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**THE FIVE ACCOMPLISHMENTS: A FRAMEWORK FOR OBTAINING
CUSTOMER FEEDBACK IN A HEALTH SERVICE COMMUNITY LEARNING
DISABILITY TEAM**

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Key words: Learning Disability; Community Learning Disability Team; Customer Feedback; Normalisation; Five Accomplishments; Health Services

Abstract

The usefulness of using the philosophy of normalisation and, in particular, O'Brien's (1992) Five Accomplishments as a basis for evaluating client satisfaction with a community based health service learning disabilities team was examined. A survey of a group of people with mild learning disabilities took place using the Five Accomplishments as a framework for a semi-structured interview. Areas of client satisfaction and dissatisfaction are discussed in the context of the use of a value-based means of obtaining feedback from clients. Limitations of interviewing techniques and specifically those used in this study are reviewed.

Introduction

The 1960`s saw the beginning of a major change in both the philosophy and policy regarding the care of people with learning disabilities. A service dominated since the 1900`s by long-stay institutional care was to be replaced by a range of community-based services. The new philosophy of care and resultant change in practice regarding services for people with learning disabilities was largely based upon the principle of normalisation developed by Nirje (1969) and expanded upon by Wolfensberger (1972).

Wolfensberger (1972) defined normalisation as "the utilisation of culturally evaluated means in order to establish and/or maintain personal behaviours, experience and characteristics that are culturally normal or valued". The term "normalisation" has remained the shorthand for a whole philosophy of care for people with a learning disability and in particular has led to the development of community-based services. This is despite difficulties arising from the mis-application of the concept (Wolfensberger, 1993), criticisms that the concept treats people with a learning disability as a homogenous group (Gilbert, 1993) and the danger that normalisation is seen as the only basis for developing services (Barr, 1995).

This new philosophy was encapsulated by the White Paper "Better Services for the Mentally Handicapped" (1971) which set out government policy and service recommendations for the care of people with learning disabilities. Concern with quality of life developed as a logical extension of the concept of normalisation; the expectation being that community care policies would lead to a better and more "normal" lifestyle for people with a learning disability.

O'Brien (1981, 1992) developed the concept of the Five Accomplishments which outlines five criteria by which a service could be judged in terms of the principles of normalisation:

- Community Presence
- Choice
- Respect
- Relationships
- Competence

Many early studies which examined quality of life issues assumed that de-institutionalisation in itself would lead to an increased quality of life. As a result of this they took as their main criteria of success, a lack of re-institutionalisation and examined the factors associated with this. Novak and Heal (1980) and Eyman et al (1984) review this literature in detail.

More recent studies have examined a broad range of indices of improved quality of life, eg increased activities, contacts (Perry and Felce, 1994) and improved abilities (Cullen et al, 1996). The importance of taking into account the views of people with learning disabilities has also been increasingly recognised. Individuals have been asked about their satisfaction with a wide variety of aspects of their life including money and friends (Flynn and Saleem, 1986), social interaction and activities (Schalock and Lilley, 1986), community integration (Donegan and Potts, 1988) and physical environment (Booth et al, 1989).

With the increase in the development of community based learning disability teams, researchers have turned their attention to client satisfaction with the services delivered by health professions (eg Dagnan et al, 1994; Lowe, 1992; Witts and Gibson, 1997). There is a growing awareness that some aspects of service quality can only be judged by the consumer

(Dagnan et al, 1993). As a result, consumer satisfaction is increasingly being used as an indicator of service quality. However, as indicated by past research, there are a number of difficulties inherent in interviewing people with a learning disability.

There is evidence that the ability to answer questions is partly a function of intelligence (Flynn, 1986) and that people with a learning disability have difficulty in expressing themselves in a consistent manner (Sigelman et al, 1981b). The nature of the questions (Malin, 1980), the interviewer setting (Card, 1983) and interviewer characteristics (Markova et al, 1988) have all been found to impact on the reliability of responses from individuals with a learning disability.

