rated the location of the Work Skills Centre as *"good"*. This individual liked the fact that the Work Skills Centre was away from Kimberley

House, and that residents had to travel to get there. He/she felt that this was a more normal

Figure 1: Reasons For Satisfaction With Client Care

"The key-worker system allows for close supervision of resident and enables the staff to build up a good working relationship with the person so they can plan appropriately to meet the needs of the resident in this environment".

"Has a supportive relationship with staff who know and understand his/her difficulties".

"There has more or less been a consistent improvement in his/her general well-being since his/her move to Kimberley House".

"Resident's mental health difficulties have been recognised, and staff have been trying to create a more independen,t supported structure to better meet his/her needs".

"Good physical care and mental health care. His/her behavioural programme has been successful: this is evident in the decrease in incidents and better co-operation from him/her".

situation for residents, it was like *"going to work".*

Two respondents rated the location of the Work Skills Centre as *"fair",* while two respondents rated it as *"poor".* The general feeling appeared to be that the Work Skills Centre was too remote, and therefore did not promote community integration:

"The Conlig site is separate from the Kimberley House site which is a good thing, but it is rather remote from the town , and could have been better sited, say, in an industrial complex closer to the town".

"Too far away (from town) *to facilitate independence".*

ii. The Facilities

Respondents were asked to rate their level of satisfaction with the facilities or resources (e.g., the work space, the building, materials and staffing levels) provided at the Work Skills Centre. Two individuals rated the facilities or resources as *"good".* One of these individuals commented *"the resources available appear adequate*". The other individual reported that, as far as they were aware, the facilities and resources provided at the Work Skills Centre were good. However, he/she went on to say that he/she had only visited the centre on two or three occasions.

Three individuals rated the facilities or resources as being *"fair".* One reported that the building in which the Work Skills Centre was based could be more *"user-friendly",* and did not really *"equate with other normal working environments …it was not purpose built for work purposes".*

iii. Activities

Respondents were asked to rate their level of satisfaction with the activities available at the Work Skills Centre. One respondent rated the activities available as *"excellent"*:

"The reports (provided by staff at Kimberley House) *indicate a wide range of well designed activities"*.

Three respondents rated the activities available as *"good"*. A typical comment was:

"Good range of different activities considered for each resident, and made available".

One individual went on to say that the staff at the centre offered their client a lot of encouragement and support in his/her activity at the centre. They felt that this was very important as their client *"often lacks motivation"*.

One individual rated the available activities as being *"fair-to-poor"* initially. He/she stated that they hoped that activity would have improved since that time as the *"clients have settled down"*.

iv. Changes or Improvements

Two respondents reported different changes that they would like to see within the Work Skills Centre:

"Re-siting the centre".

"A more purpose built, cleaner, and brighter working environment".

Two individuals reported that they had no suggestions for changes they would like to see within the Work Skills Centre, and one respondent did not comment.

- **General Outcome**

Respondents were asked *"Generally, what has been the outcome for your client after living in Kimberley House and attending the Work Skills Centre for approximately one year?"*. Four out of five individuals responded to this question, providing information in relation to eight residents. Outcome was described *as "very good"* in relation to two residents. One respondent reported several reasons why he/she felt Kimberley House had been a successful placement for their client:

" (client) has settled into Kimberley House and states that he/she is happy there. (client) cooperates well with staff, and his behavioural programme has been very successful. He/she benefits from many social activities which have resulted in him/her being more independent, i.e., travelling alone".

Outcome was described as being *"good"* in relation to six clients. Reasons for this were given in relation to two clients:

"Client has made satisfactory progress".

"Individualised to work at the client's own pace".

- **Communication With Staff At The Project**

i. How Information Is Communicated

Respondents were asked *"How satisfied are you with how information is communicated to you by staff at the project?"*. *Two* respondents reported that they were *"very satisfied"* with

how information was communicated to them by staff. Two respondents reported that they were *"satisfied"*. Typical comments were:

"Excellent - reports are thorough and typed, and good communication from staff with regard to any changes to the care plan or need for review".

"Well laid out written communication, and prompt and helpful telephone answering".

One of these individuals, while expressing general satisfaction with how information is communicated, reported that he/she would like some of the written reports to be more *"concise"*.

One respondent reported that they were *"somewhat dissatisfied"* with the way in which information was communicated to them. He/she did not explain the reason(s) for their dissatisfaction, stating that they had raised the issue with Challenge staff and that the situation was *"improving"*.

ii. Extent To Which Up-To-Date Information Is Available

Two respondents reported that they were *"very satisfied"* with the extent to which up-to-date information on their client was made available to them. Another two reported that they were *"satisfied"* with this, and one did not comment. Reasons for satisfaction were as follows:

"Regular reviews are held - minutes are shared extensively and efficiently".

"Staff have always been very courteous and co-operative".

iii. Quality Of Working Relationship

Four respondents reported that they were *"very satisfied"* with the quality of the working relationship they had with staff at the Kimberley project. One respondent reported that they were *"satisfied at present"*.

One respondent reported that while they had infrequent contact with Kimberley House staff between reviews, they had always found the staff *"very approachable, and very helpful"*. Another respondent reported that the staff at the Kimberley Project had *"Good collaboration with Trust* (Health & Social Service Trust) *staff"*.

There were no suggestions from respondents as to how their working relationships with Challenge staff could be improved upon.

- **General Issues**

i. Success in Facilitating Community Integration

Respondents were asked to rate the extent to which the accommodation and Work Skills projects had been successful in facilitating community integration. Two respondents reported that the project had been *"very successful"* in facilitating community integration, two respondents reported that the project had been *"somewhat successful"* in this. A typical comment was:

" … staff at Kimberley House endeavor to

integrate residents into the community through social activities".

One individual reported that Kimberley House had been *"somewhat unsuccessful"* in their attempts to facilitate community integration:

"I do not feel that true integration has been achieved but would agree that efforts are being made towards it".

One respondent felt that *"the architecture, layout and location"* of the accommodation and Work Skills services made integration *"really quite difficult"*. While acknowledging that "*a number of points of contact*" had been made within the community, they felt integration could be better facilitated by moving the Work Skills Centre to a more central location.

Another suggestion as to how community integration could be further promoted by the service was to hold open days and to set up a befriending service for residents:

"Open days. Befriending recruitment through the local churches".

ii. Strongest Aspect of The Service

Respondents were asked *"What do you think are the strongest aspects of this service?"*. They reported a number of areas of the service which they valued. All of these referred to the staff working at Kimberley House:

"The respect for and valued nature of the clients as individuals which is clearly evidenced by staff".

"The professionalism of the staff".

"The management of challenging behaviour. Skilled, competent management and staff team".

iii. The Weakest Aspect Of The Service

Respondents were also asked *"What do you think are the weakest aspects of this service?"*. One respondent, who had previously reported that the staff had failed to accept his/her assessment of his/her client's needs, cited this as one of the weakest aspects of the service:

"Initially the lack of understanding of the complex needs of the clients referred, and a philosophical reluctance to acknowledge this".

It was felt that this had improved over time as had "*the skills base of the staff - without loss of the positive attitude* (towards residents)*"*.

One individual commented that:

"The primary care responsibility is to have an in-depth knowledge of each individual and particular difficulties arising from each particular problem the patient has and how this may lead to an overall deterioration if not addressed promptly. Any interventions by the secondary level service must be implemented swiftly and monitored accordingly by both the

primary care staff and staff within the residential unit"

This individual cited a number of instances where this had not occurred despite feeling that, overall, the Kimberley Project was an *"excellent much needed unit"*. The examples cited were:

- an instance where there was a rapid deterioration in a resident's mental health, difficulty was experienced in getting local community staff involved to provide an urgent assessment.
- in two instances changes in medication recommended by the secondary level service were not implemented
- The individual was unaware of the involvement of a clinical psychologist in Kimberly House who had "a high level review of his/her management, in particular with specialist psychology involvement ready to address any significant deterioration in overall behaviour". In fact, Kimberly House employs an in-house clinical psychologist on as sessional basis.

Two respondents reported that they could see no real weaknesses in the service. One respondent did not comment.

One individual took this opportunity to acknowledge the complexity of the role that the staff at the project were trying to fulfill:

"Balancing the needs of a group with challenging behaviour at the same time as achieving integration must be very difficult".

iv. Any Other Changes

Respondents were asked *"Are there any other changes you would like to see in the service provided?"*. Only one individual reported that he/she would like to see a change in the service. He/she stated that while they were generally very happy with the service provided, their *" wish would be to have three or four smaller units instead of one residential home".*

8.4. Findings: The Staff Group

At the time of the evaluation there were twenty-seven staff. A total of twenty-three staff members completed the OSI and the accompanying biographical form.

The biographical form collected basic biographical details. It also examines some other factors that may effect how an individual perceives stress, and how they attempt to cope with it. Finally, it asks respondents about any sources of stress that they may be experiencing outside the work setting.

A. The Demographics of the Group

- There were twelve male members of staff and eleven females.
- Fourteen staff members were aged between 21-36 years, the remaining nine were aged between 37-55 years.
- Mean age on leaving education was 18 years (min 15; max 30).
- Two staff members had no formal qualifications, eight were educated to O' level standard or equivalent, six were educated to A' level standard or equivalent, six were educated to degree level or equivalent and one was educated to the level of a higher degree.
- Seven staff members belonged to a professional body, the remaining sixteen did not.
- Staff had been working with the Kimberley Project for an average of ten months (min three months; max twelve months).
- Staff had worked in jobs, prior to their current job, for an average of 3.7 years (min one year; max fourteen years).
- Prior to their jobs on the Kimberley Project: fifteen staff members had worked in a community care setting; four had worked in a hospital care setting; three had worked in some "other" setting. one individual did not respond to this question.
- Seventeen respondents worked within the accommodation scheme: six of which performed a managerial or administrative role, and the other eleven were responsible for direct care.
- Six respondents worked at the Kimberley Project Work Skills Centre: one performed a managerial or administrative role, five were responsible for direct care.

