# DAY CARE OF THE ELDERLY:

## A PARTICIPANT OBSERVATION STUDY OF ONE CENTRE

Submitted for the Degree of Doctor of Philosophy

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# ABSTRACT

This thesis is concerned with day care for elderly people, an area of provision about which there has been little experimental research. It reports research undertaken in one day centre for both elderly and physically handicapped (non-elderly) clients. However, as the research is focussed on the elderly, the physically handicapped clients are considered only insofar as their presence is relevant to the care of the elderly clients.

Some literature concerning elderly people is reviewed selectively. Particular attention is paid to work concerning the provision of social care for the elderly and especially day care.

The primary research methodology was participant observation. Some theoretical issues concerned with participant observation are raised and the conduct of the present research is described and discussed.

The research falls into three parts.

First, there is an analysis of the clients at the Centre based on the data available from their admission forms.

Secondly, the fieldwork is reported. A short description of the staff at the Centre is followed by an analysis of the clients' early days in day care, specifically the processes of admission and induction. Transport is then discussed. The Centre regime is described including activities undertaken by clients, group formation and membership, subjects of conversation and subjects of concern to clients, relationships with physically handicapped clients, staff-client interaction and Centre management. The operation of the Review Panel is considered.

Thirdly, there is a summary of interviews with a sub-sample of clients.

The findings point up important policy implications for Social Services Department and Centre management. The need to identify clear aims for day centres and for individual clients is emphasised. Suggestions are made concerning admission policies, induction, the way in which client progress is reviewed and Centre regimes. Attention is drawn to the roles (especially the caring roles) of different categories of staff. Ideas for future research are noted.

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# ACKNOWLEDGEMENTS

I would like to express my thanks to Professor Olive Stevenson and to the members (who must unfortunately remain anonymous) of the Day Centre in which I worked for their invaluable assistance during the preparation of this thesis.

# CONVENTIONS

Definitions and conventions adopted in the present work are listed below:

1 Anonymity. The names of all persons involved in the research have been changed to preserve their anonymity. The names 'Suilven House', 'Elgol' and 'Westshire County Council' are fictitious.

2 Age. For the purposes of the research into the Centre, elderly clients are defined as those who are aged 60 or over. Although this may appear young, it is the convention adopted by staff at Suilven House and is therefore adopted here.

3 Client. 'Client' refers to an elderly or physically handicapped person who has been admitted to Suilven House. Again, this is consistent with the Centre's own use of the term.

4 Gender. For ease of expression, as the majority of clients are women, they are referred to in the female gender.

5 Staff. The term 'Staff' refers to those persons who are employed by Westshire County Council, are based at Suilven House and interact with clients. These are Officer-in-Charge, Deputy Officer-in-Charge, instructors, caretaker/care assistant, care assistants, cleaner, ambulance drivers and ambulance assistants. It also includes the hairdresser and volunteers as they also interact with clients and from this point of view have much in common with those categories of staff listed in the previous sentence. The definition excludes kitchen staff as they do not interact with clients and visiting professionals (eg. occupational therapists, district nurses).

6 Member. 'Members' are all statuses included under the terms 'client' and 'staff'.

7 Social Worker. It was not always clear to the researcher whether some persons were social workers or social work assistants. As the distinction is not central to the work, the term 'social worker' is used to refer to staff in both categories.

8 Client names. In some cases, a client is referred to by surname, in others, by forename. This is due to the fact that both staff and clients refer to some clients by their surnames and to others by their forenames. There is, however, virtually complete consistency between members; in other words, if one client refers to another by her forename it is almost certain that all other clients and staff will refer to that client by forename. As the researcher was unable to learn all clients' surnames and forenames and as it appeared at one time as if this might reflect some status distinction between clients (a hypothesis which was not supported and was dismissed), he refers to clients in the way they were addressed by other members.

9 In the chapter entitled 'Research Findings', reported examples appear within the body of the text. Illustrative quotations which have been taken from research diaries are indented.

10 Sub-sample. In order to distinguish this group from the main sample (ie. the full elderly population of the Centre), the 29 clients admitted at the October, November and December 1980 Admissions Panels are referred to as the 'sub-sample'.

11 Handicapped. The terms 'handicapped' and 'physically handicapped' are adopted as these are the term used by staff and clients at the Centre. A 'handicapped client' is a non-elderly handicapped client. An elderly client may also be disabled but she is referred to only as an 'elderly client' unless it is relevant to draw attention to her disablement.

The writer recognises the common usage of the term 'disabled' but this is not used at Suilven House.

# SUILVEN HOUSE DAY CENTRE

A brief description of Suilven House is given below to illustrate the physical environment within which the study was conducted.

Suilven House is located in Elgol, the County town of Westshire. It is a Westshire Social Services Department facility. Elgol is a city with a population of 61,370. It is a city of contrasts. Its history, which can be traced back to the Roman Empire, attracts many thousands of tourists every year. As a consequence there is a prosperous tourist industry comprising hotels, heritage trails, museums, shops and boat trips on the river. The centre of the city is comprised mainly of medieval buildings which form the hub of a compact shopping centre which attracts customers from a large surrounding area. Within the city itself there is little industry but the city is a dormitory for workers in several nearby industrial towns. New housing estates (several of which are small with properties designed to attract high salary earners) have been built on the outskirts of the city in previously small villages. These housing estates form buffers between Elgol and the surrounding rural villages, hamlets and rich farming. Despite this prosperous picture, Elgol is not socially trouble free. There are areas of poor housing and one large council estate which is notorious for its crime rate.

Suilven House is situated in a relatively minor but busy street one quarter of a mile from the city centre. It is bordered on one side (on which there are no windows from which clients may see out) by the road and on the other by a canal which, while quiet in winter, carries frequent tourist boats in summer. The canal can be seen from the windows of first floor lounge and basketwork room. At one end of the building

private housing is screened from Suilven House by hedges and high garages. There are no windows at this end of the building. At the other end, and visible only from the first floor basketwork room, is a dual carriageway fly-over.

Suilven House is a purpose-built day centre which was opened in 1977 to house both elderly and physically handicapped non-elderly clients. At the time of the research its total roll was 313 clients of whom 241 were elderly and 72 physically handicapped. The ages ranged from 21 to 97. The majority attended one day per week. No statement is available to indicate the capacity of the Centre. The maximum attendance on any day during the research was 130 of whom 93 were elderly.

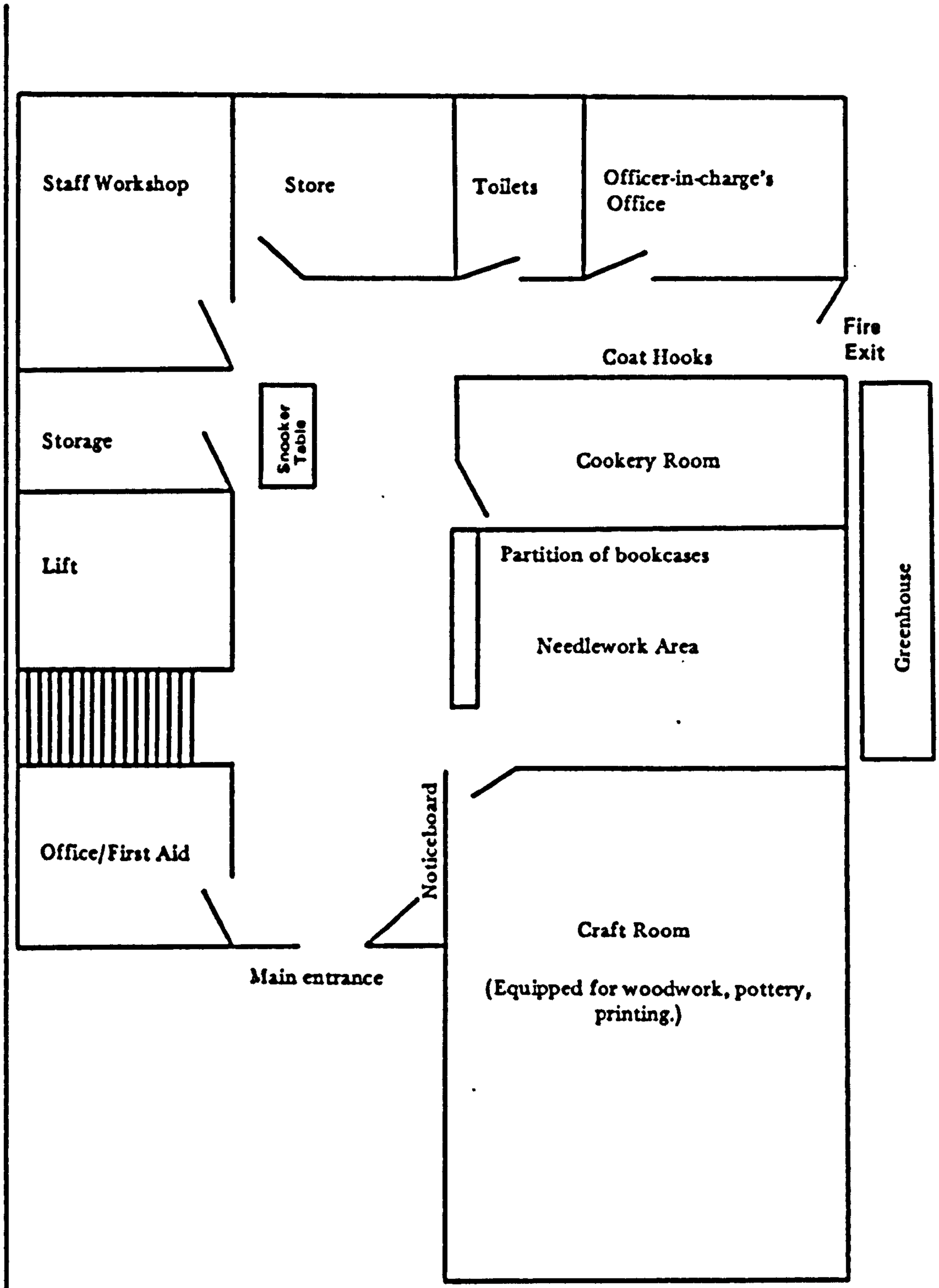
The Centre is open five days per week. Clients are allowed to arrive from 9 am and must leave by 4 pm. Services available at the Centre include lunch, tea which is served on arrival and after lunch, a mobile shop which is a two-tier trolley wheeled round the Centre once per day, a small library and a half-time hairdressing salon. There are 14 full-time and 23 part-time members of staff including volunteer staff, cooks, drivers, cleaners, care staff and instructors.

The layout of the Centre is represented diagramatically in Diagram 1.

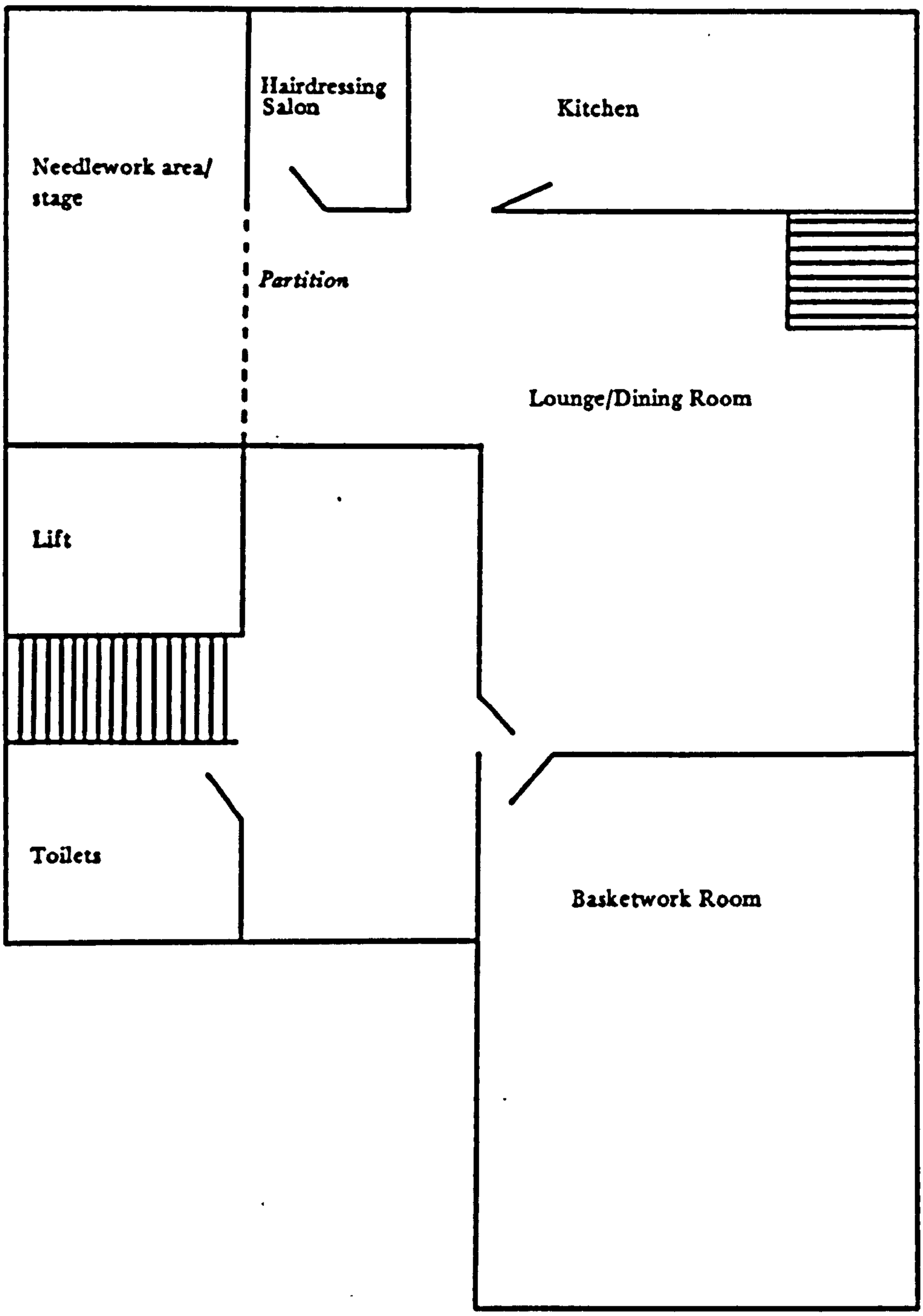
## DIAGRAM 1

## LAY-OUT OF SUILVEN HOUSE

### (a) Ground Fioor



(b) First floor



# CHAPTER 1

# LITERATURE REVIEW

## INTRODUCTION

The purpose of this chapter is to provide an overview of the literature concerning elderly people in order that the present research may be placed in the context of, and be informed by, previous work. Given the breadth and depth of such literature, this overview is necessarily selective. In view of the scope of the present research, particular attention is paid to literature concerning the provision of social care of the elderly. It is this literature which informed the present study and represents the theoretical and research contexts within which the research should be considered. As a consequence, the chapter focuses specifically on aspects of the elderly that are of particular relevence of the provision of day care.

Inevitably, therefore, literature concerning some aspects of the elderly has been omitted. For example, specialist works on geriatric illness are not considered. Most of the literature considered is British although some relevant American work is included. It does not follow that the circumstances or perceptions of the elderly in other countries are similar to the circumstances or perceptions of the elderly in Britain. The place of the elderly within social networks such as the family are different. Different social policies within different countries have different implications for the elderly.

The chapter is in four main sections which reflect the issues that influenced the research. The increase in the elderly population and the levels of provision made for the elderly are factors which must be taken into account when determining the most appropriate forms of care.

In the first part of the chapter, these trends are identified.

Secondly, there is confusion over the purposes of care for the elderly. This confusion is apparent in the literature and is a major theme in the present research. The purposes of care are often linked with problems of old age. Those most frequently identified are: poverty, deteriorating health, brain failure, the loss of existing skills and difficulty in learning new skills, past-orientation, loneliness and isolation, frequent bereavement and attitude to death. The relevant literature on these characteristics of old age is reviewed in the second part of the chapter.

Thirdly, there is an examination of theories and evidence concerning the context in which social care must be considered. 'Social Care' is used in the way suggested by Barnes and Connelly (1978) as the social, as distinct from the economic, ways in which people look after each other, directly or indirectly. (The 'economic ways' in which we look after the elderly such as the provision of pensions and concessions are clearly important for their well-being but are outside the scope of this work.)

The final section examines social care provision and this is at greater length than the previous sections because of the relevance of this literature to the present research. It is particularly relevant in that it has suggested issues that require clarification and provided theoretical and research frameworks within which Sullven House must be examined. The forms of social provision considered are residential care, community and family care, and day care. Residential care is a major form of provision and has been more researched and written about than some others. Day care is often seen as part of an alternative form of provision to residential care. For these reasons the literature concerning residential care is reviewed at some length.

Finally, the chapter focusses specifically on day care. Day care has not been as much researched or written about as some aspects of the provision for the elderly but what literature there is, is extensively reviewed here.

## INCREASE IN NUMBERS OF ELDERLY AND PROVISION FOR THEM

### Changing age structure of the population

An increase both in absolute numbers and in the proportion of elderly people in the population is one of the major demographic changes of the latter part of the twentieth century. Within the context of the present study, a detailed analysis of the change is not appropriate but it must be noted as it has important implications for the pressure on social services.

During the period 1961-1976, the total population in England increased by 7 per cent but the number of persons aged over 65 increased by more than 25 per cent (Department of Health and Social Security 1976). In 1951, 13.6 per cent of the population of Great Britain were over retirement age but by 1981 this had risen to 17.5 per cent (Office of Population Censuses and Surveys 1983). It is anticipated that this trend will continue until the mid 1980's when the proportion of retired people will reach a peak of 18 per cent before falling off slightly (Rowlings 1981).

More important than the increase in people over retirement age is the growth in the number of older old people as it is they who have the greatest requirements for care. This has been emphasised by Rowlings and by Hunt. Rowlings (1981, 17) states: 'The age of seventy-five can be regarded as a point at which the consequences of ageing begin to be most clearly visible.'[1]

1 For a summary of these consequences see Rowlings (1981, 16-20).

Hunt (1978) reports the results of probably the most comprehensive British survey of the social circumstances of old people. It was carried out in 1976 by the Social Survey Division of the Office of Population Censuses and Surveys on behalf of the Department of Health and Social Security. The sample of this work was 2,622 persons aged 65 and over. Hunt summarises the work by stating: 'the findings of the survey provide evidence that physical old age, in the sense that it is generally understood, does not begin at the age of 65 for the great majority of people . . . Physically, the 65-74 year olds are, for the most part, not much more severely disadvantaged than the age-group immediately below their own' (Hunt 1978, 4). Their housing conditions and amenities are not greatly inferior to those of younger people and they appear as likely to have hobbies, interests and social contacts. Hunt reports that the 75-84 age-group showed a moderate decline in mobility, health, ability to perform personal and domestic tasks, and favourable attitudes to life but a much sharper decline in social contacts outside the home, in having hobbies and interests, and increases in widowhood and living alone. Their standards of housing and amenities were, on average, lower. Viritually all these trends were accelerated amongst those aged 85 and over.

Increasing life expectation has resulted in a sharp increase in the population of people aged 75 and over. In the ten years to 1980 the number of people aged 75 and over rose by half a million to 2.8 million (Department of Social Security 1982). The proportion of men aged at least 75 years amongst the post-65 male population reached 30.9 per cent by 1981 (Office of Population Censuses and Surveys 1983) and is projected to rise to 36.3 per cent by 2001 (Wroe 1978). Among women over 60 years, the respective proportions are 32.5 per cent (Office of Population Censuses and Surveys 1983) and 37.6 per cent (Wroe 1978).

The numbers of people surviving to very old age are also increasing. In 1971, 4.4 per cent of men aged at least 65 were aged 85 or over but by 2001 the figure is likely to be 5.5 per cent. By the same year the proportion of retired women aged 85 or over is projected at 8.7 per cent (Wroe 1978).

It should, perhaps, be noted that the increase in the numbers of the elderly is a world-wide phenomenon and not peculiarly British. At a United Nations Conference on ageing held in 1982 it was stated that, although the world population is expected to treble between 1950 and 2025, the number of persons over 60 will increase five-fold and the number over 80 will increase seven-fold (The Observer 1982).

## The elderly as users of social services

In the present context, the importance of the change in the age distribution of the population is that the elderly, and particularly the old elderly, are the major users of many of the health and personal social services. Over 40 per cent of health authority expenditure on hospital and community services is spent on the elderly (HMSO 1983). Excluding maternity and psychiatry, over 50 per cent of all hospital beds are occupied by persons aged 65 or over (DHSS 1976 a). Fifty per cent of the budgets of Social Services Departments is devoted to the elderly and 20 per cent of Social Services Departments' expenditure is on residential care alone for the elderly (Rowlings 1981). Within the health and personal social services the average cost of care and treatment of a person aged over 75 is seven times that of a person of working age (DHSS 1978 b). The elderly and physically handicapped occupied 126,000 of the total 136,000 residential home places in England and Wales in March 1980. There were places for a further 22,000 in day centres (Barclay 1982).

However, statistics identifying expenditure on the elderly as a discreet group do not identify all public spending on the elderly. The elderly benefit from services to which all citizens are entitled, such as law enforcement and public transport subsidies, but they are likely to benefit disproportionately from some services. It has been estimated that one third of total public expenditure on social programmes is attributable to elderly people. The elderly are over-represented compared with the remainder of the population among those benefiting from housing, transport and food subsidies; supplementary pensions; tax allowances; index-linked savings; residential, domiciliary and day care services (Department of Social Security 1978 b).[1]

Despite major expansions in the services provided for the elderly during the early 1970's and, at a slower rate, during the late 1970's, Government targets on levels of provision have not been met. The cuts in public expenditure at the end of the 1970's and during the 1980's brought expansion to a halt before many authorities had approached the guidelines for services laid down by the Department of Health and Social Security in 1976 (Goldberg and Connelly 1982). The Department of Health and Social Security identified shortfalls in provision with six full-time equivalent home helps per 1,000 elderly compared with the guideline ratio of twelve per 1,000. There was a shortfall of one half in the provision of meals on wheels, and between one

1 Details of levels of provision of various services are provided by several authors. For example, Wroe (1978) cites levels of social security expenditure, Rowlings (1978) the provision of residential places, Brearley (1975) the high proportion of the population of psychiatric hospitals who are old, Wicks (1978) the extent to which an elderly person is likely to use several social services, not just one.

quarter and one half in the provision of day care facilities (approximately two places per 1,000 elderly compared with a guideline of three to four places per 1,000). There were only 18.5 residential places per 1,000 elderly compared with the guideline of 25 places per 1,000 and yet there had been an annual growth of an average 3.1 per cent in the number of residents during the previous eight years (Social Work Today 1977). There was a shortfall in the provision of beds and day hospital places for elderly people with mental infirmity (Department of Social Security 1976 a). An indication of the failure to keep pace with the demand for places is the rise in the average age of elderly people on admission to homes (Meacher 1972).

In short, the proportion of the population that is elderly is increasing and the increase in the old elderly is particularly great. The elderly, and especially the old elderly, take up a disproportionately high quantity of the country's social and health services. The percentage of gross national product spent on services for the elderly has been increasing and yet government targets for the provision of these services have not been met. There is little reason to anticipate that they will be met in the foreseeable future. As a consequence of the increase in the ratio of non-income earning elderly to income earners, an increased proportion of each worker's earnings must be devoted to services for the elderly if the present level of provision is to be maintained. Research into the care of the elderly must be viewed within these financial contexts.

## DIFFICULTIES ASSOCIATED WITH OLD AGE

Services for the elderly are not required simply because people are elderly. They are required as a consequence of difficulties that occur frequently in old age. One of the ongoing themes of this study is the importance of defining the aims of organisations concerned with care of the elderly. These aims must be derived, in part at least, from the difficulties faced by the client group.[1] The purpose of this section of the chapter is to identify the main difficulties: poverty, deterioration in health, brain failure, the loss of existing skills and difficulty in learning new skills, loneliness and isolation, bereavement. Through a review of the literature concerning these difficulties it may be possible to assess more clearly the value of the present provision.

There is a danger that the discussions of characteristics associated with old age will paint a depressing picture of the elderly. It should be stressed that this is not the

1 Other factors also contribute to the need for these forms of care. Social factors such as an increase in the number of working wives, the change in the extended family and the increase in geographical mobility have reduced the opportunities for many old persons' families to look after them (issues that are discussed later). The increase in medical knowledge has increased the possibility of an infirm old person benefiting from specialist care in a day or residential hospital.

intention. There are many people who find that their physical changes[1] do not pose problems and who do not suffer the other difficulties outlined here. Nevertheless, in many cases, changes and disabilities do not occur singly. Rowlings (1981, 59) states that many elderly people have the difficulty of coping with 'successive and accumulated changes - a consequence not necessarily of frailty due to ageing but of the immobilising and overwhelming effect of multiple change'. Even so, many elderly people who suffer single or multiple difficulties lead fulfilling lives. Social care provision might help more elderly people to lead fulfilling lives if it were possible to gear better the aims of caring organisations to the difficulties faced by elderly clients.

## Poverty

The extent to which many elderly people live on low incomes and some in poverty is well documented. 'Poverty' is a term that has been variously defined. Townsend (1981, 69) defines it as the 'inability to command resources to allow participation in the diets, customs, and activities commonly available or expected, and fulfil the obligations imposed upon individuals by virtue of the roles they play in society'. Townsend adopts the term 'structured dependency' to typify the changing conditions of elderly people in industrial societies. He believes that the term has the advantage 'of implying that the conditions experienced by the elderly are in the main neither necessary nor natural'.

1 Mortimer (1982) has summarised the likely physical changes that occur with old age as deterioration of the senses; musco-skeletal changes; a drop in the basic metabolic rate; changes in the pattern of sleep with it taking longer to get to sleep and for sleep to be lighter with frequent periods awake; and a gradual loss of neurons, especially in the brain, thus making the person more vulnerable to illness and trauma.

Although some may not accept Townsend's definitions, the implication that poverty is relative is widely accepted. In other words, a person who is regarded as living in poverty in England today may have a higher standard of living than someone who would have been regarded as 'comfortably off' in past years. Similarly, what is regarded as poverty in England today may be regarded as a high standard of living in other countries. In order to quantify poverty, it is often related to the average income of the population. Hunt (1978) found that half the elderly married couples in her survey had total combined net incomes from all sources of less than £1,500 per year. At the time of the survey the average earnings of adult male workers was £3,600 per year. Fourteen per cent of elderly married couples and 28 per cent of non-married persons were entirely dependent on the state retirement pension and/or supplementary benefits.

In a summary of the extent of poverty amongst the old, Rowlings (1981) states that the housing of older people is worse than that of the rest of the population and that half the elderly population are living close to the supplementary benefit level. Fifty eight per cent of the claimants of supplementary benefits are pensioners. The extent of poverty amongst the old may be greater than these figures suggest as it has been estimated that some 26 per cent of old people who are entitled to receive a supplementary pension do not apply.

The consequences of low income have been summarised by Brody (1977, 63): 'The lower income status of the elderly often results in them occupying inadequate housing located in high crime residential areas with limited transportation services'. Butler, Oldman and Wright (1979) identify three reasons why the elderly, as a group,

live in relatively poorer housing than the rest of the population. First, older people tend to occupy older houses and these are more likely to lack basic amenities and be in poorer condition. Secondly, proportionately more old than younger people live in privately rented property. The private rented sector contains some of the poorest quality housing. Thirdly, the 50 per cent of elderly householders who are owner-occupiers face problems of maintenance which are daunting for a person reliant upon a small income or state benefits.

The problem of housing may be exacerbated by the fact that many old people live in accommodation which is too large for their needs. In 1975, 74 per cent of single person households were over sixty years of age (Department of the Environment 1977). The Cullingworth Report describes the way that household size fluctuates with changing family compostion. It likens the final stage to a hotel - full only at certain seasons of the year (Ministry of Housing and Local Government 1969). It is often difficult to persuade old people to move. Many old people consider themselves satisfied with where they presently live. The Age Concern (1974 b) survey found that 87 per cent of the elderly were 'happy' with their accommodation. The survey also suggested that the percentage of elderly persons living in different forms of accommodation was not very different from the percentages of the total population as shown in the 1971 General Household Survey. The Age Concern findings (with those of the General Household Survey in parentheses) were; owner-occupier 47 per cent (49 per cent), renting from a local authority 34 per cent (31 per cent), renting privately 18 per cent (15 per cent), 'other' 1 per cent (5 per cent). Two per cent of the elderly were living in wardened sheltered housing and another 3 per cent in non-wardened accommodation which was purpose-built for old people.

An important aspect of the inadequacy of housing the elderly is simply that the old person may not be able to afford to keep warm. In one national study, Fox et al (1973) estimated that approximately 10 per cent of old people are at risk owing to the insufficiency of their heating. In Wandsworth, one-third of the elderly people studied by a Task Force complained of the cold by day, by night or both (Task Force 1977).

Day care cannot alleviate poverty. Structural changes within society may be required for this to be achieved. However, a full range of social services may help to alleviate poverty and day care may contribute through the provision of meals and warm day-time accommodation.

Deteriorating health

Deterioration in health is a characteristic commonly associated with old age. It is one of the factors most likely to result in an old person being admitted to a form of care. This point is argued by Isaacs, Livingston and Neville (1972) who link the increased need for care with poor health and the longer life expectations for old people today compared with those for previous generations. They argue that a consequence of advances in medicine and in the social services is that it is becoming the norm for life to end, as it begins, with a prolonged period of dependency.

It is difficult to quantify precisely the extent and degree of poor health.[1] However, the most common medical conditions of old age are those that remain beyond medical cure such as arthritis, rheumatism, difficulty with walking, forgetfulness, poor eyesight, incontinence (Rowlings 1978). Hunt (1978) found that 0.3 per cent of her sample were permanently bedfast and another 4.2 per cent permanently confined to their dwelling. Although nine out of ten of the total sample were able to go out without assistance, less than half those aged 85 and over were able to do so. Arthritic, rheumatic, cardiac and pulmonary conditions were the main causes of loss of mobility. Goldberg, Mortimer and Williams (1970), in a study of 300 elderly clients aged over 70 and newly referred to a social welfare department in London, found that only 34 per cent had 'no discernible medical condition or one which, though causing some degree of disability, like an arthritic hip-joint, was never likely to be a direct threat to life'. Isaacs, Livingston and Neville (1972) found that the five symptoms most likely to cause an old person to be dependent upon others are stroke, falls,[2] inability to walk without support from bed to toilet, incontinence and severe mental abnormality.

1 As with poverty, poor health is a relative and arbitrary term. It is less open to quantitative measurement than poverty.

2 The frequency of falls has been shown in a study by Exton-Smith (1981) of 900 old people living in their own homes. He found that 30 per cent of women aged 65 and over in the sample had sustained falls during the previous year. There was a linear increase in the frequency of falls with age and 50 per cent of women aged 90 had sustained falls in the previous year. The frequency of falls in men was less but showed a similar pattern of increase with age except that there was a decline in frequency after age 85.

Seventy-seven per cent of the population of old people's homes in a study by Peace, Hall and Hamblin (1979) had a long term health problem. The most common complaints were general aches and pains, cold or flu, and getting to sleep at night.

One of the difficulties in estimating the extent of ill-health in a population is deciding the extent to which it is possible to rely on self-reporting of health problems. This may be a particularly great difficulty with the elderly. Some researchers have found a tendency for old people to exaggerate how good their health is. (See, for example, Peace, Hall and Hamblin (1979).) Some writers have suggested that this is because old people tend to disregard health problems, preferring to 'put things down to their age'. Consequently many elderly people have lower health expectations than younger people. (See, for example, Wicks (1978) and Rowlings (1981).) However, research findings show a wide variety in old people's self-assessment of their health. For example, Fennell et al (1978) in a study of day care users in East Anglia, found that only 2 per cent rated their own health as 'excellent' and another 24 per cent as 'quite good'. However, Bowl et al (1978), in a comparable study of day care users in Birmingham, found that 37 per cent rated their health as 'good' or 'very good'. Hunt (1978) found that over three-quarters of her sample claimed to enjoy good health. The Age Concern (1974 b) survey found that 'self-assessment of health for age varies little across age groups: the over 75's are just as likely to feel their health is good for their age as is the newly retired'. Sixty-nine per cent of women aged 70 and over, 77 per cent of men aged 70-74 and 79 per cent of men aged 75 and over thought that their health was good for their age.[1] As Fennell et al (1978) point out, such figures are not only interesting in their own right but as indicators of morale.

1 The report notes that several medical studies have shown that older men are indeed healthier than women of a similar age.

However, it is not only the elderly themselves who may have low health expectations. Younger people may expect the elderly to suffer ill health. Harris (1975, 31) for example, records a disparity between the 21 per cent of elderly Americans who experience serious poor health and the 51 per cent of Americans who 'expect the elderly to experience serious poor health'. A researcher may have to decide to what extent he should accept an old person's self-assessment of his health or that of a professional carer. Peace, Hall and Hamblin (1979) are inclined to disregard respondents' estimates of their own health as 'giving a false impression' and to accept the estimates of officers-in-charge.

Taylor (1981) has surveyed the use of self-reporting methods in obtaining information on the health status and health needs of the elderly. He claims that studies of self-reporting consistently identify a large proportion of clinically diagnosed conditions that are not matched by self-reported conditions. Taylor concludes that under self-reporting is the norm. He emphasises that virtually all the studies he surveyed are American and that there is a dearth of British evidence.

However, there is British evidence concerning the extent to which general practitioners are aware of the health of their elderly patients. A study conducted in Edinburgh by Williamson et al (1964) was concerned with this issue. Their most striking observation was the extent of multiple disabilities. Only eight of the 198 people sampled had no disabilities. Men had an average of 3.26 disabilities of which 1.87 were not known by the family doctor while the figures for women were 3.42 and 2.03 respectively.

The subjects studied were patients of three different practices: two in the city and one in a small mining town. Interestingly, the doctors in the small town practice were more aware of the disabilities of their patients and no severe disability was unkown to them. Bowling and Cartwright (1982) sent questionnaires to the general practitioners of 361 widows of men and women who had died in the previous six months. Sixty-one per cent replied suggesting to Bowling and Cartwright that these were the general practitioners with the greatest level of involvement and concern with the problems of the elderly widowed. Only 53 per cent of respondents knew whether the widow had sons and daughters. Twenty-seven per cent of widowed patients were taking prescribed drugs when the doctor did not realise it. General practitioners and the widows had different perceptions of the latter's health. Doctors did not report a range of symptoms that widows themselves claimed to be suffering but Bowling and Cartwright suggest that in some cases this was because the widows had not specifically consulted their doctors about them.

Anderson (1973) suggests that general practitioners may overlook the early onset of illness in the elderly. He claims that their training has taught them to look for single conditions whereas, in the elderly, multiple diseases are common. Brotherston (1981) similarly emphasises the likelihood of multiple pathology in the elderly. Hazan (1980, 98), in a participant observation study of a day centre in London run by the Jewish Welfare Board, found that the clients mistrusted doctors 'and stories concerning medical errors, contradictory treatments, disagreements within the medical profession, disregard and negligence were constantly circulated'.

The fact that many elderly people underestimate the extent of their poor health may be connected with the difficulties many have in coming to terms with physical change. Brearley (1975) identifies this as a particular problem of old age and cites, as an example, the difficulty of coming to terms with not being able to play the piano. The problems of adjusting to disabilities have been examined by Miller and Gwynne (1972) in a study of a residential institution for incurables. They conclude that the adjustment a person makes to disability depends upon his ego involvement, the internalised values he holds about physical impairment and the response he meets from the environment. The problems of adjustment for a severely disabled young person must not be underestimated but it is probable that they are at least as great for the elderly. Ego development of an elderly person is likely to be advanced. If she has enjoyed good health she will be adjusted to a life of physical normality and yet she will be living in an environment in which poor health in old age is regarded as the norm and old age is not valued - a point that will be developed later. In adjusting to old age and the disabilities it often brings, the point may be reached at which the 'lifelong conflict between the need to retain individuality and to remain dependent upon a supporting other' is brought to a head (Brearley 1975, 17). Illness provides a socially acceptable way of coming to depend upon another person.

This issue of the way in which a person adapts to old age is developed by Williams (1976). Williams identifies two different patterns of response to the ageing process. In the first pattern, as the person becomes less physically fit he draws on inner resources to adapt, 'cuts his losses' about what he can and cannot do, and develops capacities to adapt or compensate for the present situation. The second pattern applies to persons whose self-concept is bound up with health and who see health and sickness in black and white terms. The first sign of illness poses such a threat to their self-concept that it has to be denied.

## Brain failure

Poor health is a real problem of old age as is adjustment to it. Physical poor health, however, is a disability that most people can understand and recognise even if particular aspects, such as incontinence, evoke less comprehension than others. Mental disorders, on the other hand, pose additional problems. They may be more difficult for relatives or caring agencies to recognise, to understand, to cope with. The sufferer himself may be less likely to know or accept that he has a mental disorder than a physical one. Mental disorders are common, especially amongst the old elderly, but 'mental disorder' is a term that covers a range of very different disabilities. The term 'brain failure' is often used to cover a wide variety of conditions and in view of its common usage in contexts where precise medical terminology is not necessary, it will be adopted here.

Precise data on the prevalence of brain failure is difficult to obtain. This may be due to problems of definition, the vague boundary between brain failure and such acceptable conditions as 'occasional forgetfulness' and the acceptance of brain failure by relatives who regard it as a normal concomitant of ageing and thus not recorded by general practitioners or others. With these reservations, the extent of brain failure may be suggested. One study of the prevalence of brain failure in the elderly was undertaken by Kay, Beamish and Roth (1964). They studied a random sample of the elderly in Newcastle-upon-Tyne. 'Organic mental impairment' was found in 10 per cent of people aged over 65 and, in half these cases, it was of severe degree. There was a marked increase in the incidence of such impairment in those aged 85 and over. Hall, McLennan and Wilye (1978) estimate that about 13 per cent of UK citizens over the age of 75 and 22 per cent of those aged over 80 have a significant degree of brain failure. Post (1974) estimates that 10 per cent of all

people in the UK aged over 65 are victims of severe psychiatric illness. The Department of Health and Social Security (1976 a) estimates that between 2.5 and 3 beds are required in local hospital units per 1,000 elderly for elderly people with severe mental infirmity and between two and three day hospital places per 1,000 elderly. The Department suggests that there may be over 650,000 elderly with varying degrees of mental infirmity associated with old age living at home or with relatives or in various types of residential accommodation.

In an overview of the literature on the prevalence of brain failure, Rowlings (1981, 47) states 'one in ten people aged 65 and over and living in the community suffers from moderate or severe dementia and the incidence increases markedly in the very old: about one in five of those aged 80 and over and living in the community will be affected'. Rowlings urges that we should not lose sight of the fact that four out of five persons aged 80 and over living in the community are not suffering from dementia and that 'going senile' is not the norm. Moreover, confused behaviour may not be associated with dementia but may be a consequence of illnesses or medication in which case the number of elderly confused is greater than the number suffering from dementia. The close link between brain failure and physical illness is discussed by Airie (1973) who concludes that the prevention and treatment of physical illness is sometimes the best way to prevent the onset of mental illness.