A number of approaches have been advocated to overcome these difficulties (Flynn, 1986). These include simplifying and re-phrasing questions (Wyngaarden, 1981), utilising photographs (March, 1992), multiple choice questions (Sigelman et al, 1982) and visual analogue scales, for example pictures of happy and sad faces (Dagnan et al, 1994). A recent study by Matikka and Vesala (1997) which specifically examined acquiescence in quality of life interviews found rates of 11.1 - 36.3%, which was lower than expected on the basis of previous research (eg, Sigelman et al, 1981). This indicates that individuals with a learning disability are able to give valid opinions in relation to their satisfaction with issues of quality.

While a number of studies have undertaken to obtain the views of individuals with a learning disability in relation to community services (Dagnan et al, 1993/1994; Lowe, 1992; Crocker,

1989; Witts and Gibson, 1997) as yet no format has been utilised which allows comparison across services.

The Five Accomplishments by O'Brien (1992) is often utilised by service evaluators, eg, Scottish Hospital Advisory Service (SHAS) and the National Development Team (McGowan, 1996). This has benefits as it is drawn directly from the principles of normalisation which largely prompted community care. Use of such a basis of evaluation reminds providers of the philosophical basis of the service and prevents misapplication of the concepts involved (Barr, 1995).

The present study aims to examine and evaluate the philosophy of normalisation (Wolfensberger, 1972; Tyne and O'Brien, 1981) and, in particular, the Five Accomplishments (O'Brien, 1992) as a framework for gaining feedback from people with a learning disability about the community health service they receive.

Method

The team in question is a multi-disciplinary community learning disability team, based in a rural community with a population of just over 100,000. The following professions are represented in the team (whole time equivalents in brackets): Psychiatry (0.7); Clinical Psychology (0.8); Speech & Language Therapy (0.5); Physiotherapy (0.6); Music Therapy (0.7) Nursing (3.0).

Sample

The participants were all functioning intellectually in the mild learning disability range and were selected on the basis of their perceived ability to cope with the interview, both intellectually and emotionally. Seven respondents participated in the survey and all were long term users of the team services (ie at least 1 year`s involvement). Contact was at least fortnightly and some received services from a single team member whilst others had up to four team members involved in their care. The participants represented approximately 7% of the team`s current caseload. All were able to express consent. Four respondents were female and three respondents were male and their ages ranged from 29 to 57.

Procedure

Clients were assessed using a semi-structured interview (see Appendix 1) which examined service users` views in the context of the Five Accomplishments. Questions were designed to be flexible and wording was varied according to client need for clarification.

Client Interview

The interviewer received training in interviewing individuals with a learning disability and a number of measures were adopted to increase validity:

1. Minimising acquiescence

Sigelman et al, (1981c,) report a negative correlation between IQ and response bias. As discussed above, all of the individuals involved in the study were operating intellectually in the mild learning disability range. The main aim was to minimise bias due to individuals being unable to answer the questions or to express their true opinion. In addition, questions were re-phrased and individuals were asked for feedback regarding their understanding as

recommended by Malin (1980). All of the participants were asked to give an explanation to support their stated opinions.

2. Social variables

Markova et al (1988) note that individuals with a learning disability lack social power and often adopt a passive role. This can result in their feeling obliged to provide the "correct" answer for the "expert" interviewers. The interviewer spent time with each of the clients establishing a rapport prior to conducting the interview. In addition, she was independent of the therapeutic services provided by the team. As a further measure to reduce potential social compliance, subjects were assured that participation was voluntary and that all replies were strictly confidential.

3. Environmental variables

Previous researchers have noted the impact of environmental variables in affecting the responses of people with a learning disability. Card (1983) found that contrasting views were obtained from people with a learning disability interviewed at home, with family members present, and alone at their Adult Training Centre. This highlights the importance of interviewing people in private. All of the participants in the present study were interviewed in a private place.