For all twenty-three members of staff, the Kimberley Project provided their only source of employment.

B. Our Sample Compared to the Combined Sample

When the Kimberley House sample was compared to the combined normative sample (n=7000 - 8000) on all subscales, it fell within ½ standard deviation of the norm mean on twenty-four out of twenty-eight sub-scales and within 1 standard deviation on the remaining four.

Therefore, we can conclude that the Kimberley Project group does not differ substantially from the general population on any of the OSI sub-scales.

C. Our Sample Compared to the Comparison Sample

When the same comparisons were made with the comparison sample (n=45) of nurses working in a learning disabilities unit, the findings were similar. On twenty-two out of the twenty-eight sub-scales the Kimberley Project group scored within ½ a standard deviation of the comparison group mean and within 1 standard deviation on the other six.

The following results will focus primarily on the Kimberley Project group and issues within that group. The results will be presented within the framework of the four key elements of the model of stress on which the *Indicator* is based: Sources of pressure or stress; Individual Characteristics; Coping Strategies, and Individual Effects.

8.5. Sources of Stress (Scale: Sources Of Pressure In Your Job)

This scale looks at the first element in the OSI model of occupational stress: sources of stress in the work environment. The scale is divided into six sub-scales. These are presented in sequence, from those factors acting as the main sources of pressure in the work place, to those which seemed less problematic for the sample.

i. Organisational Structure and Climate

This sub-scale examines the extent to which the structure and climate of the organisation acts as a source of pressure for staff members.

- 78% (n=18) indicated that working with *"Insufficient finances or resources"* was a source of pressure.

- 74% (n=17) reported that a source of work pressure was the *"Lack of consultation and communication"* they experienced. This was "definitely" or "very definitely" a source of pressure for thirteen individuals.

- 65% (n=15) felt frustrated by *"Staff shortages and unsettling turnover rates"*.

- 61% (n=14) of respondents, indicated that a source of pressure for them was that they had *"Inadequate guidance and back up from superiors"*.

- 57% (n=13) felt frustrated by *"inadequate feedback"* about their performance

- For 52.1% (n=12) the process of *"Sharing work and responsibility evenly"* was a source of pressure within the workplace.

- 48% (n=11) reported that general causes of frustration were:
  - ⇒ *"Covert discrimination and favouritism"*.
  - ⇒ *"Morale and organisational climate"*.

- 44% (n=10) of respondents felt that *"Inadequate or poor quality of training/management development"* was a source of pressure for them.

ii. Career and Achievement

This sub-scale looks at the extent to which lack of opportunity for the respondents personal development (as facilitated within their job role) acts as a source of pressure.

- 74% (n=17) reported that the feeling of *"Being undervalued"* was a source of pressure for them. For eleven individuals, this was "definitely" or "very definitely" a source of pressure.

- *"An absence of any potential career advancement"* was reported to be a source of pressure for 65% (n=15) of respondents.

- 48% (n=11) cited *"Unclear promotion prospects"* as a source of pressure.

- 30% (n=7) felt that they had been *over promoted*, beyond their level of ability. The same percentage of respondents felt that a source of stress for them was that they were experiencing *"under promotion"*, that is, were working at a level below their ability. The remaining 39% of the sample (n=9), reported that their job role fairly reflected their level of ability.

iii. Factors Intrinsic To The Job

This sub-scale examines the extent to which the actual tasks that individuals spend their day doing, act as a source of stress.

- 83% (n=19) of respondents rated the *"Rate of pay (including perks and fringe benefits)"* as a source of pressure. This was "definitely" or "very definitely" a source of pressure for eleven individuals.

- 61% (n=14) indicated that *"Factors not under your direct control"* were generally a source of pressure in the workplace.

- 57% (n=13) identified *"Having far too much work to do"* as a source of pressure.

- 52% (n=12) indicated that *"Having to work very long hours"* was a source of pressure.

iv. The Job Role (Sub-scale: The Managerial Role)

This sub-scale looks at the extent to which trying to live up to the role they are in acts as a source of pressure for individuals in the work place. It looks at several aspects of the job-role: role ambiguity; the balance between responsibility and degree of power, and whether or not the respondent sees himself/herself as being capable of the role demands.

- 52% (n=12) indicated that the following were sources of work pressure:
  - ⇒ *"Conflicting job tasks and demands in the role I play"*.
  - ⇒ *"Having to adopt a negative role (such as sacking someone)"*

- 48% (n=11) indicated that *"Ambiguity in the nature of the job role*" was a source of pressure.

- 44% (n=10) of the sample, indicated that the following were general sources of pressure for them in their work:
  - ⇒ *"Lack of power and influence"*
  - ⇒ *"Personal beliefs conflicting with those of the organisation"*
  - ⇒ *"Changes in the way you are asked to do your job"*.
  - ⇒ *"Implications of the mistakes you make"*.

v. Relationships with other people

This sub-scale reflects the level of pressure experienced as a result of interpersonal relationships within the workplace.

- 52% (n=12) reported that general sources of pressure in the workplace were:
  - ⇒ *"lack of encouragement from superiors*".
  - ⇒ *"Misuse of time by other people"*.
- 48% (n=11) reported *"Feeling isolated"* as a source of pressure.
- 48% (n=11) indicated that *"Personality clashes with others"* was a source of pressure within the workplace.
- 39% (n=9) respondents, reported that *"Coping with office politics"* was a source of pressure
- 35% (n=8) indicated *"Lack of social support by people from work"* as a pressure.

vi. Home/Work Interface

This sub-scale looks at the extent to which the relationship between home and work can cause frustrations for employees.

- A general source of pressure for 52% (n=12) were *the demands that work can make on their private/social life*.
- 48% (n=11) reported *"Absence of emotional support from others outside work"* as a source of pressure The same percentage of respondents felt the same about *"Lack of practical support from others outside of work"*
- 44% (n=10) of the sample, reported that an *"Absence of stability or dependability in home life"* contributed to the pressures they experienced.
- 44% (n=10) indicated that a source of stress was that they were *"Pursuing a career at the expense of a home life"*.

8.6. Individual Characteristics

Individual characteristics on the OSI involve two aspects of attitudes/behaviours: their locus of control (Scale: How You Interpret Events Around You), and the extent to which the respondent displays behaviours associated with the Type A Personality (Scale: How You Behave Generally).

A. Locus of Control

(Scale: How You Interpret Events Around You)

This scale looks at the respondent's locus of control. In other words, do they feel they have

control over the events and outcomes in their lives through their actions and decisions, or do they feel that events are generally beyond their control? This scale is made up of three sub-scales: organisational forces; management processes, and individual influence.

The overall total score for the scale entitled "How you interpret events around you provides a broad view of locus of control. The mean score for the Kimberley Project sample (42.6) did not differ significantly from that of the comparison sample.

i. Organisational Forces

This sub-scale looks at the extent to which individuals feel that forces within the organization constrain their own ability to influence events. This can be based more on a subjective feeling of constraint rather than any concrete knowledge of what the constraining factors may be. The mean score of our sample on this sub-scale did not differ significantly from the mean score of the comparison group.

- 65% (n=15) of respondents agreed and 35% disagreed that *"It is not possible to draw up plans too far ahead because so many things can occur that make the plans unworkable".*

- 70% (n=16) agreed and 30% disagreed that *"Even though some people try to control company events by taking part in social events or office politics most of us are subject to influences we can neither comprehend nor control".*

- 60.8% (n=14) disagreed and 39% agreed with the statement *" It is upper management rather than ordinary employees who are responsible for poor company performance at an overall level".*

74% (n=17) disagreed and 26.% agreed with the statement *"the trouble with workers nowadays is that they are subject to too many constraints and punishments".*

ii. Management Processes

This sub-scale takes a more specific look at the extent to which individuals see their own performance as influencing the outcomes they achieve. The mean score for our sample on this sub-scale, 15, was significantly higher than the mean score of the comparison group, 13.9 (p=0.05). This higher score suggests that our sample feels that their effort and ability are less consistent with the results achieved, compared to the comparison group.

- 48% (n=11) agreed and 52% disagreed that:
  - ⇒ *"Assessments of work performance do not reflect the way and how hard individuals work".*
  - ⇒ *"In organisations that are run by a few people who hold the power, the average individual can have little influence over organisational decisions".*

iii. Individual Influence

This is a more general comment on the degree to which individuals control outcomes, for example how they can influence promotion.

- 61% (n=14), of the sample agreed and 39% disagreed that *"With enough effort it is possible for employees generally to have some effect on top management and the way they behave*.

- 57% (n=13) agreed that *"Being successful and getting to be boss depends on ability - being in the right place at the right time or luck have little to do with it"*. However, 43.5% (n=10) of the sample disagreed with that statement. In other words they saw career success as having a lot to do with luck.

- 65% (n=15) agreed and 35% disagreed that *"The things that happen to people are more under their control than a function of luck or chance"*.

