

STAFF TRAINING AND CHALLENGING BEHAVIOUR: AN ANALYSIS OF SOCIAL
RELATIONS IN SERVICES TO PEOPLE WITH INTELLECTUAL DISABILITIES

By

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ABSTRACT

This treatise is an extended case study in the failure of applied psychologists to encourage care-workers in services to people with intellectual disabilities in the United Kingdom to use well-established, evidence-based behavioural approaches to reduce the behavioural challenges presented to services. Even when extensively taught and coached, they were rarely applied by care-workers in their everyday work, and had little or no impact on service practices. This failure had been attributed to care-workers being unwilling and unable to use these methods.

An Institutional Ethnography discovered that 'challenging behaviour' is a phenomenon nested within a complex of relationships involving private and statutory service providers, service users, and commissioners. A range of ruling texts were in use, some coordinated, some apparently used competitively. The main coordinating ruling relations were the statutory obligations placed on local authorities, despite the presentation of other discourses promoting a person-centred, human-rights focussed agenda. The rôle of applied psychology in these ruling relations is explicated using research literatures, field-work vignettes, and auto-biographical reports of professional practice.

DEDICATION

I dedicate this thesis to my wife Nicole,
for her ten years of stoic endurance

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As a social constructionist, I was aware of my indebtedness to the conversations I had been part of, in developing understanding of my practice, my profession, my research. However, more than discourse is needed at times, and direct action becomes necessary.

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CHAPTER I

INTRODUCTION: AN INFLECTED NARRATIVE

This treatise is an extended case study in the social organisation of the attempts by applied psychologists to encourage care-workers in services to people with intellectual disabilities in the United Kingdom to use well-established, evidence-based behavioural approaches to reduce the behaviour challenges presented to services. The entry-point for the case study was the well-established, evidence-based phenomenon that these approaches, even when extensively taught and coached, are rarely applied by care-workers in their everyday work, and had little or no impact on service practices (e.g. Grey, Hastings & McClean, 2007).

When I started this research project in 2004, the phenomenon was generating interest from clinicians and applied researchers wanting to find ways to overcome this *impasse*, the apparent blocking of effective treatments. At the beginning of 2007, a Special Edition of the Journal of Applied Research in Intellectual Disabilities on Staff Training and Challenging Behaviour set out to summarise the current position, and re-launch the wider research project by adding to the evidence base. With hindsight, it proved to have sounded its death-knell, with little or no follow-up, except in one derivative strand.

The articles that the guest editors felt ‘showed promise’ signalled a change in direction, with an apparently different approach. Its differences to the original behaviour approaches rests in its disavowing punishment and using positive behaviour approaches in a values-led way (cf. Allen et al, 2005). However, Positive Behaviour Support still focuses

on the interactions between care-workers and people with intellectual disabilities who challenge services with their behaviour, rather than placing them within a wider context. As will be explored, this may be the origin of the failure of behavioural research projects to have a sustained impact through knowledge transfer to everyday care practices.

As a practicing clinical psychologist, I initially sought explanations for this lack of transfer through applying psychological or social psychological theory, including borrowings from organisational psychology. The twenty-year stand-off between evidence-based psychologists and everyday care-practices in services to people with intellectual disabilities suggested a ‘stuck’ system similar to families in systemic therapy, where the approach is to help find new ideas in order to broaden its perspectives and its contextual premises (Andersen, 1997, p. 415).

In the attempt to find “other possibilities” to this *impasse*, I carried out an analysis and critique of the behavioural research literature and its underlying methodology, which became Chapter II: Staff training and challenging behaviour. The review concentrated on the articles in the Journal of Applied Research in Intellectual Disability (JARID) Special Edition (2007). The authors included represented all the principal research groups in the British Isles, reviewing and building on their own and wider international research from the previous 20 years. The quality of the research was highly questionable, and its conception and insight into the area very limited, and provided little beyond opinion about *how* the evidence-based approaches, however effective, could ‘take’ in the everyday world of providing care. Proposals were limited to two different approaches: either applying ‘more of the same’ - new, improved training and transfer of training methods (cf Grey,

Hastings, and McClean, 2007) - or to exploring the particular psychological model of attribution theory (cf Willner and Smith, 2008).

These two line of attack were responses to the general view, explicitly stated by McGill et al (2007, p. 42), that care-staff were “unwilling or unable” to carry out behavioural interventions. The complementary question appeared to have gone unasked: why were researchers unwilling or unable to step outside their usual theoretical frame to understand the lack of fit between their evidence base and everyday care?

Looking for alternative perspectives

Needing to step outside this standoff, I started my own different lines of enquiry. One was to compare the challenging behaviour literature with another literature in which care-staff had also been judged as “wrong”, namely, the study of institutional abuse. The second was to explore different approaches to learning in the work situation. A third was to investigate the ‘linguistic turn’ within research methodology. What lay behind the use of the judgemental phrase ‘unwilling or unable’ within a positivistic, i.e. ‘value free’ article and what did it suggest about the challenging behaviour field?

The institutional abuse literature was more extensive and older than the challenging behaviour literature, with a wide examination of organisational and political factors in establishing, maintaining, hiding and ultimately exposing of abuse. Despite a number of national projects and policy initiatives to respond to, and to prevent the recurrence of institutional abuse, it was far from being eradicated: during this research project, five

major enquiries related to intellectual disability have taken place (Health Care Commission 2006, 2007a, 2007b; Michael, 2008; Flynn & Citarella, 2012).

The briefest analysis of this literature suggested that abuse occurred in locked wards or isolated homes, away from public view. It was not officially condoned, but neither was it anticipated, looked for or challenged by any of the supposed over-sight functions existing within health or social care. The nature of abuse, its origins and sequelae, were investigated, establishing the conditions making it more and less likely (White et al, 2003; Marsland et al, 2007). The effectiveness of policies and guidelines in preventing abuse had been investigated (Northway et al, 2007). Pertinent ‘factors’ appeared to range from Whitehall intrigue (Butler & Drakeford, 2003) to ‘bad apple’ care-workers (Cambridge, 1998,1999). Nevertheless, abuse continued to be exposed, usually with accompanying claims of not being isolated incidents. This review and analysis became ‘Chapter III: Responding to abuse and bad practice’.

Could there be an underlying difficulty in these bodies of research – on staff training and on institutional abuse - in defining, investigating and attempting to respond to poor practice, which led to them falling short of their goals? To get beyond the simplistic ‘train and hope’ (see Lowe et al, 2007, p. 31) model of teaching and preaching to staff, common to both areas, I looked first at adult learning and practice in other work contexts, described and theorised in very different ways from the dominant Anglo-Saxon positivist tradition. Cultural-Historical Activity Theory, based on the work of the Russian School of Psychology following Vygotsky (e.g Wertsch, 1991; Daniels, 2001), particularly as exemplified by Yrjo Engeström (Engeström 1987; Engeström & Middleton, 1998;

Engeström et al, 1999) and Jean Lave (Lave, 1996; Lave & Wenger, 1991; Chaiklin & Lave, 1996) was one of a number of different psychological and anthropological approaches to learning and change in adults. Lave and especially Wenger's (Wenger, 1999) development of the notion of the community of practice seemed promising when it demonstrated evolving self-organisation of workers to meet their own as well as the employing organisation's needs, often in ways that contravened the organisation's training and work-manuals. These over-lapped with other approaches such as Work-place Studies, ethnomethodologically inspired studies of interactions of workers, work-teams and technologies, or 'distributed cognition' studies where work-related problem solving was distributed and co-ordinated amongst team-members (e.g. Heath and Luff, 1998; Heath et al, 2000; Laufer and Glick, 1998; Middleton, 1998). The conclusion was that work-practices, social practices and 'on-the-job' teaching and learning were all related (e.g. Lave & Wenger, 1991), and more powerful counter-practices in the work situation than training events appeared to be called for.

The third line of enquiry was methodological, firstly exploring discourse analysis in a number of its manifestations. Critical Discourse Analysis in Fairclough's (2003) version was a response to the documents developed by the New Labour governments from 1997 onwards - including *Valuing People – A new strategy for learning disability for the 21st century* (Department of Health, 2001) - which demonstrated how they disguised neo-liberal economic doctrines as progressive, in this case, social welfare (cf. Burton & Kagan, 2006). Mediated Discourse Analysis (MDA) took a different approach, with discourse integrated *in action*, mediating between agency and practice to form a "nexus of practice" (Scollon, R, 2001; Jones & Norris, 2006). Discursive Psychology (e.g. Potter and

Wetherell, 1987; Edwards and Potter, 1992) attended to how the situated, occasioned, rhetorical use of a wide repertoire of common sense psychological referents was used to influence others, and/or provide accountability.

Concentrating on discourse did not appear to be a 'fit' with the research area I had identified, as the *impasse* between care-workers and applied psychologists appeared to arise from competing *practices*. However, it drew to my attention to the Special Edition articles either involving one or other of the guest editors, extensively quoting their previous publications, or responding to some of their concerns. Collectively, the edition could be approached as a demonstration of the discursive and political nature of scientific texts promoting a particular perspective on who is to blame and who can resolve its issues.

Neighbouring library shelves introduced the rhetoric of scientific texts and hence to the field of the sociology of science. Gilbert and Mulkay (1984) and Latour and Woolgar (1986) reintroduced me to the world of laboratory life and the work of researching that I had experienced in the early 1970's. They challenged the orthodox 'how it's done' of research, and questioned its authoritativeness. Amongst rhetorical and other textual analytical literature was one of the works of Dorothy E. Smith, "Texts, facts and femininity: exploring the relations of ruling" (1990). This provided textual analysis from an epistemology and a methodology for mounting an investigation into the social organisation of knowledge, Institutional Ethnography.

Taking up this trail, I found much of the recent research carried out using Institutional Ethnography was in health care in Canada where it demonstrated the impact of New Public

Management on nursing practice (e.g. Campbell, 2001; Mykhalovskiy, 2001; Rankin, 2001; Quinlan, 2009) The methodology seemed useful, supplementing my evolving research method, an ethnographic study of care-workers in their everyday caring roles, and of the impact of training, with an analysis of the texts that permeated the delivery of care. A growing understanding of this deliberately alternative sociology, its ontology and epistemology, suggested it might describe the phenomenon at the start of my research – which it labelled ‘the problematic’ – as well as some of the social and historical processes involved in it, and my interactions with it as a clinician.

This research process increased my awareness of my clinical perspective and its habitual responses. Clinical psychology has an underlying model of the scientist-practitioner, an active, applied researcher solving clinical problems (cf. Milne, 1999). Although very few carry out primary research after qualifying through a taught doctorate, clinical psychologists are expected to monitor and critically evaluate research to apply it as part of their continuing professional development. Their publications and the majority of articles they subsequently monitor, almost inevitably followed the American Psychological Association Publications Guidelines, characterised by Bazerman (1987) as “behaviorist rhetoric” setting a template for conceptualising real-world issues and effective interventions. Although I embraced other conceptual frameworks in my work – such as the social-constructionist approaches to systems/family therapy – I discovered a persistent and strong influence of the underlying ‘behaviourist’ pattern on my everyday practice.

These changes in awareness and understanding led me to consider adding an autobiographical – an auto-ethnographic (e.g. Anderson, 2006; Chang, 2008; Ellis et al,

2011) – data-stream to my fieldwork. Although dismissed by some ethnographers as solipsistic (Atkinson, 2006; Delamont, 2009), the overall thrust of the approach is to link varieties of personal experience into wider social phenomena and sociological frameworks.

When I produced a first detailed proposal for fieldwork, the requirements for ethical clearance moved it beyond the scope of a part-time research project. Its basic structure was to observe care-workers in interaction with people with learning disabilities said to challenge the service, before and after some specialist behavioural training; the training event would also be closely observed. I took some time to reflect on the essence of the proposal, to see if it could be made more achievable. To my surprise, the essence appeared to be trying to “catch out” both care-workers and behaviour trainers in respective inadequacies. The ‘objective’ stance of the clinical psychologist appeared to include a high level of subjectivity and partiality, here spilling over into my research practice. Instead of taking this as solely reflecting my personal blind spots, it seemed useful to take it as a phenomenon arising within and part of the field of study, as Institutional Ethnography encourages.

Chapter IV is an introduction to Institutional Ethnography as ontology and methodology. It considers research as a process of discovery, exploring the everyday world and embodied experience of individuals to understand how it is socially coordinated and ruled across locations and time. Two of its core facets were that my professional experience was materially, socially coordinated, and that texts were important technologies for coordinating activities. The Chapter includes the Methods section that takes account of

how the research was shaped by the circumstances of my professional practice, producing a series of clinical vignettes as the clinical fieldwork.

Clinical psychology defined itself from an early stage as being based in research methodology as much as a knowledge base (cf. Milne, 1999), both highly textually coordinated. Literature defines and delineates the subject area, and structures how it may be researched (Bazerman, 1987), and determines individual consciousness. Chapter V firstly describes how texts are inserted into the work of becoming and practicing as a clinical psychologist. It then provides an Institutional Ethnographic analysis of some of the literature featured in Chapters II and III, demonstrating in particular their ideological functions in directing attention away from certain aspects of services, to focus on others. This sets off a first stage of discovery about the social organisation of services, using the literature reviews as a form of fieldwork.

The analysis of the clinical fieldwork commences in Chapter VI. As there was nothing in the literature about the doing of clinical psychology, it was necessary to sketch that in, in order to understand the analysis of the fieldwork vignettes. As described in Chapter IV, Institutional Ethnography demands what Smith characterises as an ‘ontological shift’ - a Kuhnian paradigm shift - to observing “the actual activities of actual people and the material conditions thereof” (Smith, 2005, p. 54) rather than fitting them into pre-existing theoretical concepts. The shift did not happen easily or consistently, and ‘over-learned’ psychological concepts had repeatedly appeared, and led the analysis into blind alleys. This constituted “institutional capture”: the leaking in of institutional (psychological) discourse to describe institutional (psychological) activity, which subsumed and made

invisible the ‘doings’ of actual people and of the material conditions in which we worked (DeVault & McCoy, 2002). Describing the doing of psychology from within psychology led to institutional capture and realising this, the account reflexively becomes part of the autobiographically informed fieldwork.

Chapter VII provides the substantial Institutional Ethnographic analysis of the fieldwork vignettes, placing service providers who are challenged, the people behaving in challenging ways and the Community Learning Disability Team into highly coordinated and closed social relations. This prepares the way for an explication of the *impasse* that is the problematic of the study and its implications in Chapter VIII.

This sequencing attempts to maintain the sense of discovery that unfolded as the writing of the thesis and the analysis of the fieldwork proceeded. Following the explications developed in Chapters VII and VIII, the literatures reviewed in Chapters II and III are more than a context for the research, or something errant for the study to correct, extend or negate. Due to the active nature of texts as described by Smith, they may have contributed to the problem they ‘address’.

CHAPTER II

STAFF TRAINING AND CHALLENGING BEHAVIOUR

The concept of “challenging behaviour” replaced the idea of behaviour problems or disorders lying within the individual with intellectual disability with the idea of a challenge to which services need to rise in accommodating to the person’s needs (Blunden & Allen, 1987, p.14). Challenging behaviour was also characterised at the same time by its deleterious effects upon a person’s life and on others around them in the oft-quoted definitions of Emerson and colleagues (e.g. Emerson et al, 1987; 1988). Clegg (1994) pointed out that such definitions were then often followed by a list of the forms of behaviour said to challenge, summarised for example by Hastings and Remington (1994b) as aggressive/destructive behaviour, self-injurious behaviour and stereotypy. These terms refocus attention on the behaviour itself, and hence on the individual with whom they are associated, so that practitioners and researchers refer to people with intellectual disabilities who “have” challenging behaviour (Heyman et al, 1998).

The staff training and challenging behaviour literature

In the psychology research literature on challenging behaviour, the dominant approach to working with people with intellectual disabilities is behavioural, in the analyses carried out and methods used (Whitaker, 1993; Hatton, Rose and Rose, 2004). Hastings and Remington (1994a, b), Allen (1999b), Ager & O’May (2001) and others had demonstrated

a strong, established evidence base for effective behavioural interventions in reducing challenging behaviour, and behavioural analysis had suggested that care-staff worked instead in unhelpful ways that inadvertently encouraged the behaviour. Articles on staff training are therefore predominantly on training in behavioural approaches. Although other topics such as service values or the nature of learning disability may be included in the training, the assessment of its impact is on staff knowledge of behavioural principles, with the ultimate aim of demonstrating its effects on challenging behaviour in the service.

Training staff in behavioural approaches appeared to be successful in post-training measures, but difficulties arose in encouraging care-staff to use it. This difficulty has lain at the heart of many clinical psychologists' frustrations in working with care-staff (McBrien and Candy, 1998) to eliminate or reduce challenging behaviours. Grey et al (2007) summarised the barriers to the successful use of behavioural interventions as "the absence of an organizational ethos supporting behavioural supports...the absence of adequate performance management systems for the implementation of behavioural interventions...poor competency-based training for staff...negative staff perceptions of behavioural interventions...poor understanding of such interventions...the disparity between 'everyday' belief systems and behavioural explanations as to the causes of challenging behaviour." (p. 1). McGill et al (2007) put the lack of application of behavioural approaches more firmly within care-workers' abilities and attitudes. The articles highlighted that care-workers needed the training to carry out their jobs appropriately.

The literature sample

A literature search on staff training in challenging behaviour was carried out in March 2009 (see Appendix 1). 140 articles were sorted by their abstracts to a list of 63 referring to staff training in challenging behaviour. Reading these closely led to 30 articles being identified as directly relating to staff training and challenging behaviour. The rest of the references were on cognate issues, such as care-staff beliefs and feelings about challenging behaviour, which ‘have implications for staff training’.

Rather than review all 30 articles, a critique is made of an exemplary sample of articles that appeared among the most recent in the search, with other articles referenced where appropriate. The sample consisted of the Journal of Applied Research in Intellectual Disabilities, January 2007 Special Issue on Staff Training and Challenging Behaviour, with guest editors Richard Hastings, Ian Grey and Brian McClean. It consisted of an editorial, four articles, and three brief reports. The editors were respected members of two of the main groups of contributors to research and understanding in the field. Other major groups (Lowe et al, 2007; McGill et al, 2007; Smidt et al, 2007) were featured. The Special Edition was chosen as an important snapshot of ‘approaches, methods and techniques’ (Burnham, 1992) used in applied research in staff training. The editors’ stated aim was to “contribute to the evidence base” (Grey et al, 2007, p.3).

Most of the literature, including all but one of the articles sampled in the Special Edition, acknowledged the difficulty in changing interactions between care-worker and person with an intellectual disability through the particular form of training described. This critique is

framed within the same behavioural/neo-behavioural approach – known within the field as a positive approach - as the articles. All the studies, as applied studies outside the laboratory, are quasi-experimental as described by Cook and Campbell (1979) who provided methods to reduce the threats to the interpretation of the results of such designs.

The Editorial was structured as an introduction to the issue, commenting on its contents, on related literature, and called for the reappraisal of the research agenda of staff training in challenging behaviour. As it is an overview of the articles, as well as an introduction, it is considered last. The editors commended the encouraging results of both Grey and McClean (2007) and Smidt et al (2007), as both studies focussed on behaviour as outcome. Therefore, both were subjected to a detailed critique.

Article 1: Service user outcomes of staff training in Positive Behaviour Support using person-focused training: a control group study. (Grey and McClean, 2007)

Grey and McClean (2007) contrasted applied behaviour analysis with Positive Behaviour Support (PBS), which involved collaborative working with all relevant stakeholders in typical service settings, using comprehensive functional assessments, altering deficient environmental conditions, changing behavioural repertoires and achieving life-style change, to reduce challenging behaviours. They cited Carr et al. (2002) that training “ is ‘rather as a process of mutual education carried out in on-site settings rather than the confines of university-based locations’ .” (p. 7). Reviews of PBS had showed it reducing challenging behaviour in half to two-thirds of cases; more if functional assessments were

included; less, when elements from its multi-element approach are left out, particularly direct staff training.

McClellan et al (2005) had reported care staff delivering PBS through person-focused training (PFT) in which staff conducted functional assessments of challenging behaviour then designed and implemented multi-element behaviour support plans. Data from 138 of these plans showed a 30% reduction in challenging behaviour in 77% of cases, maintained at an average follow-up of 22 months. However, there was no control group, which had not gained ethics approval, and the reductions in challenging behaviour could have occurred with the passing of time.

This study therefore repeated the McClellan et al study with a target group of 30 people with intellectual disabilities and challenging behaviour, and a control group of 30 people matched for topography and duration of challenging behaviours, and gender. Each group was assessed on the Checklist for Challenging Behaviour (CCB) before the training was provided and six months later, at the end of the training. The CCB provided three measures of challenging behaviour: management difficulty, severity and frequency, emphasising outcomes for service users as opposed to “staff outcomes such as attribution change which may mediate staff behaviour with relatively little work addressing staff behaviour or skills directly” (p. 8). Group comparisons and choice of interventions in the target group were based on the highest ranked behaviour on the CCB. Inter-rater reliability was checked for 26 individuals. Psychotropic medication received by each client was calculated in equivalent therapeutic units, and summed across diagnostic groups.

Person-focused training (PFT) was delivered to staff over 9 days, in 5 blocks, with three four-week and a three-month assignment period in between. The person focus came from three written assignments reporting the application of the behavioural methods to one individual with whom the staff member worked directly, who displayed challenging behaviour and who had been referred for psychological input.

The data were summarised as showing “for the control group, frequency of challenging behaviours as reported on the CCB did not alter significantly throughout the [training] time period”. However, “a significant difference was observed for the target group on all three measures of the CCB” although “there was no significant difference at the outset of the training period on CCB measures of frequency, management difficulty and severity between the target and control groups” (all quotes, page 12).

The staff training included extensive observation of the target group. After training “for two-thirds of the target group, the frequency of challenging behaviour dropped to below 30% of baseline rates after three months...For the remainder, the majority had a rate reduction to between 70% and 30% of baseline” (p. 12). The authors concluded, “[the] primary finding of the current study is that PFT is associated with significant reductions for service users [sic] presenting with challenging behaviour” (p.12). The control group were not observed, so the comparisons with the target group were on the three measures from the CCB.

Seven ‘methodological considerations’ in interpreting the results were then responded to. These will be considered in the next section, alongside other unacknowledged challenges to the conclusions reached.

Positivist critique

The validity threats to the McClean et al (2005) study arose from alternative explanations for their results, which Grey and McClean’s control group study attempted to reduce. It is important therefore for the control group to be designed and utilised rigorously.

Grey and McClean identified seven ‘methodological considerations’ to take into account:

1. non-random allocation to the target and control groups
2. the CCB may be insensitive to change
3. the CCB was not administered blind
4. absence of inter-observer agreement on the target group’s observation measures
5. no measures to detect if behaviours other than the one targeted were also affected
6. demographic information discrepancies across files, especially regarding psychiatric diagnosis
7. crude measure of combined medication unit equivalency.

Taking these in reverse order, items 6 and 7 referred to threats arising from the uncertain psychiatric status of the participating service users in matching the groups, and the psychotropic medication they received. Though all people on medication had been on it

for at least six months before the training course to ensure its effect had stabilised, this was negated by not tracking *changes* in medication in the same six months.

Within a quasi-experimental paradigm, item 5 is a minor point. In the Outcome Measures Challenging Behaviour section, the highest ranked behaviour on the CCB “was identified for each individual and only this behaviour was used for subsequent comparisons before and after the 6-month period of training” (p. 9). Looking at a chosen behaviour and not others does not challenge validity, providing it is the same behaviour.

Item 4 is an irrelevancy in terms of establishing the effect of PFT on service user outcomes on the CCB. The observations of the target group’s behaviours by the care staff trainees were a useful adjunct, and partially replicated McClean et al (2005), but were not part of the control group methodology, the alleged focus of the study.

Item 3 refers to the CCB used in a ‘non-blind fashion’, “completed by the person in the intervention condition”, which the authors suggested is a methodological weakness in most studies relying on self-report measures, citing Sturmeay (2002). This latter article does not refer to self-report measures, and does not use the term ‘methodological weakness’.

Although Grey and McClean suggested that a second staff member not undergoing training should have carried out the pre- and post-measure, they went on: “it is unlikely whether this would meet the criterion for a blind rating as support plans are developed in consultation with the entire team and therefore all care staff would be familiar with the support plan” (p. 13). This is a major methodological weakness. The control group staff-members were not trained, but were conferring with the staff being trained. The control

group of staff and service users should have been from separate staff teams and/or service units rated, not “drawn from the same service locations as the target group” (p. 9). It would appear that they would equally be ‘non-blind’ about the CCB status and/or referral status of the service users.

Throughout, the CCB appears to be an objective measure of challenging behaviour, when it was a subjective rating of aspects of someone’s challenging behaviour, by a care-worker responsible for assessing, intervening, and ultimately demonstrating their own effectiveness after training. In a self-report measure, changes in behaviour are impossible to extricate from changes in care-staff perceptions and reporting of the behaviour.

Presumably, the frequency observations served to counter this, although they were not part of the control group methodology.

Item 2 refers to the insensitivity of the Checklist for Challenging Behaviour as a change measure. Over the period of training the amount of change in the ‘frequency of behaviour’ rating of the target group on the CCB is less than the decrease in the directly observed frequency. The observed frequency fell over time to 11% of baseline, whereas the CCB frequency *rating* appears to fall from about 4.5 to only 2.5. For there to be sensitivity, the measure needs to be reliable, and Grey and McClean stated “[r]eliability of the instrument is reported to be accurate (Joyce et al, 2001, p.9).”

Joyce et al (2001) referred to the instrument as the Challenging Behaviour Checklist (CBC), used as part of a tool designed for broad population surveys in three London boroughs. It had two parts: the Aggressive Behaviour Checklist (ABC), rating frequency,

severity of injury and management difficulty; and the Other Challenging Behaviour Checklist (OCBC) rating behaviours for frequency and management difficulty. The CCB appeared to have the same measures as the ABC. It is not clear where in the article Joyce et al pronounced the reliability “adequate”. Rather, they reported “a high level of agreement between informants about the presence of behaviours”. (Joyce et al (2001, p.132). The *presence* is not the same as reliable ratings of frequency, severity and management difficulty. Grey and McClean’s statistical reliability figures in their clinical setting were more impressive than Joyce et al’s (2001), unsurprising given the amount of information sharing in the staff teams quoted above.

There was a more fundamental difficulty. On the CCB, “[frequency] is scored from 1 (never) to 6 (hourly or more often)” (p. 9). The other two measures also range from 1 (no problem/injury) to 5 (extreme/very serious) respectively. Although the ratings had numbers attached, they are ordinal categories, assigning values to objects based on their ranking with respect to one another. Whilst a rating of 2 shows a lower frequency than a 4, is that the same “amount” of improvement going from 6 to 3 (i.e. ‘halved’) or 5 to 3 (two steps decrease). All that can be assumed is that there are 6 categories, with 1 being less than 2, 2 being less than 3, etc. (cf.

http://www.statistics.com/index.php?page=glossary&term_id=269, accessed 6/3/11).

This means it is invalid to sum the ratings and average them to make “mean scores”. The “insensitivity” of the CCB was due to there being a discontinuous measure of frequency, without means of equating the differences between, for example, the frequency scores of 3-4 and 4-5. A more appropriate metric would be the nominal scale of numbers of staff

making each frequency rating, and the changes in distribution before and after training, which could have had more sensitivity.

Item 1 drew attention to the non-random allocation of service users to the target and control groups. Non-random allocation is a typical demand of a field setting, where “with pressing demands for intervention from management and care-staff, it is not always possible to meet such criteria” (p. 13). Cook and Campbell (1979; page 56) point out that this only means researchers need to carry out more laborious identification and ruling out of threats to internal validity arising from selection of the participants.

Although control group service users were identified for intervention, they were not seen as equally urgent. The target group of service users was more challenging to staff, in a way not reflected by the CCB frequency, severity and management ratings. Clearer specification of the challenging behaviour for matching the groups might have made this less ambiguous. The hypothesised function of the behaviour would have been a better matching characteristic (e.g. Grey et al, 2002) but this would have only come available during training.

However, for the choice of behaviour measured for each group, in Table 2 we are given the primary challenging behaviour identified “as per the CBC [sic] for the control group and referral problem for the target group” (p. 9). This suggests the referral problem for the target group was not necessarily the highest ranked according to the CCB: the matching of the groups compromised again.

Within the target group, the original 37 staff and associated service users were reduced as two members of staff left the service, and another five “did not meet the criteria for the completion of the course and are not included” (p. 9). Whereas the “control group of 30 service users consisted of clients also identified by management as requiring input for challenging behaviour” (p. 9). No mention is made of 37 people being in the control group, matched to the target group, who were then also “not included” alongside their matched person; rather, the matching appears *post-hoc*.

Grey and McClean wished to use “outcomes for service users as the focus of interest” in contrast to ...staff outcomes such as attribution change” (p .8). They tried to rule out alternative explanations for changes arising from the characteristics of the behaviours, the service users and medical treatments administered. No information was given on how care-staff were chosen, nor how they were allocated to be trained and to deliver interventions, nor not be trained. They apparently chose the service-user to work with, having known them for an average of 12 months. A previous publication on the same PFT approach (Grey, McClean and Barnes-Holmes, 2002) provided more staff details, and commented on the rapid loss of staff due to the then booming Irish economy. The loss of two staff from the services, and of five not meeting the training criteria in this study, raises a number of potential differences between the staff in the training group and the control group: undergoing training may not have been the only difference between the two staff groups.

In brief, the study is undermined by a number of additional limitations:

- 1 the selection of the services users for the target and control groups;
- 2 the selection of the staff for the two groups;

3 many doubts about the Checklist of Challenging Behaviour as a measure,
4 doubts about the analyses based on its ordinal data; and more seriously
5 the level of knowledge all care-workers had about the research design, and its
dependence on unverified data collected by them.

McClean, Grey and McCracken (2007) subsequently presented five case-studies of individuals, to demonstrate the effectiveness of PBS in community settings. They pointed out that “it is not possible in the present context to isolate the effect of individual interventions, to account for the contribution of nonspecific therapeutic factors such as staff–client rapport (Carr et al., 1994), or to separate the effects of behavioural interventions from the effects of the range of support systems illustrated ” (p. 299). Grey and McClean noted “the behaviour support plans developed through PFT were effective in supporting individuals with challenging behaviour”, but “it remains unclear what ingredients of these behaviour support plans are most effective” (p.13).

The control-group rationale for the study required a more sophisticated application of control group methodology to be able to rule out higher-level interactions. In one sense, the study has done no more than demonstrate the Introductory Social Psychology “Hawthorne Effect” (Cook and Campbell, 1979; p. 60) which showed staff productivity can be increased by management and research attention, no matter the experimental manipulation. For PFT to be established as a crucial training intervention, it needed to be contrasted not with no-intervention, but other training such as the other behavioural training interventions in Berryman et al (1994), or even other psychological approaches.

Article 2: A communication training programme for residential staff working with adults with challenging behaviour: pilot data on intervention effects. (Smidt, Balandin, Reed and Sigafos, 2007)

Rather than training assessment and intervention skills, Smidt et al (2007) instead addressed “a core risk factor for challenging behaviours – communication impairments” (p. 3), based on the communication theory of challenging behaviour (Bopp et al, 2004, cited by Smidt et al., 2007). Their review summarised the following points:

- Communicative interactions between staff and adults with developmental disabilities are often ineffective and communicative breakdowns may lead to challenging behaviour
- Low rates of staff-resident interaction are typical
- Staff-resident interactions are typically brief and infrequent
- Staff find it difficult to assess clients’ communicative abilities, to match their communication to residents’ comprehension.
- They over-estimate the length of utterance the client is able to understand, and do not modify it
- People with developmental disabilities find figurative language, sarcasm, irony and complex metaphors difficult to understand
- Staff may not praise enough

Reasonably, the authors concluded that training staff to communicate more effectively “might help prevent challenging behaviours” (p. 17), adding it may be necessary to change staff beliefs as well. They chose to use a modified version of the Challenging Behaviour

Attributions Scale (CHABA: Hastings, 1997) to measure these beliefs and any impact of staff training on them.

All members of the staff groups working with three particular individuals (focus residents) in three organisations participated. The focus resident was someone with challenging behaviour chosen by a manager in each organisation, out of 4, 6, and 5 residents respectively.

Training consisted of 4 sessions using a Model of Observational Screening for the Analysis of Interaction and Communication (MOSAIC) previously developed by Smidt. An analysis of videoed interactions between the staff members and residents led to staff and trainer identifying communication behaviours and developing communication goals and meant “the intervention is developed and implemented by a staff team based on their own beliefs rather than on those of an external professional” (p.19).

Independent speech pathologists coded video recordings of staff interactions with the focus resident or with other residents, from randomly chosen 15-min blocks. Coding determined whether verbal only interactions occurred, or staff used non-verbal communication (e.g. pointing, use of pictures) alongside verbal interactions; and whether praise or inappropriate language (e.g. rhetorical questions) was used. Challenging behaviour was measured from “incident reports (completed by residential staff according to the policy of each organization)” (p.19).

The experimental design was a non-concurrent multiple probe across settings, to reduce repeated baseline measurement and practice effects. The baseline period was for 2-3 weeks before training; there were more data collections immediately after training and at 3-, 6- and 12-month intervals. With only three data points in each phase, statistical analysis was not possible; all analysis was by graphical comparison. The three crucial measures were mode of staff communication (Verbal vs. AAC), rates of praise and inappropriate language, and instances of challenging behaviour.

Smidt et al (2007) presented these figures with little or no comment, except to note that the modified-CHABA showed small changes in six of the seven sub-scales. “results indicated that staff across all three organizations demonstrated some increase in their use of AAC [Augmented Alternative Communication] with the focus resident in the first three months after completion of training.....made some increase in their use of praise to residents and some decrease in the amount of inappropriate language they used.” (p. 22).

The impact of the training on decreased levels of challenging behaviour in the focus residents was summarised as “had little impact”; “there was a slight decrease, but this was not sustained” (p. 25). The changes in staff beliefs on the modified-CHABA scores were all slight.

Smidt et al (2007) presented a positive outcome for the overall study, which they contrasted to other studies having few positive results, with the usual caveats for this being a pilot study with small numbers. In passing, they reported that there were many environmental changes in the units involved.

Positivist critique

Graphical presentation of data is common in single-case studies written within a behavioural framework. There is a literature showing the limitations of such visual data analysis, attempts to improve its reliability and validity, and to reconcile it, or not, with statistical description and analysis (e.g. Birkimer and Brown, 1979; Brossart et al, 2006; DeProspero and Cohen, 1979; Hagopian et al, 1997). It appears neither Smidt et al nor the editors were familiar with it. Thus the first major critique of the data in Figures 1-3 is that there are not enough data points in each phase to judge any effect: three points would carry weight only if there were no overlap between data points.

The authors identified three other limitations. Firstly, data collection “involved filming whichever staff member was working on any particular day”, so that each point on the graphs “represents the skills of one staff member on one date with the ‘focus’ resident” (p.26). Thus, changes in individual staff members were not measured. Organisations underwent staff changes after training: residents moved in between recordings. The authors’ second identified limitation was a lack of consistency of reporting challenging behaviour across organisations, biases towards only reporting severe behaviours, and a tendency to underreport challenging behaviours: staff boasted that the difficult behaviour never occurred on their shift.

The third identified limitation was the briefness of the training programme, with no time for revision or follow-up. “Staff were not taught any specific skills” (p. 26). Smidt et al

explained “additional research is required to investigate if training staff using MOSAIC impacts on residents’ challenging behaviour” (p.25).

Taken together, this meant the data presented for answering the research questions are not meaningful; the impact of the training on staff communication is not measurable; the impact of the training on the challenging behaviour is not measurable; the impact on staff beliefs is negligible, and/or not measurable. The claims to have succeeded in certain aims where other established studies have failed, and that there are “implications for improving practice” generally cannot be sustained. The editors’ commendation for the study’s focus on behaviour as outcome seemed equally unsustainable.

Article 3: Staff training in Positive Behaviour Support: impact on attitudes and knowledge (Lowe, Jones, Allen, Davies, James, Doyle, Andrew, Kaye, Jones, Brophy and Moore, 2007)

Grey et al (2007) characterised the rest of the studies in the Special Issue as using staff report methods to evaluate the individual training packages described. Lowe et al’s (2007) training was described as being delivered across a whole service: “the aim is cultural change” (p. 3).

Lowe et al (2007) attributed the detrimental effects of challenging behaviour to “the nature and quality of support provided, rather than from the behaviour *per se*.” (p. 30). Increasing the level of knowledge and skills of frontline staff required a broad training strategy to enhance their understanding and skills. The effectiveness of training could be increased by

in situ training, management supervision, and its style and format. Further levels were developed for service managers and behaviour specialists/senior managers. All fitted in with national vocational qualifications, and provided a professional pathway. The introductory level involved 80 hours of direct teaching and 1.5 hours of “individual, *in situ*, practical instruction in positive interaction to promote service user engagement” (p. 33).

Trainees had to complete written assignments demonstrating knowledge of course content. To pass, they also had to demonstrate positive interactions and systematic planning in work. The course for non-professionally qualified direct support staff, “was delivered as transition training during the deinstitutionalization of a long-stay learning disability hospital, for all the staff selected to work in new community-based continuing health-care settings for people with challenging behaviour” (p. 32). Two hundred and seventy-five staff in total, registered staff as well as non-registered nursing assistants participated.

The impact on attitudes and knowledge was evaluated by a battery of self-report questionnaires, not all of which were completed by all trainees, and 15 sets of questions on the material covered in the staffs’ assessment portfolios. The questionnaires were administered on three occasions: the start and the end of the 10-day taught course, and selectively 1 year later. At 1 year, all staff completed the attitude questionnaires but impact on knowledge was assessed only for non-registered staff...from the relevant questions in their submitted assessment portfolios. These portfolios had had to be submitted by everyone within twelve months, after interim marking and feedback from assessors. The pass mark for the portfolios was 50%.

The authors overall assessment was that the results were “somewhat disappointing” (p.37) with respect to staff attitudes, with fleeting change in CHABA scores, and variable impact on fear/anxiety and depression/anger with no clear trends. “The clearest impact” (p. 37) was with some increase in self-reported confidence in dealing with challenging behaviour and coping with aggression.

Gains in knowledge were more positive and clear. Mean scores for registered staff increased from 57 (66%) to 68 (78%) immediately post-training; for non-registered staff scores increased from 38 (44%) to 59 (68%) immediately post-training, and for the 65 assessed after 12 months via their portfolios, the scores rose to 80 (92%).

Participant evaluation of the course was almost totally positive, and Lowe et al reported that comments reflected this overall rating: “...participants were grateful to have received such in-depth instruction and guidance on their expected performance in the new service” (p. 36).

Positivist critique

Lowe et al’s (2007) response to the disappointing and temporary changes in staff attributions and emotional responses identified three possible reasons: the training impact was not sufficient; the measures used were insufficiently sensitive to detect changes that had occurred; or changes might have emerged after more time or more experience.

However, they did not explore the issue any further, and passed instead to consider the “dramatic” impact the training had on knowledge, particularly for the non-registered staff.

The authors identified that the measurement of knowledge after 12 months from submitted portfolios, may have inflated the results. It was their impression that the nursing assistants were keen not just to pass the qualification, “which was the stated requirement for their new rôles” (p. 37), but also put in additional study though no data was provided to substantiate this. Motivation to continue learning does not methodologically counter the change in the method of assessment, nor that “the tutors who delivered the course acted as assessors” (p. 33) without indication of how much feedback had been given, and when.

Lowe et al highlighted other study limitations. The impact on service users was to be addressed by another study looking at the transition from institution to community. Partialling out the impact of changes in environment, ethos, relationships, organisation and staff training will be interesting reading.

In summary, the training affected staff knowledge, but not their attitudes; the maintenance of this knowledge over time was not entirely due to the training alone; and there was only anecdotal evidence for impact on the lives of people with intellectual disabilities and challenging behaviour. The crucial intervention may have been the wholesale adoption of PBS by a NHS Trust as *the* means to ‘support’ people with intellectual disabilities and challenging behaviours, with continued employment dependent on demonstrating knowledge about PBS. Registered staff made only small, transient changes in attitude where their employment was not dependent on demonstrating a particular set of attitudes.

Article 4: Impact of extended education/training in Positive Behaviour Support on staff knowledge, causal attributions and emotional responses (McGill, Bradshaw and Hughes, 2007)

McGill and colleagues were more direct in their use of applied behaviour analytic (ABA) language than the previous articles, asserting that an approach based on “the best understanding” of challenging behaviour as operant behaviour “is likely to be very effective” (p. 41). Such methods are very under-used in services, and staff may either behave in ways that maintain the challenging behaviour, or are “unwilling or unable to implement effective interventions” (p. 42).

A number of factors may contribute to this state of affairs. Firstly, staff may not have been taught the ABA approach “and therefore lack the knowledge to effectively carry out their duties”. Secondly, trained or not, “staff beliefs about challenging behaviour may interfere with their ability to behaviour in a habilitative manner” as staff beliefs “are only partly consistent with a more scientific understanding”. This leads to staff “not understanding the implications for the service user of their own (staff) behaviour and being reluctant to implement interventions which clash with their own (staff) beliefs” (all quotes p. 42). Thirdly, staff behaviour can be “trapped”: “[c]hallenging behaviour is aversive to the staff and creates motivation to escape” which results in staff behaviour ending the challenging behaviour, whilst reinforcing it and helping to maintain it in the longer-term.

These three factors led to a training strategy: to “increase staff knowledge, develop more accurate beliefs and reduce negative emotional responses” (p. 42). The training was

provided as an Undergraduate Diploma at the University of Kent, supported and funded by the NHS, and focussed on the management of challenging behaviour in community settings. It was designed to impact on staff performance, so that over its two years, students carried out practical work in their own agency over extended periods; the course trained a local supervisor; and assessment was via reports or videos of practical work with service users. Students attended a series of 2-4 day workshops over 2 years. The first year, with over 29 days of training, emphasised an ‘active support’ approach “to undercut the motivation for challenging behaviour” (p. 43). In the second year, over 28 days, students were taught functional analysis and intervention with a particular emphasis on the non-aversive, multi-element approach of Lavigna and colleagues (citing LaVigna et al, 1989).

Data were gathered from consenting students on cohorts beginning in 1998-2000. Questionnaires were filled in at three points in the course: in the first workshop of the course (T1); the last workshop of the first year (T2); and the last workshop of the second year (end of course: T3). The measures used to demonstrate the impact the training had were the Self-Injury Questionnaire (SIBUQ) (citing Oliver et al, 1996); CHABA (Hastings 1997); two Vignettes developed and used by Morgan and Hastings (1998: cited); and the Emotional Responses to Challenging Behaviour Scale (ERCB) (citing Mitchell and Hastings, 1998). Only students completing questionnaires at all three points were included in the analysis of specific measures. This meant the 1998 intake was excluded from the SIBUQ analysis.

McGill et al (2007) were more transparent in their descriptions of the measures than Lowe et al (2007), where they used the same measures.

In their discussion, McGill et al (2007) summarised the results of “mixed support” for their hypotheses, and suggested possible accounts for some of the lack of apparent support. .

Positivist critique

Evaluation of the results by the authors depended on deciphering the outcomes of the scales used, with concurrent evaluation of the scales themselves.

In sum, the study showed two years undergraduate training:-

- 1 produced statistically significant change in Knowledge, but not in Intentions for Actions, on the SIBUQ.

- 1.1 The absolute degree of change was small: from 7(T1) to 8 (T2) to 9 (T3) out of 11.

- 2 showed statistically significant change attributions in two areas of the SIBUQ, one of which (Internal Emotional) appeared to overlap the single area (Emotional) on the CHABA that showed a statistically significant change.

- 2.1 However, it is debatable if the Emotional area on the CHABA showed the necessary internal validity.

2.2 Claims about difficulties with the CHABA were based on a level of analysis that might have shown difficulties with the structure and content of the SIBUQ.

- 3 failed to show change on Vignettes on the Escape scenario, and only showed a significant change on the Attention scenario when a verbal sleight-of-hand 'allowed' scores to be combined
- 4 showed some small change on the Emotional Responses scale on the two-thirds of the items factorially related as depression/anger, but not fear/anxiety.

A lower level of support than “mixed” is suggested by the data for the impact of the training McGill et al (2007) offered, measured against the scales they chose. Further, the tools may or may not have mapped on to changes in the way students interact with people with intellectual disabilities back in their workplaces. It would have been better to have produced a thorough appraisal and analysis of the tools and a more robust alternative in advance, rather than criticise them when they have shown the training to be of minimal effectiveness, and possibly even de-skilling.

Brief Report 1: Can brief workshop interventions change care staff understanding of challenging behaviours? (Dowey, Toogood, Hastings and Nash, 2007)

Dowey et al's (2007) literature review suggested applied behaviour analytical skills can be achieved by direct instruction, and can have direct effects on service user's behaviour. Nevertheless, establishing sustained effects clinically is difficult, and under- researched.

Since no clear links had been established between staff beliefs and knowledge and staff behaviour, the authors suggested considering the working culture in services: “affecting staff beliefs and their talk to each other about challenging behaviour may be important as a means of preparing staff for responding positively to skills based training” (p. 53). In a sleight of hand, the authors therefore decided to explore if 1 day or less of workshop training could have an impact on “staff behavioural understanding of challenging behaviours”. This could only “potentially hav[e] an impact on staff talk and the working culture, and improv[e] the take-up of functional assessment information and applied behaviour analytic interventions” (p. 53).

A comparison of before- and after-workshop scores on a modified version of part of the SIBUQ, the Causal Explanation sub-scale, was undertaken. Pre- and post-workshop scores, as well as SD and Range values were tabulated from 54 sets of questionnaires: 37 others had either not been handed in, or wrongly filled out. Non-parametric statistics were used, as most of the scale scores were not normally distributed. 48% of the pre-workshop answers were either behaviourally correct or incorrect, as opposed to non-behavioural: post-workshop, 67% were either behaviourally correct or incorrect. Statistically significant change was shown in behaviourally correct responses (from 31% to 44%) and in the increased proportion of behaviourally incorrect errors in total errors, pre- and post-training (from 27% to 42%). The size of effect of the increase in behaviourally correct responses was claimed to be clinically significant.

Positivist critique

Dowey et al considered three straw-man limitations of their study. Firstly, there was no control group employed. Secondly, as the second questionnaire was at the end of the workshop, there was no demonstration that the acquired knowledge was maintained. This is a fundamental limitation on what can be claimed for the study. Thirdly, the representativeness of the 54 staff whose questionnaires were used needed to be considered in comparison with the 12 who did not return questionnaires and the 25 who didn't fill in the questionnaires properly, but there was not enough data to do this.

The unacknowledged issues were more damning. The SIBUQ items were altered, and only part of the questionnaire used, thereby retaining none of the SIBUQ psychometric qualities. Secondly, the use of non-parametric statistics due to lack of normally distributed scores undermines the statistic for claiming a clinically meaningful effect size "based on the pooled standard deviation at pre- and post-test" (p. 55). Thirdly, the textual presentation of the results appears to reflect awareness of the small differences made: the behaviourally correct score increased from 31%-44%, i.e. less than half the answers were correct after training: in the errors made, the proportion of behaviourally incorrect increased from 27% to 42%. Put otherwise, after training 56% of answers were wrong, and 58% of those errors were non-behavioural.