Interviews took between 45 minutes and 1 hour. Responses were recorded verbatim by the interviewer. Responses were then analysed from the transcripts of the interview and coded as to whether people were satisfied or dissatisfied with the aspect of the service in question. In addition, comments relating to areas of dissatisfaction were noted and fed back to the community team. Discussions then took place amongst team members as to how these

aspects of the service could be improved. Analysis of the transcripts took approximately 4 hours.

Reliability

Specific procedures were adopted as discussed above to try and ensure the reliability of responses. Given the nature of the study i.e. evaluating services received by learning disabled clients, it was felt that repeating the questioning procedure to obtain a measure of inter rater or test re-test reliability may have given a message to the client that a) they had not been believed, or b) their responses had not been satisfactory, particularly if they had expressed a complaint about some aspect of the service.

A measure of inter-rater reliability of recorded responses was however made, with responses being coded by the interviewer and another researcher not connected with the team.

Results

Reliability

Table 1 below illustrates the percentage agreement between raters coding client responses:

Table 1: Inter-Rater Reliability

Item	% Agreement	Yes	No	Don't Know
<i>Community Presence</i>				
Satisfaction with place seen?	100	7	0	0
Satisfaction with privacy?	100	7	0	0
<i>Choice</i>				
Referral source - self?	100	1	6	0
Appointment arrangements - self?	100	1	6	0
Satisfaction with help received?	100	6	1	0
<i>Respect</i>				
Appearance?	100	7	0	0
Punctuality?	100	7	0	0
Manners?	100	7	0	0
Treated properly?	100	6	1	0
Informed about confidentiality?	100	2	3	2
Informed about access to casenotes?	86	2	5	0
Informed about complaints procedures?	86	0	7	0
Informed about function of team?	100	3	4	0
<i>Relationships</i>				
Listened to?	100	7	0	0
Problems understood?	100	7	0	0
Therapist easy to get on with?	100	7	0	0
Therapist liked?	100	7	0	0
<i>Competence</i>				
Therapist helpful?	100	7	0	0
Input improved situation?	100	6	1	0
Further input from team desired?	100	7	0	0

Only two items had less than 100% agreement between raters, these were whether individuals had been informed about access to casenotes and complaints procedures. In both cases the disagreements related to a response in which the individual indicated knowledge of the item, but did not indicate that they had explicitly been told. These were coded by the interviewer as individuals having not been informed but by the independent rater as having been informed.

The results of the interview in relation to the Five Accomplishments are indicated below:

Community Presence

Five of the seven respondents were seen at home, the remaining two were seen at a day centre and at a health centre. All were satisfied with where they had been seen and all felt that they had privacy to talk.

Community Presence - Example Responses

"It's more private here, there's no interruptions, elsewhere things are more open"

"We talk about whatever we want to"

"Always in my room and (a community nurse) talks in my room alone with me"

Choice

Only one of the respondents had asked to be referred to the team. The remainder had been referred by others concerned with their care. Only three of the respondents knew why they had been referred. All the respondents were able to identify aspects of the help they had received and six out of seven were happy with it. One person felt that she was not listened to sufficiently felt they understood what the role of the team was.

Choice - Example Responses:

Source of Referral

"It was (key worker) who suggested it because I blew up"

"I mucked about the service, (key worker) suggested it"

Reason for Referral

"Don't know, because of shopping, housework"

"(Psychologist) did tests to see how far I got with my behaviour"

Help Received

"With my speaking and help to say how I feel"

"(Community Nurse) helps me by talking about problems"

Respect

All the respondents felt team members turned up on time, were well dressed and polite. Six respondents felt that they were treated properly by the team member. As above, one person felt she was not listened to properly. Five of the seven respondents were unsure about, or had not been informed about, confidentiality. Similarly, five respondents had not been told about access to casenotes. None of the respondents reported having been informed about complaints procedures. While three individuals reported that the function of the team had been explained to them, only two felt they understood what the role of the team was.