Loss of existing skills and difficulty in learning new skills

The difficulty faced by the elderly in learning new skills is one that caring agencies must take into account. Day centres and residential homes are often urged to provide activities and opportunities for users to develop new abilities. While one would not wish to discourage this objective, it must be borne in mind that increasing sensory deficits may make it difficult for many old people to learn new skills (Rowlings 1978). It is important to sustain the skills that elderly people already have. One of the conclusions of a study of the elderly in Brighton (Department of Health and Social Security 1980) was that many of the talents possessed by residents of old people's homes were going to waste. The authors identify a range of such skills including gardening, crafts and games. They suggest that open days to sell garden produce and articles made by residents, bingo evenings, participation in snooker and darts leagues would provide residents with a stimulus and increase connections with the local community.

The Age Concern (1974 b) survey found that 27 per cent of the elderly sample had taken up a new acitivity in 'recent years'. Against this, almost half the sample had given up doing something in recent years - apart from their job - which they considered important. This was usually shortly after retirement and Age Concern conclude that a falling off of activity occurs before or at retirement and not between the ages of 65 and 75. The activities given up ranged from gardening, handicrafts, walking, driving, dancing and reading to drinking and smoking. Their own or their spouse's health was the most frequently stated reason for giving up. Their age, finding the activity too tiring, financial cost and the facilities no longer being available were a second group of reasons.

## Past-orientation

Many researchers have identified past-orientation as characteristic of elderly people. This orientation may be quite non-specific and is typified in the following extract from the present writer's research diary:

> Mrs Watson, an old lady of 83 who was mentally alert, called me over. 'I'd like you to have a look at this, Mr Taylor'. She handed me a cutting from the local newspaper in which four or five extracts were reprinted from an edition of the paper of 50 years previous. All were short and included a statement on an increase in bus fares, the opening of a new bank and the naming of the next mayor. I was unsure which of the extracts was of particular interest to Mrs Watson. I enquired. 'Oh, all of them, Mr Taylor. I think it's so interesting, don't you?'.

Although such a past-orientation may be frustrating for many caring staff, some authors have pointed to the opportunities it presents for positive action. Brearley (1975), for example, suggests that reminiscing can make an old person feel valued and more of a person. This may be particularly important for someone in a residential home: 'without his own home and many of his possessions, the habits of a lifetime may become especially important to an elderly person who has few other reminders of his identity left' (Rowlings 1981, 121).

## Loneliness and isolation

It may be that the difficulty of learning new skills, a general feeling of tiredness which makes inactivity attractive and past-orientation form a vicious circle. If loneliness is included in such a circle it becomes formidable. A similar point is made by Bromley (1977, 55) who suggests that 'increased isolation and passivity of people in later life tends to cut them off from public and private sources of information important to their own welfare and to exclude them from activities which they would find beneficial'. Loneliness and isolation are well documented characteristics of old age which, while clearly not the same, may show a high correlation. It is possible for someone to be isolated and yet not feel lonely. Similarly it is possible for someone not to be isolated yet to feel lonely. Isolation is, theoretically at least, operationally quantifiable while loneliness is subjective. At this stage isolation and loneliness will be considered together.

Townsend (1962) identifies three ways in which isolation in old age may occur. First, some people may never have had any close friends, relatives of their own or succeeding generations. Secondly, some have had friends and relatives but these have been lost by death or emigration. Thirdly, others may have had relationships with friends but these have weakened through separation or infirmity.

Hadley and Webb (1974, 4) found three 'different but overlapping' reasons for isolation and loneliness among the elderly:

> First, there were the older people who had relied heavily throughout their later adult's life on a single relationship such as that with a husband or wife, a sibling, or a very close friend. In such cases isolation and loneliness can strike very

suddenly with the death of the partner. Second, we noted the problems of those old people who had been part of a large and active network of family and friends but who had subsequently become isolated . . . Third, a number of old people become isolated by chronic ill-health, whether mental or physical. Finally, we encountered old people who had lived with these problems all their adult life.

Hazan (1980) argues that the main reasons for loneliness are frequency of death amongst peers, retirement, ill health, a rejecting society, an alienating family and a non-supporting community. Hall (1976) suggests that many old people are unable to maintain social relationships as they had in the past and this causes them distress. This may 'precipitate disfunctional behaviour' in an old person and increase isolation.

Isolation is easier to define operationally than loneliness. Wroe (1978), commenting on the 1971 census which showed that 30 per cent of all elderly women lived alone compared with 13 per cent of all elderly men, suggests that the problem of loneliness is confronted more frequently among women than among men. It may be that the individual's perception of whether or not she feels lonely is more important than any operational definition of isolation. Townsend (1962, 189) argues: 'to be socially isolated is to have few contacts with family and community. To be lonely is to have an unwelcome <u>feeling</u> of lack or loss of companionship. The one is objective the other is subjective . . . the two do not coincide'. The fact that isolation and loneliness are different and the difficulty of measuring the two states are demonstrated by the results of a study undertaken by Plank (1978 b). He investigated the extent to which elderly people had spoken to other people during a period of one week. He found that 90 per cent of elderly people in old people's homes had seen someone to talk to in the previous seven days compared with 99 per cent of those living in sheltered housing, 93 per cent of those on waiting lists

for residential homes, and 96 per cent of those considered suitable for sheltered housing. Plank also asked his subjects whether they ever felt lonely. Seventy-one per cent of residents of old people's homes claimed to never feel lonely, 23 per cent claimed not to have a close friend nor to chat regularly to other residents. Forty-two per cent of subjects on waiting lists for residential homes claimed not to feel lonely while 31 per cent of these subjects claimed to feel lonely on most days.

Of the sample of the Age Concern (1974 b) survey of the elderly, two-thirds felt that they had 'a lot of friends locally'. Nevertheless, one-quarter of the sample felt lonely some of the time and 7 per cent felt lonely most of the time. The Department of Health and Social Security (1980, 15) study of old people in Brighton identified a feeling of loneliness as one of the main characteristics of the population:

> A number of things made it difficult for the elderly people to gain any feeling of belonging to the community at large. Many people lived in rented or owner-occupier accommodation on run-down estates. The other householders were often young married couples - and many were out at work as well as being pre-occupied with the tasks of bringing up children. Where neighbours were older they tended to be incapacitated in some way, either by age or physical handicap, and they too were unable to move out of their home and visit others.

Despite the extent of perceived loneliness, very few wanted to 'relieve their isolation by belonging to a club for the elderly or handicapped'.

Several other studies have emphasised the extent of loneliness among elderly people. Harrison (1973) quotes the 1972 Age Concern survey of old people in which 58 per cent of those questioned felt lonely. Goldberg, Mortimer and Williams (1970) on the other hand, found that only 13 per cent of the 300 elderly clients they sampled

admitted to feeling lonely often. In Townsend's (1962) study of residential homes, 44 per cent of men and 49 per cent of women claimed to be lonely; higher percentages than those of elderly people living in their own houses. Fennell et al (1978), in the study quoted above, found that 21 per cent of their sample claimed to be very lonely and only 26 per cent not at all lonely. Twenty per cent of Bowl's (1978) sample claimed to be very lonely and another 33 per cent lonely sometimes. Tunstall (1966) found that one-third of his sample complained of loneliness, a similar figure to that suggested by Shanas et al (1968).

Issacs, Livingstone and Neville (1972) and Ross and Kedward (1976) have shown that isolation and loneliness are predictors of the need for residential and medical care.

Townsend (1973), in a study of old people in Bethnal Green, found that elderly isolates make disproportionately heavy claims on social and welfare services whereas elderly people with daughters at hand make least claim of all.

In a recent study by Taylor, Ford and Barber (1983) elderly people living alone were not found to be significantly disadvantaged compared with other elderly. Taylor, Ford and Barber investigated the extent to which members of ten different groups of the persons aged 60 and over in Aberdeen are at risk. They identified ten potential risk groups and constructed a 'risk profile' for each group on the basis of 19 resource variables grouped into six domains - health, psychological, activity, confidence, support and material well-being variables. The 'isolated', the 'never married' and, to a lesser extent, the 'childless' were the three potential risk groups found to be minimally disadvantaged. The 'recently widowed', 'living alone', the 'poor' and those from Social Class V constitute a second category. They were close to the sample

mean and are characterised by deviations both above and below. The final category, consisting of the 'recently moved', 'recently discharged', 'divorced/separated' and 'very old', is characterised by more deviations below than above the sample mean. They all scored worse than the sample as a whole in terms of health and/or psychological functioning. This category comprises the groups at greatest risk.

Bereavement and attitude to death

An important factor to consider when examining loneliness and isolation is the amount of bereavement suffered by many old people. Several writers have compared the reactions of old people to death with those of younger persons. Marris (1974) concludes from his study of 72 widows that typical signs of grief are physical distress accompanied by worse health, inability to surrender the past (eg. brooding over the dead and not relinquishing their possessions), withdrawal into apathy and hostility against others, fate or self. Marris suggests that the acute phase of grief may abate slowly only after a year or so. He notes that all the studies he has reviewed suggest that grief must be worked out from shock through acute distress to reintegration and that, if the bereaved cannot work through this way, they may suffer lasting emotional damage. Marris contrasts this with bereavement in old age where grief reactions seem to be modified: 'Bereavement is less of a traumatic disintegration of identity, because in old age the content of life has shrunk' (1974, 38).

Williams (1974, 5) however, suggests that 'previous experience of bereavement does not diminish the pain and grief of subsequent ones; but satisfactory adjustments to earlier bereavements will have built up trust and confidence with which to face these later occasions'. Gramlich (1973) suggests that inhibited and chronic grief may

be more common amongst the old. Gramlich suggests that 'chronic grief' is associated with intense feeling over a longer time span than is found in typical grief and may give rise to hostility, suspicion or apathy. 'Inhibited grief' appears subdued but is long-lasting and often associated with physical or psychological symptoms.

Most old people are likely, because of their longevity, to have suffered the bereavement of several close friends or relatives during their lives. Cartwright, Lockey and Anderson (1973, 205) suggest that 'older people are more practised at managing their grief'. As a consequence they 'do not consult their doctor as much as younger bereaved people.' Shanas et al (1968) have linked bereavement and loneliness in old age through the use of the term 'desolation'. Shanas et al argue that living alone is not necessarily a problem for old people. Similarly, the grief of bereavement is a normal process which most people are able to cope with in their family. However, when an isolated person is bereaved he is likely to become depressed and lonely; in other words 'desolated'. The Age Concern (1974 b) survey of the elderly provided some support for this position. Only two per cent of those who felt lonely did not relate the onset of loneliness to a particular time or change of circumstances. Fifty-three per cent of those who felt lonely most of the time identified a bereavement as the onset of loneliness. Hazan (1980) found that elderly people who had lived for a long time with someone who had recently died complained bitterly of loneliness regardless of the intensity of social contacts they had at the time.

Bowling and Cartwright (1982) state that the difficulties faced by the elderly widowed are the same as those faced by other widows. However, they are faced with other problems at the time of their widowhood. They may have to choose between living alone or uprooting to live with relatives; a decision that has to be taken quickly for financial reasons. For some who are themselves disabled, widowhood may mean that they have lost the person who cared for them. As

widowhood is usually the climax of a period during which life has revolved around caring for a sick person widowhood may mean that the widow has lost the main 'occupation and pre-occupation' of life.

A possible consequence of frequent bereavement is that the bereaved may be more likely to contemplate their own death. Thus, the importance of the death of their fellows may be greater for old persons in total or partial institutions. It has been shown that the population of institutions for the elderly is essentially a population of the old elderly and that the old elderly are more likely than younger people to suffer from poor health. It follows that the death rate in such institutions is likely to be high and the effects on an individual of frequent deaths amongst people with whom she associates regularly and closely must be considered. In their study of institutionalised physically handicapped, Miller and Gwynne (1972) found that the overt response to a dying inmate is often resentment more than sympathy. They suggest that this is partly because the dying seem to be receiving more than their fair share of attention and partly because it is an unwelcome reminder of mortality. However, Miller and Gwynne's findings are not from an institution for the elderly and it cannot be assumed that elderly clients respond in a similar way.

Hazan (1980, 47) stresses the importance of impending death in the lives of the elderly people in the day centre he studied:

> The proximity of impending death impinges heavily upon the elderly person's conception of time. Recurrent losses of spouses and friends, daily confrontations with hospitals, worsening ill health and the certainty of constant deterioration, are all interlinked contributions to the realisation that life is an accelerated sequence of uncontrollable changes heading towards an inevitable end. Disenchantment and awareness rob this realisation of any acceptable meaning.

However, 144 of the sample of 151 elderly persons in the study of Peace, Hall and Hamblin (1979) claimed that death and dying did not bother them at all. It is important to distinguish fear of death from fear of dying. It may be that the former causes considerably less anxiety than the latter which might include such various factors as fear of physical pain in dying and worry over funeral expenses.

It may be that people working with the elderly find it difficult to cope with death. Peace, Hall and Hamblin state that their interviewers were worried about asking questions about death. Brearley (1975) suggests that social workers may fear any more than a superficial relationship with an elderly client because of the grief and distress that may accompany the client's eventual death. Mortimer (1982) thinks that many professional helpers find it difficult to allow themselves to become close to the bereaved. She suggests that this is basically for three reasons. These are, first, an unacknowledged fear of death, especially amongst younger people; secondly, a reluctance to allow the bereaved to express their sorrow because of ignorance of what is normal grief and what is not; thirdly, the fear that they will not be able to live up to the demands which may be placed upon them. In the context of various researches quoted above, Rowling's (1981) argument of the need for research into the impact of death on the staff of homes appears important.

## SOCIAL CONTEXT OF CARE OF THE ELDERLY

The literature reviewed in this chapter so far may be summarised. A high proportion of elderly people, particularly the very old, require formal social care.[1] As the population of old people in absolute terms and as a proportion of the total population is increasing, the numbers of the elderly requiring care is increasing, while the ratio of wage earners to retired people is falling. Although the proportion of the Gross National Product devoted to social and health services for the elderly rose during the 1960s and early 1970s this has now levelled off and levels of provision recommended by the government have not been met. In view of the need to identify reasons for the provision of caring services, the difficulties faced by the elderly that are most likely to result in them requiring these services have been discussed. These are poverty, deterioration in physical health, brain failure, the loss of existing skills and the difficulty in learning new skills, loneliness and isolation, frequent bereavement. Before considering the different forms of care that may help to alleviate these difficulties, attention must be paid to other factors which influence provision of social care of the elderly in different ways. The factors discussed are the problems of assessing the effectiveness of care by assessing quality of life in different environments, comparative costs of different forms of care, sociological approaches to old age, the fragmentation of social provision and lack of clarity concerning the aims of care.

1 The major providers of social care are relatives. Their contribution is discussed later in this chapter.

## Quality of life

Although one might feel intuitively that it is better for elderly people to remain within their own homes or within institutions, one might also wish to assess the relative effectiveness of different forms of provision through an objective measurement of effectiveness. One approach to measuring effectiveness is to determine a way of measuring the quality of life of elderly people and then comparing the quality of life in different forms of provision. The importance of assessing quality of life is emphasised by Walker (1982, 111) who states 'there is a need to measure quality, both the quality of care received by those in need and the quality of life of the carers . . . Simply to point to a continuing low proportion of old people in institutions, and a correspondingly high proportion being cared for by family or community, is clearly a very inadequate and misleading approach.' Some authors have suggested that it is possible to quantify aspects of the quality of a person's life through the construction of quality of life scales. This approach has been taken by Neugarten, Havighurst and Tobin (1961) whose Measurement of Life Satisfaction Index is based on operational definitions of five components: zest, resolution and fortitude, congruence between desired and achieved goals, positive self concept, mood tone. Ratings are based on the inferences drawn by raters from all the information available on the subject including his inter-personal relationships and the way others react towards him. A difficulty with the index is the time that it takes to construct. This has been recognised by Neugarten, Havighurst and Tobin who have tried to derive a self-report instrument from the full scale although they acknowledge that this only partially agrees with the full index.

Morris and Sherwood (1975) developed a 17-point scale which is similar to Neugarten's Life Satisfaction Index. These seventeen items were found to have a relatively stable three-factor structure. These were described as agitation, lonely dissatisfaction and satisfaction with life progression. Lawton (1977) adapted Neugarten's work to focus measurement particularly on the measurement of morale in the very old. Bigot (1974), suggests a different grouping of items from Neugarten and recommends two groupings of questions which he calls 'acceptance contentment' and 'achievement-fulfilment'.

The literature on the quality of life of the elderly has been comprehensively reviewed by Ward. He emphasises that the question of who makes the judgement is crucial, not only whether the person himself or someone else is judging the quality 'but also between one person and another making judgements of what are overtly similar sorts of lives' (Ward 1980, 10). Ward categorises instruments concerned with quality of life into measures concerned with physical illness ('proxy measure of quality of life') and measures related to feelings. The indices discussed above are examples of the latter.

Other researchers have adopted techniques other than quantitative scales in order to identify quality of life. For example, Kernie and Arnott (1973), in a study of quality of life of elderly people in Glasgow, interviewed the subjects and then assessed them post-interview on their impressions of how they rated on four 'cornerstones' of quality of life. These cornerstones were comfort (housing conditions, heating, material possessions, cleanliness), companionship (having somebody around when needed be it friend, relative or pet), adequate food, and purpose of living (the power to occupy one's time according to one's desire).

Challis (1981), writing about the measurement of outcome in social care for the elderly, suggests that three major tasks face the researcher in developing outcome measurement techniques. These are the delineation of appropriate policy objectives for the intervention, the development of tools of measurement appropriate to those objectives and deriving the relative importance of the different objectives in the final analysis. He emphasises that unintended as well as intended outcomes must be measured and illustrates his point by quoting one study which found that one outcome of intensive social work with the elderly was to increase the likelihood of admission to residential care. Challis (1981, 2) claims that there is a 'considerable degree of consensus in the literature of social administration, social work and government policy statements' concerning the broad dimensions of the quality of life on which the effects of services may be assessed for three different parties; the elderly person, immediate family and community as a whole. Challis claims that there are seven dimensions that apply specifically to the elderly person; nurturance, compensation for disability, independence, morale, social integration, family relationships, community development.

It is important to reiterate an earlier point that a person's own assessment of his quality of life may differ from the assessment by a third party. Surely there can be no doubt that, as far as consideration of an old person is concerned, his own assessment is most important. It may be that younger people's assessment of the quality of life of an old person should be treated circumspectly. A study by Age Concern (1977) found that, although a substantial minority of a sample of old people expressed very low levels of life satisfaction, the old people consistently rated their own overall satisfaction with life higher than did younger people.

## Sociological approaches

One of the further difficulties to be faced in determining appropriate forms of social care for the elderly is knowing what constitutes successful ageing. The work undertaken by sociologists is of some help in this respect. Sociologists are interested in such questions as the status of the elderly in society, societal attitudes towards the elderly, and characteristics of the elderly that are socially determined.

In a review of the main sociological theoretical approaches to old age, Wilson (1973) acknowledges that much of this work is American and that it starts from the position that old age in modern society is devalued in contrast to traditional societies.[1] Wilson argues that, in modern society, the older person suffers many disadvantages. His social and occupational skills may be rendered obsolete by the pace of social change. He loses his role of breadwinner, his children are no longer dependent upon him and, as a consequence of his low spending power, he may not be able to participate in society as a consumer. It is towards issues such as these that sociologists should direct their attention.

1 An analysis of the role of old people in traditional societies is outside the scope of this study. However, the writer acknowledges that some writers disagree with Wilson. For example, de Beauvoir (1977) claims that there has never been a golden age in which old people were accorded high status. In contrast, it is the norm for old people to be severely disadvantaged.

One of the earlier American theoretical approaches was the activity theory proposed by Havighurst and Albrecht (1953). They argue that people age successfully if society accepts the value of old people and ascribes them publicly valued roles. Old people could help by substituting new activities in old age for those which they give up on retirement. A weakness of this approach is that it fails to recognise the high degree of physical handicap amongst old people. As society has ascribed a limited number of roles to old people the range of new activities for them to choose from is limited and these are ascribed low status anyway. Further, where old people's contributions are in intellectual spheres they may continue to command respect. Some elderly politicians might be cited as examples.

Cumming and Henry (1961) argue that society withdraws from the older person but the older person co-operates in this process. Thus, there is a mutual process of disengagement between the old person and society. This process is part of a person's adjustment to approaching death with social mechanisms helping him in his preparation. Disengagement theory has been criticised on the grounds that it is a functionalist theory based on the assumption that society maintains itself in a smooth equilibrium, that the process must take place in all societies and must involve all individuals in that society (Rose, 1965). It has been criticised by Harrison (1983) on the grounds that it is 'the geriatric euphamism for social death'. She states that it serves as a justification for the exclusion of elderly people from social activities. Wilson (1973) criticises disengagement theory on the grounds that it appears to him to have an underlying value judgement that decline in status and the increasing withdrawal of the old person is a good thing. Wilson also argues that the available evidence does not show that withdrawal from society is freely anticipated by older people nor that people begin to withdraw in late middle life before they are

actually pressed to do so. There is evidence that the happiest old people are active and 'engage' in society, that only a minority of elderly people who are isolated and 'disengaged' are carefree and display high morale (Roscow 1967). One's own experience does not lend force to the theory. It is difficult to think of an elderly person who is disengaged but not depressed.

Gubrium (1973) emphasises the interplay between two factors; activity resources and activity norms. Activity resources are those things that enable an old person to do the things he wishes and may include money, housing, health. Activity norms are the norms he has come to accept and which he shares with others concerning what he should be doing. Gubrium's theory lays emphasis on the importance to old people themselves of expectations about activity. They will be satisfied when they are able to do what they and others regard as appropriate.

Comfort (177, 35) challenges all theories based on ageism. He sees the concept of ageism as part of a prejudice against the elderly. He defines ageism as 'the notion that people cease to be people, cease to be the same people or become people of distinct and inferior kind by virtue of having lived a specified number of years . . . like racism, which it resembles, it is based on fear, folklore, and the hang-ups of a few unlovable people'.

Fontana (1977, 177-8) is critical of existing theories of ageing which, she considers, are too simple. As a consequence, they provide only simplistic explanations. She believes that various theories 'seem to fit some groups of individuals while they fail to explain others'. She argues that symbolic-interactionism is one of the more useful theories 'since growing old in a particular setting is bound to be affected by the situational surroundings'. A symbolic interactionist approach is also adopted by

Mathews (1979) who argues that elderly women learn that 'oldness' is an attribute that is discrediting and by Russell (1981) who studied the meanings which the elderly attach to old age. While recognising the strengths of symbolic interactionism, Harrison (1983) is critical of the approach on the grounds that it gives too little importance to the social, economic and political contexts within which the elderly hold their self images.

Townsend's (1981 b) criticism of existing sociological approaches to old age is more fundamental than Fontana's. Townsend argues that the emphasis has been on individualistic theories that have tried to explain individual ageing within a structure that has been accepted without question. Sociologists should be questioning the framework of institutions and the rules within which the problems of the elderly are manufactured, the speed of increase in retirement rates and the role of pensions in promoting dependency. Two levels of analysis are necessary:

> One is to explain how the general position, status and functions of the elderly within existing society have been determined or established. The other is to examine and explain the kind of relationship within different structures which elderly people have, the roles they play and experience, concurrently and sequentially.

Similarly, Walker (1981 b) is critical of existing theories which have 'tended to concentrate on individual adjustment to old age' and provided 'narrow, functionalist explanations of depressed social status. He argues for a theoretical approach based on political economy which would focus on the social creation of dependent status, the structural relationships between elderly and younger people and between different groups of elderly people, and on the socially constructed relationship between age, the division of labour and the labour market. Kohli, Rosenow and Wolf (1983) also believe that a sociological theory of ageing should start from the

structural features of the economic process. It is important to ask how these processes shape work careers and how they create special risks for older workers. Kohli, Rosenow and Wolf argue the importance of labelling theory in answering these questions. This would help explain why older employees are seen in terms of 'age-limited performance evaluations that are part of the taken-for-granted meaning structures'.

Johnson and Glendenning also focus on the economic status of the elderly. Glendenning (1981, 225) refers to the way in which modern industrial societies view and treat their old members:

> Industrial society has been engaged for generations now in developing a mythology about ageing, in order to justify and reinforce its attitudes to 'retirees', cast aside from economic productivity at a particular age and in a particular way. Society manages to do this in such a way that very many of the older members of the community feel themselves rejected and discriminated against. Even advertising is geared towards the young as if to exclude older people. So they accept their new role. They acquiesce in their plight of less income, failing health and loss of status.

Johnson (1975) examines the gift relationship proposed by Titmuss which has as its thesis that the exchange of gifts is one of the factors binding people together in modern societies. An example would be the donating of blood by donors to total strangers. Johnson suggests that the gift relationship is not open to many older people as they are virtually excluded from the economic sphere.

As well as Townsend and Walker, several writers have emphasised that the elderly must not be regarded as a homogeneous group. Abrams (1978) and Taylor and Ford (1983) are examples. Taylor and Ford have tried to identify the social categories of elderly people whose personal resources are lowest amongst a random sample. They found that personal resources, which they categorised as financial, social, health and psychological resources, diminished with age from 60 onwards. However, men tended to have more personal resources than women and those from middle-class backgrounds tended to have more than those from working-class backgrounds. The main exceptions to this pattern were in the realm of social support: older people claimed to have more friends than younger people, women claimed to have more friends than men and people from working-class backgrounds reported having more children and siblings living locally than subjects from middle-class backgrounds.

What are the implications for care to be drawn from the work of these sociologists? First, it is not a consequence of loss of previous status and previous role that there is no role for the elderly. Most elderly people do have skills and experience that can be built upon and used. A task of caring agencies is to use the skills and experience in ways that benefit society, to provide a role and status for the elderly. This is the positive aspect of activity theory. Secondly, disengagement theory must not be interpreted as providing justification for neglecting the elderly by suggesting that it would be inappropriate to impede an elderly person's disengagement. Thirdly, carers must avoid the temptation to think of 'the elderly' as a homogeneous group but must be aware of the social structures which have differentiated the elderly. Fourthly, post-retirement provision is insufficient to tackle what are structural problems within society.

## Costs

The postion has been reached that there may be some support from work on quality of life measurement and sociology of the correctness of arguments that caring for the elderly in their own community (and preferably in their own homes) is preferable to caring for them in a residential establishment. In a time of scarce resources, the comparative costs of different forms of provision are important factors in determining the provision to make available. However, the available evidence concerning the costs of different services is inconclusive. This is due partly to the linked difficulties of establishing a 'unit of effective care' that may be used as the basis for comparing costs in different services and of determining what should be included within the calculations. For example, the wages of a care assistant to accompany an elderly person in a residential home to the toilet are likely to be taken into account but should the potential loss of earnings of a relative performing the same function for an elderly person living in her own home? In his study of comparative costs of residential and community care Wage (1972, 61) argues that, in order to reach a decision on 'the relative benefits of residential and domiciliary care it would be necessary to follow the progress of matched groups of elderly persons, half of whom entered residential care while the remainder were provided with intensive domiciliary care, to assess the relative satisfaction gained from their comparative situations'. He suggests that 'there is substantial scope for exploiting further the provision of domiciliary care as a means of satisfactorily keeping old people longer in their own homes' (Wage 1972, 39).

Clough (1981), however, argues that, as far as the highly dependent are concerned, domiciliary provision is only cheaper while it is less adequate. Fennell et al (1978) make a similar point. They argue that residential care may be no more expensive than day care plus the necessary community services.

Mooney (1981) emphasises the methodological problems of comparing costs of different forms of provision. He states that no one has solved the problem of placing actual monetary values on the benefits provided by caring for the elderly. The reasons for this are partly a consequence of economists being unable to solve valuation problems and partly a consequence of the lack of knowledge about the effectiveness of regimes in different care locations. Mooney suggests a marginal analysis approach to costing the care of the elderly. Marginal analysis is based on three central ideas. First, only those things which bring benefits greater than costs should be undertaken: secondly, activities whose benefits are less than their costs should be discontinued; thirdly, in the absence of budget constraints, an activity should be expanded until the marginal benefit equals the marginal cost. Mooney describes a study in Aberdeen which attempted to put the marginal analysis approach into practice. 'Marginal' clients were identified by asking health visitors to identify which of their clients they would recommend for residential homes or hospitals if places were available and asking matrons of residential homes which of their clients they would recommend for hospital or to move back into the community if less residential home places and more hospital places were available. Mooney emphasises the caution with which his work should be treated. However, he suggests that the costs per capita for the elderly population are £1,380 for a person in the community and visited by a health visitor but not 'on the margin', £1,800 for such a person 'on the margin, £2,610 for a 'non-marginal' resident of a home, and £2,500 for a resident on the 'community margin'.

Mooney's findings concerning the high costs of 'non-marginal' residents are supported by Darton and McCoy (1981). They report research in a random, national sample of residential homes in the public, voluntary and private sectors. The research assessed the influence on costs of 'intermediate output' (eg. number of places provided, day places, meals for outside consumption), level of dependency of residents, resident turnover, and structural features of the home. The major variable was found to be the number of heavily dependent residents who increased staff costs.

In contrast, Knapp (1979) found that residents of 'appreciable dependancy' may place greater demands on staff than those of 'heavy dependency' as they are more mobile and may require more supervision and care. Knapp also found that the size of a home is an important factor. Larger homes tend to be cheaper up to an optimum of 60 places but above 60 places the average cost per resident begins to rise again.

Aims of care and the fragmentation of services

In view of the wide range of single or multiple difficulties faced by the elderly who require care, the problems of assessing the quality of life resulting from different forms of provision and the difficulty of costing care, it is not surprising, perhaps, that the aims of services for the elderly are often unclear. Lack of clarity concerning the aims of care and the lack of co-ordination of services are recurring issues in the literature on care of the elderly. The confusion over the aims of the Centre is a major theme in the research into Suilven House.

Some writers recognise that the aims of care are not always stated clearly. Brody (1977) suggests that there is confusion as to the aims of care and states that the problem of developing criteria of quality of care is clouded by the lack of clarity as to the target population and the kind of services to be offered. Plank (1978 a, 18) echoes this view:

> We have failed, as a society, to devise and implement a 'care system' adequate to cope with the needs of elderly dependent people. If such policies do not exist, as they most surely do not, some of the most vulnerable members of our society will and do suffer . . . part of the blame must be attributed to our failure to understand what the elements of a true 'care system' might be and our attempts to formulate and implement policy without that understanding.

The aims of different forms of care for the elderly are considered in the appropriate places later.

Different forms of care are sometimes posed as points on a continuum related to the level of need of clients. The continuum might have provision of limited domiciliary support such as home help at one end and residential home at the other. A client may move along the continuum as her level of need changes. Despite the attractions of this argument and the frequency with which it is stated as reality, there is evidence that services are fragmented rather than co-ordinated. This may be a consequence of the way in which services in Britain are organised with different local government or health authority departments being responsible for different forms of care. The problem of fragmentation of services is emphasised by Plank (1978 a, 16-17) who argues that sheltered housing, residential homes and health service provision offer three very distinct kinds of care: 'This may be the result of a conscious development of policy for the elderly by individual local authorities.

But, in my view, it is more the result of the administrative base from which the services have developed and the continuing administrative rigidities which exist between services'. As a consequence, the major forms of service provision develop in an unco-ordinated manner and, because of the fragmentation of services, the care that any elderly person receives is, to a major extent, fortuitous. The conclusions of an Age Concern (1975 a) Continuing Care Project concerning the care of elderly patients after discharge from hospital in Liverpool are that services are not properly co-ordinated, are not clear about the limits of their responsibilities and are not designed with the needs of the elderly in mind.

Jeffreys (1977) stated that the elderly, with their multiplicity of social and medical needs, are most likely to fall victim to the administrative division of responsibility between health authority and local authority. At the same Conference, Grimley Evans claimed that 'implementation of the Seebohm report has made an integrated geriatric service impossible and a co-ordinated one difficult unless links between agencies are very much closer than legislation requires' (Grimley Evans 1977, 129).

Cartwright, Lockey and Anderson (1973) studied the lives and care of a random sample of adults who had died in twelve registration districts in England and Wales. They found geographical variations in the provision of services for the elderly which, they claim, did not coincide with variations in need. One of their main conclusions drawn is the need to ensure better co-ordination of health and social services especially for the elderly. They identify eleven 'loopholes' in the co-ordination of services. These are between patient and general practitioner, general practitioner and hospital, hospital and general practitioner, hospital and community services,

general practitioner and community services, district nurse and general practitioner, health visitor and general practitioner, housing agencies, general practitioner and relatives, relatives and patient, doctor, patient and relative.

Davies et al (1971) do not deny the fragmentation of provision but they emphasise the difficulties faced by administrators in co-ordinating services. In their paper, Davies et al are concerned with the specification of the optimal role for services in varying circumstances. They note that the optimum is dynamic, in other words the static opitima changing through time with changing need conditions, values, external 'political' constraints and resources. They conclude that the optimal role for services is dependent 'upon an understanding of how relationships between services in the system change in different conditions of need and supply. It is unlikely that the administrator will correctly foresee the implications of any hypothetical state of the variables under his control' (Davies et al 1971, 140). The issue is more problematic for several administrators, each responsible for only part of the total range of services. This is recognised by Brotherston (1981, 22) who believes that 'one of the major problems in planning services for the elderly is how most effectively to bring together the different services and interests concerned'. A different point concerning the co-ordination of services is made by Pedreigh (1981) who argues the importance of a systematic planning of services in order to compete for funds, to husband scarce human resources, to effect economies, to maximise technological advances, to cope with increasing consumer demand, and as a consequence of the planning problems brought about by the large, complex organisations we require to provide care.

The authors quoted above are concerned about the failure to co-ordinate different forms of provision. Other authors are concerned with a prior and more fundamental problem. This is identified by the Personal Social Services Council (1975, 52) as the absence of a fundamental philosophy upon which to base provision for all individuals needing care outside their own homes:

> The lack of such philosophy partly explains the considerable lack of stated or written objectives upon which residential care should be provided, other than those given in general terms of existing legislation. It also inhibits co-operation between statutory and voluntary organisations at national and local level. Aims and objectives of particular establishments and their relationships with other services are often unstated, if not unknown, with the result that the role of staff and the expectations of both staff and residents are confused and lacking in specific purpose.

The conflict identified is a further problem in the formulation of an agreed philosophy.

## SOCIAL CARE PROVISION

Having considered some theoretical and empirical issues concerning the need for care and its nature, it is appropriate to examine now the main forms of provision. These are considered under three heads; residential care, community and family care, day care. Although provision is logically and conveniently discussed in this way, these forms are not completely discreet. For example, day care is sometimes provided within residential establishments yet day care may be considered as part of community provision. Further, although residential care is often posed as 'the' alternative to independent living this implies an element of choice that often does not exist. In the discussion of literature concerning the fragmentation of services for the elderly it has been shown that provision is often not so logically integrated. Further, sufficient resources are often not available to allow such choice. One is aware that, in considering the goals of different kinds of programme and establishing the kinds of care that are best suited to particular individuals, a more idealistic situation than often exists is being discussed.

### Residential care

#### The purpose of residential care

The uncertainty about the purpose of care in general is reflected in the different views that have been expressed concerning the purpose of residential care. Goldberg and Connelly (1982, 205) claim that the 'most articulated aim is that of making it as much "like home" as possible'. Elderly people can continue to live the lives to which they have been accustomed but in 'safe surroundings with the assurance that support and care are available as and when needed'.

The Department of Health and Social Security (1977) suggest a similar aim while arguing that residential care is a last resort for elderly who are no longer capable of living in their own homes even with the support of domiciliary services. The Department defines the appropriate level of care as 'broadly equivalent to what might be provided by a competent and caring relative able to respond to emotional as well as physical needs'. Brearley (1975) is another writer to view residential care as a last resort. He suggests that, while some people are admitted into care basically for their own protection, others are admitted for the protection of others.

The Personal Social Services Council (1975) suggest that residential care is the product of two basically different responses to social problems. These are, first, the creation of group living to meet people's needs for suitable accommodation and, possibly, their social and emotional needs and, secondly, the provision of care. The references to emotional needs are significant as they reflect a change in emphasis away from a nursing model of care in which physical needs are paramount. This is not to deny the importance of providing for physical needs and this is still viewed as the paramount aim by some authors. For example, Clough (1981, 191) believes that the chief function of a residential home is 'to provide a living base in which basic physical needs are met in a way which allows the individual the maximum potential for achieving mastery'.

Tobin and Lieberman (1976) consider three factors to be important in explaining the reasons for entering residential care. These are personal deteriorative changes, the inability of the old person's relatives to provide the care that they or he thinks is required and the inability of the caring services to assure independent living.

Miller and Gwynne (1972) suggest that the tasks of the institution must be to help the individual decide how he will make the transition from social to physical death, to provide him with opportunities to follow the route chosen and to support him in implementing his decision. Although Miller and Gwynne are writing about younger adults with terminal illnesses, the purposes of the home they studied may be similar to homes for elderly people who are similarly unlikely to move again. Nevertheless, there is always the possibility of an individual moving out of the institution. As Townsend (1962) asks, is a residential home a permanent refuge, a temporary refuge for the frail while they recover or a rescue device for the present generation of old people whose needs cannot be met because such material things as good housing and adequate pensions are not yet provided by society? Donahue (1964) states that a good institution provides psychological care, aims to promote the treatment and care of individuals so that they may return to independent living status.

Linden (1964), in contrast, suggests that the best one might hope for is to prevent further deterioration. Linden states that the purpose of care is to socialise the old person to avoid regressions that might occur if he was living in isolation.

A different perspective was put forward at the 1977 Residential Care Association Conference (Social Work Today, 1977) where it was suggested that residential care provides a service for specific adults who find in it greater motivation, satisfaction and care than would be possible in their own homes. Residential care was viewed as one of a number of options open to the clients. However, the question of who should make the choice was not pursued and one suspects that this is an over-idealistic view of residential care. In most places there are not the resources to allow such a choice of facilities nor the mechanism to permit the choice to be made.

The situation is further complicated by doubts within the social work profession concerning the position of residential care work within that discipline. Although a review of literature on social work is outside the scope of this work, it is pertinent to refer to the debate concerning residential social work as this reflects the uncertainties concerning residential care itself.

Only one tenth of the evidence submitted to the Barclay Committee (1982) made reference to any kind of residential services. The Committee conclude that many people take it for granted that all social work is confined to 'fieldwork'. The Central Council for Education and Training in Social Work (1977, 2.2) suggest that residential work 'is a method of social work in which a team of workers work together with a group of residents to create a living environment designed to enhance the functioning of individual residents in the context of their total environment'. One suspects that this definition is based on idealism rather than empirical study. However, other authors have suggested there is no such thing as the residential task. This argument is based on there being no single identifiable objective that is common to all residential settings, and there being no residential acitvity unrelated to objectives of other activities taking place outside the residential setting (Social Work Today 1977). Despite the difinition of the residential task quoted above, The Central Council for Education and Training in Social Work recognise that there is a difference of opinion as to whether residential social work is a separate social work method or whether it is a matter of using casework, group work and community work in particular settings.