The authors concluded "it is possible to affect a significant shift in the models used by staff to explain challenging behaviours after brief training" (p.55). More parsimoniously: taking care-staff into a workshop for a day; introducing service values, quality of life issues, and Applied Behaviour Analysis; by trainers experienced in functional assessment and

behavioural interventions; and facilitating some discussions around vignettes, led to an small increase in behavioural language, for some trainees.

None of this is linked to “affecting the broader working culture”. The authors admitted “ we have no data on whether training such as that described here can act to prepare staff for more intensive training models” (p. 55). The sole rationale for the article was a vehicle to present the idea of bringing about organisational change in this way, with no resources to test it.

Brief Report 2: Impact of a 3-Day Training Course on Challenging Behaviour on Staff Cognitive and Emotional Responses (Tierney, Quinlan and Hastings, 2007)

Tierney et al suggested staff responses to challenging behaviour may be determined more by escape from or avoidance of the emotions provoked by challenging behaviour than by training or written programmes. Although there were no data to suggest staff beliefs are related to staff behaviour, reviews showed positive effects of training on causal beliefs. Another consistent outcome of staff training was increased confidence or feeling of self-efficacy, albeit temporarily. The authors suggested confident staff might manage challenging behaviour better whilst concurrently reporting fewer negative emotional reactions to it. Therefore, they investigated the effect of training on the three areas of staff emotional reactions to challenging behaviour, staff causal beliefs about challenging behaviour and confidence/self-efficacy.

The impact of the three-day course was measured by pre- and post-training scores on the CHABA, ERCB and perceived self-efficacy scales developed by Hastings and colleagues. Questionnaires were posted to participants before the training, and three months after; a 74% return led to 48 participants. A brief definition of challenging behaviour was provided to provide a “contextual framework definition” (p. 60).

The only impact was a moderate change in the self-efficacy scales: “staff training focused on understanding challenging behaviour and dealing with stress can improve staff confidence, but is unlikely to affect negative emotional reaction or change causal beliefs” (p. 62).

Positivist critique

The authors listed a number of caveats about the study. Firstly, there was no control group, so staff confidence might have improved for other reasons. Secondly, there were no immediate post-training measures, and larger training effects may have faded. Thirdly, without observations of staff performance or challenging behaviours, no effect of increased self-efficacy could be demonstrated. Finally, a more psychometrically robust measure than the CHABA might have detected some changes in staff beliefs. (cf. p. 62). Wishful thinking does not correct poor research design.

The Introduction suggested that staff training in challenging behaviour should address more than skills and knowledge. “The present study suggests that a typical and relatively short 3-day training is not sufficient to improve staff negative emotional reactions to challenging behaviour... emotional reactions may warrant more focused psychological

intervention with staff.” (p.62). A premise from the introduction which was not directly addressed, dismissed or vindicated in the research is re-served. Even though Day 3 was devoted to “coping with stress”, there were no changes in causal beliefs or emotional reactions. As with Dowey et al (2007), this study was a vehicle for proposing a new research programme.

Brief Report 3: Effects of training on controllability attributions of behavioural excesses and deficits shown by adults with Down Syndrome and dementia (Kalsey, Heath, Adams and Oliver, 2007)

Kalsey et al (2007) briefly reviewed cognitive-emotional approaches to care-workers views of challenging behaviour using Weiner’s (1980) and Malle’s (1999) attribution models, rather than behavioural attribution models used in the previous studies. Weiner’s model suggested to the authors that care-workers’ expressed intentions to help service-users are “predicted by optimism, optimism by negative emotions and negative emotions by the attribution of controllability” (p. 65): care-workers have more negative emotions if they feel the behaviour is under the service user’s control, hence are less optimistic about change and are less likely to help. The authors studied attributions in the care of people with Down syndrome and Alzheimer’s disease (AD), who experience cognitive impairments and may show behavioural deficits such as skill loss, or behavioural excesses, such as wandering, which care staff experience as challenging. They examined the effects of a 4-hour information and problem-solving training session on ageing, dementia and intellectual disability, comparing how care-workers attribute controllability in behavioural deficits as opposed to behavioural excesses.

Day centre staff on three training workshops were randomly assigned one of four vignettes describing a person with Down syndrome with either a behavioural excess (repetitive questioning) or deficit (lack of response to staff), and as either having AD or requiring further assessment. They then rated the controllability of the behaviour on the Controllability Beliefs Scale (citing Dagnan et al, 2004). Knowledge of aging and intellectual disability was assessed with a widely-published 20-item questionnaire. Optimism was measured on a 7-point scale of agreements with two statements of the potential for change for the challenging behaviour in the vignette.

The increase of knowledge across the 97 participants was statistically highly significant, with a mean of 14.34 pre-training, and 15.42 post-training. A highly statistically significant main effect of training on perceptions of controllability was shown with training lowering controllability ratings.

Positivist critique

Kelsey et al pointed out that training increased knowledge by approximately one correct answer out of 20, which may have been due to a ceiling effect of the questionnaire with care staff experienced in supporting ageing adults with intellectual disabilities. A very small increase in knowledge was made statistically significant by a large *n* of 97.

A small decrease in controllability ascribed to behaviours in the vignette, showed no differential effect of labelling with AD or with type of behaviour; and presumably no effects on optimism. There was a lot of speculation as to why this might have been,

flourishing in the absence of data, which also revealed the authors' (dashed) hopes for the study.

The absence of effects of behaviour and diagnosis, and the positive correlation between age and controllability contrasted with other results from Dagnan on aggressive challenging behaviour. Kelsey et al suggested that this may be because care-staff did not necessarily consider the behavioural excess/deficits to be challenging, nor did they leave staff not knowing what to do and opposing any optimism about change they had.

No results were presented on the Optimism question at all, and mention in the Discussion is oblique: “[in] considering the relationship between the attributions of controllability as a precursor to optimism.....the results of the present study do not support the relationship” (p.67). More detail on this lack of support was needed.

Editorial: Staff training and challenging behaviour (Grey, Hastings and McClean, 2007)

Grey, Hastings and McClean (2007) outlined some of the published barriers to staff using behavioural approaches: inadequate competence in behavioural techniques, poor post-training supervision, lack of organisational support, and countervailing staff beliefs.

Efficient staff training was a “logical solution” to some of these obstacles, to provide staff with knowledge and skills to improve quality of life and reduce challenging behaviour.

The research agenda had broadened to include cognitive and emotional variables as setting conditions for staff members' responses towards challenging behaviour. Studies had shown a shift after training from causal attributions based on (emotional) internal states in

the person with an intellectual disability, to the role of positive and negative reinforcement processes. Typically, those studies did not observe staff or 'client' behaviours to detect change in them mediated by attribution change. Grey et al concluded "there is little empirical support for a relationship between staff beliefs and their behaviour in relation to challenging behaviours" (p.1-2) and "when the goal of training is explicitly to increase knowledge surrounding treatment integrity, rather than attribution change, it appears that knowledge alone is insufficient to effect change" (p. 2).

Staff training to teach discrete behaviours in specific contexts was successful. Training for staff to developing more complex skills such functional assessments and behaviour support plans is less successful: such skills are not discrete behaviours and do not easily fit in to single case experimental designs. Some authors have questioned if care staff can work with such complexity, though others have shown they can (Shore et al [1995] and McClean et al, [2005] are described), when the care-staff develop their own interventions, rather than apply those of external experts, and have long term support and supervision from local managers.

Grey et al thus concluded there is "only a small evidence base for the outcomes of staff training for challenging behaviour" (p. 3), although services devote many resources towards such training. The Special Issue was intended to contribute to this evidence base. The editors' comments on Grey and McClean (2007) and Smidt et al (2007) have already been reported, and their judgement of "encouraging results" scrutinised. The rest of the studies use staff-report methods to evaluate the impact of their different approaches to staff training. The Lowe and the McGill led studies described models by which a large or entire

staff group can be trained; the remaining studies reflected shorter courses typical of intellectual disability services, with resource-limited evaluation, requiring measures sensitive to the outcomes and aims of the training. Grey et al suggested the tools used in these studies “could have practical utility” (p. 3) contrary to the analyses of the studies and the positivist critiques above. Finally, they highlighted the Dowey et al (2007) study, for “[making] a case ...to directly tackle the prevailing counter-habilitative working culture in services for people with challenging behaviour” by “[shifting] aspects of beliefs that might pervade such a culture....and prepare services for more focussed and likely skills-based training” (p. 3).

Grey et al suggested a reappraisal of the research agenda for staff training in challenging behaviour. Observable outcome measures for staff and service users were recommended, and addressing the skills deficits that defined staff responses to challenging behaviours. Staff psychological distress or rule-governed behaviour needed to be addressed directly to ensure the maximum impact of training. “That is, we need a functional analysis of staff behaviour so that training interventions for staff are, following evidence-based practice in treating challenging behaviours, based on functional hypotheses...” (p. 3). This means “training interventions should be individualised for staff rather than applied using the same model to all staff” (p. 3-4). Finally, they appealed for research into “the processes by which staff training has an impact on outcomes for service users. That is...how staff training works. Without theory development and an understanding of the processes of change, it will be very difficult to develop new and even more effective ways of working with staff who have to deal with the demands of challenging behaviours” (p. 4).

Perhaps the greatest critique of this editorial is its narrowness of theoretical approach, reflecting the almost complete dominance of behavioural approaches in psychological approaches to intellectual disability (Whitaker, 1993; Hatton et al, 2004). The inability to step outside of this perspective was reproduced in the following articles, which led to poor experimental design, with a reduced ability to consider alternative explanations for their findings.

The gathering pace of research in the field of intellectual disability since the 1970's had led to critiques of bad practice in other areas besides challenging behaviour. Care-worker communication with people with intellectual disabilities (e.g. McConkey et al, 1999; Purcell et al, 2000; Dennis, 2002; Dobson et al, 2002); emotional awareness and expression (e.g. Arthur, 2003); and lack of interaction/engagement with people with intellectual disabilities (Hastings and Remington, 1994b) which led to the development of Active Support (e.g. Bradshaw et al, 2004; Mansell et al, 2008), are examples.

The observed reactions to staff training in challenging behaviour are not unique, have precedents, and have parallels in other categories of interactions between care-workers and people with intellectual disabilities, although this has been overlooked in the dominance in the intellectual disability research literature of staff training and of managing challenging behaviours from a behavioural perspective.

In their review of research methods with staff, Hatton et al (2004) recommended bringing alternative approaches into the field. Hastings and Remington (1994a) themselves

suggested that understanding staff culture would require “a move from traditional behavior analytic methods to those more usually associated with social psychology” (p. 293) in order to apply their particular analyses. A starting point might be Dowey et al’s (2007) suggestion to “directly tackle the prevailing [...] working culture in services for people with challenging behaviour”, following Hastings and Remington’s (1994b) earlier suggestion to “carry out more analyses...from different theoretical orientations, and...extend our understanding of the influences on staff behaviour” (p. 433).

Addendum

The literature reviewed above in 2009 was static for several years afterwards. Campbell’s (2010) paper signalled a change in perspective by questioning whether it is legitimate to request care-workers to treat challenging behaviour in the manner of psychologists and researchers, or should the aim of these professionals be to support and aid care-workers to manage such behaviour or just to cope with it, within their everyday practice.

Other directions were taken. Allen et al (2013) proposed a preventative approach to challenging behaviour (and mental health); Hutchinson et al (2014) attempted to change staff attitudes to challenging behaviour by including people who had had challenging behaviour in staff training; and Bradshaw and Golbart (2013) found staff rejected expert advice if it wasn’t developed by them or adapted to the people they cared for. Campbell et al’s (2014) comments on a Matrix review on effective psychological interventions in challenging behaviour, concentrated on the very thin evidence base in application to everyday situations, i.e. what worked when used by care-workers in ‘community settings’.

“Translating the evidence base for effective interventions to everyday settings has long been a challenge for both researchers and practitioners (Burton & Chapman 2004) with the added complication of differentiating *efficacy* research – about relieving symptomology – from effectiveness research, about the more general usefulness of interventions in clinical practice...

Positive Behavioural Support frameworks and the use of Active Support interventions ...come closer to addressing the key research question of, ‘What should the person be doing *instead* of challenging behaviour?’; a question that is very different from ‘How can we clinically intervene to stop challenging behaviour?’.” (p. 184).

Burton and Chapman (2004) offered a more fundamental critique of the whole project of evidence-based practice in community settings, questioning the value of Campbell et al’s (2014) article from the start. Whilst asking a different research question may be valuable, I am more interested in how the other question came to have such persistence.

CHAPTER III

RESPONDING TO ABUSE AND BAD PRACTICE IN THE CARE OF PEOPLE WITH INTELLECTUAL DISABILITIES

“There is no doubt that the occasional scandal does an enormous amount for a social service.”

Secretary of State for Social Services, Sir Keith Joseph, House of Commons Debate, 12 July 1971, col 89, cited in Martin (1984), p. 93

It is rare in contemporary clinical practice to find the sorts of scenes photographed by Blatt and Kaplan (1966) with a hidden camera in US institutions, and large-scale ‘warehousing’ has been abolished for the majority of people with intellectual disabilities in the United Kingdom (UK). However, abuse and bad practice have still been uncovered in institutional and community settings since the millennium (e.g. Cambridge, 1999; MacIntyre, 1999; Health Care Commission 2006, 2007a, 2007b; Mencap, 2007; Michael, 2008; Flynn & Citarell, 2012, 2013). Rather than provide a taxonomy of abuse, this review focuses on the care practices disclosed, their context and the responses generated with the aim of improving practice. It follows a generally chronological format, with an initial emphasis on analysis of abuse and bad practice in institutional settings accommodating people with intellectual disabilities, in the UK and other English-speaking regions such as the United States of America (US). The policy changes and other responses to the inquiry findings follow. The period covered is from the Inquiry into the Ely Hospital, Cardiff, South Wales in 1968 to the recent inquiry into Winterbourne View (Flynn & Citarella, 2012; Local Government Association/NHS England, 2014).

Critiques of practices in institutional settings in the UK and US developed both through inquiries into particular complaints of abuse and criminality taking place in the late 1960's-early 1970's, and contemporaneous research into the nature of institutional care (e.g. King, Raynes & Tizard, 1971; Raynes, Pratt & Roses, 1979; Wolfensberger, 1969). The early inquiries uncovered corruption, abuse, exploitation, assault, and killing of people with intellectual disabilities by those regimes (Martin, 1984); the more recent investigations have confirmed allegations of abuse, exploitation, assault, torture and 'death by indifference' in health and social services.

Wolfensberger (1969) presented a list of inadequate, cruel and brutalising practices in the care of people with intellectual disabilities ('the retarded') in the United States over a period of a century. He concluded, "we can summarize the trends in United States residential care for the retarded as follows... Around 1850, a developmentally oriented residential model attempted to return the deviant to the community. Between 1870 and 1890, this model was replaced with one based on pity that called for protective isolation of the retardate. This period was brief, and was soon succeeded by one emphasizing the menacing nature of deviancy...retardates were congregated into huge groups, sequestered from society, segregated from other retardates of the opposite sex, asexualized [i.e. sterilised: KT], and dehumanized in poorly supported, inhumanely run regimented institutions. The puzzling and anachronistic mode of functioning of today's institutions can be understood if we see them as having been maintained by a tremendous amount of momentum but bereft of rationales for about 40 years". There has been no equivalent historical survey produced in the UK, but there was undoubtedly a similar momentum, and

the last forty-plus years has been dominated by a medical model of care (Hamlin and Oakes, 2008).

Disclosures, inquiries and responses

Martin (1984) summarised the lessons of the 1968-83 inquiries as having identified the following contributory factors: *isolation of the unit; lack of support for the person with intellectual disability; lack of support for staff; discovery and reporting of ill-treatment blocked; the corruption of care; failures of leadership; policy and resources; union involvement; inadequacies of training; and personal failings.*

The inquiries led to national reviews of care provision, including the roles and training recommended for professional care-staff and management structures (Department of Health 1971 [*Better services for the Mentally Handicapped*]; Committee on Nursing, 1972 [Briggs Report]; Department of Health and Social Security, 1979 [Jay Report]; Department of Health, 1990: McIntosh, 2002). As each scandal unfolded, the reviews first brought about changes in how people were cared for in institutions, then changes in the institutions, and finally, ended all institutional care in favour of community care. The reforms aimed to end segregation, isolation and the potential for abuse by providing more individualised care with a community presence, moving away from medicalised to social environments and from central government funding to local authority funding. The nursing curriculum was to develop a social care model, rather than a task-oriented medical one. Crumbling hospital building complexes were abandoned and acres of grounds underwent a change of

use. There was the anticipation that such a move would lead to lower costs, though it proved a far from cheap option (Brown and Smith, 1992, xv).

After the first major inquiry at Ely Hospital, it became clear that the Department of Health had previously known about the problems there, but had done nothing. In an early response to the inquiry, the Secretary of State, Richard Crossman, set up an independent inspectorate, the Hospital Advisory Service (HAS), in 1969. A section of the HAS was responsible for the mental handicap hospitals until 1976, when the Development Team for the Mentally Handicapped was created. The HAS adopted an open working method: inspection team members were seconded, therefore active and informed professionals; their reports were shared with the staff and management teams of the hospitals involved as well as the Secretary of State; and the inspection process was seen to help disseminate ideas. In the three years after its creation, all 267 mental-handicap units had been visited; 21 that gave cause for concern were revisited. Although the hospitals and their powerful consultant psychiatrists appeared impressed with how the HAS worked, hospital inquiries from 1976-1980 showed that not all HAS reports had not been acted upon. The Development Team continued the HAS work for both hospital and community-based services, though with fewer 'teeth' as they needed to be invited in by a service. (Adapted from Martin, 1984). They were eventually replaced by the Valuing People Support Teams, in 2001.

The transfer of services to social care provision did not guarantee protection for people with intellectual disabilities, as highlighted, for example, by Wardhaugh and Wilding (1993), The Longcare Inquiry (Burgner et al, 1998: cited in Pring, 2005), McCarthy and

Thompson (1997) and Cambridge (1998; 1999). Social Service Inspection Units (SSIUs) led investigations of concerns or allegations regarding people in residential care under the Residential Homes Act 1984 (Brown, 1999).

Early criticisms of the social care inspection functions were that their care standards were based on the physical environment, and care at the level of physical provision, such as meals, and staffing levels. The quality of the interactions between staff and service users was rarely considered, and still less rigorously inspected unless there was external concern expressed. Stein and Brown (2001) suggested there was a poorly negotiated divide between the role of the Inspection Units, which concentrated on the ‘whole unit’ and the role of care managers in the Social Services department – employed by the same local authority, to which the Inspection Units were “at arm’s length” – who investigated individual abuse allegations. There was supposed to be passing of information and responsibility between the two, but this often failed (Stein & Brown, 2001).

The history of the use of ‘pindown’ in children’s services suggested that the local SSIU failed to detect and comment on its use, giving staff some self-justification (Wardhaugh & Wilding, 1993). The Longcare Inquiry (Burgner et al, 1998: cited in Pring, 2005) suggested that inspectors had neither reported poor care practices in the Longcare homes, which had been visible to residents’ families and home neighbours, nor detected the extensive physical, sexual, emotional and financial abuse that was occurring. This inquiry was one of the factors leading to the Care Standards Act 2000, which repealed the Residential Homes Act 1984, and set up the National Care Standards Commission to

regulate residential homes in England, and a similar function for care services in Wales. Social services in-house provisions were to be regulated for the first time.

The publication of “No Secrets” (Department of Health, 2000) attempted to re-invigorate the protection of “vulnerable adults” including people with intellectual disabilities. It required Local Authorities to take the lead in multi-agency responses to allegations of abuse, and obliged all adult services to have consistent policies and processes in place. Inspection of services was meant to play a key role in protecting vulnerable adults from abuse. Although prevention of abuse was included in the guidance, it took a long second place to planning the responses to concerns and allegations (White et al, 2003; Marsland et al, 2007). A main criticism of “No Secrets” was that it did not provide a statutory framework equivalent to Child Protection legislation (Flynn, 2007). This has been redressed in the Health and Social Care Act (2012), implemented in April, 2015. A further criticism was that it had no definition of “institutional abuse” although it clearly defined sexual, physical, emotional and financial abuse, and neglect (Brown, 2007).

Thirty years after the commitment to community care for people with intellectual disabilities was formalised by *Better services for the Mentally Handicapped* (Department of Health, 1971), a new White Paper “Valuing People: a New Strategy for Learning Disability for the 21st Century.” (Department of Health, 2001) was launched, with endorsement from the Prime Minister at the time, Tony Blair. Its aim was the social inclusion of people with intellectual disabilities as full citizens, with independence and choice over their lives. Society needed to offer the support they needed to reach this end. “Valuing People” was a more generalised, values-based critique of both local-authorities

led “care in the community” and of the continued involvement of the NHS in hospital and community based residential services. The critique was based on a national survey of service provision *‘Facing the facts’* (Department of Health, 1999) as well as high levels of consultations with people with intellectual disabilities and their families.

‘Facing the facts’ established that with regard to protection from abuse “[t]here were positive signs of progress towards improved inter-agency policies to prevent, detect and investigate incidents of abuse. However, a fifth of authorities had not agreed such policies at the time of the postal survey and only half had implemented staff training programmes. There were reported difficulties in many areas concerning coordination of work across the range of relevant agencies, including the criminal justice system” (page 4).

Within the NHS, there had been no inspection function until the establishment of the Commission for Health Improvement (CHI) under the Health Act 1999. This body could investigate both “failing” health services and carry out a rolling five-yearly inspection process. One of its first two reports was on the North Lakeland NHS trust in Cumbria, where it described the inadequacy of two inquiries into "degrading, unprofessional and cruel" abuse of older patients at Garlands hospital in Carlisle as due to “systemic failure”. CHI’s success led to its expansion and integration *via* a merger with parts of the National Care Standards Commission and parts of the Audit Commission, becoming the Commission for Healthcare Audit and Inspection (CHAI), which is more commonly presented as the Healthcare Commission in 2004. The Health and Social Care (Community Health and Standards) Act 2003 set up the Commission for Social Care Inspection, amalgamating the SSI and the bulk of the NCSC, and the Healthcare Commission. Both

bodies amalgamated, with the Mental Health Commission into the Care Quality Commission in 2008.

Despite the existence and evolution of these agencies, NHS service provision in Cornwall was found to be abusive, following persistent complaints from families of people using their residential services (Health Care Commission and Commission for Social Care Inspection, 2006). The familiar range of abusive practices by care-workers, and complacency and neglect by managers, commissioners, social services and the Strategic Health Authority were exposed. A joint investigation was requested by the Healthcare Commission of the Commission for Social Care Inspection, as all aspects of the care-system had to be investigated.

The inquiry led in turn to a national audit of health care residential provision. Two NHS Trusts pre-empted this audit, and asked for full investigations. In the Sutton and Merton Primary Care NHS Trust “outmoded, institutionalised care had led to the neglect of people with learning disabilities ... some of the living environments [were] impoverished and completely unsatisfactory. Staff were not properly trained or supported to provide an acceptable level of care, and inadequate staffing levels meant that people were often left day in day out with little to occupy their time. There were failures in management and leadership at all levels, from front line managers up to the trust’s board” (Health Care Commission, 2007a). Bromley Primary Care Trust was also found to be providing care and accommodation well below the standards set by ‘Valuing People’ (Health Care Commission, 2007b).

Since then, there has been an even higher profile out-pouring of reports arising from the revelations of abuse at Winterbourne View, Bristol through a covertly filmed BBC Panorama programme broadcast on 31st May 2011. The journalistic investigation had been precipitated by a senior nurse, Terry Bryan, who left the hospital after complaining about the regime on some of the wards. He had failed to get backing or even a response from the local and regional management of Castlebeck, the company running Winterbourne View. He tried to report the issues several times with the national regulator, the Care Quality Commission (CQC). Finally, he went to BBC Panorama when all else failed. Unlike previous scandals, Winterbourne View was not an NHS facility, but a private hospital, commissioned by both NHS and local authority bodies for people with intellectual disabilities and/or autistic spectrum conditions and severe challenging behaviour. A number of official inquiries were launched by each agency involved (including the local police), requiring the police to set up a group to monitor and prevent any of them compromising their criminal investigations. Although these investigations eventually led to successful prosecutions of the care-workers filmed taunting, assaulting and torturing the service recipients, no one with managerial responsibility within the hospital or the company, or in agencies commissioning or inspecting the services, has been prosecuted (see; Flynn & Citarella, 2012, 2013). Both the CQC and service commissioners were severely criticised with consequent significant blaming and shaming of all the agencies involved, and on-going policy efforts to “ensure quality services” (Local Government Association/NHS England, 2014).

There is then, an apparent continuation and evolution of institutional abuse over the last 40 years, despite changes in the structure of service provision, in health and social care

management, in social and health care regulation and inspection, and changes from an emphasis on organisational settings to individual vulnerability (Brown, 1999).

Academic critiques of institutional care provision

It was half way through the 20th Century when systematic attempts were made to describe, and make suggestions to improve and replace institutional care. In the years immediately after the 1939-45 World War, several European countries began to build national welfare services, and existing services were opened to examination. In Scandinavia, critiques, policies and a legal framework of “normalisation” began to be developed (Emerson, 1992) to replace institutional living arrangements by a life-pattern closer to the general population.

Around the same time, in the UK, Tizard began looking at the potential of people with intellectual disabilities living in institutions for developing occupational skills, leading to the possibility of their working in the community. During the 1950's he developed and used quantitative sociological approaches to investigate policies and service provision, including those to families and children in the community (Williams, 2005). One of his well-known projects was the Brooklands experiment, where children were moved from a hospital to live in a large house in the community, and developmental rather than custodial care provided. Mansell (2005) judged it “in the British context, a defining point of departure for deinstitutionalisation and community living”, demonstrating “it was possible to care for people with learning disabilities in smaller, more homely circumstances in the community, rather than in institutions” (page 22).

The Tizard projects

King, Raynes and Tizard (1971) carried out a series of studies across a hundred living units in twenty six different establishments for children, mostly “institutions for the mentally retarded, although units caring for normal, but deprived, children and for physically handicapped children have also been examined”. They developed a number of scales for characterising the care-practices, staffing, unit and higher levels of management, which were validated and then applied to five hospitals, eight Local Authority hostels and three voluntary home, all caring for “severely retarded children”. From a theoretical background of Goffman’s (1961) concept of a “total institution”, they established a range of observer ratings how different forms of institutional care operated. Their Child Management Scale distinguished “child-oriented patterns of care” vs. “institutionally-oriented patterns of care”. In units with the child-oriented pattern of care “children were accorded respect as individuals; they had opportunities both for privacy and companionship, for personal clothing and for a share in the possessions of the community; they lived in an environment where rules were few and exceptions to them readily made, and where the staff were friendly and had an opportunity to get to know them. In these units the staff worked for long periods of time with a single group of children” (p 192). In institutionally oriented patterns of care, “the needs of young children for affection, for individual treatment, for variety of experience and for continuity of relationships received little attention. Treatment was not harsh or cruel, but the environment was bleak and the atmosphere institutional”.

King et al avoided explaining the differences by reference to personal characteristics of the staff, looking instead to the social organisation framing staff duties. Hostels generally had more child-oriented care; hospital units were generally more institutional; and voluntary bodies varied. The children's levels of disability were not a large factor in determining the care-pattern, nor were the size of the institution, the size of the living units, or the number of assigned staff. "Even well-staffed units can be run in an institutionally-oriented manner if the staff are not properly organized and if they do not receive the right kind of training" (p. 201.) Child-oriented units deployed their staff more effectively, to have more staff available at times of peak need; institution-oriented units maintained the same staff levels. Child-oriented units had greater continuity of staff than institutionally oriented units, where children might have to adjust to 100 or more different adults in a year.

The heads of the units set the orientation: heads of child-oriented units spent a significantly greater proportion of their time in activities with the children; institution-oriented unit heads spent significantly more time in tasks such as domestic and administrative activities. Child-oriented unit heads carried out these latter tasks in the presence of children, and institution-oriented unit heads in their absence. In institution-oriented units, there was more stratification of roles according to seniority; in child-oriented units, there was a greater role diffusion. Junior staff in each sort of unit carried out the same activities, though in child-oriented units they interacted more with the children, and more warmly than their institution-oriented unit counter-parts.

Unit heads who had more responsibility for running their units, and who were inspected less frequently, promoted and were involved in the most child-oriented activity. King et al

suggested that in such units senior staff felt a deeper sense of responsibility towards the children, and had a greater sense of commitment to their unit generally. Child-oriented unit heads were considerably more likely to have had training in child care; low rates of interaction with the children were associated with a nursing training. This held up over different settings supporting the view that “nurse training, as at present organized, in an unsatisfactory preparation for work in the long-term care of the handicapped” (King et al, p. 202), and suggested courses in child care provided a suitable model.

Raynes, Pratt and Roses (1979) took many of the scales developed by King et al, and the experiences they gained, in looking at institutional settings in the USA for “mentally retarded adults”. Their remit was to comment on recently re-organised services, aimed at breaking down monolithic institutions. They adjusted their measures of the quality of care to adults, encompassing both daily routines and staff communications with residents. Their initial field-work confirmed that King et al’s child-oriented vs. institution-oriented dimension was still valid in characterising units. At this stage, they were more critical of Goffman’s (1961) “total institution” concept, as they demonstrated a great variability in care within units of an institution, and multi-dimensionality in factors affecting the sort of care delivered. For example, level of cognitive ability affected the sort of care received as people with similar levels of disability were grouped together. Those with profound-severe disability received care that was almost universally institution-oriented, with greater levels of environmental deprivation, and very low levels of interaction with staff. Nevertheless, they contrasted two units for the profoundly-severely disabled, finding one unit with much higher levels of staff interaction with the residents, who reciprocated. It also appeared that unit size affected care given. “Small” units of 30 residents were all

resident-oriented, with the variability occurring across units of 30-90. Having relatively individualised care in the better larger units never approached the individualisation in the “small” units. Communication was not affected by size of unit: “the impact of total numbers is...confined to residence-wide policies rather than directly shaping minute-by-minute staff/resident interchanges” (p. 98). However, the likelihood of a particular individual being talked to would increase in a smaller group of residents.

Direct care staff interacted differently with residents when other staff were present.”The presence of more than one staff person systematically *decreases* the frequency of informative remarks to residents” (p. 99; authors’ italics), since “staff talk to each other instead of the residents when they can” (p. 100). Raynes et al concluded “simply adding staff in an unplanned way is not an effective administrative strategy for improving the quality of care” (p. 100). The presence of supervisors produced a less consistent effect, though still in the same direction. “Having your supervisor present may not consistently lower the quality of staff/resident interaction, but it certainly shows no indication of improving it.” (p. 100)

Since the study used both questionnaires and direct observations, Raynes et al were able to look at attitude/behaviour consistency. They found that that the most powerful influence on staff interaction with residents was “the extent to which they perceive themselves involved in matters relating to their work. This feeling of involvement appears to decrease when staff have been working in their buildings for more than one year” (pp. 120-121) After that time staff spoke to residents, if they did so at all, in a controlling rather than informative way. This amounted to Staff Institutionalisation, whereby “the institutional

setting drains incoming staff of interest and energy, and then discards them, in one fashion or another” (p. 120). This effect over time was independent of staff age. Interestingly, supervisors with the same amounts of time in the job as direct care staff were more likely to provide individualised care. Raynes et al suggested that promoting staff within the organisation for providing good care might help the feeling of not being recognised that contributed to the ‘burning-out’, though this could only be applied to a few staff.

Many workers who felt they had no say in all their job matters might have ‘taken it out’ on the residents in their care: they resented most professionals, supervisors and administrators. However, communicating with unit managers on a weekly basis positively influenced daily routines, which were determined by those managers’ policies. As in King et al’s (1971) study, having a supervisor who was relating directly to residents, rather than being involved in remote domestic and administrative difficulties increased positive communication by all staff with residents. The feeling of involvement was encouraged by the absence of formalised rules and constraints on roles, with flexibility to make ‘individualised’ services possible.

These two studies anticipated much of the research to follow, which in one sense does not progress much beyond them. King et al (1971) were explicit in their judgements that child-oriented practices are good, and that they have no evidence through improved speech or eating skills, say, to prove it. Raynes et al (1979) stated their principles differently:

“[I]t is not sufficient, if we are to improve the quality of residential services, whether these are large-scale institutions or smaller facilities, to cite their deficiencies or to write them off as incorrigible.....A comparative multi-

dimensional approach to these facilities can isolate specific factors contributing to institutional life. It can identify which facets of care are related to specific dimensions of the organisation's structures and characteristics of the personnel who work there. Such an approach does not assume that all aspects of care are equally affected by all dimensions of an organisation's structure; rather it assumes that these relationships have to be identified...As Tizard *et al* (1975) have said, 'Inasmuch as we can describe those determining features of institutional life...we can begin to make rational choices between different ways of running institutions' (p.1); and we can build environments which are free of features considered unacceptable" (Raynes et al, 1979, pp.15-16).

As Mansell (2005) pointed out, Tizard and colleagues were highly prescriptive, and were often making recommendations about groups of people and better institution management. "Choice" and theoretically highly individualised services outside of the institution were still beyond their horizon. Because the situations they were investigating have changed extensively, it is unlikely their methods and scales could be used currently. However, the processes they uncovered in their systematic critiques have many parallels in later critiques. Taking this space to report them in detail is to provide a comparison point for later studies.

Normalisation

Despite its salience at the time – Tizard contributed to symposia and publications alongside its advocates - little mention is made of in his and his colleague's works of 'Normalization', whether in the Scandinavian models of Nirje (1969) or Bank- Mikkelsen

(1969), or that espoused by Wolfensberger (1969; 1972). Nirje and Bank-Mikkelsen's approaches to normalisation pre-dated Wolfensberger's, and had strong impact in Danish and Swedish services. Their impact in the UK was limited to the physical design of segregated services (Emerson, 1992). Wolfensberger's approach manifested in the *Program Analysis of Service Systems* (PASS) checklists for assessing the models and minutiae of service delivery (Wolfensberger and Glenn, 1973), and *Program Analysis of Service Systems Implementation of Normalisation Goals* (PASSING; Wolfensberger and Thomas, 1981), included identifying changes to be made. Both were highly promoted in the UK by the Campaign for Mentally Handicapped People (CMH: later Values in Action) and their off-shoot the Community and Mental Handicap Educational Research Association (CMHERA).

Normalization firstly proclaimed the institutionalisation, social marginalisation and social devaluation of people with intellectual disabilities, based on social and institutional attitudes about and implicit judgements of people with intellectual disabilities. Ideas about the disabled – as objects to pity, or objects of menace – influenced service provision through its buildings and practices, which then brought about the behaviours and presentation expected. This was countered by giving people with intellectual disabilities as “normal a life as possible”. In the UK, normalization as a movement coincided with the first planned closure of institutions arising from *Better Services for the Mentally Handicapped* (Department of Health, 1971), and came to be used – and misused (Tyne, 1992; McGill and Emerson, 1992) in processes for setting the standards for the community services that slowly replaced them.

The outcome of “as normal/ordinary a life as possible” depended both on the person’s strengths and needs, and the resources available. O’Brien (1999) saw this aim as the core to normalization, as it implied a permanent state of reflection and progress on behalf of staff and managers. This is not something organisations are necessarily disposed to do (Greig, 2005). Experience in the UK showed it was naïve to underestimate the power of organisational cultures to resist change whilst incorporating normalization-speak (Emerson, 1992). Tyne (1992) suggested that the 1970’s were a time of development of the professions in learning disabilities, challenging the institutional model and its medical hierarchy. Normalisation was embraced by these professionals, and in turn it became a technological ‘fix’, as well as a prescriptive approach. One set of professionals replaced another set to decide what was good for people with intellectual disabilities.

Although Wolfensberger’s ‘Normalization’ was a powerful challenge to existing services in the UK in the 1980’s, it was criticised as a confusion of ideology, a self-proclaimed social theory and an evidence-based evaluations system (Brown and Smith, 1992) It was most succinctly conveyed by O’Brien’s (1987) re-interpretation of it as the Five Accomplishments. Evidence for the impact of normalisation on peoples’ lives is scarce, and possibly unavailable (McGill and Emerson, 1992; Culham and Nind, 2003) and the transition to community services in the context of other social theories and critiques may have brought about similar results, such as they are (Culham and Nind, 2003). McGill and Emerson (1992) discussed the potential for *rapprochement* between normalisation and behavioural approaches, which was problematic, but pointed out the common fate in services of these two challenging approaches:

“In many ways it appears that the main influence exerted on services by *both* approaches has been purely symbolic. That is, their ‘implementation’ has largely consisted of the relabelling and legitimisation of existing procedures in new terminologies...In general, services have placed little emphasis on the implementation of empirically validated methods for enhancing the personal competence of service users, have disguised inaction by a fog of high-sounding rhetoric and all too often have used normalisation as a justification for *laissez-faire* and/or punitive approaches which meet service rather than client needs...both approaches have served to provide intellectual camouflage for the implementation of often repressive social policies.” (McGill and Emerson, 1992: p. 65-66; authors’ italics.)

Hospitals in trouble

In the UK, Martin’s (1984) book “about the failures of caring in hospitals” (xi), demonstrated similar processes of ‘camouflaging’. He distinguished poor care and care-environments at the direct care level from poor management that did not provide resources or models for alternative care-practices, and allowed bad practice and abuse to emerge, be tolerated, and often covered up, by ignoring or undermining complaints. Much of his book is on the political and administrative responses to the inquiries, regarding resource provision/re-direction and increased inspection and advice, detailed above. However, he also drew out wider reflections and implications of the inquiries, and speculated on the “subjective aspects” of their findings.

Martin continued the differentiating developed by King et al (1971) and Raynes et al

(1979) between practices that benefit the patient, and those that benefit the work force. He used metaphors of industrialisation – mass production, mass handling (p.108); units on production line (p. 233) - to describe the outcomes of task-oriented nursing, as opposed to more psychological approaches. Without good management, care offered would inevitably slide towards the “preservation of order, cleanliness, etc” as an end in itself, in the absence of effective therapeutic regimes.

For Martin, a number of fundamental points had to be considered to improve standards, the first being “[t]he overwhelming importance of the working group and its morale. It is the single biggest power for good or ill.” (p. 112). He highlighted the inward looking nature of the staff-team communities, disagreeing with Goffman’s comments on the ‘total institution’ that staff “operate an eight-hour day and are socially integrated into the outside world’ (Goffman, 1961, p. 18). It would have been more true to say that the immediately surrounding part of the outside world has come to be integrated into the institution” (Martin, 1984, p. 109). The institutions were often major employers in the area, for both men and women; most staff lived in staff housing in the immediate area; inter-marriage was common; and family traditions of work developed. Martin suggested this high-level of solidarity was neither good nor bad in itself, but if standards fell and criticisms arose, ranks would close to protect the work force.

Martin divided the inquiries into three phases within the 15 years he considers. After the initial shock of the statutory inquiries in 1969-75, characterised as “problems of the old order”, there was a phase of inquiries emerging because of attempts to change regional or local practice. The third phase of 1979-83, local enquiries often ‘leaked’ their activities

and reports, and were used by management in attempts to increase resources.

Butler and Drakeford (2003) extended this analysis after having access to inquiry papers released under the Thirty Year Rule. They suggested that all the “scandals” were the result of on-going developments and changes in service provision: the abuse was already known about within the civil service and professions, albeit kept hidden. The uncovering, highlighting, and “scandal-making” served a purpose in promoting a new approach that was being resisted, namely ‘care in the community’. Once the principle of community care was accepted, institutional scandals disappeared along with ministerial interest. Subsequent inquiries regarding practice in the community almost inevitably found particular practices deficient, but not the principal of community care.

However, despite extensive research unequivocal benefits of ‘de-institutionalisation’ have proven elusive (c.f. Hamlin and Oakes, 2008; Mansell, 2005, 2006).

Defining good practice

At the centre of the 2001 “Valuing People” White Paper, was an attempt to define good practice by person-centred planning. Its value-base provided the framework for the reports into abusive practices in Cornwall, Sutton and Merton, and Bromley, and for the remedial action that was required.

Person-centred planning (PCP) emerged out of the normalization community of practitioners and teachers (O’Brien and O’Brien, 2000), to develop alternative support to existing services, through listening closely to the person, their family, friends and

community (Sanderson, 2000). In adapting itself to include people receiving existing services, PCP acknowledged and met head-on the dominant role of professionals in deciding what was best for individuals, and into which service they might be fitted (Greig, 2005). This dominance was founded on their expert position in developing and administering a skill-based, “readiness” model of “independent living” (Sanderson, 1998). The person-centred planning approach was based on finding out what the person wished for, how they wished to live and how they might be supported to fulfill these wishes. Normalization was about service development, and PCP about “continually listening to” people, in order to plan better for the people involved. In becoming Government policy, a more radical critique of how society should support people with intellectual disabilities became another service development.

This elevation of PCP led to concern about it surviving such large-scale prescription. (O’Brien and O’Brien, 2002) Its feasibility, value, and its effect on the lives of people with intellectual disabilities through this apparent appropriation have been questioned. Cumella (2003) characterised PCP as a particular form of highly labour-intensive planning taking away support from people with intellectual disabilities in order to produce imposed and yet unenforceable assessments. Further, there was no evidence-base to suggest person-centred planning improved people’s lives. Mansell and Beadle-Brown (2004) tried to address this limitation by looking at earlier, individual planning approaches, but found these in turn had little or no supporting evidence. They outlined a number of barriers and limitations to effective implementation. No-one disputed the values of “Valuing People”, but contested how they would turn into changes in social attitude and service-delivery.

Research to gather evidence of the effects of person-centred planning led by Robertson and colleagues at the University of Lancaster (Robertson et al, 2007a) suggested that having a facilitator with lots of enthusiasm for the approach outstripped other factors in producing positive outcomes. Other factors included having support, being more able, less ill &c, leading to the conclusion that those most favoured achieved the best outcomes, and may have done so without the person-centred planning process. In a parallel report, Robertson et al (2007b), barriers to person-centred planning were lack of resources, lack of services, and lack of time and interest in being involved unless paid to do so. A further working on some of the open-ended data in the study (Wigham et al, 2008) showed an increase in the number of goals set and met compared to the numbers recalled for pre-PCP planning by informants close to the person, which the authors acknowledge could be biased recall.

It had been suggested that person-centred planning and protection of vulnerable adults are incompatible (Brown and Scott, 2005; Flynn, 2007). Person-centred planning is based on the idea of building a circle of (unpaid) family, friends and neighbours to support the person in more creative and imaginative ways than paid care-workers could. Typically, it is this ring of family, friends, and neighbours are people who are most likely to be abusing an individual. “We began to characterise the practice of PCP, as it is currently being implemented, as an exercise in inspired optimism [...]. The circle meetings act as a necessary means of galvanising enough momentum to overcome depression and barriers, whether to mainstream service provision or greater acceptance in, and support from, people’s networks and neighbourhoods. The prevention of abuse, however, requires a kind of disciplined pessimism, one which uses both common sense and reputable evidence to

anticipate risk with a view to preventing harm or resolving conflict. They should not be seen as mutually exclusive but as complementary” (Brown & Scott, 2005, p.216).

Attempts to learn lessons

Martin (1984) isolated the following factors as contributing to institutional abuse, which have not significantly been challenged or extended since, except in emphasis.

Isolation of the unit, whether due to location, the inward looking perspective of a ‘community’, the tolerated ‘autonomy’ of professionals, or protection from public gaze;

lack of support for the person with intellectual disability, having no contact with outside family or networks who might care, or other supervision lacking;

lack of support for staff, who will lighten their load by misdirected humour;

discovery and reporting of ill-treatment blocked at the highest levels as well as the most local levels;

the corruption of care, where “the primary aims of care – the cure or alleviation of suffering – have become subordinate to what are essentially secondary aims such as the creation and preservation of order, quiet and cleanliness” and “people who joined a profession dedicated to the care of their fellows, and presumably

sharing its ideals, [sinking] gradually to a level of behaviour quite inconsistent with those standards” (p. 97);

failures of leadership, “both something to be explained, and also an explanation of how things came to go wrong”, allowing intellectual and professional isolation, failing to set and demonstrate standards of care, failing to provide staff with job satisfaction, failing to confront the weaknesses of the organisation, victimising “whistle-blowers”, failing to question medical autonomy;

policy and resources, where resources could be very limited, whilst policy called for standards that were thereby impossible to meet;

union involvement, which although rare, could lead to a distortion of power;

inadequacies of training, care-workers unable to meet the demands of the job, and unwilling to or lacking the opportunity to learn, being allowed by management and/or colleagues to continue in post, no provision of in-service training, professionally or to prepare for management;

personal failings, in setting standards of care, and collusion with poor care. “It cannot be denied that cruelty and weakness have played their parts in many incidents of ill-treatment, but always in situations where bad management has provided opportunities in which an unsuitable person was given the wrong tasks, with inadequate training and leadership. It was not always surprising that

managements, desperately short of staff, sometimes took on dubious recruits, what was less defensible was that they then took little further trouble to train or specially supervise those whose weaknesses were known from the start.” (p. 97)

White et al (2003) reviewed the literature on the abuse of people with intellectual disabilities within hospitals and community-based residences, bringing together previously identified aspects of service environments and organisational cultures that place people at risk. They suggested that development of effective responses to abuse has been almost entirely reactive, responding to abuse that has been committed, and for which there is supporting evidence. The right for protection from abuse was recognised in ‘Valuing People’ (Department of Health, 2001), and is a primary aim in ‘No Secrets’ (Department of Health, 2000).

White et al identified and clustered seven aspects of care environments and cultures increasing risk to people with intellectual disabilities: three are staff oriented, including staff deployment and support; staff attitudes, behaviour and boundaries; and staff training and competence. The other factors influence and enhance these staff factors: management competence; power, choice and organisational climate; isolation, physical and/or professional; and service conditions, design and placement planning. These were reconsiderations of Martin’s (1984) and Wardhaugh & Wilding’s (1993) analyses, with more recent examples of abusive community care provision added. The authors identified that “while at a theoretical level there is a recognition of the diverse causes of abuse, popular explanations appear to give little attention to the broader context of care, instead emphasizing the role of the individual” (p. 8). This could provide a “tidier” explanation, or

demonstrated an avoidance of criticizing the organisation of community care. They pointed out that the similarities between Martin's analysis of the hospital enquiries and their own were "striking". However, recommendations for prevention of abuse arising from all of them had little or no evidence base, including their own conclusion that "ensuring that service design and delivery is consistent with 'best practice' appears to play a significant role in the protection of people with intellectual disabilities" (p. 8).

In a review by Northway et al (2004), the reactive nature of policy development to protect people with intellectual disabilities was re-emphasised, as well as the lack of staff training and service co-ordination in such post-hoc policies. Northway et al were aiming to find good practice in prevention of and protection from abuse, and later summarised their findings with a quote from a participant: "policies don't protect people, it's how they're implemented" (Northway et al, 2007). The authors viewed implementation as a highly complex process, subject to individual practitioner prioritisation and interpretation, as in "street-level bureaucracy" (Lipsky, 1983). This led to uneven levels of practice across the services involved, with a lot of room for improvement.

Marsland et al (2007) built on White et al's analysis, and interviewed practitioners and family members who had been involved in proven or highly probable cases of abuse (strictly defined) about their observations of the services before the abuse had been revealed. This led to identifying early indicators of abusive services, grouped into six categories, only one of which were the changes in service users which form the usual focus of "signs of abuse" taught in "abuse awareness" programmes (e.g. "Working with the 'Unthinkable'", Brown and Craft, 1992).

