University of Kent at Canterbury

Faculty of Social Sciences

Tizard Centre

M.A. in the Management of Community Care (Mental Health)

Making Community Connections

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Contents

Abstract

Project Mission

To develop out-of-centre and community connections as part of the psychiatric rehabilitation day service.

It is argued that recipients of community care services generally experience involuntary social isolation. Relocation out of institutions has increased the number of opportunities for contact with relatives, neighbours, colleagues and friends, but this potential has not, in the main, been realised and service users remain locked into closed communities.

This study examines the importance of community participation for people[1] who are supported by community care provision. Elements from previous studies are drawn together to form a framework, and the "community connections" approach is developed and then introduced to an existing psychiatric service. A clinically-based measuring instrument is piloted, and strategies for working with clients who wish to improve their community connections are explored. Resistance to the whole approach is examined, and efforts are made to achieve some organisational changes which will allow this way of working to flourish. Enhancing community integration is revealed as an important area which deserves further attention by both researchers and service providers.

[1]I have attempted to balance the use of male and female labels in the following text, and I have only used labels such as 'handicapped' or 'normal' when referring to the work of another author who uses these terms.

Chapter 1 The Importance of Community Connections

> "You can't build communities, but you can put in place a framework on which a community can grow." (mental health service user, personal communication)

Many sociologists have attributed a range of social problems to isolation and alienation (Hughes and Gove 1981 p50). Indeed, House et al (1988) review twenty years worth of research studies and conclude that socially isolated people are twice as likely to die at a given age compared with those who enjoy strong social ties. In psychiatric literature there is an acknowledgement of the association between social integration and mental distress, but the association is revealed as complex and untidy.

Poverty and disadvantage deny people opportunities to develop and sustain community participation (Holloway 1988 p177). The relationships that do exist with family members, neighbours and work or leisure associates can provide a monitoring service, alerting the helping agencies when required. Isolated persons are without the benefit of this monitoring function and so problems remain undetected until they become critical (Hughes and Gove 1981 p70), while people with few social networks may be more at risk of abuse. Psychiatric crises can precipitate withdrawal by others, and the social drift hypothesis (Hollingshead and Redlich 1958 p369) illustrates how, as episodes of disturbance fracture established lifestyle patterns, so people move down the socioeconomic scale and away from supportive relationships. This journey into isolation appears to reach its destination in institutionalisation, where residents experience severe role constriction (Estroff 1989) and shrunken social networks (Brugha 1991 p128).

However, the picture is not as uniform as it might at first appear. Hughes and Gove (1981 p48) note that relationships with household members are not always conducive to mental health, and, on some indicators, it is better to live alone than with those who are too critical or emotionally over-involved (Leff and Vaughn 1985 p37ff). Some older people associate high levels of personal satisfaction with a reduction of social interaction (Taylor and Huxley 1984 p26) and, in some psychiatric diagnoses, relapse is correlated with an increase in social stimulation (Brugha 1991 p152).

Despite the above cautions, Brugha (1991 p152) generally sees social isolation as a sign of illness and integration as a treatment goal, since it constitutes a buffer against the development of psychiatric disorder in response to adversity and is a crucial factor in determining successful survival in the community. Finally, Burchard (1992 p137) identifies social life as among the most critical aspects of lifestyle related to quality of life.

Segregation and Isolation

Long term mental health problems and institutionalisation are associated with a range of features which will affect social contact (Holloway 1988 p176). These include: self care, as neglected personal hygiene can offend others (Bates and Pidgeon 1990); home management, as hospitality is a valued feature of friendship; unemployment; poverty, and restricted use of educational and leisure facilities. Such relationships as are formed may well be characterised by dependency, damaged during acute episodes of disturbance, inhibited by low self-confidence and experienced as very stressful. Institutional care is likely to offer a restricted set of models of appropriate behaviour and an ever-narrowing social circle (Goffman 1961). Taylor and Huxley (1984 p28) observe that:

> "Social networks of schizophrenics (were found to be) small, especially in relation to non-kin members. The members of the network are also poorly connected and their relationships with the schizophrenic tend to be asymmetric in that they are directed more by the other person than the schizophrenic individual."

So how have community care policies affected this process? Has geographical relocation from campus-based institutions into more ordinary housing resulted in enhanced community participation? The community care policies in mental health have been mirrored in learning disability services, and there are sufficient parallels in terms of philosophy and practice to allow comparisons to be drawn. The evidence from learning disability is unequivocal. Supported accommodation, domiciliary provision and day care make up the bulk of interventions in this area, and evidence is available in each of these fields to confirm that service users remain isolated.

A) In supported accommodation, Dalgleish et al (1983 p233) found that fewer than 10% of the residents had been on holiday with relatives in the past year, very few had local friends, and only half had seen any member of their family in the last three months.

B) McConkey et al (1982), working in Ireland, examined how people with learning disabilities who lived with relatives used their leisure time. Nearly half the group did not take part in any activity outside the home; only one third took part in any

community activity and only one fifth had non-handicapped friends. (See Lowe and de Paiva 1991 p309).

C) Seed (1988 p217) studied the experience of 139 day centre users and concluded, "There is no evidence, therefore, that centres contribute to the process of enabling individual clients to mix with normal (sic) people... it could be argued that centre attendance restricts the opportunities for mixing with more normal people."

So people with support needs live isolated lives and formal services do not ameliorate the problem. Government policies based upon the assumption that informal supports will spontaneously emerge appear over-ambitious (Wenger 1993 p38). Indeed, the picture is so depressingly uniform that Wilcox and Bellamy (1987 p178) sum it up by asserting that people with severe handicaps will experience few relationships, that those contacts will be restricted to other clients, staff or immediate family members, and that they will be impersonal and temporary unless there is "focused effort" to change this pattern. Such focused effort must be directed towards increasing opportunities and choices for service users, rather than prescribing a certain kind of lifestyle or degree of social integration. I hope, by the end of this study, to make some suggestions about the nature of this focused effort, but before doing so, must examine the philosophy which underpins the "community" element of community care.

New Philosophies

Integration into society has been defined in a number of ways. A limited definition is offered by Norris (1984), who, addressing the needs of people discharged from secure environments, considers 'community tenure' as merely avoiding recall to hospital, and by Reiter and Levi (1980 p25), for whom 'community integration' means no more than attendance at a work training scheme. By contrast, Perske (1993 p2) writes of the lives of disabled people "interweaving emotionally with the lives of others" in the neighbourhood. The underlying difference between these narrow and wide definitions is whether the focus is upon service utilisation (using a work scheme or a residential unit), or upon citizenship and community membership. This shifting focus has been described by Carling (1990 p969) who writes about mental health services as follows:

> "..it has been suggested that the field is in the midst of a "paradigm shift" from an era of institutional and facility-based thinking, to a transitional period in which people were seen principally as service recipients needing professional support systems, to a world view in which people are seen as citizens with a potential for, and a right to, full community participation."

Four streams of ideas have aided the growth of interest in community connecting, and they will be reviewed and commented on below. They are: normalisation, the five accomplishments, friendship, and inclusive community.

Normalisation

Integration into society is promoted as a primary means of achieving valued lifestyles for people who are traditionally devalued. Nirje perceived normalisation as:

> "making available (to the mentally retarded person) patterns and conditions of everyday life which are as close as possible to the norms and patterns of the mainstream of society. An ordinary life includes .... privacy, normal access to social, emotional and sexual relationships with others." (Nirje in Ramon 1991 p6)

Indeed, Wolfensberger (1980 p77) has no time for any kind of congregated service and he asserts:

> ".... in the long run, no good can come of any programme ... that is not based on intimate, positive one-to-one relationships between ordinary unpaid citizens and those who are handicapped."

Thus, Wolfensberger and others, such as Brandon (writing about hostels in 1986) and Steele (writing about supported employment in 1992) would close specialist residential and day care facilities and retrain the staff to deliver a service in non-specialist community facilities. They argue that congregated services meet many needs which otherwise would be met by contact with the community, such as food, friendship and recreation; that they amplify images of disability, and that excursions into the community are more likely to be affected by the presence of other disabled people.

However, the critics of normalisation have many important points to make. Congregated services have the potential to offer a safe place for participants to acknowledge their disability, talk through the emotional and practical consequences of the loss of their "healthy selves", face stigma, swap coping strategies, set realistic goals and redefine their experience as a political rather than merely a personal struggle (Hendrix 1981, Szivos and Griffiths 1990,

Chappell 1992). Normalisation is accused of encouraging people to deny their experience, "pass" as non-disabled, and conform to the values of the dominant society. Moreover, Ramon (1991 pp10,21) asserts that normalisation has been blind to issues of class, gender, ethnicity and poverty.

The Five Accomplishments

O'Brien has attempted to operationalise Wolfensberger's approach by focusing upon five areas that are viewed as having an important influence upon the quality of a person's life. The selected areas are (a) community presence, (b) choice and autonomy, (c) competence, (d) respect, and (e) community participation (Gilbert 1993 p121-122). Community presence means that people with disabilities use the same geographical space as everyone else, by living in ordinary streets, using local shops, public transport and so on, while community participation requires people with disabilities to engage in valued roles and relationships in those communities, by working and joining community associations.

Friendship

According to Chappell (1992 p45), normalisation theorists devalue relationships between disabled people. She points out that these contacts may actually be a source of great pleasure and support. Felce (1988 p356) notes that friendships take many forms, and observers should beware of imposing their own interpretation or denigrating contacts which they perceive as merely superficial. This point is picked up by O'Brien and O'Brien who note that friendships are sometimes invisible to the outside observer (in Amado 1993 p16). Individuals, whose sole interactions with others are composed of monosyllables or silent co-existence, can often be conducting intimate, emotional relationships with others in their heads and hearts.

Friendships occur when there is an exchange of practical help, shared company or intimacy (Richardson and Ritchie 1989). They sometimes form when people meet in formal relationships (co-worker, relative, carer, fellow student, neighbour, flatmate), but these relationships are not sufficient to ensure that friendship actually occurs. The building blocks of valued interpersonal relationships include choosing to meet, the opportunity to meet, continuity, reciprocity, the skills to build and maintain the contact, and a belief that each has something to offer. It is perhaps the element of choice that marks friendship out and distinguishes it from more formal roles such as fellow student or neighbour, enabling friendship to reveal something of the identity of the friends.

However, friendships also form an arena where the wider conflicts of an unequal society are played out. In the arts, for example, Traustadottir (in Amado 1993 p115) claims that the greatest friendships have been between men, while women's friendships have been portrayed as frivolous and superficial. In Western society, caring and nurturing is socially organised as women's work, and so many disabled people experience relationship with non-disabled people solely through women. It follows that a political understanding of the concepts of both disability and friendship is necessary before designing services in this field. This study is also focusing upon a wider range of roles and relationships, rather than just friendships.

Inclusive Community

Writers in this group consider that there are many possible roles and relationships available in the community to people with disabilities and they can be located and unlocked by emphasising our common bond of humanity and interdependence (Mount et al 1988, Beeman et al 1989, Ludlum 1993). Care staff are seen primarily as human beings who "walk with"

friends who are "differently able". As a result, the advocates of inclusive community sometimes present models of life-sharing, rather than developing a formal, professional relationship which is constrained by limitations of time and intimacy.

Firth (1986 p13) provides an early example of the approach. He observed that the bulk of community connections for people with learning disabilities who live in residential care occur where the care staff have introduced hostel residents to members of their own personal networks. Firth goes on to suggest that staff should be recruited on the basis of:

> "... (the extent to which they will) themselves encourage their own families and friends to make contact with the young people they serve ..... the range of friends and contacts a potential member of staff may have. Their involvement in leisure or other community activities (church, Round Table etc) may be particularly relevant."

There have always been staff who have maintained friendships with the people they care for by opening their homes, sharing holiday photographs and confiding some personal matters, but these have often been semi-secret, out of hours friendships. Firth's proposal, however, appears fraught with unresolved issues around risk and protection, the rights of the relatives and friends of an employee, and the long-term mental health of staff (Hearn and Parkin 1987 p114-5). The more recent exponents of inclusive community cited above prefer to explore the actual and potential networks of the resident, rather than the worker.

Despite these reservations, the focus upon inclusive community is attractive for its optimism about the capacity of ordinary citizens to build mutual, valuing relationships with citizens

with disabilities. This optimism has fuelled efforts to provide opportunities for disabled people to integrate into ordinary activities such as further education, employment and recreational pursuits, and has strengthened the hypothesis that, for many service users, social isolation and role constriction is a consequence of the service, rather than the person.

These four streams are not clear and distinctive in their identity or their effect upon community care services, but each one has strengthened the case for tackling the profound deficit in social and community connections experienced by people with disabilities. Each stream is subject to criticism, as has been shown, but the overall case for developing community connections opportunities remains strong, and the poverty of contact which is such a feature of the lives of disabled people demands careful but determined action.

Demonstration Projects

Having looked at a number of theories about the importance of community connections for people with disabilities, I will now describe some projects which have attempted to bring these principles to life.