The literature quoted above and the fact that the percentage of social services staff possessing professional qualifications and working in residential establishments is smaller than the percentage of qualified field workers might be interpreted as evidence of the lower status of residential work among social workers. There is other evidence which might be interpreted as suggesting that social work with the elderly enjoys lower status than social work with other client groups. For example, there is evidence that social services departments are likely to allocate elderly clients to ancillary staff. In an examination of the task of the field worker in local authority social services departments it was shown that, in many authorities, social work assistants carried case loads of predominantly the elderly and physically handicapped: 'they carried out a range of activities for and on the behalf of these clients: visiting them at varying intervals, arranging attendance at, and sometimes organising luncheon clubs and day centres and running community services such as outings. In addition the assistants normally provided such social work help as was made available to elderly clients' (Hallett 1978, 145). Hallett reports that three main reasons were advanced for allocating elderly clients to social work assistants. First, work with the elderly was more straightforward and their needs more practical than other clients; secondly, the burden of decision-making on the worker was less than with other clients as the elderly are capable of making their own decisions and carrying some responsibility for them; thirdly, the risk of emotional damage was seen to be less for clients who had 'had their life'. The same research found that where elderly clients were allocated to a social worker they were often given low priority within the worker's case load.

## Research and models of residential care

Given the variety of expectations for residential care, it is not surprising that research has not focussed on an assessment of the effectiveness of one or more homes in obtaining pre-set goals. Such research would not be characteristic of research into other social institutions; the same difficulty exists, for example, in the case of schools where there is not universal agreement as to what is a successful school. Instead, most research has focussed either on comparisons between different institutions or on aspects of life within homes. Goffman's (1961) work on total institutions has been influential in research and theory concerning many types of social institutions. It has been widely applied to residential homes for the elderly. Goffman defines a total institution as one symbolised by the barrier to social intercourse with the outside. Total institutions are characterised by the conducting of all aspects of life in the same place, each phase of the members' daily activity being carried out in the immediate company of a large batch of others all of whom are treated alike, all phases of the day's activities are tightly scheduled and the contents of the various enforced activities are brought together as parts of a single overall plan designed to fulfil the official aims of the organisation. Goffman identifies five categories of total institution. One category is for persons incapable and harmless; a category into which the majority of homes for the elderly may be placed.

Goffman's model has been applied and adapted to homes for the aged by Bennett (1964). She developed it by constructing a ten criteria index for measuring the totality of institutions and applied it to an old age home, a geriatric division of a mental hospital and a housing project. Examples of the criteria adopted are the duration of residence for which the institution was designed and the type of sanction system. According to Bennett's index the mental hospital, old age home and housing

project would receive respective ratings of high, medium and low totality. A strength of Goffman's and Bennett's models is that it is possible to use them to examine the extent to which an institution is structured to achieve the goals specified for it. Another development of Goffman's model has been by King, Raynes and Tizard (1971). They identify four characteristics of the regime of an institution that are important in that they deny inmates the opportunities for meeting certain needs. These are depersonalisation, social distance, block treatment and rigidity of routine. King, Raynes and Tizard applied this model to residential institutions for handicapped children. They suggest that the treatment of inmates in various activities as indicated in these four characteristics can typify management styles as either institution-orientated or inmate-orientated.

In contrast to Goffman's model which examines an institution along the single dimension of totality, Pincus (1968) suggests a model that allows an institution to be examined along four dimensions. More specifically, the purpose of Pincus's paper is to 'present a framework for studying institutional environments in homes for the elderly and discuss a technique for empirically measuring the various dimensions or components of such environments'. The public-private dimension refers to the extent to which the environment allows the individual to establish and maintain a personal domain not open to the public view or use and into which the institution will not transgress; the structured-unstructured dimension refers to how much the resident must adjust his life to imposed rules, discipline and other means of social control exercised in the institution; resources-sparce-resources-rich to the extent the environment provides opportunities to engage in a variety of work and leisure activities and to participate in social action in a variety of roles; the integrated-isolated dimension to the opportunity for communication with the larger

community in which the institution is based. Pincus emphasises that the model must be used to examine an institution against its own goals. His dimensions are not on good-bad axes; what is regarded as a 'good' institution for someone recovering from major surgery may be different from 'good' in an ordinary residential home. That the dimensions are fairly independent is demonstrated by Pincus's own application of his model in which he found that the inter-correlations of the dimension scores are very low.

An early approach to quality of life in residential homes was made by Townsend (1962). Townsend's work, although somewhat dated owing to changes in social policy[1] remains one of the most comprehensive. Townsend examined such diverse aspects of homes as the qualifications of staff, contact with different professionals, degree of authoritarianism, response to death within the homes, formal and informal groupings of residents, reasons for admission to the homes. Townsend attempted to provide a scale that would allow a consistent standard of comparison to be made between different residential homes. It was intended that this would bring out some of the differences between them and the extent to which they attain a 'reasonable standard'. Townsend's scale takes account of five general features of institutions; physical facilities, staffing and services, means of occupation, freedom in daily life and social provisions. Within each category are up to fifteen items weighted from one to five. One might question the somewhat arbitrary selection of the items (for example, whether a main building less than 20 years old is really that important) and the quantification selected (for example, why 'at least 50 per cent of mobile residents assisting in the home' should be allocated three points while 49 per cent is allocated none). The weighting of items is problematic and one might have doubts

1 For example, Townsend examined institutions within four categories; workhouse, post-war local authority home, voluntary home, private homes - categories which would not be appropriate today.

as to whether it is methodologically sound to compare the overall standard of one home with that of another on the basis of a maximum computed score of 100 derived from 48 items. Nevertheless, Townsend's scale does allow comparisons to be made between different institutions and the identification of aspects of a home that may be considered for change.

A different model which focusses on the kind of care offered by the institution is provided by Miller and Gwynne (1972) in their study of terminally ill adults to which reference was made earlier. They contrast what they call the warehousing model with the horticultural model. The primary task of the former is to prolong life. The hospital model is translated into the residential setting with the patient defined in terms of his physical malfunctioning and treated as a helpless body who is expected to accept a dependency role. There is an emphasis on the provision of medical and nursing care. Within the horticultural model the inmate is regarded as a deprived individual with unsatisfied needs and unfulfilled capacities. The primary task of the staff is to develop these and to encourage the individual towards greater independence by providing opportunities for the growth of abilities. Miller and Gwynne suggest that the former model is the conventional one and more often found in its pure form although both are inadequate; the former because of its failure to treat clients as individuals with potentials and the latter because the pressure to maintain independence may be distressing to some terminally ill residents. Although Miller and Gwynne do not provide a model that allows institutions to be assessed or compared in the quantifiable manner of Townsend's, they do provide ideal types of two different kinds of care within which institutions may be examined.

Miller and Gwynne's model may be compared with the model suggested in the Barclay Report (1982) which poses three broad approaches to day and residential services. As in the case of Miller and Gwynne, the authors do not suggest that some are good and others are bad approaches but that the approach taken must depend upon the needs and capabilities of clients. The first approach identified is the refuge approach which presupposes that people receiving day or residential services 'are so incapacitated by age and infirmities, or so profoundly handicapped mentally or physically, that there can be no realistic hope for the restoration of lost interests and abilities or the acquisistion of new ones'. For them, the major purpose of residential and day care services is to provide physical care from admission until death or departure to hospital. The second approach is control and learning which aims at changing behaviour, maintaining or improving skills and self dependence. It is based on the assumption that 'society has the right to decide what are acceptable standards of conduct for its members (particularly the young) and the obligation to increase as much as possible the capacities for work, leisure activity and family life for those who are disadvantaged by reason of illness or disability'. The third approach is growth and development which 'has its major purpose, the release of disabling inhibitions and the emergence of a sense of responsibility and independence of thought and action, provided only these do not infringe the rights of others'. As many clients have limited capacities for development or decision-making, and as many members of the public may not support efforts to help such people feel less inhibited or act more independently, this approach is rarely operated in its pure form. Which approach or combination of approaches is adopted has consequences for such factors as the level of client participation in decision-making, the formality of client-staff interaction, the extent to which clients are allowed to express their feelings and the extent of interchange between clients and staff and the local community.

Clough (1981) suggests that homes may be categorised according to the level of resident control of life-style. He identifies three levels of such control. These are, minimum control of which an example would be that staff enter clients' rooms without knocking; medium control in which there may be, for example, no bath rotas and residents may use their bedrooms whenever they wish; and maximum control which is characterised by residents being able to go out whenever they wish.

In view of the high proportion of the elderly suffering brain failure and the numbers in ill-health, questions concerning the mixing or segregating the relatively able bodied with the very frail, the lucid and the confused, have been central issues in the residential care of the elderly. An important study of confused elderly was undertaken by Meacher (1972) who identifies a series of characteristics of confusion while entering a note of caution that confusion is likely to be subject to a degree of periodicity with long or short, occasional or frequent, lucid intervals. The first characteristic identified by Meacher is verbal confusion involving incoherent and/or tangential speech; second, physical restlessness involving physical wandering and/or restless fiddling; third, disorientation of the person or situation; fourth, disorientation of place so that the sufferer does not know where he is; fifth, anormic behaviour which Meacher defines as 'use of objects or the reiteration of certain activities in a manner which is not sanctioned by the conventional social norms'; sixth, memory defect which may involve inability to sort former events into their proper temporal sequences, to remember the spatial relationships of previously well-known places, to remember names or to use memory as a tool. The purpose of Meacher's work was to compare the experiences of confused old people, together with the reactions of their rational companions and of the staff, in special homes where they form a majority or substantial minority of the residents, with their

experiences in ordinary homes where they form only a small minority. He examined the roles of staff, group formation amongst residents, friendship patterns amongst residents, structural arrangements within the homes including setting out of chairs and allocation of bedrooms, rights and privileges of residents and staff authority patterns. Meacher's main conclusion is that integrated homes offer many advantages over separatist homes. He argues that the major benefit for confused residents lies in the stimulation afforded by the presence of rational residents. The benefit for the rational is that they have to accept responsibility for the care of their confused fellow residents.

Meacher's work is not without its critics. Grimley Evans has attacked it strongly. He criticises Meacher on the grounds that his work was based on only 151 hours observation in six homes. Grimley Evans argues that Meacher's conclusion that confused residents benefit from being in integrated homes does not follow from Meacher's own work. (Meacher had drawn attention to the ostracism with which confused residents were treated in integrated homes by their rational fellows.) He states (Grimley Evans 1977, 141) that Meacher's book and subsequent correspondence show that his:

> appreciation of the psychiatry and pathology of old age is incomplete and his concept of what constitutes a medical model of a disease is decades out of date . . . One recognises the authentic voice of the fashionable twentieth century heresy that all biological variation must be environmental in origin . . . The idea that senile dementia is exclusively a psychogenic disorder without primary organic pathology seems in the present state of knowledge frankly perverse and not in the patients' best interest.

Bergman (1972, 595-6) is another critic of Meacher. He accuses Meacher of being 'confused about "confusion"' and believes that this is the less defensible for the availability of more precise information. Bergman states that 'confusion or delirium is an impairment of consciousness which can be the result of a generalised physical disease, infection, toxicity or acute disease of the brain itself. It does not only occur in the elderly.' Bergman further criticies Meacher for the way in which his six sampled homes were chosen.

Other writers have examined the question of the integration or separation of confused and other residents. Johnson (1982, 25) for example, claims that her research in one home 'suggests that many confused residents can manage the tasks of normal daily living given the right kind of physical and social supports. There is a possibility that placing residents together in categories may amplify the size of the problem.'

Evans et al (1981) studied six residential homes in Manchester with varying proportions of physically disabled, confused and non-confused able-bodied residents. They adopted a variety of research methods to identify staff attitudes. They interviewed nearly all the staff and a sample of residents, and systematically observed staff practices in respect of physical care and staff-resident interaction. Evans et al were surprised to find that only 12 per cent of care and supervisory staff thought that the confused are the most difficult category of clients to care for while 60 per cent thought that those who presented 'non-physical management problems' (mainly the most lucid and physically able residents) are the most difficult.[1] Conversely, 40 per cent of care and supervisory staff said that the confused are the

1 This finding complements Knapp's (1979) work on the costs of care discussed earlier and the present writer's categorisation of client status as perceived by staff.

easiest category of resident to care for. Evans et al found that staff in the two homes with the highest proportions of confused residents - 36 per cent and 54 per cent - thought that the proportion was too high. The researchers also assessed the attitudes displayed by the lucid residents towards the confused. They assessed 25 per cent as clearly rejecting the confused but 63 per cent as tolerant or accepting. In segregated homes, the authors did not observe any significant improvement in the quality of life of lucid, confused or physically disabled residents. They found that the atmosphere in integrated areas of homes was often 'more lively' than in the segregated. Evans et al conclude that homes should include residents with a variety of levels of physical and mental functioning and that the potential advantages of integration outweigh any disadvantages, especially for the handicapped. They suggest that a proportion of approximately 30 per cent confused residents within a home may be tolerated.

Another body of research has been concerned with the consequences of structural design and physical ameneties of the home or its functions. Barrett (1976, 53) suggests an institutional-domestic continuum which refers exclusively to the physical features of a home and not to characteristics of the administration or residential behaviour. An institutional environment is characterised by 'long corridors, large dormitory bedrooms and toilets with banks of open WC compartments all contained within large rambling buildings, enclosed by walls or set in spacious private grounds isolated from the local community' while a domestic environment is 'home-like'. Although the model is uni-dimensional, Barrett is able to apply it to a range of situations. He provides a notional institutional-domestic design continuum of changes made by architects in the design of homes and constrasts this with a similar continuum of changes reported by supervising staff of homes.

He compares domestically and non-domestically shaped sitting rooms and suggests a notional arrangement of types of room along the continuum. The last, for example, moves through seven stages from 'small family' at the domestic end with less than ten beds, sitting room and dining room to 'large institutional' with more than ten beds and no WC. Barrett identifies a progression within government publications from deliberately anti-institutional design intentions in the early directives to specifically domestic recommendations in more recent documents. Barrett claims that many architects make value judgements between the models with a domestic environment being preferable as it is based on two assumptions; that being alone results in loneliness and associated anti-social behaviour and that by providing facilities for social activities and limiting the opportunity of being alone, old people are likely to form relationships with other residents or staff. Barrett himself does not accept these judgements a priori.

Harris, Lipman and Slater, writing shortly after Barrett, found that architectural design and physical setting whether large or small, institutional or domestic, have little or no bearing on interaction between residents, especially on the degree of interaction between rational and confused. Interestingly, particularly in view of Meacher's main conclusion to his work, Harris, Lipman and Slater found very little interaction between rational and confused residents in integrated homes. They conclude: 'In short, architectural design - especially in comparison with the potency of an administrative regime that is not committed to integration - is irrelevant to circumstances of this nature' (Harris, Lipman and Slater 1977, 398). This research challenged one of Townsend's (1962) conclusions from his work; that homes with less than 20 or 30 beds will have more informal and closer staff/client and staff/staff

relationships. Harris, Lipman and Slater stress that the most important factor in the nature of relationships amongst residents is the wishes of the most influential members of staff.

A similar point is made by Pritlove (1976). In research into group homes for the mentally ill he found that the regime of a home - defined as the sum of the relationships in the home involving both caring staff and residents - was more important than the building itself, finance or administrative support in achieving the goals specified for a home. Pritlove emphasises that residents as well as staff have access to power but the ways in which they can exercise it differ. By analysing the roles and behaviour of residents and staff within the home it is possible to identify the type of regime operating. Within group homes this is likely to be either a 'transitional' regime with the staff role being that of 'physician' and the resident role 'convalescent', or 'compensatory' with the staff and residents filling 'nurse' and 'permanently handicapped' roles respectively. Some clients will need a transitional atmosphere and some a compensatory atmosphere but Pritlove emphasises that long-stay homes as well as half-way homes may be transitional.[1] Which type of home is appropriate is seen by Pritlove to be dependent upon the objectives of staff and residents. He provides a method of 'scoring' the independence of residents within the home. Seven elements of the resident's situation (occupation, relationships within the home, relationships outside the home, degree of dependence on supervision, self-care ability, ability with money and attitude to rehabilitation) are scored on a five point scale (1 representing 'requires a hospital place' and 5 'can

1 There are clear parallels between Pritlove's model and Miller and Gwynne's (1972) comparison of warehousing and horticultural institutions.

live beyond the home') and these are summated. By comparing an individual's score at different points in time, the effect of the regime on his level of independence may be assessed.

Other research into residential care of the elderly that is reviewed here may be categorised under three headings; induction, life within the home and the residents's continuing contact with his friends and relatives outside the home.

Induction

The importance of induction has been stressed by Lieberman (1969). Lieberman is an American writer who claims that the conditions associated with moving into an institution may create many of the effects often attributed to living in an institutional setting. He quotes five studies as finding that changing the environment of elderly persons sharply increases the death rate. Elsewhere, Lieberman acknowledges that other research has failed to show an increased mortality (Miller and Lieberman 1965). Lieberman has conducted several studies into the nature of the changes which might be brought about by institutionalisation. He found that many of the effects of self-image were set in motion by the decision to enter the institution and occurred with maximum intensity prior to entrance. He found that the psychological portraits of people entering an institutional environment are sufficiently similar to those of people already in residence to conclude that feelings of abandonment begin from the time that application for a residential place is made (Tobin and Lieberman 1976).

Kasl (1972, 381) argues that relocation or institutionalisation of the elderly will have adverse effects on their physical and psychological well-being if:

a it increases the physical distance to friends, kin and age peers, as well as to various services and facilities,

b it interferes with their engaging in their usual leisure and social activities,

c it represents a deterioration in the quality of their dwelling unit and their neighbourhood along valued dimensions (for example, independence, privacy, safety, security, convenience, familiarity, and so on) ...

It may be suggested that the following characteristics of the elderly may be particularly indicative of an adverse effect of the relocation and/or institutionalisation; being male, older and in poor health; living alone and having few contacts with friends and kin, in poor financial circumstances and of lower social class; having lived in an old neighbourhood a long time; of low morale and life satisfaction, reacting to a move with depression, giving up, and hopelessness-helplessness.

Gutman and Herbert (1976) suggest that the degree of change involved is a key factor in determining the extent of adverse consequences of admission. They argue that if there is little change and the degree of disruption is minimised, the effects are likely to be less marked. In a British study, Pattie and Gillard (1978) found that the severe adverse consequences, which they referred to as the 'negative relocation effect', are restricted to a small group of residents. In separate studies Pablo (1977) and Yawney and Slover (1973) have attempted to identify the characteristics of the old people most likely to be vulnerable to the stress of admission. Both studies

suggest that careful planning of the move is particularly important. Yawney and Slover add that persons with organic brain damage, poor physical health, suffering from depression and with a history of finding it difficult to handle change are particularly vulnerable. Taylor, Ford and Barber (1983) emphasise one difficulty of separating cause from effect. They ask whether ill elderly people move because they are ill or whether they are ill because they have moved.

Brearley (1975) has noted that the loss of an elderly person's home may cause a grief reaction that results in the dazed, regressive behaviour of some people admitted to homes. Once he arrives at the institution all the minor difficulties of entering a new group (such as which seats he is permitted to sit in) assume exaggerated importance and increase the pressures on him. This pressure may be greater if the client takes up residence without having made a previous visit to the home. Yet there is evidence that a comparatively small proportion of residents make such visits. Peace, Hall and Hamblin (1979), for example, in their study quoted above, found that only half the sample visited the home prior to admission and that 65 of 145 persons interviewed received no advice about the home. For the majority of residents (112 of 139) there was no choice over which home they were admitted to. In the Department of Health and Social Security (1980, 16) study of the elderly in Brighton, it was found to be rare for residents of homes to have visited the establishment prior to admission. The study showed that elderly people had varying ideas about what entering residential care would be like: 'Some longed for a refuge and respite from their day to day problems of struggling to live in the community. Others feared harsh regulations and the nature of other residents' attitudes and disabilities'.

Meacher (1972) found that there was little evidence of allowing potential residents to play a part in the decision to admit them or of adequate consulation concerning their future residence. In both cases there were vast differences between the confused and the rational. A study by Shaw and Walton (1977) suggests that approximately half the elderly people admitted to homes knew nothing about the home prior to their admission.

In some cases, the lack of client involvement in selecting the home or the absence of opportunity to visit prior to admission might be a consequence of the pressure that exists for places in homes. This possibility is supported by Brody (1977) who states that the allocation of old persons to homes is often a telephone search for any bed rather than the careful selection of an appropriate facility that will meet individual requirements. Brody claims that an assessment of mental and physical functioning plus a medical diagnosis is not sufficient as individuals with identical functional assessments may require different plans of care. An assessment of the individual's potential, his available resources and support is also required. Account should be taken of his socio-economic situation, personality, physical environment, eligibility for various benefits, availability of needed services and social supports. Plank (1978 b) similarly found that admission to a home is a matter of chance rather than choice. Plank's and Brody's statements are supported by a Department of Health and Social Security (1976 b) study that suggests that careful assessment of elderly clients is not possible because so many requests are presented as emergencies. The study found that between 40 per cent and 50 per cent of admissions in one large county are emergencies.

Pope (1978) has provided a model of admission to care in which he identifies four phases; 'preparation' which lasts from the time of making application to notification of the availability of a place, 'separation' from then until admission, 'transition' which occurs during the first day in the home and 'incorporation' which continues from the second day in the home until the time when the resident 'feels at home'. Each of these phases involves different foci of work for social workers and others concerned with an admission, different activities and each has different implications. These phases should, Pope considered, be underpinned by three principles; that nothing should occur during the process that violates the rights of the individual, that the prospective resident should be 'better off' in the residential home than in any other possible placement and that the activities of those workers involved in the admissions process should be complementary rather than in conflict with one another.

In a more recent paper, Pope (1979, 5-6) summarises research into the impact of admission:

> The commitment to bring about any kind of change in either the personal life, or the environment of the client, is not one to be taken lightly. Especially when set against the considerable evidence that is emerging about the impact of well-recognised day-to-day changes upon individuals let alone those that are therapeutically induced. Getting married, the birth of the first child, going to school, going from school to work, changing jobs, moving house, retirement and moving from one culture to another have all been identified as times of increased and often quite severe stress upon individuals. Neither does the matter rest there for other research has demonstrated a clear relationship between the intensity of change in a person's life over a period and the likely onset of both physical diseases ... and mental illness.

Webber (1979, 29) in describing the admission of an elderly person to care writes 'the early days are usually traumatic with behaviour similar to that which occurs after the death of a loved one has taken place'. Brearley et al (1980, 3) describe the importance of the early days in care: 'The events that happen during admission to care can be magnified for everyone involved and the things that are done to, and with, and around a client at this time often have a lasting effect'.

In this context of the difficulties faced by admission and change, Marris's (1974) concern with the way in which people understand the world around them and make sense of what happens in everyday life is relevant. Marris suggests that amongst the elderly in particular there is a strong conservative impulse to preserve the status quo and to retain a view of the world in which objects, events and people all have well ordered places. Those things that do not match understanding or which shake or undermine it are avoided.

Life within homes

Research into life within residential homes has focussed on activities undertaken within the establishments and on inter-personal relationships.

Several studies of the activities of residents have emphasised the extent to which residents are passive. Townsend (1962) found that less than one quarter of his subjects followed a pastime which occupied them for two hours per week or more. Peace, Hall and Hamblin (1979, 39) found:

> those passive indoor activities which residents can undertake without necessarily being organised, proved most popular with residents. 123 (of 155) watched TV; 122 listened to the radio; 99 read and 73 wrote letters. Organised indoor activities such as craftwork and games proved far less common. There

was very little response to the question concerning outdoor activities. Contact with the community appears minimal. Yet this was due as much to the lack of mobility and frailty of many respondents as to the lack of organised outings etc. Often staff reported that they were discouraged from arranging outings due to the poor response on the part of residents.

Peace, Hall and Hamblin conclude that a high degree of choice and individual activity within homes did not always lead to greater satisfaction and that homes appeared to be satisfying to the more passive and conforming resident. They suggest that the emphasis placed by some writers upon group activities may run counter to the wishes of residents who may not wish to be part of a group.

Meacher (1972) reached similar conclusions on the inactive nature of most residents days with reading being the single most time-consuming occupation. He found that the confused were more than twice as likely as the rational to indulge in no specific recreation and that over three quarters of the severely confused in separatist homes spent their days wholly unoccupied in any recreation. Both the confused and the rational admitted to being frustrated by inactivity which they associated with the decline of former abilities.

Goodlove, Richard and Rodwell (1983, 58) report an observation study of sixty-five old people in day centres, local authority homes, day hospitals and hospital wards. They claim to have 'spent more time in simply watching what happens in facilities where care is provided for the elderly than anyone has done before. The data we collected leads inescapably to the conclusion that for most of the time nothing happens at all ... this seems particularly to be the case in residential settings'. Goodlove, Richard and Rodwell believe that staff justifications for inactivity on grounds of clients wanting or deserving rest are rationalisations for poor service.

Felce and Jenkins (1979) undertook research into the effect of staff on the level of activity in homes. They define a person as being engaged in activity if 'she is interacting with another person or is interacting with any material which may be used in self-care, work, domestic or recreational activities'. On different days professional staff and volunteers provided newspapers, knitting sessions or ensured that a television was on in one of two lounges. In the other lounge no such activities were offered. A time graph showed that there was a significantly higher level of activity in the former lounge. Felce and Jenkins conclude that the level of activity observed in elderly people in residential care is affected by the opportunities and assistance provided and not only by irreversible factors like ageing and disease.

The importance of staff in determining the level of activity within homes is emphasised by Hanson (1972) who found an absence of conversation in homes except that initiated by staff. Lawton and Simon (1968) argue the importance of staff in a home in promoting client friendships and conversations. They state that an elderly person is more likely than a young person to suffer poor mental and physical health and likely to be more poorly socially adjusted. He may consequently find it more difficult to seek out companions. Proximity of other people may be more important in determining friendship patterns than the satisfaction of mutual needs. In a study of high rise housing occupied only by persons aged 62 or over, these hypotheses were borne out. Proximity was found to be a highly significant factor in friendship choices with a tendency to choose friends from the subject's own floor. The less healthy were more floorbound in their choices than the more healthy and the not married more floorbound than the married. Lawton and Simon contrast their findings with similar studies of college students in which proximity as a determinant

of friendship choice was relatively temporary. Lawton and Simon conclude from these studies that the role of staff in physically and socially structuring the home is important in stimulating conversations and friendships.

A very different kind of study was undertaken by Johnson. This was a participant observation study of two homes. It was specifically concerned with the relationship between the institutional environment and the lives of the residents in the homes. In her analysis, Johnson (1982, 2) focusses on 'the differences in the institutional environments in each home and the ways in which they affect the freedom, privacy, dependence or independence of residents, power, control and patterns of social interaction among residents'. Johnson found considerable differences between the two homes in respect of the hours devoted to functional care (ie. the physical care of residents) and domestic work. In one home, the balance between functional care and supervisory care (staff giving instructions to residents or enabling the residents to do something without being physically involved themselves) were approximately equal while at the other home the balance was heavily weighted on the side of functional care. Johnson claims that her analysis of staff deployment may suggest that far more is done for and to residents in the way of physical care at the latter home where care is more protective than supportive, while at the former home residents are less dependent upon staff. Johnson's work is important in drawing attention to the different levels of staffing required by homes with different organisational routines and ethoses. She suggests that the ethos of the home may be a significant factor in determining staff levels. This suggestion may run counter to the view that, if a home has more staff, it can provide more contact with the client, and consequently, a livelier environment.

## Objections to residential care

It is generally recognised that placing an elderly person in residential care is a last resort. Even so, some writers have expressed their concern at life within residential homes.

Lieberman (1969) summarises the research into old people in residential homes as demonstrating that the following are typical characteristics of residents: they are poorly adjusted, depressed and unhappy, intellectually ineffective, possess a negative self-image, feel personally insignificant and impotent, hold a view of self as old, docile and submissive, have a low range of interests and activities, live in the past rather than the future, are withdrawn and unresponsive. It may be that these are characteristics the particular population studied would possess even if they were not in residential homes and, if so, the list reinforces the need for homes. If, however, the process of institutionalisation is in some way responsible for the development of the characteristics, it is important that alternatives be examined. Before turning to these alternatives some other objections to residential care are identified.

Some objections are on the grounds of the stigma attached to being placed in residential care. Berry (1975) argues that admission to residential care for any person, not necessarily the elderly, implies that the individual has in some way broken down. Rowlings (1978, paragraph 3.49) quotes clients and social workers interviewed by her as regarding residential care as the end of the road to be taken when all possible alternatives have been considered. She quotes one social worker as saying 'the very name "part 3" suggests this is the "last resort" after parts 1 and 2 have failed'.

Several writers suggest ways in which the structure of residential homes may have adverse effects on the residents. Townsend (1962) states that although elderly people live communally in homes with the minimum of privacy, their relationships with each other are slender and he criticises the 'dehumanizing' and 'depersonalising' environments. He suggests that, often, the effects of institutionalisation are explained away by being attributed to the resident's previous history (eg. labelling him as apathetic or withdrawn) or to a present illness.

Several writers suggest that institutionalisation, with its symptoms of apathy and withdrawal, is an illness in its own right. Brearley (1975) argues that enforced institutionalisation has often led to institutional neurosis resulting in the resident becoming apathetic and withdrawn, over-dependent, lacking in initiative and disinterested. One of the contributors to institutional neurosis is the staff view of a 'good patient' as one who conforms, behaves, does not make demands and subordinates his own personality to that of the organisation while a 'bad patient' is one who makes continual demands and is determined to remain an individual.

Tobin and Lieberman (1976) classify six symptoms of institutional effects. These are de-individualisation which they define as the reduced capacity for thought and action as a result of dependence on the institution; disculturation, which is the acquisition of values unsuited to the pre-admission environment; emotional, social and physical damage from loss of security, status, etc; estrangement from technological and other changes in the outside world; isolation through lack of contact with the outside world; stimulus deprivation through prolonged institutionalisation.

Tobin and Lieberman's view that institutionalisation results in isolation from the outside world is supported by Miller and Gwynne (1972, 73) who state that 'by crossing the boundary into the institution, clients fall into a rejected category of non-contributors to and non-participants in society - thus virtually non-members of society'. When entering an institution people may fail to occupy or retain any role which confers social status on the individual. Meacher (1972, 203) refers to admission to a home as requiring the 'enforced relinquishment of the contacts which had solely or chiefly afforded a frail hold over reality'. He found that some homes deliberately encouraged as complete a break as possible with the outside world by encouraging visitors of new arrivals to leave early. Other researchers have not found such a clear break with the outside world. Townsend (1962) found that relatives adapt their lives to the absence from home of the old person. About one year after an old person had been admitted to a residential institution there was a falling-off in the number of visitors and letters he received. However, Townsend found that two-thirds of men and five-sixths of women received visitors. Peace, Hall and Hamblin (1979, 27) found that 98 of their sample of 155 had seen a member of their family in the past month. Forty-one had seen friends in the last month and 98 expected a visitor in the next month or so. However, the converse of these figures is emphasised: 'the fact remains that 60 of our sample had not seen any of their family or relatives within the last month prior to the interview and 75 had not seen any friends over a similar period. Many elderly people in residential care are therefore seldom visited'. All of these research findings must be treated with caution. The number of visitors an old person receives is connected to a range of factors including her geographical location, the closeness of family and community ties, the social composition of her home area, whether she has any living close relative. It would be necessary for research into the frequency of visits to take account of such factors for clearer conclusions to be drawn.

Some writers are critical of homes while accepting the need for them. Miller and Gwynne (1972) argue that society has assigned residential homes the task of catering for the socially dead between their social death and physical death. Such 'limbo' institutions are the consequence of medical advances which although designed to prolong life have instead postponed death, of the diminished size of the family unit which has reduced its viability in holding its ageing members, and of the declining force of values and rituals of Christianity which has left society without adequate cultural mechanisms for coping with death. The last has been replaced by humanitarian values for keeping the interval between social and physical death as long as possible.

Other writers have suggested that consideration should be given to changing the role of residential care. For example, Brearley (1975) argues the need to explore the possibility of using residential care to provide therapy. This could include short-term intensive treatment. However, unless any such treatment is very short-term, the client may find it difficult to re-enter the community. In a study of the elderly mentally infirm, Nicholas and Johnson (1966) found that few residents of institutions could be discharged home. Improvement in the physical and mental health of residents was not maintained when they left the special care of the hostel. The difficulties of re-introducing an elderly person to the community after she has lived in a residential home for some time may be considerable. Apart from logistical considerations, such as the likelihood that she will have sold her home and most of her possessions, there are the problems of the effects of institutionalisation discussed earlier. It may not be surprising that Brody (1977) found that those who had lived longest in institutions indicated more concern at re-entry to the community.

However, other writers have emphasised the potential difficulties in changing the structure of homes. For example, Lipman and Slater (1977) have shown the difficulty of allowing residents independence. They quote a Ministry of Health document of 1950 as claiming that, in old people's homes, 'the master and inmate relationship is being replaced by one more nearly approaching that of an hotel manager and his guests'. Lipman and Slater suggest that this model fails to take into account the pressures militating against independence in prevailing staff/resident relationships. It ignores the assymetric distribution of power in these relationships, discounts the discrepancies between the parties' authority-based relationship and the contractual, voluntary, manager/guest relationship posed by the Ministry model. The absence of independence and privacy have been identified by many researchers. (See, for example, Hitch and Simpson (1972), Lipman (1967).)

Tobin and Lieberman (1976) are concerned that many of the researchers that claim to have found that institutionalisation has adverse effects on the elderly have based their conclusions on research that is methodologically unsound. Tobin and Lieberman identify two kinds of methodological weakness that they claim is common in research into institutionalisation. First, researchers have not established that the population in the homes was comparable with the elderly living in the community. Secondly, they have examined the institutional effects only after the old people were institutionalised. Tobin and Lieberman do not suggest that living in an institution does not affect the individual. They refer to the 'discontinuity' of institutionalisation and the importance of distinguishing between what has been left behind and what is being confronted. On entry to a home, a newcomer will be confronted by aids, non-skid floors and a dining room that is unlike either home or restaurant which will make him aware of the prevalence of infirmity amongst his

cohorts and his own place amongst them. Townsend (1981 b, 14) argues that residential homes are serving major purposes other than those for which formally they were and are supposed to exist:

> In particular they have inhibited appeals in times of major stress for public help from the individual and the family, have operated as a cheap (because selective) substitute for public housing and community services, and have regulated public ideas of the lengths to which the family is expected to carry the burden of care.

Townsend reviews post-war studies which have examined the capacities for self-care on the part of residents. Several have suggested that over half the residents of the insitutions researched had sufficient social, mental or physical capacity not to require residential care. Townsend is further critical of residential institutions on the grounds that they are structured to 'control' residents who are placed in a category of enforced dependence. There is an ideology of 'care and attention' in homes rather than an ideology that encourages self-help and self-management.

It would be wrong to think that all researchers who have studied residential institutions for the elderly concluded their work by being critical of residential care. It might be appropriate to conclude this section by summarising the conclusions Clough draws from his research. Clough (1981, 5) tries to balance the advantages and disadvantages of residential care. He challenges the assumption that the elderly would rather not be in homes. Clough writes: 'the old age home presents society with the apathy or handicap of residents en masse. It is easy to forget that old age anywhere may be as unpleasant'. He argues that we should question also the assumption that it is appropriate to assess the adequacy of residential care by the degree to which it approaches the norm of home life. Clough acknowledges that

there are potential dangers in residential care but he also recognises that there are potential dangers in families and in living. There is a risk of seeing community care in ideal terms. The inherent possibilities of domiciliary services are not available, functional and appropriate for all elderly. Clough believes that it is common for the existing model of residential care to be contrasted with the ideal model of community care: 'The conclusion that the ideal is best is not surprising'. The potential disadvantages of residential care should be weighed against the advantages. Clough argues that the advantages are being in the company of staff able to provide twenty-four hours per day observation and care, to deal with the rapid change from feeling on top of the world to feeling under the weather which is characteristic of old age, to lend support in the many aspects of loss that have to be faced, to remove some of the problems of living thus providing the old person with the chance to pursue interests that they could not otherwise follow and to care for the miseries of old age.

## Community care

At the start of the review of literature concerning the care of the elderly in residential establishments, it was suggested that such care is a last resort. The complementary view is that elderly people should be helped to live in their own homes for as long as possible. The importance of day care may be the contribution that it can make towards helping elderly people live fulfilling lives at home. The importance of community care has been stated by Goldberg and Connelly (1982, 5):

> We want older people to remain independent and to be able to care for themselves as long as possible, living as 'normal' lives in the community as possible, yet we want them to be sufficiently supported by networks of family and friends, or by more formal services, not to suffer unnecessary physical or mental hardship. This is clearly a difficult balance to achieve.

Government policy is to enable the elderly to lead independent lives in their homes. The Department of Health and Social Security (1981) stresses the importance of relatives, friends and neighbours in caring for old people. The role of public services is to sustain and develop rather than displace such care. In a review of Government policy (DHSS 1978 b, 4) it is stated that the Government has three main aims concerning the dependent elderly. These are 'to keep old people active and independent in their own home. And where they have had to go into hospital, to get them back into their own home as soon as possible; . . . to ensure that retirement does not mean poverty; . . . to enable old people to take their own decisions about their own lives'. It has been argued that Government policy has been consistent in emphasising the importance of maintaining the elderly in their own homes since 1958 at least (Walker 1981 a). Other authors have stressed that the case for a shift away from state provision to family and local community care is based on economic as much as ideological grounds (see, for example, Parker (1981)) although it has already been shown here that the evidence on the comparative costs of community and residential services is inconclusive.

The Seebohm Committee stressed the importance of community care. Its report identified an important role for social services departments in having 'to investigate fully the contribution which relatives, neighbours and the wider community can make and how the social services departments can best enable such potential assistance to be released. In this sense, a considerable development of community care for the old may be achieved, even in the near future, by enlisting such help' (Report of the Committee on Local Authority and Allied Personal Social Services (1968, paragraph 310)). With the increased emphasis on the importance of maintaining people in their

own homes there has been an increase in the provision of all the main domiciliary services. It is stated by the Department of Health and Social Security (1978 b, 32) that over 10 per cent of elderly people go to specially run social centres at least once a week and the number of day centre places has risen by over 50 per cent since 1974'.

Community care might be seen as an alternative to residential care. However, there is not an agreed definition of community care and Townsend (1981, 76) has warned of the danger of assuming that all references to community care exclude residential care. He quotes a Department of Health and Social Security document as including hospitals, hostels and residential homes within the category of community care. Townsend states '"Community care" has become a term which everyone approves. Unfortunately, everyone has scrambled to make sure that they use the concept to include the service of organisations with which they are connected.'