The six categories of indicators suggested “action points” to reduce the risk of abuse. For example, “reducing isolation; ensuring effective commissioning, placement planning and service design; providing safe environments and care that meet identified standards and best practice; ensuring management and staff competence; recognising the ways that people with learning disabilities may express their vulnerabilities, their abusive experiences or their propensities to abuse others” (Marsland et al, 2007, p.19). Because these indicators were consistent with previous studies and inquiries, “further research to identify service-based risk factors may not be necessary. Instead, action is needed to ensure that potential whistle-blowers, service commissioners and decision makers are aware of the indicators and risk factors already identified” (p. 9). This should lead to early detection and prompt action to protect people.

Benbow (2008) contributed another list to ensure learning from inquiries in older adult abuse; Faulkner and Sweeney (2011) reviewed the literature, and provided a series of good practice case studies; and Hanley and Marsland (2014) reviewed it again to highlight the importance of relationships between care-staff and clients.

Quigley (2014) put this lack of knowledge and of progress in the field of abuse down to the weakness of the case-study basis of research into the area, restricted to the investigations that took place after each major disclosure of abuse. He highlighted the lack of theoretical frameworks and research data to guide policy making, whilst acknowledging the complexity of the social relations, particularly with legal frameworks, that have offered considerable barriers to progress.

The need for care-staff training

The need for care-staff training is a theme through all of the inquiry reports as a significant component of changing interactions between care-workers and the person with intellectual disability. King et al (1971) and Raynes et al (1979) were explicit in the training they thought appropriate – that undertaken by childcare workers, as opposed to general nursing – which was endorsed by the Jay Committee (Department of Health and Social Security, 1979). However, this supposed that a high proportion of care-workers are professionally trained or that in-service training for non-qualified staff is provided. Both suppositions have been convincingly challenged (Butterfield, 1969; Martin, 1984; Felce, 1999; Department of Health, 2001). Basic training for non-qualified staff (the Learning Disability Award Framework) was made a National Minimum Standard for services under ‘Valuing People’, which was to be taken up by services to a variable extent. Additional training, not part of the Standards, was not taken up (Department of Health 2007, p. 84ff).

In the light of the Cornwall and Sutton & Merton inquiries ‘Valuing People Now’ prioritised “[w]orking with professional bodies, the relevant Sector Skills Councils and regulators to provide new national qualification and career structures to give all workers the knowledge and skills to deliver high-quality support and *protect people from abuse*” (Department of Health, 2009, p.124: my emphasis).

Having to have such priorities underscored the lack of success of previous attempts, whether national policy development or individual worker training, to protect people from abuse. However, there was (a) no agreed definition of high quality support, as above; (b)

no analysis of the relative effectiveness of different approaches to training; and (c) no attempts to disentangle training effectiveness and other impediments to implementing protective policies, identified by Northway and colleagues (Northway et al, 2004; 2007). The BBC Panorama October 2012 sequel to their Winterbourne View exposé featured a restraint trainer used by Castlebeck and accredited by a company whose techniques were entirely legitimate techniques if taught correctly. He had told support workers from the hospital that he “had found a ‘kick in the bollocks’ was effective with larger patients, if all else failed” (Plomin, 2013, p. 184). The redeeming aspect was that Winterbourne View staff reported it to Plomin and colleagues, though Castlebeck and the accreditation company denied it for over 12 months.

Analysis

This review demonstrates the longevity of concern over interactions between care-workers and people with intellectual disability. Careful analysis of settings in which abusive interactions occurred finds recurring factors and processes. Despite strong suggestions for change, there appears a lack of progress in avoiding bad practice and abuse. There is an apparent inability in large-scale, state-sponsored organisations to learn from experience. Each scandal showed that previous attempts at preventing abuse had failed to reach all corners of the care industries.

“No Secrets” (Department of Health/Home Office, 2000) was the culmination of Government policy regarding abuse of adults, shifting focus from responses to inquiries to having consistent processes and practices in place for Adult Protection. However, the

Cornwall and Sutton and Merton investigations of the Health Care Commission (with CSCI) demonstrated limited progress, and how much insight and analysis had been ‘forgotten’ in the move to community services, whether run by health, social or independent services (Brown, 2007; Marsland et al, 2007).

In each 1970’s inquiry, it was stressed that not all units in the hospitals concerned necessarily showed the same level of bad practice, a point King et al (1971), and especially Raynes et al (1979) based their research model on. Conversely, it almost always “seems to have been known at ‘grass roots’ level that certain wards, and indeed certain individuals, were ‘bad’” and “for staff at Area, Regional or even National level to know of unsatisfactory conditions but for no effective remedial action to have been taken” (Martin, 1984: pp. 84-85).

Since the 1970’s, the absence of positive ‘models of care’ has been noted: ‘good practice’ has not been well-defined, except as avoiding ‘bad practice’. Brown and Smith (1992) pointed out there were “few relevant theoretical models from which to develop good practice” and “what has often happened is that institutional services have been physically relocated in the community, but little else about the nature of the service has changed” (p. xvi). Flynn (2006) noted that the Cornwall report urged the Trust to adopt ‘best’ or ‘good practice’ 15 times, without ever defining what it was.

Martin’s notion of good practice led to defining “the corruption of care” organisationally where “the primary aims of care – the cure or alleviation of suffering – have become subordinate to what are essentially secondary aims such as the creation and preservation of

order, quiet and cleanliness”. He also applied it to “people who joined a profession dedicated to the care of their fellows, and presumably sharing its ideals, [sinking] gradually to a level of behaviour quite inconsistent with those standards” (Martin, 1984, p.97). Good practice appears to be about unspecified values.

More recently, Jingree, Finlay and Antaki (2006) demonstrated a more nuanced subverting of post-‘Valuing People’ (2001) respectful involvement to recording having held a meeting; and of people “making choices” about social events to activities more convenient for staff. Finlay et al (2008) summarised a number of competing demands for care-workers that subordinate the current ‘cure or alleviation of suffering’ - respectful, person-centred support – to management and/or organisational demands.

Significant outcomes of comparing the literatures

Although Winterbourne View was a facility for people with severe challenging behaviour, and people with intellectual disabilities with challenging behaviour are more often abused than those without (see White et al, 2003), the historic scandals were not specifically about challenging behaviour. The significance of reviewing the institutional abuse literature as part of my research had been its demonstration that:

- 1 recurring bad practice and institutional abuse appeared dependent on the coordination of many layers of organisational involvement for it to occur and for it to continue;
- 2 this co-ordination did not appear a chance combination of events, as the same combination kept recurring, across time, localities and services;

3 following Butler and Drakeford (2003), it appeared turning abuse into scandal was also a co-ordinated political act to achieve certain ends that were given higher priority than the distress of the abused individuals (as might be inferred from the quote from Sir Keith Joseph at the head of the chapter);

4 policy making and inspection regimes to prevent abuse appears to have repeatedly been ineffective, despite politicians' 'never again' intentions, and professionals' concerted efforts; and

5 the model of systematic observational sociological research carried out by the Tizard group was able to identify at a number of levels the relative contributions of a number of interacting factors leading to bad and better practice within the same institutions.

It appears possible that the lack of transfer of knowledge and training by care-workers regarding effective ways of reducing aggression and violent behaviour in services to people with intellectual disabilities is part of a wider social organisation that had been barely scratched by clinical psychologists and applied researchers. Their approaches have not reached the same level of sophistication of the Tizard group's: indeed, such sustained programmes of research on current services are unlikely to attract funding (Northway, 2015).

There remains a lack of any conceptual framework to reconcile the day-to-day constraints of care-work, and in the one area high-level values and assumptions that can be 'corrupted' and in the other, the values and rigour of an ignored 'evidence base'.

Addressing these issues will require a methodology capable of working with care-worker/service-user interactions as well as organisational and political dynamics.

CHAPTER IV

INSTITUTIONAL ETHNOGRAPHY: A METHOD OF INQUIRY

Methodology

A methodology is needed to provide a perspective outside the frame of reference of the *impasse* between care-workers and applied psychologists, which necessarily would be a different perspective to any of my professional ones. Given Bazerman's (1987) characterisation of most psychological literature falling into behaviourist rhetoric, it needed to be from outside the mainstream of Anglo-Saxon, positivist psychology.

I had explored Cultural-Historical Activity Theory, based on the work of the Russian School of Psychology following Vygotsky (e.g. Wertsch, 1991; Daniels, 2001). I was particularly interested in Yrjö Engeström's application of this approach to work-teams (Engeström 1987; Engeström & Middleton, 1998; Engeström et al, 1999); and in Jean Lave's (Lave, 1996; Lave & Wenger, 1991; Chaiklin & Lave, 1996) anthropological approaches to learning and change in adults. These over-lapped with other approaches such as Work-place Studies, ethnomethodologically inspired studies of interactions of workers, work-teams and technologies, or 'distributed cognition' studies where work-related problem solving was distributed and co-ordinated amongst team-members (e.g. Heath and Luff, 1998; Heath et al, 2000; Laufer and Glick, 1998; Middleton, 1998).

At the most general level, they suggested that work-practices, social practices and 'on-the-job' teaching and learning were inter-related (e.g. Lave & Wenger, 1991), such that training events aimed at changing individual practice might not be sufficient to counter established practices in the work situation. However useful these approaches might be in describing the local co-ordination of care-working, they did not directly place that work within the wider social organisation that determines its nature, processes and outcomes. See also Appendix 4c.

Another line of methodological enquiry was discourse analysis. Critical Discourse Analysis in Fairclough's (2003) version was a response to the documents developed by the New Labour governments from 1997 onwards - including *Valuing People – A new strategy for learning disability for the 21st century* (Department of Health, 2001) - which demonstrated how they disguised neo-liberal economic doctrines as progressive, in this case, social welfare (cf. Burton & Kagan, 2006). Mediated Discourse Analysis (MDA) took a different approach, with discourse integrated *in action*, mediating between agency and practice to form a "nexus of practice" (Scollon, R, 2001; Jones & Norris, 2006). Discursive Psychology (e.g. Potter and Wetherell, 1987; Edwards and Potter, 1992) attended to how the situated, occasioned, rhetorical use of a wide repertoire of common sense psychological referents was used to influence others, and/or provide accountability.

These three approaches showed, respectively, how grand policy carried a social/political agenda; how some texts from that agenda might influence work

practices; and how interpersonal processes in carrying out the work might be influenced by psychological referents. They were not joined up in any way. Historically, it appeared that policy developments to, for example, prevent the recurrence of abusive practice had not had their anticipated influence. The links between policy discourse and everyday care appeared tenuous.

Concentrating on discourse did not appear to 'fit' the *impasse* between care-workers and applied psychologists which appeared to arise from competing *practices*. It drew to my attention to the Special Edition articles which either involved one or other of the guest editors, extensively quoting their previous publications, or responded to some of their concerns. Whilst the journal issue could be approached as a demonstration of the discursive and political nature of scientific texts promoting a particular perspective on who is to blame and who can resolve its issues, it did not lead to changes in care-practices: rather, it demonstrated anew the phenomenon it addressed.

Amongst rhetorical and other textual analytical literature I came across one of the works of Dorothy E. Smith (1990), demonstrating textual analysis from an approach, Institutional Ethnography, with its own ontology, epistemology and methodology for investigating the social organisation of knowledge. Much of the recent research carried out using Institutional Ethnography was in health care in Canada where it demonstrated the impact of New Public Management on nursing practice (e.g. Campbell, 2001; Mykhalovskiy, 2001; Rankin, 2001; Quinlan, 2009), making direct links between policy and practice, co-ordinated through management

practices and texts at a number of levels. Reading more of Smith's work suggested it might be able to explicate the phenomenon at the start of my research – which it labelled 'the problematic' – the social and historical processes involved in it, and my interactions with it as a clinician.

Institutional Ethnography

In a number of her publications, Dorothy E. Smith (e.g., 2005) recounted that Institutional Ethnography was founded on her response to the deep opposition between the mainstream sociology she had been educated in and her discoveries from being involved at an early stage in the women's movement of the 1970's. She lived in two worlds, two modes of consciousness: the academic world and her life as a single parent raising two children. Running a household and family is highly attentive to the particularities of a local setting, coordinating multiple particular cues, details and initiatives, and involved in relationship with particular others, adults and children. The sociology that she taught had virtually nothing to say about this part of her life.

The organised and organising world of the university setting and academic work - preparing for classes, teaching, writing papers, and staff meetings - entailed a consciousness that participated in a discourse in which particular others are represented only as their printed names in texts or as members of definite classes of people, students, colleagues, administrators. The university worker related to others beyond the local and particular, the known and unknown names on books or

articles, heroes and villains of contemporary discipline. The women's movement encouraged her to bring her "home" subjectivity into the university and her work there.

Smith starts most of her articles and books with this fundamental experience; the above two paragraphs are a gloss from a chapter in a qualitative research text (Smith 2001), and Chapter 1 of her latest rounded presentation of her alternative sociology (Smith, 2005). Because Smith sees her own texts as a progression in an open-ended enquiry, her 2005 book will be the primary text of reference for the exposition of Institutional Ethnography, as the most worked through version to date. In her introduction, Smith (2005) recommended shorter introductions to Institutional Ethnography: Campbell and Gregor (2002) and Grahame (1998), and Smith (2002 [nb, in Smith 2005, this is indexed as 2001a]). They will be the main textual resources to describe the basic methodologies, followed by additional material from Smith (2005).

The methodologies are not separate from the expository texts: "the researcher needs to learn to look at any situation *as an institutional ethnographer does*." (Campbell and Gregor 2002, p.59). The methods of enquiry overlap with many qualitative research approaches, being primarily ethnographic, based on observation and structured or unstructured interviews. The methods incorporate text analysis, which became increasingly important. I propose to follow Smith's advice by taking the three texts she recommends in chronological sequence, to introduce and elaborate this interweaving. References to Smith's works will be as cited by the respective authors in their texts, with the convention

that I will have read these texts, unless identifying them as ‘cited’. I summarise Grahame’s (1998) description first, and then add to or refine it using the other sources.

Grahame (1998): Ethnography, institutions and the problematic of the everyday world

Grahame (1998) introduced Smith’s work as drawing attention to how everyday activities are coordinated, and developing research strategies to capture how those activities are tied into the dominant forms of social organization. He proposed that her approach to sociological inquiry challenged standard sociological objectification, and its rôle in ruling.

Grahame showed that in using categories like “delinquency”, mainstream sociology produces the activities of individuals in an objectified form, defining activities that occur in particular times, places and circumstances in terms of the imperatives and procedures of the institutions concerned, in this case, the police and the courts. Objectified constructs are tied to practices of formal organization rather than expressions originating in the actualities of everyday life. Standard sociological discourse goes on to represent the social world in terms of formal relations between properties of these conceptual constructs. The presence of active subjects who are expert knowers of their everyday worlds is eliminated in favour of an abstracted mode of knowledge constituted in terms of the relevances of a ruling apparatus (Smith, 1987, pp. 152–153).

“Ruling” is used in the sense of organizing, coordinating, and regulating what happens in contemporary societies, within the framework of a society’s dominant institutions. Taken together, management, the professions, government, the media, and the academy are seen

as a complex of extended social relations, ruling relations (Smith, 1987, p. 56; Smith, 1990a, p. 14), that use specialised scientific, technical, and cultural discourses in a wide variety of textual formats as part of the process of ruling (Smith, 1987, p. 152; Smith, 1990b, p. 6).

Rather than starting from the categories of conventional sociology, Smith proposed beginning with the everyday world as it is actually lived by embodied beings and proceeding from there to develop a conceptualization which clarifies the properties of that world. Smith uses the term “problematic” to indicate a domain of possible questions, not yet formulated, but which are implicit in the way the everyday world is organized. It is developed as an inquiry questioning how things are organised, and what is linked to that organisation. Smith’s argument is that the social organization that makes possible the daily scenes of life in contemporary societies is not wholly contained within the local setting, nor in how the people within the setting understand it. Rather, this organisation is generated by social relations which originate outside of the local setting and which can only be partially glimpsed within it (Smith, 1987, p. 92 and pp. 152–154). As Grahame points out, this can lead to experiencing the everyday world as disorganized. Events may seem disconnected, incoherent, or lacking in sense, pointing to the need to rethink the everyday world as a problematic for sociological investigation.

Smith distinguished her approach from others sociologies of everyday life in how they constitute the everyday world as an object for sociological study. For example, Goffman’s dramaturgy provided a set of categories (impression management, definition of the situation, front and back regions) which opened up certain elements of the everyday world

for study (citing Goffman, 1959; Goffman, 1963). Following a different strategy, ethnomethodologists advocated treating social settings as self-organizing (Garfinkel, 1967, p. 33) and analyzable in terms of properties produced and known within the local setting. These strategies assemble the everyday world as an object of investigation by isolating it from its context and making it appear self-contained, thereby severing it from the connections with broader forms of social relations and organization Smith discovered. Although difficult to grasp from within the local setting they give that world its particular character.

Generalized social relations, such as the relations of production and consumption, state administration, and managerial control, are familiar conceptions of the institutional order of contemporary societies, reaching beyond local settings to involve individuals often unknown to one another in extended sequences of social action, are abstractions. In Smith's account, a social relation is the actual linking and coordinating of activities and work processes in diverse sites: social research is aimed at discovering these extended forms of social organization (Smith, 1987, pp. 152–155).

Smith used the term 'ethnography' to emphasize the idea of exploring this social organization concretely by using the experience of some particular person or persons as the entry point. Mainstream anthropological or sociological ethnography as a field study of a particular group of people in their "natural" surroundings aims for an empathetic rendering of the perspective of individual actors and the group as a whole, especially the meanings which events and relationships have for members of the group in their everyday lives. In Institutional Ethnography, understanding the localized social world of the individual or

group is not treated as an end in itself and inquiry is not restricted to observation and interviewing. Actual practice – how things work – becomes the focus of investigation.

Thus, an Institutional Ethnography describes the social organization of the everyday world shaped by institutional processes, from a standpoint outside of institutionalized discourses. It is therefore crucial to grasp what Smith means by “institutions.” Grahame explains:

“Institutions are not viewed as singular forms of social organization, but rather as functional complexes such as education, health care, and law, in which several forms of organization are interwoven. Institutional processes transform local, concrete, and particular actions into ‘standard forms of organizational action’; in this way, local activities take on a generalized form. Here, Smith draws on Marx’s discussion of commodity relations: when goods and services are exchanged in the market setting, their value appears in an abstract form, expressed through the medium of money. In a similar fashion, bureaucratic forms of organization make actions accountable in terms of abstract, generalized categories. The concrete experience of individuals can thus be viewed as a terrain structured by these generalizing relations but not wholly swallowed up by them. In this way, the experience of the individual presents itself not merely as “a case,” but rather as an entry point into the actual workings of those institutions which produce the generalized and abstract character of contemporary societies [Smith, 1987, pp. 157–158].” (Grahame, 1998: 352-353).

Institutional accounts are said to be “ideological” as they make local practices accountable in ways that express the functions of the institution. “For example, schoolteachers learn to

account for children's behaviour in terms of "developmental stages," "learning styles," "attention deficits," and the like; such accounts narrow and transform what can be noticed and proposed about classroom activities. Through such procedures, institutional forms of discourse are made to stand in for the situated practices and reasoning of individuals, so that the latter appear only as psychological or social processes, if at all. Institutional ethnography, by beginning with the experience of individuals, seeks to break with these processes of institutional inscription [Smith, 1987, pp. 157–161]." (Grahame, 1998: 353).

Grahame summarised the research strategy of an Institutional Ethnography in three tasks. The first addresses the ideological practices which are used to make an institution's processes accountable. The second task involves studying the work activities through which people are themselves involved in producing the world they experience in daily life. This is work "in its generous sense": all the organised, intentional activity carried out in daily life, not just in employment, but also the sociologically invisible work of, for example, organising and cooking family meals. The third task is discovering the ways in which a localized work organisation operates as part of a broader set of social relations that link multiple sites of human activity (Smith, 1987, p. 166).

The tasks related to ideology, work, and social relations are taken up and woven into an analytical narrative. Whilst responsive to all three of these tasks, not all have to be developed fully in a given piece of work; some dimensions of the tasks may be handled in a more exploratory fashion. Grahame saw the tasks as directing attention to key ingredients of the problematic, not stages or levels of analysis. Each highlights a different aspect of the coordinated and organized character of the everyday world which conventional

analysis has ignored or misconstrued, with certain topics or phenomena being excluded, particularly the standpoint of subjects who know and experience their worlds.

Investigation begins with difference between everyday experience and institutional practice, from what this awareness of different consciousnesses says about how 'things' are organised.

If Smith's account began as an experience as, say, a parent, it ends with insight into the general relations of schooling and class reproduction. The point of the analysis is not Smith (to cultivate autobiography) but starting from the experience of exclusion, going on to account for it in terms of a broader organization that is unnoticed in significant ways. This kind of analysis becomes a sociology *for* those who experience exclusion: it produces an awareness which makes it possible to begin to consolidate a knowledge outside an institutional discourse. It raises consciousness about oppression and provides a method for gaining insight into the social organization shaping their everyday world, and begins a process for changing it (Smith, 1987, pp. 88, 107, 154).

Smith (2002): Institutional Ethnography

Smith's brief exposition of her method introduced Bakhtin's (1981; 1986) concepts of dialogism and speech genres, positing both speech and texts as being "utterances", and operating through similar processes.

Smith used the notion of dialogue to hone the distinction between sociological and Institutional Ethnography approaches. Sociology aims at understanding the same world that sociologists are part of and work in. Although it uses devices to present its accounts as 'objective', standing outside of that world, sociological inquiry depends on being in dialogue, in relation with those it studies. To guard against the primary dialogue with people who are the resources and end-users of the written account, there is a secondary dialogue within sociological discourse, its conventions, methodologies, rules of evidence &c.

Ethnography is more explicitly dialogic, but in two directions: firstly, with the people whose lives are being described; and secondly with those the ethnographer is writing for, with the discourse within which the study originated. This discourse shapes the first dialogue, in choice of topics for interviews, or in what is observed. It is in the ethnographer's power to take from what the people said and reproduce it in a different setting, in a different language, to their own ends. This partly comes from changing from a dialogic to a monologic form (Bakhtin, 1981). The primary dialogue will consist of various perspectives, experiences and ways of using language, which is reinterpreted into a single overriding version.

In contrast, Institutional Ethnography does not aim to describe how people live or share understandings: it works with the primary dialogue, people's accounts of their experiences as expert practitioners of their everyday worlds. The institutional ethnographer first learns from them, and then seeks to find the social relations and organisation in which they are embedded, to hand back and inform those people. The researcher's task is "finding the social" as it arises in what people do, say or write, in particular settings and times: people are always embodied. "The social is a focus on what is actually happening; it is to be discovered in people's doings in the actual local settings of their lives" (Smith, 2002, p.21).

In a pivotal paragraph, Smith described how language, concepts, and thinking are to be recognised as among people's activities. "Thought and mind may be experienced as divorced from the local and from individual's bodily being, but the experiences of separation from local activities is itself produced right there in them as people adopt a disciplining of the body so familiar we pay no attention to it and as they take for granted the text as their medium of access to the beyond-the-local. Concepts and theories appear extra-temporal on the page but in actuality they are people's doings in their reading and thinking and in the talk in particular local settings and at particular times". (ibid, pp 21-22). The language or speech genre (Bakhtin, 1986) people use in speaking of what they do coordinates or organises people's divergent consciousnesses, and carries institutional organisation.

Institutional Ethnography is not itself institutional: 'finding' the social is a minimal theoretical leap, providing a point of entry; there is no limitation on what might be found,

no commitment to a particular level of abstraction. Institutional Ethnography starts from people's differences in experiencing, seeing and conceiving, making the concerting of activities open-ended and productive. In contrast, institutional social organization constructs forms of consciousness that override individuals' perspectives. These forms of consciousness are founded upon texts, printed, digital or otherwise replicated. "The architecture of institutions is through and through textual...and institutional ethnography increasingly incorporates attention to texts and textuality." (pp Smith, 2002, 22-23)

Smith described several aspects necessary to carrying out an Institutional Ethnography. Out of an inexhaustible world, observations and interviews need to find a direction for what is attended to, what is analysed and what the relevant institutional texts are.

Institutional Ethnography is guided by issues, concerns or problems that are real for people. As an institutional order is a complex of relations rather than a body such as a corporation, there is no obvious focus. This reinforces the choice of standpoint as a key first step. An investigation builds from one stage to the next on the basis of interviews or observations, going from an exploration of everyday particularities of some identified work (in the generous sense) to exploring the generalised relations in which each individual's everyday world is embedded.

"Institutional Ethnography isn't about explaining people's behaviour or about testing theory-derived hypotheses by relating variables derived from individual's responses to structured questions". (ibid, p. 25). What is being sampled is an institutional process rather than a population, in how the distinct generalised forms of an institutional order are

brought into being in the particularities of people's everyday doings. The choice of people to talk to depends on the direction of inquiry pursued.

In institutional settings, respondents will speak from the institutional discourse, in which the language is generalised, lacking descriptive content. Institutional ethnography focuses instead on the concrete and everyday experience that particularises, describing work in its generous sense. This “evad[es] the divorce of subjective and objective that often requires the sociologist to hover unhappily between objectified description (as in ethnomethodology's conversational analysis) or concepts of meaning which are generated by methodological apotheosis (as with grounded theory)” (ibid, p. 26). Typically, interviewing people about their work in the sense used here leads to talk about thoughts and feelings as well as the practicalities. However, it is used “to focus the attention of both parties to the dialogue on what is done and being done, under what conditions, in relation to whom and with what resources” (ibid, p. 46). Although the interviewer relies on the respondent's know-how, it is not their competence that is focussed on as that “shifts the ground away from the concerting of people's activities and ...installs people's doing in a disposition and formulated thus the social never actually happens” (ibid, p. 46).

Smith and DeVault and McCoy (2000) stressed the necessity for the interviewer to be open to being changed by the answers respondents give, to be truly open to dialogue. There will be a progression from one interview to the next, even if the same questions or topics are used, in contrast to limiting the respondent's contribution through pre-set questions and pre-coded responses. Institutional ethnographers wish “to discover not only what they did

not know but also, as they go about their work, how to think differently about what they are learning” (ibid, p. 28).

Although people’s ways of organising their work may be individual, the work produces and reproduces the standardised institutional form. Through such discovery, larger social relations are explicated, and the institutional order investigated, making it possible to locate potential sites of change (citing Pence, 1996). In tracing these co-ordinating relations, it can be useful to track the interchanges of the-time-it-takes in sorting out the interconnections. Smith uses the example of processing a call to the police reporting an incident of domestic violence through the justice system, but it will equally apply to health and care processes of referral, allocation, referral appraisal, prioritising, waiting list time, convening of referred person and significant others...

Institutions generalise across many local settings of people’s activities through standardised and replicable texts. Whatever the textual form, printed or digital text brings an identical set of words or images into local sites. Although they may be read differently in each site, one side of the text-reader conversation is fixed and unchanging; the text is open to interpretation, but does not change over readings. In Institutional Ethnography, texts are considered as they enter into action, governing the reader’s next response in the development and co-ordination of activities. Their materiality is emphasised as this enables them to be seen creating the join between the everyday actualities of people’s activities and the social relations they are coordinated by.

Campbell and Gregor (2002): Mapping social relations: a primer in doing Institutional Ethnography

Campbell and Gregor wrote their book to show experienced nurses how to recognise and analyse the relations of power within which they lived and worked. They put Smith's (2001) conceptual account into their workplace. "[N]urses work in environments that are politically highly charged. While the effects of institutional power pervade nurses' work lives, the negative effects may appear to individual nurses simply as personal problems" or due to "the personalities, competence or incompetence of ...co-workers or superiors." (Campbell & Gregor, 2002, p. 16). This level of understanding may be based in the knowledge accumulated in initial training, yet there is often discontinuity between that training and students' work experience. "Your professional theories may be out of step with the settings in which you work and with your clients and colleagues. You may not have the conceptual tools to bring the divergent pieces of your work together." (ibid,p. 18). This challenged students to find ways of studying how knowledge is structured, how things work in the everyday world, and how they might bring about change using that new knowledge.

The reading of texts was presented as more than an intellectual exercise. "The particular use of words, language and texts build organizational versions of what people say, do or know for organizational action" (ibid, pp 24-25). Textualising events, people's words and actions changes them, for example, into official and bureaucratic accounts that lead to managerial and professional action. However, texts also require skilful work to take them up and act appropriately. An assessment form requires previous knowledge and

interpersonal skill to gain co-operation with the informant, and to move through the form. An academic text requires previous knowledge and critical reading skills.

Smith (1990b) referred to texts being activated by the reader; they only rule through co-ordinating *actions* of individuals across sites; people participate in discursive activity.

“What Foucault (1984) conceptualised as knowledge/power is for Smith a social relation that comes into play as actual people participate in knowing and acting knowledgeably” and are “brought into line with ruling ideas. Some elements of ruling arise formally and explicitly through legally binding discourses. Often ruling happens less explicitly as people consult their own understandings of prevailing and dominant discourse and act accordingly.” (Campbell & Gregor, 2002, p 41)

Academic texts start to coordinate research through a literature review, which is usually required to link any project to the literature and to position a researcher’s views amongst others. Thesis writers demonstrate their skill in joining a scholarly tradition as part of their evaluation. By contrast, the institutional ethnographer reads to discover the scope of research knowledge in their chosen area, and to analyse the social organisation of that knowledge. In published accounts, the research activities that generated them are rarely present. The institutional ethnographer must “remain interested in how those accounts have been constructed as factual and in how facticity depends upon the research-writer’s standpoint disappearing from the final version” (ibid, p. 52). From the theorised approach that where the knower stands determines what can be seen, reading needs to “identify how the researcher-writer is located, the purposes to which a particular account is written and what activities this particular account supports – or, alternatively, makes invisible”. In

exploring the literature, there is the danger of concepts from the literature leaking into the description of the everyday world being investigated, and such concepts carry a particular positioning of the reader. The problematic of the everyday world may be subordinated to the interests and stance built into the literature.

Within the fieldwork, texts will appear in people's talk because they are integral to what people do and know. Rather than be used for their factual information, they are relied on as crystallised social relations, as alternatives to, and an antidote for, accepting ideological accounts based in discourse. Text based decisions can directly contradict organisational claims and intentions, as when the operation of matching needs identified from a referral form to a limited pool of available care-workers leads to a shift from an organisation's self-definition of providing "person-centred care" to "finding someone who can step in".

Whatever the source of data, the research is worked up only when the linkages are made between the two levels of data, the primary dialogue with informants, and the secondary dialogue in questioning the text to trace the ruling relations. The process of tracking back or following forward from the local site distinguishes Institutional Ethnography from other ethnographies. Data collection cannot be done at the second level without conceptualising the connections between the two, hence the explicit theory driven aspect of data collection. Bringing the data together with theory happens explicitly in the process of analysis.

Campbell & Gregor introduced the idea that presenting the research findings coherently and persuasively is part of the doing of the analysis in institutional ethnography research. Analysis includes choices about what can be said from the data collected. The story to be

told will have already begun to appear in the theoretically organised collection of data: from the rich descriptions of the everyday world of the informants, its co-ordination across settings and times would have been indicated and further investigation carried out into how that organisation and co-ordination comes about. In the writing up, the organisation and connections outside the local setting, and their implications are made explicit, producing the analysis.

The place of texts in an Institutional Ethnography

The practices followed for observation and interviewing are the same for analysis based entirely on texts, using the conceptual strategy of textual activation and analytic use of a text-reader conversation. Smith (2005, p. 101ff) presents the strategy as a response to the challenge of the everyday experience of the ‘stasis’ of texts: they do not move or act in the same way as the people reading them; reading does not appear to be an act, it does not “occur”.

In the everyday notion of a conversation, more than one person is involved, it takes place over a period of time, and there is an interaction between people. In a text-reader conversation, the reader has to first ‘activate’ the text – possibly in a way not intended by the author – as well as responding to it in some way. This inserts the text into the local situation, and into an unfolding sequence of actions. Unlike an everyday conversation, the text remains unchanged by its reading: it is fixed and unresponsive. It can be read differently, in different contexts, by different people, or in different sequences of action, but the idea of different ‘interpretations’ supposes that the text remains constant.

This constancy of a text has led to its rôle in organisations and institutions, providing standardisation across multiple sites of people's work, through a standardised vocabulary, standardised definitions of entities and processes, and their interactions. As readers talk or act to co-ordinate their actions in relation to the text, it regulates the discourse available to them. Even if readers attempt to use other vocabularies to resist the text, they will still be in response to and defined by the text.

The reader is not only the voice of the text, but also its agent, in that it will define how the text should be read. This is intrinsic in taking up the vocabulary of the text, in understanding the meaning of the words, but can be a deliberate aim of a text, whether in the artful use of words and narrative structure in a crime novel, or a self-justificatory narrative gathered in an interview. In the context of the trans-local coordination of actions, textual practices reflecting 'regulatory frames' determine what is 'relevant' to an action, what information is asked for and how it is to be recorded, usually by ignoring, removing or making invisible what those involved might consider more relevant.

Individual experience, participant-observation and autobiography

Campbell and Gregor (2002) characterised the process of writing up as a three-way conversation between the data collected, the author's understanding of the data and how it comes to be so, and the text they've written. Smith (2005) went further to show the primary dialogue is where experience is collaboratively produced. Institutional Ethnography recognises the expertise of the experiencer in presenting accounts of their

daily life/work and balances any theoretical imposition on it through a commitment to discovery. However, the researcher's ignorance, attentive hearing and probing are resources in developing the dialogue. In the interview or fieldwork, the researcher is caught up in the discussion with informants or in observing, and then it is in the writing and reading of those accounts as social relations, that the social organisation present in the accounts can be discovered. Smith distinguished between the primary data dialogue - between the interviewer or participant observer and people talked to or observed - and the secondary data dialogue between the researcher, interview transcript and/or the field notes.

Smith (2005,p.139-140) further argued that experience is not contaminated by being produced collaboratively by highlighting two studies by de Montigny (1995) and Kameni Grahame (1998), in which the data is their own experience. "The work knowledges [...] of de Montigny and Grahame were the major experiential resources on which the researchers drew, and the dialogic within which their stories emerged was with institutional ethnographic discourse. It is a discourse that avoids imposing interpretations and collaborates with informants - or, in these instances, with the ethnographers themselves - in *discovery*." (p.140: author's italics).

Work is defined in a generous sense in Institutional Ethnography, beyond the narrow concept of paid employment. It extends to anything done by people that is intentional, takes time and effort, carried out under specific conditions, and with specific means and tools. Thus it can include the purchasing, storing and laundering of specific 'office' clothing to meet 'dress codes', including for 'dress-down' days; being organised to co-ordinate with public transport, or to participate in slow traffic so as to arrive at work on

time; or opening and maintaining a bank account in order to be paid. It includes the work done by older-adult residents in a care-home at breakfast time recorded by a nursing aid participant observer: “[there] each sat before breakfast, bib in place, eyes glued to the elevator [bringing food trolleys from the kitchen]. They waited quietly, with a wild patience, practicing patienthood, actively practicing the skills of silence.” (Diamond, 1992: p. 129; cited in Smith 2005, p. 152).

An interviewer depends on identifying such work through speaking experientially and concretely for the primary data dialogue, to identify work-knowledges in the second dialogues. This differs in small ways from records captured through participant-observation. The written record in the case of the participant-observer is in the observer’s own words, not someone else’s, but is still experiential. Participation also leads to engagement in institutional processes, which a critical awareness can explore from their own experience and through conversations with fellow participants. However, engagement has its own dangers, a principal one being open to ‘institutional capture’.

Institutional capture

Institutional discourses subsume or displace descriptions arising from experience. If both the informant and researcher are familiar with the prevailing institutional discourses and know how to speak them, the transcript will be descriptively empty, as it is couched in the apparent shorthand of institutional terms. As DeVault and McCoy (2002) identified, ‘institutional capture’ happens in interviews where only those aspects that the person is

institutionally accountable for are reported. “What is not discursively recognized will not appear”: (Smith, 2005; pp. 156-7).

The generous definition of work is a prompt to the researcher to get beyond the institutional discourse, locating that work within sequences and capturing how it links to and is co-ordinated with others working in the same institutionalised processes. Different informants will have different perspectives and experiences: assembling these work knowledges allows the ethnographer to map the social relations. “The product is ethnographically grounded, drawing relevant passages of dialogue with informants into the text to stand not as illustrations or examples but as accounts of the work people are doing that coordinate with the work of others in an organized process. Ethnography discovers the institutional order rather than imposing it.” (Smith, 2005: p. 162).

This requires a style/language/speech genre that does not import concepts, practices and understandings from mainstream sociology and/or psychology: in short, to avoid institutional capture, or to detect it and explicate it.

Critiques and counter-critiques

As a *grande dame* of Canadian/North American feminism, feminist and critical sociologies, Dorothy Smith has attracted her share of academic critique. Smith (2005) identified two areas to defend, using individual experience as a data-source, and power issues within interviews. Butler and Scott’s (1992) introduction to their edited collection of papers, Scott’s (1992) chapter therein, and Moya’s (2000) critique experience. Smith’s

rebuffs of these are considered below with counter-critiques she has written in response to other articles.

Doran (1993; 2004) made two attempts at expressing his 'unease' with Institutional Ethnography: not from its foundation in ethnomethodology, grounded in everyday experience which he values, but in Smith's use of Marxism, that is, of Marx' concept of ideology. Smith neutralised Doran's and similar criticism which "applying the sociological reading of ideology to Marx's work, have accused him of not recognizing the ideological character of his own work in taking the standpoint of the working class.... It is a reading of his work that depends upon imposing on it the interpretive framework of a later sociology...In *The German Ideology* the perspective he held and the theoretical enterprise on which he was engaged are clearly contrasted to ideology." (Smith, 1999a: p. 208, note 7).

Doran (2004) identified four other authors with unease. "Lemert's (1992) concern with "fractured identities," Hill-Collins's (1992) with the entrapment of Smith within the "inner circle" of sociology, Connell's (1992) with Smith's elevation of "individualism," Clough's (1993[1993a, here]) with Smith's lack of attention to "unconscious desire" have been concerns raised by fellow sociologists."

Smith (1992) responded to the first three in the same journal: "Lemert reads the project of an inquiry beginning from women's experience as a sociology of women's subjective experience. Collins reads into my project her objective of creating a transformative knowledge. Connell confounds beginning from experience with individualism, and

interprets my rather careful (and critical) explications of the conceptual practices of power as an abhorrence of abstractions in general.” (p. 88). That is, these are attempts to reject or at best subsume Institutional Ethnography to their favoured theoretical approaches in sociology by the setting up of their own “straw Smiths” (Smith 1992; p 88).

I had aligned Clough (1993) with Hekman (1997) as both their critiques were organised around “standpoint theory”, which rely ultimately on dismissing experience as a valid source of data. The basis of Smith’s (1993) response to Clough was essentially the same as to Butler and Scott, Scott and Moya - to the post-modernist stances that nothing exists outside of discourse, including experience, which therefore has no privileged access to ‘reality’. A “sociology from women's standpoint *isn't about that experience* [my emphasis]. Rather the idea is to develop inquiry into the social relations in which that experience is embedded, making visible how it is put together and organized in and by a larger complex of relations (including those of ruling and the economy)” (Smith, 1993, p. 184).

Smith (2005) also referred to Briggs (2002) chapter on power/knowledge and social inequality raising power issues in interviews, favouring the academic’s concerns rather than those of the interviewee. She acknowledged the disparity. “The controlling interest of the ethnographer...is balanced by the institutional ethnographer’s deference to the informant’s experiential authority and by a commitment to discovery”, (Smith, 2005: p 141).

Smith's more recent critics has been Kevin Walby (2007; 2013), who also refers to Taber (2010, 2011) who aimed to improve Institutional Ethnography by using auto-ethnographic fieldwork. Walby and Taber showed a greater degree of understanding than earlier critics, and had obviously read a lot of Smith, but appear to have used Institutional Ethnography as a tool, as a qualitative-research method to further their own projects, rather than understand it as a project in itself. As with the previous critiques, "institutional capture" of Smith's closely defined terms such as ideology, experience, problematic substituted the way mainstream sociologies use these terms onto Smith's usage. In this sense, they had not made the "ontological shift" that Smith recognises took her 25 years to make (Smith, 2005; pp. 2 & 4).

Therefore, having some grasp of the 'method of inquiry' that is Institutional Ethnography; having found that its detractors have only come up with ideological as opposed to substantial flaws; having a perspective with which to have a dialogue with professional practices in intellectual disability services; we move to the Method section.

Research Method

Bazerman (1987) provided an historical and rhetorical overview of the Method section in published articles in psychology, sociology and political science. It initially was a major part of a paper, in order to make transparent the conditions and nature of the research, to ensure replicability. However, it increasingly diminished in size and importance as techniques became standardised and codified, within a

narrow rhetorical framework. This also decreased costs of publication (Sigal & Pettit, 2012).

This method section will be more extensive, to demonstrate part of the intellectual work that was involved in developing the final method around a number of drivers and associations. The narrative arc that has determined the project's method sets the context for the research. It is also consistent with the Institutional Ethnography to look at the social relations that have defined the method, and what might be said. This exploration will be carried out through analysis of texts, analysis of narratives derived from personal experience of working in the field, and from personal narrative that stands for reflexivity in materialist approaches to research on psychological therapies (Dreier, 2007). All of these can be and are encompassed within Institutional Ethnography, as detailed above.

The need to work with a range of data sources was increasingly influenced by the need to avoid if possible challenging ethical situations, the countering of which would be too time-consuming. Protected time for research within my clinical practice was initially granted, but by the time fieldwork was being considered, that protection had been removed. Other relevant material conditions of the research included the professional expectations to carry out clinical research, subsequent structural changes in the NHS that removed the protected time, and the complex structure of services to people with intellectual disabilities. The most profound influence on the final method was the interaction between these issues and gaining ethical approval.

Seeking ethical approval: I and II

My original intention had been to sample interactions between care-workers and between care-workers and people with intellectual disabilities with challenging behaviour in two or three services, using video equipment programmed to operate at intervals. The staff would be able to give or withhold their consent to such recording, as the focus of the research on the care-staff. The opinion of the Chair of the local National Health Service Research Ethics Committee (REC) on the proposed method was that the procedure of recording care-staff would be invasive for the people with intellectual disabilities who might be present and included in video recordings and would therefore require their consent.

Dye, Hare and Hendry (2007) experimentally investigated a large sample of people with intellectual disabilities for their ability to consent to being involved in research, and found that only 6% of those interviewed were able to do so. Gilbert (2004) had earlier reviewed the issues and possibilities of involving people with intellectual disabilities in research and concluded that understanding of what is meant by research has to be developed first in order to gain informed consent. Calveley (2012) argued for wide-ranging proxy and implied assent by learning beforehand a person's ways of communicating, and continuing to check on care-workers' views of the person's reaction to the research. She used the concept of burden imposed on participants as needing to be no more than that in their daily life, and encouraged a member of staff being present at all times. This would not be appropriate in trying to study everyday care-worker interactions. Morrissey (2012) suggested that appropriate relationships should be built with both people with intellectual disabilities and their supporters, which she had done over a long period across projects.

It would still be possible to involve people who lack capacity to consent, through engaging with ‘consultees’ (Department of Constitutional Affairs, 2007). These are preferably people who know the person with intellectual disability well, who are not health or social care workers, or otherwise professionally involved with the person. They are asked their opinion of what the person with an intellectual disability might think about research and if that might lead them to wishing be involved. If such people are missing from an individual’s life, then health and social care workers might be approached as consultees, but in this study, could be open to charges of conflict of interest.

I therefore redesigned the research so that attention could be on care-staff interactions alone: people with intellectual disabilities’ details and interactions would not be recorded. The data would be gathered during my everyday clinical practice by observation i.e. recorded in writing, away from the situation, from memory as in classical ethnography (Crang & Cook, 2007; Emerson et al, 2011). This would have reintroduced a high degree of anonymising precluded by videoing, but made it impossible to predict when or where a potentially significant event, interaction or insight might arise. Its significance might only be registered some time later, typically in comparison with and contrast to other events. Smith (2006) and Smith, G.W. et al, (2006) acknowledged that such an open-ended research process led to difficulties for Research Ethics Boards.

This open process of discovery in my everyday practice through observing and interviewing care-workers suggested I use the ethical principles developed by Tolich (2010) for auto-ethnography. Chang (2008) described auto-ethnography as “stemming

from the field of anthropology”, which “shares the storytelling feature with other genres of self-narrative but transcends mere narration of self to engage in cultural analysis and interpretation” (p. 43). She warned “[p]rotecting the privacy of others in autoethnographic stories is much more difficult than in other studies involving human subjects”, because “your identity is already disclosed, the identities of others connected to you sometimes becomes transparent to the broader audience and other times to smaller circles or your acquaintances ...[w]hichever format [of self-narrative] you take...other people are always present...either as active participants in the story or as associates in the background” (p. 68).

Tolich (2010) reviewed and critiqued the ethical practices of a number of high-profile practitioners, in order to arrive at ten “foundational guidelines”. These were centred on gaining informed consent in advance of the study: the virtually universal practices he criticised involved at best retrospective consent, which he put functionally on a par with no consent at all.

For this project, this would mean

- 1 getting different levels of consent within organisations;
- 2 giving advance warning in any situation that interactions or events might be used in my research;
- 3 when present in the service, reminding care-staff about my different additional rôle;
- 4 gaining permission to follow up particular incidents and to have conversations about them; and
- 5 gaining permission to use particular field-notes.

I prepared various versions of service and individual participant information and consent forms to facilitate and record both the giving of information and of informed consent.

However, this raised other potential barriers to timely access. Since the progressive closure of large institutions and people being ‘placed’ in community services, few contemporary services to people with intellectual disabilities are isolated entities (cf, Burton & Chapman, 2004, *passim*). A typical ‘annual review’ of an individual’s care package would be attended by the person and their family, the social worker or ‘care manager’ and the representatives of service hosting the review. There could also be other members of the Community Learning Disability Team; care-workers from day ‘opportunity’ services, or from the local Further Education College; and a representative from the building property owner (where Supported Living care and accommodation are separately provided). For people with more complex needs, there might also be representatives from the Adult Protection Team, and the Police; or an Independent Mental Capacity Advocate, and/or an advocate for a family member who has powers of attorney or Representative status under the Deprivation of Liberty Safeguards of the Mental Capacity Act (2005); or a Continuing Health Care Panel member, or Care Quality Commission Inspector.

Each agency would need to be approached regarding their practice governance of research carried out on their employees, for whom they would have an obligation to ensure their health and safety (Department of Health et al, 2011; section 2.3.13) especially in protecting service user, service and employee anonymity. Many small agencies would probably not

have their own governance processes, and would accept an ethical approval given by a recognised Research Ethics Committee. At the start of my research project, the same would have been true of the local authority, but later has its own processes, as did other larger organisations.

In the areas I have worked, the independent, voluntary and not-for-profit service providers have been the majority rather than the statutory sector. As well as this sector being a “small, connected community” raising issues with confidentiality, (Damianakis, T. & Woodford, M.R., 2012), they were also competitors for the finite local care-budget and sensitive to what might be critical observation (cf. Haydon Laurelut et al, 2014, p. 299).