Clubhouse

The evolution of clubhouses since Fountain House was opened in New York in the 1940's has been well documented (see for example, *Psychosocial Rehabilitation Journal*, 16, 2 which includes twenty articles on Clubhouses). The Clubhouse model forms the most clearly articulated day provision in mental health but, despite this, its relationship with the natural community is ambiguous. On the positive side, some Clubhouses offer housing support, thus

enabling members to become neighbours, and the Transitional Employment Programme is a vital part of the package for all Clubs, enabling members to become co-workers. On the negative side, Angers (1992 p122) explains how the Clubhouse forms a special nurturing environment to defend members against siege from a hostile, stigmatising society until they are restored sufficiently to re-enter it. Beard (1992 p111) observes that many members are socially isolated apart from the Club, and complains that "we who work in Clubhouses aren't really doing anything in an intentional way about members and their social network outside the Clubhouse".

Supported Employment

Pozner (1993) found 1600 people with a range of disabilities in the United Kingdom who had been supported into paid employment via intensive induction delivered by job coaches. Coaches analyse the practical and social tasks that need to be learnt, so that the jobseeker gradually acquires the necessary skills to perform successfully in their chosen occupation. The job coach activates natural support from the new work colleagues and slowly withdraws. This provides an example of focused effort, which, in an intentional way, enables people to adopt valued roles in the community.

Supported Education

Unger et al (1991 p838) provides another example of focused effort, aiming to support people who wanted to return to higher education. A four term part-time programme was offered

comprising vocational guidance, help with study skills and welfare support, after which students then moved on to integrated classes, but remained in contact with the programme. This successful project is distinctive in that it deliberately used a congregated setting as a precursor to integration.

Community Connecting

Sunderland Social Services Department have established projects in mental health, learning disability and physical disability services with the sole purpose of providing support for clients to engage in community based activities. Founded upon a clear notion of inclusive community, they employ sessional workers who are matched with individual clients in order to facilitate community membership. Training in Systematic Instruction methods are applied to social and recreational settings and workers offer intensive support for an induction phase, with the clear goal of activating natural supports and withdrawing as soon as the client can sustain their own network (Joanne Pell, personal communication 21/4/95).

Volunteering

Plymouth Volunteer Centre employs two staff who assist a maximum of 25 community care clients to become volunteers in the wider community. Each person must also have the support of a care manager, and careful matching leads on to intensive support (often with "support volunteers" paired with clients) in a twin placement. Participants meet one another weekly, and disability awareness training and support is made available to placement hosts (Peter Chappell, personal communication, 23/11/95).

Sports Activities

Leisure Direct in Hertford is a partnership between statutory and voluntary agencies which employs a worker to assist community care clients gain equality of access to mainstream sports and leisure facilities. Taster sessions are offered in both day centres and leisure centres, leading to full participation as ordinary members of the community. Around a hundred people participate (Healthy Alliance 1996, p14-15).

Each of these initiatives stands in contrast to a traditional training approach in which Day Centres act like classrooms where clients rehearse a variety of functional competencies before venturing out into the natural community. Wilcox and Bellamy (1987 p5) assert that, by emphasising complete activities rather than component skills, inventing new routes to the desired result, and focusing on objectives that make an immediate difference to the quality of life, most skills can be taught in the natural environment. The examples cited above support their belief and imply that care staff need to develop new skills. These new skills include helping people find their way around the community, making contacts with others, introducing people to one another and enlarging the capacity of the community. Amado concludes a book peppered with examples of community connecting by offering the following set of occupational qualifications for staff undertaking this role:

> ".. an ability to focus on the gifts and capacities of a person with disabilities rather than their deficiencies, a capacity to work by trust rather than authority, a belief that the reason people with disabilities are not in the community is because no one has asked them to join, and a willingness to let go after they have guided someone into the community." (1993 p292)

Chapter 2 The Project Goals

Increasing the potential for community integration is an important but often neglected goal for people who use community care services. The remainder of this study examines how this issue affected RCCS (a psychiatric rehabilitation service) over an eighteen month period of discovery and experimentation. Beckhard and Harris (1987 p17), in describing how to manage change in complex organisations, encourage planners to clarify a vision of the future state or goal that lies three or four years ahead in as specific terms as possible, and then to specify transitional goals.

RCCS provides psychiatric services to people with long term needs in a city of 620,000 inhabitants. As Day Services Manager, I am responsible for four day centres. At the beginning of the study, little effective work was being done to assist clients integrate into the wider community, and this is what motivated me to consider this area in more depth.

Table One lists the eight goals formulated by the day service and indicates the interventions, transition state and future state relevant to each one. Chapter 3 then describes the method of working towards each goal and chapter 4 gives the results of the interventions and discusses their implications.

The change process involves assessment, intervention and review in a constant cycle where internal and external forces combine in ever-changing ways. In such an environment, the "start" and "finish" time points of a project are somewhat arbitrary (Quinn in Mayon-White 1987 p79). This project is deemed to start in late 1993 when the Day Service was entirely

centre-based and there was little perception of the need for change, and the "finish" point occurred in April 1995 when the Day Service Team Leaders and the RCCS Management Group unanimously agreed to adopt a community connections approach to service delivery. The project can therefore be summed up as an attempt to change the mindset of key service providers (by offering information, recruiting allies and developing skills) so that services can subsequently change. Observers of RCCS in 1995-7 will witness the next phase of the process, in which the shared dream of service change will be converted and adapted into everyday reality. This process will require a new set of assessments, goals, interventions and evaluation.

The change journey does not have a clearly defined starting point or finishing tape and nor is there a single, straight-line route from the one to the other. The strategy adopted in this project was to pursue a set of interlinked sub-goals, recognising that, while such an approach makes neat analysis difficult, it offers the best hope for success (Hunt 1992 pp259 - 300). The goals were not all exactly specified at the beginning of the process, and some came to light or increased in prominence as the project developed - a process which Quinn calls 'logical incrementalism' (1980 p3). This report recounts the wasted journeys down cul-de-sacs and the partial solutions as well as the productive parts of the journey, but there is inevitably some of the simplification of hindsight.

Table One - The Project Goal

GOAL	INTERVENTIONS	TRANSITION STATE	FUTURE STATE
1. BUILD A MODEL	A) Review the literature and develop a model. B) Develop a measure for community connections.	Available literature will be utilised to create a model for thinking about contacts and a means of measurement.	The project will be informed by the work of others in this field.
2. ASSESS THE PRESENT STATE	Describe the local service and investigate how staff consider they are working in relation to the development of social integration.	The present state of the local rehabilitation service will be reviewed	Service development will be based on an accurate assessment of the present.
3. PLAN CHANGE	Analyse the demand system and consider available resources. Clarify a vision of what the redesigned service looks like.	Resources will be identified to initiate and sustain change towards the agreed new service design.	The service will develop effective work in enhancing the community connections of users.
4. DEVELOP EQUAL OPPORTUNITIES	Assess the community integration of 50 day service clients and make appropriate interventions.	Day Service staff will carry out some individual work, assisting and supporting people to make community connections of all kinds.	Women and minority ethnic people will receive appropriate services.

(continued overleaf)

Table One - The Project Goal

(Continued from previous page)

GOAL	INTERVENTIONS	TRANSITION STATE	FUTURE STATE
5. DEFINE EFFECTIVE STRATEGIES	Collect experiences from the staff involved in the project.	Strategies for developing Community Connections will be identified, shared and evaluated. A range of approaches will be explored.	Day Service users will be encouraged to increase their community connections. As a result, clients will have a larger circle of social contacts which will include people who are neither service users or providers.
6. CATALOG OFF SITE GROUPS	A) Develop a checklist for reviewing off-site groups. B) Survey off-site groups.	The purpose, role and functioning of all off site groups will be reviewed. Some groups will be accessible to new clients.	A number of community based groups will be available, and clients will be informed about the choice available. The development of new groups will be carried out in response to client need.
7. CLARIFY STAFF ROLE	Assess the staff response to the project, develop materials and deliver training.	Training will be available to staff. As a result, appropriate and skilled support will be available to clients.	All staff will consider it a part of their role to assist clients in the development of community connections, and will have the appropriate skills for this task. The role of paid users, trainees, volunteers and students will be clarified and operational.
8. LOCATE RESOURCES	Market the project and incorporate any resources which become available.	This project report will form a case of need which will be presented to a variety of agencies with a view to obtaining resources for developing Connections.	Specialist workers will be in place to act as Community Connectors. Their influence will affect the overall culture of the service.

Chapter 3 Methods

This chapter contains a description of what I did under each goal. The results that were obtained can be found in chapter 4, along with a discussion of the implications of the results.

Goal 1: Build a Model

I reviewed some of the available research on the community connections of community care clients in order to build a framework for describing different kinds of contact with the community, and secondly, to develop a measure which locates people on a spectrum between isolation and integration, so that changes could be monitored and interventions assessed. Reading and reflection was combined with discussions with an array of people and, later on, half a dozen more formal presentations to external bodies (see Appendix 1 for a diary). These debates provided informal opportunities to test the robustness of the framework.

The Measure needed to avoid the charge of naiveté by addressing the multi-dimensional nature of community integration; and complexity, by avoiding the need for specially trained staff to administer it and statisticians to interpret the results. The design of a measuring instrument was guided by the following four criteria:

1. The need to present Community Connections data in a way that is useful to the client and helps her/him to make a plan for the future. Nolan and Grant (1993) assert that much academic research has failed to make much of an impact upon service delivery because it has tended to describe and criticise, rather than seeking practical solutions in partnerships with care practitioners and care receivers.

2. The need to enable this data to be examined over time, so that changes in the client's own pattern of Community Connections can be discerned. The Measure needs to be sensitive, as changes may be very small.

3. The need to enable this data to be aggregated so that a population may be examined.

4. The need for simplicity. Felce summed up this viewpoint when he wrote, "To some extent, the definition of friendship remains an academic problem while the extent of social relationships outside family and staff enjoyed by people with mental handicap remains so constricted. The situation is so extreme that fairly crudely defined indicators are sufficient for pragmatic evaluation." (Felce 1988 p356)

Available measures did not meet my needs, as they tended to focus upon only a single element of community integration, such as counting expeditions out into the community (McConkey 1982, Firth 1987), use of community amenities (Saxby 1986, de Kock 1988), participation in a specific activity in the community (Reiter and Levi 1980, Schalock 1986), or social contact with no recognition of the spatial dimension (Lowe 1991, Poel 1993). As a result I designed a measure which attempted to bring the social, spatial and temporal dimensions together into a matrix which also incorporated a simple assessment of the client's satisfaction and aspirations for change. The client was asked to place on to a grid the people s/he saw and the specific location in which they were seen. Data was entered in each relevant cell in the people/place grid using a code which indicated frequency of contact. Finally, the

client was invited to circle any cell where they wished to make changes. It was helpful to invite staff to use the measure themselves prior to working with clients, and several remarked upon how vulnerable and self-conscious they felt about disclosing details of their social lives. There was an impression that some clients tended to under-report their activities, possibly out of fear that current support services would be withdrawn. Others were dissatisfied in a vague way about feeling lonely, but were unable to specify what they wanted to change. Inadequate piloting of the measure resulted in problems with aggregation and interpretation. Further information about the measure is found in Chapter 4, and a full description can be found in Appendix 2.

Goal 2: Assess The Present State of the Organisation.

Without a clear description of the present state of the organisation, it will be impossible to know if there is a need for change at all or to know if change efforts have been successful. This is followed in Goal 3 by a consideration of the forces which are at work in the organisation to precipitate or prevent change. The focus is upon the work of RCCS in assisting clients to develop community connections. Consequently, I took the four dimensional model devised for Goal 1 to each part of RCCS and interviewed staff about their service performance. The interviews were conducted either with a knowledgeable individual or a whole team of staff.

Goal 3: Plan Change.

Change will only be sustained if there is a clear understanding of the demand system, available resources, and a vision of what the future service might look like.

The analysis of the demand system and available resources was based on my knowledge of the service and discussions with colleagues. Building a vision of the future service was a highly complex task, involving open meetings with users, examples of demonstration projects drawn from the literature, networking with allies around Britain and overseas, many meetings with staff, and negotiations with external agencies.

Lessons were also learnt from the way in which staff engaged with the project. At the outset, interested staff were invited to join a Practice Development Group which met monthly, and work on agreed goals in between meetings. Subsequently, this group became a more formally structured Team which met more frequently.

Goal 4: Develop Equal Opportunities.

Day services have three options for addressing the important theme of equal opportunities - generic centres, black centres, and community-based individual work. In responding to the first option, the local day centres have attempted and failed to create multiracial environments.