Similarly, Walker (1982, 1) writes 'the policy which apparently unites politicians, planners, social services professionals and a wide range of pressure groups, is that of community care. But, for such an important concept it has proved to be remarkably elusive and has been subject to surprisingly little critical attention over its long life.' If the Department of Health and Social Security position quoted by Townsend is one of the more extreme definitions of community care at one end of a continuum, Illsley's definition might be regarded as being at the other end of the continuum. Illsley (1981, 214) argues 'the essential feature of community care is the responsibility of family members for the care of elderly persons remaining within their own homes supplemented by the minimum statutory support required to keep the situation stable'. Tinker (1981) suggests that the reason why there is a lack of satisfactory definition of community care may be partly because a number of

different theories and facts came together at approximately the same time. She suggests that these were, first, a general reaction against institutional care which led to the belief that alternatives ought to be made available; secondly, increasing practical problems associated with residential institutions such as obtaining staff; thirdly, a decreasing need to keep people with bizarre or disturbed behaviour away from society as their behaviour could now be controlled by drugs; fourthly, the cost of residential care; fifthly, the growing recognition that people have a right to live among ordinary people as far as this is possible. Implicitly, Tinker excludes residential care from community care. The term will be used here as excluding residential care.

The notion of a continuum of care including both residential and community care is argued by Brody. He agrees that it is artificial to dichotomise long-term care into institutional care and community care. Brody thinks that it may be more appropriate to consider alternative forms of provision as points on a continuum. Allocation of an individual to a form of care along this continuum must be made carefully and be based on a thorough diagnosis. Brody (1977, 22) continues 'the relevant issue is to identify those for whom long-term care is appropriate and to determine the nature of the service and qualities of the environment that would maximise their well-being.'

Some writers suggest that old people often are not allocated a form of care on the basis of the thorough diagnosis advocated by Brody. For example, Whitehead (1967) argues that many elderly psychiatric patients presently in hospital should never have been admitted or should have been discharged and he states that living at home is often possible for these people if the necessary support services are forthcoming. Day care has an important role here provided it is part of a general pattern of

supportive services. Other authors have stressed the importance of the elderly clients themselves being involved in determining the most appropriate form of care. Age Concern (1975) argue that the very elderly infirm require access to a range of medical, residential, welfare, domiciliary and other services so that they can exercise some degree of choice in the kind of care they receive.

Other writers have stated that some old people are still living in the community although residential care would be more appropriate for them. This is often a consequence of a shortage of places in residential homes. For example, Plank (1978 a) states that sometimes domiciliary care only acts as an alternative to a residential home or sheltered housing in that many old people live in their own homes simply because they are unable to get into a residential home or sheltered housing. He found that 40 per cent of those on waiting lists for places in residential homes were hardly able to look after themselves.

It is not appropriate to review extensively the literature on forms of community care other than day care. However, mention should be made of the importance of the family and sheltered housing. Both are important in helping to maintain the elderly in the community. Day care is supplementary to both.

Sheltered housing

Sheltered housing is defined by Butler, Oldham and Wright (1979, 5) as 'housing purpose-built or converted exclusively for the elderly and which consists of grouped independent accommodation linked to a resident warden by an alarm system'. The provision of sheltered housing raises questions concerning whether it is more appropriate to separate elderly people from, or to intergrate them with, the rest of the population. In America, Roscow (1967) has argued that patterns of socialisation are richer in 'age-dense' environments, ie. where people of similar age are living

In one apartment block. Fennell (1977) on the other hand, studied 160 old person's bungalows without warden supervision in Newcastle and drew different conclusions: 'the residential situation of elderly people in this form of grouped setting resembles more that of the elderly person living alone in the community than it does either the situation of a person in a residential home or the situation described in American grouped residential situations'. Butler, Oldham and Wright (1979, 17), in a discussion of research that suggests that people living alone within a sheltered housing scheme are less likely to want a common room , write 'it seems likely that after years of semi-solitary living they will not "take to" the inevitably artificial sociability of a sheltered housing scheme.' Much more research into sheltered housing in particular and housing for the elderly in general is required. Our present state of knowledge allows us to say no more than 'we can be reasonably confident that re-housing improves people's living conditions but of much else we are not clear'.

Wheeler (1982) describes the rise of the 'staying put' movement. 'Staying put' focusses on the desirability of making improvements to an old person's house in order that she can remain in her own home as long as possible. It is concerned with three aspects; the condition of the house (the need for repairs and improvements), suitability (introducing housing aids and adaptations) and warmth (insulation and heating alterations). In many cases housing alterations may be more appropriate and resource effective than domiciliary or welfare support. For example, a new heating system may release domiciliary help with coal carrying and fire lighting.

## The elderly and their families

Despite the increase in provision for the elderly by statutory, private and voluntary agencies, their care continues to be provided mainly by their families. Female relatives take the major burden of this care with consequences in many cases for their own employment and later financial security and their social lives (see, for example, Bowling and Cartwright (1982)). Grimley Evans (1981) draws attention to the pressure that is being placed on some middle-aged women as a consequence of the increase in the prevalence of four-stage and five-stage families. A woman of forty may have to look after her own mother and grandmother, her mother-in-law if she was daughterless and her own daughter. In a five-stage family there may be a grand-daughter as well. The provision of day care for the elderly may be as important for these relatives in providing some relief, privacy and possibly the opportunity for employment, as it is for the elderly themselves.

The myth that relatives of old people do not try to support them is exploded time and again in the literature. Brearley (1975, 7) for example, states 'most families accept they have a duty to care and often continue to do so beyond the point of reason'. Brearley follows this by suggesting that as the problems of an old person are inexorably linked to those of other people around him, ignoring the families of old people may cause greater problems in the long run. Isaacs (1971) supports Brearley stating 'neglect of old people by relatives played a negligible part in the demand for admission to hospital. On the contrary, the help received from relatives, who were for the most part themselves middle-aged or elderly, was vast and was given willingly and cheerfully, so long as conditions were tolerable.' Brody (1977, 113) states 'studies of paths leading to residential care have shown that placing an elderly relative is the last rather than the first resort of families and that in general

they have exhausted all other alternatives, endured severe personal, social and economic stress in the process and made the final decision with the utmost reluctance.' Similarly, Whitehead (1967, 163) states 'The idea that families want to dump their elderly relatives in institutions is misleading. A few have this attitude. Many make considerable sacrifice to keep the old person at home. The majority who seek help have withstood difficulties, inconvenience and often misery for years.' Cantor (1980) found that elderly Americans perceive their own children as the most appropriate source of support in most situations of need. In most cases this support is readily provided and elderly people and their families only turn to formal organisations when the family can 'no longer absorb the burden'.

Evidence of family support was provided by a study of the elderly in Glasgow. Ninety per cent of the sample of elderly people with a child living within a 'day-visit distance' were visited at least once a week. Grimley Evans (1981) concludes that, given the proportion of elderly people with children living within such a distance, it is likely that some 45 per cent of the elderly in Glasgow are seen once a week or more by one of their children. He contrasts this with the five per cent of elderly who receive home helps and the similar percentage who have some other contact with statutory services during a month.

Issacs (1971) found that, where it appeared that families had apparently neglected their elderly relatives, there were, in fact, difficulties faced by the carer or difficulties in the relationship with the old person that were not immediately apparent. Some writers, whilst not challenging these researches and views, argue that the extent of family support for the elderly has changed recently or that it is likely to change in the future. For example, Bebbington (1978) claims that the overall amount of family care has declined in recent years. An important factor

which may influence the next few years has been identified by Abrams (1978). This is that 35 per cent of the over-75 age group in the 1980s will be childless and therefore unable to rely on family support. A similar point is made by Grimley Evans (1981) who suggests that the improvement in housing and the increasing migration of children away from their parents may be additional factors in reducing the amount of future family support for the elderly.

Patterns of family care may differ with social class as well as with the changes in modern society referred to above. One of the researches that has focussed on different patterns of inter-generational care was undertaken by Willmott and Young (1969). They found that in Bethnal Green, a working class area, there was a traditional pattern of 'matriclocality'. In other words, when a daughter married she set up home close to her mother. As the mother got older increasing help was offered to her. In later research, Young and Willmott (1960 sic) found that, in middle-class Woodford, the pattern was for an old person to move into the locality as he or she became more dependent on their children. Although the old people of Woodford were no more isolated from their children than were the old people of Bethnal Green, there were greater strains for both generations whether the old person moved into the child's home or acquired a separate home.

It is pertinent to mention that patterns of family care also differ in some of the ethnic minorities. Although an analysis of care of the elderly in other cultures is outside the scope of this study it is important to be aware that there is sometimes an assumption within literature that old people are ethnically homogeneous. In Britain the situation is changing as the age structure of the ethnic minorities becomes more similar to that of the majority. Coombe (1981) refers to the elderly ethnic minority

as 'Britain's other elderly'. Prescott (1981, 215) refers to them as 'the forgotten ones'. Prescott argues that the ethnic elderly are suffering 'double discrimination':

> They share with the majority elderly the problems of low income, poor housing, poor health and mobility, but in addition they suffer the problems of being immigrants into British society - with all that entails: the sense of isolation; the discrimination and the prejudice - particularly against black settlers; and the uncertainty as to their role within the family in changed circumstances that they find themselves in.

Some writers have drawn attention to the difficulties that families have to cope with in looking after their elderly relatives. For example, Davies and Duncan (1978) distinguish five 'dimensions of strain' upon the caring relatives of elderly people awaiting admission to residential care. These are intolerance leading to physical ill-treatment, intolerance leading to poor relations with the old person, overcrowding of the home, aggravation of illness among the carers, and tension among the carers as a consequence of feelings of inadequate care for the old person. The problems of caring for elderly relatives are exacerbated in periods of scarce resources when available resources are likely to be allocated to elderly people living alone while those in the care of their relatives may be deprived of resources. The scarcity of resources is identified by Lewis (1974, 33) who states: 'There is still a critical lack of front-line services which enable families coping with the problem of elderly and chronic sick relatives to continue struggling with their care: these are home helps, night sitting services, respite care and the primary practical necessity - laundry services for the incontinent'. Moroney (1976) makes a similar point. He argues that if society is to develop successful alternatives to residential care, attention must be paid to alleviating the stress and strain on relatives who are providing care in place

of the residential home. Moroney suggests that the direction of future social policy must be towards the sharing of care with support being provided to families in their caring function. Daatland (1983) argues that the regular and daily burden of care of the elderly is almost entirely divided between two parties - paid personnel and the immediate family. Contracts should be established between the two parties with the former recognising the latter's 'primacy in care'. These contracts would promise relief when the care-giver feels in need of it.

It should be stressed again that, despite the difficulties faced by families in providing care for elderly relatives, changes in family structures and concerns about the future roles of families, there is not evidence of any breakdown of concern for elderly relatives.[1]

## Day care

The purpose of this section of the study is to review the literature concerning day care. Definitions of day care cannot be satisfactorily separated from statements of the aims or purposes of day care. Consequently, different authors' definitions and aims are considered together. In view of the confusion concerning the aims of Suilven House and the centrality of this confusion to the present research, the aims of day care are pursued at some length here. There is then a review of research into day care.

1 Doyle's (1981, 173) work may be regarded as dissent from this view although Doyle does not provide evidence in support of his position. He argues that the increasing number of old people dying in hospital is little related to the constantly improving medical and hospital services. It is more attributable to the increasing readiness today to turn to expert professional help and to the 'decreasing readiness of younger relatives to provide care at home because of smaller houses, more daughters at work, changing expectations for the leisure hours and holidays of the younger generation and, of course, the economic pressure to which so many are today subjected'.

## Definitions and aims of day care

A problem in defining a day centre and describing its aims is that several terms are used synonymously by some authors and differentially by others. Examples of these terms are 'day centre', 'day service' and 'day unit'. For the present, these terms will be regarded as synonymous.

For convenience, definitions of day care are presented here in four categories. The first category includes the broad, all-inclusive approaches; the second, those approaches which attempt to separate different forms of provision; the third are operational approaches; the fourth are those approaches which attempt to define a day centre implicitly through specifying aims.

The broad, all-inclusive approach is illustrated by Utting (1977, 13). He stresses the breadth of day care provision which 'covers a variety of services, from activities of an almost entirely social nature loosely based in the nutritional functions of a luncheon club, to full day care of a confused old person as a genuine alternative to residential care'. Utting's broad approach is similar to those of Bowl et al and Fennell et al whose researches are considered later. Neither defined day care but both accepted that it is part of 'the Government's overall objective in its policies towards old people . . . to enable them to maintain independent lives in the community for as long as possible' (Fennell et al 1978, 1). Thus, both Bowl et al and Fennell et al include part-time luncheon clubs, drop-in centres, social clubs and educational groups within the category of day care. These researchers do recognise the difficulties of definition in their analysis of day care. For example, Fennell et al record the differences in the age distribution of users at full-time local authority centres and day hospitals compared with voluntary and self-run centres. They

suggest that the former categories care more for the 'heavy end of the market' attributing this, in part at least, to the greater availability of special transport and of staff to care for the frail.

Four authors - Whitehead, Brocklehurst, Robinson and Bradshaw - illustrate the second approach in which attempts are made to separate different forms of provision. Whitehead (1967, 160-1) records the absence of accurate definitions. He writes:

> The terms 'occupational centre', 'day-centre', and 'day hospital' do not have accurate definitions. On the whole, day centres and occupational centres are run by local authorities or voluntary organisations, while day hospitals are the responsibility of the hospital service. Day hospitals are manned by doctors, nurses and ancillary staff offering care similar to an inpatient service without bed and breakfast. Day and occupational centres do not usually provide medical and nursing care. They are more concerned with occupation, entertainment, food and social activity, the services a good day hospital should also provide.

Brocklehurst (1970, 12) distinguishes the characteristics of a day hospital from day centre:

> In a nutshell, the aim (of the day hospital) is to dissociate the 'hotel' element of hospital care from the therapeutic content, leaving only the latter . . . It is important to distinguish between day centres and day hospitals. Day centres provide social facilities, company, a cooked meal, possibly a bath and chiropody, but none of the remedial services found in a day hospital.

Robinson (1980, 17), writing about provision for the physically handicapped, contrasts the work centre and the day centre. He states that a day centre is based on occupational therapy and handicrafts: 'In these centres clients do handicrafts as therapy to maintain limb function. The Centre also serves a social function enabling people to meet and talk. This type of centre encourages creative ability and artistic flair . . . It provides occupations for people who would otherwise be at home doing nothing. The main task of these day centres is to provide a service which enables the client to remain within the community, saving a considerable amount in public funds, whilst maintaining the family unit'. Of course, it does not follow that Robertson would argue that the purpose of day centres for the elderly are similar to those for the physically handicapped. The question of whether the purposes of day centres for different groups are similar is one that must be faced and is particularly important in a combined centre for two or more client groups; for example, the physically handicapped and the elderly.

Bradshaw (1974, 2) identifies ten different forms of day care provision; day hospitals, day care centres, psycho-geriatric day care centres, day care and social clubs in residential homes, social centres or clubs, shelters or rest centres or drop-ins, communal rooms in grouped housing schemes, lunch clubs, work centres or employment workshops and 'other facilities'. For Bradshaw the feature which distinguishes day care centres from the other forms of provision is the emphasis on care:

> A considerable amount of personal care is offered in these centres including such services as chiropody, occupational therapy, bathing and hairdressing, some of which can be provided in conjunction with the para-medical staff in the area . . . The emphasis on care and support should not overshadow the main purpose of the Centre which is that of giving fuller life to its members and enabling them to regain their independence as far as is possible.

The authors who represent the operational definitions of day care include Edwards and Carter and the Barclay Committee. Edwards and Carter (1980, 13) define a day unit as 'a form of communal care which has care-givers present in a non-residential, non-domicilliary setting for at least three days per week and which is open at least four to five hours per day'.

The Barclay Report (1982, 53) defines day services as 'special centres, private family houses, or facilities shared with the public at large, attended regularly or occasionally by clients of social services, who come to them for all or part of the day, but who return to their own homes to sleep . . . The clearest difference between residential and day services is that in one residents spend the night, and in the other they do not'. The Committee suggest three basic tasks of both kinds of service. These are tending, which involves the provision of activities necessary to ensure the well-being of clients, providing group and individual experiences that are satisfying in themselves and contribute to learning and development, and maintaining links between clients, their family and other external groups.

Finally, some writers implicitly define day care by stating its aims. Jones (1979, 92) suggests that a day centre is 'a half-way house on the road to independence for discharged institution inmates'. Whether this is an achievable role for day centres for groups other than the elderly (eg. psychiatric patients) is outside the scope of this study. However, it is an unrealistic role for day centres for the elderly. The vast majority of their clients are either going to remain in a similar condition or are going to move towards increased dependence. This is recognised by Puner (1978, 212) an American writer, who suggests that day centres are half-way houses for people moving away from, rather than towards, independence. Puner claims that day

centres can 'keep an old person from going to an old age home - or put off his going there for years'. This may be the case but it is an assertion that requires testing. This is true also of Age Concern's (1974 c, 1) statement that day care is an alternative to residential home or hospital: 'The provision of day care is being increasingly recognised as an important service which enables many of those who would otherwise have to be cared for in a residential home or hospital to continue to live in their own homes and which provides some relief and support for the relatives of these infirm old people'.

Edwards and Carter's (1980) work may be regarded as providing supportive evidence for the view of day centres as half-way houses. They found that 35 per cent of clients who left day centres in non-residential units in seventeen local authorities did so because of admission to hospital or residential care.[1]

Mortimer (1982) states that the purpose of local authority day centres is helping 'to overcome the problem of loneliness for many of the isolated, and also offer leisure activities, mid-day meals and sometimes chiropody and beauty care, which help to maintain the mobility and sense of worth of those who attend'.

1 Other causes of departure were death (25 per cent), deterioration in health (10 per cent), moved to another area (10 per cent), dislike of the centre (7 per cent), to attend another day centre (4 per cent), transport difficulties (4 per cent), to continue activities at home (3 per cent).

Tinker (1981, 107) also begins by referring to loneliness and leisure activities. Tinker states: 'the purpose of day centres and clubs is to provide a means of social contact and recreation'. She emphasises the importance of creating structures within day centres that enable the elderly to help each other. In a review of research on the help that the elderly give to other people, Tinker concludes that although some elderly are able to help their neighbours and to undertake voluntary work, much of the help given by the elderly is to their own families. The implication is that the elderly have abilities which society is not maximising and that we should be examining ways in which more use might be made of such abilities.

The Department of Health and Social Security (1980, 82-3) study of the elderly in Brighton found that the majority of the inter-professional team of carers (social workers, home help organiser, community nursing officer and representative of the local authority housing department) concerned with assessing clients thought that more day care should be provided but there was considerable confusion as to how this might best come about. There was agreement that day care should be a full day out, available throughout the week and that there was as much, if not more, need for provision at weekends. There was agreement that day care within residential homes was undesirable because of the intrusion of day visitors into the homes of long term residents. There was agreement that, to avoid long drives which tired clients, more and smaller centres near people's homes were needed. Despite consensus on these points, 'A universally acceptable concept of day care remained elusive' and 'it was not easy to define who might need day care'.

Morley (1974, 6) emphasises that it is not possible to look at day care and club facilities in isolation from the other services offered in an area. She illustrates her argument by suggesting that the need for day care will not be so acute if good residential homes are available. Although they are not strictly comparable services, one will 'balance out' the other. Morley differentiates between clubs and social centres on the one hand and day centres on the other. She suggests that clubs and social centres 'exist for all old people to increase social contact and to give scope and facilities for new pursuits in retirement'. Day centres 'exist to provide the facilities of a club plus support during the day for those in difficult circumstances at home'. Morley argues that although it is important to provide day care for those groups which research findings suggest are most 'at risk', such provision should not detract from the need to provide facilities for the average, active people of retirement age. Day centres offer them the opportunity to participate in new interests and activities at their own pace and of their own choice.

## Research into day care

There has been comparatively little research into day care for the elderly. The purpose of this section of the study is to review the British research that has been undertaken. This research falls into three categories. The first comprises national surveys which have sampled local authorities in Scotland, England and Wales and some smaller, more local studies all of which have aimed at obtaining overviews of provision. The second category comprises researches that have compared day care with other forms of provision. The third category comprises researches that have examined aspects of one or two centres. These three categories are considered here consecutively. Finally, brief consideration is given to the importance of transport, an aspect of day care which has been identified as important by several authors.

In drawing conclusions from the research it is important to bear in mind the differences in definitions adopted and the wide range of provision incorporated into some of these definitions (as demonstrated above). These factors may make it difficult to make comparisons. For example, there may be no reason to think that there will be similarities between users of a Darby and Joan Club and users of a centre for the elderly mentally infirm yet both may be included within a day care category.

### 1 Overviews of provision

Two pairs of recent British studies have been concerned with obtaining overviews of provision. Fennell et al (1978) researched day centres in East Anglia while Bowl et al (1978) undertook a study of day centres for the elderly in Birmingham. The two studies were designed to complement each other. The general aims are stated by Bowl et al as 'to discover more about the role which different forms of day care can play in meeting the Government's objective in its policies towards old people of enabling them to maintain independent lives in the community for as long as possible' (1978, 1). Edwards and Carter undertook a study of day units in a random sample of local authorities in England and Wales in 1976 (1980), while Tombs and Munro's (1980) 'Scottish Day Services' study paralleled Edwards and Carter's work. Although there are differences in the types of provision included in the two pairs of studies,[1] their findings concerning provision may be considered together under four

1 Fennell et al and Bowl et al included a wide range of types of provision in their researches. They included full-time and part-time day centres, full-time and part-time luncheon clubs, drop-in centres and day hospitals. Edwards and Carter's definition of a day unit (quoted above) was 'a form of communal care which has "care givers" present in a non-residential or non-domiciliary setting for at least three days per week, and which is open four to five hours per day . . . The day unit was also to be a non-profit making personal service which recruited attenders on the basis of their inclusion in a defined administrative category of disability or age'. Interestingly this definition was chosen to exclude the luncheon and other social clubs which the Birmingham and East Anglian studies included.

heads: aims and the fragmentary nature of provision; the characteristics of users; benefits of the centre for users; benefits for the users' relatives.

First, all the studies found that the fragmented structure of provision referred to above in the context of services for the elderly also exists in the more limited sphere of day care provision. This is attributed partly to the absence of a clear set of aims and a philosophy for day care. Bowl et al (1978, paragraph 11.24) confirm 'the lack of clarity and a coherent policy for provision of day care activitity'. They identify several reasons for this:

> it reflected low priority given to the elderly generally - behind children and the mentally handicapped; increased pressure on social services because of the growing population of elderly and society's raised expectations of what should be provided; the fragmentation and diversity of provision and its piecemeal development which is difficult to grapple with, and bring order to, and confusion over the objectives of the day centres for the elderly and handicapped where it was stated 'rehabilitation has declined'.

Bowl et al illustrate the extent of fragmented provision with an example from Birmingham where three separate sections of the local authority are responsible for day care in social welfare centres, residential homes and liaison with voluntary centres. Yet formal meetings do not take place between them to discuss day care policy.

Fennell et al also found fragmentary provision. They state (1978, 1) that, in reality, there is not the tidy continuum of day care from 'a Darby and Joan Club meeting one afternoon a month, through part-time luncheon clubs and part-time centres run by charitable organisations meeting once or twice a week for a longer period in the day

to full-time local authority centres and day hospitals operating all five days a week'. Instead, chance factors have influenced the provision of centres and their distribution to an extent where the idea of a continuum of provision may be useful for analytical purposes but not as a guide to formulating policy.

In common with other writers quoted here, Carter (1981, 13) found that it was unusual for an authority to have a clearly formulated policy concerning day care. She found that health authorities had less clear policies than social services departments but even so she concludes that 'Central Government statements had not been transferred into hard local realities'. Often, the variety of aims expressed by workers in day centres were ends in themselves. For example, the serving of a meal was seen as an end in itself with no attempt to link it with aims such as improving the user's nutritional health: 'The medium itself is the message, unbuttressed by theoretical or philosophical beliefs' (Carter 1981, 139).

Tombs and Munro found the confusion concerning aims that other writers have indentified. Munro (1979, 38 and 30) writes 'From our study it is clear that the (officially stated) aims are neither self-evident nor always obviously rational . . . The aim of clinical treatment was not stressed by many staff; in fact a higher percentage of users than staff viewed the treatment or therapy provision to be the main aim of the unit'.

Secondly, the four studies identified a wide range of characteristics of users. The range was so great that few generalisations may be drawn. Although there was a preponderance of women there were considerable variations between centres in the

proportion of women clients. While the majority of users in Tombs and Munro's study were 75 years old or younger, one third of Edwards and Carter's sample were over 80. All the studies found that approximately half the users lived alone. Both the East Anglian and Birmingham researches investigated housing conditions and found that very few users experienced housing difficulties such as an external WC or no hot water supply. This suggested to Fennell et al that the users were not a group suffering multiple social disadvantages.

Thirdly, the Birmingham and East Anglian researches examined the benefits of day care for users. They identified a range of benefits although the nature of these was perceived differently by different role occupants. Social workers stated that the most beneficial aspects were the relief provided for relatives, giving the elderly person a day out and, the most important, affording additional flexibility for the social workers themselves in providing suitable care. Social workers were critical of the lack of stimulation provided within centres. Geriatricians claimed to be able to discharge patients more quickly from hospital if they could continue to attend day hospital for support while policy makers and organisers regarded the company of other people and the day's outing as the main benefits. Even the organisers of luncheon clubs felt that the provision of a nourishing meal is of secondary importance to bringing people together. The users themselves saw the value of the centres as affording the opportunity to get out of the house, to meet people, to have something to look forward to, to have meals provided and to provide some relief for their relatives. Bowl et al found differences between types of centres in the benefits of attendance as perceived by users. Therapy, for example, was seen as an important benefit at the day hospitals sampled. Fennell et al add a note of caution concerning the favourable views of users stating that as the users belong to a group of people who are not accustomed to having things done for them they are likely to be grateful for extremely little.

Fennell et al's note of caution is reinforced by Bligh (1979) who found that of 166 elderly people offered a place in a day centre 30 had attended either once only or not at all. It is suggested that the major reason for this may be the shock experienced at first attendance or on a preliminary visit at encountering very disabled or confused people. As much attention needs to be paid to induction at day centres as at residential homes.

Edwards and Carter asked members of their sample what benefits they had obtained from day care. The majority thought that they had at least maintained their functioning as a consequence of day centre attendance. A much larger proportion (one-fifth) of day hospital attenders thought they had improved than did users of other day facilities.

Fourthly, research has been concerned with the benefits gained by the relatives of day centre users. It has already been suggested in this chapter that day care might help relatives by allowing them a break from caring for the elderly person. Sixty per cent of the relatives of users interviewed by Bowl et al said that they found it very difficult to cope with their dependent relative, and nearly half found the centre a great help to them. The main benefits were claimed to be relief from constant day and often night time responsibility with accompanying stress and worry. Day care enabled them to go out knowing the relative was in good hands. Fennell et al state that relatives themselves are often isolated as a consequence of having to provide the user with constant care. For relatives, day centres provide the stimulus of escaping from each other's company, the opportunity to relax where a relative requires constant attention, time to do household chores, the opportunity for some privacy, enables them to continue in employment, to boost morale through the feeling that something is being done to help, and provides the security that the user

is being well looked after. Fennell et al recommend that centres should try to offer more support to relatives through provision of opportunities for discussion of problems with staff and the arranging of occasional functions where they might meet other relatives with similar difficulties.

However, both Bowl et al and Fennell et al found that day care has disadvantages for the relatives of some elderly clients. Fennell et al list these as prolonging an agonising situation where referral to permanent care is indicated, difficulty caused by unreliable transport and exhaustion when it takes a long time to prepare the user in relation to the time spent away. It must be noted, that, with the exception of the last, these are not disadvantages of day care as such but of inappropriate use of day care (eg. because it is not possible to arrange residential care although appropriate) and of inefficiency in the provision of transport. Bowl et al also focus on the problem of transport and on the extra burden of preparing the relative for the day out.

2 Comparisons with other forms of provision

There is very little reasearch that compares the relative merits of day care and other types of service. Plank (1978 a) suggests that one of the reasons for this is the difficulty in assessing the effects that services have on the well-being of the client. In contrast to the proponents of the quantification of quality of life, he suggests that the measurement of well-being is an art, not a science. Whitehead (1967, 163) states that client well-being is one of three factors, along with community tolerance and impact on the family, to be measured in any assessment of the usefulness of a day hospital:

> It is difficult to assess the usefulness of a day hospital. To obtain even a vague picture it would be necessary to do a detailed study of patients, families and the

effects on the community. A rough estimate of how many patients have been kept out of hospital and how many more have been discharged because of day care is possible. These figures do not measure patient well-being, community tolerance or impact on the family.

A study that was designed 'to find out what happens to elderly people when they receive care or services in four different types of environment' was undertaken by Goodlove, Richard and Rodwell (1983). The extent of the inactivity they found among elderly clients has been referred to above (p 77). However, day care clients were much more active and talkative than clients matched for disability in residential homes. Goodlove, Richard and Rodwell conclude that the environment has greater impact on activity and interaction level than does disability. Although 'local authority home subjects spent a much greater proportion of their time in small groups of residents than did subjects in the other three environments . . . remarkably little interaction took place. Clearly, the simple expedient of putting people together in small groups does not, of itself, promote increased social contact.' The role of the staff is important and yet, in both wards and homes, staff activity mainly consisted of carrying out 'routines of physical care and housekeeping chores'. Day centre staff spent 24 per cent of their time in contact with clients compared with staff in local authority homes, 5 per cent, day hospitals, 15 per cent and hospital wards, 3 per cent. Subjects were asked whether they felt ill at ease with people and whether they felt any desire to avoid contact with others. A higher proportion of day centre clients expressed 'unsociable' attitudes than clients in other settings. In day centres, 38 per cent, in homes, 33 per cent, in day hospitals, 5 per cent and in hospital wards, 29 per cent responded affirmatively to one or both questions.

## 3 Studies of single centres

While some researchers have undertaken broad overviews of provision, other researchers have undertaken studies of single centres. A study that has many methodological similarities with the present work was undertaken by Hazan (1980). He undertook participant observation research in one day centre for elderly Jewish people in London. His report of his research focusses specifically on 'the supreme importance of their pre-occupation with the management of time'. In addition to the fact that it is run by the Jewish Welfare Board, the Centre has several unusual features. It is larger than most (with some 350 members) and the clients have a major say in the daily routine. It is open from 9 30 am to 5 pm from Monday to Friday and on most Sunday afternoons. On Friday mornings the clients go to the Jewish Blind Society's day centre along with that Society's members. In other ways the Centre has similar characteristics to those depicted as most common by other writers. There is a high proportion of very old clients, women outnumber men and the formal criteria for admission are various. They fall within the range of 'social isolation, physical handicap, inability to cope at home, the prevention of an explosive home situation getting out of hand by separation, mental illness symptoms such as withdrawal, depression etc' (Hazan 1980, 51).

Hazan (1980, 83) found two groups of members at the Centre:

> Those who professed to use the Centre merely for its material provisions, as a day centre and communal kitchen, and those who declared that for them the meaning of the Centre extended far beyond the obvious services it provided. The former group tended to view the Centre as a transitional, insignificant stage in their lives, divorced from the outside world, while for the latter the Centre was the hub, the most meaningful part of their existence.

The Centre provides help in selling client's homes, arranges television licenses, winter clothing, convalescence, telephone and electricity bills, legal advice, negotiations with landlords. Hairdressers, opticians and beauticians visit the Centre. The Centre has several facilities that one would normally seek in home surroundings. These include a special handicap bath, sewing machine and carpentry tools for clients to use for their own repairs. The Centre provides a wider range of services than one suspects from other research exist in most day centres. If the major aim of day centres is to maintain elderly people in the community, it may be that many elderly clients require assistance on the scale described by Hazan.

Although Hazan found consensus of both clients and staff as to what the Centre is not (neither a luncheon club nor a recreation centre; neither a voluntary friendship club nor a compulsory environment) they were unable to agree on positive definitions of purpose. Hazan suggests that the main criteria for admission are 'sociability and poverty'. 'Attendance in the absence of financial hardship, although obviously motivated by other difficulties, is often frowned upon and considered an abuse of the Centre's fundamental mission which is catering for the poor' (Hazan 1980, 85). The Centre is strongly demarcated from the outside world. Hazan quotes the example of a member 'caught' in a local park chatting to a non-member about the Centre. He was told off by fellow members who warned him not to involve the Centre in his 'private life'.

Two studies describe the mobile day centres that have been used in Sunderland and rural Staffordshire to provide day care for elderly clients living in isolated areas where no permanent day centres are available or easily accessible. These two centres are mobile caravans 22 feet long and $7\frac{1}{2}$ feet wide with kitchen and toilet

facilities. They are towed by a mini-bus which, when unhitched, may be used to collect clients needing transport. Each centre can cope with twelve users per day. Johnson (1979, 25), describing the Staffordshire scheme, argues that the advantage of the mobile centre is that it can be moved to a number of different places to try to detect the demand for it. The organisers attempt to give priority to the clients who feel most isolated. Johnson suggests that 'there is always a danger in selecting people that may become stigmatised for using the Centre or the Centre may become known as a place that only certain sorts of people use'. In summarising the advantages and disadvantages of the Sunderland scheme, Kaim-Caudle (1972) argues that the cost of the mobile centre is approximately one-quarter of the capital cost of a purpose-built day centre. He admits that he is comparing the caravan with a purpose-built day centre designed for 100 people and that this comparison is analogous to comparing a five-star hotel to a youth hostel. Johnson argues that a realistic comparison would be with a 'Portacabin'. In this comparison, the mobile centre would be shown to be much more expensive owing to the salary for a full-time driver and the greater depreciation.

One small American study (Pilch 1978) concentrated on a centre which tried to increase the community involvement of the elderly clients by involving them in amateur dramatics. The clients formed the workforce for an amateur dramatic company. Centre users made costumes, printed tickets, distributed programmes, manned the box office and painted scenery. In Britain, attempts at involving the community in day centres have included an autobiographical writing project (Cheeseman 1980) and a project that brought library services to three day centres (Simes et al 1980).

Although day centres and residential homes are sometimes regarded as alternative forms of provision, there is little research in which the two are compared. In one small-scale study, thirty residents of elderly people's homes and ten elderly members of day centres in Brighton were compared (Department of Health and Social Security 1980). The residents of the homes were found to be physically more able than the day centre members but more incontinent and mentally confused. Of course, such conclusions may do little more than reflect the local authority's policy concerning admission criteria. However, an interesting finding was that substantially more medication was prescribed in the residential homes than in the day centre. Only 13 per cent of those in residential homes received only occasional or no medication while the figure in the day centre was 40 per cent. The authors question whether some of the medication given to residents in the home was actually needed or just convenient from a management point of view. It should be borne in mind that the samples in this research were very small.

4 Transport

Many elderly are totally dependent upon transport provided by the Centre to get to the facility. They may have to get up early to be ready for collection. Yet there is evidence that transport is often unreliable and a major cause of problems for elderly day care users. Transport is stated to be a potential difficulty by Morley (1974), by Whitehead (1967), by Edwards and Carter (1980), although Carter (1981) emphasises that the major problems only existed when use was made of National Health Service Transport, by Utting (1977) and by Airie (1975, 36) who, writing about day care in geriatric psychiatry, goes as far as to say, 'transport and practicalities of picking up and delivering old people are fundamental, and may make the difference between a viable day care solution and one which is a non-starter'. Bradshaw argues that

transport is crucial if day care is to benefit those who really need it. Hazan (1980, 55) quotes the organiser of the day centre he studied as saying 'Perhaps the most crucial, frustrating and sensitive area of operations for the staff is the transporting of handicapped and less mobile participants to and from the Centre. The tail-lift ambulance and the Ford transit coach call for tact, anticipation and invariably an element of luck.' One of Fennell et al's recommendations is that users must be prepared for their first visit to the centre and ideally meet the driver and/or escort and organiser beforehand, that special efforts to welcome and support new users are necessary. Fennell et al state that the journey to and from the Centre is an important part of day care provision - not just a means of getting there and back. It provides a link between homes and centre as well as an opportunity for users to see their surroundings. In this context the driver has an important social work role.

The importance of ambulance-men's judgements in assessing the condition of a patient and the way in which he will be processed before he comes to the attention of a doctor has been stressed in research by Hughes (1980, 116): 'Their definition of the patient's condition not only affects the immediate attention he receives and the style of his journey to hospital, but constitutes a significant part of the 'information' available to hospital staff members as a starting point for their own investigations'. Although Hughes' research was concerned with the national health accident and emergency services, one may argue that the ambulance crew is, at least potentially, as important in day care services.

# CHAPTER 2

## RESEARCH METHODOLOGY

The purpose of this chapter is to discuss the research methodology adopted for the study. The chapter starts with a descriptive, chronological summary of the way the research was undertaken. This is then developed with a more detailed exposition of the selection of the subject studied and the choice of research method. Two sections of the chapter then summarise the characteristics and advantages of participant observation as a research method. Certain aspects of any research method are problematic and this is true of participant observation. There is therefore an examination of some of the problematic aspects of participant observation, namely sampling, the role of the researcher, recording of data, and validity. These examinations are followed by a section on the generation of hypotheses and, finally, the particular constraints imposed by the subject of the research.

## CHRONOLOGICAL SUMMARY

This summary is included to provide an overview of the way the research developed and to identify the chronological context within which the remainder of the study may be placed. Specific issues are discussed later and this summary is intentionally a simplistic one.

The study commenced during Autumn 1979 with the choice of 'the elderly' as the broad subject to be researched. At this point there was no focus on any particular aspect of the elderly. As the researcher had a modest background in research but only a layman's knowledge of the elderly, his initial work was on two fronts. First,

he read widely. Secondly, he approached the officer-in charge of a home for the elderly that was recommended to him to ask whether he might visit the home. His initial letter detailed the reason for the request:

> I am Head of the School of Social Sciences at Hope College where my responsibilities include social work education. At the College we offer CQSW, CSS, Preliminary Certificate in Social Care and the In-service Course in Social Care.
>
> As I am not a social worker and I have never been involved in a home for the elderly I would like to spend some time in a good home studying for myself the care within it. A colleague of mine has recommended yours as a home that exemplifies good practice. I wonder, therefore, whether you would be kind enough to give some thought to the possibility of my spending some time in your home for my study?

The Officer-In-Charge replied immediately by telephone saying that she would be delighted to agree to the request and that she had obtained approval from her superior for the visits.

The researcher visited the home for one day per week for six weeks during which time the Officer-In-Charge and her colleagues devoted a great deal of time explaining to him how the home operated. He also spent considerable time talking with the residents. During these visits, the Officer-In-Charge recommended other homes for visiting that differed from hers in various aspects. She also made frequent references to a day centre; Suilven House. At the time, the researcher did not know of the existence of day centres and, from the description he was given, was unable to understand their purpose or operation. Accordingly, he accepted the offer of the Officer-In-Charge of the home to arrange for him to pay a visit to the day centre.