The revised application was formally submitted for formal review by a second regional REC, after re-organisation and consolidation of the local REC system. I planned to invite individual staff to an interview away from their work context, building the conversation around an event at which we had both experienced, however differently. This would anchor the event into a time, place and sequence of action, to discover how it was described by each of us, and how co-ordinated. The regional REC judged that the people with intellectual disabilities *in situ* during my observations of the care-staff, needed to give their consent to me observing or interacting with the staff from a research perspective as opposed to my everyday clinical practice.

The REC may have been guided by the opening sentence of section 11.3 of the Code of Practice (Department of Constitutional Affairs, 2007): “Researchers must state clearly if an activity is part of someone’s care and not part of the research.” The REC said that the

people with intellectual disabilities present needed to be able to distinguish between when I was functioning in my clinical capacity and when in my research capacity (although being a researcher involved no treatment). This would be highly problematic for people with intellectual disabilities. For many, the distinction between my rôle as clinician and as researcher would be hard to grasp, particularly if couched in “accessible”, concrete terms: my interactions in front of them in each rôle would be virtually indistinguishable. Difference would lie principally in my intentions. It has still not been clarified experimentally whether adults with intellectual disabilities can judge intentions, when children with intellectual disabilities can (Jervis and Baker, 2004). This may in part be due to care-workers being adept at providing mixed messages (Jingree et al, 2006).

Final design

The second REC application refusal was a major motivational challenge, as it appeared that carrying out research within the contexts of being a full-time professional was not going to be approved. The difficulties of researching the experiences of people who are highly unlikely to be able to give informed consent has led to claims that they are being excluded from academic interest because of the layers of protective processes required (e.g. McClimens & Allmark, 2011). It would seem that this could also apply to those working with them. My aspiration for presenting ‘practice-based evidence’ appeared to have foundered on not being an ‘outsider’ (Merton, 1972) researcher.

The REC had not recognised the argument that it was not individuals, whether care-workers or people with intellectual disabilities, who were the subject of the research, but

the *processes* within which they were embedded, which they actively set in motion minute by minute. Was the REC making an ideological decision, in the Institutional Ethnography sense, founded in institutional, academic discourse? This reflective ‘conversation’ with the discourse of Institutional Ethnography regarding events in my everyday experience led to at least a perceptual shift if not an ontological one. ‘Relevant’ data were actually around me all the time. From many entry points – the experience(s) of a person with a learning disability shared with me; a referral form; a Community Learning Disability Team allocation meeting; documents developing local policy; national reports on high media profile events involving people with a learning disability; or Care Quality Commission reports on individual services – the same processes, issues and ruling relations might operate.

This meant critical autobiographical reflections (after Delamont, 2009) on my everyday practice could provide vignettes, narratives based on composites of particular situations, events, interactions and individuals in order to avoid any way of identifying individuals with learning disabilities, care-workers, managers, or services. If successful, these vignettes would be “telling” episodes that would strike someone familiar with the field of working with people with intellectual disabilities as being true to their own experience. These would be complemented by the publicly available narratives about individuals with learning disabilities and workers in the services provided to them, in journal articles and other literatures. This completes the move started by Campbell and Gregor’s (2002) critical review of texts, by seeing them as very active texts in the interactions between applied psychologists and care-workers.

My third ethical application, to the University Ethics Review System, for this research project therefore specified three distinct sources of potential data, to be investigated and explicated using Institutional Ethnography. The sources of data identified were:

- (1) the academic and applied research literatures (a) directly and indirectly referring to staff training and challenging behaviour, its difficulties and attempted remedies, and (b) a parallel literature on institutional abuse;
- (2) texts available in the public domain involved in the defining, delivering and judging the merits of services to people with intellectual disabilities and behaviours that challenge and disrupt the character, definition and practices of those services; and
- (3) a reflective autobiographical account of my clinical and research experiences - the 'field-work' – in the form of a number of vignettes based on composite narratives, i.e. the experiences of a number of people, who could therefore not be identified.

The texts in data sets (1) and (2) generally existed prior to and materially influenced practices described in data set (3). This was through their contribution to discourses and ideologies; to their definition of the work of health and social care professionals, health and social care workers, people with intellectual disabilities and their families and friends; and to the relations of ruling occurring in the provision of services to people with intellectual disabilities. That is, they affect and co-ordinate the work (in the widest sense) of health and social care-workers and people with intellectual disabilities.

This was a wide-cast net, to avoid having to vary the Ethics approval. Institutional Ethnography is a method of exploration and discovery, hence needs a broad data-set. It is not prescriptive about the data or the methods used to generate it. Rigour in Institutional

Ethnography comes from demonstrating and explicating ruling relations (DeVault & McCoy, 2002). This replaces the usual research technique of, for example, finding a representative sample. Smith (2005) has further argued that institutional ethnographies performed by different researchers are a “collective work”. Although they share the same ontology to explore and discover social relations, the studies are across widely differing situations. However, many of the same relations of ruling are uncovered, and collectively more of the ‘boss’ rules – higher levels of rules that co-ordinate lower levels of ruling relation – had become evident. For her, rigour comes from this process of adding to and developing the collective work.

I Specific academic and applied research literatures

The immediate entry point to the academic and applied research literature was the literature on staff training and challenging behaviour identified through a systematic literature review (see Appendix 1) carried out in 2009, which formed the basis for Chapter II. This was a sub-set of the “challenging behaviour” literature, the first phase of using behavioural methods to teach individuals with ‘mental retardation’ in hospital settings featured in ‘The Journal of the Experimental Analysis of Behavior’ (JEAB) starting in 1958. The applied field expanded rapidly, with ‘The Journal of Applied Behavior Analysis’ (JABA) starting in 1968, and many others subsequently (see Laties, 2008). With the publication of Tharp & Wetzel’s (1969) *Behavior modification in the natural environment*, “mediated” interventions by those closest to individuals under the guidance of research teams increasingly became the model for interventions in care environments.

Methods to train mediators effectively and efficiently became a research area in itself (see Allen, 1999b), alongside the difficulties in applying this training.

The second sample was the review summarised in Chapter III, comparing descriptions of bad practice and attributions about care staff in the literature on “institutional abuse”. It ran from the enquiries into Ely Hospital, Cardiff in 1969, to the Winterbourne View revelations (BBC1, 2011), the Serious Case review (Flynn and Citarella, 2012), and related inquiries and projects (e.g. the Winterbourne View Review: Concordat: A Programme of Action, Department of Health, 2012).

The sample was developed using a discovery method, of working backwards and forwards from one review paper to another, until saturation had been reached. Marsland et al (2007) suggested no further research into what factors led to abuse was needed: what was required was the systematic application of this knowledge. Quigley (2014) has characterised the field as poor in data collection and analysis, relying on “case studies” or descriptions of catastrophic events.

The two literatures were compared to suggest ways to analyse the identification of and subsequent attempts to change poor care practices. The abuse literature is more extensive than that of staff training and challenging behaviour, though they started as identifiable academic literatures about the same time, 1966-68. It included cruelties meted out to the mentally ill, children, and the elderly, as well as the mentally handicapped and tapped into wider societal and sociological concerns about the ‘corruption’ of health and social care. With these wider associations, the abuse literature has brought a wider range of conceptual

analyses into play than those used by the behaviour modification, applied behavioural analysis and clinical psychology communities to establish their techniques, overcome their apparent failure and develop their evidence base.

2 *Texts available in the public domain*

The second source of data could include texts such as:

- (a) policy and guidance documents at national, regional and local level;
- (b) inspection reports, inquiry reports, and press releases; and
- (c) texts responding to any of these, for example from service user and carer organisations or professional bodies;
- (d) promotional literature for services, their self-written reports of their activity, and media reports of aspects of their activities; and
- (e) at the more mundane level, assessment materials, behavioural and motivational templates for recording care practices, behaviours, contextual information, and summaries of these 'data'.

3 *An autobiographic account of clinical and research practice*

The entry point for my ethnography, the third source of data, was the tension between the 'evidence base' for my clinical practice – founded in the academic literature – and my everyday clinical experience as a clinical psychologist providing 'expert' advice to care-workers and managers regarding the management and minimising of behaviour they found

challenging. The fieldwork consisted of my clinical experience in interaction with this literature.

Four Vignettes of 6500-10500 words were produced, describing a Community Learning Disabilities Team (CLDT) Allocation meeting and three clinical ‘cases’ – Padraig, Danielle and Jess - arising from three referrals made to Psychology at the meeting. The interactions and other work in the meeting and responses to the referrals are autobiographic narratives based on composites of particular situations, events, interactions and individuals in order to avoid any way of identifying individuals with learning disabilities, health and social care-workers, managers, or services. Although written in the first person, some of the events and practices described are also composites, based on my direct clinical work and on giving and receiving clinical supervision.

In the course of the Institutional Ethnography discovery process, it was found necessary to introduce two accounts relating to the practice of clinical psychology: ‘The use of texts in clinical psychology: a participant’s observations’ (Chapter V, p. 128ff) and ‘The work of a Clinical Psychologist: information gathering, observation, therapeutic conversations and note-making’ (Chapter VI, p. 157ff).

Producing and analysing the Vignettes

The Vignettes were produced from my experiences of working in applied psychologist rôles over a period of 40 years across the British Isles. Appendix 4a -Professional History gives a brief account of these experiences. To my surprise, I found that at the stage of

writing the Allocation Meeting, Padraig and Danielle Vignettes it was possible to set aside other discourses, re-enter my “complete member” consciousness and produce full “complete member” accounts: without effort, I contacted and maintained my everyday clinical orientations, rationalisations, critiques and interventions in developing the narratives. I wrote the Jess Vignette at the same time as reading Institutional Ethnography texts more deeply for drafting the first part of this Chapter. Although more conscious of potentially writing to an Institutional Ethnography format, it was still relatively easy to switch between researcher and clinical consciousness, with only minimum need to curtail sociological analysis in clinical mode. There is further discussion of this in Appendix 4b.

My experience of writing the Vignettes was akin to gathering information and writing clinical aides-memoires. The starting points – for instance, with Padraig, a deterioration in behaviour requiring a psychological intervention; in a younger man with moderate learning disabilities, a residential service and a college placement; a relatively straight-forward, non-behavioural staff-team intervention – brought to mind a number of scenarios, including those involving younger women with similar impairments, from which a composite account could be developed.

The scenarios from which the composite was compiled occurred in community settings over the previous 25 years, but must have also been experienced in the previous 1-3 years, to allow an analysis of historical and contemporary situations. There was very little difficulty in finding such scenarios, reflecting either a high level of stability in the sorts of referrals made despite many changes in service structures and policies over that time, or an inflexible clinical characterisation of changing services and service users. With my shifting

theoretical preferences and involvement in service development (detailed in Appendix 4, Professional History) the latter inflexibility might be reduced but not ruled out. I would now characterise it as one of the factors at play in the problematic.

If 'I' were a truly and solely 'evidence-based' clinician, I should be able to make theory-practice links for each professional statement, which is not an accurate reflection of everyday practice. As Latour and Woolgar (1986) demonstrated, the construction of scientific facts follows a particular progression from being highly contested, with lots of context, detail and justification in support, to being stated as a fact, without context, justification or attribution. A proportion of the statements made will be at the fifth, latter stage in the 'just-so'-ness of everyday practice and not formally referenced.

Extracts from each of the Vignettes are provided in Appendix 3.

Analysing the Vignettes

The analysis of data taken up from these sources will be framed by the three research tasks summarised by Grahame (1998) from Smith (1987), centred on ideology, work and ruling relations in order to explicate the rôle of clinical psychological discourse and practice in the *impasse* between care-workers and applied psychologists.

In Chapter V, an initial study of ideologies inherent in practice as reflected in some of the literature sampled in Chapters II and III will be undertaken, to provide a frame for the

analysis of the fieldwork in the following Chapters. This focuses on the active nature of texts, and their ideological function in camouflaging ruling relations.

In Chapter VI, the Vignettes are summarised, and analysed by identifying themes based in the social relations described regarding the organisation of professional and care-worker responses. Some higher level themes are suggested.

In Chapter VII, the Vignettes are analysed by following Smith's (2002: see above, Chapter IV, page 96) suggestion to track the interchanges of the-time-it-takes in sorting out interconnections in services, attending to the detail of interactions and their external referents, e.g. to data-bases, to the Care Quality Commission, practice guidelines, or research literature.

The difference of analysis between these two Chapters is more fully discussed in Appendix 4b.

Member-checking Vignettes and the analysis.

The Vignettes were shared with my supervisors, who both had extensive experience in working in services to people with intellectual disabilities, and felt that they closely reflected their experiences. I did not share them with work-colleagues, as it might have been possible to construe the descriptions as criticisms of their practice. However, having written the Vignettes, I checked the content and processes against subsequent meetings and interventions. I did not feel that I needed to change the Vignettes, as they seemed an

accurate depiction of the sorts of issues and interactions, if not exactly the same content, to my on-going experience.

As mentioned in more detail in Appendix 4c, I shared some of the outcomes of my research project with health and social care colleagues in individual and group supervision. I also raised my emerging hypotheses arising from the analyses, as I carried them out, usually in the context of discussions regarding support being provided to people with intellectual disabilities, but also in discussions of differences and difficulties with colleagues and managers. This helped me refine both hypotheses and how I communicated them. I had relationships with some managers and senior care workers in the independent sector in which it was possible to discuss some of my hypotheses and emerging perspectives.

Indirectly, the people with intellectual disabilities I worked with individually also provided important feedback: although denigrated, and experiencing life differently to staff and professionals, many are astute observers of the processes they are subject to, and willing to share their observations if they are not casually dismissed. 'Care Quality', the (Commissioning) 'Panel', and other 'bosses'; 'rotas', 'communication books' and 'behaviour plans'; 'winding me up', 'making me', 'putting me down', and '[ig]noring me'; the rôles and disagreements in the CLDT have been noted and commented on.

Finally, I triangulated against other published works giving the same level of details, such as Finlay et al (2008), Levinson (2005, 2010), and Nunkoosing & Haydon-Laurelut (2011).

Although their interpretations might differ, the interactions and processes they described were comparable to those I observed.

In sum, in my study I will engage in an Institutional Ethnography analysis. I have considered the situated ethics and found a solution that satisfied the University Ethics review system. I will be concentrating on the mundane practices of clinical professionals and care-workers. I will be using vignettes made up of composite events and people to feature the processes involved, to protect against the sort of difficulties raised by Chang (2008) and Damianakis & Woodford, (2012) regarding confidentiality. I will also be recounting personal professional events, to demonstrate mundane clinical practices of a psychologist.

I shall be following a similar route to de Montigny (1995), in his autobiographical Institutional Ethnography of being a social worker in Child Protection in Canada. The texts that ruled his work were statutes, and academic discourses on social work practice. The lack of a statutory basis to psychological advice has been regretted by the profession.

CHAPTER V

Beginning the Institutional Ethnography dialogue: the literatures

In this chapter, an initial study of ideologies inherent in practice as reflected in the literature samples in Chapters II and III will be undertaken, to provide a frame for the analysis of the fieldwork in the following Chapters.

Smith (2002) described how social relations are implicit in how people talk about their work. In analysing transcripts, what people “say about the ‘work’ they do that connects them to the work others are doing elsewhere and elsewhere” (p.31) can be identified. In the case of clinical psychology and applied research, it is suggested social relations are implicit in how people *write* about the work they do, and collectively a ‘literature’ produces and reproduces a standard institutional form, to be studied and explicated. The danger in paying too close attention to the content of articles will be “institutional capture”, the capacity of institutional discourse to subsume or displace descriptions based in experience (DeVault & McCoy, 2002). “Institutional discourse selects those aspects of what people do that are accountable within it. What is not discursively recognized will not appear” (Smith, 2005, p. 156-7). Instead, texts are considered as they enter into action, governing the reader’s next response in the development and co-ordination of activities: their involvement, not their meaning is analysed. “Or they are at work in talk or in writing/reading as organizers of local settings, referenced, aimed at, governing, the on-going development or concerting of activities” (Smith, 2002, p. 35).

The institutional abuse review in Chapter III revealed that services to people with intellectual disabilities were open to a number of influences from both within and outside services and particular service providers. Services were part of a co-ordinated web of social relations that belied both their apparent physical and social isolation. This led to interventions to reduce the incidence of abusive practice through the development of policies and guidelines; providing training about them to encourage particular practices; and regulation and inspection to ensure they were applied, as well as to reduce other 'risk factors'.

By contrast, the world of staff training and challenging behaviour reviewed in Chapter II appeared much more enclosed. The main social relations were between psychologists and care-staff, in order to influence the interactions between care-staff and service recipient. Other relations such as management practices and staff supervision to support behavioural interventions were considered rare or absent.

Plainly, services to people with intellectual disabilities and challenging behaviour exist in the same world as services in which institutional abuse occurs: they may be co-located (White et al, 2003). Are there ideologies that are more visible in the literature on institutional abuse that also operate in the more enclosed, inward looking literature of staff training and challenging behaviour? Particularly, how do individual texts act as 'active texts' (Smith, 2001, p. 120ff), institutional accounts that set up directions for reading other accounts, and provide a rationale for interpreting and subsuming them into the institutional accounts.

The use of texts in clinical psychology: a participant's observations

Texts are central to the claim of clinical psychology being a profession that is profoundly evidence-based: examples of such claims are in the texts in Appendix 2, taken from university web site descriptions of the aims of clinical psychology doctoral courses.

'Evidence-based' refers to being organised and co-ordinated by academic literature (cf. Milne, 1999; Burton & Chambers, 2004), a particular genre of texts. This co-ordination acts across time and locations, supporting professional autonomy in the absence of direct professional supervision (Smith, quoted in Walker, 1986). The texts are typically published in academic journals after peer review, and may be subsequently evaluated against various criteria of research rigour and validity, and collated into guidelines (e.g. Ball, Bush and Emerson, 2004; Royal College of Psychiatrists, 2007; British Psychological Society, 2015).

Texts organise and coordinate the activities of clinical psychologists and other applied researchers in their everyday practice at a number of levels. Working with and on published texts is expected to be a significant part of the work of clinical psychologists and applied researchers. In order to become qualified, trainee clinical psychologists must produce doctoral level research that will generate 'publishable' articles to add to the literature (cf. Appendix 2). After qualifying, there is a (rarely met) expectation for psychologists to continue to add to the literature throughout their career, and a requirement to be expert consumers of such literature to ensure biennial re-registration.

Firstly, published texts are summarised and made accountable in a literature review as part of the practice of academic and applied psychology. Accountable, that is, to both an underlying ontology and epistemology that are so well established, they are no longer required within the article format (c.f. Bazerman, 1987). The précised ‘Positivist critiques’ of the articles in Chapter II demonstrated (a) the critiquing and making the articles accountable, and the conclusion (b) that the authors/editors’ knowledge claims within both the behaviourist framework that underlies the ontology of behaviour management, and the neo-behaviourist (more epistemological) framework crystallised by Cook and Campbell (1979) were questionable.

Next, these published articles are used by clinical psychologists to guide their own practice. They are usually accepted relatively uncritically as they have been peer-reviewed. The Grey & McClean (2007) article has been used by colleagues in neighbouring services to validate their PBS-inspired approaches to working with provider services who refer individuals for challenging behaviour. Whilst not meant as a manual for a particular practice, within the dominant discourse and approach to challenging behaviour it participates in, the article signals changes in practice and emphasis to the expert group of specialist professionals, who ‘activate’ it in Smith’s (2005, p.105ff.) terms, interpret and apply its methods and techniques. Since its publication, it has not been directly contradicted by further publications: it was the only one of the Special Edition articles cited positively in a later review looking at the application of psychological interventions to challenging behaviour (Campbell et al, 2014).

Guidelines are accepted even more uncritically, being distillations of peer-reviewed articles, evaluated against conventionally strict standards. However, a thorough evaluation, The British Psychological Society's practice guidelines *Challenging Behaviours: Psychological Interventions for Severely Challenging Behaviours Shown by People with Learning Disabilities* (Ball et al, 2004) found no established approach to recommend unequivocally. It therefore rated methods and techniques as 'essential' and 'best practice', dependent on the circumstances found in a 'pre-assessment'. Except, that is, for a 'functional analysis' which must be central to all assessments. This amounts to a 'best-to' as opposed to a 'how-to' manual, even if not formally evidence-based, with different aspects 'activated' according to circumstances.

Many of the guidelines contained in the BPS document provided the impetus for the multi-professional *Challenging Behaviour: a unified approach* (Royal College of Psychiatry, 2007) "which aims to build on the evidence-base, by producing a consensus position statement on best practice for those clinicians who provide services to this group of people". These guidelines slightly altered the definition of challenging behaviour to include the restrictive practices used in response to specific incidents, which thereby linked challenging behaviour with the potential for abusive practices. However, its uptake as a clinical tool has remained over-shadowed by the BPS guidelines. It remains to be seen what impact the NICE (National Institute for Health and Care Excellence) Guideline (NG11) 'Challenging behaviour and learning disabilities: prevention and interventions for people with learning disabilities whose behaviour challenges' (British Psychological Society, 2015) has.

An Institutional Ethnography dialogue with the institutional abuse literature

The reporting and critiquing of the literatures in Chapters II and III were predominantly made from within the institutional discourses of clinical psychology, although Institutional Ethnography had some influence on the framing of the conclusions to Chapter III

It is intended to examine one of the organising concepts used to make sense of the institutional abuse case-studies, the corruption of care, introduced by Martin (1984) and taken up by Wardhaugh and Wilding (1993).

'Corruption' of care

Thirty years ago, Martin (1984) used the term 'corruption of care' in two ways. Firstly, where "the primary aims of care – the cure or alleviation of suffering – have become subordinate to what are essentially secondary aims such as the creation and preservation of order, quiet and cleanliness". Secondly, with respect to "people who joined a profession dedicated to the care of their fellows, and presumably sharing its ideals, [sinking] gradually to a level of behaviour quite inconsistent with those standards" (both extracts, p. 87). This set out two of the main themes in the subsequent field of institutional abuse: the opposition between 'care' and the 'needs of the institution'; and high-minded people apparently 'losing' their ability to care.

Wardhaugh and Wilding (1993) wished to explore how "institutions, organisations and staff, supposedly committed to an ethic of care and respect for others, become 'corrupted'

and abuse their power and their clients” (p. 4). They extended Martin’s analysis to a wider range of organisations and institutions, including community services, to “construct a general theory of the corruption of care” (p. 5). They attempted to relate ‘how such things happen’ in practice. Although dated in some respects, the article is still cited widely (e.g., Attar-Schwartz, S., 2011; Garner, 2014; Hanley & Marsland, 2014; Kelly, 2010; Preston-Shoot, 2012); sometimes, a little talismanically (e.g. Garrett, 2013; Gibson, 2014; Paterson et al, 2010); and usually uncritically. This suggests that it has been successful as an ideological text, even if it has not significantly impacted the incidence of institutional abuse. The following analysis therefore includes reference to later work in its explication.

Wardhaugh and Wilding’s ‘preliminary analysis’ is based on the findings of a 1990 inquiry (Levy and Kahan, 1991) into ‘pindown’, a concerted set of abusive practices in children’s services in Staffordshire, and on Wardhaugh’s field notes from working in one of the principle sites involved. Although focussed on child abuse, the authors refer throughout to, and equate the abuse to that experienced by other client groups in different circumstances.

Wardhaugh’s observations and the inquiry findings recorded “forcible humiliating activities and physical violence”(p. 8); sexual assault (pp. 9 &13); “the more or less arbitrary withholding of heat, clothing or food, or psychological and emotional cruelties, such as manipulating family conflicts as a means of control”(p. 11); and the children’s emotional reactions including anger, depression, weeping, sobbing, anxiety, loneliness, desperation, and despair, as well as frantic attempts to get out, temper tantrums and absconding (p.13).

Wardhaugh and Wilding explored ‘how such things happen’ by propounding eight elements or systems of organisation playing a part in the corruption of care, thus contributing to explaining it. After providing limited evidence for each proposition, empirical evidence from the inquiry and field notes were presented “to illustrate the application of our propositions to a specific issue in the corruption of care” (p. 5). The authors concluded the eight propositions were “helpful in pinpointing circumstances in which care systems are at risk” (p. 30). This emphasis on the risk to care systems as opposed to the ‘cared-for’ seemed callous after the description of the assaults that had taken place.

Pinpointing circumstances of risk

Proposition number	Proposition
1	The corruption of care depends on the neutralisation of normal moral concerns
2	The corruption of care is closely connected with the balance of power and powerlessness in organisations
3	Particular pressures and particular kinds of work are associated with the corruption of care
4	Management failure underlies the corruption of care
5	The corruption of care is more likely in enclosed, inward-looking organisations

6	The absence of clear lines and mechanisms of accountability plays an important part in the corruption of care
7	Particular models of work and organisation are conducive to the corruption of care
8	The nature of certain client groups encourages the corruption of care

The propositions and their organisation can be taken as directions to define both “the problem we are addressing”, and “how such things happen”. Thus, they are “factors which threaten or weaken a commitment to the normal canons of good practice in human services” (p. 6). ‘Commitment to normal canons of good practice’ and ‘corruption of care’ set a moral framework of reference, concurring with the inquiry’s judgement that pindown was “intrinsically unethical, unprofessional and unacceptable” (Levy & Kahan, 1991, p. 167, cited by Wardhaugh and Wilding, p. 5). This conclusion contrasted with the view a Juvenile justice worker expressed to Wardhaugh before the inquiry that it was “illegal” (ibid, p. 23). This moral framework was reinforced by Proposition 1, the neutralising of normal moral concerns.

In their beginning paragraphs, Wardhaugh and Wilding distinguished two forms of corruption: that involved in pindown was “aimed at securing generally desired change in behaviour”, whereas “violence towards long-stay hospital patients is quite unrelated to any official policy objectives and would be defended by no-one” (ibid, p. 5). It appears they were making a distinction based on intent. From the standpoint of the children – and others in “certain client groups” - involved, it is highly unlikely they would have experienced neutralisation of moral concern. They would have directly experienced verbal

and physical assault from the moment they entered into the ‘corrupt’ service. Wardhaugh and Wilding later pointed out the “presentation of a disciplinary and punitive system as caring or therapeutic is itself an example of the corruption of care” (ibid, p.21).

What they thought essential was the “active betrayal of the basic values on which the organisation is supposedly based. It is much more than a passive neglect of the principles of good practice. It amounts to an active abuse of a position of responsibility and of a client’s fundamental human rights” (ibid., p. 5).

The neutralisation of normal moral concerns

“For people to be abused.....they have to come to be regarded as beyond the normal bounds of moral behaviour which govern relations between person and person or carer and client. They have to come to be seen as less than fully human....a necessary stage on the road to the corruption of care.” (p. 6)

The academic precursor for this Proposition was Bauman’s analysis of the Holocaust, and ‘the silencing of moral considerations’ in bureaucratic organisation (Bauman, 1990, cited by Wardhaugh and Wilding, p. 7). “Our argument is that the corruption of care depends on the neutralisation of what... all normal people feel in the presence of physical suffering of other people. That neutralisation takes place via the processes of depersonalisation and dehumanisation, which depend on the creation of moral distance”. (Wardhaugh and Wilding, p. 7). The authors then referred to Goffman’s (1961) descriptions of institutional processes of humiliation, depersonalisation, dispossession and degradation during

admission procedures, but wished to consider both the inmate world and the staff world to understand – with Foucault – what “permits the fabrication of the disciplinary individual”. (Foucault, 1977, p. 308, cited by Wardhaugh and Wilding, p. 7).

The evidence for Proposition 1 consisted of descriptions of experiences of some of the children and general descriptions of pindown processes styled on Goffman’s (1961) analysis of admission processes and ‘mortification’. Wardhaugh and Wilding presented these as “intended to degrade and depersonalise” the children and “so neutralise ordinary moral concerns” (p. 11). The authors also related the activities to Foucault’s ‘calculated methods, techniques, “sciences”’, &c.

Asserting that corruption takes place, whether as an active betrayal of values, or people having to come to be regarded as beyond the normal bounds of moral behaviour, or through neutralisation of pity, depersonalisation, dehumanisation or creation of moral distance are examples of what Smith (2001: p.166) identified as two sociological devices, use of metaphor and nominalisation, turning activities of individuals into nouns. Having abstract entities interacting with one another makes it virtually impossible to agree what is going on. “People, their doings and the everyday production of the existence of an organizational or institutional order in particular local sites disappear from view”. (ibid, p. 172). Instead the corruption of care, abusive practice, consisted of on-going activities that would be accountable to discourses other than the culturally assumed and undefined ‘normal moral concerns’. More directly, such activity would be coordinated by texts, for example as guidance or as forms to be filled in a particular way determined by those discourses.

Pindown, as an aspect of everyday care practice, was coordinated by “written versions of its rules and procedures”, though it remained “an informal, albeit (tacitly) officially sanctioned system” (Wardhaugh and Wilding, 1993, p. 21). Some of Wardhaugh and Wilding’s quotes from the enquiry report included ‘a residential worker recorded that..’, ‘extract from logbook..’, ‘statements taken from staff log books’, as examples of other texts in use, but not details of how they arose from, were used in and affected practice. Thus, it is impossible to substantiate Wardhaugh and Wilding’s distinction between “passive neglect of the principles of good practice” versus “active abuse”.

There is, moreover, an ideological use of the words ‘passive’ and ‘neglect’ in this context. It is a doubtful rhetorical contrast with “active” and “abuse”. In a care-work setting, neglect is an act of ignoring; if the reason for it is an individual’s ignorance of good practice as defined locally, it is a team-leader’s responsibility to correct it. No verbal, emotional or physical assault is ‘passive’, but neither would be turning away from local good practice. However, that local good practice can be at odds with definitions elsewhere, whether the same organisation, as described by Martin or the Tizard researchers, or an academic social work department.

The wider ideological shift the authors made is two-fold: asserting that there is a universal definition of good practice, and universal priority given to it; and that whatever can be observed in a service deemed to be going against that definition is due to ‘corruption’. This diverts attention from what is observed being an accomplishment: intentional, on-going, coordinated work to bring about a certain state of affairs. What acts or activities in

contrast to, and in addition to verbal, emotional or physical assault does “neutralising moral concern” consist of, and where and when do they take place?

Wardhaugh and Wilding described pindown as starting as an expedient response to particular misdemeanours in some of the children in care, and evolved into being routinely applied (p. 8). This suggested a bottom-up process for individual incidents of assault being progressively recognised and condoned by colleagues, staff teams and local, middle and senior management. However, pindown was said to take off in the absence of any other guidance or leadership, which again is not ‘passive neglect’ of professional and managerial engagement in service delivery, but active focussing on other ruling relations. (More on this is in the discussion of Principle 7).

The examples given of procedures that ignored good practice were not “intended to degrade and depersonalise” *in order to* “neutralise ordinary moral concerns”; they were emotional assaults that were condoned – openly or tacitly – in an organisation focussed on priorities other than the “cure or alleviation of suffering”. Any ‘neutralisation’ that had occurred was coordinated across and throughout the organisation; with regards to service users, care-workers, and management; and reproduced daily in hundreds of local interactions.

The balance of power and powerlessness in organisations

The Proposition 2 argument stated: “[m]ost of those who have been victims of the corruption of care have also suffered from powerlessness. Weakness and vulnerability are

essential characteristics...” (pp. 11-12). This piling up of nominalisations regarding the abused is then extended to staff. “Those responsible for these...very vulnerable groups have almost absolute power over them. That is a potentially corrupting situation. If power corrupts, so too does powerlessness. While staff have near absolute power over many clients, they are in many other respects powerless. They are taken for granted by the organisation, seldom regarded as its heroes, given little support, not consulted about the organisation of their work.” (p. 12)

Wardhaugh and Wilding then built on Proposition 1 in that “a necessary precondition to the corruption of care is depriving clients of the status of full moral beings. If the staff’s status as full moral beings is damaged by powerlessness, they may well cease to behave in a fully moral fashion. The crucial issue may be that staff are simultaneously powerless and powerful and that this creates a dangerous ambivalence.” (p. 12).

Wardhaugh and Wilding gave many examples of the different types of power staff had, but this was “set against their self-perception as victims of emotional and physical abuse by their charges”, through physical attacks leaving marks on staff or by emotionally depriving them: “you give them everything, but they give nothing back. They’re ungrateful little bastards...” (p. 14).

The argument appears to be that the recipients of corrupted care also “suffer from” powerlessness. That is, they are weak and vulnerable, have little influence, lack understanding of how the organisation works, and how to assert their rights. They do not know how to call to account those abusing them, on whom they are highly dependent for

survival ('basic elements of living': pp. 11-12). Abusive staff-members are also vulnerable, being corrupted by absolute power in their everyday roles, yet powerless within the organisation, and thereby 'suffering from' a dangerous ambivalence. They feel under attack from the people they support, and emotionally unfulfilled in their role. In these highly abstracted terms, the suffering of victims of institutional abuse and their abusers begins to appear equal, through their being equally damaged as full moral beings. This does not take into account that one group was able to go home at the end of the shift, took a wage, and changed jobs if it really got tough.

Wardhaugh and Wilding linked the remarks quoted above by staff about their charges in the context "of a changeover of team leadership, rapid staff turnover [see above], high levels of staff dissatisfaction and alienation, and deteriorating staff – resident relationships." (p. 14). They suggested lack of accountability allowed staff teams to address their vulnerability and powerlessness by seizing power for themselves, as an outlet for their frustrations. Or put more directly, in the absence of other guidance and monitoring, care-workers did what appeared expedient in the situation.

One of the main ideological functions of authorised texts is to define agency (Smith, 2001, p. 186). Contrast the above accounts with that of Hamlin & Oaks (2008) who considered the stability of institutional discourses, the most pervasive of which they identified was regarding power and powerlessness. "People with intellectual disabilities were placed in a position where others were able to restrict their possible fields of actions in a one-sided and dominating manner...staff making decisions about everything from the admission itself to the person's every activity during the day...Institutional life was organized around a

hierarchy of power based on a medical narrative... power was exercised through the hierarchies through money, information, restriction of activities, segregation, block treatment, physical force, and denial of sexuality (Goffman, 1961). For the person at the bottom of this hierarchy, the possibility of resisting the power wielded by those above them was minute.” (Hamlin & Oakes, 2008; pp. 49-50).

In this account, people with intellectual disabilities are actively *'placed'* in a powerless position rather than it being due to their weakness and vulnerability, fields of action were *restricted*, decisions were *made* by staff about every activity, and power was *exercised* in multiple ways. Neither the actors nor the coordination of their activity was identified, but here there was recognition of arrangements that *accomplish* bad practices, through a coordination of activities and interests. Putting agency back into Wardhaugh and Wilding's account, the suffering involved was from multi-faceted assaults made possible by the induced powerlessness and the carefully constructed and maintained care-system that – at best - allowed the assaults to happen and punished attempts to escape them with more of the same. Promoting abstractions about victims and abusers being deprived of full moral status veils the active nature of the abuse, and the decisions made by staff and management.

Hamlin & Oakes were not concerned with cases of abuse: they were describing the everyday operation of institutions, and the carryover of the same discourses into community settings. This raises the prospect that Wardhaugh and Wilding's Propositions described services more generally, a point which will be returned to below (p. 142).

Particular pressures and particular kinds of work

Wardhaugh and Wilding introduced Proposition 3 by referring to the social marginalisation of the groups most likely to be abused. “They are all groups for whom...society has little regard” which “affects the resources made available for their care. Policy is built up of fine words...but the resources and facilities made available convey to staff the low value which society puts upon their work and their clients. Official aspirations and standards are therefore deprived of legitimacy.” (p. 14).

This led to staff emphasising survival, on getting by: specifically, emphasising control and order. “The slide from stress on control, inevitable in some situations of pressure, into violence towards patients is all too easy to comprehend.” (p. 16).

It seems it was ‘all too easy’ for Wardhaugh and Wilding to comprehend the idea that caring for profoundly mentally handicapped people or very disruptive children puts staff under “enormous” pressure, without having to specify what it consisted of, and how it came about. This description of the situation distracted from considering how staff came to see these groups as “trying patience and reason to, and beyond, the limit” (p. 16). Had they been led to believe their work or the people they worked with would be any different? Is this ‘pressure’ in the work equivalent to and compounded by that from the lack of resources and moral undermining, service reorganisation and uncertainty? Wardhaugh and Wilding added “the almost universal fact of social service provision that those staff with the most difficult jobs are the least trained, least supported and lowest paid. In many caring and controlling situations, staff are therefore simply out of their depth.” (p. 16). The universality of this fact means the pindown services were similar to non-abusive services,

but this situation coming about with such ‘difficult’ people was not the care-worker’s responsibility. Instead of these ‘enormous pressures’ being an explanation of how and why a corruption of care took place, that pressure is a ‘corruption’ in itself.

Management failure

Proposition 4 was a ‘truism’ for Wardhaugh and Wilding, and they reproduced at some length the comprehensive failures at every level of management that Martin (1984) reviewed. By failing to set clear aims and objectives, ‘care and rehabilitation’ are replaced by the ‘goals of order and control’, too much depended on the work of fallible individuals, and there is no basis for effective monitoring and evaluation, or calling to account. The Levy Report identified the managerial stance “that so long as there was no trouble, a blind eye was turned to some practices” (Levy & Kahan, 1991, p. 154 cited by Wardhaugh and Wilding). “Team leaders.....were isolated, ‘grappled alone with problems’ and were discouraged from aspiring to high standards of care.” (Levy & Kahan, 1991, p. 153, cited by Wardhaugh and Wilding). Middle managers reported an ethos where “raising of concerns over standards or other ‘care’ issues tended to be regarded as evidence of individual inefficiency or lack of managerial ability. The former director of social services claimed that until his appointment there was a clear policy decision to let the creator of pindown “get on with it and not to interfere as long as he “produced the goods” (Levy & Kahan 1991 p. 136). This notion of “producing the goods” is central to our understanding not only of the pressures on team leaders to manage their institutions efficiently but also of the linkage between senior managerial attitudes and priorities.” (Wardhaugh and Wilding, p. 20).

The text's directions are being made clear. It was not the case of individual staff being 'bad apples': the pressure on them made it easy to comprehend any slips they made into violence. Team leaders were expected to deliver, not to question standards, or to share concerns. Middle managers turned a blind eye, as long as there was no trouble, and did not want to be thought weak or inefficient. Senior managers applied pressure to middle managers, knowing about the practices but not officially sanctioning them, nor offering any viable alternative. "Pindown, we would argue, had as its primary aim the control and management of recalcitrant children. It was a measure of the extent of managerial failure, not only that this was allowed to take place, but that it was able to continue while maintaining the façade of a therapeutic regime." (Wardhaugh and Wilding, p. 21).

Enclosed, inward-looking organisations

Proposition 5 returned to the isolation Martin (1984) identified in the hospital enquiries, whilst suggesting the 'pin-down' services had a social rather than a geographical isolation, being enclosed, tightly-knit and inward-looking. This led to an organisation that stifled criticism; that cut itself off from new ideas; and set up routinised and conservative care-practices. Wardhaugh and Wilding claimed the managers' world was equally inward looking, and a factor in not exercising their given authority: if "they fell out with their subordinates, then their social world collapsed" (Wardhaugh and Wilding, p. 19).

The basic proposition about social and/or geographical isolation being a key contributor to abuse has echoed down the years from Martin (1984) to Winterbourne Views' isolation on an industrial estate (Flynn & Citarella, 2012). The review in Chapter III demonstrated that

most early institutional abuse was known about for some time, within the institution and at every level of oversight outside it. This is isolation through active control of information, access, and containment of criticism, similar to being enclosed, tightly-knit and inward-looking; stifling criticism; cutting itself off from new ideas; and setting up routinised and conservative care-practices.

Within the services, team leaders were isolated, care-staff spent long hours away from the rest of the team when supervising a child under pindown, and a key component of pindown for the children was isolation from both family and other children in the service: “children and staff...at least had in common their sense of isolation” (p. 24). To this could be added their shared sense of powerlessness (Proposition 2), and of “extreme pressure” (Proposition 3). By dividing these three separate areas, and making them contributions to, rather than aspects of, abusive organisations, this commonality of experience and the relations of ruling underlying it, are glossed over.

The absence of accountability

Proposition 6 suggested abusive practice arises because services are “not clearly accountable to anyone”. Indeed, “where no formal documentation or authorisation of a system exist, it is clearly difficult to apportion responsibility or blame.” Service users and families lacked the knowledge and status, and local communities lacked the interest, to make services accountable. Management “neglects its own responsibility” to set the standards Wardhaugh and Wilding would like to see, and to be enforced. This left care-

staff unsupervised, and “the organisation comes to judge itself by its own internal standards”. (Wardhaugh and Wilding, p. 24).

It appears they were proposing that management standards would be independent of and different to the organisation’s internal standards. Whether written down or demonstrated through practice, managers will have set standards for their team-leaders and care-staff, monitored them and provided sanctions for not following them: Sobsey (1994) reported threats to staff, being placed in unpopular units, or on unpopular shifts, for complaints about abuse. Managers’ objectives were “to produce the goods” for the organisation, and were met to the extent that services managed and contained troublesome children.

Regular statutory visits raised occasional questions, but critical comments would be dropped from or watered down in the negotiated Visit Report. When a 1987 Social Services Inspectorate final report said nothing about pindown, it was interpreted as giving a green light to the system (ibid, p. 25). Wardhaugh and Wilding came to a judgement of culpability against senior and middle managers: either they were aware of pindown, and did nothing about it, or they did not know about it, and were therefore negligent. To the extent that they were supposedly independent of the organisation, and expected to take a critical stance, this would equally apply to the inspectors.

Particular models of work and organisation

The models discussed in Proposition 7 were said to create the context for corruption of care rather than directly cause it. Wardhaugh and Wilding identified professionalism,

hierarchical structures, size of organisation, concentration or congregation of ‘the most difficult cases [sic]’ together and bureaucracy. Professionalism led to some staff concentrating on their area of responsibility, ignoring physical conditions and regimes; led to managers refusing to hold professionals to account because of ‘professional autonomy’; and assuming the ‘professional ethic’ required no further support. Wardhaugh and Wilding particularly highlighted professional discretion to act in the best interest of the patient: sometimes it had more value than a patient’s rights; mostly, it was abandoned for “a range of routinised responses to categories of familiar ‘problems’” (ibid, p. 27).

Whilst hierarchy may stifle complaints, it also distances those who should be setting and monitoring standards from where the care is delivered. Care-staff feel ‘they’ don’t know what it’s like on the shop floor, so develop their own aims. This can be an aspect of the size of the organisation, where standardisation ensures efficiency, which includes clustering the most ‘difficult’ people together.

In the analyses above, staff and management being focussed on priorities different to ‘good practice’ however defined has been offered as a material alternative to corruption, neutralising, powerlessness, and so on, if only because it provides a basis for action. Here, Wardhaugh and Wilding suggest some of those other foci, particularly ‘professionalism’, hierarchy associated with bureaucracy, and bureaucracy associated with standardisation. These have interests of their own, distant from the shop-floor and hence service-users’ and care-workers’ experience (cf. Flynn & Citarella, 2012, Section 2, especially p. 19-26, with respect to Winterbourne View Hospital).

Certain client groups

Proposition 8 identified common characteristics of those most at risk of abuse that “contribute to the corruption of care” (p. 27). They are seen as “less than fully sentient beings” hence can be treated in ways those more sentient wouldn’t be. They also “tax the patience of staff”; “create permanent anxiety about the possibility of violence”; and “offer staff few rewards in the sense of positive achievements” (p. 28). ‘Society’ is not interested in their care, leading to low material standards that legitimate low standards of care. Their relatives are often not very involved, because of ‘stigma’, and not able to stand up for their family member.

(Sobsey, 1994: p. xvi) confronted this directly. “Recognizing that disability or any other trait of the victim of abuse is associated with increased risk must not be misinterpreted to imply that victims are partially responsible for their own abuse... . . . subtler degrees of blame can be found in traditional explanations of abuse of children and of individuals with disabilities, which assert that the dependency of the victim causes stress for caregivers, which subsequently leads to abuse... there is little empirical evidence to support this hypothesis and much evidence to contradict it... Such a misinterpretation can have two major negative effects. First . . . blame often leads to the further punishment of victims who have already suffered. Second... the actual causal and contributing factors are obscured...”

Although Wardhaugh and Wilding stopped at eight propositions, they also mentioned under Proposition 4 Management failure, that the “presentation of a disciplinary and punitive system as caring or therapeutic is itself an example of the corruption of care.” (p.

21). Sobsey turned this on its head: “the fact that institutions are viewed as agencies of protection and healing allow them to intrude on the freedom and dignity of the people they purport to help” (Sobsey, 1994, p. 92). It is because “caregivers are seen as helping people with disabilities, they are allowed to do things that would not otherwise be permitted.... People with disabilities...are thought to be ‘helped, not punished’ by these interventions” (ibid, p. 142: supported in more current jargon by Hanley & Marsland, 2012). Hamlin & Oakes (2008; p.50) linked this therapeutic definition of institutions in the UK with the medicalisation of intellectual disability when local authority ‘colonies’ were changed into hospitals with the founding of the National Health Service in 1948.

Corruption of care or business as usual?

Hamlin & Oakes (2008) were not concerned with cases of abuse: they were describing the everyday operation of institutions, and the carryover of the same discourses into community services. The putting together of systems that end in powerlessness for people with intellectual disabilities occurs across services, even if this is unintentional (Hanley & Marsland, 2012). As was described in Chapter III, Jingree, Finlay and Antaki (2006) showed how subtly (and intentionally) this can be done. The ‘neutralisation of moral concerns’ is an abstract way of describing this: people with intellectual disabilities, particularly those with challenging behaviour, are subjected to care-regimes that would not be tolerated for other groups.

Emphasis on geographic or social isolation of abusive services disregards the general social isolation that most community services for people with intellectual disabilities

demonstrate in reviews of ‘de-institutionalisation’ (e.g. Mansell, 2006; Hamlin & Oakes, 2008). Although ‘in’ the community, services and service-users usually do not engage with the community. ‘Society’ is given some of the responsibility in its marginalisation of people with intellectual disabilities, but this may be an insider view: the chances of a member of the public knowing someone with intellectual disability is relatively low (by definition, they are less than 2% of the population).

These ‘risk factors’ are foundational to how services are currently configured, and a corrupted version only of an ideal model of care-provision.

Summary of ideological moves

The Institutional Ethnography definition of ideological moves encompasses the use of texts and discourse to divert attention towards abstract concepts of how ‘corruption of care’ came about, away from the co-ordinated activities of care-workers, managers and applied researchers. Bereft of agency, these abstractions appear to mysteriously descend on services that have a critical combination of circumstances of risk.

The text appeared to try to move from placing blame on care-workers – who were presented as much at risk as service-users in a corrupted service – to management, and especially senior management. This group – as opposed to individual managers – were held to have some ability to stand aside from the circumstances of risk and be in a position to correct them, apparently since they operated them. This does not consider that managers

were successfully carrying out coordinated activities that had a different focus, possibly keeping a service going with minimal resources and no higher strategy or guidance.

People mentioned from outside the immediate service were the inspectors who did not criticise the pindown programme, the councillor and solicitor who brought it to public attention, a social worker who was intimidated by the pindown meeting style, and a Juvenile Justice worker who judged it illegal, but apparently took the matter no further. From the other literature, this is a limited view of outside contact. Inspectors, social workers and Juvenile Justice workers were accountable to separate institutions who are thus implicated and should be accountable. It is to the credit of the councillor and solicitor that they persisted in their respective institutional contexts.