In considering the option of black-only centres, Sassoon and Lindow (1995 p97) note that some black users "may prefer to explore issues related to the psychiatric system with other black people" and black users have asked for black centres in user surveys (McGovern and Hemmings 1994, Radia 1996). However, the clear call for black users to obtain some control over the design of mental health services (Christie and Blunden 1991 p13; Faulkener 1995 p21) cautions white service providers against creating prescribed, congregated black-only spaces before they have undertaken extensive consultation. There

appear to be a growing number of black day centres for people with mental health problems (for example, the King's Fund Centre in London have a list of twelve centres, see also Sone 1992 and Francis 1994)

In the light of the evidence cited above, it is necessary to re-profile the existing day services to provide both black-only spaces and times, and to establish a more community-based, individualised approach. It is this latter strand which was pursued in the project.

Ten members of staff used the Measure designed for Goal 1 as an assessment tool with a total of 50 clients. They were then asked to monitor their community contact interventions for a six month period before repeating the assessment. This exercise linked together the use of the measuring instrument, the development of staff skills and the collection of strategies for supporting clients.

Goal 5: Define Effective Strategies.

Simply being there in the community is not enough, since a person may carry an old role into a new social context and continue to be perceived as dependent and odd rather than wise and resourceful. This is the reason why individual support packages must be tailored to the needs of a specific client at a specific time with the aim of achieving a valued social role in a specific setting. The aim is to gradually replace professional support to a client with alternative natural supports delivered by other citizens, rather than simply withdraw professional support.

Appendix 3 contains a catalogue of strategies that was devised from the literature and the observations of staff involved in the project. It offers a language for describing some of the myriad of initiatives which might help a person develop community connections, examples from the literature, local examples within RCCS, lessons learnt about the best use of a particular strategy, and some hazards. Staff involved in the project were asked to add to this list from time to time as a way of focusing on strategies and developing conscious expertise.

Goal 6: Catalogue Off-Site Client Groups.

I led a discussion amongst RCCS day service staff which resulted in the creation of a checklist for use in periodic reviews of each group. This covered the diversity of groups and required the staff to consider the group's role in community connecting, amongst other aims. The checklist can be found in Appendix 4. Day service staff adopted this checklist for routine use in all the off-site groups they run. A brief questionnaire was also sent out to all RCCS teams and the results collated and returned, so that all staff had a directory of current activities across the Directorate.

Goal 7: Clarify Staff Role

Although many staff were interested in the project, few managed to attend meetings or undertake community connections development work with clients or services, and so some work on the diagnosis and management of resistance was undertaken (Beckhard and Harris 1987 p98).

It was especially interesting to note Wenger's (1994a p16, 20) comments on the subject of staff resistance when she tried to introduce a social network questionnaire to a number of

social work teams. In her work, managers were committed to the project, but practitioners needed a much bigger investment of time to achieve the shift to a new approach (see also Segal 1991 p89), and were in danger of falling back into old ways in the face of workload pressure (Marsh and Fisher 1992 p47). Staff feared that such a blunt exposure to the poverty of their social lives would be distressing to clients (Wenger 1994a p18) and that taking notes would interfere with the interview (Wenger 1994a p87). There were difficulties in interpreting standard interview questions, difficulties in following instructions and problems with the interpretation of results (Wenger 1994a p9). In addition, workers may fear stigma and rejection in the wider community, and Holloway (1988 p170, 178) notes that the informal support systems between day centre users are experienced as so valuable that they generate a "gravitational pull" which draws people back into congregated services.

Wenger's explanations for staff resistance were enriched with informal guesses and comments from other literature (Evans 1992 p33; Nolan and Grant 1993 p307), to form a checklist of 15 possible reasons. I then asked fifteen staff members to place a value between 0 and 9 against each of these possible reasons, to show how influential they considered each reason to be (they were all involved in the project or had some knowledge of it and were available at the time. There were no other selection criteria for this group). There scores were aggregated and the 15 reasons were then ranked in order of priority.

Beckhard and Harris (1987 p98) note that "Educational intervention can unfreeze attitudes and initiate new ways of working", and this advice was followed by delivering a number of

training events for staff as shown on the diary at Appendix 1. Training materials are found in Appendices 3, 6 and 7.

Goal 8: Locate Resources

Analysis of the present state of the organisation and the demand system (goals 2 and 3) showed that real progress would only be made if specific resources could be ring-fenced for the project. These were located within RCCS by inviting interested day service staff to join the Practice Development Group, and later on, establishing this group as a part-time Team. New resources were identified through negotiations with external agencies who were willing to work in partnership with RCCS. Substantial time was spent in the search for partners - in exploratory meetings, clarification of roles, searching for a common agenda, liaison with colleagues, securing funding and providing supervision.

Chapter 4 Results and Discussion.

In this chapter I return to the table of Project Goals set out in chapter 2, and reproduce the table goal by goal so that the outcomes can be clearly checked against the transition state and future state. The results achieved by the interventions are summarised and discussed, while lengthy evidence is generally relegated to an appendix.

GOAL 1	INTERVENTIONS	TRANSITION STATE	FUTURE STATE
BUILD A MODEL	A) Review the literature and develop a model. B) Develop a Measure for community connections.	Available literature will be utilised to create a model for thinking about contacts and a means of measurement.	The project will be informed by the work of others in this field.

A) Review the literature and develop a model.

This section reviews some of the available research on the community connections of people who receive community care services. I suggest a framework of four elements that describe different kinds of contact with the community. These are not exclusive, and a single activity may well include two or three of the elements, but it is helpful to isolate them for care planning and discussion. Each element is briefly considered in turn, and the framework is summarised as Table Two.

Going Out

This is the simplest topic for research and is generally applied to residential situations. For example, Firth and Short (1987 p345-9) studied the lives of five young people who moved

from hospital to hostel accommodation. The number of outings and their duration increased by over 50% following the move. It is possible to add a layer of complexity to this kind of study by listing the destinations of the outings, with either few or many categories. For example, Lowe and de Paiva (1991) devised eighteen categories of outing. However, a list of outings tells us little about the meaning of those excursions to the person concerned.

Outings of almost any kind can be enriching, enlarge the repertoire of topics for conversation, and stimulate interests. Organised visits, repeatedly using the same destination, can build up a sense of familiarity and so add these venues to an individual's personal map. Dalgleish et al (1983) devised an "accessibility index" which awarded positive scores for facilities such as nearby shops and negative scores for barriers such as busy roads, allowing comparisons to be made between residential or day service locations. Staff or other allies can often help in this field by assisting with the arrangements, providing transport, or serving as an escort.

Community Amenities

Once the person has left their home or day centre and ventured out into the community, there are a wide range of amenities and activities which might be accessed. In using "community amenities" the person enters a functional relationship with others, and undertakes activities which often relate to personal survival. Forrester-Jones and Grant (1994) note that isolated people value the contact they have with people via their occupational roles in the community (such as the shopkeeper or hairdresser). If the person fails to make use of some of these community amenities, he or she will not survive.

Saxby et al (1986) examine the way in which people with a learning difficulty used shops and cafes. They offer the notion of "substantive participation" to describe actively engaging in appropriate behaviour in a particular setting. This would distinguish, for example, passively accompanying a staff member who was shopping, from an occasion where the person with a disability was pushing the trolley, selecting items, offering money to the cashier and packing bags.

Firth and Short (1987) also draw out a distinction between those activities which do not actively promote interaction (they cite watching football or visiting the library as examples), and other activities which hold a definite potential for meeting new people and developing such contacts into friendships.

The operational procedures in a residential or day service will help or hinder the use of community amenities. If service users must buy their own lunch, the local fish and chip shop may be patronised; if building maintenance functions are the responsibility of residents, then the hardware shop may be visited.

A distinctive factor in these environments is the nature of contact with others. Although interaction with non-disabled people does take place, it tends to be instrumental, brief and impersonal. However, people who already know each other might use these community amenities together to develop their friendship; acquaintances may go for a drink together, walk in the park or spend an afternoon shopping.

Integrated Pursuits

While the use of community amenities is characterised by brief contact with other citizens, this element is concerned with longer term membership of social groups. The pursuit might be remunerative employment, further education or a recreational activity and may provide a social role which is highly valued in the community. Those attending have some sense of group identity and are bound together by a common interest or activity, rather than a medical diagnosis. The role of a carer or ally may range from companionship to making introductions or repairing an activity when it appears to be in danger of breaking down.

Saxby and her colleagues (1988 p138) observed that residents could be assisted in using shops and cafes, but "further development is required to support them in integrated social and leisure pursuits." Both Evans et al (1992) and Schalock and Lilley (1986) note that people with disabilities sometimes achieve geographical integration by attending the same group as other citizens, but fail to integrate socially. It may be easier to create the illusion of integration than the reality.

The distinction between Community Amenities and Integrated Pursuits will be difficult to maintain at times, depending upon the nature of the environment at the time it is accessed. For example, attending a church service might fall into "Community Amenities" if it is used like a classical concert, or "Integrated Pursuits" if the congregation are friendly and active in including newcomers.

Social Networks

Willmott (1986) gathers together data from a number of sources and reports on the frequency, amongst the general population, of contacts with relatives, neighbours and friends. He found that men have more contact with others than women; that African-Caribbean and Asian elders have less than average contact with neighbours; and that young people have more contact with friends than older people.

However, support is a combination of both quantity and quality of contact. Tolsdorf (1976) examined the social networks of psychiatric in-patients and found that their relationships were less intimate than a comparison group and the subjects perceived themselves to be dominated by network members. Furthermore, they were less likely to draw on network resources due to worries about the ignorance or insensitivity of network members, compared to a control group. Silberfeld (1978) found that his group of psychiatric patients were in touch with as many relatives as the control group, but met them less frequently and spent less time at each encounter. In contrast to these findings, Nelson (1992) examined the networks of a number of people who were receiving psychotropic medication and found considerable evidence of reciprocity in relationships. Transactions between patients were characterised by a higher level of emotional support than the relationships with relatives or professionals.

A substantial body of work by Wenger and colleagues (Grant and Wenger 1993; Wenger 1993; Wenger and Scott 1994) focuses upon support networks and care needs amongst a sample of elderly people, rather than the broader notion of social networks and the development of valued social roles. It is important to be clear whether the focus is upon role or support networks.

Relationships with relatives, neighbours and associates confer a sense of identify, value and role. Allies can use a wide range of strategies to support people who wish to expand branches of their social network, increase the degree of intimacy or replace negative exchanges with more positive ones.

Firth and Rapley (1989 p8) liken social networks to a growing tree:

> "Some branches will lead nowhere, they stop growing. Other branches may grow and expand vigorously for a time until conditions change, when other, smaller branches may in their turn grow into an extensive network of interwoven activities, acquaintances and friends."

Discussion

This framework has held up well in the face of extensive debate and access to further literature. For example, Richardson and Ritchie (1989) distinguish roles, such as work colleague, confidante, leisure companion - but these could easily be utilised as subsets of the "Social Networks" element. When the framework was utilised with colleagues in assessing the present state of the organisation (goal 2), staff found it both easy and helpful to think about their service in relation to the four elements. It also moved some staff forward from the pre-contemplative stage to the contemplative stage of change (DiClemente 1994).

However, the model has not explored the relevance of literature about unemployed people, and there may be some similarities in terms of financial resources, self esteem and lack of time structure which would be worthy of consideration.

Table Two - Components of Community Connections

GOING OUT - leaving the residential or day care building for any reason.
GOAL/RATIONALE - To enlarge experiences, develop interests, gain respite from other household members, acquire topics for conversation, add to collection of "safe places".
INTERVENTION - Site units to maximise accessibility. Staff or other allies to escort.
EVALUATION - Frequency of outings, destinations.
RESEARCHED BY - McConkey (1982), Firth (1987).

COMMUNITY AMENITIES - places to shop, eat, drink, walk, look.
GOAL/RATIONALE - To develop independence in activities of daily living, to reduce use of specialist services, to develop existing acquaintances into friendships.
INTERVENTION - Clients to spend own money, agency to devolve budgets so clients can spend them, withdraw hotel services after suitable supports are in place.
EVALUATION - Use of shops, eating and drinking places, "substantive participation" in these settings.
RESEARCHED BY - Saxby (1986), de Kock (1988).

INTEGRATED PURSUITS - joining a group of citizens without apparent disabilities to work, learn or enjoy leisure time.
GOAL/RATIONALE - To socialise into valued roles, to make acquaintances who have common interests, to pursue skills and interests with those people over a period of time, to develop an active life and support network apart from formal welfare services.
INTERVENTION - staff or allies to introduce clients to activity and others involved, arrange or repair activity, or participate in the pursuit.
EVALUATION - Membership of integrated groups, frequency of use of integrated settings.
RESEARCHED BY - Reiter and Levi (1980), McConkey (1982), Schalock (1986), Seed (1988), Evans (1992).

SOCIAL NETWORKS - relatives, friends, neighbours, colleagues who care.
GOAL/RATIONALE - For companionship, practical help and emotional support, to buffer against stress and illness, to connect with a growing network of contacts.
INTERVENTION - Focus on growing branches of the network - relationships that can lead on to other acquaintances, arrange opportunities for a wide range of introductions, interpersonal skills training.
EVALUATION - Personal support network, contacts with relatives, role of contacts (are network members mostly family? other service users?)
RESEARCHED BY - Mueller (1980), Dalgleish (1983), Firth (1987), Lowe (1991), Poel (1993).