The initial visit to Suilven House was of one morning's duration but the researcher was immediately interested in the possibility of making this the subject of his study. It may well be that this decision was essentially emotive and not open to full rationalisation. However, it is possible to identify at least three reasons for this decision. First, there had been little research into day care for the elderly. Secondly, the elderly people in the day centre were more alert than those the researcher had seen in residential homes. This was considered important as the potential difficulties of obtaining responses to questionnaires, of interviews or other forms of data collection had been regarded as barriers to researching residential homes for the elderly. Thirdly, and least tangible but most important, the researcher was more excited by the day centre than he had been by the homes.

The research into day care that was available at this early stage in the present study was essentially quantitative and provided comparative overviews of centres within large areas. This research was valuable in indicating the extent of day provision and take-up in certain geographical areas and providing an analysis of the reasons old people attended the centres. However, the data was obtained through surveys and questionnaires administered at several centres. While such research methods are valuable in providing data from sufficient centres to increase the likelihood of conclusions drawn from such data being applicable to other centres, they only provide superficial data. For example, they do not allow a detailed analysis of the reasons for attendance at a centre. Fennell, Emerson, Sidell and Hague (1978, 270) asked clients to indicate which of ten possible reasons led to their attendance at the centre. Such a question makes assumptions about the completeness of a list, about the ability of an individual to accurately identify which reason applies to her and her willingness to then state the reason to an interviewer that the present writer finds difficult to accept.

It is difficult for any member of society to analyse his reasons for entering a social group. To ask an elderly person (who may be confused, who may identify the researcher with the management of the centre) to make an instant analysis in response to a specified list of possible reasons may well suggest avenues for further more detailed research but does not, of itself, provide more than a superficial analysis of the reasons for attendance.

There were many questions concerning day care that appeared important and that could be studied through an interpretative methodology. These included questions about the aims of day care as perceived by staff and clients, the daily routine, the selection of activities, the relationship between staff and clients.[1] As a consequence of his interest in Suilven House and questions such as those identified above, the possibility of a participant observation study of one or a few day centres emerged.

The possibility of studying a day centre other than Suilven House was considered but Suilven House became the subject of the study for two reasons. First, it was the only centre that was geographically convenient for the researcher. Secondly, the Officer-in-Charge and the Assistant Principal Officer (Residential and Day Care), Westshire Social Services Department, (hereafter referred to the Assistant Principal Officer) indicated that they would welcome a study of the Centre. Formal approval for the research was obtained from the Director, Westshire Social Services Department, for 'a small scale research project into day care for the elderly' (letter from M Taylor to the Director, 18 July 1980). Fieldwork began the following month.

1 Hazan's (1980) work is a study of day care that adopted an interpretative methodology. However, it was published some time after the fieldwork of the present research had commenced.

Regular participant observation visits were undertaken from August 1980 until December 1981. The frequency of these visits varied according to personal circumstances as the visits had to be undertaken while pursuing a full-time job, by the timing of any activities of special interest at the Centre and by the need to follow up specific clients or research undertakings. On average, the Centre was visited the equivalent of one full day per week.

In Autumn 1980 the decision was taken to study a sample of clients in greater depth. It was intended that these clients (referred to hereafter as the 'sub-sample') should be interviewed immediately after the decision to admit them had been taken and again three and six months after admission. The sub-sample was to comprise the complete intakes from the October, November and December 1980 Admissions Panels.

The research involved a variety of quantitative and qualitative methods of obtaining data. These included the description of observed incidents, recording of overhead conversations and of conversations in which the researcher participated, formal interviews, references to Centre records, the simple counting of clients in certain situations at certain times and the photographing of situations.

Further literature searches continued while the field work was undertaken and while the work was written up.

## CHOICE OF RESEARCH METHOD

It would be naive to say that the study of day care began from a value-free position. It is, nevertheless, true that it began with what is believed to be an open mind on the subject. Never having been in a day centre before, not having been a social worker or worked in a social services context, the researcher began with very few pre-conceived ideas of what to expect and no intention to criticise or praise any particular role occupant or group. Nonetheless, it should be acknowledged that anyone familiar with the literature on the possible effects of institutionalisation is likely to enter an institution (albeit a partial one) with some concerns and the awareness that institutionalisation may be accompanied by some negative consequences for the inmates as well as some advantages.

Clearly the work could not begin from a value-free position with regard to the elderly generally. The writer was able to summarise his position tentatively as sympathetic to elderly people on account of the extent of loneliness, ill-health and suffering that they apparently suffered. His position changed during the research in that while he remained sympathetic, the sadness inherent in the sympathy was lessened while there was an increase in the fondness and respect he felt for the members of the Centre as well as an increase in his awareness of the potential of old age. It is difficult to know how these values and the slight changes in them influenced the research.

The study began with two commitments to which attention must be drawn. The first was to view the Centre through the eyes of the sociologist and apply certain sociological concepts to it. In particular, these concepts are those of interactive middle-range sociology in which there is an emphasis upon the socially constructed nature of the world and on the inter-relationship of objective reality and subjective reality.

This commitment to a sociological perspective needs to be acknowledged but requires no justification. The day centre is a sub-world that is socially constructed, where individuals interact, where they view the world in meaningful ways. This is more than sufficient to make it the province of the sociologist.

The second commitment, which does require justification, was to participant observation as a research method. It was necessary to use a method that would allow phenomena to emerge of which the researcher was unaware at the start of the study. The study was not one in which a number of variables and hypotheses could be identified at the start. It was necessary to adopt a methodology that allowed the researcher to identify the aspects of life in the Centre that were of importance to the members and to pursue the interconnections between these. It was thought important for the researcher to see the sub-world of the Centre as nearly as possible through the eyes of the members in order that he might have greater understanding of how the members behave. Participant observation was considered the most appropriate method by which to achieve these demands, particularly the need to explain the meanings that the subjects attach to their social world.

The centrality of the problem of meaning in social research can be traced back at least to Durkheim. Particularly relevant here is Weber's argument for the subjective interpretation of social reality. Weber has stated that the sociologist's task is to understand and interpret social action which includes 'all human behaviour when and insofar as the acting individual attaches a subjective meaning to it . . . Action is social insofar as, by virtue of the subjective meaning attached to it by the acting individual (or individuals), it takes account of the behaviour of others and is thereby orientated in its course' (Weber 1964, 88).

Schutz has developed some of Weber's arguments. Schutz argues that the application of the research method of the natural sciences cannot be transferred to the social sciences owing to the completely different nature of the basic data of each. The natural scientist, he argues, studies a field that 'means' nothing to the 'molescules, atoms and electrons therein' (Schutz 1962, 5). The world of the subject matter of the social scientist, ie. people, on the other hand, is essentially meaningful. The social world is subjectively structured and has particular meanings for its inhabitants. An essential task for the social scientist is to examine the ways in which an orderly social world is established in terms of shared meanings. Roche has noted that 'each successive phenomenologist produces a different meaning for the term "phenomenology"'. There are, however, common denominators, one of which 'is the injunction, accepted in theory and practice by all phenomenologists to "be true to the phenomenon"' (Roche 1973, 1).

The present writer supports this emphasis on the importance of interpretative sociology and believes that participant observation is an important research method for obtaining such understanding.

## PARTICIPANT OBSERVATION: A SUMMARY

There is a long tradition of participant observation in British social research. The Webbs, for example, wrote, 'An indispensable part of the study of a social institution, wherever this can be obtained, is deliberate and sustained personal observation of its actual operation' (Webb and Webb 1975, 158). Payne, Dingwall, Payne and Carter (1981, 87) have referred to this tradition: 'In Britain this (ethnography) has a complex long history of indigenous developments, exported to America and subsequently re-imported in isolation from their original roots.'

Participant observation is not one single technique but a blend of research methods. The actual methods adopted by the researcher vary according to the nature of the study but they are likely to include both qualitative and quantitative techniques. Woods (1977, 41) has summarised participant observation as 'a combination of methods, or rather a "style" of research, in which the chief instrument is the researcher himself'. Woods suggests that 'many of the techniques of actually doing the job are implicit in the theory and methodology, that is to say that, given the theoretical position, many of the "techniques" follow almost automatically'. As a consequence, he writes, textbooks tend to be individualistic discussions by researchers of how they carried out their own work.

McCall and Simmons (1969) agree that participant observation involves a blend of techniques but they provide a list of the most common techniques involved. These are social interaction in the field, direct observation of relevant events, formal and informal interviewing, systematic counting, collection of documents and artifacts, open-endedness in the direction of the study. All of these techniques were used in the present work.

Bruyn is careful to locate participant observation within interpretative sociology while emphasising the rigour of the method. He states 'The participant observer initially seeks to locate particular meanings which people share through communication. He is immediately concerned with whether what he identifies and describes as existent meanings really exist' (Bruyn 1966, 204). Bruyn suggests that the more emphasis the participant observer gives to the 'traditional' approach of 'recording visible behaviours and counting action patterns . . . the less likely the observers will go beyond visible behaviour to grasp essential meanings conveyed through communication' (Bruyn 1966, 205). However, Bruyn recognises that the participant observer must face 'the problem of maintaining objectivity in his reports and investigations even though he seeks to make adequate subjective descriptions. In his role as a "participant" he must record and interpret subjective meanings accurately within an objective framework.' Bruyn acknowledges that this is not easily done.

Smith (1981, 75-6) writes:

> Participant observation is characterised by the researcher's intense immersion in some social setting. Total participation allows the researcher to experience a social setting from the occupant's point of view; it can create an understanding of groups and experiences about which we know little or nothing. This ability to gain insight into the subjective features of social behaviour is the key objective of field studies.

Not all participant observers would agree about the extent of the 'intense immersion' to which Smith refers. The various kinds of involvement that a participant observer may have with his subject will be discussed later.

Zelditch (1979, 125) recognises that different levels of immersion are possible: 'The field worker directly observes and also participates in the sense that he has durable social relations in S (the social system under investigation). He may or may not play an active part in events or he may interview participants in events which may be considered part of the process of observation.'

It will be noted that although Zelditch suggests a choice of role for the participant observer and makes specific reference to interviewing, he does not make reference to the use of documentary evidence. He does, though, make an important point concerning the advantages of combining qualitative and quantitative data. In the present work both qualitative and quantitative data have been used. Although more attention is paid in this chapter to a discussion of qualitative research this is not to deny the importance of quantitative data. The writer supports Zelditch's argument that there is an artificial and unhelpful discussion of opinion between 'those who have sharply criticised field workers for slipshod sampling, for failing to document assertions quantitatively and for apparently accepting impressionistic accounts: and, on the other hand, those who have sometimes bitterly, been opposed to numbers, to samples, to questionnaires, often on the ground that they destroy the organic whole' (Zelditch 1979, 122).

The need for quantification has been argued by Atkinson (1977, 42) who is critical of much participant observation which seems characterised by:

> a funny story here, an apt quote from a "subject" there, a few extracts from a newspaper or television. Indeed, it sometimes seemed that anything one happened to stumble across would do, so long as it seemed relevant in some way to the arguments being presented. This was very different from the ordered way in which survey research could be carried out, and it was not easy to make the decision to forget so many hard-learned principles and exchange them for so vaguely specified an alternative.

The relationship between participant observation and theory is different from that between quantitative logical positivism and theory. Most logical positivistic researchers begin with at least one hypothesis which they set out to test. Such researchers would say that the early formulation of hypotheses, resulting from theory, is essential. Bennett (1973, 11), for example, writes that the research problem 'has to be translated into precise operational hypotheses upon which a research plan can be designed'. In contrast, the participant observer seeks to 'generate' theory 'from his observation and to "ground" it in the facts, rather than to test out all "a priori" theory through the deduction and testing of hypotheses' (Woods 1977, 6).

## THE ADVANTAGES OF PARTICIPANT OBSERVATION

Before examining the way in which the methods of participant observation summarised above were used in the present study, some of the particular strengths of participant observation that led to its adoption should be stressed. It is insufficient to say that as participant observation is a method adopted by interpretative sociologists and as interpretative sociology underpins this study, participant observation is an appropriate methodology.

In an article on the evaluation of broad-aim programmes, Weiss and Rein argue the disadvantages of an experimental design for such programmes. They characterise a broad-aim programme as one which it is hoped will achieve non-specific forms of change for the better involving unstandardised, large-scale interventions. With some reservations over the definition of 'large-scale', a day care programme fulfils these criteria. Weiss and Rein (1970, 97) state that the traditionally preferred research design is based on the underlying assumption that:

> action programmes are designed to achieve specific ends, and that their success

> can be established by demonstrating cause-effect relationships between the programmes and their aims. In consequence the preferred research design is an experimental one in which aspects of the situation to be changed are measured before and after implementation of the action programme. . . . This plausible approach misleads when the action programmes have broad aims and take unstandardised forms.

Weiss and Rein identify a series of difficulties that such an experimental design has for broad-aim programmes. Results are open to multiple interpretations, it is difficult to select satisfactory criteria, the research situation is essentially uncontrolled, 'treatments' are not standardised, the experimental design is limited in the information it can produce and there are administrative difficulties. They suggest three alternative but complementary methodologies which may be characterised as:

1 process-orientated qualitative research (although the writers state that there is no need to exlude quantitative data),
2 historical research,
3 case study or comparative research.

Participant observation is an appropriate blend of methodologies to satisfy Weiss and Rein's arguments. Some of the particular strengths of participant observation that resulted in its adoption for the study may be identified under five heads:

1 It permits the development of grounded theory.

This is the argument introduced above, that participant observation permits the generation of theory from research findings. The importance of grounded theory has been discussed by Glaser and Strauss (1967, 28) who believe that the main goal of researchers is 'developing new theories in their purposeful systematic generation from the data of social research'.

The present writer has some doubts about the emphasis which Glaser and Strauss give to the generation of theory at the expense of testing existing theory and, possibly, at the expense of accurate evidence[1] but not of the importance of generating theory from research data.

The inductive generation of theory may be particularly important in studies such as the present one in which there is little formal theory presently in existence. Participant observation permits the researcher to enter an organisation with a more open mind and ask 'what is happening here?'. Most other methods require him to delineate the possible 'happenings' beforehand. In participant observation, not only does the researcher identify new ideas or information or relationships but the subjects often do this for him. The subjects who says 'Did I ever tell you about x?' or 'It wasn't only y but z as well' may introduce data or reorientate the research in a direction the researcher would not otherwise have taken.

2 The researcher can reformulate the problem as he proceeds and can constantly modify his categories.

As research proceeds, the researcher may find that his original definition of the research problems requires modification in the light of the evidence that is collected. Unexplained facts or incongruities force him to revise and adapt.

1 'Since accurate evidence is not so crucial for generating theory, the kind of evidence, as well as the number of cases, is also not so crucial. A single case can indicate a general conceptual category or property' (Glaser and Strauss 1967, 30).

Participant observation allows the reformulation of the problem. Similarly, a researcher may discover that the categories in which he anticipated locating his findings require modification as it is seen that certain data does not fit the proposed categories. An example within the present study concerns the model of good and bad drivers. When it became clear that clients saw different drivers as 'good' or 'bad', the researcher tried to identify the characteristics of drivers in four different categories. However, as these categories were tested by further observation it was evident that data was emerging which did not fit into these categories and that there was contradictory evidence. Accordingly, the categories were modified and the correspondence between these categories, existing and emerging data, further checked.

3 It allows the discrepancy between 'real' and verbal behaviour to be avoided.

It is self-evident that what a person thinks and says, or says and does, are not necessarily consistent. This is a problem which all researchers have to face but one which is particularly difficult for those using such methods as questionnaires and interviews. The reasons for the inconsistency between, for example, the verbal responses of a subject and her actual behaviour are many. She may genuinely not realise that there is any inconsistency, she may wish to present herself to the researcher in a more favourable light, she may just wish to be quickly rid of the researcher and thus she gives the first answer that enters her head.

It may be that the elderly in general, and those in receipt of social services in particular, present special problems in this respect. Some may be confused and fail to understand the question. They may be less used than younger generations to being researched and they may be flustered as a consequence. They may identify the researcher with 'officialdom' and feel that their entitlement to services will be withdrawn unless they answer particular questions in certain ways.

Whatever the reasons, such inconsistency obviously reduces the validity of research. Participant observation in itself may not reduce the likelihood of such inconsistency. (Although one might argue that the relationship between participant observer and subject might reduce the likelihood of the subject lieing or being unwilling to talk about certain subjects.) The advantage of participant observation in this context is that the use of a variety of methods allows checks to be made on the data obtained. An example of the way in which such checks operate is referred to later in the study. One client had suggested that she had a close relationship with her son who visited her regularly and undertook all the household chores his mother could not manage. However, on visiting the house with an ambulance driver it was clear that the only housework that had been undertaken for some time in the house was what the mother had done.

As Becker and Geer (1957, 31) have stated: 'In short, participant observation makes it possible to check description against fact and, noting discrepancies, become aware of systematic distortions made by the person under study; such distortions are less likely to be discovered by interviewing alone.'

4 It assists the researcher in providing a temporal context for the work.

Some sociological theoretical frameworks, notably structural functionalism, have been criticised on the grounds that they present a static view of a society. Interpretative sociology emphasises the ongoing, changing nature of society and the importance of understanding events, actions and the reasons for them in understanding the present. Participant observation is able to take account of past action. This is partly achieved through the use of records and other archive material, partly through the subject's own references to the past and to her interpretation of present events as part of the ongoing process of society, partly as a consequence of the time scale during which the researcher works.

Although the subject's own interpretation of present events in the light of her experience of the past is important, such interpretation must be cross-checked against other sources. The possibility must be borne in mind that a consequence of change in a subject's social world may be to change the subject's own orientation or perspective on that world to such an extent that she is no longer able to accurately remember her former attitudes, beliefs or feelings.

Owing to the time scale of his research, the participant observer is able to examine changes in the subjects over a period of time for himself. An interview or questionnaire only samples a subject's behaviour, attitudes or beliefs at a specific time whereas participant observation usually samples such characteristics of a subject time and again over several months or even years. In the present study, the population of the Centre was studied over a period of almost one and a half years while a sub-sample was interviewed twice during a six month period specifically to examine changes in orientation to the Centre during that time.

5 It allows the researcher to feel part of the society studied.

It is true that 'one does not have to be Caesar to understand Caesar'. Nevertheless, one may be better able to understand a society if one is able to identify with the members of that society. If a researcher is able to share meanings of his subjects by interpreting words, gestures and other signs as they do he is in a better possition to explain the social world of those subjects.

Later, a continuum of participant observation will be discussed with the researcher as full participant at one end of the continuum and non-participating observer at the other. The closer the researcher is to the first, the more likely he is to be able to accurately share the meanings within the society.

A danger, of course, is that the participant may only participate with one status group within a role set and, in so doing, may fail to see the society from the perspective of other members of the role set. Participant observation in schools presents this danger when researchers teach in the school for a period but do not participate as pupil, cook or caretaker.

## SAMPLING

'There is no single correct procedure for sampling' (Entwhistle and Nisbet 1972, 35). However, the sampling procedure adopted by the researcher requires justification. Sampling in this study involved three different stages; the selection of the Day Centre itself, selection of individuals within the Centre and selection of subjects or issues for particular study. The first two are discussed here, the last in the section entitled 'The Generation of Hypotheses'.

## The Day Centre

The first sampling decision to be taken was the number of centres to include in the sample. On the one hand, the greater the number of centres sampled, the greater the probability that findings from the study would be applicable to other day centres. On the other hand, the greater the number of centres sampled, the less time would be available for the researcher to spend at each centre and the more superficial were going to be his analyses of each centre.

There were two reasons for the decision that this study should focus on just one centre. The first has already been mentioned. That is that other authors had already undertaken studies in samples of twenty-plus centres. There appeared to be less point in replicating such studies than in pursuing previously un-researched questions.

The second reason was located in the nature of the research methodology. Much quantitative research involves the relatively easy collection and analysis of large quantities of data. If, for example, the researcher wants to discover the age structure of day centre clients, he can obtain the necessary data from a number of centres and analyse it quickly. However, if he is interested in such issues as users' first impressions of a centre or the reasons users choose to undertake certain activities rather than others, he has moved into a sphere of interpretative sociology in which quantitative research is likely to provide less insights and in which the collection of data is likely to be time consuming. It is, for example, both more time consuming and more likely to lead to a greater understanding of the centre if the researcher obtains his data in respect of such questions as those identified above through participant observation than through questionnaires.

It should be stressed that it is not suggested that the findings of this study are applicable to other day centres. One hopes that it may provide insights, theories or ideas that might be tested in other centres but there is no suggestion that the findings concerning what was happening at Suilven House at one particular time are automatically applicable either to other centres or, indeed, to Suilven House at other times. To the person who suggests that by limiting the sample to one, and who criticises the researcher for not suggesting that his results are more widely applicable, one must respond 'such is the nature of social research'. Cohen and Taylor (1977, 71) defend their decision to study interaction within a prison in similar vein. They argue that as they were studying a natural environment it was, by definition, unique:

> Therefore, some of the assertions by official critics that the research said little about what was the case for all prisoners or even all long-term prisoners, or that it did not take into account the different circumstances pertaining at another security wing, were largely irrelevant. Neither was it appropriate that we include a control group in our research design . . . We were describing the <u>specific</u> reactions of <u>specific men</u> to <u>specific</u> circumstances (Emphasis in original).

The same argument is equally applicable here.

A large sample is not sufficient of itself to guarantee wide applicability of findings. The researcher making use of positivistic, quantitative methods has to ensure representativeness of sexes, socio-economic groups, ages, size of centres, management styles within centres, etc. He cannot be exhaustive in his identification of potentially relevant social variables. The more precise he attempts to be, the more artificial is his research in danger of becoming. As he increasingly imposes his

own definitions on the study - socio-economic groups have to be delineated, management styles categorised - the more remote it may become from the meanings given by the inhabitants to their interaction.

The researcher did give some consideration to studying a few centres for short periods rather than studying just one centre intensively. It was felt that a disadvantage of the former possibility was that it would force the researcher to adopt a position on the observer participant continuum which would be very close to the observer pole. He would never move beyond what Janes (1961) has described as 'the newcomer stage' and would therefore be unlikely to achieve the necessary rapport with his subjects to understand how they interpret the social world. A more intensive study would provide the opportunity to achieve greater rapport with all members of the centre, study the development over a period of time and verify or disprove ongoing impressions.

The reasons for the selection of the particular centre were entirely pragmatic and have already been discussed. There is no reason to think that Suilven House differs from other centres in important respects but, equally, no claim is made that it is typical of day centres regionally or nationally. The Centre was visited frequently over a period of one and a half years. The visits were never regular partly as a consequence of the research having to be fitted in with the researcher's other commitments and partly because of a desire to study as wide a range of events at the Centre as possible. It was considered important to visit the Centre on every day of the week, to attend committee meetings, parties, off-site visits. The timing of the participant observation varied to take account of these. At other times it was necessary to attend on the same day for several consecutive weeks, for example, when following the progress of a new client. The Centre was attended at least once per week throughout the research period but the frequency of attendance varied from half-a-day to four days per week.

Sub-sample

It was intended to identify a group of some fifteen-twenty individuals and interview them and their close relatives between their acceptance by the Admissions Panel but prior to their first day at the Centre, three months after admission and six months after admission. These clients have been referred to as 'the sub-sample'. This comprised all clients admitted at the October 1980, November 1980 and December 1980 Admissions Panels. It was not known who would be considered at these meetings or how many would be admitted. The total for the three months was twenty-nine. There was no reason to think that they would be untypical of the full population. In the event, the study of the sub-sample provided less data than had been hoped and consequently the final (six-month) interviews were not held. This was because the interviews were very expensive in time and more useful data was being collected from the regular participant observation visits to the Centre than had been obtained from the earlier interviews.

Two reasons may be identified for the comparative paucity of data gleaned from the interviews. First, the expectations of the researcher were unrealistically high in respect of the amount that could be obtained from the interviews. Secondly, the elderly clients had less clear-cut views about the Centre than anticipated by the writer.

Individuals

Once the researcher had selected the Centre to study he had to consider which individuals within the Centre to sample. There is a sense in which the sampling procedure adopted here was post hoc as sampling was carried out throughout the study; the very nature of the research precluding the prescribing of a sample in advance. As Zelditch (1979, 132) has stated, 'the danger is that 'events and persons represented in field logs will generally be sampled according to convenience rather than the rules of probability sampling. The sample is unplanned, contains unknown biases. It is not so much random as haphazard.' Nevertheless, there are rigorous sampling procedures that may be adopted in a participant observation study: quota sampling, snowball sampling and the search for exceptions (McCall and Simmons 1969, 61-7). Each was an important feature of this work.

Quota sampling involves the studying of some individuals from each category that the researcher has delineated. In some cases the categories are obvious; for example, staff, clients, physically handicapped clients, elderly clients, men, women. In other cases, the categories are less obvious and only emerge as the study progresses and hypotheses are formed.

In some cases, the study of a sample from supposed 'categories' may show that they are not categories at all and the hypothesis that suggested such categories is dismissed or refined. At one time for example, the data collected suggested the possiblity of categorising staff according to criteria recognised by the clients. However, in seeking evidence for the existence of such categories, it became apparent that there were numerous inconsistencies and contrary evidence and the 'categories' were abandoned.

In some cases quota sampling is either not possible or inappropriate. It may be, for example, that the area being studied is not amenable to categorising.

A second sampling technique that may be appropriate in these and other circumstances is snowball sampling. This involves the recording of one incident, then looking for and recording a similar incident, then another and another. In this way a series, or snowball, of similar cases is built up. The point at which one stops enlarging the snowball is determined by the researcher. In some cases, an entire population or category may be sampled. In some instances, for example, hypotheses that can be supported by evidence from interviews, the researcher can continue to collect evidence ad nauseam. In other instances involving data which cannot be collected via methods initiated by the researcher, he will be grateful for any supporting cases that can be observed.

This somewhat unsatisfactory state is made much more satisfactory through the use of the third type of sample, the search for exceptions. At the same time as supporting evidence is being sought, so is falsifying evidence. On some occasions the search involves looking for exceptions in the behaviour of a certain individual, sometimes of someone in a certain role category. For example, a hypothesis was formulated that 'clients who consider themselves to be no longer proficient at an activity at which they believe themselves to have been proficient previously are unlikely to continue that activity at Suilven House but may, if they are still reasonably dexterous, engage in an activity they have not previously attempted'. This was only included in the study after attempts had been made to identify clients who were continuing an activity in which they had previously been proficient but who had lost that proficiency, had proved unsuccessful.

As Popper (1945) argues, there can never be a complete absence of bias in sampling as all scientific descriptions of fact are highly selective. Popper argues that it would be undesirable if it were not thus, for the alternative to selection is not a more objective description but a heap of entirely unconnected statements. Kuhn's (1970) argument that normal science is no more than an accepted model or pattern, no part of whose aim is to call forth new sorts of phenomena, is similarly relevant. He argues that the acceptance of one paradigm rather than another involves both comparison of each paradigm and with each other. Both arguments are applicable here.

## ROLE OF THE RESEARCHER

In some forms of research, a discussion of the role of the researcher would be unnecessary. In a participant observation study, however, the researcher may take one of several roles and the role that he chooses (or into which he is forced) will influence the type of research that he undertakes.

Gold (1969) suggests that it is possible to identify the role taken by the participant observer on a continuum with the role of complete participant at one end and complete observer at the other. Gold suggests that there are four possible roles for the participant observer. The researcher who fills the first role, that of 'complete participant', has a true identity and purpose not known to the subject he observes. In the case of 'the participant as observer' the mutual awareness of the researcher's role minimises the problems of the researcher having to pretend that he has a role other than his true one but increases the risk of over-identification with his subjects. Gold suggests that the role of 'observer as participant' is usually reserved for single visit interviews while the role of 'complete observer' removes the fieldworker from participation with his subjects.

Bell (1969, 17) suggests that social systems can be characterised by their degree of 'openness', by which he means the ease of access for the researcher. Thus 'communities are more open than universities, universities than firms, firms than prisons and so on. "Openess" is a relative concept but may for these purposes be dichotomized as "open" and "closed"'. Bell believes that the research worker may choose to work openly and overtly or secretly and covertly. The combination of these two dichotomies provides a matrix which identifies a classification of styles and types of participant observation;

| ROLE \ SYSTEM | OPEN | CLOSED |
|---|---|---|
| OVERT | 1 | 2 |
| COVERT | 3 | 4 |

Thus, Bell suggests community studies usually operate in boxes 1 and 3 while industrial sociology operates in box 2 and covert studies (such as those of industrial managers) operate in box 4.

Some writers have suggested that one would expect the role of the researcher relative to his subjects to change during the research. Janes (1961), for example, reports that, during his participant observation of an American community, his status underwent progressive redefinition through five sequential phases - newcomer, provisional member, categorical member, personalised member and immigrant migrant. It is argued later that, in this study, the researcher moved from the first category to the last if not in one step, at least quickly enough for the intermediate stages to be unidentifiable. It is important for the observer to be able to identify

which of these stages he is at and to treat data gathered during the intial period with caution owing to the likelihood of subjects behaving in an abnormal way as a consequence of the presence of a strange observer. Similarly, Bruyn (1966, 212) is less concerned with identifying a model of the possible roles for the researcher than he is with the importance 'for the observer to record what social position he occupies in the culture he studies and what images others develop of him as he functions in this position.' A similar point is made by Woods (1979) who states that the sociologist should assume a recognised role within the social system and contribute towards its function.

McCall and Simmons (1969) also argue that it is important to identify precisely the role of the researcher. They stress that the participant observer is well-advised to structure his role in such a way as to include explicitly the concept of researcher. More important, however, they state that it is important that the participant observer teaches his subjects what the role of the researcher is. He must teach them the sort of activities that his role will involve, the sorts of information that fall within the legitimate purview of his study, the uses to which the information he obtains will be put, and the manner in which he would like his subjects to aid him in his pursuits. Mann (1970, 120) similarly argues that 'when the researcher plans to work with people who have little conception of what a social researcher does, it is necessary for him to build their understanding of this role.' Mann illustrates his concern by quoting a researcher who never established his relationship with his women subjects who placed him in a 'mother-son type of relationship'.

The models presented by the various writers above were useful in clarifying the position of the present researcher. His position may be identified on Gold's continuum as between complete observer and participant as observer. There are, however, certain peculiar characteristics of day centres for the elderly in general and Suilven House specifically that either increase or reduce problems faced by participant observers in some social systems. For example, one difficulty was that there is more than one status group involved; minimally, clients and staff. Yet there was a willingness amongst both groups for the researcher to be given access to the group. This made entry to the Centre non-problematic. The initial, formal stages in gaining entry have already been described. However, the researcher has to ensure that his entry does not change the social system significantly. If he is studying a large community (eg. a town) or one in which inter-personal relationships are either distant (eg. some churches) or transitory (eg. a short-stay hospital ward) he may be able to gain entry without being seen by the population as an 'outsider'. However, in a relatively closed social system in which the opportunity to develop inter-personal relationships is important, the entry of a newcomer cannot be ignored. When the social system is an elderly persons' day centre and the newcomer is neither an elderly person nor a physically handicapped client the justification for his entry has to be carefully considered and his actual entry carefully acted.

It was decided to give clients an honest, although incomplete, explanation for the researcher's presence. The following was published in the Towpath Times, the

Centre's magazine, and in the minutes of the Discussion Group:

> Please note: A man will be coming to the Centre and he writes as follows:
>
> > 'My name is Michael Taylor and I am a teacher at a college in Applecross. I am particularly interested in Day Centres and Mrs Fitzpatrick has kindly agreed to my coming here to see for myself what happens at Suilven House. I will be here regularly for the next six months and I look forward to meeting as many of you as possible during my time here.'

Some clients had read this statement and asked such questions as 'Are you the man from the college?'. Others had not read it and asked such various questions as 'Who are you, love?' 'Are you a new client?'. Still others just accepted the newcomer without apparently noticing his presence.

The staff at the Centre were told the same as the clients and, although the Officer-in-Charge and her deputy had the impression that the researcher's account might be published, there is no reason to think that they communicated this to the other staff.

It was not necessary to give a fuller explanation to members of the sub-sample who were interviewed in their own homes or to the referral agents who alerted the members of the sub-sample to the researcher's first visit. Each client interviewed was told:

> I'm talking to people who are about to start going to Suilven House to find out what they hope to do there, what they're looking forward to and anything they might be worried about. I'll talk to them again in a few months to see how they're getting on; whether they've achieved what they expected to, what they've liked and what they've not liked. After talking to a lot of people I hope to have a better understanding of the Centre from the member's point of view.

The inconsistency between this accurate description of the research purpose given to the new clients in the sub-sample and that given to existing clients did not appear to be noticed. This may well be because the new clients came to the Centre as an unfamiliar social system but already having met the researcher in their own homes. Thus his presence at the Centre required no explanation - he was no more out-of-place or in need of comment than any of the staff. Indeed, the fact that they had already met him in their own homes may well have resulted in them behaving more 'normally' at the Centre at an earlier stage in their Centre careers than would have happened had they not met him previously. Conversely, to the existing clients a new adult's presence did require explanation.[1]

Apart from discussing his role with the Assistant Principal Officer, the Officer-in-Charge and her deputy, no attempt was made to teach subjects what the role of researcher involved. This was simply because it was felt that there would be no benefit in so doing. The majority of the elderly clients would not have been able to understand and the clients and staff were willing to interact naturally with the researcher having the knowledge of the reasons for his presence already spelt out. Erikson (1970, 253 and 259) has suggested that it is unethical for a participant

1 However, this is not an entirely satisfactory explanation. One might suppose that a new client would see the researcher who he had already met as a common subject for conversation with existing clients and that during any such conversation the differences in the reasons stated for his presence might emerge.

Whatever the reason, there was never any cause to think that the clients either resented or questioned the researcher's presence.

observer to adopt a disguised role. Erikson states:

> the practice of using masks in social research compromises both the people who wear them and the people for whom they are worn . . . It is unethical for a sociologist to deliberately misrepresent his identity for the purpose of entering a private domain to which he is not otherwise eligible; and, second, it is unethical for a sociologist to deliberately misrepresent the character of the research in which he is engaged.

The present writer agrees with Erikson's arguments but does not think that the criticisms may be applied to this research.

Many writers have stressed the importance of the participant observer recording not only the position he occupies in the culture he studies but also the images others develop for him as he functions in this position. (See, for example, Bruyn 1966, 212.) Vidich (1954, 356), while arguing the importance in a field situation of the assumption by the researcher of some position in a structure of relationships, states: 'In every case the field worker is fitted into a plausible role by the population he is studying and within a context meaningful to them.' Woods (1979) suggests that the subjects may variously perceive the researcher as relief agent, counsellor, secret agent, factor to appeal to in power struggles, substitute member of staff or fellow human. However, Argyris (1969) believes that it is normal for subjects to erect defence mechanisms against the researcher and that maybe the latter should be worried if such defence mechanisms are absent. Wallis (1977, 164), in his account of his own research, explains the way in which:

> the researcher and researched sought not only to define the behaviour of the other, but also to locate the other within a conceptual framework and

> theoretical schema, thereby rendering the other party's behaviour understandable and predictable and providing guidelines for reacting to it . . . Both parties began with a certain suspicion of the other based on stereotypes which were culturally available.

In this study, it seemed that the researcher's acceptance by staff and clients was not a problem. However, this is not open to objective measurement. All one can say is first, that the researcher was unable to distinguish any difference in the behaviour of members when they were aware of his presence from when they were not aware of his presence (eg. when he was watching through an open door). Secondly, in cross-referencing data, there was a high degree of consistency between what he observed and was told by different parties (eg. his own observation of the behaviour of a client was similar to a statement given by a member of staff in which she described that same client).

However, there are certain incidents that should be recorded as indicating changes in the degree of acceptance of the researcher. Possibly the most important events were the series of Christmas parties. At these the researcher served drinks, washed up and undertook the same menial tasks as the staff. Although he had felt accepted in the weeks before the parties, he was subsequently conscious of a greater degree of acceptance by the staff who treated him as 'one of them'. This acceptance was sometimes an embarrassment as (with the exception of the Officer-in-Charge and her deputy) it was taken for granted by the staff who expected him to undertake the same instructional and other jobs as they were doing. They often asked him to help a client or show someone how to do basket work at a time when he was following a strict recording schedule. In such cases, the researcher was faced with a choice between abandoning the schedule and risking offending the member of staff, thus making his role in the Centre more difficult. The solutions varied according to the circumstances of each case but sometimes a compromise was possible, at others the schedule had to be abandoned.

The Officer-in-Charge was the only person who asked the researcher for his views on any aspect of the Centre. (She and her deputy were the only members of staff with comparatively full knowledge of his purpose in being at the Centre.) These questions were always friendly and often led to a discussion during which the researcher was careful not to say anything which might lead to changes in the social system he was studying. The questions may have been asked out of genuine desire for independent advice, or out of concern that the researcher may have been forming adverse opinions of the Centre. They did not present difficulties for the research.

This lengthy discussion of the researcher-subject relationship has been necessary to support the claim that the observer was treated openly by both clients and staff. His official role as someone who was ignorant of day centre life but wanted to learn resulted in a willingness by clients to say things about the Centre that they probably would not have said to staff (eg. the complaint that the Discussion Group was a tool of management, the complaints of some members in the 'disgruntled' category). However, it is also possible that staff would say things to other staff that they would not say to the observer, although there was no evidence to support this.

It was stated earlier that participant observation involves a combination of research methods. Several were involved in this study and, according to the method invoked, the role of the researcher (as indicated by, for example, Gold's (1969) model) changed. Four role methods may be identified:

1 Extrapolation of data from Centre records. Here, the researcher was not acting as a participant observer and his role did not involve any interaction with clients.

2 Complete observer. This role was filled for different purposes. It was appropriate when systematically recording events according to a schedule (eg. recording activities of staff at fifteen minute intervals, recording discussions between a single new client and existing members throughout a day) and when acting as 'fly on the wall'.

3 Observer as participant. This was the role adopted for unstructured interviews conducted with members of the sub-sample.

4 Participant as observer. This was a common role with the researcher acting variously as, for example, instructor or ambulance driver's aide or his sitting talking with one or more clients at his instigation or theirs while making observations.

## RECORDING OF DATA

There are two stages in the recording of data that are of importance. The first is the manner in which the primary data (observations, statements and so on) are recorded and the second is the way in which this data is then stored. As far as the first stage within the present research was concerned, the most common method was to enter recordings into a notebook as they happened or immediately afterwards. A tape recorder was openly used when recording interviews with members of the sub-sample. Each member of the sub-sample was asked at the start of her interview whether she minded her interview being recorded. To the researcher's surprise not one person objected, the recorder was placed between interviewer and interviewee and none of the subjects appeared to be constrained in any way by the presence of the machine.