Dialogue with Staff training and challenging behaviour

The Special Edition texts were all directive in one way or another, if only to hide their methodological weaknesses and at best ambiguous results. For example, the key phrase that care staff “may fail to behave in more habilitative ways, being *unwilling* or *unable* to implement effective interventions” (McGill et al, 2007, p. 42: my emphases) directed taking a critical, blaming position towards care-workers as its starting point. The phrase sets up an assertion of a number of factors at play that can be addressed by the university course the authors’ developed. We are then directed towards the reason that results of the course were “mixed” after great effort and expense for the students and their employers: students’ unwillingness, given the sophistication and thoroughness of the training course, to accept the behavioural model in place of their own ‘non-scientific’ explanations.

The authors' characterisation of staff being 'unwilling and unable' disregarded, for example, the perception in the field of a significant annual turnover of staff, and what lay behind it. In a study of small community residential homes where it was measured, Mansell et al (2003) found the "length of service of all staff in each home averaged 45 months (range 5 months to 116 months). Average staff turnover was 45% (range 0 to 227%)." This would limit how many could be offered and could complete a two-year course.

Campbell (2010) challenged such critiques of care-staff to consider whether it is legitimate to request care-workers to treat challenging behaviour in the manner of psychologists and researchers, or should the aim of these professionals be to support and aid care-workers to manage such behaviour or just to cope with it, within their everyday practice. However, as will be seen, Campbell introduced another form of reproach to care-workers at the same time, suggesting the operation of the same discourse (Chapter VIII, p. 232, paragraph. 3).

Many other aspects could be identified that weren't paid attention to, which could be argued lay outside the authors' immediate concerns. Grey et al (2007) made a weak argument about the power of training to answer some of the difficulties they had identified, and as far back as 1994, Hastings had identified that alternative psychological perspectives were needed: "[more] analyses of this kind, perhaps from different theoretical orientations, and research to develop and extend our understanding of the influences on staff behaviour are priority areas" (Hastings and Remington, 1994a, p. 433). The invitation had not been picked up by 2007, nor since.

A non-systematic search carried out in March 2012 showed that the transfer of training is an entire field of study addressing what makes it more or less likely, across industrial and non-industrial settings. This appeared to be based on the influential review of the area by Baldwin and Ford (1988), which had been periodically updated, e.g. Burke and Hutchins (2007), Grossman & Salas (2011). Whilst offering no transferrable solutions to staff training and challenging behaviour, this independent field of study showed that the difficulties were not unique to this area of work, and were subject to a wide range of influences in the work-place. It therefore emphasises the ideological aspect of Staff Training and Challenging Behaviour in intellectual disability studies.

Grey and McClean's (2007) text masked the social relations involved. The service changes described did not come about solely through training. They required a significant commitment to change by the agency involved: to release staff for the blocks of training; allowing them time to carry out their assignments in addition to their on-going duties (identified as significant adjustments by Berryman et al [1994], who were also cited by Grey et al [2002]); and then implementing the range of PBS support plans developed. These plans involved considerable environmental change, including access to new services. The new services went unmentioned in McClean et al (2005), and Grey and McClean (2007), but were reflected in a Quality of Life measure published later by McClean et al (2007).

No information was given on how the organisational commitment came into being, how it was communicated to care workers; how the care-workers interpreted such commitment;

and how much impact this had relative to the PBS support plans and PFT. Social or organisational activity was only referred to through the ethics committee not allowing a control group in the McClean et al (2005) study, which the Grey and McClean (2007) study remedied without identifying how the judgement came to be reversed. By concentrating on PFT, Grey and McClean appeared to have obscured their most significant intervention, the organisational realignment to allow significant changes in practice, and its drivers. From such realignment, the barriers identified to effective intervention in the adjacent article by Grey et al (2007) appeared to have melted away.

Lowe et al (2007) concentrated on aspects of their teaching programme, rather than the fact that by passing it, the nursing assistants were kept on after the service re-organisation. The professional staff-members were not at similar risk and the training programme was less successful with them. Emphasising the success or failure of staff to benefit from the training offered is a co-ordinated turning of attention from the influence of the social organisation of services.

The other articles are even narrower in focus, more closed and inward looking. As suggested, their rôle appears to be acting as platforms for ideas for further research, which are nevertheless dislocated from the research reported. All of the articles use an experimental psychology structure, as described by Bazerman (1987), for what are at best quasi-experimental studies. Their methodological efforts are focussed on reducing the impact of poorly controlled variables, rather than widening their focus to consider social relations of any kind. They demonstrated “institutional capture” in using experimental psychological formulations in a field where those formulations have proved wanting. The

following Chapters attempt to address this by using Institutional Ethnography to analyse a series of vignettes on clinical responses to referrals of ‘challenging behaviour’.

CHAPTER VI

DESCRIPTION AND ANALYSIS OF THE FIELDWORK

Introduction to the fieldwork

A data-set has been compiled, consisting of four vignettes: an account of a Community Learning Disabilities Team (CLDT) Allocation meeting and three clinical ‘cases’ arising from three referrals made to Psychology at the meeting. The interactions within the meeting and the case studies are autoethnographic narratives based on composites of particular situations, events, interactions and individuals in order to avoid any way of identifying individuals with learning disabilities, health and social care-workers, managers, or services.

The vignettes show what an experienced clinical psychologist working in community learning disability services can access for information, what they attend to, and how they transcribe their observations. They reflect both the explicit and implicit frameworks used in a clinical psychological analysis of events and interactions in the services described. It is difficult to say how typical or otherwise ‘my’ experiences and analyses are; there are few if any other public accounts of this nature. The closest account is that provided by Burton & Chapman (2004) in their critique of evidence-based practice claims. They proposed “types and levels of evidence (the nested macro, meso and micro levels) and explored the integration of these diverse types of evidence at the point of service delivery through the construction of practical, realist theories, which can then be tested as the

service (and its interventions etc.) is provided” (p. 68). Moving through this formal structure mimics the thought processes I describe below. However, I can anticipate from the experience of giving and receiving clinical supervision, for example, that there will be alternative experiences, observations and understandings, even in colleagues with the same theoretical stance. What is common is that they use those to help bring about change.

For an Institutional Ethnography, experience is the foundation of all else, and however ‘atypical’ it is, the analysis is to explicate the work that is being done, the ideologies in play, and to discover the relations of ruling – crystallised in texts and discourses – that shape them.

The work of a Clinical Psychologist: information gathering, observation, therapeutic conversations and note-making

The vignettes are the compiled outcome of transcriptions into a text of different sorts of activities – conversations, observations, reading - and other texts incorporated from elsewhere, using various genres: descriptive writing; stream of professional consciousness, consisting of ‘internal’ responses to and comments on events; notes extracted from other texts; and more complete sequences of conversation or interaction. The more complete appearing accounts, apparently more crafted, are typical of the degree of detail an experienced clinician can recall or reconstruct from memory or notes made at the time (see Appendix 4b). Such sequences are not recordings of events. Like the other genres, though, they are what clinical judgements and actions - ‘formulations’ and ‘interventions’ in clinical psychological discourse - are based on.

In clinical work, brief or more fully reconstructed notes will have observations and comments added. They are gathered in *aides memoires*, a clinical psychologist's private notes, which are the source for case-notes and texts produced for other functions or audiences. The vignettes show a gathering, developing, and sifting of a range of information, in a chronological sequence of discovery. The sequence starts with what is closest to hand – the discussion in the referral meeting, and internal dialogues with the information. It goes on to conversations with colleagues, case-notes and other documents on service databases or other filing systems. Next is information which needs to be tracked down – interviews with family members or care-staff. Finally, it comes to information that takes more time gather – conversations with the people who are the focus of the referral, or observations of them in interaction with others. Depending on the case and judgements of circumstance, little, some or all these sorts of information may be gathered.

Much of the textual data is initially given to the clinical psychologist rather than systematically sought out or selected. That is, it comes as a constructed account, from the perspective of an individual working in a particular context. Putatively, attending to both details and presentation of the narrative is the equivalent process to letting a client in psychotherapy tell their story in their own way, noting how they tell it as much as what they tell, and surmising what they may be leaving out or glossing over. The presenting is as important as the content. In the case of psychotherapy, the therapist will have a theoretical model, from which an assessment or diagnosis is developed, which will justify interventions based on that model (Korman, 1997). Such assessments do not simultaneously test the validity of the theoretical model.

In the UK, Clinical Psychologists will have been trained in Cognitive Behaviour Therapy (CBT) and will have a variable depth of knowledge of a range of other psychotherapies. They are also expected to apply their knowledge of a range of psychological research evidence to their applied research and clinical practice. Crucially, they are expected to test the validity of any particular theoretical model against the situation they are working with.

Sometimes, trainees in clinical psychology on placement in services will, prompted by this latter aspect of their course ideology, ask about 'theory-practice' links: why I chose to attend to certain events, make certain judgements or responses, with respect to which theories. This demonstrates an academic consciousness, *starting* in discourses and following the practices they prescribe.

In contrast, an astute trainee shadowed me in a clinical interview with a middle-aged man with intellectual disabilities with relatively limited verbal skills. I described what difficulties he had been causing in his service that led to referral; his personal history as I had gleaned it from a number of sources, partly corroborated, partly corrected by him in our previous two sessions. I then shared my plan for this session: the topics I hoped to cover, the approach I planned to take, and the hoped-for outcome. Half an hour later, I felt very satisfied with the discussion: we had found some links between his earlier experiences at home with a highly punitive father, now deceased, and his aggressive outbursts in the service. In psychoanalytic or psychodynamic theory, this would be called transference; in behavioural theory, generalisation.

I asked the trainee for her observations. “Did you realise you changed tack three times in the session, from what you said you were going to do?” In experienced practice, there is not always a scientific thought process of theory-hypothesis-attempted intervention-analysis of result. Instead, there is a more rapid, iterative process of applied curiosity, ranging across theoretical discourses, tracking what is developing within a conversation or other interaction. This is how clinical psychology practice distinguishes itself from other psychological interventions - psychotherapies, behaviour therapies, cognitive behaviour therapy, etc.

The *aides-memoire* of this interaction – without the trainee’s observation – would have first recorded the plan for the session, and then some of the dialogue, especially any of the person’s individual phrases, or ways of responding to questions or comments from me. In particular, it would have highlighted the positive outcomes as I saw them, of the conversation, in this case, the similarities between his current experience and his earlier family experiences.

What would not have been tracked and recorded was my shift from my original aim of exploring the person’s (prompted) recall about the most recent event, and his thoughts and feelings about it. I had picked up something in the conversation about the recent event that reminded me of something he had previously said about an interaction with his parents, so I shifted the conversation in that direction. Having found that the connection appeared to make sense to him, I then asked about other events in the service that reminded him of what had happened at home between him and his parents. This had proven difficult, so I took a more systematic approach to describing three ‘challenging’ incidents in the service,

two of which he could recall. I then asked for each of the incidents if they reminded him of something that had happened at home. He found it difficult to express, so I offered educated guesses that he fed back on positively and negatively. We arrived at a theme of inconsistent rules and punishment: what he labelled “not fair”, which made him very frightened and angry.

In a formal case-note, this would have been recorded as “Session with Mr Bravo at [place/time]. He consented to Ms Delta, Trainee Clinical Psychologist being present. I reminded him of the confidentiality rules. As planned, we continued to talk about the most recent incident in the Centre (date: see notes on page yz), and made links regarding triggers, thoughts and feelings with a previously discussed incident at home. This opened up wider exploration of situations he judged to be “not fair”, i.e. inconsistently applied rules and punishment, and his consequent anger. This is shared on a need-to-know basis, to reduce risk to Mr Bravo and others, with Mr Bravo’s approval. Next meeting [place/date/time].”

This exploratory, iterative approach contrasts most with behavioural ones, which begin with systematically gathering and recording information – data - according to a protocol, whether as text, or as a textual form to write onto or mark. Sometimes this is based in observation, so that in an event, particular aspects of the on-going interactions are selectively attended to and recorded, and others ignored. However, people’s accounts might also be gathered, following a particular framework for detecting and prioritising aspects of those accounts. Prescribed, practiced and consistent responses are then made as interventions, based on the analysis of those observations. The behavioural framework is

explicit in what it considers, characterising interactions as observed behaviours and observed events (stimuli) within contexts. Behavioural training for care-staff, if they are the observers, recorders and responders, is to give a rationale for this selective attention, as well as the skills to carry out the observations, recording and responding. That is, it also gives a rationale for what to transcribe.

The notes made by other professionals or care-workers will lie somewhere in between these two sorts of accounts. This is not just a difference in style. As seen in the difference between the 'events', *aides memoires*, and formal case-note above, each telling is adapted to different audiences, has different functions and accountabilities: the content and style are part of this differentiation.

A brief outline of the vignettes

The Allocation Meeting describes a fictional geographical context and a typical organisational and management structure; a typical office base of a health and social care community learning disability team; and a typical process of 'allocating' referrals. The description also involves 'background' information, filling in the context, such as the definition of an intellectual disability or the security of the referral system. The referrals to Psychology are read out by the Team Manager, and reacted to both by myself and by other Team Members. This information will have been processed in various ways to arrive at the meeting, and is further processed within the meeting before being taken up as a referral worthy of attention and further work. Other sorts of work in its widest sense that happens in the meeting is described, include making judgements of 'appropriateness' of the referral,

who can appropriately comment on the nature and outcome of the referral, and enhancing the perceptions of usefulness of each profession, the Team, absent senior management and the referring services.

Vignette 1: Padraig starts with summarised narratives regarding Padraig, his interactions with people around him, and their interpretations of his behaviour. These were saved as texts on ©Panopticon-I, the Local Authority data-base (discussed in greater detail, p. 213 ff). After this initial gathering of information - data filtered by unacknowledged discourses – hypothesis making or an initial formulation takes place. The hypotheses are not explicitly recorded, but they inform the initial interviews with those involved, and are refined before and during a meeting with the staff group. This staff group had previously received training in working behaviourally with Padraig's challenging behaviour, and the behavioural plan is reported. It has had positive results, but the current issues have puzzled staff and behaviour nurses alike.

A psychological analysis will ultimately selectively discard much of the information detailed, as described above. In this vignette, theoretical approaches are equally being taken up and put down, as they fitted the situation or shifted the conversation. The intervention was to facilitate the staff group to think differently about how best to support Padraig. It seemed to work within the session, and did not require any follow-up.

Vignette 2: Danielle begins by reiterating the information presented in the Allocation Meeting and some immediate thoughts about that information based on clinical experience. She is a 26 year-old woman lacking verbal skills, being returned to the county having been

placed in a medium secure hospital unit, and now being discharged under Section 117 of the Mental Health Act (1983/2007). Historically she had shown extreme aggression against herself and other service users, targeting less mobile service users, injuring some of them quite badly. She had responded well to programmes of behaviour modification in the hospital under the watchful eye of their psychologist. The discharge plan has asserted that she will require similar psychological support to live in the community. She will be placed with a service provider - Fairbairn Care- offering specialist care to people whose behaviour challenges: they are a new provider in the area.

Further information is solicited from the social worker co-ordinating Danielle's discharge process, and then reports and case notes saved as texts on the ©Panopticon-I database.

There is an unusual amount of information available on the data-base about Danielle's experience from the age of 14, leading to a summarised account of her eventual admission into hospital from the perspective of the services she received.

The subsequent sections are based on clinical supervision sessions between my junior colleague and 'myself', discussing in turn: the treatment Danielle received in the hospital, and its progression; her discussions with the Fairbairn staff group; Danielle's move and reactions; settling in and being unsettled; and the evolution of the care-service. During the first supervision session, it was decided to interview her parents for an alternative account of her history from their point of view, which was gathered by myself over two sessions. The narrative shape of the accounts is similar, but differing enough in detail and emphasis to highlight different 'truths' about events, as in the transcription of the psychological therapy session with Mr Bravo above.

Vignette 3: Jess is about a more able person with an intellectual disability, who has shown both promise and self-destructive behaviour, challenging behaviour and charm. The behavioural approach taken was to use ‘behavioural contracts’. Historically, these used to involve removing all ‘privileges’ from someone, and reintroducing them in a ‘systematic’ fashion for good behaviour (one of the rationales behind ‘pindown’; see Chapter V). In the human rights discourse of ‘Valuing People’ (Department of Health, 2001), rewards have to be something positive, not access to ordinary standards of living which are people’s right. A contract implies a negotiated agreement between equals, and obligations as well as outcomes for both parties, which is debatable in this context. Although a behavioural explanation appears to be of limited value, the use of the contract is supported as a less confrontational means of raising concerns about each other’s behaviours and creating resolutions.

All of the vignettes include commentaries and expansions of detail and context to some of the descriptions and interactions that (a) provide explanatory background to services, processes, and professional practices of the CLDTs and (b) reflect wider discourses of intellectual disability, challenging behaviour and support services.

Analysis of the vignettes

The first level of analysis was constituted in the writing of the material for the vignettes: these specific processes were chosen and distilled from multiple cases. The selection of

instances will have been influenced by both implicit and explicit hunches and notions about significant events and significant phenomena.

The Allocation Meeting

This vignette was written first, setting up the context and locating the 'Cases'. Differing views amongst the team regarding some of the referred people, their services or other service users mentioned are described; a number of complimentary and parallel processes and systems, such as Education and Looked-After Children, the Inter-service Committee, and ©Panopticon-I; and senior management and small-p political issues are commented on. The CLDT members' responses to challenging behaviour referrals were organised through their 'processing' of the people referred into 'ours/not ours' and the challenge they presented into 'our area of expertise/not our area'. Services and care workers were 'dumb' in relation to the 'smart' Team. Team members were person focussed and flexible, giving way only under extreme pressure from bureaucratic senior managers who were resource focussed.

Issues discussed are access to the services of the Team; access to the services of individual professionals within the team; prioritisation against current caseloads and new referrals; and protocols maintaining highly controlled access to residential and day services.

Applying this theme back into the text demonstrated that in the contextual scaffolding, wider issues of access were also present: access of Team members to parking space; restricted access to the building; the selective exclusion of service users and their families from the building; and hence their exclusion from discussions and decision-making. Re-

reading again, bringing together two apparently unrelated topics led to realising that these exclusions resulted from policies put in place by the same local authority directorate that set one of the performance indicators for the team to be how quickly it collectively responded to referrals.

The Clinical Cases: “unwilling or unable”

It had been expected the vignettes would demonstrate the ‘inability’ of care-staff to apply behavioural methods in their services across the three cases, in order to explore how their abilities were challenged and/or motivation dissipated. Care-staff, having previously been trained in behavioural approaches with varying degrees of success, subsequently arrived at a situation that defeated them. It was anticipated that in either case, a clinical psychological intervention would be built upon the limitations of a behavioural approach where the situation had already arrived at a local *impasse*. This reflected a recurring experience that: (a) more than a behavioural intervention is needed; where (b) the problem of challenging behaviour might lie in a relational problem between staff and people with intellectual disabilities; which (c) might be resolved with a systemic intervention to re-organise staff responses. This reorganisation would be different to and posited as more radical than reorganisation of staff responses accomplished through behavioural approaches.

The Padraig vignette describes a typical experience with both men and women with ‘moderate’ intellectual disability who are referred for challenging behaviour. Importantly, it included the successful interventions used by care-workers under the tutelage of a

behaviour nurse. These approaches appeared to fall down and the clinical psychologist developed a different sort of intervention based on a 'relational' rather than a behavioural framework.

This framework is based on post-modern system/family therapy (e.g. Anderson, 1997; Andersen, 2006; Rickberg Smyly, 2006) where people are not treated on an individual level, but as people in relationship, dealing with the interactions of groups, their interactional patterns and dynamics. In a family or a residential home, how the individuals understand 'what is going on' is both socially and linguistically constructed through family member or care-worker/resident interactions. Systemic therapy operates to offer system members different ways of talking and thinking about what happens, providing nudges that help them to develop new patterns of interaction. The meaning of Padraig's behaviour was negotiated by the psychologist and the staff group towards being (1) a reaction to being forced to do some activities that he strongly disliked or blocked from doing some he liked, (2) to which care-workers were contributing by ignoring his clear preferences. They were (3) under the influences of the views of more authoritative figures such as the home proprietor, or his father, which is (4) in clear opposition to 'being person-centred'.

Danielle's progression in hospital started from a highly staffed, highly structured, highly controlled environment that encouraged her to develop different ways of coping with fear and frustration whilst teaching her a wider range of activities of daily living, taking account and using her favoured activities, her needs, and her ability to learn visually and through imitation. This was an amalgam of Active Support – in which individuals are involved in the everyday 'board and lodging' tasks of the unit rather than be passive

recipients of care (Bradshaw et al, 2004; Mansell et al, 2008) - and Positive Behaviour Support. Having gained successful control of her behaviour, and encouraged acceptable modes of communication, she could gradually be moved to closer approximations to community living. The 'treatment' had been successful, in its optimal environment: 24-hour residential accommodation with a high level of environmental control; high levels of trained staff; high levels of surveillance and where necessary, of intervention; and highly co-ordinated ('consistent') ways of interacting. According to the individual's adaptation to and difficulties with change, step-up or step-down levels of intervention were relatively easily accessible. Tracking adaptation and difficulties was continuous. Above all, it was a milieu centred on bringing about change in an individual in a humane way, within a time-limit, at the end of which the individual leaves that setting.

The challenge was to transfer this successful behavioural development to a less than optimal environment. The involvement of a psychologist was deemed essential; the training of the community staff in the rules and routines that Danielle had lived under had been arranged; the signs of 'relapse' and responses to them passed on. This implied that these – psychological expertise plus following certain routines – were the crucial aspects of treatment that could function in isolation from the other aspects of the hospital environment, and 'maintain' the changes in Danielle and/or her behaviour.

In the main, the vignette supports this case. Where care-workers appeared unwilling (their distress at dealing with self-injury) or unable to carry through the routines, the psychologist stepped in to demonstrate and to remind them how to resurrect the routines and put them into effect. The disruptions in care-worker confidence and/or competence were generally

through external events, such as the arrival of noisy second tenant and the unexpected presence of the third tenant, impinging upon the safe space they had (co-)created.

However, such disruptions diminished in occurrence or effect, and the care-teams were able to introduce change at a pace they (and through her responses, Danielle) could control.

In Jess's case, two different psychological approaches were brought into play to explain her behaviour, which on the surface appeared to have little to do with relations between person and care-workers. The first was the 'discovery' through cognitive assessment that Jess was less able in a number of areas than her 'presentation' – how she interacted with those around her - might suggest. The second was the "attachment difficulties" approach, originating in "attachment theory" (cf. Bretherton, 1992, for a history of the development of attachment theory by Bowlby and Ainsworth). People with traumatic backgrounds as children can adapt in particular ways, in their relationships to others and to themselves. The traumata produce their own effects such as 'flashbacks' – memories so vivid, the person believes the events to be happening in the present – or feelings of terror, as well as the adaptations. These adaptations *are* relational, and unsuspecting care-workers can find themselves reacting in very particular ways around such people, either 'over-caring' or 'under-caring/rejecting'. It can be effective, therefore, to use impersonal objects, such as behavioural contracts, to mediate those relationships.

Conclusions

In the fieldwork, it was possible for the staff-groups involved to learn and to use behavioural interventions to address some issues, but not all. This contradicted – or more

exactly, nuanced - the aim of demonstrating the inability or unwillingness of care-staff to apply behavioural methods in their services. In each case, the use of behavioural techniques was successful, up to a point. At this point, the behavioural approach required either a more in-depth knowledge of the technique used, for example, to trouble-shoot the use of behavioural contracts with Jess, or being abandoned in favour of a different problem-solving approach, based on attachment theory. For Padraig, the residential care staff needed to find a consistent approach that all staff could use, but also to consider why a particular behaviour was being demanded of Padraig, when it would regularly lead to him becoming 'challenging'. With Danielle, the hospital environment in which she had 'learned' to deal with frustrations and challenges, and to pick up new skills, was not sustainable in the long term. The techniques used to move her to a community-based home only fell down when Danielle's care-workers had had little or no warning of events that intruded upon her space and had no direct control over them. Due to the success of the hospital environment, the community staff had had no experience of Danielle's self-harm and aggression and only a theoretical notion of how to deal with them.

In the hospital, there was near total control over Danielle's environment, and total control over whether and when she was moved into or out of an environment with lower degrees of control, i.e. in the presence of other people with intellectual disabilities, and with fewer staff to monitor interactions. For Padraig, care-workers were shown by the behaviour nurse how to set up situations in public spaces that reduced his anxieties, reduced his aggression, and kept him, colleagues, other service users and the public informed and safe. This contrasted strongly with the lack of control support workers were able to exert in the college situation and the negative outcomes there for Padraig and others. It also contrasted

with a lack of planned approach for working with his 'emotional' behaviours. For Jess, the more significant aspect of the environment was people: residential care staff, members of the Looked-After Children (LAC) team, the other residents in Jessamine Court and her family, past and present. Apart from the disagreement between the Jessamine Court staff and the LAC Team regarding the structure and consequences of the behaviour contract, there was both support and competition with the residents, and deeper contradictions between the care services and Jess' experience of her family's expectations of and demands on her. For Jess and the Jessamine Court staff, there was little control over this relational environment.

This suggests that the limits of care-worker use of behavioural approaches may depend on whether or not they have sufficient control of the aspects of the environment that would enable their successful application. This would include appropriate training and other resources such as the materials, time in the working day to plan and co-ordinate with each other, the supervision and support alluded to by Gray et al (2007). However sophisticated and extended a course of training may be in behavioural - or any other - approaches, it is only a small part of the story. That is, the limits are not the capabilities and motivation of individual staff members, but in the resources made available to them, including the guidance and advice of authoritative others, whether proprietors, CLDT members or family members.

The Clinical Cases: differing accounts

After the Allocation Meeting vignette, I wrote the ‘back story’ to the Padraig referral, based on working with individuals over a period of time, and with families with adult offspring. Family work allowed more detail of family narratives to emerge than working with the individuals. The narrative simultaneously described Padraig’s life in Lothian Lodge, as well as events leading towards his being ‘placed’ in the residential service. The historical account foreshadowed Padraig’s ambivalence towards women coupled with his ‘macho’ presentation and his love of Irish music, as well as slowly escalating aggression towards family members. It also suggested a potential way of avoiding the aggression.

Having completed this back-story, I proceeded with the post-referral vignette. Until this analysis was under way, I had set aside the back-story as an interesting exercise, but not in the same narrative mode as the vignette. However, in the subsequent vignettes, it appeared there was a similar difference between the organisational accounts – typically encountered first in the gathering of information - and accounts collected by psychologists from those directly involved. The latter were inevitably longer, and more detailed. Both sets of accounts might be ‘problem saturated’ (White & Epston, 1990), i.e. taken up to a large extent by the individual’s challenging behaviour, rather than taking them as rounded individuals with strengths and interests outside the difficulties they posed to others.

The Padraig ‘back story’ and Danielle’s history given by her parents both suggested that earlier intervention, more sensitive to their respective points of view, might have prevented the challenging behaviour escalating to the degree it did in their later adulthood. This

contrasted with the apparent inevitability of their ‘deterioration’ in the organisational accounts. Jess’ story was one of a disorganised – dysfunctional - family background, and incorporation into service texts from age of 12, so there was not the same contrast.

However, there are still differences between service texts and the account she gave to Karen Daley, the deputy manager at Jessamine Court. These can be inferred from, for example, the lack of proof of abuse in the family when it was investigated, and what Karen reports of Jess’ account of her childhood which made Karen fear for other youngsters visiting Jess’ mother’s home.

In the account of the psychological session in the section above on transcription in clinical psychology practice, the difference between the psychologist’s notes and the formal case-note is quite stark. The organisational accounts might be explained with reference to ensuring self-justification through implicit reference to organisational processes, good practice, ‘manuals’, and standards. They are a highly condensed form. The more personal accounts of parents or staff might still be self-justificatory, exonerating the individual or themselves and implicating others involved in the development of the behaviours that challenged them. They are less condensed than the organisation accounts, and remained open to different interpretations, and hence different interventions.

In particular, the less formalised accounts allowed the relational aspects of challenging behaviours to be more salient. The organisational accounts tended to place the problems that had arisen firmly within the person with an intellectual disability.

The Ontological Shift

The most difficult challenge in this analysis has been to overcome ‘institutional capture’, continuing to use institutional psychological language and concepts in both description and analysis of services and processes, and not making the ontological shift required of an Institutional Ethnography (Smith, 2005: p. 2; p. 4 note 2; pp. 50-60). This was brought to my attention once again in writing the section above on page 167 headed ‘The Clinical Cases: “unwilling or unable”’. The first paragraph starts: *“It had been expected the vignettes would demonstrate the ‘inability’ of care-staff to apply behavioural methods in their services across the three cases, in order to explore how their abilities were challenged and/or motivation dissipated. Care-staff, having previously been trained in behavioural approaches with varying degrees of success, subsequently arrived at a situation that defeated them.”* The paragraph was originally brought to an end with: *“Concurrently, the limitations of behavioural approaches could also be described, in (a) understanding the demands of services on care-workers; (b) understanding their everyday interactions with people with intellectual disabilities, and in (c) clarifying the sort of training that is an appropriate intervention into such situations.”* It was in re-reading it, and then the rest of the above analysis, that it was clear I could not address any of these latter issues with the material I had gathered in the vignettes; the sort of material I routinely had access to in my clinical practice.

Despite being one of the hunches in my work as a clinician that understanding the world of the care-worker was important; despite my initial observational research proposal methodology being aimed at capturing the everyday interactions of care-workers and

people with intellectual disabilities; in writing the vignettes to reflect typical clinical practice, such concerns disappeared. The use of published assessments, observational charts, records and reports used by psychologists are active texts, as were the texts consulted during ‘information gathering’ demonstrating how people’s actualities become a resource on which work is done to extract formalized and highly restricted representations

To see such selective *inattention* to everyday care in the vignettes was astonishing.

Although this far into the analysis, I wondered if it would be possible to construct a vignette from the point of view of a care-worker, but concluded it would have been a work of total fiction. Perhaps this was the reaction of Griffiths and Smith when in the course of their research into parental work with children in primary school was coordinated with the work of the school, “we discovered what we came to call the ‘mothering discourse’. That discourse had imposed on our thinking about ourselves and our research a model of mother’s responsibilities for their children’s schooling that we had built in to our research design and practice. The data collection was already done at that point, but we were able, so far as possible, to correct our analysis and interpretation” (Smith, 2005, p. 51).

It was equally astonishing to see that my aim of understanding the rôle of applied psychologists in the *impasse* had yet again reverted to exploring the difficulties arising between care-workers and people with intellectual disabilities.

The analysis had been a critical psychological analysis of psychological fieldwork, rather than an Institutional Ethnography. The 33,000⁺ words of the vignettes and back-story, and the 5000⁺ words above were examples of the work of clinical psychologists: their selective

attention to and evaluation of the information available to them, the assessments and the interventions they inform, the analyses and critiques they carry out, some on their own practice, but mostly on the practice of others. The discovery of the total absence of attention to staff experience beyond their understanding and use of behavioural techniques might increase understanding the nature of the *impasse* between care-staff and psychologists, but not how it comes about. The vignettes provide an unexpected account of clinical psychology practice, and the analytical (Institutional Ethnographic) task is to now identify the ideologies behind that practice.

Proposed Institutional Ethnographies

Two Institutional Ethnographies are needed for the Allocation Meeting Vignette and Clinical Case Vignettes; these will be carried out in the next Chapter. The section above ('The work of a Clinical Psychologist...: starting on page 157) arose from the need to explain psychological practice in the vignettes. The mode chosen was a one-to-one, psychologist/client interaction (albeit with an observer). Post-ontological shift, this needs to be explicated further. The second entrée to the next chapter is a re-examination of the section 'The Clinical Cases: differing accounts' (page 173ff.)

An Institutional Ethnography of 'The work of a Clinical Psychologist....'

The vignettes showed a similar process of gathering, decoding, and sifting of a range of information, following a chronological sequence of discovery. It typically starts with what is closest to hand – discussions in and after the referral meeting, and internal dialogues

with the information, based on previous experience. Conversations with colleagues are mentioned as the next step, alongside case-notes and other documents on service databases or other filing systems. Smith (2005; p. 105 ff) contends that readers activate texts, and are in conversation with them, responding to them, acting from and interpreting them. Texts may be accounts written by the same colleagues with whom spoken conversations take place, but whereas spoken conversations are shaped by responding to each other, the text is fixed, predetermined and unchanged by the act of reading (though the reader's interpretation may differ on different readings). From experience, it is wise to discuss particular texts with their author, to resolve ambiguities, and especially to check whether the situation remains as recorded: have circumstances and/or interpretations changed? Although both assessments and interactions with people with intellectual disabilities and the people around them change constantly, it is rare for there to be systematic updates or corrections of previous entries.

“Next is information which needs to be tracked down – interviews with family members or care-staff.” The tracking will often be set off by the conversations held previously, like the interaction with the Learning Disability Nurse Jenny in Vignette 3: Jess (lines 93-100).

“When I left the meeting, CLD Nurse Jenny suggested I talk to Joyce Bingley in the Children and Families Team: ‘She used to work with Jess a lot when she was younger and got to know her really well. I worked with Jess briefly on some personal hygiene issues when she started to menstruate: they thought she was having difficulties because she was ‘slow’, but I thought it was more than that, and Joyce probed a bit more and that’s when the sexual abuse allegations came out. Not that it got anywhere; these things often didn’t, in my experience, unless you got the family on-board’.” In this case, there was no follow-

up: the information about abuse allegations was sufficient, at the time, given the opinion of two experienced professionals.

Much of the information gathered thus far has been given in chunks of text to the clinical psychologist rather than them selecting it from direct engagement with key participants.

These chunks are constructed accounts, from the perspective of an individual working in a particular context. Some of the 'particulars' (Smith, 1990a, p. 160ff) of these accounts will subsequently be selectively attended to by the psychologist. The psychologist's particulars might be both the details of the narrative, and how the narrative is presented. However, in Smith's use of 'particulars', she demonstrated there is an ideology lying behind their selection, to work them up into a form that is institutionally actionable, and any actions will be institutionally accountable.

Finally, there is information that takes more time to collect, through direct engagement with key players, such as direct interviews with Danielle's parents, or the participant observation by a colleague, Sam, in supporting Danielle. Depending on the case and judgements of circumstance, little, some or all these different sorts of information may be gathered. Interview data can be gathered through questionnaires or schedules that are usually behavioural in approach, or 'clinically', gathering narratives and finding themes, as with Danielle's parents. The observations carried out are typically behavioural in nature, systematically gathering and recording information according to a protocol, whether as text, or as a textual form to write onto or mark.

The labour-intensive work of observation and structured interviewing had historically been the domain of assistant psychologists, high-level psychology graduates gaining 'relevant

experience' necessary to apply for the restricted number of places on clinical training courses. Until recently, they had a strong presence in services due to the chronic shortage of qualified clinical psychologists. A service that had failed to recruit a clinical psychologist used the money to hire (a number of) assistants. Training course places were expanded to meet demand, so more posts for qualified psychologists were subsequently filled, at a time when cutbacks in the NHS started. Vacant qualified posts fell, the numbers of assistants fell, and detailed observation fell in parallel. This had led to the situation Haydon-Laurelut et al (2014; p. 300) - whose study will be looked at in more detail in the Chapter VII - noted, that service managers and CLDT members could agree an assessment of and design an intervention for challenging behaviour without meeting the person with an intellectual disability.

Thus, the type of information that can be gathered is subject to a number of social relations. Most of it is constructed accounts, whether verbal or textual, having a variety of functions and audiences. To a greater or lesser extent, it may be gathered through direct engagement, which might in turn be structured according to texts in the form of recording sheets and schedules. In the institutionally captured account above, a link is made between attending to details and presentation in information gathering in individual psychotherapy and the same process in the vignettes. The individual psychology session demonstrated the intellectual work that also informed interactions with the staff groups in the Padraig and in Danielle vignettes. In particular, attention was drawn in both contexts to the rapid, iterative process of tracking across theoretical discourses, searching for the most applicable in understanding and directing the development of a conversation or other interaction,

repeating informal sequences of theory-hypothesis-attempted intervention-analysis of result.

Korman (1997) characterised psychotherapy as starting with an assessment, diagnosis or formulation developed from its particular theoretical model, which then justifies interventions based on the same model: all assessment and intervention is theory based. His paper is titled 'On the ethics of constructing realities', that is, on choosing one particular theoretical model that in practice *produces* the phenomena deemed to be characteristic of its diagnosis. The differentiation from and superiority to psychotherapies asserted by clinical psychology is by having multiple models, evaluating them and choosing the best fit for the context. That is, choosing one discourse from a range of discourses, whilst continuing to ignore the relations of ruling operating on the person or staff group to which help is being administered.

Walker (1986) explored the work of professionals in health and care systems using Institutional Ethnography to explicate the 'conceptual imperialism' of the term 'burnout'. She demonstrated that this condition of cynicism, depletion and withdrawal was readily identified by many health and social care professionals and set the scene for a range of solutions such as stress management training, improvement of managerial practices and the provision of organizational supports for beleaguered sufferers. "One of the purposes of "burnout" as ideology has been shown to be the provision of psychological (i.e. "stress-related") explanations for people's experience of adverse working conditions." (p. 48)

The practices leading to this term were characterised by Walker as conceptual work that brings about ideological effects. "It is not something which takes place merely in thinking but in sets of work processes and relations. 'Typically,' Smith (1981) notes, 'work

processes are reconstructed as social or psychological processes, depriving them of their necessary anchorage in an economy of material conditions, time and effort'." (Walker, 1986; p. 38). In this study, applied academic work processes and relations defined care-workers as "unwilling or unable", and in clinical practice, they are constructed as requiring a form of group psychotherapy to shift their understandings of clients. The adept psychologist, operating under a different set of relations, sorts through a range of theoretical models to fit the situation with others' constructs of events, themselves filtered in their telling through their institutional accountabilities.

The *impasse* is another ideological move, by characterising care-practices as unchanging in the face of an established evidence-base for behavioural interventions and proven training in these interventions. This "formalized and highly restricted representation" (Smith, 2005; p.186) was demonstrated by the fieldwork to be inaccurate. *Care-working will be influenced by behavioural approaches to the degree that carrying them out is in the care-staff's control*. Following Walker (1986) it appears that care-workers "like mothers, are held responsible for the solution of difficulties or the successful outcome of projects the determinates of which are beyond their sphere of control." These determinates "are not to be found in the everyday world of professionals and their clients but ...in social relations which organize but do not necessarily originate or conclude in the realm of everyday experience". (p. 52). For the care-workers in the vignettes, the social relations need to be discovered and explicated without resorting to psychological or abstract sociological processes. This means going beyond the 'relational' concept, for example, which implies that issues/events are between individuals, and that those individuals are somehow independent of anything happening outside the room. This diverts attention from wider issues of service organisation and resourcing, and the ideologies behind them.

‘The Clinical Cases: differing accounts’: an Institutional Ethnographic glance

The idea of the difference in content and style between the ‘events’, *aides memoires*, and formal case-notes was that each telling is adapted to different audiences, for different reasons. This is a position from post-modern systemic/family therapy and is part of the wider post-modern programme that there are no absolute truths, only local conversations.

The organisational accounts might be explained as texts accounting for one’s practice according to the co-ordinating ideologies within organisational processes, good practice, guidelines, and quality standards. As Garfinkel (1967, *passim*) showed with paper case-notes, they are a highly condensed form, expressed in and depending on familiarity with service discourses for full meaning/accounting. In particular, the organisational accounts more often placed the problems that had arisen firmly within the person with an intellectual disability, and rarely within services or service policies.

It was suggested the less formalised accounts allowed the relational aspects of challenging behaviours to be more salient. The more personal accounts of parents or staff might also be self-justificatory, exonerating the individual or themselves and implicating others involved in the development of the behaviours that challenged them. The parenting discourses active throughout the Danielle vignette claim special knowledge of and responsibility for their off-spring’s well-being; privileged emotional responsiveness to their behaviour; and lack of trust of services and their presumed authority.

What is rarely considered is the lack of information and understanding most families have of learning disabilities: their offspring may be the only person with a learning disability they have met. They are therefore dependent on health and social care professionals for information and reassurance. Pdraig's father's 'unrealistic' expectations of his son's life-course – a wife, family and paying job – will reflect in part such professional discourses as the 'everyone's a winner' ethos in special education and the 'ordinary life' discourse in adult services.

Although more or less dependent on services, families often retain a perspective about their family member different to services, whose ideological move subsumes the accounts that might be more explicit about the rôle of service organisation in the development and maintenance of challenging behaviour. Institutionally, positing challenging behaviour as persisting over a number of years, despite the difficulties in measuring both challenging behaviour and persistence (Totsika & Hastings, 2009; Totsika et al, 2008) is the ultimate diversion of responsibility.

In order to return to an Institutional Ethnography, the fieldwork vignettes will be approached differently. The chronological sequence will be expanded to include some of the limited literature that is available on how referrals for CLDT involvement come about from services, how they are evaluated and responded to by the Team, how interventions are made, and how each of these steps is co-ordinated with respect to which ideologies. The focus will be on actions and events and their co-ordination.

CHAPTER VII

AN INSTITUTIONAL ETHNOGRAPHY OF THE FIELDWORK

This fieldwork will follow the chronological sequence from a service making a referral to ending an intervention, drawing on both relevant literature and the Vignettes. Following Smith (2005: p. 165 ff), it will be important to try to find where texts and discourses are inserted into the sequence and the active part they play, recognising the authority of individual's experience in the everyday aspects of their work.

Making a referral

In his study of mental health institutions, Goffman (1961) famously described the social processes of being admitted to a mental hospital in detail, whilst acknowledging that admission was preceded by a process involving the person's family and friends as much as health professionals. Smith (1990a; Chapter 2, p.12), one of Goffman's graduate students, wrote about how a group of friends came to present one of them as mentally ill. As the work of making a referral to a CLDT was not included in the Vignettes, the research literature was consulted.

Nunokoosing and Hayden-Laurelut (2011), and Hayden-Laurelut, Nunokoosing, & Millett (2014) provided a rare analysis of the referring process. The first study investigated all 59 referrals for challenging behaviour made over 18 months to a Community Learning Disability Team. The referral form "asks for basic biographical information such as name,

address, date of birth, name of General Practitioner and their address as well as the name of the person referring the person. Tellingly, it does not ask about the relationship of the referrer to the person who is subject to the referral. The form asks the person to ‘describe the problem they would like help with’. It goes on to ask a series of questions about where the problem occurs, who with and how often. It asks who is affected by the problem and to describe the risks involved. It leaves space for further comments.” (p. 408). Some Teams include the relationship of the referrer to the person referred, but otherwise this is a common format.

Nunkoosing and Hayden-Laurelut (2011) acknowledged that the creator of the referral form may be influenced by “theoretical concepts like applied behaviour analysis with its premise of the importance of contexts such as place, time, environments and people to understanding behaviour” and that the referrer is “responding to what has been identified as relevant by the designer of the form” (p.408). One of their principle objectives was to use Critical Discourse Analysis (CDA) to “ask how relations of dominance and control are being reproduced in referral texts” (p. 408), and posited the referral form as having power in itself.

From an Institutional Ethnography perspective, power arises through ruling relations that extract formalized and highly restricted representations from people’s actualities, usually initiated through an interrogation in order to fill in forms (Smith, 2005, p.185ff). Whatever a care-worker’s knowledge of an individual, the service they work in, and the people they work with, service concerns are only recognised if they can represent them within an institutional discourse. These representations are then actionable and accountable.

The CDA interpreted the content of the forms as rhetorical moves where “workers attempt to show professionals their worthiness and the difficulties of their work; ...[and] construct derogating documents about men and women with learning difficulties...engaging in the business of power to create actions to regulate the actions of the group home resident. The CLDT has a part to play in the production and maintenance of these discourses.”

(Nunkoosing and Hayden-Laurelut, 2011: p. 414). This implies that there is only this conversation in play, with no account of the production and insertion of “theoretical concepts like applied behaviour analysis”, the limited training care-workers have been given, or the requirement on workers to demonstrate compliance to a regulatory body’s standards.

By concentrating on the referral form as “the ‘first turn’... in the conversation between the group home and the CLDT” (ibid, p.415), the rhetoric obscures the text’s co-ordinating effect. Typically, as here, the text limits the formulation of the situation to an applied behaviour analysis framework, with a matching intervention that can be provided by the CLDT. This removes the possibility, for example, of giving the care-workers the freedom and resources to apply their understanding of behaviour principles, the individuals and their working environment, to sort out the situation themselves. (Grey & McClean [2007] suggested that giving this freedom to care-staff lay behind the successful application of person-focussed training in PBS in their study.)

Nunkoosing and Hayden-Laurelut (2011) then analysed six of the 59 referrals and concluded that their data “find the person under surveillance may be referred when the

routine of the home is threatened” (p. 414). These referrals derogated the people with intellectual disabilities who “don’t get up and dance when they ought to; ...want to go to college when they *should* want to take a holiday; ...eat their food too quickly, and ...don’t go to the toilet when others decide they need to, [whose] asking questions are [sic] verbally abusive.” (p. 415)

Nunkoosing & Hayden-Laurelut interpreted the “acts of transgression” as “both outside of the discourses of the institution and of the contemporary social construction of intellectual disability. When this support/power is challenged by the person who ‘won’t listen to reason’ a referral is invoked and a higher authority is sought to provide ‘total life management’ of the man or woman with learning difficulties” (p. 415). In the invocation, “Mortifying discourses are employed that serve the purpose of presenting the person with learning difficulties as embodying an individual problem in need of fixing by the CLDT. The referral does the work of neutralising the threat to the power of the home”, (p. 414).

Diamond (1992: cited in Smith, 2005) observed that the texts and reports the staff in a nursing home filled out at the end of the shift to meet the supervisory requirements of the residence and of the funding authority constituted care-work in its widest sense.

“Documenting and charting make the [care] assistants’ work accountable to the authorities. Each task also makes invisible the work of caring and the human encounters involved....we find again how institutional discourse subsumes and displaces the actualities of the work that people do” (Smith, 2005, p. 179). Ensuring that premises have no urine smell, that service-users engage in leisure activities, and are being taken on holiday in order to comply with standards set by the CQC which can apply bureaucratic

and ultimately financial sanctions against the service, is being ignored as accountable care-work. Being derogatory can be considered work a care-worker or manager must do to construct a text within a behavioural framework to be successful in eliciting a response from the CLDT. Nunkoosing & Hayden-Laurelut's Foucauldian analysis obscures rather than clarifies the social relations that lead to privileging particular routines and their maintenance over other care-practices.

In the second study, Hayden-Laurelut, Nunkoosing & Millet (2014) retained interest in the use of discourses. They interviewed eight managers who had made some of the 59 referrals in the previous study about "the processes that led to the referral being made, their expectation for the outcomes of the referral, their past experiences of making referrals and the work of the CLDT" (p. 292), and carried out a thematic analysis on the interview transcripts.

To their surprise, Hayden-Laurelut et al found that the referring managers had a very different view of making a referral to those discussed above. "The super-ordinate theme is one of making referrals as a residential home managerial practice. Referring a person for the services of the CLDT professional is used as a procedure for justifying managerial decisions made in the service provider organisation" (p. 294). The first related sub-theme was to provide legitimacy for the referring service – the CLDT was a source of advice and approval for the manager's work. The second, confirming support practices: through the authority of their professional status, the CLDT professional reassured the staff that they are doing what is required under the guidance of the manager. Third, the Team member

could legitimise manager's decisions, in the face of opposition from or discontent of staff members.