B. Type A Behaviour

(Scale: The Way You Behave Generally)

This scale looks at the extent to which the respondent displays behaviours associated with Type A behaviour, for example, achievement orientation, ambition, time urgency, and irritable impatience. This scale comprises three sub-scales: attitude to living, style of behaviour and ambition.

The total score on the scale "*How You Behave Generally*" provides a more global measure of Type A. The mean score of our sample for total Type A, 47.7, was comparable to that of the comparison sample, 49.3. Overall, our sample did not appear to differ from the comparison sample in terms of total Type A.

i. Attitude to Living

This sub-scale examines the respondent's level of achievement orientation and dedication.

- 83% (n=19) of staff members, indicated that they had *"no qualms about expressing feelings or opinions in an authoritative and assertive manner"*.

- 74% (n=17) disagreed with the statement *"Because I am satisfied with my life I am not an especially ambitious person who has a need to succeed or progress in their career"*. That is, the majority saw themselves as moderately to highly ambitious.

- 74% reported that when doing a task they concentrated on that one activity and were fully committed to giving it 100% effort.

- 65% (n=15) of the sample felt that, compared to others they were not *"more responsible, serious, conscientious and competitive"*.

- 52% (n=12) reported that while they took their job seriously they could not be described as being *"completely and absolutely dedicated"* to it.

- 74% (n=17) agreed that *"When I am establishing my priorities, work does not*

always come first because although it is important, I have other outside interests which I always regard as important".

ii. Style of Behaviour

This sub-scale examines the respondent's pace of living and their sense of time urgency - does it have an aggressive and irritable flavour?

The mean score for our sample on this sub-scale, 14.1, was significantly lower than that of the comparison group, 17.1 (p=0.01). It would seem then that our group have a more relaxed pace of living, and a less urgent sense of time, compared to the comparison group.

This is reflected in their responses to the individual questions comprising this sub-scale, for example:

- 78% (n=18) disagreed with the statement *"I am a very impatient person who finds waiting around difficult, especially for other people"*.

- 100% of respondents disagreed with the statement *"I am time conscious and lead my life on a 'time is money and can't be wasted' principle"*.

iii. Ambition

This sub-scale provides a very broad indication of how generally ambitious a person is.

- 35% (n=8) agreed with the statement *"I am not an especially achievement-oriented person who continually behaves in a competitive way or who has a need to win or excel in everything I do"*.

- 61% (n=14) agreed that *"I am a fairly easy going individual who takes life as it comes and who is not especially action-oriented"*.

- 74% (n=17) agreed with the statement *"I am usually quite concerned to learn about other people's opinion of me, particularly recognition others give me"*.

8.7. Coping (Scale: How You Cope With The Stress You Experience)

This scale comprises six sub-scales, each looking at different coping strategies commonly employed by people when dealing with stressful situations.

i. Social Support

This sub-scale looks at the extent to which social support exists for the individual, and is sought.

- 83% (n=19) reported that they would *"seek support and advice"* from their superior.

- 78% (n=18) stated that, generally, they would *"Seek as much social support as possible"*.

- 83% said they would *"Talk to understanding friends"* when stressed.

- 87% (n=20) reported having "*stable relationships"*.

ii. Task Strategies

This sub-scale looks at how individuals organize or plan tasks as a coping strategy.

- 83% (n=19) reported that they *"Set priorities and deal with problems accordingly".*
- 78% (n=18) reported that they reorganised their work, and planned ahead in an effort to cope with stress.
- 65% (n=15) reported the *"Use of distractions to take your mind off things"* in response to stress.
- 39% (n=8) reported that they *"Try to avoid the situation"* as a coping mechanism.
- 57% (n=13) reported that they used delegation in times of work stress.

iii. Logic

This coping strategy involves looking objectively and rationally at the facts of the situation.

- 87% (n=20) reported that when faced with a stressful situation they would *"Try to stand aside and think through the situation"*.
- 70% (n=16) reported that they try to deal with stressful situations *"objectively and in an unemotional way"*.
- 61% (n=14) of the sample reported that in the face of stress they would *"suppress emotions and try not to let the stress show".*

iv. Home and Work Relationships

This sub-scale looks at the extent to which staff members use support outside the work setting to help them cope with work stress.

- 74% (n=17) reported that they often *"resorted to hobbies and pastimes"* in an effort to alleviate work stress.
- 70% (n=16) reported that they *"Expand interests and activities and interests outside work*" in an effort to alleviate work stress.
- 65% (n=15) reported using their home as a *"refuge",* a place to escape from work problems.
- 61% (n=14) reported that they *"Deliberately separate home and work"* in an effort to deal with work stress. That is, work problems remain at work when staff go home at the end of the day.

iv. Time

This sub-scale looks at the extent to which staff utilise time management as a way of controlling stress in the workplace.

- 83% (n=19) reported that they usually dealt with work problems *"immediately"*, as they occurred.

- 74% (n=17) reported that they used *"effective time management"* as a method of controlling stress in the work setting.

- 48% (n=11) reported that they would force their *"behaviour and lifestyle to slow down"* when they were finding work stressful.

- 30% (n=7) reported that they *would " 'Buy time' and stall the issue"*, when faced with work problems.

vi. Emotional Involvement

This sub-scale looks at the extent to which the respondent becomes emotionally involved, for example, whether they are realistic about what they can and cannot change.

- 96% (n=22) reported that they looked for *"ways to make the work more interesting"* in order to try and control or alleviate work stress.
- 83% (n=19) reported that for them *"Not 'bottling things up' and being able to release energy"* was a strategy that they used fairly extensively in response to stress.

- 83% (n=19) stated that, as a way of coping, they would try to *"Accept the situation and learn to live with it"*.

- 78% (n=18) stated that they often tried to *"recognise their own limitations"* when faced with stressful or frustrating situations at work.

- 74% (n=17) stated that they *"Use selective attention (concentrating on specific problems*)" as a way of dealing with stress.

- 70% (n=16) reported that they tried to *"Stay busy"* in an attempt to alleviate stress.

8.8. Individual Effect/Outcome

Stress can impact on an individual's mental health, physical health and on job satisfaction. These outcomes are explored individually below. When the Kimberley Project group were compared to the comparison group, the only sub-scale on which they differed significantly was job satisfaction.

A. Mental Health

This scale entitled *"How You Assess Your Current State of Health*"[1] is designed to look at the respondents current state of mental health. This is intended to give an insight into general health and is not an in-depth assessment. It does this by asking a series of questions relating to how the individual feels or behaves, particularly in relation to stress within the work place.

Although the group did not differ significantly from the comparison group, five individuals scored more than one standard deviation below

the comparison group mean. Therefore, there were five individuals who scored less than the average expected result for mental health.

B. Physical Health

(Scale: Your Physical Health)

This scale is designed to assess the current physical health of the respondent by examining the occurrence of physical symptoms commonly associated with stress.

On this sub-scale, although the group did not differ from the comparison group, eight individuals scored more than one standard deviation below the comparison group mean. Therefore, there were eight individuals who scored less than the average expected result

Three individuals scored below the average expected result for both mental and physical health.

[1]The questions on this scale were rated on a continuum of 1-6. for physical health.

C. Job Satisfaction

(Scale: How You Feel About Your Job)

The mean score on job satisfaction for our sample was 89, which is significantly higher than the mean score of the comparison group, 78.4 (p=0.05). This indicates that overall, our sample is more satisfied with the various aspects of their job than the comparison group. This scale is comprised of five sub-scales. On three of these scales the Kimberley House sample was significantly more satisfied than the comparison group. These were:

- organisational design and structure (p=0.01)
- organisational processes (p=0.05)
- atmosphere and interpersonal dynamics of the workplace (p=0.05)

i. Satisfaction with the job itself

This sub-scale looks at the degree of worker satisfaction with the specific requirements of the job, independent of the context in which it is placed. In other words, it looks at satisfaction with work tasks, work load, and job security.

- Only one individual expressed dissatisfaction with "*the actual job itself*". 78% (n=18) expressed at least "much satisfaction" with their actual job.

- Small numbers of individuals expressed dissatisfaction with some aspects of their job:
  - ⇒ 26% (n=6) with the *"kinds of tasks you are required to perform"*
  - ⇒ 22% with the *"workload"*
  - ⇒ 22% with the *"level of job security"* they had.

ii. Satisfaction with achievement, value and growth

This sub-scale looks at the career development aspect of the job: does the worker feel valued by the organisation; is there potential for personal growth in the job, and do workers feel

current rewards reflect their input. A number of areas of dissatisfaction emerged (see Figure 3 overleaf).

- 74% (n=17) expressed at least some dissatisfaction with pay
- 44% (n=10) of respondents were dissatisfied with *"current career opportunities"*.
- 40% (n=9) expressed some degree of dissatisfaction with the degree to which they felt they *"could personally develop or grow"* in their job.
- 40% (n=9) expressed some degree of dissatisfaction with *"the way they felt they, and their efforts, were valued."*

Figure 3Satisfaction With Salary Relative to Experience

	Frequency	%
Very Much Dissatisfaction	**9**	**39.1**
Much Dissatisfaction	**3**	**13**
Some Dissatisfaction	**5**	**21.7**
Some Satisfaction	**4**	**17.4**
Much Satisfaction	**1**	**4.3**
Very Much Satisfaction	**1**	**4.3**
Totals	**23**	**100**

iii. Satisfaction with organisational design and structure

This sub-scale is designed to reflect satisfaction with the characteristics of the organisation. More specifically it looks at factors such as satisfaction with communication within the organisation, and satisfaction with how the organisation implements changes, or resolves conflicts.