B) Develop a Measure for Community Connections

At the beginning of the project I devised a method for collecting community connections data and negotiated with staff for it to be piloted. Informal reports indicated that both clients and staff found the instrument to be helpful as a discussion starter. However, the data turned out to be ambiguous (as several life situations would show up as identical returns) and impossible to aggregate. In consequence, the instrument was abandoned and resources were located to enable a better measuring instrument to be developed by a doctorate student from the local University.

A detailed description of this instrument, and the reasons for its failure, can be found at Appendix 2.

Discussion

In terms of research design, more thorough thinking through and piloting of the instrument, especially by doing some aggregation of data, would have been useful (Oppenheim 1976 p3). However, the basic axes of "people" and "places" continues to be a significant feature of newer models, and debate continues about who should conduct the structured interview. Some clients speak more freely to a stranger and do not try to give the "right" answer, whilst others find the prompts from staff who know them well can unlock "forgotten" parts of their lives.

GOAL 2	INTERVENTIONS	TRANSITION STATE	FUTURE STATE
ASSESS THE PRESENT STATE	Describe the local service and investigate how staff consider they are working in relation to the development of community connections.	The present state of the local rehabilitation service will be reviewed	Service development will be based on an accurate assessment of the present.

RCCS works with five hundred clients with severe and enduring mental health problems (Howat et al 1988) and is divided into four service areas:

* A residential service (88 people at seven sites supported by 104 staff)
* An intensive domiciliary support service, known as DISH (63 people are supported in their own homes by 38 staff)
* A day service (300 clients at four sites supported by 40 staff).
* a care management service (478 people are supported by 33 staff)

Geographical relocation of traditional hospital services is now almost complete and so more attention can be given to quality of life issues. In order to find out what kind of priority was being attached to community connections, I discussed the four "Components" with representatives of each RCCS service and recorded their responses as Table Three. The major conclusions are summarised below.

Going Out. Many clients go out, but often in groups. This will often be in the vicinity of the service, unless that service is delivered at the person's home. Staff who have been used

Table Three - Current Service Performance

	Residential	DISH	Day Services	Care Management
	80 staff, 60 clients	40 staff, 65 clients	40 staff, 300 clients	25 staff, 500 clients
Going Out	Occasional group visits and holidays. Staffing levels restrict amount of going out so help limited to advice and support. Pre-discharge persistent exposure to one or two potentially safe places.	This is an essential part of the role of staff. Group holidays, day trips. Also work on enlarging map of safe places.	Home to centre travel is valued by some. Outings from centre most days, some to safe places. Occasional trips and holidays, sometimes on public transport. Help obtaining bus pass.	A few individual one off trips. Would repeat visit 3 or 4 times if necessary. One or two enclave groups in community centres that also visit new places.
Community Amenities	Core business. Moving away from middle class white notions of how one should look after oneself.	Core business. Long term support but aiming for eventual fade away. A few befrienders found to go to pubs and cinemas with clients.	A lot of shopping for centre activities and lunches. Staff work hard on substantive participation. Frequent group outings for a meal or a drink. Personal needs (eg weekend shopping) addressed rarely, and only if no one else can do it.	Only a small amount of short term help with daily life skills. Leisure and recreation is used to build relationships with care manager. A few befrienders linked up - and can be paid.
Integrated Pursuits	Staff say that clients don't ask for this and have bad experiences of "failing". People enter residential units at a difficult time so may not be ready for the challenge of this area. Not much staff time or skill.	Encourage activity. Visit potential sites, gather info, talk through, help with transport, attend a couple of times as co-participator. No introductions to other citizens or long term support.	College becoming safe place for substantial proportion of clients. Apart from this, focus is often on keeping old contacts alive, rather than starting new ones. Work-based units develop roles and relationships as trades-persons. Info on leisure pursuits offered.	Most clients get advice and direct assistance to visit and enrol if they have a clear aim. Tiny number would find care manager co-registering and then fading. If a number of clients need long term input then form an enclave. Linkworkers scheme starting to help here.
Social Networks	Counselling support is very strong. Peer friendships grow strong and are maintained post-discharge. Relatives and friends visit quite a lot.	Contact relatives sometimes. Recently helping clients re-establish contact with fellow patients. Advice on loneliness and sexuality. Day trips and lunch groups to bring users together. Encouraging pairing of clients - visiting each others homes.	Strong friendships at centres, encouraged by staff. Occasional group on 'relationships' or similar. A small amount of contact with relatives or neighbours.	Most clients get space to discuss their relationships. Care managers often meet relatives. Specialists sought if skilled counselling needed. A small number of clients very occasionally are offered social skills training.

to helping with the arrangements for a group outing need to re-focus on strategies that will assist clients to enlarge on their own map of safe and frequented places.

Community Amenities. Clients make frequent use of community amenities in support of that part of their life which is carried on in relation to the service. For example, some clients buy milk daily on behalf of the day centre tea club. Intensive support in daily living skills is available pre-discharge in the residential units or in-situ for DISH clients, but not for others.

Integrated Pursuits. This area is in need of significant development, apart a link with colleges which has been established since autumn 1993. None of the teams felt that they had made much progress in this area, although DISH (with a good staff-to-client ratio and no buildings or congregated services to maintain) had made the most effort. Resources in the way of staff, befrienders, stories of success and effective strategies are in short supply.

Social Networks These are highly valued and staff perceive client-to-client contacts to be often mutually supportive and positive. There is little faith in formal training packages for clients, such as assertiveness courses, and most workers rely on 'live' opportunities to shape appropriate behaviour. Support for carers is available via Care Management and an occasional support group, but the paucity of network members outside of the family and mental health circle means that little work has been done on this kind of relationship.

Discussion

My aim here was to describe the state of the organisation at the project's inception. The analysis of the present state of the organisation (Table 3) did show that work on integrated pursuits was needed and gave real weight to subsequent discussions and planning for the project. As Holloway (1988 p167) has remarked, one aim for day centre workers is to 'build bridges to other sources of support' away from the unit, but there is little evidence of this happening. However, assessing the present state of the organisation also served to: raise awareness of the importance of this kind of intervention; help staff teams to clarify their specialist role; and locate areas of unmet need for individual clients and in the spectrum of RCCS services.

GOAL 3	INTERVENTIONS	TRANSITION STATE	FUTURE STATE
PLAN CHANGE	A) Analyse the demand system B) Consider available resources. C) Clarify a vision of what the redesigned service looks like.	Resources will be identified to initiate and sustain change towards the agreed new service design.	The service will develop effective work in enhancing the community connections of users.

A) Analyse the demand system.

My full review of the demand system is found at Table 4, from which specific issues arise in respect of staff, client need and philosophy.

Staff attitudes were investigated (Appendix 5) and it was concluded that the present workload is perceived by many staff to be excessive and any new duties or novel approaches demand energy, time and commitment which may not be forthcoming. For some, working on

the development of community connections is not immediately recognised at legitimate health service territory; is sometimes construed as social care or entirely outside the remit of statutory services (Lart 1993); and is sometimes seen to be low priority compared with finding ways to respond to the increase in violent incidents in some of the residential units. Work was done under Goal 8 to seek new resources in response to this problem.

Client Need is surveyed by the Care Management Team each six months and data collected on ten dimensions. These are: daily living skills, occupation and day time activity, social networks, legal, finance, housing, home supports, physical health, mental health and medication. The areas of need which consistently score the highest are, first, the area of "social networks", and joint second the areas of "occupation and daytime activity" and "mental health". Since clients are identified and referred to the service for mental health problems, the inclusion of the area of mental health in the top three is unsurprising. This leaves the two major areas of potential unmet need as daytime activity and social networks.

The referral population to RCCS is growing younger, moving from an average of 58 years in 1990 to 35 years in 1993. The day care referral population has only made two thirds of this move, averaging 42 years in 1993. Assuming that older clients will have experienced a longer period of traditional congregated services whilst younger clients have a shorter history of institutionalisation, and so may prefer community based services, then the indications are that the day service is not keeping pace with these changes in client demand.

The data on gender and race are important also, as they provide another example of the inequality which is endemic in mental health services. On a national scale, traditional,

congregated day facilities have not been accessed by women or people from ethnic minorities (Lart 1993). Locally, no more than 25% of places are taken by women, and less than 5% by black and Asian people - well below the local population ratios. Women's persistent experience of inequality correlates with a higher incidence of depression than men (Carmen 1981 p1321-1322) and significant differences in their experience of schizophrenia. Goldstein (1988 p684) notes differences between the sexes in the age at which people acquire a diagnosis of schizophrenia, as weel as in symptom expression, the course of the illness and response to medical treatment. Perkins and Rowland (1991 p78) focus attention on inequality in the provision of services and conclude their study by saying that:

> "women appeared to have been in contact with the services for longer, to have received less intensive input from the services, and it is possible that the services had been less responsive to their needs."

Similarly, people from ethnic minorities find inequality to be widespread. The MIND Policy on black and ethnic minority people (MIND 1993) notes that black people are more likely than white to be subject to the restrictions of the Mental Health Act 1983, diagnosed with a psychotic illness, given high doses of medication, and detained in locked wards; but are less likely to receive early interventions or talking treatments, such as psychotherapy and counselling (see also Christie and Blunden 1991 p5; Fernando 1995 p34; Francis 1991 p82; Perkins 1995). Littlewood and Lipsedge (1989 p269-271) discuss a range of alternative explanations for these variations, noting how statistics showing improved mental health amongst Asians or non-Western cultures are frequently ignored, in order that racist, biological interpretations remain dominant over explanations involving concepts of justice.

In conclusion, significant efforts need to be made to improve the equality of access to day centres, alongside other mental health resources. At the same time, increasing the supply of individualised, integrated, community-based provision may make the service more accessible.

The Philosophy espoused by RCCS is the 'Strengths Model' as an approach to people with psychiatric disabilities and this has a dual focus on the strengths and capacities of both client and community. "The community is viewed as an oasis of potential resources for consumers rather than as an obstacle. Naturally occurring resources are considered a possibility before community or hospital mental health services." (Stevenson and Parsloe 1993 p38).

Table Four - Summarising the Demand System

	Against the Project	For the Project
Strong Forces	* Most day service staff feel overworked * The project has been seen as a low priority * It is not obviously healthcare and might be seen as outside the remit of the organisation * One team moved to new premises and this absorbed all their attention for many months * Staff sickness reduced available resources in another team.	* Social networks are known to be an area of high need * Over recent years there has been a new group of referrals who don't want congregated services * Some staff want to experiment with new ways of working * The RCCS Management team want flexibility from the day service * There is a client demand for day services * The Advocacy Group ask for more flexible provision
Weak Forces	* Limited flexible budgets for transport, room hire and other individualised packages * Some teams in the service teams resist working collaboratively.	* The RCCS "Service Philosophy" asserts the value of individualised, accessible services. * Shrinking budgets encourage the service to dispense with buildings * Users can be employed as sessional supporters for individuals or groups * the "contract culture" within the health and social services increasingly emphasises outcome measures. * The service inherited resources devoted to community based work * An affinity with the activities of other agencies

B) Consider Available Resources

The demand system which has generated the need for the project has also provided some resources to assist with provision. These are itemised below:

a) During 1993 an additional staff member was added to each day centre, thus raising the establishment above the bare minimum where all hands were needed to offer the in-house activities and support. However, by the autumn of 1994 almost all of this time had been absorbed by the centres, and strong encouragement was needed to persuade staff to work on the project. It appeared that day centre staff experienced their building-based duties as exerting a "gravitational pull" which inhibited their community connections work.

b) Resources became available from external agencies, as indicated in Goal 8.

c) As Day Services Manager with responsibility for the development of appropriate services, I have a high level of commitment to the development of the project.

On balance, the project can be summed up as high priority in the long term, but low priority in the short term. The survival of the project in the face of short term pressures depends almost entirely on my energy as Manager.

C) Clarify a Vision of the Redesigned Service

Between April 1994 and February 1995 the Practice Development Group was

asked to focus on selected clients, individual assessments and the whole gamut of potential community connections. After a weak start a number of staff with enthusiasm and commitment were formally obliged to allocate a fixed number of hours to the project. After

this more rapid progress was made and it became clear that individual staff should focus on a single life domain and offer a "travel agent" function of expert guidance and access to that area. The life domains which were identified were education, employment, voluntary work, sports, and community associations. Each worker who took on a domain was charged with the tasks of gathering information, seeking appropriate entry points, recruiting allies, giving and receiving training, and exchanging successful strategies with colleagues in the Community Connections Team.

Present day-service staff run four buildings and carry out a very small amount of outreach work. Two centres focus on vocational activities (Bates 1990 p14-16), and two on social and psychological support. From May 1995 the teams will examine the feasibility of compressing the centre-based activity into fewer buildings and thereby releasing staff to offer support to community based groups and individualised community connections work.