The authors acknowledged that these themes might not have been the Team members' views of their interventions: they may challenge services rather than only going along with the managers' version of events and suggested actions. However, taking them at their word, in some extracts, managers refer to doing things "right" (Extracts 1, 11 and 17); not being "qualified" to make some decisions (Extract 6); and legally having to cover their own backs (Extract 8). These are all based in external referents or directives, often mediated by Care Quality Commission (CQC) inspectors. If there is a challenging behaviour 'incident' in the service, the manager is obliged to report it to the CQC, who will usually expect a CLDT referral be made if they are not already involved. By not asking about these external discourses and social relations, the authors' surprise about the managers' themes is unsurprising. Their condemnatory conclusion is that "referrals are often made for purposes other than enabling the person with intellectual disabilities to live a fulfilling life" (p. 299). This statement needs to be taken instead as a valid observation to start rather than conclude an investigation, to discover the relations of ruling in operation.

The managers reported some disappointment with the advice given by Team members, particularly psychologists (*ibid*, p. 297). Hayden-Laurelut et al (2104) suggested this might occur when the manager's implicit request is to 'fix' the individual, which Team members resist, seeing the situation instead as "problems of living in a place that is not one's home" (p. 297). This last phrase is the authors', focusing within the four walls of the service and not considering extended interactions that govern how the referring service

operates, or that guide the Team discussion and evaluation of the referral and their response.

Working the referral: the Allocation Meeting Vignette

(Quoted extracts from the Vignettes will take the form (ll.p-q/Vignette), i.e. line number p to line number q, in the Vignette with name given)

The Team allocation meeting was “to consider new referrals, discuss issues arising from recent referrals, and track the ups and downs of Team members’ work-loads and waiting lists,” (ll. 6-8/Allocation), to share information about and co-ordinate services offered to individuals and/or services supporting them. The issues discussed are access to the services of the Team, developing and applying rules controlling access by residential and day services, especially those in the private sector; access to the services of individual professionals within the team; and prioritisation of new referrals against current caseloads.

Co-ordinations of professional discourses

Responding to a referral for challenging behaviour appeared to demonstrate work of negotiation between professions regarding use of their skills and of their available time, to ascertaining the severity of the ‘challenging behaviour’ and who might be best placed to help the referring service. Psychology claimed to be “for higher complexity issues: emotional, mental health or relationship difficulties, which may be ‘presenting’ as difficult behaviour; or if complex interventions beyond clear-cut training are required to encourage

change in staff or organisation practice.” (ll.314-317/Allocation). This would be based in their professional discourses relating to training, qualification and knowledge-base.

Negotiation work involved gathering more information, without committing to ‘picking up’ the referral. “‘Screening’ will often be the initial response in the case of ‘challenging behaviour’, where the apparent cause or degree of challenge someone is posing to a service is not clear. The behaviour could be health related, perhaps a response to pain, and therefore might require support and advice from a Community Learning Disability Nurse. A nurse will also be able to give ‘basic’ behavioural advice for managing behaviour. If the challenging behaviour appears to be more obviously aggressive to self, others or property; and appears based on the lack of ability of carers or care-workers to meet the challenge, a Challenging Behaviour Nurse might “screen”. They will behaviourally assess what is maintaining the behaviour, and if necessary to train and advise the carers or care-workers to manage the behaviour more effectively.” (ll. 298-308/Allocation).

Allied Health Professionals (AHP’s) generally work less with people with challenging behaviour than nurses, behaviour nurses and psychologists, having lower numbers in CLDT’s than nurses or social workers, and higher demand for their skills with the more severely disabled. (Although there are even fewer psychologists, working with challenging behaviour is seen as a significant part of their rôle.)

Speech and Language Therapists contribute to managing challenging behaviour by increasing communication skills for both service users and staff: their Royal College collaborated with the Royal College of Psychiatry and the British Psychological Society to

produce the 2007 good practice guidelines, ‘Challenging behaviour: a unified approach’. (cf. ll. 336-341/Allocation). OT’s can provide sensory assessments for people with Autistic Spectrum Conditions (ASCs) or dementia, in which sense perception and processing can be markedly different. The assessment may suggest increasing or decreasing sensory stimulation, but can also deal with other perceptual or motor anomalies. The OT might ‘screen’ if the referral mentions ASC or dementia and the form of challenging behaviour ‘appears sensory’.” (cf. ll.343-349/Allocation). Physiotherapists could provide a programme of physical fitness activities, an evidence-based intervention for reducing challenging behaviour (e.g. Cannella-Malone et al, 2011) in the same way it is a first level approach to reducing anxiety, depression and stress across other adult populations. (cf. ll.353-364/Allocation).

The missing rôle from the Vignette is the Psychiatrist – from this meeting and referred to in only one of the clinical vignettes - who saw more people with behaviours that challenge than everyone else. They refer individuals who challenge, but who appear not to have a diagnosis of mental ill health, to the rest of the team. The Team make referrals to Psychiatry where a ‘challenging behaviour’ is assessed as reflecting distressing/disabling levels of anxiety, depression or other mental health problems, which medication might help the individual manage. Psychiatry referrals mostly come from G.P.’s who “still follow historical medical protocol, and refer to the Consultant Psychiatrist, presumed to be the head of the team.” (ll. 267-268/Allocation).

If there is no consensus on who should ‘pick up’ a referral, or reluctance to do so, the Team Manager Briony intervened: “Ken, can you pick it up quite quickly please, you or

Sam. If you think it's behavioural, obviously bring it back but it sounds a bit more like yours. It would be good if we got some feedback at the next meeting." (ll. 422-424/Allocation).

Additional work in allocating referrals is the sharing and weighing of information regarding the referring service, its managers, the person referred, or other people with intellectual disabilities involved in incidents. Information from ©Panopticon-i might be contributed by the Team Manager, but much of the information is from Team members, for example, regarding individuals: "Arabella H, social worker chips in: 'I think he was lucky Kelly doesn't have family, else he might have had the police on to him for assault. Seems she was quite bruised and bleeding from a nasty graze from the fall. I think it should at least have gone to Adult Protection' " (ll. 382-385/Allocation); "Sarah B, Community Nurse: "Is that Kelly M? Well, she can be bit of a madam. Not that it merits being pushed downstairs, mind, but it might not all be one-sided.' " (ll. 393-394/Allocation). Services are judged: "Sighs of exasperation go around the room at this last interpretation: the disablist equating of intellectual disability with being like a child, a cultural remnant that hasn't disappeared after 30 years of professional effort." (ll. 406-409/Allocation); " 'She's been assessed as FACS eligible, by the Transition Team' [murmurs of scepticism from social workers; the Transition Team assessments can be 'generous'...]" (ll. 517-522/Allocation).

Further discussion of services is programmed in the final section of the meeting, where "Team members shar[e] difficulties they are having with current cases, either because of the complexity of needs, or...care-practices that are falling short of what the Team expects, or might signal more systematic bad practice" (ll. 614-617/Allocation).

How then is this work ideological? Negotiating rôles, sharing information and concerns as described is not about building consensus or team-identity but is co-ordinating practices across multiple professional and institutional discourses. It defines whether the person is 'eligible' for Learning Disability Services; whether a person's 'challenging behaviour' is sufficiently disruptive to merit the Team's input; and whether their service merits the support of the CLDT or other resources.

An Institutional Ethnography of the Clinical Case Vignettes

The 'service disruption' leading to referral in Padraig's case was in college, his supported-living accommodation and the practice of the behaviour nurse. Danielle was in transition from a hospital to community accommodation, the hospital admission being the culmination of increasingly severe disruption of a number of organisations. Changing from the highly controlled and controlling hospital to a less controlled environment was judged by the hospital team to present a high probability of resumed challenging behaviour and potential re-admission. Jess was defiantly disruptive to care-workers, co-residents and nearby public houses, both in the aggression she displayed, and in failing to rise to staff expectations.

For Padraig and Jess, organisational accounts placed the problems that had arisen in firmly within the individual with an intellectual disability, and not within services or service practices. That attribution existed for Danielle before the admission. However, the vignettes demonstrated a range of other ruling practices at work.

Padraig

During the meeting, Briony the Team manager hinted at some additional context to the referral, which she shared afterwards.

“You’ll have heard about the BURR [*Best-Use-of-Resources Review*] Team: identifying people in high-cost placements whose last two annual reviews might question whether they really need that level of support. Well, Bridget Hope [proprietor of Padraig’s supported-living provision] stood up at the last providers’ meeting and shouted the odds about how her homes work with very difficult people, and if they aren’t so bad now, it’s because of the skill and resources they put in, and cutting back will just lead to problems re-emerging...BURR plan to go into Lothian next month to look at Padraig’s package. The providers were told they’d need some strong reasons not to reduce funding...”

“Do you think the referral might be to justify the rate he’s on?”

“No, I don’t: this has been going on for a while now; since before the provider’s meeting anyway. Bridget might also try to put in a formal complaint about us losing the referral, and exposing her staff to unnecessary increased risk.”

““The ones who have high levels of skill and resources to control behaviour, you mean?”

“I know, but it sort of adds up that if the support isn’t there from us, because we lost the referral, she really needs to be able to have those staff resources in place, and not cut back...”

“So, it would suit them better if I don’t have a magic wand?”

“Just be aware of some of the tensions there could be in the house now, okay?” (ll. 83-102/Padraig).

This highlighted some of the financial relations between commissioners and providers, and the ‘gaming’ that they and the CLDT might participate in. Financial tensions and reputational management recur in the examples below. It was generally ‘known’ that Mrs Hope “closed two other houses in the last twelve months when they fell below a level of economic viability through Supported Living taking over from residential care” (ll. 51-54/Padraig) in a changing financial and policy environment.

At the time of referral and intervention, Padraig was excluded from college, with a planned return closely supervised by two support workers, one funded by the college, the second, one of the residential care-workers. This could be his last term at the college, as his disengagement in class and consequent lack of progress meant he would not get any further funding. “Incident report sheets...about the three episodes of more extreme aggression showed it occurred outside the session rooms: once in the corridor approaching the college refectory; once moving between tutor rooms mid-afternoon; and finally...on the main staircase, going to the first session of the day.” (ll. 208-212/Padraig). The first incident involved non-disabled students on vocational courses; the second and third, other students with intellectual disabilities. The college interventions had removed Padraig for increasing amounts of time and increased surveillance on return, reducing the risk to other students and the college reputation. Removing him from college altogether meant Mrs Hope losing

a source of funding for day support: week-day support would have to be resourced from within the home.

At the staff meeting I asked: “Angie, what is the one thing you think would make P’s life better?” “Staying away from college.” “So what’s stopping that?” A long silence. Joan: “His dad would complain a lot, and go bawl at Mrs Hope. Anyway, we wouldn’t be able to cover him staying at home all day” (ll. 431-434/Padraig) The subsequent piece of psychological work was – *inter alia* - to argue for the home to take Padraig out of the college straightaway, and for them to find and fund alternative activities. The manager Justine, finally commented: “Well, at this stage, I don’t think there’s much to lose, him not going to college anymore. I’m sure we could try out a few things.”

...”Do you want me to say anything to Mrs Hope?” “Let’s just see: proof’s in the pudding. If he’s happier and everyone feels safer...” (from ll. 554-561/Padraig).

On follow-up, Justine reported: “Mrs Hope wasn’t too keen on forking out for the drumming, but is happier now he’s settled down again, and it looks like he might not need the extra support when they all go out.” (ll. 570-572/Padraig).

“Any reaction from Mr O’C?”

“A bit: I just blamed you! ‘The psychologist said...’ They’re due to visit this week-end, so I can give him all the good news, too.”

“Thanks, Justine! But if they want to talk to me about it, that’s fine. (ll. 577-580/Padraig).

The Behavioural Nurse previously involved felt the “escalated” behaviours in community settings could be brought back under control by the residential care staff following the established “behaviour management plans” and agreed “risk management strategies”. She had drawn attention to the new behaviours at home - Padraig going to his room and crying – with tears, and his breathing affected, like sobbing - and reframed the issue as ‘emotional’, triggering psychology intervention.

In discussing the community issues with staff, the following conversation developed. “So you’ve mostly tracked down when and maybe why he sits down, and why he hits out at the public... because he really doesn’t want to be there”. Justine: “But we have to take him out with us”. “Why?” “Because we can’t leave him at home on his own” “What happens if he’s left on his own?” “It’s just too risky...” “Is it more risky for him to be left at home, than to sit down in the road?” “But he has to go out; he has to access the community. We have to show the CQC that all the people living here, access the community”... “I’m quite happy to write to the CQC and tell them that in my professional opinion, it’s in P.’s best interest not to have too much community access.” (ll. 409-418/Padraig). There were multiple challenging discourses.

The disruptive behaviour at home was Padraig not responding to comforting, cajoling, or confronting. Some of the staff team thought he was really upset, and sympathetic support needed to be given; others thought it was all “put on”, and part of his increased “naughtiness”. Possibly, the discussion with staff provided enough solutions to the staff group dilemmas so it was all that was needed. More likely, it kick-started a process of working through a number of issues that the staff group completed for themselves, from

the knowledge they had of Padraig's positive as well as difficult characteristics, and their various ways of supporting him, once some discourses had been challenged.

For example, from Anne: "Well, I noticed that, like Angie says, P. can stand really close to you when he's out. And she [Angie] lets him. Sometimes, she even takes his hand...."

Anne blushes. "Uh-oh: that sounds like holding hands is a no-no." ... Joan: "Mrs Hope tells us not to: it's not age-appropriate, and draws attention to his disability" (ll.421-425/Padraig).

Or in reaction to Nicky: "Well two Downs; they can be a bit touchy-feely. Mrs Hope's not always happy...."

"It's great how well it works, that bit of comfort and reassurance. It might have helped P. too. Thanks, Anne. So there're lots of good ideas for shifting P.'s life-style a bit. (ll. 547-552/Padraig).

It appears that Justine and Natalie's referral to psychology led to endorsement of Justine's managerial position *vis-à-vis* her proprietor, who was responding to the intrusion of reputation and market forces into care, but also working with some out-dated normative ideas; with regard to CQC ideologies; in asserting her approaches to staff; and lastly, in responding to Padraig's parents. There is a level of complexity and of contradictions between a number of agencies and their respective discourses beyond those proposed by Hayden-Laurelut et al (2014). Inserting them into or removing them from sequences of interaction through a professional discourse – "the psychologist said...." - appeared to resolve the identified issues. By suggesting ending the college placement, whose service-

provider was distressing Pdraig for reasons they chose not to explore, and reducing the impact of the CQC in one area, the local authority retained a stable service in its own portfolio, at no additional cost.

Danielle

The referral was an unusual one: for psychology in the CLDT to continue to monitor an established behavioural regime, ensure its consistent application where necessary and adjust it where appropriate, as had been carried out in the hospital by the psychologist there.

The Danielle vignette is divided into two parts: pre- and post-admission to hospital. The pre-admission part is a series of contrasts of educational and day-opportunity settings, that are able or not to make responsive adjustments to meet Danielle's needs, two of which are explored below. The post-admission section is about setting up the environment necessary for the successful application of the behavioural techniques established in hospital to sustain the changes in a person's behaviour repertoire, and the changing the environment to more closely match an 'ordinary living' community setting. The environment included the routines and interactions that Danielle needed to feel calm and safe.

At her first 'transition' review, Danielle was characterised by her teacher as "a bundle of energy: although more petite than her peers, she has a big presence in the classroom, interested in what everyone is doing and always on the move...will engage with tabletop work if allowed to stand at the desk...can identify a number of simple shapes by name, and

distinguish 8 colours, ...visual matching is excellent... too impatient to use hand signing and quickly resorts to pointing and gesturing. In outdoor sessions, her curiosity knows no bounds, and she can examine both flora and fauna, intensely and for protracted periods: her expressive nature-vocabulary is larger than the total of her other vocabulary...self-care skills are impeccable:...uses a fork and spoon to eat with, again taking great care to keep herself clean: she enjoys most foods, and has learned the basics of healthy eating at home; she describes less healthy options as “fat”. Danielle is challenged by having to wait her turn, to sit still, and being admonished or corrected either by staff or by other children. She has a number of ways of expressing her frustration, which can sometimes present a danger to people near-by...has yet to grasp any formal number tasks;...shows sufficient brush, marker and crayon control to produce recognisable pictures, yet does not appear to have any interest in copying or recognising letterforms... her teaching assistant concentrated on supporting Danielle to recognise a number of social signs..” (ll. 155-187/Danielle).

A Speech and Language Therapist reported Danielle “able to produce a range of speech sounds beyond her limited utterances, and her reception skills were dramatically different to her expressive skills” (ll. 197-199/Danielle) and “probably because of her slight stature, Danielle was often interacted with as a 6 or 7 year-old with a learning disability, rather than a 14 year old. Her mobility and lack of concentration in the class-room may be related to frustration rather than attention difficulties.” (ll 200-203/Danielle). The Educational Psychologist suggested Danielle was at her best outdoors with her TA. “Her observation skills were impressive, and her drawing sufficiently controlled...to produce intelligible and differentiated pictures of a variety of flowers and insects, almost on a par

with mainstream peers...her relative skills appear to go largely unrecognised, and a less verbally oriented curriculum would be of great benefit. Like many children with such a high visual dominance, I suspect Danielle is a fairly sophisticated people watcher, and much of her 'self-stimulatory' behaviour allows covert surveillance of her surroundings." (ll. 205-213/Danielle).

The review concluded Danielle should progress to senior school. After a honeymoon period mostly in home economics, her behaviour began to escalate: rocking and self-stimulation led to more serious self-harm, picking at the skin on the back of her neck and hands. She was less tolerant of others' physical presence, and attacked those who were teasing her. She was increasingly isolated within the school for others' safety and increasingly difficult at home. "[S]ometimes school found her too difficult to contain, and she was sent home....Her mother was phoned at work and given twenty minutes to get home to receive Danielle. Danielle's parents protested about this – both for the intrusion into her mother's work life, and the loss of income for that day - but the school appealed to staff health and safety, and safeguarding the children." (ll. 235-240/Danielle).

Her father reported that senior school had "got more and more demanding on her, so she started to get really stressed, and they wouldn't let her wander off like before. It had always been there, sort of in passing, but she started rocking herself a lot, and rubbing herself to calm down...Then she'd rub herself raw, and she started picking at the skin on the back of her neck and hands....God, it was awful..." Her mother reported her getting aggressive to her parents. "*I* thought it was when she started her periods. She was quite

late, and they were pretty irregular. We wondered if she got a lot of pain and that's what made her so...angry...with everyone. I felt so helpless...." (ll. 503-514/Danielle)

They took the matter to their local councillor and their MP, and Danielle was transferred to the county Special Behavioural Unit. "This seemed to work much better for her: she was the only learning-disabled child/young adult amongst 'conduct disordered' and repeatedly excluded children, and staff gave her a lot of protective attention. Within a limited curriculum, she was allowed to set her own timetable from a small range of options through the day, and given relative freedom to move around the classroom...Her difficult behaviour at home subsided significantly" (ll. 244-252), according to the Panopticon-I reports. Her parents also followed up on the issue with her periods, with the help of a Community Nurse and a different GP, which they felt also significantly contributed.

When additional demands were placed on them in supporting Danielle's grandmother during her convalescence, the relative calm was disrupted, and led to Danielle going to a residential school. The parents next evidenced this as an expensive placement doing little or no educating, and requiring Danielle to be placed on increasingly high levels of medication after-school. On return home, subsequent day opportunities broke down for similar reasons: practices not being flexible enough to respond to her needs. After a series of injuries to others, she was admitted to hospital. Her parents disputed many of the particulars of those incidents: they followed them up whilst she was away. In their eyes, they were all avoidable, and unfairly interpreted. They felt hospitalisation was "the best thing that happened" (ll. 771-1/Danielle).

Within education is a normative, developmental, discourse that – even if adapted to individuals with special educational needs who cannot access the National Curriculum, such as the latest P-scale attainment targets (Department of Education, 2014) - provides a sequence of expectations for the individual to meet in various areas, and the curriculum to bring them about. Within many ‘reasonable adjustments’ to intellectual disability, there were the unadjusted concepts of attainments and targets as ruling discourses in the school, which appeared less salient in the Special Behavioural Unit.

Danielle’s parents’ accounts demonstrated the work that support systems expect families of people with intellectual disabilities to do in supporting the school. These are over and above the expectations of the ‘mothering discourse’ Griffith & Smith (2004; cited by Smith, 2005, p. 132) experienced as single parents with children in mainstream education. For example, parents being responsible for managing challenging behaviour provoked by school, once the staff can no longer manage it.

An alternative discourse and practice was offered fifty years ago by behaviour analysis pioneer, Ogden Lindsley’s concept of the prosthetic environment: “Retardation [intellectual disability] is not the property of a child but of an inadequate child-environment relationship...Classrooms should be tailored to children— not children adjusted to classrooms. Retarded behavior is penalized and any sub-skills ignored in environments designed for average children. In prosthetic environments tailored to their skills, exceptional children will behave adjustively, efficiently, and with full human dignity” (Lindsley, 1964, p. 79-80).

Thus challenging behaviour appeared to be associated with non-adjusting institutional environments and their practices; with the interactions family have with schools and colleges, whether as on-call care-workers or organisers of system change; in undiagnosed physical discomfort; each in interaction with each other and with Danielle's particular characteristics and her personal adaptations to them in those environments. In essence, the hospital provided the prostheses Danielle needed, albeit at very high financial cost.

The post-admission process involved "a new-to-this-area, specialist supported-living provider, Fairbairn Care. Fairbairn have sent their care-workers to shadow Danielle in the Community Discharge Unit at the hospital at zero cost to the Local Authority, as part of their training. In return, the company has asked for funding for a two-person shift, 24/7, for a minimum 12-month period." (ll. 443-448/Allocation). The commissioners are using this "to build a relationship with Fairbairn, as a possible competitor to Threshold." (ll. 450-451/Allocation)

Other ideological discourses given for the move were: "[h]er family are keen for her to be closer to home. And of course, we have to bring people back from out-of-county...Such placements are a known risk-factor for abuse. It's a humanitarian gesture to families, as well as an organisational cost-effectiveness and corporate risk-reduction agenda." (ll. 456-461/Allocation).

Discourses influencing the care-workers were revealed by the CLDT psychologist directly involved in the transition, Sameera P., who joined the Fairbairn staff team in supporting Danielle in the Community Discharge Unit, and collected detailed background information

on both the acquisition and maintenance phases of work with Danielle. In clinical supervision, she explained: “Some of the staff were okay with the way the nursing staff interacted with Danielle: she has very special needs requiring a special approach. The others were much more social model/choice and control: ‘why should she be forced to get up and make her bed so early?’ Because that’s how *she* needs it to be; shredding her nappy and getting wound up if you leave her is her way of saying ‘you let me down’. “But I’d be in a bad mood if I was woken up too early”. For her, it’s *not* too early. Blame her parents, whatever, but that’s the way she likes it: if you don’t do it her way, don’t accept her choice and let her control when she wakes up, she’ll let you know.” (ll. 825-833/Danielle)

Two particular care-workers took this view, and through negotiation one of them, Haley, a shift-leader was removed from Danielle’s team. “Even if they follow the rules, at best it’ll be half-hearted, and they’ll always be looking for ways to do it their way.” (ll. 839-840/Danielle). The second care-worker left when Danielle’s self-management broke down after four weeks of successful transition to the Fairbairn residence: a second tenant was being introduced and some messy self-harming occurred. Sam took her place, and helped the other care-workers restore a calming way of working.

When the third and last tenant moved in, he was present in the communal area without Danielle’s team or Danielle being forewarned. “Danielle was startled, and ran forward to attack him. Staff responded by quickly and efficiently, physically restraining her. Sam reported that this seemed to undo the remaining fear in her care-team about whether they could support Danielle in all circumstances”. (ll. 933-936/Danielle).

The transfer from a high-cost, restrictive environment to a less costly but comparatively expensive community service had been successful, and a reasonably sustainable service provided the prosthetic environment Danielle and her parents had previously sought, in vain.

Jess

The Jess Vignette is the most “psychological” of the three. It first described the evolution of the Jessamine Court residential and day services, and aspects of the Looked-After Child service, these being the two agencies involved with Jess. It goes on to show how some of her difficulties arose, the contribution of care staff-group expectations, and, how the use of behavioural contracts could help with emotional issues.

Jess contradicted a number of expectations of working towards an “ordinary life”. In “the day facility at Jessamine Court... she had made good progress, [and] it was expected she might show the same qualities and quickly learn to ‘become independent’ ...[but] her home-based skills very different to her work skills: she appeared to not have any.” Having developed one particular skill area, another skill area would be introduced. “Progress would be made here, but the previous area worked on ‘deteriorated’”. This led to “a decision by her key-workers not to tackle the issue of her personal hygiene and laundry, so that she wouldn’t ‘lose’ them and she could continue to ‘make a good impression’ at work training, through their regular monitoring and prompting” (from ll.238-250/Jess).

The manager, Jason Greene saw this as being “lazy and very manipulative”, “typical of looked-after kids”. (ll.320-321/Jess). Before this conversation, I had carried out the cognitive assessment, and a trainee clinical psychologist did the adaptive/functional skills assessment. To my surprise, I had assessed her cognitive functioning in the mild range of learning disability; her adaptive skills were in line with this. So my response to Jason was “I saw something relating to this during the assessment...I don’t think Jess’s issues are just about laziness: I think they are related to people treating her as more able than she is. They do that because she is very skilled at picking up cues from them, and giving them the ‘right’ answers, the answers they are looking for...[with] her daily living skills, she is expected to do them on her own, whereas her work-skills are about her being in a group, and being able to follow what others do.”

“So you sort of agree: she *is* fooling the staff, in a way?”

“Or your staff-members are seeing the good she’s doing, and not wanting to question it.”

(ll. 366-374/Jess).

The other Nunkoosing and Hayden-Laurelut (2011) ‘transgression’ – not following current social construction of intellectual disability – was when she “finished her training and was about to start a supported part-time job working for a charity organisation, [but] she refused to co-operate. She initially feigned illness, and eventually refused point-blank to go into work: she had ‘had enough of that office stuff, hidden away on her own’ and wanted to ‘work in a shop or a café, to get to meet people’...she was offered a training placement in a council-run café in a city park. She made good progress, getting her food hygiene certificates, and was a popular member of staff... When the manager phoned to offer Jess the job, she said she wasn’t interested. The staff team tried to encourage her to

take the job over the next few days, when Jess “went mad”, trashing her flat.” (ll.253-265/Jess).

In the first job, it seemed Jess had some idea of the difficulties she would face on her own in a back-office, without the tacit guidance of others. However, the second refusal was based on a basic distrust of the café-manager which emerged in a more nuanced and complex narrative from Jessamine Court’s Deputy Manager, Karen. This was founded in Jess’s history of childhood abuse and care experiences. Many of her challenging behaviours could be subsumed under a discourse of attachment difficulties. This would be considered a severe emotional difficulty, not a behaviour one: indeed, in my experience, attempting to introduce behavioural measures leads to a rapid escalation in disruption, possibly to regain a feeling of control and/or safety. What is required from professionals is “[c]onsideration, emotional and practical support, and a dependable, receptive relationship” (Frederick & Goddard, 2008, p. 308), even when the consideration and dependability are being tested to destruction for their authenticity. This approach can be provided by a properly negotiated and consistently applied behavioural contract. “They need to, first, be possible for Jess to fulfil, so she gets back into a winning streak. Second, they need to be a contract: negotiated, compromised, sets of wins for both sides, and stuck to and stuck with. It’ll take a while for her to build up trust again...Third, only the pay-offs in the contract are in play. Not ‘doing it for me’, ‘doing in for yourself’, or independence: just what is in the contract. No shouting, no upset, no stony silences if she breaks it, unless you write it in the contract.”

“But that’s crazy: how can you not show your feelings? Or put them in a contract.”

“That’s the whole point with contracts. They’re a third party. It’s not for you to bawl her out – she can bawl back harder, and smash things up, run off : it should just be the consequence of the contract, that she negotiated with you and signed. Bawling her out, from her perspective, is you breaking the contract first: it’s bringing in something else, from outside the contract. Unfair.” (ll. 408-420/Jess).

Implicit in the manager’s question is that staff feelings are important, and not fitting into contractual relationships, without giving Jess’s feelings identical weight and worth (cf Drinkwater, 2005, p. 234), Following Phillips & Rose (2010), the manager believes Jess to be in control of her behaviour, and is working towards declaring a placement breakdown. The psychological discourses of attachment theory and behaviour contracts counter these moves and maintain the placement.

The organisational framework: database and ‘Calculator’

From the plethora of ruling practices described above, there appeared to be co-ordinated action to minimise service disruption through managers’ moves to maintain services and psychological interventions interacting.

Two aspects of the work of the CLDT members in the Allocation meeting were co-ordinating a Team approach to the referral, as described above, and that co-ordination being directed by the organisational framework that operated through ©Panopticon-i, performance indicators, and other text-based managerial discourses. Whilst the Team discussion was experienced as a set of considered clinical judgements, they were

influenced by a set of dominant texts: the ©Panopticon-i data-base, with its eligibility and resource allocation functions; and psychologically based definitions of being intellectually disabled.

When a referral is read out, and the referral person “is someone known to the people in the room, there will be discussion of the referral. If the person is not known to anyone present...the Local Authority data-base, ©Panopticon-i, is checked.” (cf. ll 145-50/Alloc).

“Since intellectual disability is considered a life-long condition, genetic or congenital in origin, a person should be ‘known’ to Local Authority services.” (ll. 173-175/Allocation)
Young adults should have been identified in Education, through the process of providing a ‘statement of special needs’ after a statutory assessment; or through the transition process of assessments and reviews from Education to Adult Services. Other adults in receipt of some service previously should have been assessed.

“The data-base records personal and family details, involvement from services, contacts, documents, statutory assessments and the all-important expert-system led ‘care-process’.
This co-ordinating function has two main uses for our service. It records statutory assessments of need, particularly if someone is “FACS eligible”...It includes the “Calculator” that rates and sums the level of support and hence the amount of funding a person can expect; the decision about funding; the contracting and setting up of a service; billing; and reviewing. Unless each step of this flow is properly filled in, no funding will be available...” (ll. 152-161/Allocation).

The “Fair Access to Care Services criteria for service eligibility across care groups are founded on an individual’s need for support in daily living skills, offset by the ability of family or other [unfunded] support networks to provide that support, and by some limited assessment of risk of neglect or abuse. Ratings about people’s need for support are banded into low, moderate, substantial or critical needs...Our local authority met only substantial and critical levels of need.” (Il. 198-210/Allocation) [FACS was replaced in April 2015, to follow the new processes and changes to eligibility, and commissioning required under the Health and Social Care Act, 2012]

“Not being on the database could be for a number of reasons. The person’s family has [recently] moved into the county, or the person has been placed in a service in the county from another local authority. They could be from one of the small number of county families who have never accessed services – possibly not even Education – and who now have had some crisis. Or they don’t have a learning disability. (Il. 181-186/Allocation).

“Learning disability is defined here as having an IQ below 70, defined by a range of sub-test scores on psychometric cognitive assessments such as the Wechsler Adult Intellectual Scales [...] as well as similarly ranked social and adaptive (self-care) skills, defined by scores on the Vineland Adaptive Behavior Scales. In the UK, clinical psychologists are licensed by the publisher to apply and interpret the Wechsler scales; the Vineland is also available to some other health professionals, or additionally-qualified teachers.” (Il. 188-194/Allocation). Despite the apparent precision in such assessments, statistically it is impossible to say that a person with a score of 71 is functioning much differently from one who has a score of 69: all scores need to be regarded as plus-or-minus 5 points; a degree of

interpretation by a qualified practitioner is always necessary. The Vineland Scales use indicative ranges instead.

The influence of the organisational framework in defining and responding to challenging behaviour

Meeting the information and workflow needs of the expert system directly influenced who would screen a challenging behaviour referral. When “a referral may be motivated by a request for additional funding to support the person involved, either a Community or a Challenging Behaviour Nurse will screen. Both professions have received training in operating the ©Panopticon-I assessment, care-planning and purchasing system and also have more experience and judged expertise in working directly with difficult behaviour than Social Work colleagues, the ©Panopticon-i specialists.” (ll. 308-313/Allocation). The nurses would be asked to assess whether a no- or low-cost change in practice were possible, and if not, what level of additional support would be necessary at what cost. However, if the service appeared unwilling or unable to change its practices to reduce the frequency and intensity of a challenging behaviour, a reassessment of need would be requested from social work colleagues, anticipating that another service would be needed to support the individual concerned. This would not include an analysis of the individual’s needs that were unmet by the previous service, and/or what their challenging behaviour was provoked by (cf. Smull, 2000).

Thus, the CLDT has a range of assessments and interventions in response to a referral of challenging behaviour:

- 1 negotiation between Team members to coordinate various approaches to reducing the behaviour:
 - 1.1 individually focused: physical health issues; mental health issues, via Psychiatry or individual psychological work (e.g. based on past trauma)
 - 1.2 service focussed: changing practice through temporary involvement of Team members
- 2 increasing the level of funding provided to the service, typically for increased levels of staffing, typically for a fixed period;
- 3 finding a different service, that ‘meets the person’s needs better’ and/or reduces the (need for) challenging behaviour.

Once decided, “[t]he team ‘admin support’ person, Harriet A.,... takes notes of the decisions made in the meeting to circulate in the next two days: as ‘referrals’ and ‘minutes’. ‘Referrals’ are sent out as a spreadsheet: name; address; date of birth; reason for referral in 4-6 words.” (ll. 212-216/Alloc) “The last piece of information...Harriet, needs to record on the referral sheet is which profession the referral is ‘allocated’ to” and the “information from it will also be added to “The Tracker”, which is also used to generate reports about referrals, waiting lists and work-loads, and other performance indicators. One of the standing topics at my six-weekly management...supervision with the Team Manager is to discuss the progress of referrals to psychology in our locality, as

read off the Tracker spreadsheet, and to check the spreadsheet's accuracy against our own list of people waiting, being seen, being monitored, or discharged. (Il. 280-289/Alloc).

Smith noted that recording in an older person's care home was for administrative surveillance, in both the supervisory organization of the residence and for the municipal department responsible for the oversight of the residence. (Smith, 2005, p.179). Whilst the information about the referrals might aid Briony's supervisory organisation, it was also for the local authority's oversight. Wilson (2014), writing as director of a domiciliary care service added a higher level of ruling relation, in commenting: "The system of recording proformas and managerial checking exists to ensure that I, as the Chief Executive, am able to evidence how the Commissioner has discharged their responsibility through us" (Wilson 2014, p 62). The "framework for compliance and accountability" this created meant "the definition of people's needs was dominated by the commissioner's assessment process. This process is concerned with meeting the needs that the commissioners are legally required to meet rather than the things that the individual needs or desires" (ibid. p.63), for example, financially prioritising personal care over having people having fuller social lives.

This suggests the framework for accountability for the CLDT responding to challenging behaviour referrals is directly about aiding Commissioners and the local authority to discharge their responsibilities, as defined by them, rather than meeting the needs of people using the services. The objectives of a referral to the CLDT proposed by Nunkoosing and colleagues in their two papers, minimising disruptions to the routines of services and justifying service managers' decisions, are fulfilling the same proxy responsibilities.

Widening the picture

Thus far, the impression is that most ‘challenging behaviours’ are managed by the CLDT, when management is shared and coordinated with other public functions. The Safeguarding Teams in health or social care providers have a rôle if other service-users are at risk from aggressive behaviour. With severe violence towards property, service-users or staff, the police may be asked to directly intervene in a way care-workers would be criticised for. Safeguarding may also be involved for services that the CLDT has identified as provoking the challenging behaviour through poor care practices; who are incapable of managing and protecting either the perpetrator or the target(s) of the behaviour through lack of training, skill or motivation of care-workers; or who have poor administrative, organisational and support (training, supervision of staff) structures in place. These service characteristics overlap with those more likely to lead to a placement breakdown due to challenging behaviour, in comparison to services who maintain placements in the face of the same levels of severity of challenging behaviour (Allen, 1999a; Broadhurst & Mansell, 2007; Phillips and Rose, 2010).

The Good Practice Team (cf ll. 657-672/Allocation) - a section of the Governance function in the local authority - ensured ‘the quality of commissioned services...intervening before safeguarding is compromised’ (ll. 659-660/Allocation). They audited service-providers and provided guidance and advice on appropriate systems, paper-work, routines, and structures, with support and accountability in place to meet the requirements of CQC inspectors. This team expanded to include Learning Disability services in the wake of the Winterbourne View inquiries, which underlined the responsibilities of commissioning authorities for ensuring the quality of services, as much as the service providers

(Department of Health, 2012a, 2012b). The Good Practice Team often insisted a service request the involvement of the CLDT where intervention skills were found wanting, or if individual service-users needed the specific help of Team members. Broadhurst & Mansell (2007) and Phillips and Rose (2010) identified that the lack of such specialist involvement led to an increased risk of placement breakdown. It appears the co-ordinating principle behind all these public functions is maintaining the *status-quo* of care-provision.

“In the first phase of integrating health and social care services, the CMHTs [Community Mental Health Teams] took on the management of social workers, and the Learning Disability health workers moved to local authority management.” (ll. 71-73/Jess). This led to an overall expectation for ever closer “integrated” working throughout the Team, particularly between health and social work/care-management professionals, reflecting higher-level integration between NHS Trusts and local authority social care (e.g. NHS England, 2014).

Initially, it appeared that integration meant subsuming health care practices to local authority social care concerns. Requests for Psychology to provide cognitive assessments were “more often to settle an argument between [local authority] managers about whose budget will fund this person’s support, rather than the need for [clinical] support... (ll.544-546/Allocation). On closer examination, it appears that integration is a significant shift towards meeting local authority statutory requirements instead of maximising the physical and mental health, the choice and control, or the social inclusion of a person with an intellectual disability.

The performance indicators chosen by senior management: "...driving down waiting list times, and making sure 12-monthly statutory social work reviews take place...are what currently define good services" for the whole team. (ll. 8-11/Allocation). They are about fulfilling the local authority's statutory obligations, and previously led to Community Learning Disability Nurses functioning as care-managers/social workers in integrated teams, though recent emphases on addressing health inequalities for people with intellectual disabilities (e.g. The Health Equalities Framework: NDTi, 2013) is helping to reverse this trend.

Drawing together

The Institutional Ethnography of the Vignettes has shown that 'challenging behaviour' is a phenomenon nested within a complex of relationships involving service providers, service users, family members, commissioners, local authorities, Community Learning Disability Teams, hospitals, schools.....There are numbers of discourses in play, some of which can be coordinated, some of which can be used competitively. The main coordinating ruling relations are the statutory obligations placed on the local authority, despite the presentation of other discourses that promote the person-centred, human-rights focussed agenda presented in 'Valuing People'.

Care-workers do not specifically appear in the above list. In the previous chapter, it was shown that they are both willing and able to use behavioural approaches, providing they have the freedom and resources to do so. These two essentials are not within their control, but the manager/proprietor/commissioner's. The activities of clinical psychologists and applied researchers are considered more fully in the next chapter.

CHAPTER VIII

DISSOLVING THE 'IMPASSE'

Summary and interim conclusions

This thesis is the outcome of attempting to understand and hopefully remedy a long-standing issue in my practice as a National Health Service clinical psychologist working with people with intellectual disabilities. The research was carried out whilst continuing to work in encouraging care-workers in services to people with intellectual disabilities to use well-established, evidence-based behavioural approaches to reduce the challenges presented to services by the behaviours of some service users. This rarely completely succeeded, at best needing to be regularly revisited and revised, for both the individual and for anyone else in the same service should they be referred. Research had not accounted for the lack of transfer to the everyday world of care, and researching that phenomenon had not led to any greater success.

Chapter II provided an analysis of a sample of the literature on Staff training and Challenging Behaviour that attempted to remedy the situation. The articles were from a Special Edition of a journal, and were presented to be both a pinnacle in the field at their date of publication and a platform for further progress. Blame for the lack of transfer of training was explicitly or implicitly placed within care-workers and care-practices, in most of the articles. The quality of the research was demonstrated to be highly questionable, and

its conception and insight into the area appeared limited. It provided little to develop the area, other than ‘more of the same’.

In order to provide a wider understanding, Chapter III summarised a different literature that had also been critical of care-workers and care-practices, that regarding institutional abuse, particularly of people with intellectual disabilities. The main contrast with the challenging behaviour literature was the recognition that institutional abuse was and is a system-wide phenomenon, at various times implicating every level of health and social care, from hands-on care-worker to government minister. In the case of Winterbourne View Hospital, this included agencies specifically in place to prevent and respond to such abuse. Despite this wider view, there appeared no understanding of how to tackle it other than ‘more of the same, only more so’, and disclosures have continued to be made.

Giving local authorities some legal obligations for adult safeguarding similar to that for child safeguarding through the Health and Care Act (2012) was a significant advance in policy, but may not be enough in practice.

Taking the two Chapters together, the conclusion was that there remained a lack of any conceptual framework to bring together day-to-day caring and constraints of care-work with the expectations of highly trained health professionals (e.g. applied psychologists) or with the promotion of high-level values and assumptions in inquiry reports and policy documents reacting to abuse. A significant part of my researching was in finding such a framework, upon which a suitable methodology could be built.

I proposed a suitable framework in Institutional Ethnography, the social research approach developed by Dorothy E Smith and her colleagues based on experiences in the feminist movement, symbolic interactionism, ethnomethodology, Marx's *Grundrisse*, and Bakhtinian dialogism, exposition of which was provided in Chapter IV. It is a 'method of enquiry': a theoretical framework, an ontology and a research process, concentrating on the embodied experiences of people in their everyday lives and on the social relations that coordinate these across locations and time. Exploring and writing 'the social', the coordinating relations, are what constitute research in this approach. Texts play a powerful coordinating rôle, materially intervening in sequences of action. The final section of the Chapter described the Research Method and the material conditions that shaped it.

Chapter V first described how texts are used in the training and practice of clinical psychologists, and introduced Smith's notion of the 'active text'. A key text from the institutional abuse literature was then re-evaluated from an Institutional Ethnography perspective, particularly how the text directed the reader ideologically. That is, towards certain assumptions and understandings of the nature of care-services and their operation, and away from others, subsuming the experiences of care-workers and people cared-for to the institutional needs of the care-system. A similar process was then demonstrated in some of the articles previously examined in the challenging behaviour literature. These actively diverted attention away from other social elements heavily contributing to their reported results, and towards the apparent failure of staff to utilise training. It was suggested that this inward looking, enclosed stance was effectively ruled by the discourses of experimental psychology that emphasise reducing the number of 'variables' that can influence the outcomes of experimental research. This is based on the assumption that

applied research in intellectual disability is developed enough for such an approach to be valid, which the evidence of the *impasse* suggests it is not.

Chapter VI began an analysis of the four vignettes describing the Allocation Meeting at which referrals for challenging behaviour were discussed and allocated, and the case-studies of the referrals for three adults. It first described the work of a Clinical Psychologist when information gathering, observation, therapeutic conversations and note-making. This work was contrasted with that of a behavioural approach. The content of each vignette was then briefly described, before a more full analysis was developed for each.

The conclusion was that, contrary to the Staff Training and Challenging Behaviour literature review, care-staff were both able and willing to use behavioural methods, up to a point. The limits were not the capabilities and motivation of individual staff members, but in the resources made available to them, including the guidance and advice of proprietors, CLDT members or family members. Another phenomenon briefly examined was the difference between the organisational accounts – typically encountered first in the gathering of information - and accounts collected by psychologists from those directly involved.

There was then a reflection on ‘the story so far’, based on not being able to answer particular questions from the vignettes. A critical-psychological analysis of psychological fieldwork based on institutional accounts had been produced, which had ignored the care-workers’ perspective. This surprising demonstration of “institutional capture” included

extending the aimed-for Institutional Ethnography of the practices of applied psychology contributing to the *impasse* into an Institutional Ethnography of wider health and social care-practices.

The *impasse* was shown to be an ideological move, characterising care-practices as unchanging in the face of training in behavioural interventions: the fieldwork demonstrated this to be inaccurate. The institutional accounts of health and care services were shown to subsume any account that might be more explicit about the rôle of service organisations in the development and maintenance of challenging behaviour. Institutionally positing challenging behaviour as unchanged from childhood and the family context appeared to be the ultimate diversion of care-system responsibility.

In Chapter VII the fieldwork was structured to follow the chronological sequence from a service making a referral to ending an intervention. The chronological sequence included some of the limited literature that is available on how referrals for CLDT involvement come about from services, before considering the Vignette accounts of how they are evaluated and responded to by the Team, how interventions are made, and how each of these steps is co-ordinated with respect to which ideologies.

The Institutional Ethnography showed that ‘challenging behaviour’ is a phenomenon nested within a complex of relationships and social relations involving service providers, service users, family members, commissioners, local authorities, Community Learning Disability Teams, hospitals, schools.....There are many discourses in play, some of which can be coordinated, some of which can be used competitively. The main

coordinating ruling relations are the statutory obligations placed on the local authority, despite the presentation of other discourses that promote the person-centred, human-rights focussed agenda initially presented in ‘Valuing People’.

Care-workers are not in the above list as they were both willing and able to use behavioural approaches, providing they had the freedom and resources to do so. These two essentials were not within their control, but the manager’s, proprietors, or commissioners’ sway. The activities of clinical psychologists and applied researchers are considered next.

Applied psychology in institutional form

The concept of “challenging behaviour” has not been explicitly defined in this study, as it would be in most texts on challenging behaviour, with the intention of demonstrating instead how it is used in clinical practice. Academically, Emerson’s 1995 (with Bromley) and 2001 versions are the standards, cited and modified in the ‘Unified Approach’ guideline (Royal College of Psychiatry, 2007), but which Emerson and Einfeld (2011) considered equivalent to the originals. The use within services encompasses far more people than the group specified by Emerson & Einfeld (2011) and others, i.e. with a severe intellectual disability, with little or no verbal communication, and with other neurological conditions. The cases Nunkoosing and Hayden-Laurelut (2011) reported were not the relatively high frequency behaviours that Emerson referred to, and the people did not have the same level of impairment. In the Vignettes, only Danielle’s behaviours were similar, but her range of skills was not. Emerson and Einfeld (2011) promoted the socially constructed nature of challenging behaviour, as it is culturally determined, occurs in

interactions with others, and constitutes a challenge to services: it is not a trait inherent to the person and/or their intellectual disability. However, after the second chapter of their book, 'The social context of challenging behaviour', it was treated as if it is.

The claim of social construction is repeated in The NICE Guideline, NG 11 on Challenging Behaviour and Learning Disabilities, published in May 2015, produced by the British Psychological Society and Royal College of Psychiatrists, and commissioned by the National Institute for Health and Care Excellence. It reinforces the notion of 'behaviour that challenges' thus: "The intention of the term 'challenging behaviour' was to prevent the phrase being used as a diagnosis and to stop people feeling that they needed to 'fix' the person, so that they would instead concentrate on 'fixing' the environment. However, since the introduction of the term many professionals and carers have felt that the reason for the change in terminology has been lost sight of. The frequent use of personal pronouns and verbs (such as 'his challenging behaviour' or 'she has challenging behaviour'), imply that the problem is within the person. It is important to recognise that 'challenging behaviour' is rather the result of an interaction between the person and their environment, and as such is largely socially constructed. The term 'behaviour that challenges' is preferred as an alternative, and this phrase will be used in this guideline." (p. 21)

A few pages earlier, the stated aims of the guideline were "to:

- improve access and engagement with treatment and services for people with a learning disability and behaviour that challenges
- improve the methods of assessment and identification of those at risk of developing challenging behaviour

- evaluate the role of specific psychological, psychosocial, environmental and pharmacological interventions
- integrate the above to provide best-practice advice on the care of individuals
- promote the implementation of best clinical practice through the development of recommendations tailored to the requirements of the NHS in England.” (p.17)

These are goals for the management and support of individuals, not for the management and support of cultures, social groups, services, or environments, otherwise they might read:

- improve services and treatments to support people with intellectual disabilities so they have no, or no further, need to challenge
- improve methods of assessment and identification of services that have a history of generating or maintaining behaviour that challenges,
- evaluate the rôle of organisational, managerial and commissioning strategies, alongside work-force training, knowledge base and practices, that produce services which generate or maintain behaviour that challenges
- integrate the above to provide best-practice advice on the care of individuals, to provide those individuals and families with guidance on standards expected in services, against which they can make judgements of any services offered.