- 83% (n=19) expressed moderate to high levels of satisfaction with the design or shape of the structure of the organisation.
- 70% (n=16) expressed moderate to high levels of satisfaction with the degree to which they felt extended in their job.
- 74% (n=17) expressed a moderate to high degree of satisfaction with the way in which conflicts were resolved within the organisation.
- 65% (n=15) indicated moderate to high levels of satisfaction with the way changes were implemented within the organisation
- The sample was fairly evenly split in terms of satisfaction and dissatisfaction with the way information flows around the organisation with eleven staff expressing satisfaction and twelve expressing dissatisfaction.

iv. Satisfaction with organisational

processes

This sub-scale looks at the degree to which employees see themselves as participating in decision-making; the degree of flexibility staff are allowed in performing their duties, and staff satisfaction with supervision.

- 91% (n=21) expressed satisfaction with the degree to which they felt motivated by their job.

- 87% (n=20) expressed satisfaction with the amount of flexibility and freedom they had in their job.
- 78% (n=18) expressed moderate to high levels of satisfaction with the style of supervision their superior used.

- 61% (n=14) were satisfied with the level of participation they had in important decision making.

v. Satisfaction with The Work Place (Sub-scale: Satisfaction With Personal relationships)

This sub-scale is designed to look at the atmosphere and interpersonal dynamics of the work place. It also looks at how well staff relate to the public image of the organisation.

- 87% (n=20) expressed moderate levels of satisfaction with their relationships with their colleagues.

- 78% (n=18) expressed a moderate to high degree of satisfaction with the extent to which they identified with the *"public image or goals"* of the organisation.

- 65% (n=15) of staff expressed some degree of satisfaction with the psychological *"feel"* or *"climate"* that dominates the organisation.

8.9. Staff Turnover

The staff turnover rate for Kimberley House during the period 1st January 1996 to 31st December 1996, was 18.75% (see Appendix M). Seven members of staff left during that period: two individuals left due to family commitments; one individual left due to ill health, and four individuals did not give a reason for leaving. The average length of service of leavers was six and a half months.

9.0. The Study

On entering the Kimberley Project, all residents are given an information booklet entitled ***The A-Z To Your Home***. This booklet details rules and regulations relating to every aspect of residents' lives within Kimberley House, from alcohol consumption to visiting family and friends. It was reported that staff members work through the booklet with residents on entry to the scheme. If a resident appears to have difficulty with a particular rule(s), then their knowledge of the booklet is revised. However, in order to facilitate service user empowerment, it is desirable that as many of the residents as possible can look at and understand the booklet for themselves. For example, this would enable residents to consult the information in the booklet independently, in the event of them having a query that they were reluctant to discuss with staff, allowing them to feel empowered at a very basic level.

In order to determine whether or not residents would be able to consult the booklet independently, we looked at its 'readability'. Readability, in its simplest terms, refers to the understandability of written text (Ley & Florio, 1996) and it can be determined through the application of one or more readability formulas.

- **The Formulas**

The A-Z To Your Home was examined using three readability formulas: *Flesch Reading Ease*; *Mc Laughlin's SMOG Grading*; and *Gunning Fog Index* (Ley & Florio, 1996). These formulas have been used to assess the readability of a wide range of texts such as medication leaflets, anti-smoking pamphlets and individual warning, safety direction and first aid statements.

Three formulas were used in order to try and maximise the reliability of the data. When used individually, the three readability formulas selected are estimated to have an average reliability of 0.93. When all three are used, their combined estimated reliability is 0.97 (Ley & Florio, 1996). Hence, the readability of the booklet will be taken as the mean of these three formulas.

9.1. The Findings

The mean reading grade of ***The A-Z To Your Home*** was grade 12 (see Table 1).

Table 1: Readability Rating of *The A-Z To Your Home*

Readability Formula	Reading Grade
Flesch	**10-12**
SMOG	**12.06**
FOG	**13.6**
MEAN	**12.22**

A reading grade of 12 equates to a reading ease of approximately 50-60. This means that approximately 54% of the general population could read and understand the information within the booklet with ease (Ley & Florio, 1996).

There is some debate as to the recommended Reading Ease score written materials for general use should have. It has been suggested that any text designed for general use, which

has a reading ease of less than 70 (i.e. 83% of people would be expected to understand the text), should be rewritten (Nicoll & Harrison, in Ley & Florio, 1996). Ley & Florio suggest aiming for a Reading Ease of 90-100 (Reading Grade 4-5). They comment "this may be difficult to achieve, and will usually lead to a longer document. However, set an upper difficulty limit of 6th to 7th Grade, or a Reading Ease score of 79-80."

The A-Z To Your Home had a reading ease of approximately 50 (reading grade 12 - 54% of the general population could be expected to read and understand the text). In other words the reading ease of the booklet is lower than that recommended for materials aimed at the general population. Therefore, alterations to the booklet would be required to increase its reading ease for residents.

9.2. Ways of Improving Readability

It should be noted that the practice of staff working through ***The A-Z To Your Home*** with residents is a good one and should be continued. Likewise, the practice of reviewing the residents' knowledge of the booklet should be continued. However, it is important that, where possible, residents have the opportunity to consult information independently if they choose to do so.

Bashford et al (1995) and Ley & Florio (1996) highlight a number of ways to maximise the readibility of documents. There are some simple practical steps which can be taken to increase the readability of the information booklet for residents:

- the document should use short sentences in plain language, i.e., sentences should be between 15-20 words in length, and should contain only one main idea.

- Use active sentences, rather than passive ones. This helps to make ideas more concrete and real for the reader. One way of achieving this is to use the personal form. For example:

"You can only bring alcohol back to Kimberley House on special days. You must ask staff first", is preferable to

"Alcohol can only be brought back to Kimberley House by arrangement on special occasions".

- Three syllable words should be replaced by shorter ones wherever possible. For example *"two consecutive nights"* could be replaced by, *"two nights in a row".* It is allowable to use words which are part of the cultural vocabulary of the group, for example, medication and assessment. Where such words are used, the reader should be provided with an index of simple definitions.

- Where possible, use familiar words, and use the same word consistently throughout the text. For example do not refer to *"a member of staff"*, and then change to *"a Care Auxillary"*, later in the text.

- Text should be presented in short, clearly separated chunks of text, with white spaces to separate text.

- Examine the text for any ambiguity or omitted words. While the readability formula may indicate easy text, it may still be incomprehensible.

Consideration could also be given to developing a video communicating the same information, or the use of other visual materials.

- The paper on which the document is printed should be thick enough so that the shadow of the text from the next page cannot be seen .

- Wherever possible, text should be supplemented with graphic illustrations. Use of photographs is preferable, they are more clear and more human for the reader.

10.0. The First Year

This report provides an overview of the first year of the Kimberley project, the majority of residents having moved there from hospital. The report is a snapshot of their life in the very early stages of this community setting. While data was being gathered as part of the evaluation, the service was evolving and developing. It is hoped that some of the development that has taken place is captured throughout the report.

Throughout the interviews and questionnaires, those involved in the evaluation raised a wide range of issues and these are reported in detail in the relevant chapters. This chapter aims to bring together some of the main issues raised. As a result, much of the important detail will not be reflected in this chapter. This overview, therefore, needs to be read in conjunction with the relevant chapters reporting the detailed findings.

10.1. Interviews with Residents

Overall, residents reported that they liked living in Kimberley House and enjoyed attending the Work Skills Centre. They were also generally positive about their relationships with staff and other residents. From their comments, it was clear there were many examples of good practice on the part of the service provider. Areas were also identified for development.

A. Autonomy and Choice

Each resident had their own bedroom, with their own individual storage space. The majority of individuals had chosen the colour scheme and decor of their bedrooms, and each had their own personal belongings in their rooms. Residents had their own key to their own room.

Furthermore:

- Each resident had their own bank account.
- Residents could choose how to spend their money. However, staff helped most residents to budget their money, and advised them to save for planned large expenditures (for example, holidays).
- Residents could have visitors whenever they wanted to.
- Residents could invite people to Kimberly House for a meal.
- Residents could have their say regarding menu planning during residents' meetings.
- Residents went to bed whenever they chose and on weekends could get up whenever they chose.
- Residents could bath/shower as and when it suited them.
- Residents could choose whether or not to attend residents' meetings (though this was a source of confusion for some individuals)

- Residents decided to have a pet, and chose whether or not they wanted to be involved in taking care of it.

Given that many of the residents had histories of challenging behaviour, and in some cases absconding, it was not possible to allow residents to have their own house keys, or to go out unaccompanied by staff [1].

Assessing whether a group of individuals living in a residential setting have *enough* autonomy and choice in their everyday lives is a difficult judgment to make. Also, the evaluation did not assess the extent to which residents could function independently. For example, although each resident had their own bank account, there was no assessment of the extent to which they could independently administer it. It is apparent from interviews with some of the residents that, although they very much enjoyed living at Kimberley House, they had aspirations to live elsewhere. Choices of places to live, where their care needs can be met, are usually very limited for individuals with a learning disability moving from a hospital to a community setting.

[1] Although it should be noted that two residents were allowed out alone on a restricted basis. This was in association with a behavioural program.
This is an instance where there are external constraints on the level of choice that can be exercised.

Within the Kimberley project, it is clear that a good foundation has been laid for the development of resident independence and exercising the right to make choices. However, this is something that should be continually evolving and keeping pace with the developing skills and aspirations of the individuals living there.