Senior members of the Community Connections team will each focus on a life domain, so that development work is carried out in each field. Whilst it would be ideal to cover a comprehensive list of life domains, selection will depend to some extent upon the willingness of other agencies to work in partnership. At present, activity is underway on the following domains: education, employment, volunteering, cultural activities, sports and neighbourhood. The team will offer an advice and information function to clients as well as escort and support services to enable clients to engage in individualised community activities alongside other citizens.

The resultant spectrum of daytime support will allow clients to find the level of support they need at any time, and to move easily from one kind of support to another. It will enable the project team to explore the relative merits of direct access to community connections versus access via the day centre. Brandon (1980) asserts that "It is virtually impossible to integrate people from a segregated service", but offers no evidence in support of this claim. Whilst there does seem to be a "gravitational pull" that drags would-be leavers back into congregated settings, it would be helpful to gather some evidence on this matter before jumping to conclusions.

Discussion

The outcome of the project was a broad-based commitment to change the shape of the existing day services - a significant indicator of success. There was a recognition that community connections work will not happen without focused effort. Four pieces of evidence confirm this interpretation of events in April 1995. The Day Centre team leaders took a day out to look at the future and concluded the day by making a unanimous commitment to a community connections approach; the 1995/6 Business Plans for the Directorate and the Trust both record a commitment to developing the project; the main purchaser wishes to "increase use of mainstream community facilities by mental health service users through the continued development of methods of integrating specialist services with "ordinary" community support", (Nuffield 1994 p4) and external agencies such as Leisure Services and educational establishments invested resources in the project.

It might be noted that, although the thinking and practice of enhancing community connections has been discussed in some agencies, the local service has not had independent

access to this material, and therefore the planned change in service design is not a consequence of external pressures.

GOAL 4	INTERVENTIONS	TRANSITION STATE	FUTURE STATE
DEVELOP EQUAL OPPORTU-NITIES	Assess the community integration of 50 day service clients and make appropriate interventions.	Day Service staff will carry out some individual work, assisting and supporting people to make community connections of all kinds.	Women and people from ethnic minority communities will receive appropriate services.

The Measure was used with a total of fifty clients between April and November 1994 to establish a baseline. However, as mentioned above, the Measure was faulty, and was abandoned before completing the six month follow up interviews. Despite this, a few accounts of integration had been assembled, and examples can be found in Appendix 7.

Discussion

Whilst some work had been completed with clients, no real progress had been made on specifying the competencies and therefore appropriate disciplines and grades needed for community connections staff. However, despite this disappointing result, a number of staff had developed a vigorous commitment to the approach and this provided some vital impetus. Overall, my subjective perception of the staff involved was that commitment and energy had increased, and practical arrangements for the development of skills were forming.

The inequalities associated with gender, ethnicity and age clearly demand that further attention is given to supporting individuals. The team has subsequently worked closely with the PhD researcher to devise and use a new Measure with 60 clients.

GOAL 5	INTERVENTIONS	TRANSITION STATE	FUTURE STATE
DEFINE EFFECTIVE STRATEGIES	Collect experiences from the staff involved in the project.	Strategies for developing community connections will be identified, shared and evaluated. A range of approaches will be explored.	Day Service users will be encouraged to increase their community connections. As a result, clients will have a larger circle of social contacts which will include people who are neither service users or providers.

Before the project there were few experiences of how clients can be supported in community settings and a low expectation of clients. Mansell (1988 p11) asserts that one of the elements of a successful service development is a "bias for action" and the collection of hopeful stories encouraged staff to recognise that users could develop community connections and that the wider community could be welcoming. A second of Mansell's success factors is a capacity to "learn from real-life experiences" and the discussions of strategies and their usefulness kept the project anchored into reality. Evidence is found for these assertions in the listing of strategies at Appendix 3, and the selection of case studies found at Appendix 7. Not only has the organisation learnt 26 strategies, but has also established some guiding principles, such as the value of providing clinical supervision to the staff of other agencies who work in partnership with us.

GOAL 6	INTERVENTIONS	TRANSITION STATE	FUTURE STATE
CATALOG OFF-SITE CLIENT GROUPS	A) Develop a checklist for reviewing off-site groups. B) Survey off-site groups.	The purpose, role and functioning of all off site groups will be reviewed. Some groups will be accessible to new clients.	A number of community based groups will be available, and clients will be informed about the choice available. The development of new groups will be carried out in response to client need.

Studies by Brewer et al (1994) and Bryant (1995) have pointed out the attractions of holding groups for service users in community premises, rather than day centres. Such groups can be: neighbourhood based, cheaper than a day centre; sites from which community education may naturally flow; more discreet and therefore more popular and less stigmatising for users; easier to change in response to emerging needs; more sensitive to local needs and issues than large congregated facilities; and can assist members in building relationships with other citizens who use the community centre.

Before the project there was already a wide range of groups in place (Appendix 4). By the end of the project there was no change in the number and variety of groups, but there was a small amount of literature on the subject, a listing of current groups and a checklist to review them in a standardised way. Generating a directory of off-site groups served to: raise their profile; reveal that most groups consisted of Enclaves (see Appendix 2 for definitions); and generate some interest in plugging service gaps.

GOAL 7	INTERVENTIONS	TRANSITION STATE	FUTURE STATE
CLARIFY STAFF ROLE	Assess the staff response to the project, develop materials and deliver training.	Training will be available to staff. As a result, appropriate and skilled support will be available to clients.	All staff will consider it a part of their role to assist clients in the development of community connections, and will have the appropriate skills for this task. The role of paid users, trainees, volunteers and students will be clarified and operational.

The results of the survey of staff resistance is shown in Table 5 and the questions are further discussed in Appendix 5. Top of the list came a collection of items associated with staff resources ("I am already too busy"; "I have to neglect other clients to do this work"; "There are already too many forms to fill in"). The second cluster related to training ("It is a new and different way of working, which I don't fully understand"; "I don't have the knowledge, training or skills"; and "The task of reducing isolation is too hard"). An assortment of other reasons were awarded lower scores.

TABLE FIVE - STAFF RESISTANCE

Possible Reason	Mean Rating
I am already too busy	5.2
I have to neglect other clients to do this work	4.8
The community is not welcoming enough	4.3
There are already too many forms to fill in	3.9
It is a new and different way of thinking, which I don't fully understand	3.9
Clients are afraid that they will have to give up their day centre place or other services	3.7
I don't have the knowledge, training or skills	3.7
Clients don't want to develop community connections	3.7
It is unusual amongst the client group for a client to be making community connections	3.5
The task of reducing isolation is too hard	3.5
It is less important than the crisis work I have to do	3.3
It is for the benefit of the researchers rather than the clients	2.1
We are already doing it.	2.0
It is trying to pass responsibility from the State to already overburdened neighbours, relatives etc	2.0
It is someone else's job	1.9

The efforts that have been made to secure additional resources in response to the first cluster of resistances are documented under Goal 8 and the response to the need for training is set out below. As the project progressed, opportunities arose to present the material to both internal and external audiences. Preparation for these training events spurred me on towards clarity of thought and the discussions during the training served to check the validity and usefulness of the project, as shown by a sample of minutes from an Open Meeting (Appendix 8). Some staff who attended training sessions found that they were already offering clients opportunities to develop their community connections, and drawing these examples together helped to define good practice and remove the more negative aspects associated with any novel idea.

Appendix 1 provides a diary of presentations. The observations of training session participants on the strategies were added to Appendix 3, and case studies offered at the training sessions were followed up and added at Appendix 7.

Discussion

The staff resistance exercise diverted discussions about lack of project progress away from guilt and blaming into a neutral debate about pressures to work in certain ways. It thus helped the practitioners to identify their personal obstacles to progress on the project, as well as providing a prompt for thought and discussion about the existence of these barriers.

On the negative side, asking staff to spend time on a Measure which did not yield useful outcomes was poor change strategy. I should have done my preparation work more

thoroughly, rather than letting staff experience the disappointment and discouragement of the failed Measure.

There are some indications that the overall culture of the wider organisation has changed as a result of the project as, by the end, colleagues were offering stories of work on "integrated pursuits", whereas eighteen months before the focus had simply been on "community amenities". A number of staff who are not directly involved in the project have sought information and requested presentations.

Before the project, community connections work was not seen as legitimate activity by many staff, as was seen in Table 3. By the end the decision to re-shape the day services indicates that there was common recognition of this approach.

GOAL 8	INTERVENTIONS	TRANSITION STATE	FUTURE STATE
LOCATE RESOURCES	Market the project and incorporate any resources which become available.	This project report will form a case of need which will be presented to a variety of agencies with a view to obtaining resources dedicated to the goal of developing community connections.	Specialist workers will be in place to act as Community Connectors. Their influence will affect the overall culture of the service.

The results of my negotiations with external agencies are set out below.

Education Counsellor

Discussions with a local further education college generated an offer to second a staff member on a half time basis to support RCCS clients gaining access to educational services. The salary was paid by the college, but I was instrumental in drawing together the job description, which focused upon use of colleges as opportunities for integrated pursuits, learning alongside other citizens. The college have continued to support the post, making it full time in the middle of year two, and providing permanent funding from year three. In September 1993, the month the Counsellor began, less than a dozen clients were registered with colleges, but over the following year the Education Counsellor assisted 98 RCCS clients to gain access to colleges.

One effect of this initiative has been to raise the profile of further education with all RCCS staff, illustrating how a small investment in personnel dedicated to a certain task can generate enough momentum to achieve cultural change.

Supported Employment

As Day Services Manager, I joined the local Committee for the Employment of People with Disabilities in 1993 to represent the area of mental health. In 1994 the Committee adopted the concept of Supported Employment as a worthwhile goal for the county, but has been unable to locate funds to initiate such a programme. However, a local Training Company obtained £12,000 from the European Social Fund, enabling the project to recruit an Employment Counsellor to work with the team on a half-time basis from October 1995, and full time from April 1996.

Medical Geography

Informal discussions with the Geography department at the University of Nottingham highlighted the relationship between medical geography, where models for mapping service utilisation are highly developed, and the practice development work taking place in RCCS which is reported in this dissertation. The result was that the Geography department appointed a doctoral student for a three year period from October 1994 to focus on this issue, and attend all community connections team meetings. In January 1995, the Ethical Committee of the Trust approved an application to undertake a study of the resources available to the 500 RCCS clients in their local neighbourhoods. The student has also redesigned the Measure and conducted joint interviews with team members.

Social Services

The local Social Services department are exploring whether it is feasible to deliver daytime services to people with a learning disability in a community setting rather than via the medium of large congregated day centres. There is a plan to close a Social Education Centre and substantial revenue funds have been made available to purchase alternative community based services in one area. Some interest has been expressed in collaborative working, using the community connections model described in this dissertation. Successful strategies for community connecting might be exchanged, specialist skills (such as the education and employment initiatives described above) might be shared, or research be conducted to evaluate the comparative effectiveness of different strategies. I was invited to describe my project at a stakeholders conference concerning this day centre in May 1995.

Linkworkers

A separate initiative undertaken by the Social Services Department resulted in some training for a group of 15 citizens (some of whom are service users) who can now be paid as sessional workers to undertake community connecting with nominated clients. This initiative points up the distinction that might be drawn between travel agents and travelling companions. The Education Counsellor offers expert guidance to a large number of people, rather like a travel agent, whilst the Linkworker accompanies people into new social settings, rather like a travelling companion. It would appear that both services are needed.

Leisure Services

The education outreach department of the museum service have committed staff time and around £5,000 per annum on a recurrent basis to offer cultural activities which have been taken up by around 100 mental health service users. The community connections approach fits well with their agenda, and the work was presented to the annual conference of the Museums Association. The staff at the museums are restructuring their studio events programme to make it more accessible to people with support needs.

Health Promotion

Negotiations with a range of agencies have consistently generated a request for mental health awareness training and this issue has been picked up by the Health Promotion team, who have agreed to prepare materials and deliver training sessions as part of the Community Connections Project.

Volunteering

The local Volunteer Bureau is piloting a "Side by Side" project with the team in which client volunteers are paired with support volunteers and twin placements are located. In excess of 50 clients have expressed an interest.

Sports

As a result of liaison with the Community Connections project, the induction of all sports centre staff now includes some basic information on mental distress. A half time worker has been seconded from the RCCS day service to develop access.

Discussion

Mansell's critical success factors for organisational change have already been mentioned (1988 p11). They include a capacity to "build bridges" with other organisations. Locating resources for developing a new service requires contacts to be maintained with a wide range of possible allies. Some of these contacts bear fruit quickly, whilst others require lengthy and careful cultivation before any results are seen. Meanwhile, proper attention must be given to re-using existing resources, rather than simply waiting for windfalls.

External personnel have valuable independence which should not be compromised by too close identification with mental health services, as well as expertise in their host organisation and , most importantly, they offer new roles and identities to clients, such as employee or student, instead of the well-worn roles of patient and client.