By being oriented to behaviour, the person with an intellectual disability with behaviour that challenges remains ‘the problem’ that needs to be ‘fixed’: he or she is the person that ‘behaves’. The proposed, more accurate alternative is a different ontological concept that it is the individual and their environment that ‘behaves’, in systemic terms is ‘co-created’.

However, it is unsurprising that the medical model of protest and treatment of protest (Smull, 2000) is being promoted, as it is part of the development of recommendations tailored to the requirements of the NHS in England.

More troublingly, the guideline is “relevant to the work, but will not cover the practice, of those in:

- occupational health services
- social services
- the independent sector.” (p. 17).

That is, had it been in place at the time, it could not have been held up as a required practice standard to Winterbourne View Hospital, and currently does not apply to the vast majority of the environments in which people with intellectual disabilities (with or without behaviour that challenges) receive services. This begs the question of how it will apply to CLDT health care professionals working with people placed in those environments, working through and with the staff employed there.

This is applied psychology in its most institutional form, giving an ideological nod to the social nature of behaviour that challenges, but continuing to act as if the problem is the person's, to which services need to respond in the right way according to the formulations of a behavioural approach.

Applied psychology in 'empowering' form

The NICE guidelines suggest “that behaviour that challenges often indicates an unmet need” (e.g. p.111), which is individualising, and points to one of the suggested alternatives in PBS to reducing behaviour that challenges: being person-centred, and meeting an individual’s needs. (See discussion in Chapter III on person-centred planning).

Finlay and Antaki carried out a series of studies in the early 2000’s, brought together and commented on in their paper with their principal collaborator (Finlay et al, 2008), on giving people with intellectual disabilities ‘choice and control’. Their ethnographic studies showed with great clarity how difficult it was for care-workers to understand what giving people with intellectual disabilities ‘choice and control’ entailed, and how challenging it was to put into practice. “While some...obstacles are the result of informal routines and cultures of working at particular sites...others are due to regulatory frameworks, local organisational policy, resources and the existing structure of services...In both cases staff are held accountable: in the first case to fellow workers, in the second to management” (Finlay et al, 2008, p. 351).

They concluded “Promoting empowerment is about changing what it means to be a good worker, changing what it means to have a well-run day service or home and having the skills and strategies available to workers in order to realistically offer choice in situations where understanding and communication are at issue.

We should not underestimate the challenge. Disempowering discourses of care have been with us for a long time and are bound up with layer upon layer of practice, policy, patterns

of relationships and ways of speaking. *Disempowerment is woven into the fabric of social care* [my emphasis: KT]...It is not enough to say services should be based around what service users want. *Staff know there is more at stake and that they are answerable to other agendas which often conflict with the choice agenda* [my emphasis: KT]" (ibid. p. 358). Finlay and Antaki are experienced social psychologists, following discursive approaches rather than experimental psychological templates. Although recognising that staff are having to choose between policy directives and what they know they will be measured against (cf. also Mansell and Elliot, 2001), disempowerment is also woven into their account unless they consider how those "layer upon layer of practice, policy, patterns of relationships and ways of speaking" came about, and continue to be coordinated.

Some implications of these discoveries

Using Institutional Ethnography led to discovering a ruling professional discourse within applied psychology in Staff Training and Challenging Behaviour, namely the dominant perspective of experimental psychology that limited explorations outside of the *impasse*. The ethnography led to seeing challenging behaviour as a product of a care system rich in recent policy development that diverted attention from the narrowness of its overall coordinating and ruling focus, which produces 'support' that provokes protest behaviours. The rôle of clinical psychology was principally in maintaining placements in danger of breakdown, either by emotionally 'fixing' the individual or inducing change in care-practices via the use of 'trump card' discourses. The trump value was established through its professional discourses, in particular, its appeal to a strong evidence base of culturally counter-intuitive practices.

When such practices failed, as in the transfer of staff training in challenging behaviour, the blame appeared placed on the group of relatively powerless individuals, care-workers.

These people may have had faults, with a number of bad or abusive practices: whilst non-supportive managers were mentioned in the Staff Training and Challenging Behaviour literature, this area was not systematically explored. An Institutional Ethnography in the literature of institutional abuse indicated that bad practice was accomplished through the acts and activities of many levels of management, up to ministers, as well as on the front-line, despite ideological moves to favour 'factors' arising – apparently beyond anyone's control - and coinciding to produce 'corruption'.

In this Chapter, it has been seen how applied psychology and psychiatry have continued the discourse of the individual pathological nature of behaviour that challenges. The strongest implication is that this is a massive injustice against people with intellectual disabilities with relatively modest aspirations: support from people caring for them; to not be forced into behaving in ways they find difficult for individual reasons; to support them towards finding and moving towards their individual goals. Countering these professional positions would take another conceptual shift for applied psychology: realising how psychological interventions have become a technical issue, a 'fix' for 'behaviour', rather than a deeply listening understanding of a person's point of view in order to work with them to meet those modest aspirations.

Campbell (2010) appeared to make a positive contribution (see Chapter V, p.146) to the staff training literature by pointing out that expecting care-workers to 'treat' challenging behaviour was inappropriate; it would be better to train them in managing behaviour that

challenges, or how to cope with it. He suggested recognising “that for the majority of challenging behaviours, the behaviours of other people are the main antecedents and consequences, is uncomfortable for many staff. It is an acknowledgement that their own behaviour is a crucial determinant in the overall success of services in reducing and preventing challenging behaviour.” (Campbell, 2010, p. 189). Secondly, he suggested that the reason “staff who are professionally qualified have a greater understanding of the evidence-based recommendations...and consequently may be more likely to identify and recommend them as effective strategies may be that qualified staff think and question themselves more before they act and are also more aware of the consequences of their actions.” (ibid, p. 190). It appears applied psychologists have similar discomfort to staff in acknowledging that whilst their own behaviour might contribute to reducing some behaviours, it does little to prevent challenging behaviour. It appears that unlike other professionals Campbell refers to, applied psychologists are not thinking and questioning themselves as much as they could.

One of the personal shock points was how my practice as reflected in the vignettes was so textually determined, and so ideologically channelled, that I did not have the information necessary to answer my own research questions or problematic. Even the challenges made to service managers and commissioning colleagues took place within a limited perspective of alternatives. Historically, I have been a hero-innovator, setting up new services, either with collaborative support or rushing in to vacuums left by management (cf Appendix 4a, Professional History). Cumulative changes in commissioning and management of statutory and private services have removed the opportunities for innovation of either sort.

A similar process in university management and funding has led to similarly reduced opportunities for innovative research in intellectual disabilities (Northway, 2015). My experiences with health and social care research ethics committees suggests that direct observations by practitioners will be increasingly difficult to make: ethnographic studies or participative action research by external researchers will still be possible, without the detail of participant observation, but unlikely to be funded. Pending successful negotiations with research ethics committees that gathering work-knowledges is not about individuals - care-workers or cared-for - but about practices, the world of everyday care and everyday being-cared-for may only be accessible by practitioners through analyses arising from autobiographical narratives – as this has been.

This might be problematic within the neo-behavioural, experimental psychology template for psychological research demonstrated above. Within the template, it has become conventional to discuss limitations of one's study before someone else does, and to guide the anticipated discussion in certain directions. For an Institutional Ethnography, experience is the foundation of all else, and however 'atypical' or 'biased' it may be, the analysis is to explicate the work that is being done, the ideologies in play, and to discover the relations of ruling – crystallised in texts and discourses – that shape them.

The main limitation in this study is the quality of the Institutional Ethnography, which has been gleaned from texts, and not tested and refined in one of Dorothy Smith's and colleagues' workshops in Canada. In comparison with Campbell and Gregor's (2002) examples of completed Institutional Ethnographies (pp. 103ff), this is an exploratory exercise in the method of inquiry in this particular field, that has begun to explicate some

of the issues within a problematic. A completed ethnography should enable the author and particularly non-expert others to bring about change.

Before then, my recommendation would be to revisit Wilson's (2014) article on restructuring how his service functioned, to prioritise people's needs rather than following the usual practices of meeting the local authority's needs. Its apparent success required negotiating change with both commissioners and regulators, who were already active collaborators; changing the structure of the service substantially; and building a 'transcendent purpose', an ethos within its practices. This is not psychology: knowing the limits of psychology has been one of the necessary changes proposed in developing community psychological approaches (Kagan et al., 2006: p.174), which follow many of the same perspectives and processes as the Vanguard method Wilson used. Both approaches should benefit from Institutional Ethnography's mapping process to better inform them what the ruling relations are, and the potential for changing them within current political, economic and social contexts.

Appendices

Appendix 1 – Details of literature searches carried out in March 2009, regarding care-staff training in challenging behaviour, in services for people with intellectual disabilities

Appendix 2 – Screen shots from three Clinical Psychology Training Course web sites

Appendix 3 – Extracts from the Vignettes

Appendix 4 - A reflective account of a work-based research project

Appendix 1 – Details of literature searches carried out in March 2009, regarding care-staff training in challenging behaviour, in services for people with intellectual disabilities

Search Terms

- 1 Developmental disability OR intellectual disability OR learning disability OR mental handicap OR mental retardation (OR related terms in database thesaurus functions)
- 2 Care-staff OR care-workers OR direct care staff OR care personnel OR staff (OR related terms in database thesaurus functions)
- 3 Challenging behaviour OR aggression OR self-injury OR violent behaviour (OR related terms in database thesaurus functions)
- 4 Education OR training OR development
- 5 Communication
- 6 Emotions

Searches

- 1 Search terms 1 AND 2 AND 3 AND 4
- 2 Search terms 1 AND 2 AND 5
- 3 Search terms 1 AND 6

Searches 2 and 3 were carried out for other purposes, but included articles and chapters relating to care-staff interactions involving challenging behaviour and training or training needs not arising in Search 1.

Databases searched (alphabetical order)

- 1 CINAHL
- 2 Medline
- 3 Proquest
- 4 PsychInfo 1980-present
- 5 Social Sciences

Search results

A literature search on staff training in challenging behaviour using the above data-bases and search terms was carried out in March 2009, and produced a total of 140 articles. Duplicates were identified and removed, and the remainder sorted by their abstracts to a list of 63 articles directly or indirectly referring to staff training in challenging behaviour. This was reduced to 19 articles on staff training programmes or activities in the context of services to people said to have challenging behaviour. However, amongst these 19, it was clear that, for example, only four of the eight articles in the Special Edition of the Journal of Applied Research in Intellectual Disabilities (Volume 20, issue 1) devoted to staff training in challenging behaviour had been identified by the searches. It was necessary therefore to add these additional four articles, as well as relevant articles arising in their reference lists, and those of the other articles, not already retrieved. This increased the staff training and challenging behaviour list to 30. In the table of articles relating to staff training and challenging behaviour overleaf, the articles identified by the searches, those identified from references in those articles, and the Special Edition articles are differentiated.

From the remaining 44 articles out of the 63, a number of recurring themes were identified. Staff attributions, beliefs and feelings about challenging behaviour were grouped into a list of 29 articles. Some of the staff training articles included measures of staff attributions, but articles designated to the staff attributions group did not involve staff training: rather, they typically discuss their results as having “implications for staff training”. A second group of five articles described, developed and evaluated “Active Support” models of staff interactions with people with intellectual disabilities, which typically included staff training, and were measured against reductions in challenging behaviours, those these were not focussed on directly. Active support emphasises engagement of staff and people with intellectual disabilities, the latter’s involvement in everyday activities and choices, and extended opportunities. A third group of ten articles were regarding stress, emotional responses and coping mechanisms in direct care staff working with people with intellectual disabilities whose behaviour is said to challenge. These articles also included “implications for staff training”. These articles are only a part of the literature on attributions, Active Support and staff stress, respectively, but are cognate areas of research and theoretical approach, explored by the same researcher/practitioners as staff training and challenging behaviour (c.f. Hatton, Rose and Rose, 2004).

Table of relevant studies on staff training in challenging behaviour

No.	Details
1	†Allen, D. (1999) Mediator analysis: An overview of recent research on carers supporting people with intellectual disability and challenging behaviour. <i>Journal of Intellectual Disability Research</i> , 43(4) 325-339.
2	† Allen, D., McDonald, L., Dunn, C. & Doyle, T. (1997) Changing care staff approaches to the prevention and management of aggressive behaviour in a residential treatment unit for persons with mental retardation and challenging behaviour. <i>Research in Developmental Disabilities</i> . 18 (2), 101-112.
3	‡Allen D. & Tynan H. (2000) Responding to aggressive behavior: impact of training on staff members' knowledge and confidence. <i>Mental Retardation</i> , 38 , 97–104.
4	†Anderson, J. L., Albin, R.W., Mesaros, R.A., Dunlap, G. & Morelli-Robbins, M. (1993) Issues in providing training to achieve comprehensive behavioral support. In Reichle, J. & Wacker, D. P. (Eds). <i>Communicative alternatives to challenging behavior: Integrating functional assessment and intervention strategies</i> . (pp. 363-396). Baltimore, MD, US: Paul H Brookes Publishing.
5	‡Anderson, S.R. (1987) The management of staff behaviour in residential treatment facilities: a review of training techniques. In: Hogg, J. & Mittler, P. (eds) <i>Staff training in mental handicap</i> . London: Croom Helm
6	†Baker, D. J. (1998) Outcomes of behavior support training to an agency providing residential and vocational support to persons with developmental disabilities. <i>Journal of the Association for Persons with Severe Handicaps</i> , 23 (2) 144-148.
7	†Baker, D.J., Craven, K., Albin, R.W. & Wieseler, N.(2002) Training and technical assistance strategies to prevent and respond to behavior-related crisis. In Hanson, R.H., Wieseler, N.A. &Lakin, K.C. (Eds). <i>Crisis: Prevention and response in the community</i> . (pp. 165-197) Washington, DC, US: American Association on Mental Retardation.
8	‡Berryman, J., Evans, I.M. & Kalbag, A. (1994) The effects of training in non-aversive behavior management on the attitudes and understanding of direct care staff. <i>Journal of Behavior Therapy and Experimental Psychiatry</i> , 25 , 241-250
9	†Campbell, M. (2007) Staff training and challenging behaviour: Who needs it? <i>Journal of Intellectual Disabilities</i> , 11 (2), 143-156.
10	†Campbell, M. & Hogg, J. (2008) Impact of training on cognitive representation of challenging behaviour in staff working with adults with intellectual disabilities. <i>Journal of Applied Research in Intellectual Disabilities</i> , 21 (6) 561-574.
11	‡Dench C. (2005) A model for training staff in positive behaviour support. <i>Tizard Learning Disability Review</i> , 10 , 24–30
12	*Dowey, A., Toogood, S., Hastings, R.P., and Nash, S. (2007) Can brief workshop interventions change care staff understanding of challenging behaviours? <i>Journal of</i>

No.	Details
	Applied Research in Intellectual Disabilities, 20 , 1, 52-57
13	‡Gentry M., Icceton J. & Milne D. (2001) Managing challenging behaviour in the community: method and results of interactive staff training. <i>Health and Social Care in the Community</i> , 9 , 143–150.
14	†*Grey, I. M., Hastings, R. P. & McClean, B (2007). Staff Training and Challenging Behaviour. <i>Journal of Applied Research in Intellectual Disabilities</i> , 20 (1), 1-5.
15	†*Grey, I.M. & McClean, B. (2007) Service User Outcomes of Staff Training in Positive Behaviour Support Using Person-Focused Training: A Control Group Study. <i>Journal of Applied Research in Intellectual Disabilities</i> , 20 (1)
16	†Grey, I.M., McClean, B. & Barnes-Holmes, D. (2002) Staff attributions about the causes of challenging behaviours: Effects of longitudinal training in multi-element behaviour support. <i>Journal of Learning Disabilities</i> , 6 (3) 297-312
17	†Hastings, R. P. (1996) Staff training and management in services for people with learning disabilities. <i>British Journal of Clinical Psychology</i> , 35 (3), 480-482.
18	†*Kalsy, S., Heath, R., Adams, D. & Oliver, C. (2007) Effects of Training on Controllability Attributions of Behavioural Excesses and Deficits Shown by Adults with Down Syndrome and Dementia. <i>Journal of Applied Research in Intellectual Disabilities</i> , 20 (1), 64-68.
19	*Lowe, K., Jones, E., Allen, D., Davies, D., James, W., Doyle, T., Andrew, J., Kaye, N., Jones, S., Brophy, S. And Moore, K. (2007) Staff training in Positive Behaviour Support: impact on attitudes and knowledge. <i>Journal of Applied Research in Intellectual Disabilities</i> , 20 , 1, pp 30-40
20	†McDonnell, A. (1997) Training care staff to manage challenging behaviour: An evaluation of a three day training course. <i>British Journal of Developmental Disabilities</i> , 43 (85, Pt 2), 156-162.
21	*McGill, P., Bradshaw, J. and Hughes, A. (2007) Impact of extended education/training in Positive Behaviour Support on staff knowledge, causal attributions and emotional responses. <i>Journal of Applied Research in Intellectual Disabilities</i> , 20 (1), 41-51
22	‡McKenzie K., Paxton D., Patrick S., Matheson E. & Murray G. (2000) An evaluation of the impact of a one-day challenging behaviour course on the knowledge of health and social care staff working in learning disability services. <i>Journal of Intellectual Disabilities</i> , 4 , 153–165.
23	‡McKenzie, K., Sharp, K., Paxton, D. & Murray, G.C. (2002) The impact of training and staff attributions on staff practice in learning disability services: a pilot study. <i>Journal of Learning Disabilities</i> , 6 , 239-251
24	†McKeown, M., Anderson, J., Bennett, A. & Clayton, P. (2003) Gender politics and secure services for women: Reflections on a study of staff understandings of challenging behaviour. <i>Journal of Psychiatric and Mental Health Nursing</i> , 10 (5), 585-591.

No.	Details
25	† Mozingo, D.B., Smith, T., Riordan, M.R., Reiss, M.L. & Bailey, J. S. (2006) Enhancing frequency recording by developmental disabilities treatment staff. <i>Journal of Applied Behavior Analysis</i> , 39 (2), 253-256.
26	† Newman, D.W., Summerhill, L., Mosley, E. & Tooth, C. (2003) Working with an adult male with Down's syndrome, autism and challenging behaviour: Evaluation of a programme of staff support and organizational change. <i>British Journal of Learning Disabilities</i> , 31 (2), 85-90.
27	† Shore, B. A., Iwata, B.A., Vollmer, T.R., Lerman, D.C. & Zarcone, J.R (1995) Pyramidal staff training in the extension of treatment for severe behavior disorders. <i>Journal of Applied Behavior Analysis</i> , 28 (3), 323-332.
28	† Smalley, K.A., Certo, N. J. & Goetz, L. (1997) Effect of a staff training package on increasing community integration for people with severe disabilities. <i>Education & Training in Mental Retardation & Developmental Disabilities</i> , 32 (1), 42-48.
29	†* Smidt, A., Balandin, S., Reed, V. & Sigafoos, J. (2007) A Communication Training Programme for Residential Staff Working with Adults with Challenging Behaviour: Pilot Data on Intervention Effects. <i>Journal of Applied Research in Intellectual Disabilities</i> , 20 (1), 16-29.
30	*Tierney, E., Quinlan, D. and Hastings, R.P. (2007) Impact of a three-day training course on challenging behavior on staff cognitive and emotional responses. <i>Journal of Applied Research in Intellectual Disabilities</i> , 20 (1), 58-63

<p>Key † From database search, 27/03/09 ‡ from article reference lists * article in <i>Journal of Applied Research in Intellectual Disabilities</i> Special Edition, 20(1)</p>

Appendix 2 – Screen shots from three Clinical Psychology Training Course web sites

Programme 1

<http://www.bath.ac.uk/psychology/clinical/programme/>

Accessed 30-05-2015

About the Doctorate in Clinical Psychology

- [Teaching](#)
- [Research](#)
- [Placements](#)
- [Why study with us](#)

Programme ethos

The Bath programme aims to recruit trainees who are committed both to the core principles of Clinical Psychology and the principle of practising within an NHS setting. Trainees will be academically able and interpersonally sensitive individuals capable of flexibility in the application of their thinking, understanding and experience to the practice of Clinical Psychology.

The Bath programme is committed to an evidence based and empirically grounded ethos, whilst at the same time encouraging qualities such as reflection, creativity, innovation, collaboration, and leadership. We also recognise that Clinical Psychology relates in a reciprocal way to wider organisational, social and cultural contexts. Our graduates will develop the ability to form meaningful and productive connections with a wide range of vulnerable people and to always act in their best interests. The willingness and capacity to develop and manage these connections in clinical, research and other roles is crucially dependent, amongst other things, on important personal qualities, values and beliefs that we expect trainees to bring to training and develop further.

The aim of the course is to encourage the development of highly capable 'scientist practitioners'. It emphasises a clear understanding of how psychological theory can be applied to practice (and vice versa) through paying close attention to the processes, strategies and techniques in the work of Clinical Psychology. An explicit feature of this approach is the recognition that excellent practitioners will be able to skilfully integrate the scientific basis of Clinical Psychology ('clinical science') with reflective practice and personally / socially / culturally adapted approaches ('clinical art'). This type of development requires a thoughtful and collaborative relationship between trainees, programme staff and placement supervisors.

Learning, teaching and training is largely 'research led'. In clinical practice this will mean a primary focus on approaches that draw on cognitive, systemic, behavioural, mentalisation, interpersonal and other models where there is demonstrable or emerging evidence of their clinical effectiveness. Trainees will not only become skilled in the use of evidence-based approaches but will also contribute to the evidence base.

The training provided by the course draws upon a wide range of theory, not only in relation to psychological difficulties and wellbeing, but also, for example, in areas such as social and developmental psychology, to encourage a consideration of both context and lifespan development. Thus the emphasis in assessment and therapy will be person-centred in the broad sense, with an active recognition of these wider factors in the development, maintenance, amelioration and resolution of psychological and psychosocial difficulties.

In addition to, and within, the core areas of training (adults of working age; children and adolescents; older adults; learning disabilities) and research on the course, trainees will be offered the opportunity to develop a range of special interests. The course places a particular focus on Clinical Health Psychology, in which the majority of trainees complete a specialist placement. Trainees will also gain BABCP accreditation on completion of the course and AFT accreditation at Foundation level is pending.

Finally, the course and this ethos are not fixed, and we invite those who participate (including programme staff, trainees, supervisors, teachers and people with personal experience of psychological interventions) to reflect on, collaborate in, and contribute to its ongoing evolution - with the aim of maintaining it at the forefront of training and development opportunities within our field.

Programme 2

<http://www.birmingham.ac.uk/postgraduate/courses/combined/psychology/clinical-psych-doctorate.aspx#CourseDetailsTab>

Accessed 30-05-2-15

This programme comprises a combination of academic teaching, research and research training, and professional training during clinical placements. You complete five placements in a range of health settings in the West Midlands. We encourage an attitude of critical open-mindedness to a range of theories and models, and emphasise the importance of evidence-based practice and reflection on clinical work.

The programme is examined by continuous assessment, with students completing a series of assignments and projects over the three years.

Research, which is conducted in the second and third years of the programme, is written up for examination in the form of two papers for publication. The programme is organised on a collaborative basis with local NHS psychologists, and many local clinicians are involved in teaching.

Birmingham is one of the major centres for clinical psychology training in the UK and most graduates take up posts in NHS departments: candidates offered a place on the programme are funded by salaries provided by the NHS.

This programme is subject to a Code of Professional Conduct and Fitness to Practise regulations, to which trainees are required to sign up.

Programme 3 -

http://www.southampton.ac.uk/psychology/postgraduate/research_degrees/courses/doctorate_in_clinical_psychology_pgr.page#overview

Accessed 30-05-2015

The overall aim of this doctorate in clinical psychology programme is to ensure that high quality clinical psychology services are made available to the public. The DClinPsych advocates the use of good case formulation and effective clinical methods with no adherence to a particular theoretical orientation. We value the concept of evidence-based practice; a large part of the teaching is cognitive-behavioural in orientation. We also value the use of evidence-generating practice. Trainees will recognise the value of the research and clinical literatures in determining the optimal treatment for the individual client, but will also acknowledge the use of psychological theory in generating new ideas when the research and clinical literatures are insufficient.

The DClinPsych Doctorate in Clinical Psychology programme is funded by the NHS, and students on this programme are also salaried employees of the Taunton and Somerset NHS Trust.

To Apply

Applications for this DClinPsych Clinical Psychology doctorate are made 'online' through The Clearing House for Postgraduate Courses in Clinical Psychology, 15 Hyde Terrace, Leeds, LS2 9LT, www.leeds.ac.uk/chpccp

Closing date: Early December

Programme Structure

Given the philosophy of evidence-based and evidence-generating practice, this clinical psychology doctorate programme structure and content are designed with the aims of developing explicit theory-practice links. It is split between academic study, Clinical Experience, research and private study.

Further details, including support and welfare, and evaluation, are given in the DClinPsych programme [eHandbook](#).

Some placements on the DClinPsych Clinical Psychology doctorate call for a large amount of travelling, and it is a great advantage if you possess your own means of transport. Placements are visited and monitored in line with accreditation guidelines. On average, placements are of three and a half days per week (outside of the teaching blocks).

Key facts

- The programme at Southampton equips you with the knowledge and skills to work with clients across the lifespan, ranging from children to older adults, in a variety of settings and contexts. Your research teaching will enable you to be a reflective-scientist practitioner, capable of adding to the development of Clinical Psychology knowledge and practice.

Appendix 3 – Extracts from the Vignettes

Extracts from the Vignettes are presented in the same order as followed in providing analyses in Chapter VI.

The Vignettes vary in length:	Allocation Meeting	7600 words
	Padraig	6500 words
	Danielle	10500 words
	Jess	8000 words

The number of quoted extracts from each Vignette in the Institutional Ethnography analysis in Chapter VII is:

Allocation Meeting	28 references
Padraig	10 references
Danielle	12 references
Jess	7 references

There is thus little correlation between Vignette length and number of quoted extracts, due to the change in analytical strategy described in the second half of Chapter VI. The pages extracted from each Vignette contain a proportion of the relevant references.

Each Vignette has had line numbers attached, and references to quotes in the analysis are made in the form (ll.[lines] abc-xyz/[Vignette name]), for example, (ll. 382-385/Allocation).

Individual pages from each Vignette have been scanned for insertion into this thesis in order to preserve the original line numbering.

Extracts from Allocation Meeting Vignette	pp ii-viii
Extracts from Padraig Vignette	pp ix-xiii
Extracts from Danielle Vignette	pp xiv-xix
Extracts from Jess Vignette	pp xx-xxiv

PDF copies of the complete vignettes can be requested by email to ktresearcheractivist@outlook.com

Extracts from Allocation Meeting Vignette

92 with frosted wire-reinforced glass to let light into the corridor; small windows
93 similarly glazed at the tops of the wall have the same function.
94
95 Today, the meeting room temperature is reasonable, and the light, from its northerly
96 aspect, even and fairly bright. The door arrives in the corner of the room. Opposite,
97 along the shorter wall, in the corner by the window, is a small electric boiler, a filter-
98 coffee machine, a tray of cups; tea bags, instant decaffeinated coffee and milk (bring
99 your own sugar or sweeteners); and a small food box for compulsory donations. On
100 the 'board-room style' table around which team members sit on stackable plastic
101 chairs, are a packet of milk-chocolate biscuits, and a packet of plain Hob-nobs. The
102 grapes introduced as a 'healthy alternative' at the New Year haven't been in evidence
103 for a while.
104
105 The board-room table around which everyone sits is made up of six large multi-use
106 tables. It's hard to see why such a big table space is needed: it is not loaded up with
107 meeting papers; people generally don't write anything because Harriet takes notes;
108 Briony the manager uses a bit more space with a lap-top and two piles of A4 sheets.
109 Many of the team members sit back a bit from the table, to enable leg-crossing; most
110 of the rest lean forward with their elbows on it; Helen habitually leans her folded arms
111 on it, and they slowly progress towards the centre as she sinks into apparent despond,
112 and retreat when she sits up to make a point or join in a conversation.
113
114 As the team integration has progressed, team members have distributed themselves
115 fairly evenly around the table instead of sitting in professional groups, though Kirsty
116 always tries to sit next to Briony. Depending on the collective Team mood, there can
117 be occasional concerted efforts that proceed without any comment to fill the seats
118 next to Briony before Kirsty can get there.
119
120 Along one narrow side of the large table is the Community Team manager, Briony J.
121 She has been delegated responsibility for meeting the needs of people with intellectual
122 disabilities and their carers throughout the market towns and rural districts (total
123 population 157,000) of this area. The North West Community Team and Manager are
124 also based in this building, covering the county capital city (pop 99,000) and a nearby
125 large market town (pop. 35,000). The building is on the edge of the county capital,

126 near to the market town. These two Community Teams come under the West
127 Locality Manager, who has overall responsibility to meet people with intellectual
128 disabilities' needs over these two areas. There is a second, East locality, made up of
129 larger towns and their relatively close rural hinterlands, together having a population
130 of 276,000.

131

132 The East locality has a slightly higher proportion of people with intellectual
133 disabilities. Historically, the county mental handicap hospital was based there, and as
134 the institution was wound down, people tended to be re-settled locally. This led to the
135 sense that services were more progressive in the area, and families with members with
136 learning disabilities moved to there to take advantage of them. However, in the final
137 throws of its closure twenty years later, the institution's remaining population – those
138 requiring very high levels of 'support' - tended to head to our locality. A small private
139 company, Threshold Care, had set itself up to meet the needs of those people who
140 challenged services through their aggression, directed against both themselves and
141 others. Because of the company's initial successes, they had been asked by previous
142 service commissioners to expand, becoming a 'preferred provider', and took a number
143 of the most difficult people from the institution.

144

145 Briony has an open, operating lap-top next to her on the table top, and several piles of
146 papers. She may use the lap-top to track down existing Local Authority information
147 on the person referred. If he or she is someone known to the people in the room, there
148 will be discussion of the referral. If the person is not known to anyone present – and
149 some of the Team members have 10 or 20 years experience in the area – the Local
150 Authority data-base, ©Panopticon-i¹, is checked.

151

152 The data-base records personal and family details, involvement from services,
153 contacts, documents, statutory assessments and the all-important expert-system led
154 'care-process'. This co-ordinating function has two main uses for our service. It
155 records statutory assessments of need, particularly if someone is "FACS eligible", i.e.
156 meets the Local Authority criteria for providing services under Fair Access to Care
157 Services processes. It includes the "Calculator" that rates and sums the level of

¹ This is a fictitious name not in use for computer software (Intellectual Property Office search, 12-11-12, 20:40 at <http://www.ipo.gov.uk>). I claim copyright to the name.

158 support and hence the amount of funding a person can expect; the decision about
159 funding; the contracting and setting up of a service; billing; and reviewing. Unless
160 each step of this flow is properly filled in, no funding will be available; unless all the
161 information needed is provided and signed off, progress cannot be made. As part of
162 this function, there are various side-branches, the most important of which for me is
163 the Care Programme Approach (CPA) assessment, care-plan, monitoring and review
164 process for those service-users who present risks to themselves or to others, or who
165 are at high risk of being victimised. There is a similarly structured workflow for
166 addressing reports of alleged Adult Protection violations: a process involving the
167 recording, reporting, investigating (according to levels of seriousness), of coming to
168 conclusions and action plans.

169

170 If the person is not recorded on ©Panopticon-i, suspicion is aroused as to whether
171 “they are one of ours”, i.e. a person with an intellectual disability who can qualify to
172 receive support from one or both branches of the integrated health and social care
173 services to people with intellectual disabilities. Since intellectual disability is
174 considered a life-long condition, genetic or congenital in origin, a person should be
175 “known” to Local Authority services. For young adults, they should have been
176 identified in Education, and therefore to have been through the transition process:
177 administratively moving from Education to Adult Services through a set of
178 assessments; moved from the Child to Adult databases on the ©Panopticon-i data-
179 base; and from wrap-around services to support and desert, according to some
180 families. For other adults, the expectation is that they will have been assessed and/or
181 in receipt of some service previously. Not being on the database could be for a
182 number of reasons. The person’s family has moved into the county, or they have been
183 placed in a service in the county from another local authority. They could be from
184 one of the small number of county families who have never accessed services –
185 possibly not even Education – and who now have had some crisis. Or they don’t have
186 a learning disability.

187

188 Learning disability is defined here as having an IQ below 70, defined by a range of
189 sub-test scores on psychometric cognitive assessments such as the Wechsler Adult
190 Intellectual Scales– now in Version IV, standardised for UK populations – as well as
191 similarly ranked social and adaptive (self-care) skills, defined by scores on the

294 recommend whether and by whom the referral might most appropriately be “picked
295 up by”. This is the usual course when referrals have been made simultaneously to
296 two or three professions, and a judgement of priority of involvement needs to be
297 made; when the referral is not clear about what is being asked for; or if there is
298 overlap between professions in what they deal with. Screening will often be the
299 initial response in the case of “challenging behaviour”, where the apparent cause or
300 degree of challenge someone is posing to a service is not clear. The behaviour could
301 be health related, perhaps in response to pain, and therefore might require support and
302 advice from a Community Learning Disability Nurse. A nurse will also be able to
303 give ‘basic’ behavioural advice for managing behaviour. If the challenging behaviour
304 appears to be more obviously aggressive to self, others or property and appears based
305 on the lack of ability of carers or care-workers to meet the challenge, a Challenging
306 Behaviour Nurse might “screen”. They will behaviourally assess what is
307 ‘maintaining’ the behaviour, and if necessary to train and advise the carers or care-
308 workers to manage the behaviour more effectively. If there is suspicion that a referral
309 may be motivated by a request for additional funding to “support” the person
310 involved, either a Community or a Challenging Behaviour Nurse will screen. Both
311 professions have received training in operating the ©Panopticon-I assessment, care-
312 planning and purchasing system and also have more experience and judged expertise
313 in working directly with difficult behaviour than Social Work colleagues, the
314 ©Panopticon-i specialists. Psychology is reserved for higher complexity issues:
315 emotional, mental health or relationship difficulties, which may be “presenting” as
316 difficult behaviour; or complex interventions beyond clear-cut training are required to
317 encourage change in staff or organisation practice.

318

319 Referrals for Occupational Therapy (OT), Physiotherapy or Speech and Language
320 Therapy (SaLT) members of the Team – the Allied Health Professions or AHP’s –
321 tend to be considered within the Team as more ‘straight forward’. They are usually a
322 specific request, based on a referrer’s ideas of what each profession covers: OT’s for
323 functional issues of access, mobility aids and daily-living/occupational issues arising
324 from physical difficulties; Physiotherapy to address the underlying anatomical
325 difficulties (sometimes the two professions are confused by referrers). The SaLT has
326 a high level of “Eating and drinking assessments” for dysphagia, swallowing
327 difficulties, which can be fatal in people with severe learning disabilities and other

396

397 Briony cuts across the developing conversation: “What about the new behaviours?”
398 Natalie had also visited Pádraig at home on three occasions because she was not sure
399 that the new behaviours were ‘behavioural’, i.e. having a ‘function’ of either avoiding
400 an activity or event, or producing a positive outcome for him. She thought they were
401 ‘really’ emotional, as they consisted of going to his room, and crying – “with tears,
402 and his breathing affected, like sobbing”. He wouldn’t respond to comforting,
403 cajoling, or straight telling to ‘pack it in’. However, there seemed nothing at home or
404 in college that could be seen to have brought this on, and no obvious triggers. The
405 new behaviours were splitting the staff team, though: some thought they meant
406 Pádraig was really upset, and sympathetic support needed to be given; others thought
407 it was all “put on”, and part of his increased “naughtiness”. Sighs of exasperation go
408 around the room at this last interpretation: the disablist equating of intellectual
409 disability with being like a child, a cultural remnant that hasn’t disappeared after 30
410 years of professional effort. Natalie had tried to talk to Pádraig about his feelings, and
411 what might be upsetting him, but the effort had foundered upon his limited
412 communication. She felt, therefore, that it might be better for Psychology to get
413 involved, sooner rather than later.

414

415 “Fine, we’ll pick it up. Will be a few weeks, maybe.....”

416

417 “I’m not sure that it can wait long, Ken; this is the referral that got lost, and they’ve
418 been waiting quite a while now....” Natalie argues. I generally trust her judgement,
419 but our case-load at the moment means a quick response could only be justified by an
420 urgent and/or serious case. “Besides, the crying and stuff *might* be linked to the
421 aggression: I just don’t know.”

422

423 Briony intervenes again: “Ken, can you pick it up quite quickly please, you or Sam.
424 If you think it’s behavioural, obviously bring it back but it sounds a bit more like
425 yours. It would be good if we got some feedback at the next meeting.” It’s unusual
426 for her to be quite so directive, so there might be another agenda. Perhaps my
427 reservations are reflected in my face. “We’ll talk outside the meeting”

428

429 Natalie slides the original Referral Form across the table to me. Although not strictly
430 necessary, because it will have been up-loaded to Panopticon-1 and would be down-
431 loadable, this has become the way referrals are concretely handed over within Team
432 meetings. Harriet notes the transfer and will change 'the spreadsheet' accordingly,
433 after the meeting.

434

435 The second referral is Danielle A, a 26 year-old woman returning to the county after
436 placement in a medium secure hospital unit in the North Midlands. She has been
437 referred by Richard E, the social worker co-ordinating her discharge under Section
438 117 of the Mental Health Act (1983). The referral is for psychological support with
439 living in the community, as Danielle has undergone programmes of behaviour
440 modification in the hospital under the watchful eye of their psychologist: her lack of
441 verbal skills prevented any individual psychotherapeutic approaches. She had been
442 sent to the hospital after extreme aggression against herself and other service users.
443 Historically, her most challenging acts have been to target less mobile service users,
444 injuring some of them quite severely. The aim is for her to be placed with a new-to-
445 this-area, specialist supported-living provider, Fairbairn Care. Fairbairn have sent
446 their care-workers to shadow Danielle in the Community Discharge Unit at the
447 hospital at zero cost to the Local Authority, as part of their training. In return, the
448 company has asked for funding for a two-person shift, 24/7, for a minimum 12-month
449 period. "How was that agreed?" Arabella asks.

450

451 Richard replies "Apparently, the commissioners want to build a relationship with
452 Fairbairn, as a possible competitor to Threshold."

453

454 "If she needs that level of support, are we sure she's ready for discharge?" Peter C.,
455 once a nurse in the county mental handicap hospital, now a Care Manager in the team.
456

457 "Her family are keen for her to be closer to home. And of course, we have to bring
458 people back from out-of-county. Rachel's involved." [Rachel – a social worker – has
459 been seconded from the team to a project aimed at bringing people back from long-
460 distance placements. Such placements are a known risk-factor for abuse. It's a
461 humanitarian gesture to families, as well as an organisational cost-effectiveness and
462 corporate risk-reduction agenda.]

Field work Vignette

Allocation Meeting

page xiv

496 I cut across: “We’ll discuss it at our business meeting, but probably Sam will pick it
497 up. Is Danielle sharing the Community Preparation Unit with anyone? Other service
498 users I mean. And will she be sharing when she goes to Fairbairn?”

499

500 “Yes there’re two other people in the Community Unit with her, a bloke who had
501 fairly aggressive behaviours himself, and an older woman who apparently had a lot of
502 self-harm behaviours. *He’s* built like the proverbial latrine, but she’s fairly frail, and
503 Danielle hasn’t gone for either of them. Nor herself.”

504

505 “Sounds too good to be true. Okay, leave that with Psychology. Obviously work
506 closely with Richard, whichever of you picks it up, and let’s hope for a smooth
507 transfer back in-county.”

508

509 The last referral for Psychology regarding challenging behaviour comes via a request
510 for a psychological assessment, which most often means a cognitive assessment. A
511 young woman, Jess, who recently left the Looked After Children after-care service
512 was “displaying challenging behaviour” in the group of flats she has lived in since
513 she was 17 with access to 24-hour support. This consisted of verbal aggression to
514 staff, physical aggression to other residents, and some self harm. She had previously
515 been suspended from the Independent Living course at the local college for setting off
516 fire-alarms, swearing at tutors, “and ‘inappropriate use of materials’ whatever that
517 means.” Briony is reading from her own notes. “Got much better once she started at
518 the training academy on-site. Bit of a star. Then it all went downhill. She’s been
519 assessed as FACS eligible, by the Transition Team” [murmurs of scepticism from
520 social workers; the Transition Team assessments can be ‘generous’ at formally
521 assessing someone as having significant support needs, and informally assessing a
522 learning disability as, for example, “she doesn’t seem to understand what we’re
523 saying to her”]. Tim [*the West Locality manager*] was given the case at the Inter-
524 service Committee [*where he was representing LD services*]. He said he didn’t think
525 it appropriate for LD: historically she’s not been in our services, her needs are
526 probably LAC related, and anyway LD took the last person [*whose funding was*
527 *contested*] from the ISC. They said prove it, so...”

528

529 I ask: “How old is she; under 23?”

Extracts from Padraig Vignette

- 66 • “It went through the college Adult Protection; that’s when Padraig got his
67 warning. He has to have two members of staff with him now, one from the
68 house as well as his college support.
- 69 • Justine [manager] reported the incident to us straight away,” – she pauses,
70 looking to Briony, who nods, “and CQC; she’s conscientious, not like some
71 registered managers.”
- 72 • “Is that Kelly M? Well, she can be bit of a madam. Not that it merits getting
73 a beating, mind, but it might not all be one-sided. She...”
- 74 • “can you pick it up quite quickly please, you or Sam. If you think it’s
75 behavioural, obviously bring it back but it sounds a bit more like yours. It
76 would be good if we got some feedback at the next meeting.”
- 77 • “We’ll talk afterwards; I’ve got some more information”.

78

79 Further information gathering

80

81 *Briony’s information*

82

83 “You’ll have heard about the BURR (*Best-Use-of-Resources Review*) Team:
84 identifying people in high cost placements whose last two annual reviews might
85 question whether they really need that level of support. Well, Bridget Hope stood up
86 at the last providers’ meeting and shouted the odds about how her homes work with
87 very difficult people, and if they aren’t so bad now, it’s because of the skill and
88 resources they put in, and cutting back will just lead to problems re-emerging. Since
89 then I’ve heard that BURR plan to go into Lothian next month to look at Padraig’s
90 package. The providers were told they’d need some strong reasons not to reduce
91 funding...”

92

93 “Do you think the referral might be to justify the rate he’s on?”

94

95 “No, I don’t; this has been going on for a while now, since before the provider’s
96 meeting anyway. Bridget might also try to put in a formal complaint about us losing
97 the referral, and exposing her staff to unnecessary increased risk.”

- 129 • Take or check if P has enough of his personal money to be able to buy
- 130 something he has expressed interest in today, e.g. buy juice drink, have a
- 131 tea/coffee, buy magazine (don't make any assumptions from recent trips)
- 132 • Judge P's mood before leaving house: have a conversation about the 2 CD's
- 133 he wants to bring; if he appears down, distracted, confused, anxious or angry,
- 134 arrange for P to stay at home
- 135 • Judge your mood before leaving the house: confidence in co-workers, the
- 136 mood of co-residents, feeling below par, feeling anxious yourself – 2 or more
- 137 'niggles' should lead to conversation with colleagues
- 138 • For the planned trip, remind yourself where there are places to sit
- 139 appropriately or where P. otherwise feels safe
- 140 • As P is getting shoes/coat/hat and gloves, discuss planned outing, asking what
- 141 might like to do whilst out, e.g. buy juice drink, have a tea/coffee, buy
- 142 magazine.
- 143 • Remind P that if he feels worried or frightened, to tell you: you'll stay with
- 144 him until he feels safer
- 145 • Remind P that there are safer places on the way

146

147 Preventative Strategies/Out of the house

148

- 149 • Stay close to P, but do not let him hold tightly on to you to prevent being
- 150 pulled to the ground or pulled into the road
- 151 • When P appears nervous - walking more slowly, shaking his head, mumbling
- 152 - place a hand on his shoulder or elbow, direct attention to [pleasant, non-
- 153 threatening] aspects of his surroundings, or other staff
- 154 • Ask group to stop at a safe distance if P feeling unsafe or anxious
- 155 • Ask P if he would like to sit down soon and talk about how to get there
- 156 • Avoid crowded paths and busy roads unless there are traffic lights to cross by.
- 157 • Warn when need to cross road
- 158 • Cross at a zebra or panda crossing, or where there is good visibility in both
- 159 directions, even if this means going out of your way slightly
- 160 • Only cross if there's plenty of time: do not cross if there is any need to hurry;

225 early to allow him to pass through un-crowded spaces, and be settled at his meal
226 before the rush to the refectory began.
227
228 At the second incident, the support worker was walking ahead of Padraig, on the way
229 to the Music Room for “one of Padraig’s favourite sessions”, a drumming group. As
230 he was usually enthusiastic in the group, the worker was going slightly ahead to
231 reserve one of the two bodhrans (drums used in traditional Irish music) Padraig
232 particularly enjoyed using. She heard some raised voices behind her, and turned to
233 see Padraig trying to elbow his way past two other students, who were protesting at
234 his pushing. “He grabbed RD by the arm and spun her around, and slapped her across
235 the face. Straight away, her nose started bleeding. She screamed and other students
236 started shouting. PP pushed POC back from RD to protect her, so he then grabbed
237 her by the hair.” In the ensuing pandemonium, one member of the college staff was
238 trying to calm RD, and control her nose-bleed, and Padraig’s support-worker and
239 another support-worker were trying to get him to let go of PP’s hair, which took 10
240 minutes of cajoling and disentangling, as the music tutor tried to get the other students
241 out of the way into the music room. Padraig was again suspended, this time for a
242 week and a half, up to the half-term break. The Adult Protection process was opened,
243 and a number of students reported that RD and PP had been teasing Padraig,
244 deliberately blocking him from getting to the music room. Despite the provocation, it
245 was felt that his response was disproportionately aggressive, and that he needed to be
246 referred to Psychology to investigate his disengagement from the course sessions and
247 for anger management.

248
249 Lothian Lodge made the referral to Psychology and faxed it to the Team: they kept
250 the record of faxing it. However, it got lost somewhere between being taken off the
251 fax-machine/printer, and the Referral folder, so was not recorded nor brought to
252 allocation. The College Adult Protection Officer made a complaint to Briony about
253 the lack of response from the Team when the third incident happened, suggesting that
254 the Team had some responsibility for this incident happening in not responding to the
255 referral. It was only at this stage that Briony was aware there had been a referral.