B. Going Out More

Residents enjoyed going out and reported participating in a wide variety of activities. However, many residents expressed a wish to go out more often. Three individuals expressed a wish to be able to go out on their own without being accompanied by staff. While this may be a necessary condition of their residence at Kimberley House and part of their care-plan, it is important to appreciate the impact this can have on residents' independence. Achieving a balance between the right to autonomy and ensuring proper care and protection is an ongoing issue in the care of individuals with learning disabilities.

C. Understanding The Options

There appeared to be some confusion regarding attendance at residents' meetings, with two residents believing that attendance was compulsory. Likewise, two residents reported that the timing of meetings was a staff decision. It is important to ensure that all residents understand that they have a choice about whether or not to attend these meetings, and can decide when the meetings should take place. It could also be considered a useful learning opportunity about consensus, and

learning that the wishes and constraints of others need to be taken into consideration.

D. Consulting Residents About Change

There was evidence that some systems had been changed since residents had moved to Kimberly House. One resident reported that, while they had been informed of these changes, reasons had not been given for them (decision to lock linen cupboard). It is important that when a system within the house changes, residents are fully consulted. If residents are made to feel that their views and opinions are listened to and understood, it will give them a greater sense of confidence in the service, and at a more personal level, it will give them greater self-confidence, encouraging them to be more assertive in their everyday lives (Bourlet, 1996).

Minutes of residents' meetings held subsequent to the interviews revealed that the resident who reported that he/she was going to bring up the issue of the locked linen cupboard in the next residents' meeting had done so. The minutes of the meetings revealed that, following discussion, the cupboard was left unlocked for a trial period of one month. The trial proved successful, and the cupboard has remained open since.

E. Residents Meetings

In general, residents seemed to enjoy going to the residents' meetings and were able to give a number of examples of things they discussed during meetings. However, some residents expressed a preference for meetings to be held without staff supervision.

Once again, minutes of residents' meetings held after the interviews took place indicate that this issue has now been discussed. It has been agreed that residents now have one meeting each month which is for residents only, and one meeting each month where the Scheme Manager is present.

The comments of some residents suggested a strong sense of not being kept informed about some matters. For example, with regard to holidays, residents reported that requests for information regarding the timing and destination of holidays had not been responded to. Some residents expressed dissatisfaction with this.

However, it is important to note that during the first year of the scheme, residents' meetings took place only when residents requested them. Only four residents' meetings took place in that period. With a change in management at the twelve month stage, however, meetings are now being held once a month. It is likely that the increased frequency of meetings has led to improved communication between staff and residents. Indeed, it is noteworthy that the minutes of one meeting revealed that residents acknowledge the benefits of having direct access to the Scheme Manager within the group setting provided by the residents' meeting.

G. Work and Day-time Activity

There was considerable individual variability in the specific day-time activities residents were involved in. At the time of the evaluation most of the activities were based in the Work Skills Centre, with some individuals on work placements or attending a course at the local college. Overall, residents enjoyed the Work Skills Centre. There were, however, mixed feelings about the course at the local college.

Three individuals (two within the Work Skills Centre, and one within a work placement) were unhappy with the payments they received for their work. One went as far as to describe it as an insult. In order to retain their current benefits, there is a maximum amount they may earn per week. This is not an issue specific to the Kimberley project, but has wider policy implications in relation to "therapeutic earnings". A Committee of Inquiry set up by the Mental Health Foundation highlighted this issue and emphasised that

"People with learning disabilities should receive the appropriate rate for the job … There is a need for a more imaginative approach. Changes in the benefit system are needed to make it easier for people with learning disabilities to have jobs without the permanent loss of benefits" (MHF, 1996).

G. Opportunities To Develop Domestic Skills

Residents reported that they were responsible for cleaning their own bedrooms, and doing their own laundry. These tasks were carried out on a "home-based" day which was usually a weekday. Many residents, therefore, worked a four day week. To keep with the principles of normalisation, residents would be required to carry out these tasks over the course of the week, working a full five day week. This issue has been raised by staff at residents' meetings held subsequent to the resident interviews. Residents voted against the scrapping of the home-based day, stating that they very much valued having that quality time with staff set aside so that they could develop their domestic skills on a one-to-one basis.

As stated previously, residents are responsible for cleaning their own bedrooms. However, in a normal shared house, usual practice would be that people would also help clean the other rooms of the house. This was not in practice at the time of the interviews. However, minutes of residents' meetings held subsequent to this evaluation have revealed that residents have now been asked to participate in other house chores on a voluntary basis (for example, putting the bins out). Most residents have now agreed to take on some more general house duties.

The majority of residents reported that the only time they cooked for themselves was at supper time when simple snacks were made. During the course of the interviews, two residents reported that they would like to have more opportunities to learn how to cook. This may be a care-plan issue in that, for these individuals, other areas may have been given priority over cooking skills. This indicates the importance of attaining a balance between therapeutic concerns and the wishes of residents.

Similarly, residents seemed to have limited opportunities to help staff shop for food. Food shopping is a basic skill of daily living, and as such it is vital that residents are given the opportunity to develop experience in this area. It is understood that most food is purchased in bulk for the sake of economy. However, it might be possible that each resident could be given some responsibility for buying the food, for example, for their suppers each week, and for any cooking they might do on their home-based day.

H. Complaints

Encouraging individuals to make a complaint when they are unhappy about an aspect of a service can be difficult. This is particularly so when an individual is dependent on that service for accommodation and support (Mawhinney & Mc Daid, 1996). It is not surprising that a concern was expressed about making a complaint about a member of staff if the need arose. It is important that complaints procedures are under frequent review to examine how effectively they are working and to review residents' understanding of them. In a situation where there is a dependency on a service and a close relationship with staff, creating a climate in which individuals feel they can complain about any aspect of the service with which they are dissatisfied is as important as having a procedure in place. Residents need to be reassured that their views and complaints will be taken seriously, and dealt with accordingly. They must understand that staff, like residents, have a set of rules which they must follow, and which, if broken, have practical consequences. An advocate might be able to support residents in voicing queries about sensitive issues like use of control and restraint procedures which they may find difficult to discuss with staff, and could play a vital role in facilitating residents in voicing any concerns or complaints they may have regarding staff.

I. Relations with staff

Generally, residents reported that they got on well with staff. Most residents reported that they would talk to staff about their feelings or any problems they might be having and that this was helpful. Residents reported that staff helped them in many practical ways too.

J. Research Issues

It is common when canvassing consumers for their views on health services, to find high levels of reported satisfaction (Baldock & Ungerson, 1994). Caution must be exercised, however, in assessing whether the reported satisfaction actually reflects what clients really think about a service. Factors such as low expectations, acquiescence, being asked about aspects of a service that are not important to the client and limited response categories in questionnaires may all impact on reported satisfaction (Mc Daid et al 1997). The issues specific to obtaining the views of individuals with learning disabilities are highlighted earlier in this report. There were occasions during interviews where individuals appeared to show some tendency to *"portray an unrealistically favourable impression of their lives"* (Flynn, 1986). However, in these instances, asking for examples and/or using follow-up questions

were effective ways of obtaining a more detailed picture.

If interviewers are aware of the potential response biases and attend to non-verbal cues, interviews can be a successful way of developing a picture of how resident's view their social worlds. Furthermore, many of the residents stated at the end of the interview that they had enjoyed the experience and offered to talk to the interviewer again if it was ever necessary. Some stated that it was nice to be listened to. Therefore, not only does this study support the conclusion that if interviews are presented in a structured and supported format (Mc Villy, 1995), learning disabled adults can make a very valuable contribution to research knowledge, it also can be a very positive experience for service-users.

10.2. Adaptive Behaviour

The ABS initially assessed the group of residents at Kimberley House as having above average personal independence skills and below average social behaviour. Both these areas showed significant improvement over the one year period. On both scales, this was characterised by most of the change occurring in the first six months, followed by a levelling off period. As on many of the measures used in this evaluation, there was considerable variability between residents in how they changed across the year. It will be important to assess whether the improvements in the group can be sustained and built upon in the longer term. It will also be important to follow individual progress.

10.3. Daily Activities

Activity logs indicated that the residents of Kimberly House were participating in a wide variety of both home-based and community-based activities. Many of these are activities which non-learning disabled individuals participate in on a day-to-day basis. Residents were also generally happy with the activities they participate in, and the frequency with which they get out and about.

A. Opportunities For Integration

The data suggests that, while residents spend almost one quarter of their day participating in community-based activities, they still spend the majority of their time with staff, either alone or in the company of other residents.

The evidence suggests that while Kimberly House residents are being given opportunities for integration and do make frequent use of community facilities, their time is still spent primarily with people living or working within Kimberly House. Hence, actual contact with individuals who do not live or work in Kimberly House would appear to be limited.

B. Individual Differences

Given the often structured nature of activity in residential settings, it is a very positive finding that each resident spends their time in very different ways. The analysis of their Social Networks indicated that certain individuals within Kimberly House prefer more solitary activity while others are more sociable and prefer to get out and about and meet people. It is likely that the activity log data are a reflection of these preferences. However,

variability in the opportunities made available to different individuals or individual differences in social skills and confidence may be another possible reason for the variability in activity. It would be useful to achieve a more in-depth understanding of the reasons underpinning this variation to ensure that all residents are provided with the appropriate choices, opportunities and supports.