On one occasion a camera was used in order to accurately record group membership of the Centre at fifteen-minute intervals throughout the day. Although this was welcomed by many clients, some of whom requested (and obtained!) close-up portraits, it was the source of the only friction between staff and the researcher. Although the researcher obtained the permission of the Officer-in-Charge to use the camera and he explained the purpose to her staff, it was evident that most members of staff were unhappy at being photographed. One can only speculate about the reasons for this. Perhaps there were fears that the photographs would show a high incidence of staff in situations that might be interpreted as not involving work. There were, for example, several photographs of staff talking with each other while clients were alone. As there was no reason to believe that the staff unhappiness at being photographed influenced group membership (whose identification was the purpose of the activity) and as the tension between staff and researcher did not continue after that one day, further speculation is unnecessary here.

However data is obtained, the manner in which it is stored is of importance especially in a participant observation study where the researcher has to record and interpret subjective meanings within an objective framework. While the researcher must identify himself with the subjective meanings as an observer he must, at the same time, maintain the objectivity of a researcher. The way in which recording takes place is therefore of importance for the guidance and support of any subsequent hypothesis.

In this study, data was recorded and indexed under a number of headings, each recording being placed under as many headings as possible. Naturally, as new hypotheses emerged, so did new headings. The way in which the subjective aspects of the data were retained within an objective framework was considered particularly

important. It was seen as essential that certain information should accompany each entry in the research notes. Reference has already been made to the sequential phases that a researcher moves through as he gains increasing acceptance in the community he is studying. Such information clearly affects the credence that recordings will be given with later data being treated with less suspicion than early recordings. It was therefore considered essential that the dates of recordings be noted along with a reference to the phase that the researcher had reached.

The circumstances under which information was obtained was considered to be of similar importance. For example, it was important to record whether data was obtained from a semi-structured interview or from an informal discussion. The inter-personal climate of the group in which recorded interaction took place was noted. For example, a comment made by a care assistant to one client on her own in a relaxed atmosphere may be interpreted differently from a comment made when surrounded by a group of clients waiting patiently for assitance and from one made when surrounded by a group of clients, all seeking her attention.

It is important to note barriers to information, although these seemed rare in the present study. Was any topic raised by the researcher ignored or did some topics make the subjects appear uneasy? Were any comments made by the informants that the researcher thought were meant to deceive him? Was information volunteered or elicited?

The coding of such information allows different sorts of conclusions to be drawn. Consider, for example, the differences between:

1 All members of staff at the Centre volunteered x

2 No member of staff at the Centre volunteered x but all stated x when questioned

3 All members of staff at the Centre said x during the first weeks of the research but all said y during the final weeks

4 All members of staff at the Centre said x when alone but all said y when in the presence of a client

5 Some members of staff at the Centre said x and the remainder said y but all behaved in y.

Clearly, the contextual information adds considerably to both the validity of the research and the depth of analysis that can be made.

## VALIDITY

The question of value judgements and validity have been hotly disputed issues in social science. In quantitative positivistic research debate has centred upon the ways of attempting to verify or prove one's hypotheses. However, as Dahrendorf (1968) has emphasised, the question of value judgements is a wider one than questions of verification and falsification. One may argue that even participant observation research that superficially appears solely qualitative eventually takes a quasi-quantitative form by virtue of the numerous observations or recordings. What the researcher must do, and has done here, is make use of as many indices of a particular fact as possible and insist on a high degree of consonance between these. This check was made rigorous by adopting a grid, suggested by Becker, Geer, Hughes and Strauss (1961, 44) in which frequencies could be recorded in the appropriate cell:

| | VOLUNTEERED | DIRECTED BY OBSERVER | TOTAL |
|---|---|---|---|
| Statements to observer alone | | | |
| to others in everyday conversation | | | |
| Activities Individual | | | |
| Group | | | |
| TOTAL | | | |

The use of the grid permits a check to be made between different forms of observation. It is not intended to be a crude substitute for a test of significance for, as Becker says 'the absolute number of observations does not so much indicate that the perspective is frequent as negate the null hypothesis that it is not' (Becker, Geer, Hughes and Strauss 1961, 44). The grid's value is as a check which helps prevent incorrect conclusions being drawn. For example, the conclusions to be drawn from a grid concerning interaction between the elderly and the physically handicapped in which there are recordings in all cells will be different from those from a grid in which there are recordings in the 'statements to observer alone, directed by the observer' cell only. In the former case one might reasonably conclude that the subjects' claims to the researcher concerning the desirability of integration are their genuine beliefs and that the nature of interaction within the Centre confirms these. In the latter case, one must ask additional questions to explain why these recordings are not supported by entries in other columns. One may ask, for example, if the recordings are an artefact of the observer's technique.

The participant observer is open to charges concerning the validity of his research which are similar to those levelled at other social scientists but which are directed at the participant observer in a particular way. Several concerns have been expressed about the social relationship between the participant observer and his subjects in general and of over-rapport with a group of subjects in particular. Vidich (1954), for example, states that what an observer will see will depend on his position in a network of relationships. He warns that the social positions of observer and observed and the relationship between them at the time must be taken into account when the data is interpreted. Vidich argues that this is a separate problem from the fact that the way in which the researcher sees and interprets his data may be largely conditioned by his theoretical preconceptions. McCall and Simmons (1969, 78) argue

that there are three categories of what they call 'threats to the interpretability of data'. These are the reactive effects of the observer's presence on phenomena being observed, distorting effects of selective perception and interpretation, and limitations on the observer's ability to witness all the relevant aspects of the phenomena in question. Miller (1969) emphasises the problem of over-rapport. He believes that once the participant observer has gained a close relationship with one group and become committed to continuing that relationship, other possible lines of enquiry may have to be dropped. Miller suggests that the researcher may become so attuned to the ideology of one group that he becomes blind to the problems of a second group.

One must obviously take careful account of these potential difficulties. Some devices, such as the grid suggested by Becker and described above, are useful but the researcher must be especially aware of the importance of adequate sampling, must constantly ask himself of what bias he is guilty and try to remedy this. Finally, it is again open to others to challenge the validity of his work. In the present work, the researcher was aware of these dangers that would reduce the validity of the work. It may be that as he was never at the 'complete participant' end of Gold's (1969) continuum and as he was interacting with different role statuses within the social structure of the Centre (eg. elderly clients, handicapped clients, centre staff, visiting professionals) the dangers of bias through over-rapport were reduced. However, it might equally well be argued that interaction with different groups is more likely to result in the observer sympathising with one particular group and opposing others.

In the final analysis, validity is established by asking whether what is found is understandable in terms of accepted schemes of interpretation and for the sceptic to present alternative explanations which better satisfy this criterion. Schutz's (1962) postulate of adequacy which stresses that the actor himself must understand the researcher's construct has considerable attractions but assumes that the subjects have an ability that they may not posses to understand the researcher's analysis.

The writer's main concerns about the validity of the work may be summarised. The first was the possibility that entering into the research with preconceived ideas might lead to a one-sided argument being presented. Although he entered with no conscious ideas of what a day centre should be he was aware of other possible preconceptions of which the most important were probably those concerning old people. The second was the credibility of informants. Checks were made on this by using a combination of research methods and by the constant comparison of data. Thirdly, the researcher's own influence on the social situation he was studying is thought to have been slight owing to the greater importance of other members of subjects' role-sets.

## INTERVIEWS

Interviews were an important research method within this study. Some authors have thought of interviewing and participant observation as different research methods. The present writer does not see them as two approaches but regards interviewing in the way that Dean and Whyte (1969, 107) regard it: 'The interview situation must be seen as just one of many situations in which an informant may reveal subjective data in different ways'. Becker, Geer, Hughes and Strauss (1961) suggest that interviews

are of value in participant observation to check conclusions against a new body of data and to make quantitative analyses of points that lend themselves to that mode of analysis.

Even when interviews are used as one of a repertoire of research tools as in this study, there are certain dangers in the method of which one must be mindful. Various difficulties in interviewing have been identified. These include problems of the motives of the subject in giving the replies she does, dishonesty in her responses as a consequence of desire to please, the degree to which the interviewer really understands what is said to him by the interviewee (and vice versa) and matters about which interviewees are unable or unwilling to talk. However, one of the strengths of participant observation is that not only is it possible to check the quality of data obtained through interviews with data obtained through other methods but it is possible to pursue items on which it is thought that interviewees are, for example, evasive by asking why they should be evasive and adopting other methods to pursue such questions.

A simple, if crude, distinction is often made between formal structured interviews and informal, less structured interviews. In the former, the interviewer works through a series of pre-worded questions which often require the respondent to give no more than short, easily codeable responses. In the latter, the interviewer knows in advance the issues on which he seeks the interviewee's responses but he does not necessarily ask each subject the same questions in the same way or in the same order. Structured interviews have the advantage of being more easily quantifiable whereas informal interviews have advantages in that questions can be worded according to the ability of the interviewee to understand, full responses may be given and interesting responses may be followed up.

In the present work, there were three kinds of interview. First, interviews were held with specific role occupants with the purpose of obtaining information which only those occupants possessed or of obtaining views on a subject that had already been researched by other methods. Interviews with the Officer-in-Charge often fell into this category. The purpose was not to be able to make quantifiable comparisons but to obtain the fullest information. To this end they were informal. Secondly, very short interviews of just two or three questions were held with clients to establish the extent of the validity of evidence obtained through other means. As the aim was to quantify the extent of support for pre-determined categories of response, these were formal. Thirdly, there were interviews with the sub-sample. It had been intended that these should be formal and a series of questions was prepared prior to the first interview. It was thought that such a structured formal interview would make comparisons between clients easier, make it possible to quantify responses in a meaningful way and, by asking a client the same set of questions on entry to the Centre and periodically after entry, allow comparisons to be made between her attitudes and perspectives at different stages in her Centre career. It became apparent that these interviews would have to be de-structured for three reasons. First, the majority of interviewees were unable to concentrate for sufficiently long to be able to work through the twelve questions. Secondly, they were all so eager to talk that it was impossible, without being rude, to keep them to the proposed structure. Thirdly, some of the clients found it difficult to understand the questions which had instead to be asked in alternative ways. Consequently, these interviews became very informal. All the planned questions were asked but often not in the intended manner and they were asked when the opportunity arose during informal conversations. Consequently, full information was obtained but not in a form that was amenable to the proposed quantitative analysis.

## THE GENERATION OF HYPOTHESES

It was suggested earlier that an advantage of participant observation as a research method is that it permits the generation of hypotheses and theory from research findings. According to Geer (1969) hypotheses arise almost accidentally from fieldwork. Friedrichs and Ludtke (1975), however, suggest that there are five steps in the research procedure:

1 A rough definition of the phenomenon to be explained is formulated.

2 An hypothetical explanation of that phenomenon is formulated.

3 One case is studied in the light of the hypothesis with the object of determining whether the hypothesis fits the facts in that case.

4 If the hypothesis does not fit the facts, either the hypothesis is re-formulated or the phenomenon to be explained is re-defined so that the case is exluded.

5 Practical certainty may be obtained after a small number of cases has been examined, but the discovery by the investigator or any other investigator of a single negative case disproves the explanations.

Clearly, the discover of a negative case requires the modification of the hypothesis so that new facts will fall under it or the redefinition of the phenomenon to exclude cases defying observation by the hypothesis.

Glaser (1969) records that there are two normal participant observation methods. In the first, the researcher codes all data and then analyses it with the aim of provisionally testing the hypothesis. In the second, he inspects his data with the aim of generating theoretical ideas. Glaser argues for a third method which he calls the constant comparative method in which the explicit coding of the first approach is

combined with the style of theory development of the second. The constant comparative method has four steps:

1 Comparing incidents applicable to each category (while coding an incident for a category, the researcher compares it with the previous incidents coded in the same category and, with several repetitions of the same coding, he stops coding and records a memo on his new ideas).

2 As coding continues comparisons of incidents with incident changes to comparison of incidents with the properties of the category which resulted from initial comparison of the incidents.

3 The theory is delimited, ie. the theory 'solidifies' as major modifications become fewer. There is a reduction in the number of concepts to a higher level, small set.

4 The theory is written.

McCall and Simmons (1969) suggest that there are three kinds of hypothesis typical of participant observation. In the first, propositions are discovered after the conclusion of data collection. These, the writers suggest, are usually not central to the conclusions. In the second, 'mine-run' propositions are discovered while in the field; usually in sufficient time for them to be pin-pointed. These are propositions that are not sufficiently critical as to require 'over-rigorous' procedures. In the third, the central propositions usually emerge long before the conclusion of the fieldwork and may justify the use of measurement.

Becker, Geer, Hughes and Strauss (1961) take a simple view. They suggest that analysis proceeds not by establishing correlations but by building tentative models and revising these as new sets of phenomena come to the researcher's attention. Lacey (1976) is similarly concise. In his research he constructed models that could be tested at various points during the fieldwork and, if necessary, could be revised and re-tested.

The present writer has some reservations concerning the case presented by McCall and Simmons. Their suggestion that some propositions are not sufficiently critical to require 'over-rigorous' procedures is difficult to accept. All research methods should be rigorous. McCall and Simmons also suggest that some propostions are 'discovered' after the conclusion of data collection. It has been argued in this work that one of the strengths of participant observation is its potential for incorporating emerging hypotheses into the ongoing research and to test them. However, no research is ever complete in that knowledge is never total, and despite the logitudinal nature of participant observation it is possible for hypotheses to emerge after the data collection has been completed.

The writers quoted above would appear to differ more in the degree of detail in which they explain the way in which they believe hypotheses are generated than in their theoretical beliefs.

In the present study, the writer began with the ill-defined intention of 'finding out what happens in a day care centre'. The absence of hypotheses at this stage left open two main possibilities. Either central propositions would emerge allowing time for verification, or post hoc hypotheses would emerge after the conclusion of the data collection. It is fair to say that none of the propositions here is of the latter type. This is probably to be expected in a research project that had allowed the observer more than a year to observe, collect, analyse, discuss and observe in ongoing cycles.

The hypotheses generated in this study were of the former type; they emerged while in the field. Some hypotheses emerged during the initial visits to the Centre. For example, it was apparent at an early stage that the extent of integration between elderly and physically handicapped clients was not as great as one might have

expected and this was to become an important theme of the work. However, attempts were made, it is believed with some success, to delay the formulation of hypotheses for several weeks as it was felt that there was a danger of pursuing a few hypotheses that might or might not have been accurate at the expense of generating alternative propositions. It would, of course, be naive to deny that, once even vague hypotheses were being formulated, certain sorts of evidence were focussed on rather than others. However, a conscious effort was made to follow the matters suggested by Becker, Geer, Hughes and Strauss (1961); those that seemed to be important to the people studied and those that seemed to be the occasion of tension between categories of subjects as the study of tensions is most likely to reveal the basic elements within a relationship. Propositions were developed either through what may be termed 'inspiration', the sudden spark lit by just one observation which may or may not have been linked at that moment with a previous incident, or more usually, through the regular, systematic examination of research notes looking for patterns. In both cases, of course, the importance of the work by other authors was influential either overtly or covertly in the identification of a possible hypothesis. Once generated, a hypothesis was constantly modified so that new data would fall under it, rejected as exceptions were located or put aside owing to the shortage of supporting evidence.

## CONSTRAINTS IMPOSED BY THE SUBJECT

Finally, it is necessary to record certain characteristics of the Day Centre and of the elderly themselves that have not yet been commented upon which presented circumstances that were easier than those faced by participant observers studying other subjects.

Several common difficulties faced by other participant observers were not as problematic to the present writer. First, there were no problems in obtaining frequent interviews with senior personnel within the Centre. Some writers (see, for example, Woods 1977) have been able to have just one interview with the chief officer of the establishment being researched and have been faced with difficulties as to how to use that single interview, the status to accord the interview and related difficulties. The present writer was able to interview and interact as fully with the senior personnel as with any other members of the Centre. Other observers of day centres for the elderly have commented on the co-operation they have received in their research from staff (Hazan 1980, Goodlove, Richard and Rodwell 1983).

Secondly, in this research, the participant observer claimed no specialist knowledge of day care, the elderly or related areas. He made this clear at the start of his research and was not, therefore, expected to provide expert comment or criticism of the establishment. It may also, although this can be no more than speculation, have resulted in subjects being more open with the researcher than they would have been if he had presented himself as an expert. This is in contrast with the experiences of other writers. Vidich (1954), for example, has recorded the difficulties faced by a participant observer who 'has the disadvantage of living in a society in which his experience is limited, while, at the same time, he is regarded as a knowledgeable member of all segments of it.' Hargreaves (1967, 198), in a discussion of his participant observation within a secondary school, states:

> Conversations with the staff over lunch or in the staff room were potential sources of conflict. When the conversation took a controversial turn - especially when the subject was education - I tried to keep silent, but my opinion was frequently sought and I was drawn into the conversation and forced

to take sides. On such occasions participation strongly over-rides observation, and may well introduce frictions which could undermine the work.'

The present writer did not have to face these difficulties.

Thirdly, some participant observation studies have involved the study of groups with their own specific vocabularies. Studies of gangs, delinquents or medical students would be such cases. Becker and Geer (1957, 29) refer to the difficulty as 'learning the native language'. They describe the problem faced by the participant observer:

> nuances are peculiar to that group and fully understood only by its members ... In interviewing members of groups other than our own we are in somewhat the same position as the anthropologist who must learn a primitive language with the important difference that, as Icheiser has put it, we often do not understand that we do not understand and are thus likely to make errors in interpreting what is said to us.

Whilst being aware of this last difficulty, it may be fairly said that the native language of Suilven House did not appear to have any particular esoteric characteristics.

# CHAPTER 3

## RESEARCH FINDINGS

In this chapter the research findings are presented in two main sections. These are quite different in nature and thus separated here. The first section is an analysis of the total population of elderly clients at Suilven House derived from the clients' admission forms. The second section is an analysis of the field-work. In view of the different natures of the two sections they have separate introductions here.

## ANALYSIS OF THE CLIENTS

This study does not provide a detailed quantitative analysis of the clients at Suilven House partly because time spent on such an analysis would have reduced the time available for participant observation and partly because previous studies of day care have focussed on such analyses. However, some quantitative analysis of this kind is necessary for at least two reasons. First, it gives sufficient data on the clients to provide the context within which the participant observation may be placed. Secondly, although it is not the purpose of this work to make comparison with other studies it provides sufficient information on the population for comparisons to be made with other centres where the population may be similar or different in various aspects.

The potential difficulties of obtaining accurate data from elderly persons have already been discussed. In view of these, it was considered that the time required to collect such data from all 241 clients would not be well spent, especially as the admission papers on each client were available and these contained some of the information that the writer's own enquiries would aim at eliciting. The data on the admission forms was entered by the referral agents prior to the forms being considered by the Admissions Panel. The forms provided information on the age and health of the clients, the length of time they had been at Suilven House, who referred them, the type of housing in which they lived, the social services they enjoyed, their nearest relatives and their religion. A copy of the admission form is included as Appendix 1.

The data should be treated with some caution. In some cases, the referral agent did not answer certain questions on the form. These instances are acknowledged in the following analysis and there is no reason to believe that the non-responses have led to bias in the analysis. Of more concern is the fact that some entries are obviously wrong. For example, one client was referred to the Centre from a Geriatric Day Unit and yet the question on the form: 'What illnesses or other health problems does the applicant have?' has been answered: 'None'. It is not possible to know the extent of these inaccuracies. Only three answers are known to be wrong which on 241 forms of more than 20 entries per form is a very small proportion. However, these are concerns that should be borne in mind and the statistics presented should be considered in the light of these reservations.

It is important that the statistics are of a recently established population. The date on which the statistics are based is 31 December 1980, one third of the way through the research. At this time the Centre had been open less than four years. It is likely that the age structure of the Centre will change during the next few years as the present Centre population grow older, the vacancies become fewer and, eventually, vacancies are created only by the withdrawal (often death) of the present clients. Very few of the present population of elderly were admitted with a major physical handicap but eventually the young physically handicapped will reach 60 years of age.

In the following exposition, the physically handicapped are included in the analysis of age structure in order to show the total age structure of the population of which the elderly were part. All other tables and data refer exclusively to the elderly (ie. persons aged 60 and over) as the inclusion of data on the physically handicapped is not relevent to the present work.

## Population

The total population of the Centre, defined as the number of clients accepted by the Admissions Panel since the Centre opened and who, on 31 December 1980, were still alive and who had neither withdrawn from the Centre nor been withdrawn, was 313.

TABLE 1

Distribution of population by category and sex

| | MEN | WOMEN | TOTALS |
|---|---|---|---|
| Elderly | 83 | 158 | 241 |
| Physically handicapped | 32 | 40 | 72 |
| TOTALS | 115 | 198 | 313 |

Thus the elderly formed 77 per cent of the population.

Age

TABLE 2 shows the date of birth of clients and their ages at 31 December 1980 by sex. This shows that the ages of the clients ranged from 97 to 21. In view of the small numbers involved, these are presented in TABLE 3 in quinquennial intervals.

Ages of Elderly Clients by Sex

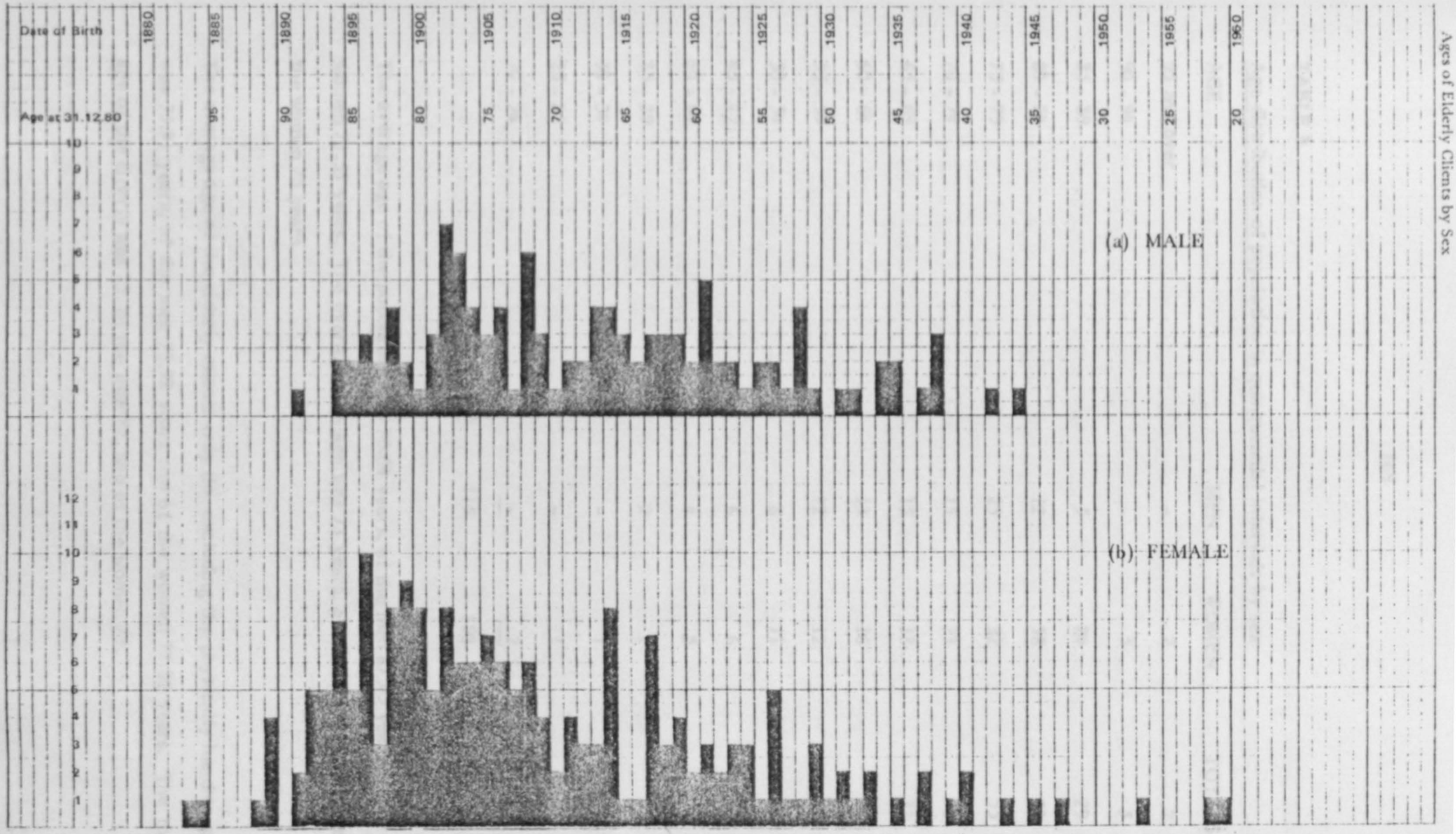


TABLE 3

Age distribution of population in quinquennial intervals by sex

| AGE | MEN | WOMEN | TOTALS |
|---|---|---|---|
| 95 and over | - | 2 | 2 |
| 90 - 94 | - | 5 | 5 |
| 85 - 89 | 5 | 24 | 29 |
| 80 - 84 | 12 | 38 | 50 |
| 75 - 79 | 23 | 32 | 55 |
| 70 - 74 | 15 | 23 | 38 |
| 65 - 69 | 15 | 18 | 33 |
| 60 - 64 | 13 | 16 | 29 |
| 55 - 59 | 12 | 12 | 24 |
| 50 - 54 | 8 | 11 | 19 |
| 45 - 49 | 6 | 6 | 12 |
| 40 - 44 | 4 | 5 | 9 |
| 35 - 39 | 2 | 2 | 4 |
| 30 - 34 | - | 1 | 1 |
| 25 - 29 | - | 1 | 1 |
| 20 - 24 | - | 2 | 2 |
| TOTALS | 115 | 198 | 313 |

The average age of the population was 70.04 years, of the men 67.45 years and of the women 71.55 years. The overall mean age was 73 years, of the men 68 years and of the women 75 years.

The average age of the elderly clients only (ie. excluding the physically handicapped) was 75.91 years, of the men 73.78 years and of the women 77.02 years. The mean age of the elderly was 75, of the men 72, and of the women 77.

The average and mean ages of the population are not particularly useful figures given the wide age range of the clients and TABLES 2 and 3 are more useful in depicting the population. The average and mean ages of the elderly are of value only in so far as they portray the clients who were the subject of this study. Again, these statistics should not deflect attention from the range of the ages. TABLE 3 shows that there were between 12 and 23 men in each five-year age interval from 60-64 to 80-84 and between 16 and 38 women in each age interval from 60-64 to 85-89.

TABLE 4

Length of time elderly clients had been registered at Suilven House

| | MEN | WOMEN | TOTALS |
|---|---|---|---|
| Less than 1 year | 31 | 33 | 64 |
| At least 1 year but less than 2 years | 20 | 37 | 57 |
| At least 2 years but less than 3 years | 20 | 51 | 71 |
| At least 3 years but less than 4 years | 12 | 37 | 49 |
| TOTALS | 83 | 158 | 241 |

TABLE 4 illustrates how new was the social structure of Suilven House. It may be suggested that there has been comparatively little time for norms to develop, and that the ratio of long established members to newcomers was lower than in many social institutions, thus making it difficult to establish norms.

The mean age at entry was 74 years. (For men 72 years, for women 76 years.)

The length of time that clients have been at the Centre will probably change with the length becoming greater. There is no reason to believe that the age of the clients at entry will change; there is no evidence to suggest that the Centre initially recruited only the very old and is now recruiting younger clients who may be considered to be in less need of day care.

## Health of Clients

TABLE 5 shows the health of clients at entry. The data is obtained from answers to the admission form question: 'Summary of current situation and problems (stating why case needs to become "live")'. In view of the short period that the Centre has been open, it is reasonable to assume that the health of the population has deteriorated slightly during the period between the completion of the admission forms and the research. It is also possible that the referral agent only indicated the major health problems of the applicant and that some clients had illnesses which were not recorded. Despite the caution with which the Table must be treated, it does provide an indication of the health of the clients.

TABLE 5

Health of the elderly clients at entry[1]

| ILLNESS | MEN | WOMEN | TOTALS |
|---|---|---|---|
| Arthritis | 9 | 31 | 40 |
| Blind (including partially sighted) | 5 | 10 | 15 |
| Bronchitis | 2 | 4 | 6 |
| Confused[2] | 6 | 22 | 28 |
| Deaf | 1 | 6 | 7 |
| Disabled[3] | 6 | 12 | 18 |
| Epilepsy | 1 | 2 | 3 |
| Fracture | - | 1 | 1 |
| Heart disease | 10 | 12 | 22 |
| Hernia | 3 | 1 | 4 |
| Parkinson's disease | 1 | 5 | 6 |
| Rheumatism | - | 8 | 8 |
| Sciatica | 2 | - | 2 |
| Sclerosis | 1 | 1 | 2 |
| Slipped disc | 1 | 2 | 3 |
| Strokes | 14 | 14 | 28 |
| Ulcers | 2 | 1 | 3 |
| Others[4] | 20 | 22 | 42 |
| None | 15 | 20 | 35 |
| TOTALS[5] | 99 | 174 | 273 |

1 The Table specifies the illnesses that were suffered by more than one client. Illnesses suffered by only one client are classified under 'others'.

2 Of these clients, 15 were specifically stated to be 'mildly' confused.

3 The clients in this category were variously specified on the admission form as 'disabled', 'zimmer', 'wheelchair'.

4 This category includes clients who were stated on the admission form to be 'ill' and clients with illnesses suffered by no other client. The single-client illnesses were; amputee, asthma, colitis, dyphonic, fracture, gastritis, kyphysis, mentally ill, polio, schizophrenic, spine operation, toe removed.

5 The totals exceed the number of clients as several clients had more than one illness.

A notable figure in TABLE 5 is the 28 confused clients. This may be lower than anticipated especially as 15 of these were considered only 'mildly' confused.

Referral Agent

TABLE 6 shows the entry on the application form of each client in respect of the designation of her referral agent. This is valuable in that it demonstrates the wide range of persons and professions that referred potential clients to the Centre. It must also be treated with caution. Some referral agents indicated the person who completed the form, others indicated the person who initiated the action that resulted in referral. For example, the response 'sons', 'self', 'spouse', does not indicate that the role occupant presented the client's case to Suilven House but that he initially drew the attention of a professional to the client and initiated a course of action (which he may or may not have foreseen) which resulted in referral.

TABLE 6

The number of elderly clients referred to Suilven House by different role occupants

| ROLE OCCUPANT | MEN | WOMEN | TOTALS |
|---|---|---|---|
| Community psychiatric nurse | 2 | 2 | 4 |
| General practitioner | 6 | 10 | 16 |
| Geriatric day unit | 1 | - | 1 |
| Health visitor | 4 | 15 | 19 |
| Home help | 3 | 7 | 10 |
| Hospital doctor | 12 | 16 | 28 |
| Hospital nurse | 2 | - | 2 |
| Nephew or niece | - | 3 | 3 |
| Occupational therapist | 20 | 24 | 44 |
| Self | - | 4 | 4 |
| Sibling | - | 1 | 1 |
| Social worker or social services department | 23 | 55 | 78 |
| Son or daughter (or in-law) | 3 | 10 | 13 |
| Spouse | 4 | - | 4 |
| Warden of sheltered housing | - | 2 | 2 |
| Not stated | 3 | 9 | 12 |
| TOTALS | 83 | 158 | 241 |

Isolation of clients

Day Care is often advocated on the grounds that it offers a setting in which elderly people who are socially isolated might meet other people. The data on the application forms under consideration here suggests the extent to which Suilven House clients were socially isolated. Data from several different sections of the application forms are drawn together here to illustrate the extent of social isolation.

TABLE 7

Marital status of elderly clients at entry to Suilven House

| MARITAL STATUS | MEN | WOMEN | TOTALS |
|---|---|---|---|
| Single | 11 | 23 | 34 |
| Married | 42 | 26 | 68 |
| Widowed | 28 | 105 | 133 |
| Separated | 1 | 1 | 2 |
| Divorced | 1 | 2 | 3 |
| Not stated | - | - | - |
| TOTALS | 83 | 158 | 241 |

TABLE 8

The numbers of elderly clients living with different role occupants

| ROLE OCCUPANT WITH WHOM THE CLIENT LIVES | MEN | WOMEN | TOTALS |
|---|---|---|---|
| Friend | 2 | 3 | 5 |
| Lodger | 1 | 1 | 2 |
| Nephew/niece | - | 3 | 3 |
| Other persons in sheltered housing complex | 1 | 10 | 11 |
| Sibling | 2 | 7 | 9 |
| Son/daughter | 10 | 33 | 43 |
| Son-in-law/daughter-in-law | 1 | - | 1 |
| Spouse | 38 | 24 | 62 |
| Vagrant | 1 | - | 1 |
| Alone | 27 | 75 | 101 |
| Not stated | - | 2 | 2 |
| TOTALS | 83 | 158 | 241 |

These tables require little clarification. It is to be expected that a large number of elderly clients would be widowed. Of the 133 widows and widowers at Suilven House, several had been recently bereaved. The sudden isolation may have made them feel more lonely than other widows. Such loneliness was demonstrated in two of the sub-sample interviews, referred to later.

The application forms of the 102 clients who lived alone (42.3 per cent of the total population) were analysed further to discover the extent of their isolation. The referral agent was required to state a client's relatives. Of the 102 clients who lived alone, 44 had a relative who lived in the same town and a further 23 a relative who lived in another town.

TABLE 9

Location of geographically closest relative of elderly clients living alone

| | Living in same town as the client | | | Living in a different town from the client | | | Totals | | |
|---|---|---|---|---|---|---|---|---|---|
| | MEN | WOMEN | TOTAL | MEN | WOMEN | TOTAL | MEN | WOMEN | TOTAL |
| Brother/ sister-in-law | 1 | - | 1 | - | 1 | 1 | 1 | 1 | 2 |
| Divorced spouse | - | - | - | 1 | - | 1 | 1 | - | 1 |
| Grandson | - | - | - | - | 2 | 2 | - | 2 | 2 |
| Nephew/niece | - | - | - | 3 | - | 3 | 3 | - | 3 |
| Sibling | 1 | 2 | 3 | 2 | 2 | 4 | 3 | 4 | 7 |
| Son/daughter | 10 | 30 | 40 | 1 | 10 | 11 | 11 | 40 | 51 |
| Son/ daughter-in-law | - | - | - | - | 1 | 1 | - | 1 | 1 |
| None | | | | | | | 8 | 21 | 29 |
| Not stated | — | — | — | — | — | — | — | 6 | 6 |
| TOTALS | 12 | 32 | 44 | 7 | 16 | 23 | 27 | 75 | 102 |

Of course, there is no necessary correlation between having a relative living nearby and seeing that relative. The only reliable way of establishing how often a person sees a relative is by observing the person over a period. Some clients saw very little of their relatives but pride or other emotions led them to claim that they had regular contact. For example, one client (Mrs Easton) spoke of the hours that her son spent decorating her house for her. When the writer went to her house it was obvious that no decorating had been done for many years. It does not, therefore, follow that the 44 clients with a relative in the same town were not socially isolated. Conversely, some of the 29 clients without any relative may have had regular contact with friends or neighbours. However, all the clients in the sub-sample claimed that they had no friends and that they visited, and were visited by, only their relatives.

Further factors in determining the isolation of a client are whether she has a phone and whether she benefits from a social service (for example, social worker, home help, district nurse). Of the 241 clients, 124 were without a telephone (TABLE 10).

TABLE 10

The number of elderly clients with telephones

| | MEN | WOMEN | TOTALS |
|---|---|---|---|
| With telephone | 42 | 75 | 117 |
| Without telephone | 41 | 83 | 124 |
| TOTALS | 83 | 158 | 241 |

Of the 124 clients without telephones, 54 lived alone. TABLE 11 summaries the agencies supporting the clients in addition to Suilven House and the location of any relatives. The Table identifies just 7 clients as potentially the most socially isolated on the basis of the evidence available.

TABLE 11

Agencies supporting elderly clients without telephones and the location of their geographically closest relative

| | MEN | WOMEN | TOTALS |
|---|---|---|---|
| No telephone, no relative, no additional services | 3 | 4 | 7 |
| No telephone, no relative, but with additional services | 7 | 15 | 22 |
| No telephone, relative in a different town, with or without additional services | 2 | 7 | 9 |
| No telephone, relative in same town with or without additional services | 4 | 12 | 16 |
| TOTALS | 16 | 38 | 54 |

Additional services

In the last paragraph, reference was made to the support of other agencies provided for clients. Referral agents were asked to state other agencies that assisted the clients. The responses are summarised in TABLE 12. It is probable that some clients enjoyed more services than were entered on their forms and this Table should be regarded as showing the minimum numbers of clients benefiting from each service.

TABLE 12

Agencies assisting elderly clients[1]

| | MEN | WOMEN | TOTALS |
|---|---|---|---|
| Books on wheels | - | 1 | 1 |
| Church clubs | 2 | 5 | 7 |
| Community Psychiatric nurse | 2 | 2 | 4 |
| District nurse | 5 | 15 | 20 |
| Geriatric day unit | 6 | 8 | 14 |
| Health visitor | 12 | 32 | 44 |
| Home help | 21 | 69 | 91 |
| Meals on wheels | 5 | 12 | 17 |
| Medicare | - | 1 | 1 |
| Occupational therapist | 35 | 30 | 65 |
| Physiotherapist | 1 | - | 1 |
| Social clubs (secular) | 5 | 4 | 9 |
| Social worker | 27 | 60 | 87 |
| WRVS | - | 1 | 1 |
| None | 23 | 28 | 51 |
| Clients being assisted by more than one agency | 48 | 101 | 149 |

1 Contact with hospitals and general practitioners has been excluded from the Table owing to the inconsistency with which referral agents included/excluded such contact from application forms.

Type of accommodation

The difficulties of identifying the social class of elderly people are considerable and well documented. However, the type of housing in which a client lives may provide some indication with middle-class clients being more likely to live in owner-occupied accommodation or in the private rented sector and working class clients more likely to live in council accommodation.

TABLE 13

Type of accommodation in which elderly clients live[1]

| | MEN | WOMEN | TOTALS |
|---|---|---|---|
| Council | 39 | 52 | 91 |
| Farm tithe cottage | - | 1 | 1 |
| Owner occupier | 30 | 74 | 104 |
| Private rented | 13 | 13 | 26 |
| Sheltered housing | 1 | 9 | 10 |
| Not stated | - | 9 | 9 |
| TOTALS | 83 | 158 | 241 |

1 The accommodation may be in the name of the person with whom the client lives.

Addresses of clients

Although the majority of the clients lived in Elgol, 19.19 per cent lived in other towns and villages in Westshire.

TABLE 14

Addresses of elderly clients

| | MEN | WOMEN | TOTALS |
|---|---|---|---|
| Elgol | 70 | 123 | 193 |
| Other addresses in Westshire | 13 | 35 | 48 |
| TOTALS | 83 | 158 | 241 |

Religion

The referral agent was asked to state on the admission form his client's religion. A summary of these statements is included here as TABLE 15. Those clients whose religion was stated on their admission form are summarised as 'religion stated' while those who were atheists, who had 'none' entered or the space left blank are summarised as 'religion not stated'.