One of the functions of day services is to offer mental health monitoring to clients, and the ideal shape for this is currently unclear. One approach is to train our partners to look out for warning signs and alert mental health services, and each of the partner agencies has requested

mental health awareness training and responded positively to our offer of clinical supervision for workers operating face-to-face with clients. A second approach is to consider that the client's mental health needs should be addressed in a different setting to the community connections work. In this scenario, the partner organisation has no greater responsibility than they do with any other citizen - a general duty of care. In this option the mental health service must create monitoring systems which stand apart from the community connections work.

Chapter 5 Conclusions

Literature suggests that increasing community connections is a worthwhile goal for the rehabilitation day services and the service should offer both congregated and integrated services to users. It is important to develop a repertoire of hopeful stories, a catalogue of strategies and a measure of outcomes; to focus on identified life domains and to specify the qualifications needed by staff.

However, the task of achieving organisational change is complex. I worked on many sub-goals concurrently, and this has made for a time-consuming and sometimes confusing programme of activity. However, defining eight distinct goals has served to keep the work on course, and they remain useful in defining the next phase of the change process. The task of changing the mindset of key service providers has been partly successful. After a lengthy search to locate a sufficient 'critical mass' of people to initiate and sustain change (Beckhard and Harris 1987 p92), I established the part-time Community Connections team by isolating a small band of enthusiasts from competing responsibilities and defining the specific task of each participant. The RCCS Management Team have adopted the goal of developing the community connections approach, and this has been warmly welcomed by the Chief Executive of the Trust. The management commitment to reduce the number of day centres and so release staff to support off-site groups and community connections work is a major success, and will address equal opportunities goals (Goal 4). However, some workers and clients are anxious and uncertain about the proposed changes and the next phase of the project will include a broad consultation about the implementation.

During this study I have neglected a psychological perspective on community connections. there would be considerable merit in exploring themes of self esteem, assertiveness, loss and sexuality and their effect upon community participation. The project is still in its infancy. A framework for analysis has been formed, work has begun on a Measure, and a part time team has been created. There is a commitment to aim for a major redesign of current services. The task that remains is neatly summarised by Forrester-Jones and Grant (1994 p26):

> "If one of the goals of policy is to facilitate a shift from community presence to community participation, then care staff will need clearer guidance and support in identifying community resources, in developing effective strategies to harness those resources to support the identified needs of individuals, in helping residents to come to informed choices about the use of those resources, and in evaluating outcomes as an integral part of the care process."

As the project progressed, I repeatedly realised that the task was ambitious. Perhaps the clearest example of this is in relation to achieving a service where there is greater equality of opportunity. It became increasingly obvious that the service would have to be more individualised and less congregated, and repairing the historical bias towards white, middle aged men would require a total re-shaping of the service. While I was able to isolate some tasks for separate consideration, such as the design of the measuring instrument which was handed over to the doctoral student, a more limited Project goal (might have been more easily achieved.

I also became more aware of my personal style as a service developer. I am comfortable with developing a theoretical framework, recruiting allies and creating external networks but

comparatively less attentive to the detailed implementation in a specific location. Achieving a balance of environmental scanning and methodical execution of plans must be a goal for my personal development.

A second issue which has left me with a sense of unease has been the need to involve service users in the project. While the whole purpose of the community connections approach is to create support opportunities for individuals to pursue their own ambitions, I did not systematically involve users in the project design. People who enjoy using the present congregated facilities will be consulted about the plans for changing the service in the next phase, but their expressed preferences might be for no change. Here is one of the paradoxes of service planning: that institutionalised users sometimes choose the least empowering option, and planners must decide how vigorously to expose them to new experiences (and risk being charged with manipulation) and when to take their words at face value. The dilemma of when to discuss plans which are radical, but disturbingly tentative and imprecise, remains a further serious challenge to practice.

Finally, it is clear from the project that the limits to community participation are set by service design, rather than by user aspirations or abilities. When creativity, optimism and adequate supports are combined, the community is welcoming and active citizenship beckons.

Appendices

Appendix 1 Diary of Events

Date	Development	Goal
1993	Additional staff member for each team	3
1993	Develop a model of "Components of Community Connections"	1
1993	Unsuccessful bids for additional funding	8
Mar 94	Monthly meetings of Practice Development Group began	5
Apr 94	Staff were asked to use the Measure. Discussions with University Geography Department.	4 8
May 94	First presentation to staff, carers and clients in RCCS and feedback incorporated. Eleven others followed (9/2/94 DISH, 2/3/94 Mac Close, 18/3/94 Westminster House, 1/6/94 Community Rehab Teams, Feb 95 Carers Support Group, 12/4/95 Community OTs, 16/6/95 702, 12/7/95 Non-exec board member, Aug 95 Manor Road, 22/8/95 Foster Drive, 8/9/95 Oct 95 Chief Executive.	7
June 94	Met Social Services regarding learning disability services. Assessments not yet started, so prompts given.	7
July 94	Current service performance reviewed. Reasons for resistance gathered.	2 7
Sept 94	50 assessments completed.	4
Oct 94	PhD student started 3 year project.	8
Nov 94	Presentation to regional conference, feedback incorporated. Nine further presentations to external agencies followed (1994 MPsych Students, 20/5/95 Belvoir Vale, Sept 95 Museum's Association, 13/11/95 Leisure Services Managers, 8/12/95 King's Fund, 5/1/96 Purchasing Manager, Nottm Health, 29/2/96 Second Base, 7/5/96 School of Nursing.)	1
Dec 94	Measure abandoned; search for alternative began.	1

Date	Development	Goal
Jan 95	Ethical Committee approved request to examine home addresses as a way into "Neighbourhoods" domain. Off-Site Groups surveyed.	8 6
Feb 95	Negotiations with a training agency to co-recruit an Employment Counsellor for the project	8
Mar 95	Managers approved launch of Community Connections Team. Practice Development Group began to meet weekly.	4

Appendix 2: Measuring Community Connections

The initial handout which was given to staff is set out below. The lessons that were learnt during its use are found in boxes like this one.

1. I have defined a "Community Contact" as occurring when the client
   - leaves their own home and goes to another place, or
   - encounters another person, either at home or somewhere else.

   I have excluded sending or receiving letters or telephone calls.

We found that some clients reported that letters and phone calls were a valuable part of their lives - especially as there was a greater degree of control over them that in face to face meetings.

2. "The Grid" is an instrument for assisting the client and staff member in the task of summarising the clients' community connections. A copy is appended, and guidelines for completing the Grid are found below.

3. I have defined a "Community Connections Intervention" as a special meeting between a client and a staff member for the purposes of completing or revising the Grid, or of specifically working on items from the agenda raised by the Grid. One would expect that a "Community Contact Intervention" would last more than half an hour, would review one or more aspects of the Grid, and would include material which you would wish to record in the casenotes as of sufficient importance that your colleagues should be informed. The purpose of the first Community Connections Intervention is to complete the Grid.

We found that staff found it exceedingly difficult to devote time to this work and few interventions were recorded.

4. The Grid is a method of collecting a summary of the client's community connections on to a single A4 sheet. The information is inevitably limited, but it provides an overview and indicates areas for further discussion. It is expected that staff will use the Grid as a framework for their work with the client.

5. The Grid is to be used to establish a baseline for the client. After six months the client and staff member should review the completed Grid to see if there have been any changes. In the intervening period, the staff member and client may agree to have one or more further Community Connections Interviews. Such further interviews will

include a discussion of the work which the client is doing on the Grid, the tasks they have set, the progress they might have made, and the difficulties they are experiencing. Community Contact Interviews should be recorded in casenotes.

> *Where clients were receiving support from a range of staff, we found some dispute over who should undertake the Community Connections Interventions and who should record them in which casenotes.*

6. Any staff member using the Grid with a client is expected first to subject their personal lives to the exercise. This might be privately, or could be undertaken with a colleague or a friend if you wished to do this. The aim is to provide you with an experience of what it feels like to see your community connections described on the Grid, and perhaps how the client might feel in sharing this with another person.

> *Staff who used the Measure were asked to complete an assessment for their own lives, simply as a way for alerting them to the fact that the exercise exposed sensitive information. This aspect could be extended in the future to explore whether the attitudes and expectations of staff concerning community integration differed from, and affected, the clients with whom they worked.*

7. The Grid can be used with any client who wishes to examine their community connections. Staff may wish to use it with clients who are already known to want to make changes in this area of their lives. Since this will not be a random sample, the result may well be somewhat biased towards people who are motivated to change their community connections. The purpose is to develop a tool that has a real application and usefulness to individual clients, rather than collecting data on people for the sake of the staff member or researcher.

> *We found that some clients tended to under-report the range and frequency of their activities, possibly due to poor self-esteem or fear that support services would be withdrawn.*

8. The Grid should be completed in the following steps:

a) Ask the client to make a rough list of the places they go, perhaps on the back of the sheet. You may wish to prompt with suggestions, such as the day centre, or the shops, if the client appears to be missing out major areas. If the list includes more than 6 places, then client should group them into similar "families" of places, with your help

if necessary. Pre-determined categories are not offered, as it is the client's own definition which is of interest, rather than the staff members'. For example, separate visits to the local pub and a club might be grouped together as the category "bars". These are then written into the header cells of the x axis on the Grid. The aim is to include everywhere that has significance for the client on to the x axis of the Grid. Note that the first cell is already specified as "Home" and the last cell is "New Places".

b) Repeat the exercise for people that the client is in touch with. These provide headers for the rows on the y axis. Note that the first cell is "Alone" and the last cell is "New People".

c) The next task is to fill in the cells in the body of the Grid. These should be filled in with a letter which relates to the current frequency of contact. Available codes are

D = daily or more than once per day,
W = weekly or more than once per week, but not as often as daily,
M = monthly or more often, but not as often as weekly, and
Y = yearly or more often, but not as often as monthly.
N = none.

We found that the coding was not sensitive enough. It would have been better to write in a number for the approximate number of contacts in a year.

Descriptive material may also be written in these cells, to bring the information to life for you and the client, as long as the frequency code is also included. Some people or places might be visited irregularly, but intensively (such as daily contact with a relative during a once-a-year visit over Christmastide). In this example the contact is treated as a single episode and scored "Y".

We found that this created ambiguity. If a client visited the pub each week, for example, with relatives and friends, the grid could not tell us if it was one outing or two.

d) Then put a circle round any cell where the client wishes to make some changes. The object is to identify those areas which the client wishes to work on changing, and not those areas which are unsatisfactory to the client, but s/he sees no point in trying to change.

We found that some clients had a vague feeling of dissatisfaction, but could not be specific enough to circle a cell. They were simply lonely

or wanted to go out more. In this case, the client and the worker might spend several sessions clarifying the aims.

e) The final stage is not recorded on the Grid, but will be summarised in the casenotes. If the client has identified a number of areas which s/he wishes to change, then it will be important to agree priorities. There may also be work indicated which you cannot undertake, and so negotiations with appropriate personnel may have to be instigated, or unmet need recorded. These outcomes from the Community Connections Interview should be recorded in casenotes in the usual way.

It may be useful to consider the difference between repatriation - returning to familiar places or people - and migration to new settings.

9. The completed baseline Grid should be dated and copied to the researcher. In order to preserve confidentiality, the client name should be removed, and a code reference added (staff surname plus a reference number. The reference number will be 01 for the first one you do, 02 for the second etc), so that you may identify the client, but no-one else can do so. The reference should be placed in the client's casenotes. When the six month review is conducted, the revised Grid should also be copied to the researcher.

We could not find a way of aggregating the data.

"THE GRID" People and Places: Listing Community Connections

	Your Home							New Places
Alone								
New People								

Appendix 3 A - Z of Community Connections Strategies

The goal here is not to create a secret professional jargon, but to illustrate the range of available strategies and encourage people to select the most appropriate ways of providing support, rather than habitually utilising the same narrow repertoire of options. It may be possible in some future work to compare the effectiveness of these strategies to find out which ones work best under which conditions. This would be done both objectively, by measuring the community connections of clients before and after using the strategy, and subjectively, by asking clients and staff which approaches are more popular.

Activity Arranger. The support worker selects an activity (which might be social or practical) within the setting and helps the client to engage in it. Where the client's independent participation in an activity is breaking down, the Activity Repairer intervenes to repair it. Providing the client with a lift, a taxi or a bus fare may help them to go places which are too hard to get to without this practical help.

> See Evans et al 1992 p 25 for an example of this approach.
>
> Day Centre staff may be very skilled at arranging and repairing activities, but sometimes activities break down because they are inappropriate and should be replaced rather than repaired.

Befriending. A befriending scheme artificially brings together a citizen and a client who are both interested in making a new friendship.