Respect - Example Responses:

Appearance/Manners/Punctuality

"Very properly dressed and very smart"

"Speaks nicely"

"Sometimes (Community Nurse) is not on time but she has a reason"

Confidentiality

"I think so, what is that?"

"No, and I would like to know more"

"Yes and my key worker says everything privately"

Access to Casenotes

"No, I would like to see them"

"It is the first time I've heard that and I would like access"

"Yes I know there is casenotes, and if I want to look at them I can"

Complaints Procedures

"I feel if I had a complaint I might get into trouble"

"No I have no idea about how to complain and I would like to know more"

Knowledge about Team Role and Function

"They've never explained this to me at all"

"Yes, the first time (Psychologist) met up with me"

Relationships

All those interviewed reported that the team member listened to them, was easy to get along with and understood the issues they needed help with. All the respondents liked their contact team member. Three of the respondents would like to have been seen more often.

Relationships - Example Responses:

Feelings listened to and understood

"Yes when I'm upset or anything"

"I get my feelings over and everything is confidential"

Liking for Team Member

"I think we get on fine with each other"

"Yes (Community Nurse) cares for me and is interested in my case"

Competence

All the respondents felt the team members were helpful and were able to identify aspects of the help they received and how it changed things for them. However, one individual felt that, on occasion, the input had resulted in a situation becoming worse. Despite this, all respondents felt that if they needed help in the future they would wish to be seen by the team.

Competence - Example Responses:

Helpfulness of Input

"Yes (Community Nurse) helps me a lot"

"She does anything she needs to do"

"Things are better in all ways"

"Worse sometimes"

Discussion

The definition of quality in health care has increasingly moved from broad categories of individual functioning and/or systems change to personally identified outcomes that individuals desire from the service (Gardner et al, 1997). The Five Accomplishments developed by O'Brien (1992) were used as the basis to evaluate client satisfaction with community health services provided by a multidisciplinary team. This philosophical approach has been used at a broader level by a number of organisations involved in the accreditation and evaluation of services, eg, SHAS and the National Development Team in the UK and the Council on Quality and Leadership in support for People with Disabilities in America (Gardner et al, 1997).

The current study found that the Five Accomplishments provided a useful, value-based framework for evaluation of customer satisfaction. The most significant findings were, that although the participants were generally satisfied with the service at a therapeutic level, the majority had not been involved in the referral process and had not been given fundamental procedural information regarding confidentiality, access to casenotes and about how to make a complaint.

The general pattern of results is similar to that found in recent satisfaction studies, for example by Witts and Gibson (1997). The main areas of dissatisfaction highlighted in this study were limited involvement of client opinion and limited knowledge regarding the function of the team. A number of procedural changes have been made in response to the

survey results. In particular, clients and/or their advocates are now routinely informed about confidentiality, casenotes, access and complaints procedures. In particular the need to inform the clients about the referral process and the role of the team was highlighted and is currently being addressed.

However, there are a number of potential flaws in the survey. The most obvious one is that only the most able clients were asked their views which clearly may not be representative of the population served by the team as a whole. While the involvement of more able individuals in the survey was intended to increase the reliability and validity of the information obtained, it is possible that the exclusion of less verbal and intellectually able respondents introduced biases into the results in that the views may differ markedly from the more able respondents used.

Some inconsistencies in responses were found, for example, one respondent felt listened to in relation to discussions about relationships but not when talking about choice. However, this may also be a function of the area addressed and the response may be entirely valid.

Past researchers have often measured the satisfaction of less able individuals in terms of increases in skills, engagement and community integration. Longley and Collins (1994) argue that satisfaction can usefully be assessed in such individuals by using individualised behavioural observations. In addition, however, Whitaker (1989) argues that generally the factors that determine the quality of life for people with profound learning disabilities are the

same as those with lesser disabilities, although a difference in the emphasis on the various factors may occur.