TABLE 15

Religious views of elderly clients

| | MEN | WOMEN | TOTALS |
|---|---|---|---|
| Religion stated | 28 | 42 | 70 |
| Religion not stated | 55 | 116 | 171 |
| TOTALS | 83 | 158 | 241 |

Summary

The main feature of the population was its variety. The ages of clients ranged from 21 to 95. Although 77 per cent of the population were elderly there were clients in all quinquennial groups between 60 and 90. Although only 35 elderly clients did not have health problems, there was a wide variety of sicknesses; arthritis (40 cases), strokes (28) and heart disease (22) being the most common. Twenty-two clients were diagnosed at entry as confused. A variety of professions were referral agents; although 'social worker/social services department' was the largest category it only provided 78 of the 241 referrals. Although the majority of the population were widowed, more than a quarter of the clients were married and almost one-seventh were single. Two-fifths lived alone but the remainder lived with a variety of occupants. The number of clients with telephones was approximately equal to the number without and the number of owner-occupiers was approximately equal to the number of council house tenants. (This may very tentatively be interpreted as suggesting a breadth of social background.) The clients enjoyed a wide range of social services in addition to day care but although 149 benefitted from more than one service, 51 enjoyed no other social services at all.

## FIELD-WORK

This section analyses the findings of the field-work. It begins with a short description of the staff at the Centre and their roles. This is followed by an analysis of the early days in clients' Centre careers, specifically the processes of admission and induction. Transport is a particularly important issue and this is discussed separately. A lengthy section then considers aspects of the daily life of the Centre which may be summarised as the Centre regime. This includes the activities undertaken by clients, group formation and membership, subjects of conversation and subjects of concern to clients, relationships with the physically handicapped, staff-client interaction and Centre management. There is then an analysis of the Review Panel. During the exposition reference is made to the findings of the interviews with the sub-sample but a final section is devoted to discussing aspects of these interviews not covered under the previous headings.

Policy implications of the findings are discussed in the final chapter.

Staff and their roles

Suilven House had a staffing complement of 37 made up as follows:

| | FULL-TIME | PART-TIME |
|---|---|---|
| Officer-in-Charge | 1 | |
| Deputy Officer-in-Charge | 1 | 1 |
| Care Assistants | 4 | |
| Craft Instructors | 2 | 5 |
| Caretaker/Care Assistant | 1 | |
| Cleaner | 1 | |
| Ambulance Drivers | | 3 |
| Assistants in Ambulance | | 3 |
| Hairdresser | | 1 |
| Voluntary staff | | 10 |
| Cooks | 4 | |

Some explanation of these figures is necessary. The Officer-in-Charge was studying on a Certificate in Social Service (CSS) Course throughout the research. She was required to attend college every Thursday and to spend Fridays away from the Centre studying privately. She was therefore only at work for three-fifths of each week. On Thursdays and Fridays a second Deputy Officer-in-Charge was employed to assist the full-time Deputy who assumed command on these days.

Craft instructors were employed in the same ratio of instructors to clients as craft instructors at adult training centres. This ratio allowed for 3.5 full-time equivalent instructors to be employed. Although the instructors worked with both the elderly and physically handicapped clients, the Officer-in-Charge stated that they were technically engaged only to work with the latter and there was no inclusion in the staff establishment of craft instructors for the elderly.

The Caretaker/Care Assistant[1] had wide duties. In addition to his caretaking duties he worked face-to-face with clients in a similar role to the care assistants. Clients were not aware that his role was any different from that of the care assistants. The Cleaner's role differed from that of many cleaners as she worked during normal working hours instead of during the twilight hours. Consequently, she was cleaning while clients were in the Centre. Although the Cleaner did not act as a care assistant in that she did not set out to work with clients, the nature of her work brought her into face-to-face contact with clients. In fact, the Cleaner was often the first staff member to be alerted to client problems. For example:

> Mary (the Cleaner) was vacuum cleaning the floor. She required one of the clients to move in order for her to clean part of the floor.
>
> Mary: 'Lift your feet a minute, ducks.'
>
> Mrs Green: 'Will you give me a hand?'
>
> Mary: 'You don't need a hand.'
>
> Mrs Green: 'I do today, I'm having awful trouble with my leg.'
>
> Mary: 'What's wrong with it?'
>
> Mrs Green: 'I don't know, it just comes on after I've been up a while.'
>
> The conversation continued in this way for some minutes. Mary established that Mrs Green had not seen a doctor about her leg and reported this to the Officer-in-Charge who pursued the matter.

1 The Caretaker/Care Assistant was referred to equally often in conversation and documents as the Care Assistant/Caretaker.

Although this example may appear somewhat unusual, it does illustrate the way in which the Cleaner, by virtue of her moving around the whole building, was required to make contact with clients in a way that most other workers were not. Particularly important is the fact that the Cleaner came into contact with the isolates who sat quietly in the corners of the lounge and who met no other staff except, possibly, the ambulance crews. This question of the quality and quantity of interaction between staff and clients is taken up more fully later.

The ambulance drivers and their assistants were part-time workers as far as the Day Centre was concerned. They worked for the Centre during the early morning and late afternoon.

The Hairdresser occupied a unique position within the Centre. She was self-employed, fixed her own cutting charges and retained all the money paid to her by clients but Westshire Social Services Department provided her with an appropriately furnished room, electricity and hot water free of charge.

There were ten voluntary staff and their roles varied according to how the Officer-in-Charge viewed their individual talents and how many hours each week the volunteer was able to work. The majority worked one or two mornings or afternoons per week for some two hours on each occasion. However, some volunteers worked longer hours; one woman worked three full days per week.

All the volunteers were middle-aged, married women with husbands in middle-class jobs. The ages, sex and background of the remainder of the staff varied considerably and no pattern existed on any of these criteria. The ages of the employees ranged from 21 to early fifties. The Officer-in-Charge was a woman and her full-time Deputy was a man, one full-time craft instructor was a man and one a woman, all but one full-time care assistants were women, there was only one woman ambulance driver. All the part-time staff were women.

Although the Caretaker/Care Assistant and three Care Assistants were transferred from an elderly person's home which closed at the same time that Suilven House opened, the background of the remainder of the staff varied. Some had previous employment in the caring professions, others moved into the work from industry.

The amount of training that had been provided for the staff was very small. One Craft Instructor had been awarded the In-service Study Scheme for Residential Staff Statement of Attendance by the Central Council for Education and Training in Social Work and, as previously mentioned, the Officer-in-Charge was studying for the Certificate in Social Service. No other member of staff had a relevant professional qualification.

A brief mention must be made of the professional workers who visited Suilven House to see clients at the Centre rather than in their homes. Social Workers and Social Work Assistants visited infrequently but there were regular visits by District Nurses to bathe clients and by Occupational Therapists. Westshire Social Services Department employed two full-time and two part-time Occupational Therapists. All four referred clients to Suilven House and then visited the clients at the Centre.

They considered day care an asset to themselves as they were able to visit a greater number of clients at the Centre in one day than they could by visiting them individually in their homes. Their visits to clients at Suilven House replaced the visits they would have made to the clients at their homes. Admission to Suilven House did not result in additional contact with these professionals.

Admission

Each person recommended to the Social Services Department for a place at Suilven House was formally considered by an Admissions Panel. The purpose of this section of the study is to examine the way in which the Panel operates, to trace the career of a client prior to and after her consideration by the Panel, and to question whether an Admissions Panel is necessary.

The Admissions Panel met once per month and comprised the Assistant Principal Officer, the Officer-in-Charge and the person who referred the applicant (hereafter referred to as the referral agent). It has already been stated that although the referral agent was the person who formally initiated contact between a candidate and the Centre, he may or may not have been the person who first thought that day care would be appropriate for the candidate. For example, it may have been that the person who first identified the appropriateness of day care was a consultant geriatrician at a hospital who passed the case to a hospital social worker. The hospital social worker may then have worked with the client, agreed with the geriatrician on the appropriateness of day care and become the referral agent. As a consequence of the membership of the Panel it was possible that, if, say, twelve applicants were considered at one meeting, the third chair on the Panel would be occupied by twelve different people.

The structure of the Panel had several advantages. The most senior member of the Centre staff was able to take part in considering the applicant's case. She was able to discuss the merits of an individual case, question the referral agent about the reasons for the referral and suggest what specific kinds of provision might be made for the applicant. For example, if an applicant had a particular interest in a specific activity the Officer-in-Charge may have suggested that she attend the Centre on one of the days that activity was available. Panel membership placed her in a position to pass on to her colleagues the recommendations of the Panel. The Assistant Principal Officer acted as Chairman of the Panel. It was important that he was a Panel member owing to the importance of the decisions being taken on whether to accept or refuse an applicant and the possible repercussions of such a decision for the Social Services Department. Attending the Panel was time-consuming for the referral agent. He had to attend for just twenty minutes but would probably have to set aside most of a morning to travel to the Centre, wait his turn (the schedule of applicants to be considered inevitably ran late), then speak for his client. However, his attendance was clearly important as he was the person best placed to provide any additional information that may have been required concerning the client and to raise any queries that the client may have had.

The procedure adopted for the consideration of each client was identical. Copies of a form submitted by the referral agent in support of the applicant were sent to all Panel members in advance of the meeting. The form provided background information on the applicant such as date of birth, marital status and a detailed case specifying the reasons why the referral agent considered day care necessary. The Chairman allowed the Officer-in-Charge and himself a few minutes to re-read the form before inviting the referral agent to join the meeting.

The Chairman then asked a series of questions, the answers to which were already available on the application form. For example: 'Where did the request for day care come from?' 'Has she been for a preliminary visit to the Centre' 'How old is she?'

These opening questions led into a discussion of the applicant in which some of the statements on the form were amplified. For example:

> In November 1980 Mrs Quinn's application was being discussed with the referring social worker.
>
> Social Worker; 'She has bad eyesight. Can she come on a Wednesday?' (There were large number of blind clients on a Wednesday).
>
> Officer-in-Charge: 'We try not to arrange anything special for the blind. We don't want to create a stigma.'
>
> Assistant Principal Officer: 'What sort of thing is she doing at home at the moment?'
>
> Social Worker: 'Not a lot. She sits and sleeps downstairs.'
>
> Assistant Principal Officer: 'Has she any particular interests?'
>
> Social Worker: 'Not really.'

And:

> In October 1981 Mrs Jones was being considered for a place. Her case was put by an occupational therapist.
>
> Officer-in-Charge: 'Has she had a chance to visit the Centre?'
>
> Occupational Therapist: 'I've not had a chance to bring her round. She knows about the Centre through contacts. Her main problem is isolation. She can't walk about outside to meet anyone.'
>
> Officer-in-Charge: 'What does she think of day care?'
>
> Occupational Therapist: 'Her main worry is transport. She has difficulty getting in and out of a car and she worries that she may need to go to the toilet urgently.'
>
> Assistant Principal Officer: 'What does she think she may do here?'

Occupational Therapist: 'She wants people around her to talk to. She would like to do some crochet and some knitting.'

Officer-in-Charge: 'Does she live alone?'

Occupational Therapist: 'Yes, although her daughter lives in the next street.'

Assistant Principal Officer: 'Does she have any other form of help?'

Occupational Therapist: 'District nurse and home help. She is well organised; she bakes at home.'

Assistant Principal Officer: 'She sounds a good candidate.'

At this stage, two features of the Admissions Panel meetings may be noted:

1 The questions asked by the Assistant Principal Officer and Officer-in-Charge were unstructured. There was no consistent pattern of questioning of referral agents. The questions were intended to enable the Panel members to obtain a general impression of the applicant.

2 Normally, the questions asked required information that was already available on the admission form either in response to a specific question (for example, in the case of Mrs Jones quoted above: 'Does she have any other form of help?' 'Does she live alone?' were both questions asked in similar words on the admission form) or information that was already provided by the referral agent in the open-ended section of the form. In Mrs Jones' case, the questions concerning her focus on transport and incontinence, her isolation, undertaking her own baking, her wish to meet more people, her interests in knitting and crochet were all spelled out on the admission form.

In some cases, the meeting of the Admissions Panel allowed the referral agent to introduce his own value judgements that he might have been unwilling to write on the referral form. For example:

> At the April 1981 Panel, Mrs Davison's case was being supported by a social worker. The social worker opened the conversation:
>
> 'Mrs Davison's being a bit naughty. She had a stroke earlier in the year. She's just been rehoused but the lips on her steps stopped her getting out. The steps were fixed and she could get down similar steps at the geriatric day unit and at home when supervised. But she says the steps are still stopping her from getting out. She's terrified of going back to the geriatric day unit. Her husband has a job at a betting shop so she just sits all day on her own. Her husband says that he needs a break but he goes out first thing every day and comes back late.'

And:

> The same Panel considered Mrs Johnson whose case was supported by an occupational therapist.
>
> Assistant Principal Officer: 'What's her home like?'
>
> Occupational Therapist: 'Quite nice, well furnished. She's got lots of odds and ends around the house that she's acquired recently. Small pots, little ornaments, that sort of thing. I can only think that she shop-lifted them but of course I've got no proof. She goes into town on her own most days so she has plenty of opportunity.'

It may be that it was appropriate for referral agents to have an opportunity to voice concerns such as these. On the other hand, it may be felt that any factors that were relevant to the Admissions Panel when considering clients should have been formally placed on record in writing. Certainly, one is concerned that statements or suggestions which were not open to proof or support were made about applicants even if the intention of such statements was to assist the senior officers of the Centre by making them aware of needs and characteristics of their future clients. There is now sufficient social science research into the consequences of labelling to show the likely consequences for the career of the client of comments made at Admissions Panel.

A number of further questions concerning the form of the Admissions Panel may be asked. These concern the criteria taken into account by the Panel when considering applicants, the number of applicants refused places and the way in which attendance days were allocated.

The question of the criteria taken into account by the Panel is a difficult one to answer owing to the fact that there were no criteria specifically laid down. The different expectations that staff and clients had of day care are discussed later. Suffice to state here that the role of the Centre was not closely defined and therefore the criteria to be applied when determining whether or not to accept an applicant were not spelt out. It was thus very difficult to say that a certain applicant was not suitable because she did not fulfil certain criteria and, conversely, it was difficult to say that an applicant should be offered a place because she met certain criteria. As a consequence, decisions to accept an applicant were made on very different and, at times, inconsistent grounds.

For example:

Mrs Frances Jones was considered at the November 1980 meeting of the Admissions Panel. Her referral form stated:

'Medical History

Has recently been in hospital with heart attack. Fell on the floor and had to lie there all day before family came and she went to hospital.

Physical Assessment

Walks with fender walking aid. Rather nervous.

Social and Home Conditions

Lives alone in quite large and terraced house. Walks with fender aid. Sleeps downstairs. Family are supportive and call every day at tea time but is alone all day and getting depressed as she isn't active any more and just sits.

Objectives and Work Plan

1 To provide stimulation and craft work.

2 To socialise, she is very lonely.

3 To maintain in own home as long as possible.'

The discussion concerning Mrs Jones was brief.

Assistant Principal Officer: 'Where did the request for day care come from?'

Occupational Therapist: 'From herself.'

Assistant Principal Officer: 'Does she receive any other services?'

Occupational Therapist: 'No. She has some relatives who live nearby and they bring her a hot meal every night.'

Assistant Principal Officer: 'How can we help her?'

Occupational Therapist: 'She is on her own after being in hospital and now she needs some company.'

Officer-in-Charge: 'What particular activities does she want to carry out here?'

Occupational Therapist: 'She's keen to get her hair done.'

Assistant Principal Officer: 'What kind of transport will she require?'

Occupational Therapist: 'She sleeps downstairs but she should be able to get up three steps of an ambulance.'

Assistant Principal Officer: 'There doesn't seem to be any problems here. What day, Susan?'

Officer-in-Charge: 'Thursdays from the end of November?'

Occupational Therapist: 'Fine.'

In this particular example, the referral agent was asked specifically what day care could offer the applicant. The justification for offering her a place was her need for company. Yet it has been stated that she had relatives living close enough to her to provide a daily meal. This was not set against the suggestion that she was lonely. Setting this aside, which, given the scarcity of resources for the elderly, perhaps we should not, no reason was given for offering Mrs Jones a place other than the provision of company. This appears incompatible with the Assistant Principal Officer's statement that 'the need for company or other social reasons are, on their own, not grounds enough for offering an applicant a place.'

The writer intended to analyse the reasons stated on admission forms for advocating day care. This proved impossible owing to the absence of sufficient information on many forms. However, there is no doubt that loneliness and the need for company was the reason stated most frequently on the forms and the statements of referral agents at Panel meetings reflected this. One suspects that the reasons stated by referral agents were not always be the same as those put forward by their clients.

It will be shown later that, of the twenty-nine clients in the sub-sample, seven identified the need for company as a reason for joining the Centre, eight identified the availability of activities, while twelve specifically referred to their need for para-medical facilities that were not available within their own homes. The last reason was not stated once by referral agents. It is reasonable to assume that this was because referral agents knew that such facilities did not exist at the Centre. Nevertheless, the disjunction between the reasons why a candidate wanted to attend the Centre and her expectation of Suilven House on one hand and the reasons and expectations put forward by her referral agent on the other must be viewed with some concern.

The referral agent's reasons for advocating day care were not challenged at any of the Admissions Panels attended by the writer. Yet nobody was refused a place by these Panels. No records exist to show how many, if any, candidates have been refused places but neither the Assistant Principal Officer nor the Officer-in-Charge could remember a case. Deferring a candidate's case to the next meeting of the Panel appears to be the only decision that has been taken other than acceptance. Even this step has only been taken in cases where the referral agent's documentation was incomplete in the sense that certain sections of the admission form were not completed rather than incomplete in the sense that additional information was required before a decision could be reached. In other words, the deferral was due to administrative failures only.

It is notable that the Officer-in-Charge's only criticism of the way in which the Admissions Panel operated focussed on the shortcomings of the documentation:

> 'You will notice a difference in the form of the submission made by social workers and occupational therapists. It is not just that occupational therapists refuse to complete the same forms as the social workers, it's that they put just the right amount of information on the form for the client to appear an ideal client.'

This is an interesting observation. The form completed by the occupational therapists differed only in that the form-head was different from that submitted by social workers and the amount of space for providing answers differed. The information contained on the form was similar. Further, the writer was unable to identify any qualitative or quantitative differences in the information provided by the two groups of workers. However, the accusation that the client was presented as the 'ideal' member is significant. It may well be that this was so. Indeed, it may be argued that, once the referral agent was convinced of the need for day care to be provided for his client, he would have been failing in his duty if he did not paint such an ideal picture. The evidence of the way in which Panels operated and the one hundred per cent acceptance rate suggest that there were so many different forms of 'ideal' client that the referral agent did not have to take special steps to obtain a place for his client. Given the suspicion of the Officer-in-Charge, it may be surprising that the questioning of the referral agent at Admissions Panel meetings was not more rigorous.

Some consideration must be given to the manner in which the number of days allocated to a client and the specific day(s) of the week allocated were determined. The policy on the number of days to be allocated was quite clear. Unless there were quite extraordinary circumstances only one day per week was allocated in the first instance. When the case was reviewed after six months the referral agent was able to make application for the number of days allocated to be increased. The allocation at 31 December 1980 is shown in TABLE 16.

TABLE 16

No. of days per week allocated to clients

| DAYS PER WEEK | ELDERLY | PHYSICALLY HANDICAPPED | TOTALS |
|---|---|---|---|
| 1 | 212 | 30 | 242 |
| 2 | 27 | 21 | 48 |
| 3 | 2 | 19 | 21 |
| 4 | - | 2 | 2 |
| 5 | - | - | - |
| TOTALS | 241 | 72 | 313 |

The reason why a higher proportion of physically handicapped clients attended more than one day per week is that day care for many physically handicapped clients was seen as short-term either to help them adjust to their handicap before provision was reduced to one day per week or before it was cut out completely.

There was no set of criteria on which decisions to allocate extra days were based and the three cases allocated extra days during the research period demonstrate the range of acceptable reasons. The first two were put forward at Review Panels and were accepted without question:

Social Worker: 'I would like Mrs Fox to have an extra day at the Centre. Her husband is becoming an even greater alcoholic and an extra day here will help her maintain her programme.'

And:

Social Worker: 'There is a lot of redevelopment taking place around her home and this (the Centre) is her only contact with the outside world.'

The final example is from an Admissions Panel - the only example from the period of the research. Again, it was accepted without question:

Social Worker: 'Mrs Parry is very confused. The pressure on her husband is quite enormous. He is beginning to feel very tired, he's never free of his wife. I'd like her to come two days.'

Oficer-in-Charge: 'Her husband brought her for her preliminary visit, didn't he?'

Assistant Principal Officer: 'I think it would be best if he continues to bring her.'

Social Worker: 'No real problem. That would be fine. What days could she come?'

Assistant Principal Officer: 'What do you think, Susan? You met him when he brought his wife for the preliminary visit. Does he need the break? Would it help?'

Officer-in-Charge: 'I think it would help to keep him going.'

Assistant Principal Officer: 'OK. We're agreed.'

Attempts were made to allocate a new client a day that was felt to match her particular needs. However, this was an ad hoc exercise and, further, the decisions were often based on inacurrate or incomplete data. Two examples illustrate this:

> An occupational therapist was putting the case of Mr Thorley. It has been established that he met the criteria for a place and should be admitted.
>
> Officer-in-Charge: 'Does he have a preference for day?'
>
> Occupational Therapist: 'He would like to come and play snooker.'
>
> Officer-in-Charge: 'Let him come on Thursday. That's a day when snooker's played.'

In fact, no more snooker was played on Thursday than any other day.

And:

> An occupational therapist was discussing the admission of
>
> Mr O'Reilly, a client she had referred.
>
> Officer-in-Charge: 'What's he like as a person?'
>
> Occupational Therapist: 'Very talkative. Broad Irish. Catholic. Priest calls every Monday.'
>
> Assistant Principal Officer: 'Has he expressed an interest in any particular activity here?'
>
> Occupational Therapist: 'No. It's just the company. He could probably do some woodwork.'
>
> Officer-in-Charge: 'Transport?'
>
> Occupational Therapist: 'I think he could get in a mini-bus.'
>
> Officer-in-Charge: 'He can come here on a Thursday then. There's another Irishman, Mr Feeley, comes on a Thursday. They should get on well together.'

The reason why two men, one of whom the Officer-in-Charge had never met, should get on well together merely because they were both Irishmen was not clear. However, Mr O'Reilly was not Irish. He had lived all his life in Liverpool.

The main features of the Admissions Panel may be summarised. The referral agent supported a written application for a place. The application was based on one or more of many criteria. After superficial questioning by the Officer-in-Charge and Assistant Principal Officer, a place was invariably offered to the candidate. An attempt was made to match the client to other clients or to particular activities when allocating attendance days. However this was not done on a rigorous basis. Given this description of the way in which admissions were conducted and the large amount of time involved, one must ask whether the Admissions Panel was necessary or whether the decisions reached would have been the same if the documentary evidence had been sent to either the Officer-in-Charge and/or the Assistant Principal Officer for executive decisions. This is discussed at some length in the final chapter.

## Induction

In any social setting the 'first impressions' obtained by a newcomer are important. This has long been recognised as being particularly true of formal social groupings as various as a child's introduction to school and a soldier's into the army.

The importance to a new client of the first days at Suilven House was recognised by the Officer-in-Charge who designated one of the care assistants responsible for the induction of new clients. The duties of this role were not clearly laid down although the Officer-in-Charge and the Care Assistant concerned both appeared to have similar views of the job. The Care Assistant said:

> 'I'm there when they arrive on the first day - sometimes I see them before they start if they come for a visit. I make sure they've got someone to talk to, know their way around, what there is to do, where the loo is and things like that.'

In describing the role of the Care Assistant concerned, the Officer-in-Charge stated:

> 'The first few days are particularly important for a new client. I think that they are so important that I have one of my staff responsible for the induction of new clients. When someone comes for the first time she makes them welcome, shows them round and supports them for the first few days until they feel at home. Then she gradually fades into the background . . . She has other duties to carry out as well, of course, but when there is a new client, the other duties must be fitted around her induction duties.'

Despite the formal recognition of the importance of induction, clients' first days at the Centre were often lonely and little attempt was made to introduce a newcomer to the facility systematically. Detailed recordings of the first days of many newcomers demonstrate this. The following example is a record of the first morning at the Centre of one client:

> Mrs Sarah Jones commenced at the Centre on 8 January 1981. She arrived by ambulance.

9 30 am

The ambulance driver helped Mrs Jones out of the vehicle. She looked around her and followed the other clients from the ambulance into the building. The other clients moved off in different directions.

Mrs Jones stood still. David (Caretaker/Care Assistant) saw her standing alone and walked to her: 'Hello. Are you new? What's your name?'

'Mrs Jones'

'Where are you from Mrs Jones?'

'Pardon.'

'Where do you live?'

'Saughall.'

'You come with me.' He led Mrs Jones into the lounge and guided her to a seat on her own.

David (to nobody in particular): 'This is a new lady; Mrs Jones.'

One or two clients called out 'Hello, Mrs Jones.'

David: 'What will you have to drink?'

Mrs Jones: 'Nothing, thank you.'

David: 'What do you usually have?'

Mrs Jones: 'Tea.'

David: 'With sugar?'

Mrs Jones: 'No thank you.'

David took her a cup of tea and departed leaving her sitting at the table on her own staring at her tea.

9 40 am

A client walked across to Mrs Jones' table and introduced himself. They talked for four minutes about the Centre, discussing such matters as the time that the day started and finished. The other client then left.

9 50 am

David wheeled in an old woman in a wheelchair. He pushed her to the table at which Mrs Jones was sitting: 'This lady comes from Saughall as well, Mrs Jones. Her name's Dora.' David left both women at the table.

Mrs Jones: 'What part of Saughall do you live in?'

Dora did not reply.

Mrs Jones: 'This is my first day here.'

Dora: 'Yes.'

There was no further conversation and at 9 56 am Dora wheeled herself to another table leaving Mrs Jones alone.

10 47 am

Mrs Jones got up and walked across to one of the volunteers who was pouring tea. She asked her the way to the toilet. The volunteer replied: 'On your right just outside the door.'

10 56 am

Mrs Jones had not returned from the toilet and the observer went out of the lounge to check that he had not lost her. She was standing outside the toilet, clearly lost. She addressed the observer: 'Which way do I go?'

At this moment a care assistant (Anne) arrived at the top of the stairs and heard the question.

Anne: 'Is this your first day, darling?'

Mrs Jones: 'Yes.'

Anne: 'Come with me, I'll show you where to go. Do you want to do some sewing?'

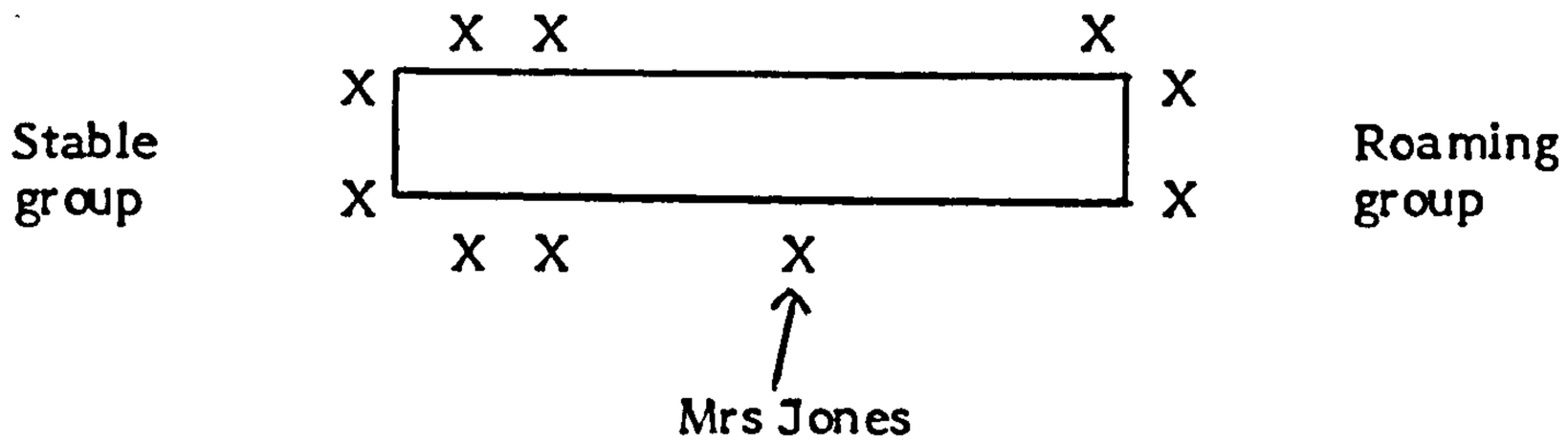
Mrs Jones: 'Yes.'

Anne led her into the sewing room where the instructor was introduced to her. The instructor was engaged in instructing some other clients. Anne left.

Mrs Jones (to another client): 'Where do I sit?'

Mrs Greenway (Client): 'Sit anywhere you like."

Mrs Jones sat down. The other clients in the room sewed together regularly and were already formed into two closely knit groups - one stable, one roaming.[1] Mrs Jones took a free chair but as the two existing groups were sitting at opposite sides of the table she was again isolated as the following seating diagram shows:




(X represents one client)

The instructor continued to talk with the stable group.

11 07 am

Anne (Care Assistant) returned and saw that Mrs Jones was still alone. She pulled up a chair and sat beside her: 'You're new today, aren't you?'

Mrs Jones: 'Yes.'

Anne: 'What would you like to do, make toys? Sew? Knit?' A short discussion followed concerning what Mrs Jones was to do. It was decided that she would knit.

11·20 am

Anne went away to collect wool, needles and a pattern.

1 These terms are defined later.

11 31 am

Anne returned. She sat down and helped Mrs Jones by knitting the first row. She was then called away and left the next row to Mrs Jones.

11 39 am

Mrs Jones called out to the instructor 'I like plain knitting. I can't do this.'

Instructor: 'I'll be with you in a minute.'

11 43 am

Anne returned: 'How are you managing?'

Mrs Jones: 'I like plain knitting.'

Anne discussed this with her, found her a plain pattern which Mrs Jones commenced and Anne left.

12 02 pm

Anne returned. She called out 'Time for Lunch.' Then, to Mrs Jones: 'Come along for lunch, darling.'

Mrs Jones: 'Where do I go?'

Anne: 'I'll show you.'

She took Mrs Jones to the dining area and sat her at a table.

It should be noted that Anne was not the care assistant with responsibility for induction of new clients. In fact, Mrs Jones did not meet this care assistant (Mrs Stephenson) until her second afternoon at the Centre. Three reasons for this may be identified. First, there was no formal system by which Mrs Stephenson or any employee other than the ambulance drivers were informed by the Officer-in-Charge or her deputy that a new client was to be admitted. Mrs Stephenson only knew of a new arrival if she happened to see a new face or if the Officer-in-Charge or her deputy chanced to tell her. Secondly, despite the importance of induction claimed by both the Officer-in-Charge and Mrs Stephenson, induction of newcomers was a task that the latter fitted in amongst her other duties and it assumed no importance above these for her.

Thirdly, there was no formal programme for inducting newcomers and the Officer-in-Charge left Mrs Stephenson to decide for herself how to assist newcomers. Even when Mrs Stephenson was aware that a new client was arriving, the special attention she received was slight. For example:

George was an elderly man in a wheelchair spending his first day at the Centre on 19 March 1981. At 10 15 am, he was wheeled into the lounge by Eric (Care Assistant) who took him to a table occupied solely by one wheelchair-bound man.

Eric: 'I'll leave you here. David, this is George.'

Eric left the two together.

At 11 10 am, Mrs Stephenson arrived.

Mrs Stephenson: 'Hello. You're new aren't you?'

David: 'Yes.'

Mrs Stephenson: 'I'm Joe. We don't seem to have any records for you. We're not usually so inefficient. Wait here a minute and I will show you round.'

She left and returned ten minutes later. She took him round the Centre and left him in the pottery room at 11 20 am without introducing him to the pottery instructor who was working with other clients.

It was 11 50 am before the pottery instructor was aware that David was in the room and during the wait, David had been sitting alone watching what was happening around him. The pottery instructor spent 15 minutes talking with David and then wheeled him to lunch.

In this example, although Mrs Stephenson did meet the newcomer and showed him around the Centre, the attention he received was a matter of chance rather than careful planning.

The interviews with the sub-sample of clients demonstrate how little the prospective clients knew about the Centre. These interviews show the prospective clients to have had very little knowledge of the activities available in the Centre and to have found it very difficult to imagine what Suilven House was like. Some clients, however, were taken on a preliminary visit to the Centre. No records were kept to show what proportion of newcomers had a preliminary visit but of the sub-sample interviewed only four of twenty-nine clients had been on a preliminary visit. Owing to the absence of records and the unreliability of clients' memories it is not possible to establish the pattern for the full population. It appears probable that occupational therapists visited with all the clients that they were going to recommend for a place while it was unusual for a social worker or other referral agent to make a visit.

Preliminary visits took one of two forms. In the first form, a referral agent took the potential client to the Centre and spent approximately one hour at the Centre with her. During this time the potential client was introduced to some of the staff, to some of the clients and had an opportunity to see the facilities available. In the second form, the referral agent took the prospective client to the Centre on a day when he was visiting Suilven House to see a client, appear at the Review Panel or for some other reason. As in the first form, the potential client had an opportunity to meet the Centre staff, to see the clients, and watch the activities but was then left with some clients while the referral agent went about his other business for one or more hours. Although the sub-sample interviews suggest that new clients who have paid a pre-entry visit may be more confident about starting at the Centre, the pre-entry visit can only be part of the induction programme. Old age and long

experience of life may not make the transition into a different (and established) social group any easier than it is for a younger person. More than three-quarters of the sub-sample interviewed before their first day at the Centre asked the interviewer whether he would be at Suilven House when they arrived. This may demonstrate a need for re-assurance, security and a link with the old person's own home that was not otherwise available.

Transport

Once a client has been admitted to the Centre, the link between her home and Suilven House was provided by the ambulance drivers and their assistants. There was no formal policy concerning the provision of transport for clients. A decision was reached by the Admissions Panel on the need of each new client. A client was asked to make her own way to the Centre if she was thought capable or if a car-owning relative was known to be available to transport her. Otherwise, either an ambulance with a tail-lift for the entry of wheelchairs or an ambulance without this facility was provided. In practice, very few clients were either sufficiently mobile to travel independently or were able to arrange private transport and virtually all clients were dependent upon the Centre's ambulances.

Each ambulance left the Centre at approximately 8 45 am. The driver was provided with a list of clients to collect but he determined his own route and, hence, the order in which he collected clients. The ambulance collected up to a dozen clients and delivered them to the Centre between 9 30 am and 10 30 am. Consequently, a client may have been on the ambulance for as long as one-and-a-half hours. Occasionally, an ambulance made a second journey to collect further clients. In the afternoon, the ambulance left the Centre at approximately 3 45 pm.

The ambulance drivers and their assistants were the most discussed staff at the Centre. They had a major influence in determining whether a client continued happily at the Centre or left (as shown by the sub-sample interviews). There are several aspects of the importance of the drivers and these may be identified under eight heads.

First, some drivers were perceived by the clients as 'good' in that they drove smoothly while others were 'bad' in that they drove jerkily, cornered fast or in other ways provided a less comfortable ride. For example:

> Mrs Edmunds was sitting at a table with two other clients at 10 20 am when Mrs Coffin walked in and joined her.
>
> Mrs Coffin: 'What a journey.'
>
> Mrs Edmunds made some 'tutting' noises in sympathetic response.
>
> Mrs Coffin: 'That Harry. He drives like a man possessed. First one side of the road, then the other. Then the lights change and he stops so suddenly we all fall out of our seats.'
>
> Mrs Edmunds: 'I came in with Dave.'
>
> Mrs Coffin: 'Well you're lucky.'
>
> Mrs Edmunds: 'I've no complaints.'
>
> Mrs Coffin: 'I should think not. You stay in your seat with Dave. With Harry you're holding on for dear life. I'll have to have word with Susan about it. I'm going to stop coming if I have to keep coming with Harry.'

Secondly, some drivers were perceived as reliable time-keepers and others as unreliable. A reliable driver called to collect the client at a similar time each week, always followed a similar route to the Centre and collected the remainder of his clients in a regular order. The return journey would be equally predictable. An unreliable driver varied the time at which he collected a client and varied the route that he took to Suilven House so that clients were often collected in a different order one week from the next. Given the lengthy preparations many old people had to make in order to be ready for the transport, it was understandable that driver reliability was important to them.

A group of women clients were discussing transport.

Mrs McBayne: 'It's Robbie today. He's always very good and on time.'

Mrs Hesketh: 'I wish you could say the same for wee Dave. It was nearly quarter-to-ten when he called for me this morning. Last week he was at my house before nine o'clock. I'd been sitting there with my coat on for nearly an hour when he arrived this morning.'

Mrs McBayne: 'Dave's terrible. You don't know whether you're coming or going with him.'

The unexpectedly early arrival of the ambulance was as unpopular as unexpected lateness:

Mrs Taylor was having her hair cut.

Mrs Taylor: 'I'm a bit flustered this morning, love.'

Joyce (Hairdresser): 'Why's that?'

Mrs Taylor: 'It's that Albert. He was so early this morning that I wasn't ready for him. Then he rushed me - expected me to be ready. So I didn't have time to do my hair properly or check my bag or anything.'

Joyce: 'He doesn't mean it.'

From the driver's point of view, there were genuine reasons for delays or altering the route. The addition of new clients to the driver's list may have caused him to take a different route, to collect clients in a more efficient order. Road works may have caused delays and led to a different route being chosen. All mechanical work on the vehicles was undertaken at Elgol Fire Brigade Station and even the simplest of tasks such as inflating tyres had to be carried out there. One morning the detour to re-inflate one tyre caused a twenty-five minute delay to clients.

The drivers were aware of the concern that the timing of their arrival caused:

> One morning the ambulance was following its usual route. The driver turned to his assistant as he stopped at one house: 'Watch it when you knock on the door, George. You know what a mouthful you got last time we were a few minutes late.'

And, another morning:

> The driver was a little ahead of schedule. His assistant said to him: 'We'd better not be too early for Mr Cummings or he'll come out eating his toast in protest again.'

The third important aspect of the work of the drivers was the predictability of their moods. Drivers whose moods were predictable and consistent were preferred to those who were less predictable. This was a feature of drivers' personalities which was often discussed by clients although they did not discuss this characteristic of other members of the Centre staff so frequently:

> Two clients were drinking tea early in the morning.

Mrs Holbrook: 'Who did you come with this morning?'

Mrs Tattum: 'Albert and George.'

Mrs Holbrook: 'I wish I did. You know where you are with them. Not like that Paul. I don't get on with him. One day he's as pally as can be, putting his arm round you. The next day he doesn't want to know you. He was like that this morning - slamming the door, not a civil word to say to anyone.'