C. Work Skills Centre - Individual Choice

The individual nature of the Work Skills time-table suggests that care programmes within the centre are individually tailored. The Work Skills Coordinator reported that trainees are actively involved in planning their own time-table, and that nothing is planned without resident consultation. This is supported by resident reports that they talk to staff about their preferences, and are happy that their views are listened to.

Staff at the Work Skills Centre reported that time-tables were reviewed on an informal basis within the centre once every four to six weeks. In addition to this, residents are given evaluation forms which ask them about their satisfaction with several aspects of the service provided at the Work Skills Centre (see Appendix I). These forms are completed (with the help of the Work Skills Coordinator), and presented at individual formal review meetings which take place at Kimberley House and which residents are encouraged to attend.

D. Work Skills Centre - Opportunities for Integration

At the time of the evaluation, the Work Skills Centre was offering a service to Kimberley House residents only. Apart from those in a work placement and/or attending a course at the local college, there was little opportunity for contact with anyone other than staff and other Kimberley House residents. Therefore, there were limited opportunities for community integration. This compounds the situation highlighted in 10.3.

While the course at the local college (Mainstream) cannot be considered as fully integrated in that it caters specifically for a disabled group, it does take place in an integrated setting and potentially offers residents vital opportunities to meet other people and to develop a social network. Given that the course is based in a college setting, there are potential opportunities for meeting a range of individuals. However, the extent to which these opportunities exist for the residents concerned, or can be availed of, is not clear from this evaluation.

Seed (1996), found that the vast majority of day care centres offered some opportunities for mixing with other non-learning disabled individuals. In contrast, there was no evidence that centres actually contributed to the process of enabling clients to mix with other non-learning disabled individuals within the community. However, it must be remembered that, at the time of data collection, residents had been attending the Work Skills Centre for a maximum of twelve months. It would be useful to assess whether there has been development in the programme and in

opportunities for community and employment integration as residents become more established in the community.

Since the evaluation has commenced there has been a change in the resources available. At the time of the data collection it was reported that limited availability of transport meant that residents were unable to spend as much time out and about in the community as the Work Skills Coordinator would have liked. Since then Kimberly House has purchased a people carrier which is available for daytime use by the Work Skills Centre. Also, at the time of writing this report, several residents had progressed to the stage of using public transport. Therefore, transportation is no longer an obstacle for the Work Skills Centre in facilitating community-based activities. Furthermore, the Work Skills Centre has developed considerably recently with the establishment of the Challenge Cookie Company in Sept 1997 and the opening of a café in Newtownards. This will provide a greater range of opportunities for development of skills and integration into the community.

10.4. Social Networks

Based on staff reports, residents' overall social network sizes are comparable to those of other adults with learning disabilities living in hospital, or within the community. The mean network size of 7.9 is comparable to the findings of other studies of the social networks of individuals with learning difficulties. For example, in a community study carried out by Grant (1993), the average social networks size for adults with learning difficulties was 7.5, while Dunn et al (1990), found that the average social network size of long stay hospital patients was 8.

While there is evidence of residents developing new friendships within the community, it is apparent that for some, a move to a community setting has not equalled integration. Service-users' social networks have remain limited primarily to their families and to the staff who care for them. However, as has been highlighted earlier, one year living in a community setting is a very short time period in which to develop a cohesive network. It will be very important in the short-term to assess, through care-plans and the review process, opportunities and support available to extend and develop social networks. In the longer term, it will be useful to assess the impact on residents' social networks and the quality of social support available to them.

A. Staff Relationships

There is an obvious risk that staff reports may be somewhat biased in relation to residents' relationships with other staff members: staff reported that for the majority of residents, staff were the most frequent point of contact, and relationships with staff were described in very positive terms. However, it should be noted that these staff perceptions were corroborated by resident reports. Furthermore, staff acknowledged that the majority of friendships, for staff at least, were primarily working relationships.

Both staff and residents report that after family, the most important contributor to social

networks is staff. Therefore, the frequency and reported quality of staff contact cannot be ignored. In light of this, it is important that the value of these relationships for residents is not overlooked, and that the appropriate supports are available to staff to enable them to continue in this role.

B. Differences Between Staff & Resident Reports

There was a discrepancy in resident and staff descriptions of residents' social networks. Residents reported having larger social networks than staff. In some instances, the discrepancies between staff and resident reports may be attributed to the fact that staff members are not with residents twenty-four hours a day and so may be unaware of some of the residents' friendships. For example, acquaintances made while out and about, or friends from hospital. However, it is also important to keep in mind the effect of social desirability, which may have led to over-reporting on the part of residents. This issue was raised earlier in the introduction. Staff and residents may also have varying perceptions or definitions of what constitutes social contact.

C. Opportunities For Integration

Both of the individuals who were in a work placement at the time of the evaluation had developed friendships with work colleagues. Hence, work placements appeared to provide opportunities for residents to develop new friendships. In contrast however, none of the three individuals attending the local technical college reported having made any friends there. For one individual, this may be attributed to the fact that he/she had not been attending college long. However, for another individual who had failed to make friends at college, it appeared to be because the other people attending the mainstream course also had learning difficulties, or a physical disability. This individual did not associate him/herself with, or did not want others to associate him/herself with, either of these groups:

"I don't like it like. It's all for like you know people in wheelchairs and stuff. And I don't like it really you know".

It may also be that the work placements provide a more structured support environment compared to the college environment. This more structured support would facilitate residents in forming relationships, allowing them to make better use of their opportunities. Whatever the reason, it would appear that in this instance, work placements provided better opportunities for developing friendships than attending the local college.

D. Individual Differences

In addition to highlighting individual variation in the activities engaged in, the data revealed considerable individual differences in the sizes of residents' social networks. There are many reasons why one individual may have developed a larger social network compared to another. One potential factor would be the level of disability of the individual involved. However, analysis of residents' social networks in relation to their scores on the

AMMR Adaptive Behaviour Scale revealed no significant results.

Having a work placement has already been identified as a possible factor (see Para. 3.4) leading to individual differences in network sizes. Another factor might be the attitudes of the individual with the learning difficulties. For example, the individual reporting the largest social network had a very positive approach to making new friends in the community. He/she saw the development of new friendships as being an important personal goal. Yet another factor may be the hobbies and/or social interests an individual is engaged in. For example, one individual reported enjoying quite a lot of solitary activities and when asked if he/she ever went to the pub/disco with the other residents he/she replied:
"No, I wouldn't do that sort of thing".

Similarly, staff described this individual as a private person who liked to spend a lot of time alone. The only relationship this individual had developed in the community had happened through a work placement. This may highlight the particular importance work placements might have in the development of the social networks of those individuals who are more inclined towards private or solitary social/recreation activities. This raises an additional issue that some people are simply not gregarious, whether they have learning difficulties or not.

E. Loss of Existing Support System?

Kennedy, Horner, and Newtown (1989) express a concern that the move from hospital to the community may cause individuals' existing support systems to crumble, and that new support systems may fail to emerge. While we have no baseline measure of residents' social networks within hospital, it would seem that many have indeed left a network of relationships behind.

For example, staff reported that for one individual who had stayed in touch with a friend from hospital, the relationship had become strained as a result of their move to the community. This was felt to be due to the fact that they now had fewer friends and interests in common. As a consequence, contact had progressively declined.

Additionally, while Kimberly House staff promoted continued contact with friends residents had lived with in hospital, some residents expressed a definite preference to keep in contact via letters and telephone. One individual seemed to feel that to keep in touch with friends from hospital would work against the goals of his/her move to the community. Some merely had negative associations and did not want to return: *"I was glad to get out of it"*, one service user even referred to it as *"the lock up"*. Therefore, while there is some evidence that residents' social networks may have suffered from the move to the community, it is not always a direct consequence of the move; for some it was a conscious choice, and one they were quite happy to make. There is an additional issue here, that, for any individual moving to a new

area, there will often be an impact on their social network, albeit with larger social networks the impact will have potentially less impact.

F. New Support System Emerging?

There is evidence that a new support system is emerging for some of the residents of Kimberly House. Relationships with staff and other residents within the project play an important part in this developing network.

While many of the relationships between residents are described in casual terms, they could be considered quite developed. For example, the fact that residents generally felt relaxed with one another is positive considering the amount of change they had experienced in the year prior to the interview, and the strains that can exist for any group of individuals living in a group setting. Residents had developed preferences for specific individuals and actively sought them out in order to sit with them at meal times. Residents would get together for a smoke and chat about the latest gossip, holiday plans and so on.

Despite the fact that many of the relationships reported were not felt to involve emotional disclosure and support, many had other valuable assets to offer the residents. For example, in relation to work placement relationships, having someone to talk to about your hobbies and interests can be very satisfying. Likewise, being invited to outings with other members of staff at a work placement may provide opportunities to develop other friendships. For these relationships to have reached this stage is an achievement in itself for the individuals concerned.

It would seem that, overall, many residents share relationships with other people which are based on similar grounds to the friendships which non-learning disabled individuals have in their daily lives (e.g., talking about common interests, sharing news, and so on). Opportunities to build on this good foundation will be important.

10.5. Views of Carers and Guardians

Information was available from the family or guardian of six of the residents. Comments were very positive on most aspects of the service. This was particularly so in relation to the staff and the respect and flexibility with which they approached their work with residents. The friendly and welcoming atmosphere of Kimberley House was also commented on. Respondents felt that the move from hospital to community had been handled well by hospital and Kimberley House staff. The high level of consultation, from both sources, in the planning stages of the project was also commented on. A number of improvements were noted in residents' skills, behaviour and emotional stability since the move to Kimberley House. Suggestions were made by parents/guardians for changes/improvements in the service and these are outlined in Chapter 6.