> "One to One" (tel 0181 992 7766) do this in Islington, working with people with learning disabilities.
>
> "There is however all the world of difference between a volunteer or staff member who acts as the link person and who introduces a person with a disability to a variety of activities and social relationships, from the role of 'befriender' as it is often practised. The 'befriending' role usually involves what are essentially solitary activities ... where the 'befriender' and the person with the disability spend time together but may never meet or spend time with other people. Befrienders should see themselves as bridges - essentially temporary - between a person with a disability and a range of acquaintances and activities which involve others." (Firth and Rapley 1987 p33).

Companionship. Another client, a volunteer, or an ordinary citizen provides informal support as an escort to the client whilst sharing a part or all of the community contact. An extension of the companionship escort is the companionship group, where a number of clients, as well as offering one another mutual emotional support, might visit places or meet people together as a group. This group might be accompanied by a worker, a befriender or a Guide.

> RCCS examples include the TAG group and the "Circle of Friends."

Companionship often builds up around an activity.

Deliberate Integrated Group. This is a group which is developed with the specific aim of providing a forum where people with and without apparent disabilities can meet as equals. It probably aims for equal numbers.

> An example from learning disability would be Gateway Clubs or, locally, "Integrated Leisure," the group which use a RCCS day centre on a Thursday evening.
> A variation on this occurs when a group makes a special arrangement to offer an integrated event. Schalock and Lilley, in writing about the experiences of 85 persons with learning disabilities in Mid-Nebraska comment that:
>
> "the community also lacks awareness and knowledge of how to interact with retarded adults. For example, community service clubs often planned activities for them as a "club project," but they failed to accept them at other times as co-equal members of the community." (Schalock and Lilley 1986 p675)

Enclave. A group of clients who stay together but use an ordinary, non-specialist setting, and socially remain segregated.

> RCCS examples include special classes for clients in a College, the YMCA group and the museum studio group.

Follow up. "Reinforcing the contact made afterwards (for example, by simply saying "I'm so glad you met ..."). Giving feedback to either of the parties involved. This may include specific advice or guidance or comment for the person with the disability, or for the non-disabled person. Helping the person with the disability to learn from their experience by suggesting alternative courses of action, and helping thus to prepare for other encounters in the future." (Firth and Rapley 1987 p32)

> Staff can find it easier to follow up with the client than the host organisation, but doing it well can expand the capacity of the community to welcome people with disabilities.

Goal Oriented Counselling is based on the notion that you can think your way into a new way of acting. Goal Oriented Counselling aims to help the client identify the positive attributes they bring to others, set goals, make plans for achieving them, and deal with anxieties or other difficulties along the way. It takes place away from the community.

> "it may be necessary to tackle someone's state of depression, ..lack of self-esteem ...learned helplessness ...tendency to assume that oneself is always the cause of failure in social situations." (Firth and Rapley 1987 p21)

Hearing how the client feels may help them accept the life they currently live, perhaps by offering some counselling work on loss, or by identifying and rejecting societal pressures to be more active in the community. If the client accepts the life they lead today, and is free of pressures driving them into making changes, the natural development of community connections may arise in due course.

It is important to listen to all the players and not just the client.

Introductions by a Skilled Worker. The client and the worker negotiate the details of the introduction - how mental health problems might be described, if at all, why the skilled worker is involved etc. The Worker might then speak privately to one or more representatives of the host organisation. Finally, the Worker brings together the representatives of the host organisation and the client and introduces them to one another. The Skilled Worker will have a long term relationship with the client, but will not know the host organisation very well.

> "This may range from an introduction in the literal sense (hello, have you met Mr Winter?), to a much more subtle process of helping to facilitate two people in getting to know each other. This is of course the kind of role which a good host or hostess will play in many social situations. ..What is meant by this role is as follows: ...presenting the person with the disability in as valued a manner as possible; ...preparing for the introduction, for example, by telling each of the parties a little bit about the other before they meet; ...unobtrusive prompts such as 'You were telling me yesterday about what you did at the weekend..."' (Firth and Rapley 1987 p32)

Just Visiting. Making a 'dry run' or visiting the place beforehand as a way of becoming familiar with the journey and the physical environment of the setting.

> This can include a more detailed analysis of the skills utilised to engage with the setting.

Know the community. Information about community resources can be provided in the form of posters, stories, booklets, phone numbers etc.

> Beard (1992 p113) describes offering information to a client, then transport to the stamp club.
>
> This is so time consuming that it can become the only strategy offered.

Like-Minded Escort. If this person is already a member of the host organisation, they would be a "Welcoming Host", but this person is a citizen with common characteristics who is not already a member of the group. The focus is upon the way both newcomers are perceived by the host group. If they are seen as an incongruous pair (such as a retired gentleman being escorted to an old time dance by a young female nurse) then the group will struggle to welcome them and the escort may not be a very successful advocate for the client.

> "The key to success may lie in selecting the person most likely to help the client achieve integration to act as a co-participant in activities, e.g. a local teenager to help an individual become integrated into youth club activities." (Evans et al 1992 p33)
>
> Is this a licence to adopt racist, agist or sexist preferences?

Matching - by professionals, or other knowledgeable members of the community who draw together their knowledge of the individual and of community resources in order to offer recommendations to the person.

Networks. A person with support needs invites a group of people s/he already knows to meet together to help her or him improve the quality of her/his life. The focus is not solely on community connections, but the model is based on the belief in "inclusive community" - that many citizens can and will make efforts to improve the richness of the wider community for all members, including those with awkward needs, and that all will benefit from this effort. (See Ludlum (1993)

Organised Visits. Guests might be invited to the mental health building for the purpose of meeting one or more clients and perhaps undertaking an activity with them. The Guest might build a relationship with clients, enabling the Guest to subsequently become a Guide or take on other roles.

> Visiting speakers, or visiting adult literacy tutors to a day centre are examples of this.
>
> Alternatively, a Guide might be arranged who will meet the client or group of clients and accompany them on a guided tour of the host organisation.
>
> In RCCS, the Education Counsellor has undertaken this role when she offers taster visits to College which comprise a walk round, an explanation and a cup of coffee in the canteen.

Participating Together. The support worker (or befriender or other clients) and the client join the group together and take the responsibilities of membership seriously.

> There are three hazards here. Firstly, the escort who is a full co-participant might be side-tracked by the responsibilities of membership and forget the needs of the client. Secondly, the host group will only have a limited capacity to welcome newcomers, and this resource may be used up by the escort. Thirdly, the group of co-participants might form an enclave which has no social interaction with the host organisation.
>
> A RCCS example is the General Library Art Group where clients and staff co-registered and participated as learners together.

Qualified and Skilled Escort. This is a worker who carefully delivers skilled personal and psychological support to the client and shares part or all of the community contact with them.

Registering Together. The client and others (a worker, befriender, other clients) join the host group together. The ally may choose to drop out of the group once the client is established.

> Groups from the vocational day centre have co-registered on college courses.

Support Group. A number of clients who are undertaking solo work on their community connections might meet to exchange experiences and offer one another emotional support. A worker might facilitate the group.

Training the client. The client is taught how to complete successfully some or all of the behaviours undertaken in the host organisation. This training can take place either off-site or on-site. Skilled workers, companions or hosts can serve as trainers. The training syllabus might be practical, such as how to clean cars for a valeting service, or interpersonal, such as how to behave in committee meetings. Where the trainer accompanies the client in a community contact, this training might be as subtle as 'shaping'- offering tiny bits of feedback to encourage appropriate behaviour.

> "lack of experience leads to inappropriate behaviour, as well as inappropriate interpretations of others' behaviour. ..Moreover, other people may give unclear signals because of their different behaviour towards people with learning disabilities. As a consequence, subtle messages about warmth, interest, response and so forth may be confused or misunderstood." (Richardson and Ritchie 1989 p62)
>
> Where the behavioural function of mentally handicapped people in the community has been the subject of research, the emphasis has been upon teaching them skills." Saxby et al (1986) offer references which describe training in each of the following skills: eating out, pedestrian skills, handling money and shopping.
>
> Carr and Carlson (1993) describe an example of a training strategy which helped people to use local shops. A number of people with profound learning disabilities and challenging behaviour were helped to adapt their behaviour until checkout staff were no longer anxious about their presence.
>
> "Brown et al (1979), have set out a strategy for effective teaching of the functional skills in the natural environment. This involves six steps:
>
> a) the taking of an ecological inventory;
> b) the identification of the skills required for successful performance (i.e. what non-handicapped people do in that environment;
> c) task analysis of the skills so that social and other behaviours are put in sequence; and
> d-f) the writing, implementation and evaluation of a teaching programme with cues, reinforcers and generalisation strategy specified." (Felce 1988 p357)
>
> "social skills...Such approaches set up artificial prerequisites to friendship, based on an abstract analysis of assumed social deficiencies in people with developmental disabilities." (O'Brien and O'Brien in Amado 1993 p24)
>
> RCCS Staff have reported that when they are specific and precise about appropriate behaviour, then clients frequently adapt their usual practices to fit in. It might be compared to the way in which it is courteous to explain to visitors from another culture how to behave in new social settings.

Unique and Individual Work. Each person's package will be unique as workers respond to the individuality of each client. Wolfensberger spelled out the reasons why group size should be as small as possible to facilitate the formation of relationships with other citizens, and, whenever possible, work should be done with individuals rather than groups.

> "In more than half the homes we visited, residents (with learning disabilities) went out in groups of two or more on a regular basis. For instance, group outings to the mall, barber, beach, fast food restaurants or sporting events were not uncommon. Typically, on these trips the group would congregate and have very little interaction with others in the community." (Lord and Pedlar 1991 p218)

Visiting Places. This is simply going out. One or more clients may wish to visit a place simply with the aim of becoming familiar with the physical setting. Repeated visits to a single place may generate a sense of safety, whilst visiting new places can be interesting.

> Day trips and holidays can achieve this.

Welcoming Host. An ally already in the host organisation is recruited, and perhaps paid, to take care of the client and introduce the client to other members of the organisation. The Welcoming Host will know the host organisation well, but will not know the client at first.

> "An alternative and often more effective approach is to contact directly the club, society or recreation centre where the proposed activity is to take place, and attempt to find one or more individuals prepared to help out. This approach obviously needs careful planning, with a delicate balance to be struck between giving information to potential helpers and the individuals' personal privacy." (Gilbert 1993 p100)

eXpanding the Community's capacity to welcome people with support needs. This can be done either in general terms, such as by education and awareness raising activities, or by focusing on a particular person in a particular setting.

> "..social isolation due to the stigma of being labelled a psychiatric patient can be overcome by making direct links with employers, key figures in personnel departments, or employee organisations. Where these strategies are effective, they may lead others in the social network to change their ideas (or perhaps more specifically their own expectations) about the patient's personality." (Brugha 1991 p 153).

> "Robert Kegan (1982 p19) observed "Who comes into a person's life is in part a matter of luck, in part a matter of one's power to recruit others, but in large part a matter of other people's ability to be recruited. People have as varying capacities to be recruited as they do to recruit others." (quoted by O'Brien and O'Brien in Amado 1993 p14)

Where the host organisation gains benefit from welcoming a person with a disability, there is sometimes a temptation to introduce another disabled person to the same organisation, rather than maintaining the commitment to individualised arrangements.

In reviewing a number of studies on public attitudes to people with learning disabilities, Felce draws out the following lessons:

"(a) attempts to prepare communities for the future provision of residences (for people with learning disabilities) are likely to have little positive effect and, if anything, to generate community opposition,
(b) opposition in practice can arise from individuals who have shown positive attitudes hypothetically,
(c) actual experience of mentally handicapped people in the community is more important in shaping attitudes,
(d) positive experiences shape positive attitudes and therefore there is more an argument in favour of structuring contact to be successful than for promoting contact per se, and
(e) opposition to community residences prior to opening moderates to acceptance or indifference following actual experience. (Felce 1988 p353)

"One would hope that the increased level of contact between people with and without mental handicap arising from community integration will result in the lessening of negative stereotypes, improved public attitudes and greater community acceptance." (Felce 1988 p352)

Stein et al (1990 p222-3) offer an example in which intensive support is offered to both community members and also staff of public agencies who have historically neglected people with psychiatric problems.

Yet more to see! A single setting, such as a public house, may in fact conceal a whole range of possible settings. By simply choosing the bar and time of day it can be quiet or crowded, noisy or quiet, homely or stylish.

"If an individual is being supported to attend a swimming club, or other similar club or activity, and there are scarce staffing/support resources, then initially attending under-used sessions can be advantageous. In such a situation more support may be available from instructors, and in a more relaxed setting others may be more willing to become involved. (Gilbert 1993 p 100).

Zero-failure systems. It is important to design the experience with the client in such a manner as to ensure that self-image and confidence is protected should the integrative effort is unsuccessful. This will be more likely to be successful if the ally knows a wide range of possible community locations.

Appendix 4: Evaluating Off-Site Client Groups.

The following checklist was made available to staff setting up off-site groups to encourage careful consideration of all aspects of the groups' functioning. Overleaf, the results of the January 1995 survey of RCCS groups are reported.