256
257 The third incident happened in the second week of the new half-term, reportedly
258 starting when the college support worker met Padraig at the door. The Lothian staff

359 "Blonde like Justine?" No. P finds a photo. "Sarah". Hair like Sarah's: brunette. P
360 puts the sketch on the pile of photos. Happy for Justine to leave and us to talk.
361
362 P. can name all the staff, not all clearly. Proprietor is 'Mrs.' Set up happy/sad faces
363 and 50 cm space between; call them 'like', 'don't-like'. P makes the appropriate
364 faces as I point. Justine is definitely at the happy/like end; Angie's picture about
365 quarter of the distance from like to don't-like. Anne and Beat[?] at don't-like end;
366 rest gather round the middle. I check out some of the middle group: more here or
367 more here? No, in middle: definite. Then loses interest. Looks at me, signs/draws
368 beard on his face. "You like my beard?" Shakes his head. "Shave." "You think I
369 should shave?" Nods, smiling. Do you shave? Nods, smiling, cheeky. "Grow up"
370 "You're grown up now?" P, scowls. "No." "You want to be grown up". "You,
371 shave" pointing at me, seems angry. "You'll have a beard and shave when you grow
372 up?" "Yes. Stop now". "Okay. Can we talk again another day?" Nods, smiles. We
373 tell Justine.
374 *Meeting with staff group*
375
376 Six of nine staff present, including Justine. Anne and Beatrice, Angie and two middle
377 of like/don't-like scale. Anne is the youngest, and in chat as the staff gather seems
378 quite daunted by working with people with learning disabilities, but she volunteers
379 first after introductions that she finds it hard to see P in one of his turns: 'there must
380 be something wrong and we can't think what it is'. Turn to positive behaviours.
381 Good fun in the house, helpful with cooking, washing up; tidying, cleaning bathroom,
382 polishing he says is 'for ladies' and won't do it, but will stay and chat. Will lift and
383 move furniture, baskets of laundry. 'Bit macho really'; 'Definitely old-fashioned';
384 'Specially dancing'. Good natured labels, rather than 'dissing'.
385
386 "So what about when he's out and about". Angie: "I think he's actually quite scared,
387 out there, of people. I always think he must have been bullied some time, by a gang
388 of yobs or something. He clings to you, almost trying to hide behind you". Beatrice:
389 "But not in the woods or across the fields: that's when he's happiest, I think. It's just a
390 business getting there." Beatrice has an East European accent; problem for P.?
391
392 "What do you think his idea of heaven would be?"

393 “Going for a walk with Angie”; “Doing anything with Justine”; “Or for Justine; I
394 think it makes him feel like one of us if she asks him to do something.” Anne: “I
395 think some days he’d just like to play his CD collection from one end to the other, and
396 then start all over again”. “Yeah. It’s funny his folks don’t like him to do that, being
397 Irish.” “But they still bring him the magazine: Irish Music”. “It’s the only thing he
398 accepts from them: they look so heart-broken at times...”
399
400 “And his idea of hell?”
401 Chorus: “Going shopping”. Beatrice: “Going out anywhere with other residents.”
402 Angie (quietly): “Going to college, *again*”. Justine: “Anyone looking at his CD’s”.
403 “Apart from the CDs, is that mostly when he plonks himself down, or hits out?”
404 Justine: “Not so much now. I guess we’ve sort of compromised a bit with him. He
405 has to come along, but he’s allowed to bring his Walkman CD player. Natalie’s idea.”
406 “Last week he sat down with me when we’d forgotten to charge up the batteries and it
407 went flat in the middle of Tesco’s”.
408
409 “So you’ve mostly tracked down when and maybe why he sits down, and why he hits
410 out at the public...because he really doesn’t want to be there”. Justine: “But we have
411 to take him out with us”. “Why?” “Because we can’t leave him at home on his own”
412 “What what happens if he’s left on his own?” “It’s just too risky...” “I don’t want to
413 criticise, I’m just trying to understand. Is it more risky for him to be left at home,
414 than to sit down in the road?” “But he has to go out, he has to access the community.
415 We have to show the CQC that all the people living here, access the community.”
416 “So they have to go, even when they really hate it?” “Well, not if you put it like
417 that....” “I’m quite happy to write to the CQC and tell them that in my professional
418 opinion, it’s in P.’s best interest not to have too much community access.”
419
420 “Someone said that P. will go anywhere with Angie. What is it that Angie does that’s
421 different to anyone else? No, not you Angie. Any ideas, you others?” Anne: “Well, I
422 noticed that, like Angie says, P. can stand really close to you when he’s out. And she
423 lets him. Sometimes, she even takes his hand....” Anne blushes. “Uh-oh: that sounds
424 like holding hands is a no-no.” One of the middling staff members, Joan: “Mrs Hope
425 tells us not to: it’s not age-appropriate, and draws attention to his disability.” “Hmm:
426 I wonder. More than being a frightened young man with Down Syndrome does? Or

Extracts from Danielle Vignette

34 “If she needs that level of support, are we sure she’s ready for discharge?” Peter C.’s
35 question pertinent, from both his care-manager and hospital nurse rôle.

36

37 Care-manager, anticipating costs. Two staff, 24/7, allowing for holidays and sickness,
38 works out at 7 or 8 care-workers, which is £2.5k a week already, bit more for waking-
39 night staff. Maybe lots of overheads for management and in-house specialist support.
40 £3.5-4.5k. Plus costs of Psychology support, and may be other team members if any
41 health issues.

42

43 Hospital nurse. It might be cheaper in a hospital or other collective care situation.
44 Increased levels of safety for all, from wrap-around care. What does access to the
45 community mean? Visits and shopping can be done from hospital setting, no longer
46 closed, but higher level of protection, and higher level of expertise in staff, on-hand.

47

48 Assessment by experience: immediate thoughts arising at the Allocation meeting,
49 based on previous experience with working in this particular residential setting,

50

51 The Team has no experience of working with this sort of residential setting, nor the
52 company running it. “Interesting” (to use Richard’s expression) about the over-
53 lapping care arrangement for new staff team. Good practice, but rarely done: smart
54 marketing? An apparent ‘loss-leader’: unusual, to say the least.

55

56

57 Further information gathering

58

59 *Discussion with Richard E: New placement*

60

61 “Interesting set up”. Richard was referring to the architecture: the accommodation is
62 a new-build, single-floor – “like a bungalow with three wings, around a centre shared
63 sitting room and bigger dining area, and office space though each of the wings is self-
64 contained too. There’s a big garage, which they’re already thinking of converting to
65 an over-night suite for visiting family members. Quite a big garden at the back,
66 totally enclosed, each wing has access. They’re thinking of being able to split it up if
67 they get, like, three people with autism who need their own space.”

135 "Bit of a backward step then, the new place."
136 "Maybe. We thought it might reduce the stress of the move this way, but hopefully in
137 the longer term, they'll come together more. Danielle's move is planned for 4 weeks
138 time, and the next bloke will arrive a month after that. So are both of you going to be
139 involved in this?"
140
141 "Sam will do most of the liaising: she'll go up and learn the ropes from Nick, and
142 maybe do some shifts alongside the old and new staff. Then once Danielle is back,
143 she'll do most of the troubleshooting down here. I'm going to do a bit of historical
144 research, to see how she coped with being in the community before and help keep
145 Geraldine's risk aversion under control."

146
147 *Narrative compiled from Information on ~~the~~ Panopticon-i*

148
149 Daniel attended a Special School for Children with Developmental Disabilities. She
150 went through the first phase of a systematic transition process from Education to
151 Adult services. Unusually, the transition discussion with Adult services staff led to a
152 number of review reports that normally would stay with Education being scanned and
153 stored in her Adult files.

154
155 Her class teacher's 'pen picture' described her at 15 as "a bundle of energy: although
156 more petite than her peers, she has a big presence in the classroom, interested in what
157 everyone is doing and always on the move. Her gait is steady, and her fine motor
158 skills satisfactory. She finds it hard to sit still, but will engage with tabletop work if
159 allowed to stand at the desk: she can identify a number of simple shapes by name, and
160 distinguish 8 colours, but finds a six piece jigsaw challenging. Her visual matching is
161 excellent, and in co-operation with the school Speech and Language Therapist, we
162 aim to explore various visual augmentative communication systems. She is too
163 impatient to use hand signing and quickly resorts to pointing and gesturing. In
164 outdoor sessions, her curiosity knows no bounds, and she can examine both flora and
165 fauna, intensely and for protracted periods: her expressive nature-vocabulary is larger
166 than the total of her other vocabulary. Danielle can also identify natural objects in
167 photographs and drawings but does not always recognise e.g. butterflies, in more
168 stylised cartoon forms. Danielle's self-care skills are impeccable: she takes pride in

202 old. Her mobility and lack of concentration in the class-room may be related to
203 frustration rather than attention difficulties.”

204

205 The Educational Psychologist went further. “To see Danielle at her best, she needed
206 to be outside with her TA. Her observation skills were impressive, and her drawing
207 sufficiently controlled to produce many letter precursors, in controlled sequences to
208 produce intelligible and differentiated pictures of a variety of flowers and insects,
209 almost on a par with mainstream peers. This is not to say that she is a prodigy, but
210 her relative skills appear to go largely unrecognised, and a less verbally oriented
211 curriculum would be of great benefit. Like many children with such a high visual
212 dominance, I suspect Danielle is a fairly sophisticated people watcher, and much of
213 her ‘self-stimulatory’ behaviour allows covert surveillance of her surroundings.”

214

215 A ‘honeymoon’ period in senior school followed, concentrating on home economics,
216 and developing picture-based recipes and shopping lists, but Danielle’s behaviour in
217 school then ‘deteriorated’. In the regular review reports – reviews which Adult Team
218 members stopped attending – a gradual ‘escalation’ is presented. Increased rocking
219 and self-stimulation at moments of stress and possible conflict led to more serious
220 self-harm, picking at the skin on the back of her neck and hands. She ‘escalated’ from
221 physically pushing or hitting at peers who came close, to lashing out if fellow students
222 looked like they might come too close, or who might have been teasing her.

223

224 This led to Danielle being more and more isolated in school, for safety reasons and as
225 children kept their distance, with 2-to-1 TA support. She also showed increased
226 difficulties at home: her parents found her self-harming particularly upsetting, and if
227 they tried to intervene, she became physically very aggressive towards them. Her
228 return from school was especially difficult: after lots of aggression towards the taxi
229 escorts, she would storm in and run to her room at the back of the house, and rock and
230 self-harm for up to an hour. The escorts eventually threatened to withdraw their
231 service. It was difficult for her mother to get Danielle in to the taxi in the morning,
232 she attempted to hit the escort whilst being driven, and harder to get her out of the taxi
233 on arrival at school. If left on her own with the door open, she came out of her own
234 accord after about 10 minutes. After school, she was aggressive to the escorts during
235 the drive, and as they accompanied her to her door. According to parents, sometimes

473

474 "She was happy as a child, and a joy to be with." She was fine in junior and middle
475 school, no pressure to perform, allowed to roam. Was treated like a much younger
476 child; some good teachers, some not-so good. "That transition report was from a not-
477 so good one, and we had to laugh. Those 'social signs' she learned: we taught her
478 those, ever since she was 5 or 6, whenever we were out and about. When *they* took
479 her out of school at 13, they noticed she knew them. Of course, they use their own
480 special signs in school. Total communication, whatever: I could never figure it out
481 and neither could Danielle. What is the use of teaching special-needs kids a language
482 no-one else uses: how does that lead to inclusion? Then of course, they took the
483 credit for teaching her 'social signs'!"

484 "Mind you, that Speech Therapist said as much: treating her like a kid, *and* she could
485 understand a lot more than she said, and could have said more than she did."

486 "Yeah, we were all too soft on her, not making her talk more; she was just so
487 expressive she almost didn't need it."

488

489 "Her sister Claire was 8 when she was born, and when it was obvious Danielle wasn't
490 progressing too well, she sort of took it on to teach her how to be a 'proper girl' when
491 everyone else just treated her like a doll and Dec just loved it. They'd spend hours
492 together, just drawing things...Claire's gone on to do textile design: often with lots of
493 leaves, flowers, insects, birds...."

494

495 "Like your curtains! So she taught..?"

496

497 The parents grinned. "Oh, we never said anything..."

498

499 M: "And the psychologist got it right too: she was clever in ways; she could read us
500 like a book, and all those teachers, too. We always said... But then it all started to go
501 wrong, in senior school."

502

503 F: "It got more and more demanding on her, so she started to get really stressed, and
504 they wouldn't let her wander off like before. It had always been there, sort of in
505 passing, but she started rocking herself a lot, and rubbing herself to calm down..."

506

742

743 M: "And the next one where she nearly broke her leg; the bloke, Ryan, used to tease
744 her at times. To me, it looked like normal 13 or 14 year olds, starting to deal with
745 fancying each other, being a bit rough with it. She liked it, but got a bit giddy. They
746 were mucking about, dancing, and he tripped her up, then fell over her, landing on her
747 leg. She let out a scream, and the staff came to see what was happening. Another lad
748 was helping her to get up, which she did, but her leg was hurting and she couldn't
749 stand her full weight on it for days after, and – we think anyway – she was going into
750 melt-down as we call it. She gets this horrible grin on her, and sort of burbles, it's not
751 nice to see. If we can't find something to get her out of it quick enough, she just sort
752 of glazes over and shuts down, freezes."

753 F: "Rabbit in headlights sort of thing."

754 M: "So she sort of stumbles off, and stands on Ryan's arm, cause he's still on the
755 floor, laughing."

756 F: "Until she stands on him, anyway."

757

758 "And the dog?"

759

760 F: "That bloody thing! Well, they say don't blame the dog, blame the owner. It had
761 been a problem for weeks, wandering about all hours, half the time looking for food,
762 frightening kids. Some of us had had a word with the CSO, the Support Officer
763 about it, and she'd given the owner grief, so then she, the owner, gave us all grief,
764 every time she walked past..."

765

766 M: "We think Danielle got really frightened when it jumped over the gate after her.
767 She went into melt-down, not calculating psychopath, she was totally fit."

768 F: "Then berserk. With fear."

769 M: "But not according to the smart-ass young copper."

770 F: "Or Madame Dr Packer."

771 M: "Tell you what though; ending up in that hospital was the best thing that
772 happened.

773

774 ~~Supervision session 2 with Sam; regarding meeting with Psychologist and hospital~~
775 ~~staff group~~

810 This way, the support staff were able to teach her a wider range of 'activities of daily
811 living'; caring for her room and clothes, preparing and cooking food, tidying and
812 cleaning her surroundings. These were the skill areas she was introduced to when
813 moving to senior school, which had originally appeared to contribute to her becoming
814 'challenging'.

815

816 The order of distress or anxiety scale: from least anxious/aroused looking for
817 twiddles/twiddling; rocking; rubbing neck; rubbing arms; picking at back of neck;
818 picking at arms; slapping own face; scratching own face as most anxious/upset. As
819 the scale moves from least to most anxious, 'personal space' increases, i.e. can get
820 closer without being hit out at with twiddles, but when self-injuring, staff will be
821 approached and attacked if they get within 2 metres of Danielle.

822

823 Supervision session 3 with Sam, regarding meeting with Fairbairn staff group in the
824 hospital.

825 "It was a mixed bag. Some of the staff were okay with the way the nursing staff
826 interacted with Danielle: she had very special needs requiring a special approach. The
827 others were much more social model/choice and control: 'why should she be forced to
828 get up and make her bed so early?' Because that's how *she* needs it to be; flittering
829 her nappy and getting wound up if you leave her is her way of saying 'you let me
830 down'. "But I'd be in a bad mood if I was woken up too early". For her, it's *not* too
831 early. Blame her parents, whatever, but that's the way she likes it: if you don't do it
832 her way, don't accept her choice and let her control when she wakes up, she'll let you
833 know."

834 "How many of them were like that?"

835 "Just two: Haley and Steph."

836 "I think we need to speak to the manager, and get them taken off her team; they could
837 screw up everything. You want me to do it?"

838 "No, it's okay. You think they could really upset the apple-cart?"

839 "Even if they follow the rules, at best it'll be half-hearted, and they'll always be
840 looking for ways to do it their way. Mixed messages Danielle doesn't need,

841 especially in the first month or so. I'll take it to safe-guarding if necessary. I don't
842 think Fairbairn will push it though."

Extracts from Jess Vignette

88 back and forth between the two services, as claims about individual's 'principal'
89 needs were assessed, re-assessed and debated.

90

91 *Assessment by colleagues' experience*

92

93 When I left the meeting, CLD Nurse Jenny suggested I talk to Joyce Bingley in the
94 Children and Families Team: "She used to work with Jess a lot when she was younger
95 and got to know her really well. I worked with Jess briefly on some personal hygiene
96 issues when she started to menstruate: they thought she was having difficulties
97 because she was 'slow', but I thought it was more than that, and Joyce probed a bit
98 more and that's when the sexual abuse allegations came out. Not that it got
99 anywhere; these things often didn't, in my experience, unless you got the family on-
100 board."

101

102 "And they weren't?"

103

104 Jenny made a grimace: "You'll see."

105

106 *Different Team professionals historically had different age cut-off points for*
107 *eligibility. In this county/Trust, nurses originally worked with children from 7 years*
108 *old, once they had been discharged from the Child Development Centre. This had*
109 *been slowly increased, and the age had been raised to 13 years, possibly to coincide*
110 *with the [typically slightly delayed in learning disability] onset of adolescence. The*
111 *AHP's now worked with 16+; Psychology with 16+ if the issues were to do with*
112 *increasing independence, as opposed to within-family issues, otherwise 18+, through*
113 *negotiation with colleagues in CAMHS. Social workers only worked with young*
114 *adults of 18+. Before these ages, children/young people were supported by the social*
115 *work-only Children with Disabilities Team, CAMHS, or health professionals working*
116 *in and through special schools.*

117

118 Further information gathering

119

120 *Information in Psychology Files*

121

122 Although I didn't expect anything being on record as Jess had just reached adult age,
123 our admin support worker identified her as having been referred three years
124 previously. The LAC team had requested an assessment to determine future care
125 pathways for Jess. As this was before integration, the single referral process wasn't
126 operating, so I had taken the referral along to the team meeting. Although known to
127 some colleagues, there was a difference of opinion over whether she had a learning
128 disability, and the Service Lead at the time was keen only to accept people already
129 identified as having one. I had concurred, in the interests of being a "team-player":
130 she would have been assessed in the educational process, so if evidence would be

218 disability range, despite her best efforts and wishes. Allowing for the depression of
219 scores associated with an abusive background, she was still in the mild range.
220
221 The Vineland-II Assessment for social, adaptive and communication skills was only
222 filled in with information from Jessamine Court staff: Jess didn't want to be involved
223 in any further "useless" assessments, though staff could waste their time on it if they
224 wanted to, as it got them off her back. The measures supported her difficulties in
225 Motor and Daily Living Skills, with relatively good Social and Communication skills;
226 overall, her levels were consistent with the cognitive assessment.
227
228 In CLDT terms "she's one of ours". Briony pulled a face when I fed back at the next
229 allocation meeting, on the results and on the manager's warning regarding giving
230 notice. "Put her on the social work list. See about the behaviours, Ken. I'll get Tom
231 to feedback to the ISC."
232
233 *Information on ©Panopticon-i*
234
235 Entries on Jess were limited to the last 18 months, since her eighteenth birthday.
236 In the Transition Team assessment, in the History section, I found that after her 17th
237 birthday, Jess had moved into the ground-floor Jessamine Court flat. She had been
238 accessing the day facility at Jessamine Court after she had been expelled from the
239 Tech. Since she had made good progress, it was expected she might show the same
240 qualities and quickly learn to 'become independent' and move out in 18 months-2
241 years time into her own place. The residential care workers were surprised to find her
242 home-based skills very different to her work skills: she appeared to not have any.
243 When they concentrated on developing one particular skill area – e.g. shopping and
244 cooking for one person – she improved, so another skill area would be introduced.
245 Progress would be made here, but the previous area worked on 'deteriorated'.
246
247 There seemed to have been a decision by her key-workers not to tackle the issue of
248 her personal hygiene and laundry, so that she wouldn't 'lose' them and she could
249 continue to 'make a good impression' at work training, through their regular
250 monitoring and prompting. Although Jess had some issues around irregular sleeping
251 patterns, including sleep walking, staff had followed the GP's advice always to wake
252 her at the same time, having prompted her at night to get into bed. They then made
253 sure she was always at work on time. When she finished her training and was about to
254 start a supported part-time job working for a charity organisation, she refused to co-
255 operate. She initially feigned illness, and eventually refused point-blank to go into
256 work: she had "had enough of that office stuff, hidden away on her own" and wanted
257 to "work in a shop or a café, to get to meet people".
258
259 Because of her good training record, she was offered a training placement in a
260 council-run café in a city park. She made good progress, getting her food hygiene
261 certificates, and was a popular member of staff. There was no job available at the end

305 Behaviour Contracts always referred back to the Agreement. If a resident was not
306 able to keep their flat tidy and clean by vacuuming it three times a week and dusting it
307 once a week, a programme was offered. This went from (a) teaching them how to do
308 it; (b) how to schedule the activities into their Personal Weekly Planner and (c) to give
309 themselves a reward for sticking to the schedule (which couldn't be 'giving
310 themselves a break from the task'). If the resident managed to learn the task, and
311 keep the vacuuming/dusting going, then they were 'inspected' at longer and longer
312 intervals. This skill building was used to get the residents used to identifying what
313 needs they had, and problem solving to build their independence skills. Then higher-
314 level areas could be tackled, like "Living and Working Together" which ranged from
315 interaction skills, to attitude problems to overcoming major 'social adjustment'
316 problems. A parallel track to this was "Managing my mental health", a recovery
317 based model building on similar skill areas, plus self-monitoring for anxiety,
318 depression and/or stress and 'relapse prevention strategies'.

319
320 Jason's view of Jess was that she was "lazy and very manipulative", "typical of
321 looked-after kids". I must have looked puzzled, in my attempt to suppress a sarcastic
322 retort about "old-fashioned and judgemental authoritarian approaches bordering on
323 abuse" or "victim blaming". "Like you nag and nag a teenager to wash-up, then one
324 day they go at it like a whirlwind, break or chip half the crockery, bend the forks and
325 crack the knife handles, so you'll never ask them again."

326 "Sounds like the voice of experience. Is it your kids or was that you?"

327 "I wouldn't have dared: my mum would have made me mend each chip and crack, eat
328 off the repaired plates and buy a new set for everyone else to use!"

329 "Restorative justice they call it, I think. It only works if you give a damn about the
330 other people, or they do about you. Not always there with looked-after kids. And if
331 you do give a damn about them, then they'll test it to your limits, until they push you
332 over the edge, like they need to know 'just how safe are you'? It's difficult in
333 community settings, because you don't have the last word: they can always do
334 something you'd get sacked for doing, like hitting out. So what positive incentives do
335 you use?"

336 "Well, they collect brownie points. I know, it was the residents' choice; they didn't
337 like gold stars, merits, tokens, whatever we came up with - which can mount up to a
338 £10 voucher. They each have a multi-outlet card that has £10 on when they move in,
339 then we can top it up over the internet. Some of the residents thought the outlets were
340 a bit boring, but once they could use them on Amazon, that helped a lot. To some
341 extent, we depend on the programme mostly being about pleasing the staff, with a bit
342 of extra money now and again: well, pleasing staff first, and then getting personal
343 satisfaction."

344 "So everyone buys into independence?"

345 Jason laughs: "They all buy into getting us off their backs, if that's the same thing?"

346 "What about the Jesses of the world who escalate things?"

347 "Well, that depends. We set up various lines in the sand: about aggressive behaviour;
348 about absconding; and about self-harming. And a three-strikes rule. We tell them

349 they've crossed a line the first time; we write to them to say they've crossed the line
350 twice, and remind them the third time means they'll be given 28 days notice to leave."
351 "Is that three times for each area, or is it mix-and-match?"
352 Jason gives me a hard stare, and then a hollow laugh. "That's weird: I remember it
353 was the first thing Jess said to me, and I thought, here's a cunning one."
354 "Is that what you meant by 'manipulative' earlier?"
355 "No, that's something different. Have you read anything in the reports about her
356 morning routine, self-care, and so on? That the staff 'decided' they would still give
357 her a lot of support to get up and get out on time, to not disrupt her work-training. It's
358 not the only thing they 'decide'" – fingers writing quote-marks in the air – "to help
359 her or let her off something. She has them wrapped around her little finger. I went to
360 talk to Liz over in the day centre, the manager, who pooh-pooed the idea. She said I
361 was being too authoritarian, too behavioural. The centre's informal approach worked
362 much better than the more tradition college approach for Jess, and maybe support
363 workers were finding it was the same."
364
365 "Well, I have some good news and some bad news. The good news is that I saw
366 something relating to this during the assessment. The bad news is that I don't think
367 Jess's issues are just about laziness: I think they are related to people treating her as
368 much more able than she is. They do that because she is very skilled at picking up
369 cues from them, and giving them the 'right' answers, the answers they hope for. Left
370 to her own devices, she's probably much less able to figure things out. It seems to me
371 in a lot of her daily living skills, she is expected to do them on her own, whereas her
372 work-skills are about her being in a group, and being able to follow what others do."
373 "So you sort of agree: she *is* fooling the staff, in a way?"
374 "Or your staff are seeing the good she's doing, and not wanting to question it."
375 "Okay, so what does that mean about the behaviour contracts?"
376 "Which warnings is she on, at the moment?"
377 "She's on a second warning for aggression, a first for self-harm and god knows how
378 many for absconding.."
379 "But you haven't given her notice."
380 "The Transition Team said she's not done anything that would end the tenancy of
381 someone with known emotional adjustment issues. She stays out very late – or very
382 early, sometimes - but she usually does come back, so it's not absconding, they say."
383 "Negating your contract. So if you can't deliver, why are they still in place?"
384 "We have to have something to tell her she's off-limits."
385 "Do you have anything for her drinking?"
386 "She doesn't get much chance: because she's paying back for the smashing up of her
387 flat, she's got little spend, now. With all her playing up, she's got banned from
388 anywhere nearby."
389 "So where does she go?"
390 "We don't really know. She just says 'out'. It doesn't seem to be to her Mum's,
391 except very occasionally. We usually know she's been there because she comes back
392 in a foul mood. Otherwise, I think she just stays 'out'"

393 "Even in bad weather?"
394 "There's a big fancy 1930's bus-shelter just down the road. Even the local thugs don't
395 seem to vandalise it."
396 "So how do you reinforce her staying home in the evening? What's that side of the
397 contract look like?"
398 "She just hangs around with the others: I think she sort of likes being the only girl,
399 even though you'd hardly notice, the way she dresses... She likes chatting with staff;
400 sharing pizzas. Actually...she's usually too embarrassed to invite the others into her
401 flat, it's too messy..."
402 "But no brownie points? Do some workers think that's rewarding her bad behaviour:
403 if I break the rules, they'll pay me to be good, but good is what she should be
404 anyway."
405 "Something like that." I suspect Jason thinks it, at times.
406
407 "Right. We need to look at your behaviour contracts, but mostly, to start over with
408 some of them. They need to, first, be possible for Jess to fulfil, so she gets back into a
409 winning streak. Second, they need to be a contract: negotiated, compromised, sets of
410 wins for both sides, and stuck to and stuck with. It'll take a while for her to build up
411 trust again, but if there's a real payoff for her, I'm pretty sure she'll co-operate.
412 Third, only the pay-offs in the contract are in play. Not 'doing it for me', 'doing in
413 for yourself', or independence: just what is in the contract. No shouting, no upset, no
414 stony silences if she breaks it, unless you write it in the contract."
415 "But that's crazy: how can you not show your feelings? Or put them in a contract."
416 "That's the whole point with contracts. They're a third party. It's not for you to bawl
417 her out – she can bawl back harder, and smash things up, run off – it should just be the
418 consequence of the contract, that she negotiated with you and signed. Bawling her
419 out, from her perspective, is you breaking the contract first: it's bringing in something
420 else, from outside the contract. Unfair."
421 "Do you think they can work with someone with her sort of issues?"
422 "They're especially good for someone with her sort of issues: that's why I'm hoping
423 we can get them back on track, properly. That said, I think there's a whole lot of stuff
424 you're doing fine on, flicking through these ['failed' contracts]. It's only because it
425 worked so well, at first, that drift set in."
426 "Anything else?" Meaning, that's enough for today.
427 "Yes: I need to know more about the abuse history. I'm thinking that a lot of her
428 staying out late, staying up late, blocking the door is all about that."
429 "Karen's looked into it a lot. We haven't put it in the general files: it's not need-to-
430 know for everyone."

431

432 Conversation with Jessamine Court Deputy Manager, Karen Daley

433

434 Karen Daley was the relatively new deputy manager at Jessamine Court, having been
435 in post 9 months. She told me she was a community LD nurse by training, and she
436 had moved to the area with her husband and children two years ago. She had found a

Appendix 4 - A reflective account of a work-based research project

Dreier (2007) proposed a materialist definition of reflection as comparing and contrasting experiences – actions, events, emotions, understandings – across the many contexts and situations people experience in their everyday life. Following this approach, I have provided a Professional History as Appendix 4a, outlining the clinical experience from which the Vignettes were developed, and giving a context to the research project and my reflections. Appendix 4b - Experience of the Research provides the more directly reflexive account. Appendix 4c - Other research approaches: impact on clinical practice describes spin-offs into my clinical practice from my explorations into the approaches and methodologies that I rejected in favour of Institutional Ethnography.

Appendix 4a - Professional History

I started working in clinical settings in 1973, and have worked across a number of regions of the British Isles in institutions and community services, mostly but not only with children and adults with intellectual disabilities. I graduated in 1971, and started a PhD in the study of operant behaviour, to develop research models for understanding social behaviours. I changed from full-time to part-time research in taking a hospital research psychologist post, to develop behaviour modification methods for people with mental handicap and abnormal behaviours. I experienced individual interventions failing for lack of follow-through by nursing staff; a ward-wide intervention was very successful, until the sponsoring deputy nursing officer moved on, as did I shortly afterwards. I returned to an operant laboratory, as a locum lecturer, where I extended the programmed learning approach developed with nursing assistants and nurses to undergraduates. My third project was working with voluntary groups of parents of children with mental or physical handicaps, to enable them to keep their children out of local institutions. (At this stage, I let go my PhD). This was in a very rural part of the British Isles, where it was possible to be highly innovative due to lack of established service models. I supported myself by working in the local psychiatric hospital developing token economy wards, until the health authority responded to local political pressure to pay for the service developed with the parents. The authority also suggested to a well-known children's charity operating across the British Isles that their local social worker became involved, and together we developed a specialist family therapy approach to the work, to complement and facilitate the behavioural developmental programmes.

I developed a community based service model for families, with toy library, advice groups and a supporting nurse, which the health authority took over and moved me to the just-starting psychology service. I continued the family work, and became more interested in psychodynamically informed approaches. With a subsequently appointed psychologist colleague and a new consultant psychiatrist, we started a psychoanalytic teaching group with the support of a Lacanian psychoanalyst, and explored psychodynamic practice.

On my return to the NHS in 1987, I joined a study group supported by Valerie Sinason and Pat Frankish, developing psychoanalytic approaches to working with mental handicap, Sinason's preferred 'label' (see Sinason, 1992). My job role was to support local authority learning disability services to cope with the arrival of several hundred people from a closing institution. This was also the time of the 'managerial turn' in health professions, when many clinical psychology colleagues became high level NHS service managers. The principal outcome of my Diploma in Management Studies was learning I wished to remain a clinician.

The qualification allowed me to gain my first Consultant Psychologist position in a neighbouring service, where I developed a service to keep people with intellectual disabilities and challenging behaviour in their community services, and a service for offenders with learning disability returning or being diverted from prison. In my next post, the health and social care services worked very closely together, with an historical (but not current) reputation for service innovation, and a legacy of a disproportionate number of families moving to the area to benefit from them. All services were community based, with close co-operation between day and residential services (health, social and third-sector). My closest working relationships were with social and third-sector colleagues; my favoured theoretical approach returned to being systemic/family therapy.

My last post was as Learning Disability County Lead Psychologist, to re-establish psychology services in Community Learning Disability Teams that had had no clinical psychologists for 2 and 5 years, respectively. A second clinical psychologist was appointed at the same time, with experience in post-modern systemic/family therapy and a social-constructionist orientation. This was immediately following the publication of 'Valuing People', with a number of significant shifts in service provision and models, some progressive, all driven by political/economic factors. In response, I designed the service to be authentically person-centred, and supportive of family/carer networks, with a strong advocacy position.

In this post, I helped the Trust Psychology Service understand and make the transition to the Agenda for Change job evaluation and grading system operating from October 2004.

Clinical Psychology typically did well out of this restructuring, because of its post-graduate level of training, its involvement in clinical management, and having an active research rôle. For Consultant Psychologists, the research rôle needed to be a major portion of the job. As described in Chapter V (p. 123ff), this was an often unmet professional expectation, which now appeared necessary, providing the opportunity for this project. As time went on, and particularly after Clinical Psychology was re-structured, time for the project was severely curtailed. Thereafter, in neither my professional CPD process, nor my annual NHS performance/development review was the need for a major part of my job to be research arising from Agenda for Change, ever broached.

I started in a new PhD programme at a nearby university college, designed to enable practicing health professionals gain research skills and generate research proposals to a doctorate level, feeding after 12 months into the doctoral research programme of the University of Birmingham Medical School. The research topic was to have arisen from a clinical question, and would be pursued as a part-time research doctorate. After an initial delay, leading to 24 months in the new programme, the arrangement appeared to collapse. Due to the efforts of one of my subsequent supervisors (SC), I was able to start anew in the Medical School doctoral programme, with the recognition that I had gained a thorough understanding of research methods. SC remained my supervisor, but due to university restructurings, my second supervisors changed twice: at the first change, I left the Medical School for the Institute of Applied Social Studies (latterly, Department of Social Policy and Social Work, School of Social Policy).

Appendix 4b - A reflective account of a work-based research project

Writing a reflective account of this research project could have added another layer of complexity to my experience of the conversations between my on-going clinical practice and my developing researcher consciousness, and between those and Institutional Ethnography. At times, these conversations had to be suspended to allow ‘unreflective’ practice in order to cope with the everyday professional demands of providing support to people with intellectual disabilities and care systems in some crisis or distress. It helped to hold off awareness of the problematic nature of the support being provided and the lack of available alternatives. However, the barriers were breached, leading at times in the last two years to periods of fluctuating mental health beyond significant work ‘stress’.

Time has been significant: whether finding time, as long experience, or accelerating change in the provision of health and social care. Getting to the point of writing consumed a lot of institutional time: several abuse enquiries; changes in organisation and funding of services; changes in government; changes in practice guidelines.

Initially, generous allocated research time allowed indulgent exploration of the Aladdin’s cave of disciplines, literatures, and discourses different to my core profession. I also needed to catch up on the ‘linguistic turns’ in both my own and other disciplines, and on qualitative methodologies. Both had developed since my former professional education, and I wished to integrate my professional experience with them. I wasn’t quite starting from scratch: post-modern systemic/family therapy had evolved from these historical developments. The idyll ended with the removal of research time at work, and the need to progress the research project.

The fig-leaves I carried out of this Eden were those of Cultural/Historical Activity Theory (see Engeström references); Work-place Studies (e.g. Heath et al, 2000); Bazerman’s (1987) rhetoric of science; science studies (e.g. Gilbert & Mulkay, 1984; Latour & Woolgar, 1986); anthropology (e.g. Lave & Wenger, 1991; Ingold (2010); and Institutional Ethnography (Smith, 1990c; Quinlan, 2008). The discovery process involved both physically wandering along library shelves (Engeström, Bazerman, Latour, Smith), and

virtual rambling (Table of Contents alerts, following up article reference lists): see Ingold (2010)

The special edition of the *Journal of Applied Research in Intellectual Disabilities* on Staff Training and Challenging Behaviour came out in January 2007, soon after starting my part-time doctoral research in the University of Birmingham. Reading it made me very angry: a series of applied psychologists' attacks on care-workers, knowing they would have no opportunity to reply. With a cooler head, I was able to systematically review and critique the articles, a précis of which makes up Chapter II. I was able to see the rhetorical aspect to the articles, and some clear alternative social explanations, as well as the – to me – lamentable level of research (e.g. parametric statistics carried out on ordinal scales; misunderstanding of quasi-experimental methods). The anger reflected acute ambivalence: the incompetence and injustice of the articles against my everyday clinical experience of belligerence or passive-aggression from care-teams when attempting to alter their often oppressive practices, in order to reduce challenging behaviour.

I decided therefore to do more fundamental observation research of care-worker interactions with people with intellectual disabilities who challenged, before, during and after behavioural training. Having run into ethics committee and logistical problems with the design, I re-evaluated what might be possible. In the process, I found that I too was trying to “catch out” both care-workers and behaviour trainers in respective inadequacies. Although initially depressing, my later reading and understanding of Institutional Ethnography led me to appreciate this not as solely reflecting my personal blind spots, but a phenomenon to investigate.

At the same time as developing another research proposal, I began the extensive review of the institutional abuse literature that became Chapter III, in order to understand ‘bad practice’ more generally. This led ultimately to realising the wider social organisation of abuse within services and of the ineffectiveness of policy in eliminating it and hence the likely wider social organisation of ‘challenging behaviour’. Reading many accounts of abuse, as well as it being a recurring phenomenon and concern in clinical practice, led me to spent far too much time, intellectual and emotional effort in trying to find ‘solutions’ to

it, and kept returning to it even until well into the writing of the thesis. At times, I had to remind myself it was not what I was investigating, though might be worth returning to.

I was also distracted by using my new theoretical stances to critique the vagaries of my work-place refusal of research-time; of university demands much heavier and more bureaucratic than in my first thesis; of research's more general neo-liberal 'turn'; and of the apparently conspiratorial blocking of my research as an NHS employee by Research Ethics Committees. I thought my second proposal was sufficiently defined and focussed on the co-ordination of activities - rather than being centred on personal aspects - that there was no prospect of damage to individual care-workers or people with intellectual disabilities, emotionally or reputationally. Being turned down again was a major blow, and the point at which I very nearly gave up the project. Stuart Cumella, my supervisor, suggested if I did I could write a novel instead, which I silently dismissed out of hand.

Instead, taking Smith literally for the first time, I realised that the processes and practices that I would have been observing and describing, were in fact already happening all around me at work, all the time, and had been for years (cf Chapter IV, p.115ff). I needed to write them down: without writing them initially to an Institutional Ethnography or any other agenda; rooted in my experience; and not journalistically or 'novelistically'. As recounted, this came much more easily than I had anticipated. The emotional impact of the REC rejection receded, but placing the problematic into my everyday practice – rather than at an arm's length in observational mode – made the theoretical notion of 'my' practice as representative of clinical psychologists directly contributing to challenging behaviour and ideologically covering it up, all too real, personal, and shameful.

The final intellectual shock was when I caught myself being devastated half-way through Chapter VI at the Vignettes being inherently unable to answer my research questions. I became aware the further I got into writing the Chapter that I was not producing an Institutional Ethnography account: despite several fresh starts, I was providing critical social psychology analyses of the Vignettes, being taken up with the content of the accounts, rather than the co-ordinating ruling relations. The same clinical consciousness assumed the answers would be 'in the data', when the data had been selected under the

influence of the same inward-looking framework. On the positive side, it suggested that the Vignettes had authentically reproduced clinical experience in not being able to address the *impasse*.

‘Consciousness’ is not common currency in mainstream academic and applied psychology: a specialist study area within psychology, it is much more current in philosophy, neuroscience, and cognitive science/artificial intelligence. I use it in the Institutional Ethnography manner, whereby institutional social organization constructs forms of consciousness that override individuals’ perspectives (Smith, 2002, p.22). Smith often describes her experience of the dislocation between her life as a parent and as a university worker, where it took special effort, for example, to remember at work to take her children to a dentist appointment.

This dislocation between parallel researcher and practitioner consciousness explains how I could write the Vignettes authentically, in practitioner not researcher consciousness, having set up the starting points appropriately. I related this to the full accounts produced in clinical psychologists’ *aides memoires* (Chapter VI, p. 157) that might look ‘crafted’ or novelistic. In starting to write such texts, significant amounts of material can be recalled: more limited contemporaneous notes appear to act as triggers for this more extensive recall. The same can happen in sessions, where interactions with individuals lead to recalling many more details from previous sessions, often to the person’s or group’s surprise if mentioned. A similar process can happen between joint therapists: colleagues and I have shared our surprise about how much we can recall/reconstruct after appearing to have little or no memory of events initially.

I was not able to reliably distinguish between the researcher and practitioner consciousnesses until I arrived at the ontological shift required of the Institutional Ethnographer, through the process of discovery promoted by Smith, in writing the thesis under Campbell and Gregor’s guidance. (It goes against [psychological] science discourse to discover through writing, as opposed to writing about a discovery arrived at by other means.) This was in the middle of writing Chapter VI, late in the research process: being forced to escape from my pervasive ‘institutional capture’, by following the-time-it-takes

procedure. Extracting from the Vignettes the doings and coordinatings, the texts activated and active, and revisiting and activating for myself Garfinkel's (1967) template upon which Institutional Ethnography is built, led to Chapter VII's discoveries regarding the *impasse* in staff training and challenging behaviour and Chapter VIII's wider implications. Before this, it seems I have fallen into the same trap I had criticised Walby and Taber for falling into: using Institutional Ethnography as a tool, rather having a complete grasp of it (Chapter IV, p.107).

Vitality for me, being able to distinguish the two consciousnesses led to re-establishing the barriers that allowed me to function, or rather to understand that I was switching between the two consciousnesses and began to monitor and manage it better. I was then able, as well, to identify the negative effects of ruling relations that are typically regarded as personal problems or due to the personalities, competence or incompetence of co-workers or superiors (cf Campbell & Gregor, 2002, p. 16), when "work processes are reconstructed as social or psychological processes, depriving them of their necessary anchorage in an economy of material conditions, time and effort" (Smith, 1981, cited by Walker, 1986).

Unfortunately, that firm anchorage did not allow me to make much impact in changing clinical practice during the time I had left in my job before retirement, when the material conditions of cuts to health and local authority spending were significantly amplifying the pressures to follow local authority obligations, to the cost of people with intellectual disabilities in services. I plan to bring my discoveries to the attention of qualified and trainee clinical psychologists, to suggest they work more directly with care-workers, negotiating change with them from their perspectives, rather than imposing any particular approach, whilst being an advocate for the person with an intellectual disability who has been referred. Wider reform of health and social care services will need to be approached differently, informed by clinical experience and further Institutional Ethnography discoveries.

'Reflecting' on this Reflective Account

My opening line of this reflective account was “Writing a reflective account of this research project could have added another layer of complexity to my experience...” If the thesis were writing about writings, this account would be writing about writing about writings. I say ‘writing’; ‘thinking’ and ‘thoughts’ would also be apposite. Complexity, or rather complication, *was* added: this version is the result of evolving drafts of a third substantially different approach to the account.

In a sense, the thesis could already be seen as a reflective account: my experience in producing and analysing the Vignettes, of then finding them inadequate to the task, of finding a way to describe and explain what was happening/had happened is a demonstration of, a providing of evidence about the problematic. What this Appendix (4b) has added are emotional aspects of that experience; Appendix 4c considers some of the impacts of the research process on my clinical practice. However, presenting Chapters II, III and IV in the historical order they were written rather than a more traditional thesis format, was not only about providing a context and proposed approach to the problematic, but also an account of ‘coming to write’ the thesis, following the discovery process of Institutional Ethnography. The Chapter IV Method section was consciously extended to show how the carrying out of the research came to be. Keeping to the chronological, discovery process it could not anticipate the dramatic shift in Chapter VI, in which the data analysis shifted from the literature reviews and detailed contents of Vignettes, to finding the ‘social’ in Institutional Ethnography terms, within those Vignettes.

Chapters V, VI and VII are also in deliberate chronological sequence. I would now characterise them as a progression in grasping Institutional Ethnography in practice: Chapter V was a partial understanding, in the manner of Walby and Taber (as above); Chapter VI showed an initial, apparent loss of this understanding, which was instead an institutional capture by practitioner discourses triggered by the Vignettes: redemption came in becoming aware of this. Chapter VII appeared the long-awaited explication of the problematic, but was not so much the researcher’s ‘a-ha’ experience or ‘da-dah’ flourish as the next step, albeit a fundamental, ontological one.

So why three approaches to this reflexive account? Institutional capture! First a clinical psychologist's reading of the term; then a threateningly long account of all intellectual twists and turns. This Institutional Ethnographically informed account is a compromise based on Dreier (2007), as a 'reflexive account' belongs to a different ontology.

Appendix 4c - Other research approaches: impact on clinical practice

Although providing detailed observation of interactions in localities way beyond those in the behavioural tradition, other approaches such as ethnomethodology, Work-place Studies, CHAT and Discourse Analysis did not appear to access the co-ordinated actions across layers of management and political systems that the institutional abuse review suggested was necessary. Nevertheless, the first three had impact in my clinical practice.

Levinson (2005; 2010) showed how an ethnomethodologically informed ethnography could be carried out in a residential service for people with mild learning disabilities. He described interactions between care-workers, service-users, and care-workers and service-users that were highly familiar, despite being in a facility in New York. Whilst some service users occasionally showed challenging behaviour, the focus of the service was on personal and social development, in what Levinson characterised as a never-ending, essentially impossible task, which directly challenged much contemporary UK discourse asserting the possibly of and necessity for ‘independence’.

Finlay and Antaki’s project (cf. Finlay et al, 2008) consisted of an extensive ethnography in residential services, and detailed recording of specific events for Conversational Analysis. These showed the fine detail of how care-workers managed to control service-user ‘choices’, which directly confirmed clinic experience, and providing a challenge to overcome. Work-place Studies essentially incorporated mechanical and electronic devices, as well as paper technologies (forms) into Conversational Analysis. The co-ordination of activities including (predominantly electronic) texts within work-situations had high resonance when observing care-teams interacting in providing their support to people with intellectual disabilities who challenged, particularly in deciding whether to follow texts or not.

However, it was the concept of ‘distributed knowledge’ and its co-ordination that had most impact clinically. I introduced the notion into clinical supervision with psychology colleagues, and in group supervision with CLDT colleagues. It had some resonance with system/family therapy ideas of each family member being an expert in their family, but made wider sense to both health and social care colleagues as part of team-working,

recognising each team member's contribution. It was not always possible to help them extend the notion to include the person with an intellectual disability's expertise. There was nothing within the scope of these ideas to explore where their 'knowledge' came from.

A Cultural-Historical Activity Theory/Socio-Cultural Activity Theory (CHAT/SCAT) research group in the University had disbanded, but an applied psychologist remained, and I arranged to have clinical supervision with her. Our conversations led me to map the social networks around individuals, and to clarifying a 'meso-' phenomenon within difficult behaviour. Challenging behaviour was deemed to function predominantly as a means of avoidance of particular activities, situations or people, though also to gain access to desired activities, situations, &c. If the avoidant nature of behaviours were established, what led the care-workers to repeatedly insist on the person's involvement in those activities, situations, &c., or to limit access to more desired ones? Although previously clinically responding to such anomalies (as shown in the Padraig Vignette) this supported a more systematic assessment approach having been able to articulate it in this way, including passing it on to CLDT colleagues and psychology trainees. However, it also became clear that CHAT models had not included the rôle of texts within its cultural-historical influences on individuals, despite their influence in the work-place.

Given the discussion in Appendix 4b on the problematic of clinical psychology and CLDT practice, the ease with which these approaches could be taken up into that practice indirectly supports the judgement that they would not have provided the level of analysis to have resolved the *impasse* in staff training and challenging behaviour.

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