10.6. Views of Statutory Professionals

As with the carers, the statutory professionals were very positive about the staff, their

professionalism and their respect for residents. Related to this, the majority of respondents were very satisfied with the quality of their working relationship with the staff at Kimberley House. The majority of respondents were also happy with how information was communicated and the extent to which up-to-date information on their client was made available to them. The individual who expressed some dissatisfaction with communication of information felt the situation had been improving since raising the matter with staff.

There were mixed feelings about how successful the service had been in achieving community integration. Responses ranged from "very successful" to "somewhat unsuccessful". One respondent highlighted the complexities of achieving a balance between integration and the support needs of individuals with challenging behaviours. This echoes some of the comments made earlier in relation to the aspirations raised by some residents for greater independence and balancing this with a need for care and protection. Statutory professionals were also asked to comment on what they felt were the weaknesses of the service. The issues raised were mainly about the interface between the Kimberley project and other community services/supports required by residents.

10.7. Issues for Staff

The section of the evaluation which focused on staff, aimed to identify sources of pressure in the workplace and to examine their impact on staff. When compared to a general population group and a group of nurses working in a learning disabilities unit, the Kimberley staff rated quite similarly on the majority of the scales. While these were not proper control groups, they do provide a useful reference point for comparisons.

Job satisfaction was high, with the majority of staff "much" or "very much" satisfied with the job itself. On three of the sub-scales satisfaction was significantly higher than the nursing comparison group. However, there were areas of dissatisfaction for a number of staff and it may be useful for the project to explore these in more detail to identify areas for change. There was also a subgroup of staff who, on the health dimensions (physical and mental health) scored considerably below the rest of the group. If these dimensions are taken together, this indicates a small subgroup of staff displaying symptoms of stress. These cannot be unequivocally attributed to the work setting. However, it clearly raises the issue of what supports, if any, an organisation should have in place for staff experiencing stress in the work situation.

Although the Kimberley Project staff did not differ significantly from the nursing comparison group on the sub-scales for sources of job pressure, not surprisingly, breakdown of the sub-scales indicted that there were a number of sources of pressure in their working environment. These are reported in detail in Chapter 8. There were three issues in particular that were described as "definitely" or "very definitely" a source of pressure for approximately half of the staff. These were

"*lack of consultation and communication*", "*being undervalued*" and "*rate of pay*".

Some of the sources of pressure may be easily receptive to change. Some of the changes or developments required may be obvious, others may require more in-depth exploration of the issues involved. Some may reflect the teething problems and pressures of establishing a new project. Some of the sources of pressure identified by staff may be intrinsic to the job and therefore difficult to change. Ensuring that, where necessary, appropriate supports are in place for staff may be the most appropriate mechanism in this instance. There were clear instances where this was already in operation. For example, a coping strategy that a large majority of staff reported using to deal with stressful situations was seeking support and advice from their superior. The majority of staff reported using a range of positive coping strategies, such as seeking social support, prioritising and dealing with problems accordingly, and forward planning. These can be characterised as providing a buffer against the sources of job pressure which result in stress symptoms.

10.8. Recommendations

This chapter has provided an overview of the findings of the evaluation. There are a range of more detailed recommendations that have arisen from the findings. These both highlight good practice and identify areas for improvement.

Andrews, G. and Tennant, C. (1978). Life event stress and psychiatric illness . In: Rutter, M. (1981). Stress, Coping and Development: Some issues and some questions. *Journal of Child Psychology and Psychiatry and Allied Disciplines, Vol. 22, No. 4, pp. 323-356.* Pergamon Press Ltd.

Atkinson, D. (1989). Research Interviews With People With Mental Handicaps. In A. Brechin & J. Walmsley, Making Connections: Reflecting On The Lives And Experiences Of People With Learning Disabilities.

Atkinson & Ward (1986). A Part Of The Community: Social Integration and Neighbourhood Networks. In A.L. Chappell, "A Question of Friendship: community care and the relationships of people with learning difficulties". *Disability and Society*, *Vol 9, No.4.*

Baldock, J., & Ungerson, C. (1994). Becoming Consumers Of Community Care. Joseph Rowntree Foundation: London.

Bashford,, L., Townsley, R., & Williams, C. (1995). Parallel Text: Making Research Accessible To People With Learning Disabilities. *International Journal of Disability, Development and Education, Vol, 42, No. 3, pp211-220.*

Baumeister, A., & Zaharia, E.S. (1987). Withdrawal And Commitment of Basic Care Staff In Residential Programs. In J. Rose: Stress And Residential Staff: Towards An Integration Of Existing Research. *Mental Handicap Research*, *Vol. 8(4), 1995*.

Blegen, (1993) Nurses' Job Satisfaction: a meta-analysis of related variables. In: Parahoo, K., and Barr, O. (1994). Job Satisfaction of Community Nurses Working With People With a Mental Handicap. *Journal of Advanced Nursing, Vol. 20, pp. 1046-1055.*

Blunden, R., & Allen, D. (1987). Facing The Challenge: An Ordinary Life For People With Learning Difficulties And Challenging Behaviour. London: Kings Fund Publishing Office.

Bourlet, G. (1996) The Impact of Self-Advocacy: The Role Of People With Learning Difficulties In European Research. British Institute of Learning Disabilities Annual Conference: Working In Partnership With Service Users.

Bourne, P.G., Rose, R.M. and Mason, J.W. (1967). Urinary 17-OCHS levels in combat: data on seven helicopter ambulance medics in combat. In: Rutter, M. (1981). Stress, Coping and Development: Some issues and some questions. *Journal of Child Psychology and Psychiatry and Allied Disciplines, Vol. 22, No. 4, pp. 323-356.* Pergamon Press Ltd.

Brandon D., & Ridley, J, (1983). Beginning To Listen: A study of the views of residents living in a hostel for mentally handicapped people. London: MIND.

Brown, G.W. and Harris, T. (1978a). Social Origins of Depression: A Study of Psychiatric Disorder in Women. In: Rutter, M. (1981). Stress, Coping and Development: Some issues and some questions. *Journal of Child Psychology and Psychiatry and Allied Disciplines, Vol. 22, No. 4, pp. 323-356.* Pergamon Press Ltd.

Carmelli, D., & Swan. G.E. (1996). The Relationship of Type A behaviour pattern and its components to all-cause mortality in an elderly sub-group of men from the Western Collaborative Group Study. *Journal of Psychosomatic Research, 40(5), pp. 475-483.*

Cohen, F. (1979). Personality, stress and the development of physical illness. In: Monat, A., & Lazarus, R.S. (!985). Stress And Coping: An Anthology. Colombia University Press.

Cooper, C.L., Sloan, S.J. and Williams, S. (1988). Occupational Stress Indicator Management Guide. ASE, A division of NFER Nelson.

Cooper, C.L., Sloan, S.J. and Williams, S. (1994). Occupational Stress Indicator Data Supplement. ASE, A division of NFER Nelson.

Cullen, C., Whoriskey, M., Mc Kenzie, K., Mitchell, W., Ralston, K., Shreeve, S, & Stanley, A. (1995). Effects Of Deinstitutionalisation On Adults With Learning Difficulties. *Journal Of Intellectual Disability Research, Vol. 39, Par 6., 484-494.*

Department Of Health (1989) Needs and responses: Services for adults with mental handicap who are mentally ill, who have behaviour problems, or who offend. In, C., Kiernan (ed): Research to Practice? Implications of research on challenging behaviour of people with learning disability, 1993. BILD Publications.

Department of Health (1995) Carers Recognition and Services Act. London: HMSO

Department Of Health and Social Services. (1990). People First: community Care In Northern Ireland In The 1990s.

Donegan, C., & Potts, M. (1988) People With A Mental Handicap Living Alone In The Community: A Pilot Study Of Their Quality Of Life. *The British Journal Of Mental Subnormality, Vol. XXXIV, Part 1, No. 66.*

Dunn, M., O'Driscoll, C., Dayson, D., Wills, W., & Leff, J. (1990). The TAPS Project 4: An observational study of the social life of long stay patients. *British Journal of Psychiatry*, *157.*

Emerson, E. (1985). Evaluating The Impact Of Deinstitutionalisation On The Lives Of Mentally Retarded People. *American Journal Of Mental Deficiency, 90, 277-288.*

Emerson, E., & Hatton, C. (1994). Moving Out: Relocation From Hospital To Community. London: HMSO.

Felce, D. (1996) Ways To Measure Quality of Outcome: An essential ingredient in quality assurance. *Learning Disability Review, Vol. 1, Issue 2.* Pavillion Publishing: Brighton.

Felce, D., & Lowe, K. (1993). Supporting People With Severe Learning Disabilities And Challenging Behaviour In Ordinary Housing. In, C., Kiernan (ed): Research to Practice? Implications of research on challenging behavioutr of people with learning disability. 1993. BILD Publications.