1. Identifying the need. What research has been done? What is the demand? Who is it aimed at?

2. What is the purpose of the group? Specify the aims and objectives and the nature of activities.

3. What type of group is it? Open, closed, of what duration, how much pre-planning, what is the optimum number of members?

4. Advertising. What type, how, when?

5. Accountability. Who coordinates the group? Who are staff responsible to?

6. Staffing. Which staff of what discipline and grade, how many sessions minimum/maximum?

7. Responsibility. If someone leaves the group unexpectedly or in a distressed state, who should do what?

8. Membership. Must clients have Care Managers or Care Programme Approach keyworkers or day care workers or contact with the psychiatric services?

9. Referral process. Written or not? Verbal, recorded or not? Use of a form or informal?

10. Records and registers. What is recorded and how? Care plans? Any information kept at all?

11. Reviews. Do they happen, how often, and who organises them? Where will they happen?

12. Supervision and Evaluation of the group. How is this carried out, by whom and when?
13. Liaison with other agencies. Carried out at which stage? Intermittent or ongoing? Feedback to Care Managers or Registered home owners or relatives or others?

RCCS Off-Site Groups in January 1995

When	Where	Who/What	Number	Staff	Referral
Mon lunch monthly	Resource Centre	Carers/ Lunch	9	1 or 2	Turn up
Tuesday afternoon	Arts Centre	DISH users/ Art Group	New, so unknown	Up to 4	Turn Up
Tue, all day	Community	Users/ Outings	10	3	Referral
Tue afternoon	Community Centre	DISH or ex-DISH users/ Badminton	14	1	Turn up
Wed lunch	Shopping Centre	DISH or ex DISH/ lunch	8	2	Turn up
Wed afternoon	Community Centre	Day Service /Women's group	10	2	Referral
Wed evening	Day Centre	RCCS Users/ Social	15	2	Invitation by existing members
Wed evening, monthly	Social Club	Carer's/ talks, support	40	2 or 3	Turn up
Thurs morning	Community Centre	Hostel Residents	10	3	Turn Up
Thurs afternoons	Football stadium	Anyone/ Football	40	2	Turn up
Friday lunch	Neighbour hood Centre	Anyone	2	1	Turn up
Friday lunch	Community Centre	RCCS Users	15	2	Referral
Friday afternoon	YWCA	Users	9	2	Referral

Appendix 5: Some Reasons Why Nothing Changes

I assembled this list by thinking about the service, and from published literature, and used it to create the checklist of possible resistances found at Table 5.

1. Where ideas and skills seem very like existing ones, they will be ignored.

2. Staff operate intuitively and lack a precise language for thinking, planning or sharing progress in this area.

3. At the management level, there is a need to clarify the respective roles and expectations of day service staff and Care Managers to avoid misunderstandings, overlaps and omissions.

4. 'Changes of attitude and belief and new ways of working always involve resistance and hard work.' (Segal in Ramon 1991 p89) The paradigm shift required is harder and slower and requires a bigger investment of time than the researcher (who has already made the shift) has imagined (Wenger 1994a p20). When asked about the community, many staff offer 'horror stories' of stigma and rejection rather than a mixture which includes anecdotes of friendship and welcome.

5. Staff believe that clients do not want to make community connections. Clients have failed in previous attempts to make community connections and are now reticent to try and perhaps fail again. For some clients, staff fear that such a blunt exposure to the poverty of their social lives would be distressing. Was this the case? It was in Wenger's study (1994a p18).

6. The culture of the congregated services does not value community connections. For example, when a staff member suggests a client might wish to try a community based activity, the client will sometimes interpret that as a threat of discharge from the day centre.

7. The informal support systems between day centre users are valuable (Holloway 1988 p170,178) and generate 'gravitational pull' which draws people back into congregated services.

8. The stress and workload already in place is substantial and the community connections work is seen as additional.

9. Wenger had 3 problems with her forms (1994a p16): interpretation of questions, following instructions, interpretation of results. Some staff and some teams are buried under a mass of research studies and questionnaires, along with Care Programme Approach forms, Social Services Department assessment forms and the client database. Wenger (1994a p87) adds 'for most of the teams, writing down elicited information or taking notes was felt to interfere with the therapeutic nature of the social work interview.'

10. Staff lack information about community resources, skills to facilitate engagement with them, and flexibility to make contact with these resources in the evenings or at weekends. Sometimes the support worker is so obviously out of place in the community setting that discreet integration becomes especially difficult, for example, when a white worker is asked to help a client join an Afro-Caribbean community association.

11. This is essentially individual work and day service staff tend to work with groups. They feel that spending time with an individual is depriving a number of others.

12. Insufficient number of staff with a commitment to the project. Committed staff are managers, whereas the real change have to be won at the practitioner level (Wenger 1994a p16)

> 'one route is to identify practitioners with special skills and an 'evangelical' approach, and to create roving roles for them, seeding ideas in other practice forums and offering a special form of practice supervision to encourage practice change.' (Marsh and Fisher 1992 p41)

Community connections work is acknowledged to have long term importance, but is often crowded out by immediate crises. Marsh and Fisher (1992 p47) comment 'in the face of ..pressure..workers and team leaders found it difficult to give priority to establishing new skills when the old ones would at least provide some form of service.' Wenger (1994a p25) says 'In this climate of uncertainty, unpredictability and demoralisation, the workers found it difficult to maintain interest in the project, although they stated their determination to fulfil their commitment to the researcher.'

13. Wenger says (1994a p90), 'social workers preferred to negotiate (to complete) a minimum number of forms. This had the effect of ..making assessment of network type an optional extra completed as a favour to the researcher, rather than as an added tool in the social worker's repertoire.'

14. It is hard work! Evans et al (1992 p33) say it is a 'notoriously difficult goal.' Wenger (1994a) concluded that it is not possible to create networks, but merely nurture existing ones, and Nolan and Grant (1993 p307) say that one condition of successful change is that the situation is seen as amenable to change.

15. Political anxieties - is this a way of shunting responsibility from statutory services to the informal community and should it be resisted as such? Was it a way of identifying informal contacts and then overloading them to breaking point?

Appendix 6: Why Work on Community Connections?

I assembled this list as a training resource.

1. Natural supports are cheaper than professional supports and funding is getting scarcer. There is a shortage of day care places.

2. Attending a day centre is not a highly valued social role.

3. Social apartheid should be minimised.

4. Natural supports are more in tune with power sharing, whilst professionals symbolise power relationships.

5. Community connections are more individualised and so respect all clients more, and are more responsive to minority groups.

6. Friendships are intrinsically valuable.

7. It values friends and relatives, whilst professional thinking tends to focus only on the individual.

8. Natural supports can provide lasting relationships, whilst professionals stay a short time and then move on. Lasting relationships are valuable.

9. A natural support network may consist of a number of people, while professional support is often delivered by a single person. Natural systems are therefore more resilient in times of change.

10. Natural supports can enable people to access things which have never been on offer via the professional service, such as education, employment and evening activities.

11. Since there is no standard package of service, the worker must consider the needs of the person, rather than slotting them into existing provision.

12. It encourages workers and clients to locate agendas which are shared by other citizens and to make allies of them, instead of defending one's own narrow corner. Thus common themes such as community, ecology or stigma; or common interests such as employment or sports, become the shared concerns of people with and without apparent disability.

13. A sense of participation in a community is one of the things which gives life meaning.

14. It is good for the worker to spend time on expanding the community, as well as helping people to find their place in that community.

Appendix 7: Case Studies from RCCS

1. John lives in a staffed residential unit and attends a day centre two days a week, but closer examination reveals that, whilst superficially friendly, he remains solitary, and tends to use communal facilities when there is nobody else about. He likes doing "anything interesting" but was unable to be more specific. The worker agreed with John that they would research community resources together, thus building up knowledge of how to do this, what is available, and developing their working relationship. They finally settled on a luncheon club and visited twice together. A year later John is still attending and has not needed further support.

2. Richard thoroughly enjoys art and has real skills in this field. He has no short term memory, but gains a lot of pleasure from conversation with people, although he can never remember them from one meeting to the next. After some months of attending a day centre, a support worker arranged to regularly escort him to a further education college, where he is a member of an art class with other citizens. He gained a lot of self-esteem from this group, chatting warmly with others and being eager to attend.

3. Dean tended to stay in bed until late afternoon, felt very anxious in group situations and was socially isolated. He expressed an interest in weight training. The support worker accompanied him to the gym and assisted with filling out forms, and they began to attend regular morning sessions, which Dean could sustain for about 45 minutes. He eventually initiated a conversation with another gym user and felt very positive about this. After two months, he moved house and decided to transfer to the gym nearby to his new address. The support worker accompanied him for a few occasions, but Dean felt confident about attending the place alone. He was very pleased to initiate a conversation with a woman who was using the centre on his first visit.

4. Andrew had spent many years in hospital and was anxious about looking after himself. In more independent accommodation he began by self-catering one day a week, visiting the shops with a support worker. This was gradually increased to five days a week, but Andrew continued to be fearful of going alone. The support worker accompanies him to the shop, but waits in the cafeteria whilst he shopped. He uses both small and large shops without difficulty now.

5. Sean mumbles constantly and tells people details of his psychiatric history at inappropriate times. He expressed an interest in weight training so the supporter spent some time planning this with him, but initial attempts to visit the sports centre together terminated in the car park - Sean felt unable to go in. Subsequent attempts were more successful, but Sean needed frequent prompts about appropriate behaviour. After the training session they went to the cafe in the facility, which is sited right next to the creche - which Sean found very difficult at first. An incident in the residential unit set the process back three months, but they were gradually able to re-start the weekly sessions. A year later, Sean was regularly using the gym and cafeteria, feeling he belongs to the gym and knows the people. He has not yet spoken

to other users, but has some contact with the staff who talk to him and know his name.

6. George has attended the day centre for many years and is rarely seen doing anything apart from sitting silently smoking. However, a photography group for mental health service users running at the local college was mentioned to him and he expressed a murmur of interest. Photography groups have been run from time to time in the day centre, and Ray has never taken much of an interest, but he was invited to attend the college group. Day centre staff talked to staff at his residential unit and they agreed who would offer to escort Ray at first. After three months he was still attending regularly, joining in conversation with other group members, taking an interest in their work and going two hours without a cigarette. He has subsequently bought his own enlarger.

Appendix 8 Community Connections Meeting 4th May 1995.

Both staff and clients participated and some 55 points were made. The following is a brief selection.

1. There are limitations inherent in professional relationships, and a different quality of relationships with professionals, volunteers and "natural friendships". Relationships that form in congregated mental health services can be valuable. Work by Richardson and Ritchie emphasises the fact that friendships begin with a formal relationship, then move on to more voluntary relationships. A realistic model of the development of friendship will acknowledge the formal roles which serve as a basis for starting a friendship.

2. A Team would need to take care in deciding how much energy to invest in direct work with clients, thus fragmenting the care for clients who would receive a multiplicity of services; compared with the community education and development role of the team. Also asked where CC work should lie in the order of priorities when there are many other tasks to undertake in the organisation. The question is where CC fits in relation to the spectrum of client needs, and where it fits in the spectrum of organisation priorities.

3. Pointed out the dearth of services out of hours, and encouraged more flexible working for day service staff. An example is the MIND group which is opening at weekends in response the client demand.

4. Emphasised that decision making for individual clients and for service planning needs to be centred around what clients ask for, and we need to be careful about management led changes in service.

5. Asked about the research framework. Are clients going to be informed that they are involved in a piece of research? How much will the research influence service design? Feedback and the values underpinning the research. How will clients find out about their individual contribution to the research process? How will staff in RCCS hear about the development of the service? How will everyone hear about the progress of the research? Is the community connections philosophy prescribing a certain kind of lifestyle for clients, adopting the high moral ground? These issues may not have been adequately addressed. Would there be a classical experimental design, including a control group for comparison purposes? A control group is not available, as there is no "normal" population. Concerned that the research should be co-owned and co-authored by the stake holders in the process, academics, clinicians and clients. It was suggested that the research may be assisted by a council of reference which offered guidance for the research and service development activity.

6. What will happen to clients who move out of secure places in the Day Centre into Community Support, if the CC team collapses or fails? There is a danger that such clients will be left without any service at all.

7. The Canadian experience of developing CC suggests that the approach is ultimately more cost effective, as some professional supports are replaced by free community supports for individuals.

8. Reminded the Group of the importance of stigma and the fact that the community of often not as welcoming as we would like. The response to stigma in the community is community education and perhaps this is the role of the Health Promotion Service. For example, there is a full time team doing community education on HIV and AIDS. It may be more effective to use specialist training staff to do this work on community education, rather than asking clinical staff to divert resources from direct client work.

9. Commented on the success of the Education Counsellors post. It is salutary to note that the Counsellor has no mental health professional training and yet has been very successful. It may be more effective to import external workers, rather than expect mental health professionals to learn about other life domains.

10. Any framework which looks and social and spatial maps of service users should include a power dimension. Some users will continue to need RCCS buildings and we should not abandon centre based services.

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