The current study, based on the concept of normalisation and the Five Accomplishments, is underpinned by a philosophical, value-based approach to service provision. It may be that such an approach which shapes the way in which services are evaluated is equally applicable to individuals with greater disabilities as Whitaker (1989) suggests.

A further difficulty with the present study relates to acquiescence. Although a number of measures were taken to maximise the reliability of responses, some of the participants did have a tendency to answer questions initially in terms of "Yes" or "No". The interviewer was required to ask the individual to elaborate further to ensure that the question had been understood and that the individual was happy with their response.

No direct measure of true test reliability was undertaken because it was felt that the participants may have been reluctant to criticise aspects of a service twice (Foote and Rose, 1993). However, responses were recorded by two raters, giving a measure of inter-rater reliability. Only two items had less than 100% agreement and disagreements were due to ambiguous answers. Both items were rated by the interviewer as indicating a failure on the part of the team to inform clients about procedural issues. This illustrates the importance of placing individual responses in a context. Overall, however, agreement between coders was very high.

Recent research (Matikka and Vesala, 1997) examined a variety of individual and situational factors in quality of life interviews and found acquiescence to occur less than indicated by previous research. However, all participants in the present study were aware that the information given would be available to team members. It is therefore possible that individuals modified their responses because of this knowledge.

Past studies have suggested that individuals with a learning disability are reluctant to make negative or critical comments about the services they receive (Foote and Rose, 1993; Justice and McBee, 1978). In the present study however a number of participants did feel able to make negative comments about the service they received. In addition common areas of dissatisfaction were found among participants.

This apparent openness on the part of the respondents may be largely attributable to the fact that the interviewer, although experienced in working with individuals with learning disabilities, was not part of the community service being evaluated and clearly identified herself as such. This suggests the importance of any researcher/evaluator being independent of, but familiar with, the service being evaluated. The willingness of participants in this study to be critical gives some indication that the respondents' replies indicated genuine feelings of satisfaction and dissatisfaction with the services they received.

Summary

The present study examined the usefulness of using the philosophy of normalisation and in particular, O'Brien's (1992) Five Accomplishments as a basis of evaluating client satisfaction with community

health services. This structure was found to be useful in providing a value-based means of obtaining feedback from clients. Common areas of client satisfaction and dissatisfaction are presented and limitations of the study are discussed.

APPENDIX 1: Customer Satisfaction Survey

Background information

1. Service/s received from the team
2. Frequency of contact
3. Duration of contact
4. Other services involved
5. Any other relevant information

Community Presence

1. Where were you asked to be seen?
2. Were you seen in the best place? If not, where do you think you should have been seen?
3. Did you get a private place to talk?

Choice

1. Did you ask to be seen? If not, who arranged it?
2. Why were you referred? What did you get help with?
3. How were the appointments made?
4. What sort of help did you get?
5. Were you happy with the help you received?

Respect

1. Did the person seeing you dress properly?
2. Did the person turn up on time?
3. Did the person seeing you have good manners?
4. Were you treated properly by the person seeing you?
5. Were you told about confidentiality?

6. Were you told about access to casenotes?
7. Were you told about how to complain if you were not happy with how you were treated?
8. What is the Community Learning Disability Team for?
9. Was is explained to you what the Community Learning Disability Team do?

Relationships

1. Did the person seeing you listen to you?
2. Was the person easy to get along with?
3. Did they understand what you wanted help with?
4. Did the person understand how you felt about things?
5. Did you like the person you saw?
6. Do you think they liked you?
7. Were you seen often enough/too often/not enough?

Competence

1. Was the person you saw helpful to you?
2. What sort of help did you get?
3. Are there things that you didn't get help with? If so, what sort of things would you have liked to have had help with?
4. Did the person make things: better/no different/worse?
6. If you wanted help again would you want to see them again?
7. What do you think should have been done differently?
8. Do you have any other comments or suggestions?

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