Felce, D., Lowe, K., & Beswick. (1993). Staff Turnover In Ordinary Housing Services For People With Severe or Profound Mental Handicap. In J. Rose: Stress And Residential Staff: Towards An Integration Of Existing Research. *Mental Handicap Research, Vol. 8, No. 4, 1995.*

Flynn, M. (1986) Handicapped As Consumers: Issues And Guidelines For Interviewing. *Journal of Mental Deficiency Research, Vol. 30(4) 369-377.*

Grant, G. (1993). Support Networks and Transitions Over 2 Years Among Adults With A Mental Handicap. *Mental Handicap Research, Vol. 6 (1), 36-55.*

Hastings, R.P., Remingtom, B., & Hopper, G.M. (1995). Experienced And Inexperienced Health Care Workers Beliefs About Challenging Behaviour. *Journal of Intellectual Disability Research, Vol 39, Part 6, 474-483.*

Hatton, C. and Emerson, E. (1995). Staff in Services for People With Learning Disabilities: An overview of current issues. *Mental Handicap Research, Vol 8, No.4, pp. 215-219.*

Heal, L.W. & Sigelman, C.K. (1995) Response Biases In Interviews Of Individuals With Limited Mental Ability. *Journal of Intellectual Disability Research, Vol. 39 (4), 331-340.*

Hemming, H., Lavender, T., & Pill, R. (1986). Quality Of Life Of Mentally Retarded Adults Transferred From Large Institutions To New, Small Units. *American Journal Of Mental Deficiency, Vol. 86, No. 2, 157-169.*

Henderson, S., Byrne, D.G., & Duncan-Jones, P. (1981). Neurosis and The Social Environment. In S. Cohen & T.A. Wills, Stress, Social Support, and The Buffering Hypothesis. *Psychological Bulletin, Vol. 98, No.2, 310-357.*

Hoge, G. & Dattilo, J. (1995) Recreation Participation Patterns of Adults With And Without Mental Retardation. *Education And Training In Mental Retardation And Developmental Disability, December.*

Jahoda, A., Cattermole, M., & Markova, I. (1990). Moving Out: an opportunity for friendship and broadening social horizons?. *Journal of Mental Deficiency Research, 34, 127-139.*

Joyce, T., & Close, W. (1996) Listening To Service Users: How Can We Improve Choice?. British Institute of Learning Disabilities Annual Conference: Working In Partnership With Service Users.

Kennedy, C. H., Horner, R.H., & Newtown, S. J. (1989). Social Contacts Of Adults With Severe Living In The Community: A descriptive analysis of relationship patterns. In: D. Barber & S. C. Hupp. A Comparison Of Friendship Patterns Of Individuals With Developmental Disabilities. *Education And Training In Mental Retardation*, *March 1993.*

Kleinberg, J., & Galligan, B. (1983). Effects Of Deinstitutionalisation On Adaptive Behaviour Of Mentally Retarded Adults. *American Journal Of Mental Deficiency*, *Vol. 88, No.1, 21-27.*

Lazarus, R.S. and Launier, R. (1978). Stress related transactions between person and environment. In: Rutter, M. (1981). Stress, Coping and Development: Some issues and some questions. *Journal of Child Psychology and Psychiatry and Allied Disciplines, Vol. 22, No. 4, pp. 323-356.* Pergamon Press Ltd. Lazarus, R.S. and Launier, R. (1981).

Lee, D.J., Gomez-Marin, O, & Prineas, R.J. (1996). Type A behaviour pattern and change in blood pressure from childhood to adolescence: The Minneapolis Children's Blood Pressure Group. *American Journal of Epidemiology. 143(1), pp. 63-72.*

Legault, J.R. (1992). A Study Of The Relationship Of Community Living Situation To Independence And Satisfaction In The Lives Of Mentally Retarded Adults. *Journal Of Intellectual Disability Research*, *36, 129-141.*

Ley, P. & Florio, T. (1996) The Use of Readability Formulas in Health Care. *Psychology, Health & Medicine, Vol. 1, No. 1.*

Lloyd, C. (1980b). Life Events and Depressive Disorder Reviewed. II. Events as precipitating factors. In: Rutter, M. (1981). Stress, Coping and Development: Some issues and some questions. *Journal of Child Psychology and Psychiatry and Allied Disciplines, Vol. 22, No. 4, pp. 323-356.* Pergamon Press Ltd.

Lowe, K., & De Paiva, S. (1991). Clients' Community and social contacts: results of a 5-year longitudinal study. *Journal of Mental Deficiency Research*, *35, 308-323.*

Mansell, J., & Beasley, F. (1993). Small Staffed Houses For People With A Severe Learning Disability And Challenging Behaviour. *British Journal Of Social Work*, *23, 329-344.*

Mason, J.W. (1975). A historical view of the stress field. In: Monat, A., & Lazarus, R.S. (!985). Stress And Coping: An Anthology. Colombia university Press.

Mawhinney, S., & McDaid, C (1996). 'Having Your Say': Self-advocacy and individuals speaking up for themselves. Praxis: Belfast.

McDaid, C., Mawhinney, S., & Graham, C (1997). Portadown Home Response: An evaluation of the Home Response Scheme in Portadown. Praxis: Belfast.

MHF (1996). Building Expectations: opportunities and services for people with a learning disability. Report of the Mental Health Foundation Committee of Inquiry. London.

Newtown , T.J., & Keenan, A (1985). Coping With Work Related Stress. In: Cooper, C.L., & Payne, R (1988). Causes , Coping And Consequences Of Stress At Work. John Wiley & Sons.

Nicoll, A. & Harrison, C. (1984). The Readability of Health Care Literature. In P. Ley & T. Florio. (1996) The Use of Readability Formulas in Health Care. *Psychology, Health & Medicine, Vol. 1, No. 1.*

Nihira, K., Leland, H., & Lambert, N. (1993). AAMR Adaptive Behaviour Scale - Residential and community. The American Association of Mental Retardation.

O'Connor, N.J., Manson, J.E., O'Connor, G.T., & Buring, J.E. (1995). Psychosocial Risk Factors And Non-Fatal Myocardial Infarction. *Circulation, 92(6), pp. 1458-1464.*

Parahoo, K., and Barr, O. (1994). Job Satisfaction of Community Nurses Working With People With a Mental Handicap. *Journal of Advanced Nursing, Vol. 20, pp. 1046-1055.*

Paykel, E.S. (1978). Contribution of Life Events to Causation of Psychiatric illness. In: Rutter, M. (1981). Stress, Coping and Development: Some issues and some questions. *Journal of Child Psychology and Psychiatry and Allied Disciplines, Vol. 22, No. 4, pp. 323-356.* Pergamon Press Ltd.

Payne, R.L. (1988). Individual Differences And Occupational Stress. In: Cooper, C. L., & Payne R.L. (1989). Causes, Coping And Consequences Of Stress At Work. John Wiley & Sons.

People First (1994) Outside But Not Inside … YET! Leaving Hospital And Living In The Community: an evaluation by people with learning difficulties. London: People First.

Perry, J., & Felce, D. (1995). Objective Assessments of Quality Of Life: How Much Do They Agree With Each Other? *Journal of Community and Applied Social Psychology, Vol. 5, 1-19.*

Rose, J. (1995) Stress And Residential Staff: Towards An Integration Of Existing Research. *Mental Handicap Research, Vol. 8, No. 4.*

Rutter, M. (1981). Stress, Coping and Development: Some issues and some questions. *Journal of Child Psychology and Psychiatry and Allied Disciplines, Vol. 22, No. 4, pp. 323-356.* Pergamon Press Ltd.

Sands, D. J., & Kozleski, E.B. (1994). Quality Of Life Differences Between Adults With And Without Disabilities. In G. Hoge, & J. Dattilo (1995) Recreation Participation Patterns of Adults with and without Mental Retardation. *Education and Training in Mental Retardation and Developmental Disabilities*, *Dec. Vol. 30(4), 283-298*.

Schalock , R.L., & Genung, L.T. (1993). Placement From a Community Based Mental Retardation Program: A 15 year follow-up. *American Journal Of Mental Retardation*, *98, 400-407.*

Seed, P. (1996) Is Day Care Still At A Crossroads? Jessica Kingsley Publishers.

Shah, A., & Holmes, N. (1987) Locally-based residential services for mentally handicapped adults: a comparative study. *Psychological Medicine, 1987, 17, 763-774.*

Shepherd, G. (1985). Studies in the assessment and treatment of social difficulties in long term psychiatric patients. *Unpublished Doctoral Dissertation.* Institute of Psychiatry: London University.

Sherrard, H.E. (1992). Feeling The Strain: Job stress and job satisfaction of direct-care staff in the mental handicap service. *British Journal of Mental Subnormality, Vol. XXXVIII, Part 1, January, Vol. 74.*

Simons, K. (1995) My Home, My Life: Innovative Approaches To Housing And Support For People With Learning Difficulties. Values Into Action: Norah Fry Research Centre.

Sinson, J.C. (1993). Group Homes And Community Integration of Developmentally Disabled People. Jessica Kingsley Publishing Ltd.

Sundin, O., Ohman, A., Palm, T., & Strom, G. (1995). Cardiovascular Reactivity, Type A behaviour, and coronary heart disease: comparisons between myocardial infarction patients and controls during laboratory-induced stress. *Psychophysiology, 32(1), pp. 28-35.*

Szivos, (1992). The Limits to Integration? In: A.L. Chappell. A Question of Friendship: Community Care and the Relationships of People with Learning Difficulties. *Disabilty and Society*, *Vol. 9, No.4, 1994.*

Twigg, J., & Atkin. (1994). Carers Perceived: policy and practice in informal care. Open University Press.

Wagner, G. (1988) Residential Care: A Positive Choice. London: National Institute for Social Work / HMSO.

Wright, K. et al (1994). Evaluation Community Care: Services for people with learning difficulties. Milton Keynes: Open University Press.