Fourthly, some drivers did more at the clients' homes than help them in and out of the ambulance. Although they were only required to meet a client at her door, the majority did more than this, often helping with minor jobs within the home that had a considerable effect on the ease and the peace of mind with which the client was able to leave her home. For example, one driver always locked a particular client's door for her and took the key to a neighbour for safe custody. He collected the key for her in the evening. Another driver turned out a client's gas fire and carried out a room-by-room inspection of the house to ensure that windows were locked and doors shut while the client waited in her lounge. These acts provided the client with a feeling of security that, to an independent observer, was out of all proportion to the importance of the act. Clients often sought advice on minor matters on which they must have been taking their own decisions on days when they were not attending Suilven House. Drivers who did not undertake these home duties were resented by some clients:

Mrs Allen was talking to other clients.

Mrs Allen: 'I was so annoyed this morning. Wee Dave came for me and you know George, when he comes, always checks my doors for me before I leave. Well Dave came and just knocked and stood by the gate waiting. I said to him "Will you just check my doors for me?" and do you know what he said? "I'm sure you'll have locked them." Well I'm not sure now that I did. I can't remember locking my back door this morning.'

Fifthly, drivers were the only members of the Centre staff who were in contact with clients at their own homes. This put them in a unique position to comment to Centre staff on home circumstances but also to take positive steps to help clients improve their home circumstances:

Colin Wilson, Deputy Officer-in-Charge was alone in his office when George, one of the drivers' assistants, entered.

George: 'I've just picked up Mrs Cunningham.'

Colin: 'Oh, yes. Nice old lady.'

George: 'She is. But I went into her house again this week and the living room paint is peeling very badly. I was wondering whether it's possible for you to get one of the voluntary organisations to come and repaint it for her.'

Drivers formed the link between the client's own home and Suilven House. A client lived in two worlds; her own home and the Day Centre. All her social and welfare contacts (with the possible exception of occupational therapists who visited clients at the Day Centre) were members of one or other of these worlds. The ambulance crews transcended these worlds and had the potential to provide the client with continuity between one and the other.

On the basis of the five dichotomies illustrated above it is possible to identify an ideal-typical model of a popular and an unpopular driver;

| POPULAR | UNPOPULAR |
|---|---|
| Drives smoothly; | Drives fast and jerkily; |
| Reliable timekeeper; | Unreliable timekeeper; |
| Predictable in his moods; | Unpredictable in his moods; |
| Undertakes odd jobs within clients' homes. | Has no contact with clients inside their homes. |

A sixth aspect of the importance of drivers is that the driver was the client's first contact with the Centre both when she first became a client and, subsequently, at the start of each day.

Seventhly, the ambulance crews were the only staff with whom a client interacted over whom she had no choice. A client could choose not to interact with a particular care assistant or instructor albeit at the price, in some cases, of reducing her choice of activities. A client had no choice over who should act as her driver; she had to travel with whoever arrived at her door. This was particularly important in view of the personal knowledge that an ambulance crew could gain of a client.

By remaining silent or opting out of relationships with certain staff, a client could keep to a minimum the knowledge that these staff had of her. She could not prevent the ambulance crew knowing the condition of her house, where she left her key and other intensely personal matters.

Finally, the ambulance driver had considerable power as to who attended and who did not attend the Centre and the enjoyment the attenders obtained from their visits. The last has already been illustrated. It has been suggested that some clients stopped attending the Centre as a consequence of poor relationships with a driver and there is evidence to support this:

Mr Woolley stopped attending the Centre in November 1980 as a consequence of his poor relationship with the ambulance driver who collected him. After a period of two months, during which Mr Woolley only attended infrequently, the Officer-in-Charge received a letter from Mr Woolley's son in which he stated that his father would not be attending again. The letter stated that Mr Woolley had no control over his bowels and that this had led to friction with the ambulance driver. The driver was accused of calling Mr Woolley a 'shifty old buggar' and of asking him 'why don't you take a bath? There are other people on this bus?'

This was the only case during the participant-observation (and the only one the Officer-in-Charge could recall) of a client's driver being changed at the client's instigation. The change required Mr Woolley to attend on a different day and hence with a different population of clients in order that he might travel with a different driver whose route took him close to Mr Woolley's house. This demonstrates the lengths a client had to go to in order to travel with a different driver.

In some cases the drivers consciously determined whether or not a client would continue at the Centre:

> One morning an ambulance was following its usual route. The Driver turned to me and said: 'We used to pick Mr Grout up from that house but he attended so infrequently that we don't bother now.'

This demonstrates the power of the ambulance crews to determine, without reference to a higher authority whether or not a client would remain on the Centre's register. Mr Grout was later deleted as a non-attender.

Some clients developed a series of signals to notify the driver whether or not they intended to attend. One lady, for example, left a plant on a window sill if she intended to go to Suilven House that day. If there was no plant pot, the driver did not call. On the one hand this allowed a non-attender to stay in bed without being disturbed by the driver and allowed the driver to pass by without wasting a few minutes parking, walking up the garden path and waiting at the door. On the other hand, it was an easy option for the less committed client. A client who sat up late, thought the weather was cold and could not face rising early the following morning could make the choice that evening not to go to the Centre the next day. If drivers had been unwilling to agree to such a system of signals, such a client may have been more likely to attend the Centre. She would have known that she would be disturbed by the driver calling and that if she were absent herself she would have to explain to him why she would not be attending the Centre.

Client recognition of the importance of the drivers was frequent although the comments were usually brief:

> Two elderly women were talking to me at a table when a driver and his assistant walked through the lounge.
>
> Grace: 'Look, here comes George and Albert. Hello, George!'
>
> George: 'Hello, love.'
>
> Grace: 'Albert and George keep us going. I don't know what we'd do without them.'
>
> George: 'You keep us going! We'd have nothing to do if you didn't come!'

## Activity

'Activity' is used here in the sense of a pastime organised by the staff for the clients, possibly with instruction but definitely with supervision.

The activities available to clients were determined by several factors. The cost of the materials for an activity were of some importance although many of the articles produced at the Centre were sold either privately or at sales of work in order to cover the cost of materials. Available space was of comparatively little importance as there was sufficient space available for most indoor activities and the building was reasonably flexible. Some design features and equipment made it easier to follow some activities than others. For example, a dividing wall between one particular room and the lounge enabled the room to be used as a stage. Although a piano was provided, there was no soundproof room and playing of the piano was discouraged. The large activity-specific equipment which was available comprised a kitchen with cooking facilities, the stage, hairdressing salon and a large room with pottery and woodwork equipment.

A more important factor influencing the activities offered was the availability of instructors. It has already been stated that the number of instructors that the Centre could employ was determined by the County Social Services Department formula for Adult Training Centres. However, the salaries offered to instructors were low and it was difficult to attract male instructors. Consequently, all but one of the instructors was female.

Another important factor was the perceived popularity of a particular activity. This perception may have been the Officer-in-Charge's based simply on her own expectation, her experience or views. It may have been based on a more formal request for an activity that had been made at one of the monthly meetings of the Discussion Group. However, none of the suggestions made by clients at the Discussion Group during the period of the research were implemented by the Officer-in-Charge. For example:

> At the February 1981 meeting, Mrs Clarkson, the representative of the clients who attended on Wednesdays, asked whether it would be possible for macrame and cookery to be offered on that day. The Officer-in-Charge promised to investigate the possibility of offering these activities although she did not report back to the following meeting and no changes were made.

Often, the client delegates did not help their cases by their own uncertainty over their aims:

> At the December 1980 meeting of the Group a discussion took place on the activities that were available on different days of the week. The delegate representing the clients who attended on Mondays expressed her view. 'Nothing goes on on a Monday. There's basketwork on Tuesday, nails are done on Wednesday. There's French on Thursday but nothing on Monday.'

Officer-in-Charge: 'There's sewing. There's cards.'

Delegate: 'They want to make something.'

Officer-in-Charge: 'Well there's craft.'

Delegate: 'Yes, but there's not the bits of extras that go on other days.'

Officer-in-Charge: 'We try to balance things out. We do things as experiments and if they don't take off we try them on other days. On Monday there's macrami, dressmaking, pottery, jewellery.'

Delegate: 'Yes but that's crafts and they want things a little bit different. It's all work on Mondays; no recreation.'

The Officer-in-Charge explained the way in which she decided the activities to be offered:

'First, of course, I have to take into account the staff that I've got available. Some of them can turn their hands to anything. Anne, for example, could do anything I asked her; sewing, knitting, cooking. Others can only do one or two things. Then I try to choose activities that provide a variety. I don't have two physically demanding things like singing and PE going on at the same time. I spread it so that there's always something for the less active. And I try to change things round as far as the days are concerned so that if there's not been any basketwork on Thursday for a while, I'll change it from Monday although that's not always easy because of the days that staff can work.'

Some clients took their knitting to the Centre and there was an occasional game of cards, dominoes or snooker but these were the only client-organised pastimes. A client who did not take part in the programme organised by the staff was most likely to spend her day sitting quietly or talking.

There was a trolley of some two hundred library books but the writer did not see anyone read one of these throughout the period of participant observation. Similarly, there was a greenhouse in which clients had worked in the past but the writer did not see a client enter the greenhouse. The programme of activities offered remained consistent throughout the research. The activities were not necessarily offered for the full client day; in some cases the instructor was only employed from 10 am, sometimes the instructor only worked half the day, in some cases (eg. cookery) the activity only lasted an hour or two. All activities stopped for lunch shortly before noon and recommenced at 2 pm. Thus, a typical day for a client who participated in activities may have been:

9 45 am

Arrive. Drink cup of tea brought to the client's table by a volunteer. Sit at the table and talk or watch.

10 40 am

Join with other clients in one of the Centre activities.

11 50 am

Prepare for lunch. Move into dining area.

12 15 pm

Lunch served.

12 45 pm

Sit at a table or in an arm chair; talk or watch.

2 pm

Join with other clients in one of the Centre activities.

3 30 pm

Prepare for departure. Move into lounge.

3 45 pm

Departure.

The availability of activities during the period of the research is shown in TABLE 17.

**TABLE 17**

Availability of activities by day

| ACTIVITY/ DAY | BASKET-WORK | SEWING | COOKERY[1] | CRAFT[2] (MAINLY POTTERY/ WOODWORK) | JEWELLERY | OTHER |
|---|---|---|---|---|---|---|
| Monday | - | √ | - | √ | √ | Macrami, Cards. |
| Tuesday | √ | √ | √ | √ | √ | Play-Reading, Singing. |
| Wednesday | √ | √ | √ | √ | √ | Physical education for the blind. |
| Thursday | √ | √ | √ | - | √ | PE, French. |
| Friday | √ | √ | - | √ | - | PE. |

1 Available morning only.

2 Activities taught concurrently by the same instructor.

√ Indicates that the activity was available.

\- Indicates that the activity was not available.

In addition, the Hairdresser was present every morning and a manicure was offered two afternoons per week.

It was stated above that not all clients engaged in activities offered by the Centre. Many of the old people spent their time sitting in the lounge talking to other clients, knitting or sitting without engaging in either activity or conversation. The numbers who did not engage in a formal activity were approximately fifty per cent of the population per day. The numbers were counted at thirty minute intervals on five different occasions; each occasion being a different day of the week. The figures obtained are shown in TABLE 18. In the Table, the population is the number of elderly clients who were recorded as being present on the day sampled. The numbers participating in activities were counted only at times when the activities were fully available (ie. between 10 30 and 11 30 in the morning; between 2 and 3 in the afternoon). A client was counted as taking part in an activity if she was in the activity area. Thus is was possible that a client could sit at, for example, the basketwork table, and not do any basketwork for an hour or two but be included as an active client in TABLE 18. In practice, it is not thought that this distorts the results. It is extremely unlikely that a client could (or would) spend a complete day in an activity area without taking part in that activity. The average participation is the average number of participants at the six sampled times. The average percentage of clients participating is the average number of participants expressed as a percentage of the population on the sample day.

TABLE 18

Participation of elderly clients in activities on five days

| | SAMPLE | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|---|
| | DAY | MON | TUES | WED | THURS | FRI |
| | TIME | | | | | |
| Number of elderly clients participating in activity | 10 30 am | 39 | 20 | 31 | 40 | 28 |
| | 11 00 am | 35 | 32 | 28 | 39 | 32 |
| | 11 30 am | 30 | 31 | 31 | 43 | 31 |
| | 2 00 pm | 35 | 31 | 26 | 41 | 27 |
| | 2 30 pm | 37 | 34 | 25 | 41 | 25 |
| | 3 00 pm | 37 | 31 | 25 | 40 | 25 |
| Number of elderly clients present | | 84 | 71 | 56 | 72 | 63 |
| Average Participation | | 34.2 | 29.8 | 27.6 | 40.6 | 28.0 |
| Average % of elderly clients participating | | 40.7 | 42.0 | 49.4 | 56.5 | 44.4 |

The Table shows that, with the exception of Sample Four, less than half the clients in a sample participated in activities. Contrary to the expectations of some of the staff who thought that clients were more willing and able to take part in the morning when they were 'fresher' than in the afternoon, there is no evidence to suggest that clients were more active during one or the other. In two cases, morning participation was greater than afternoon, in two cases afternoon participation was higher than morning, and in one case it was identical.

It is difficult to explain why the participation rate in Sample Four was so high (56.5 per cent). Singing was the only activity available that was not offered on other days of the week but this was availalbe only during the afternoon when the participation rate was the same as the morning's. This suggests the possibility that the range and nature of the activities available may not have been crucial in determining the number of participants. It may be that certain clients wished to participate in activities and if a particular activity was not available they opted for another.

This last possibility leads to the question of whether it is possible to categorise clients who participated in activities and those who did not participate. Attempts were made to identify whether age or sex were significant variables. It was found that neither of these variables correlated with activity participation.

It has been shown that the number of people participating in activities remained constant throughout a morning or afternoon. The greatest variations between three half-day counts in TABLE 18 were nine persons between 10 30 am (39 participants) and 11 30 am (30 participants) in Sample One, and eleven persons between 10 30 am (20 participants) and 11 30 am (31 participants) in Sample Two. Apart from these two half-days, the greatest variation was four persons. The possibilities still remain, however, that either the participants at one count were not the same people who were included in the previous count (ie. some clients had ceased an activity while others who had previously been non-active became active) or that the same clients were active but had changed from one activity to another. There is evidence to suggest that neither of these possibilities is correct but that the active clients tended to continue with the same activity both throughout the day and from one day to another.

The participants in a Tuesday basketwork class were recorded over a seven-week period. The participation is shown in TABLE 19. Participants were recorded at the same half-hourly intervals as shown in TABLE 18. The problem of whether to regard someone as a participant if she was only recorded as active once during a day did not arise as every client who took part in the activity was recorded as participating for at least three of the half-hourly counts. Three such recordings are thus the minimum requirement for recognition as a 'participant' in TABLE 19.

TABLE 19

Participation of twelve elderly clients in the Tuesday basketwork class during a seven-week period

| PARTICIPANT | SEX | WEEK | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| A | M | ✓ | ✓ | ✓ | a | ✓ | a | ✓ |
| B | M | a | a | ✓ | ✓ | ✓ | ✓ | ✓ |
| C | M | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| D | M | a | ✓ | a | a | ✓ | ✓ | ✓ |
| E | M | | | ✓ | | ✓ | | a |
| F | F | ✓ | a | ✓ | ✓ | a | ✓ | ✓ |
| G | F | a | ✓ | a | a | a | ✓ | a |
| H | F | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| I | F | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| J | F | ✓ | a | ✓ | | ✓ | a | ✓ |
| K | F | ✓ | ✓ | ✓ | a | d | d | d |
| L | F | - | - | - | - | - | ✓ | ✓ |

KEY

✓ Participated

a Absent from Centre

A blank space indicates that the client was present at the Centre but did not take part in the class.

d Deceased

- This client was not a member of the Centre for the weeks indicated.

The Table shows a pattern of consistent participation within the class. Of the ten clients who were members of the Centre for the seven-week period (ie. excluding the woman who died after the fourth week and the woman who joined in the sixth week) three clients were present at the Centre and participated in basketwork classes every week while a further five participated each week they were at the Centre. The remaining two clients were infrequent participants; one took part in just two of the six days he was present, the other on four of the five days she was at the Centre.

It may be argued that regular participation is most likely in an activity such as basketwork where the client is producing an article on an on-going basis. In other words, she may be working for five or six days on the same basket and continue one week from where she left off the previous week. It may further be argued that participation may be less regular in an activity in which there is not such continuity from one week to another. Cookery is one activity in which there is no continuity from week to week; each morning's activity is self-contained in that one item is prepared, cooked and eaten in a morning and the following week a different dish is prepared.

In order to find out whether participation in cookery was as regular as in basketwork, a Wednesday cookery group was followed for a seven-week period. Although the number of participants is smaller, the pattern of regular participation is similar to that of the basketwork group. The participation is shown in TABLE 20.

TABLE 20

Participation of seven elderly clients in the Wednesday cookery class during a seven-week period

| Participant | Sex | Week | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| A | F | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| B | F | ✓ | a | ✓ | a | a | ✓ | a |
| C | F | ✓ | | ✓ | | | ✓ | |
| D | F | a | ✓ | ✓ | ✓ | a | ✓ | ✓ |
| E | F | ✓ | a | ✓ | ✓ | a | ✓ | ✓ |
| F | F | ✓ | ✓ | | | ✓ | ✓ | a |
| G | F | ✓ | ✓ | | ✓ | a | ✓ | ✓ |

KEY

✓ Participated

a Absent from Centre

A blank space indicates that the client was present at the Centre but did not take part in the activity.

The Table shows that only one client was present and cooked each of the seven sessions. A further three clients cooked each week they were present. Of the remaining three clients, one cooked on just three of the seven days she was present, one cooked on four of six days, one cooked on five of the six days she was at the Centre.

In both the cookery and the basketwork samples, there was a core of clients who attended the class each week that they were at the Centre with a second group who took part in the activity most of the weeks they were at Suilven House. Occasional participants were rare and there were no 'samplers' who moved from one activity to another. This pattern of consistent groupings was investigated in respect of non-active clients and the question of group membership is considered later in this chapter.

The question arises: 'How did clients decide which activity to take part in?' This is an important question for at least two reasons. First, the answer may assist the Officer-in-Charge to decide which activities or which kinds of instructor to provide and the way in which the activities should be organised. Secondly, given that participation in an activity is regarded as more worthwhile than non-participation (a position that will be considered later), the answer may suggest ways to increase the rate of participation.

The problems of administering a questionnaire to elderly people have already been considered and, in view of these, it was decided not to give a questionnaire even on such an apparently narrow subject as this. Instead, the participants in all activities held one Thursday morning were asked, verbally, why they had chosen the activity they were participating in that morning. It was anticipated that the answers to this question would not be as decisive as one would wish. After all, how many younger people are able to state accurately why they take part in one kind of activity rather than another? This reservation was supported by the response to the question. Of thirty-seven clients questioned, twenty-two said that they did not know or that they just liked it. A further five were unable to answer at all. Of the remaining ten, four said they wanted to have an interest that would keep them active but were unable to suggest why they engaged in that particular activity. One said that jewellery-making was something she had always wanted to try, three that they wanted to be with their friends who took part in the activity and two that they had always sewn, wanted to continue in their old age but now needed help with it. Interestingly, not one client suggested that the presence of a particular instructor or care assistant was a factor in choosing an activity.

In contrast to the uncertainty depicted above, several members of the sub-sample interviewed prior to admission had clear views as to the activity they wished to pursue. Of the twenty-nine clients interviewed, eight stated the kinds of activities in which they wanted to participate. These clients may be divided into two categories - a division hinted at by a few of the responses from the main sample. The first category comprised clients who had engaged in a particular activity for many years and considered themselves to have remained proficient at it. The second category comprised clients who wanted to pursue an activity that they had not tried before.

Three hypotheses concerning choice of an activity may be tentatively suggested. These are:

1 Clients who entered Suilven House without a pre-disposition toward any activity were more likely to engage in an activity if they were provided with a 'directive' induction programme than if the induction programme was 'non-directive'.

2 Clients who considered themselves to remain proficient at an activity that they had participated in over a period of years were likely to continue that activity at Suilven House, if it were available.

3 Clients who considered themselves to be no longer proficient at an activity that they believed themselves to have been previously proficient at were unlikely to continue that activity at Suilven House but may have engaged in an activity they had not previously attempted if they were still reasonably dexterous.

There is further support for the third proposal:

Mrs Powell was talking with three other women at a table in the lounge.

Anne (Care Assistant) approached her.

Anne: 'Hello, love. How are you? Why aren't you downstairs making mince pies with the other ladies?'

Mrs Powell: 'Oh, no. I used to be a good cook before I had my stroke but now I just make a mess on the floor.'

And:

Mrs Vickers was seventy-four. She was talking to me while she was making a basket; a task that she undertook slowly and not very well.

Mrs Vickers: 'I'd never done anything like this until I came here.'

She chuckled. 'I never thought you'd see me sitting in a chair making a pot!'

M Taylor: 'You enjoy it now, though.'

Mrs Vickers: 'Oh, yes.'

M Taylor: 'What else do you do here?'

Mrs Vickers: 'Nothing. What I really enjoy is sewing. I used to make all my own clothes. You wouldn't think it now, would you? I can't even thread a needle. I can't sew straight. I get so mad with myself I just throw it down on the floor.'

M Taylor: 'Why don't you do some sewing here? Anne or Rosemary will help you.'

Mrs Vickers: 'No. There's some good sewers here. You just see some of the work they've done. No. I'm all right here.'

A client's concern at her inability to work at her previous level or at the level of some of her contemporaries was recognised by some of the staff:

> A care assistant was discussing the way in which she organises her sewing group: 'It's best if they are all doing different things. If they all do the same, a lot of them feel inferior because other people can do better than them.'

Despite this claim, clients in the particular class quoted worked at whatever kind of sewing they wished. There was no clear attempt by the instructor to match the task to the client's ability. In a needlework class taught by a volunteer, an attempt was made to help the clients progress through a series of activities matched to their abilities. There was nothing formal about this in the sense of there being a laid-down programme or scheme of work. It was an ad hoc arrangement based on an individual client's interest and the volunteer's perception of her abilities. The volunteer explained the philosophy in this way:

> 'When they come here they want at first to do the things they did some time ago but they find they can't do it and they pack up . . . If we start off with something simple they then want to do some more.'

Only this one volunteer and the woodwork/pottery instructor organised the clients' work in this progressive way. Other instructors and care assistants gave basic instruction to new clients who were attempting an activity for the first time but otherwise the client was left to take the initiative. If she showed an interest in making a particular article she was encouraged to do so, otherwise suggestions were made without particular reference to her ability.

Often, if the instructor thought that making a particular item would be too difficult for a client, the instructor would start it, finish it or do the difficult tasks leaving the client with the technically easier tasks:

> Mrs Carter, an elderly client, had just finished painting a paper-mache 'hill' that was to be one of the features in a model village. She had been sitting looking at her completed work for a few minutes when Jean, the instructor, moved round the table to join her.
>
> Jean: 'Have you finished it, Mrs Carter? Oh yes, that'll look nice just on the edge of the village, won't it?'
>
> She took the 'hill' and placed it on the model which was on a large table a few feet away and returned to Mrs Carter.
>
> Jean: 'Let's see what else there is to do. We need a few houses painted still, then there's some fencing to make and ... '
>
> Mrs Carter: 'I'll have a go at one of the houses. I won't promise what it will look like, mind!'
>
> Jean: 'Well you paint the roof red this morning, leave it to dry lunch-time, then this afternoon you paint the walls. Then tomorrow I'll do the door, windows and tiles.'

In the construction of a model village it is obviously not possible to plan in advance which client will produce which objects in an order that will take account of the individual's increasing skills. There are too many unpredictable factors. Nevertheless, it may not be desirable to reduce the part played by a client in the production of an article to a routine level. It may be desirable that a degree of challenge should exist which varies according to such factors as the client's temperament, powers of concentration and interest in the skill.

A defence of the practice of producing an object that is simple and does not challenge the client was made by the Officer-in-Charge:

> 'Clients like things they can do quickly so that they can have something to take home at the end of the day.'

The writer found no evidence in support of this view. Indeed, other than items produced in the cookery class, very little was made that could be taken home at 'the end of the day'. Some of the most regular activity attenders were those clients in the basketwork and woodwork groups whose products took several weeks to complete.

Several clients would have preferred more freedom to decide the precise nature of the articles they were to make within their chosen activity. This dissatisfaction was sometimes voiced privately, sometimes at Discussion Group meetings:

> At the January 1981 meeting there was a discussion on the 'lack of client initiative' at the Centre. One of the client representatives defended the clients: 'What's the point in trying to take a lead. We can't even decide what to cook. I've given up cooking because we never cook anything I like.'
>
> Officer-in-Charge: 'The problem with cooking is that the ingredients have to be bought in advance so you can't decide on the day what you want to cook.'
>
> Representative: 'Why can't we decide one week what we want to cook the next?'
>
> Officer-in-Charge: 'That would be difficult.'

An underlying value at Suilven House was that it was more worthwhile to engage in the activities offered by the Centre than to be passive, sit and knit, read or be similarly engaged. This was made clear by the staff both verbally and non-verbally. Efforts were made to encourage passive clients to become active:

> Basketwork usually took place in a room off the lounge that was used exclusively for this purpose. For one week in October 1980 the basketwork equipment and class were transferred to the middle of the lounge. The purpose of this move was to publicize the class in the hope that more clients would take part. There is no evidence that additional clients were recruited as a consequence.

In a private conversation the Officer-in-Charge explained why she considered activities to be so important:

> 'Doing something gives the members confidence. It's not just a matter of keeping them occupied. They come here for social development among other reasons and I think that it is important to provide activities to help increase the confidence that so many of them lack. I don't think that it's worth increasing the number of activities we offer on any day because the addition of a new activity would take clients away from existing groups. So I keep the same activities and try to increase the number of people in each group.'

Junior staff reflected this view of the importance of activity. For example:

> Tom (Craft Instructor): 'I think clients should do something if possible. There's a lot of choice here.'
>
> Anne (Care Assistant): 'I don't know why some of them bother. They could take part in sewing, jewellery, cooking, but they'd rather just sit in the lounge all day.'

David (Caretaker/Care Assistant): 'Some of them (the clients) can't do much but most of them could if they wanted to.'

Anne (Care Assistant): 'I prefer to work with old people. If I think they can do something more productive I send them to Janet to do basketwork or Joe who does the soft toys.'

There was an underlying and sometimes overt assumption in these comments that clients who took part in activities had accepted the norms of the Centre and were more highly regarded by the staff. Non-active clients were regarded as lazy or as having failed to grasp the opportunities offered to them by the Centre.

It was not only the active clients who were seen by the staff as having the highest status. There were similar distinctions in the staff groups between those who were employed specifically to be involved in activities and those who primarily had other functions. The latter aspired to higher status which they hoped to gain by providing instruction in skills. For example:

I was discussing with Anne (Care Assistant) the way in which sewing was organised. Anne was teaching a group of women to sew.

Anne: 'You're not really talking to the right person. If you want to know how the sewing class is organised you ought to talk to Janet. She's an instructor; I'm only a care assistant.'

M Taylor: 'I'm sorry. I thought that you were an instructor. You teach the clients how to sew, don't you?'

Anne: 'Yes but I'm only employed as a care assistant. But I prefer to be involved with something worthwhile so I normally work with one of the classes.'

It was common for care assistants to act as instructors as will be shown later in the discussion of the way in which staff spent their days. However, it should be noted here that a consequence of this and of the employment of staff specifically as instructors was that the clients who took part in activities had considerably more interaction with staff than those who were passive. As it is probable that the clients who engaged in activities were more physically competent and thus more easily able to make social contacts and/or more socially competent (as demonstrated by their willingness to become involved in activities) this is a particularly important aspect of the deployment of staff.

If non-active clients were regarded as low status members by staff, this was equally true of clients themselves. The active clients regarded their status as being higher than the non-active. For example:

> I was sitting amidst a group in the basketwork room. Clients were engaged in discussion of various topics including the Centre and what they were going to do at Christmas. One woman turned to me and said: 'This is supposed to be a room for quiet work although you wouldn't think it, would you?' (Laughter from the other clients in the room.) 'It's the only room here where you get intelligent conversation.' The other clients echoed this with a chorus of 'yes' and 'that's true'.

And:

> Several women were sitting sewing. I was discussing their work with them. One woman said 'It's positive in here. That's what I like. There's nothing worthwhile out there' (indicating the lounge).

And:

> Mrs Livingstone, an elderly and slightly disabled client, was talking to me about the basketwork that she did every week. She suddenly introduced other clients into the conversation: 'Many of them could do basket-work or cook or sew if they wanted to. Their hands are good enough. They just can't be bothered. They annoy me.'

While active clients held this view of their superior status compared with the non-active, many of the latter accepted this. This was sometimes expressed in the form of a jealous rejection of the active in a voice that gave the lie to the sentiment:

> An elderly woman was sitting in a chair in the lounge on her own. I was on my own at a neighbouring table. Nearby, a group of five women were cutting felt in preparation for carpet-making. After watching them for a few minutes, the lone woman turned to me: 'They're making a carpet. I'll believe that when I see it.'

And:

> Two men sat together in the lounge every week and watched the other clients. I asked them whether they had ever joined the woodwork group. One replied: 'Join them? No, lad, we wouldn't join them. They think they're too good for us.'

And:

> The Discussion Group was discussing activities for the blind. Mrs Crosland, an elderly representative, expressed a sentiment echoed by others: 'I think it's marvellous the way the blind members do all these activities. It's a pity some other members don't follow their example. A lot of them just won't bother and let themselves go.'

The Centre was, then, orientated towards organised activities. One must recognise that the Officer-in-Charge had a difficult task in achieving a balance between active and non-active clients. On the one hand, one must ask why it should have been regarded as more worthwhile to be engaged in a formally organised activity than to sit reading, knitting, talking, playing dominoes, or just sitting and watching other people. Certainly, one might be critical of the amount of interaction with staff that 'active' clients had compared with 'non-active'. On the other hand, if the activities had not been promoted and allowed to run down, the Centre would have become a very passive place and one would question the quality of life within it. On one occasion, these question were recognised and pursued at the Discussion Group:

A discussion was taking place on the relative involvement of men and women in the Centre's activities.

Miss White, an elderly representative: 'The men don't fit in any groove.'

Mrs Crosland, another representative: 'I don't know why they don't do some work.'

These comments upset Mr Gleave, a forty-five year old disabled man: 'What's the phobia for work? People come here for company. Why can't someone come here just for a talk?'

Mrs Crosland: 'Some people sleep all day. They're not enjoying the company.'

Miss White: 'There's got to be work. If there wasn't work there couldn't be the sale of work and then where would the money come from?'

Mr Ellis, a blind representative: 'I endorse what Bennie (Gleave) says. But even if someone comes along and does nothing it may be better than what they're doing at home. They may not get up all day, or get dressed or draw the curtains.'

Before leaving the issue of the status accorded to activities, one must ask whether there is any evidence to suggest that clients who took up activities at Suilven House continued those activities either at home or in other contexts (for example, in other clubs or with friends) outside the Centre. In an attempt to establish this, all the clients taking part in formal activities on two separate days in one week were asked: 'Do you do any basketwork (or whatever activity the client was doing when asked) at any place other than Suilven House?' If the answer was 'no' the client was prompted with the further question by the way of clarification: 'Not at home or with friends in another club?' Clients who answered 'yes' to the first question were further asked where else they carried out the activity. All interviewees were asked whether they had taken part in that activity prior to their joining the Centre. The results are shown in TABLE 21.

TABLE 21

Involvement of elderly clients in activities outside Suilven House

| | |
|---|---|
| Number claiming to take part in the activity at a place other than the Centre | 13 |
| Number claiming not to take part in the activity at a place other than the Centre | 27 |
| No response[1] | 1 |
| TOTAL | 41 |

1 A confused woman was unable to respond to the question.

Of the thirteen clients who claimed to take part in the activity at a place other than the Centre, eight were sewing and five cooking. All thirteen of these clients said that they had taken part in the activity prior to joining Suilven House. Of the twenty-seven clients who claimed not to take part in the activity at a place other than the Centre, fourteen had taken up the activity at Suilven House and ten had taken part in it previously. The remaining three were unable to answer the question.

There is, therefore, no evidence to suggest that clients pursued, in any other place, activities they had taken up at the Centre.

It is notable that, despite the importance attached to client activities, client-initiated pastimes were not encouraged. Opportunities for such encouragement existed but were not pursued. For example:

> Mrs Harding was an elderly woman who was both fit and active. One Wednesday morning she was one of the first clients to arrive. There were four other clients in the lounge when Mrs Harding moved to sit at the lounge piano and started to play accurately and not loudly. After a new minutes David (Caretaker/Care Assistant) came past: 'I think that's enough Mrs Harding. Why don't you come and do something else?'
>
> Mrs Harding smiled and continued playing. David passed by. Mrs Harding started to sing and was immediately joined by another lady. David returned and stopped by the piano: 'I said "that's enough" Mrs Harding.' He slammed the piano lid. 'Now go and sit with the other ladies.'
>
> He stood and waited until Mrs Harding had sat elsewhere.

One might have some sympathy with David's position. After all, it was not possible to play the piano without the possibility of disturbing other clients although there was no evidence that the few other clients in the room were bothered by the playing. There were other instances of clients initiating pursuits that were no threat to the peace of other clients but these were allowed to continue without attempts by the staff to encourage other clients to join in. Cards and domino-playing were pastimes that regularly took place between small groups of two or three members seated in the lounge.

The policy of staff non-involvement in informal pastimes is one that may be strongly defended, although there is no evidence that such a defence had been considered by the staff. The defence may be that some clients were likely to prefer initiating their own pursuits as part of a large organised group. If the staff had attempted to capitalize on these informal pursuits their attraction to the original participants may have been lost. The weakness of the Centre's position was that these possibilities had not been thought through; client-initiated activities were not pursued through default rather than as a consequence of an adopted policy.

In addition to the regular activities of the Centre, there was a range of extra-curricular activities. 'Extra-curricular' is used in the context of this study to describe activities that were offered either occasionally or on special occasions. These were sometimes compulsory in that it was almost impossible for a client to avoid some involvement with the activity but more often were optional.

Two examples of extra-curricular activities demonstrate both the range and the similarities of the activities. These were the Christmas party and a day trip to a public house.[1] Their similarities were that they were initiated by staff but discussed at an embryo planning stage with clients at the Discussion Group, they were focal points for discussion some months before and after the events, they were repeated on several days during the same week to ensure that all clients had the opportunity to participate and they were both heavily subsidised from the comforts fund.

1 The annual holiday may be an important third example but as the writer was unable to participate in it, it is excluded from the study. Each year a group of clients along with two or three members of staff spent a week in a Colwyn Bay guest-house. The holiday was organised by the Centre but paid for by the clients, the only Social Services Department financial input being the provision of a coach to transport clients to and from the resort.

There were two major dissimilarities. First, the time of the Christmas party was dictated by the calendar and was an annual event while the day trip was an isolated event. Secondly, it was impossible for a client who was present at the Centre not to be involved with the Christmas party whereas the day trip was an entirely optional activity. Nevertheless, the staff put pressure on some clients to ensure that they attended on one of the days the party was held. During the weeks before the party they drew up lists of the clients who were to attend each day. Sometimes they were not met with enthusiasm:

Joe (Care Assistant): 'I can put your name down for the party, can't I love?'

Mrs Willis: 'I'm not sure.'

Joe: 'What do you mean, "you're not sure?" Of course you'll come!'

Mrs Willis: 'Well I don't know what I'll wear and my leg's playing me up still.'

Joe: 'Wear the dress you wore last year. You enjoyed it last year, didn't you?'

Mrs Willis: 'Yes.'

Joe: 'Right, I'll put your name down this year.'

She walked away. Mrs Willis did attend the party.

The Christmas party was repeated on four days of the week. Clients who normally attended on more than one occasion per week were limited to one day and those who usually only attended on Friday (the one day a party was not held) were allocated an alternative day to attend. This involved a major reorganisation of transport in addition to the extra work for the staff in both the organisation of the activities and coping with some twenty per cent more clients per day than usual. The catering staff, for example, had to cook extra meals and were at the Centre at seven o'clock in the morning to light the ovens.

Each party day followed the same pattern. On arrival, which was somewhat later than usual, clients were provided with paper hats in addition to the usual cup of tea. Women clients, and some of the men, had gone to considerable trouble to dress smartly and many had been to the hairdresser. Usual client activities were suspended for the day and clients sat excitedly talking in the lounge until approximately 11 30 am when alcoholic drinks (beer, sherry, port, cider) were served by the staff. Staff then distributed small gifts to the clients and at 12 30 pm they sat down to lunch which was also served by staff. In the afternoon the clients were entertained by a concert which featured sketches by staff, carols sung by a small group of clients who had been rehearsing for several weeks, and by a singing, story-telling monk from a nearby monastery. The entertainment ended at approximately 3 30 pm when tea was served before the clients went home.

The party was important as a social event that had a unifying effect on the clients. Clients who, for the majority of the year, were social isolates joined with other clients in both the organised activities (such as pulling of crackers) and the informal talk of the day. Secondly, the party provided a purpose in life for some of the clients for several weeks before the party and a topic of conversation for the majority of clients for many weeks afterwards. An example of the pre-party interest was provided by the client choir. The participating clients were all volunteers who had been rehearsing for two months before the party. The rehearsals were conducted by one of the volunteers who practised with the singers for an hour on each of three afternoons per week. It is notable that only one of the choristers was a client who did not regularly take part in other activities. The choir provided a specific focus for clients who were otherwise engaged in activities - it did not provide a focus for clients who would otherwise have been non-active.

The party provided a topic of conversation for clients for many weeks afterwards. In some cases there was a common experience that clients could relate to:

> On 21 January, Mrs Edwards was sitting at a table in the lounge with two other elderly women clients. None of them had spoken since they arrived separately more than fifteen minutes previously.
>
> Mr Edwards broke the silence: 'That party was good. I did enjoy it. Everyone was singing "One man went to mow".' The other two women replied to this observation and a rather broken conversation continued for almost half-an-hour. Although the conversation moved on to other topics, every time the conversation died, it was reopened with a reference to the party.

The writer's last recorded reference to the party was on 18 March:

> I had arrived at the Centre at 10 15 am before the majority of the clients arrived. I sat at a table with Miss Jones and, despite several attempts, I was unable to engage her in conversation. After a long silence she turned to me and said: 'Do you know, that was the best Christmas party I've been to since I stopped nursing. You were there, weren't you? You brought the wine round.'

The day visit to the Wheatsheaf pub was not on the same scale as the Christmas party, nor did it have the same long-term influence on the clients. The visit was the idea of one of the care assistants who discussed the possibility with the Officer-in-Charge. She was enthusiastic and, in turn, raised it at the Discussion Group where the idea was developed.

The purpose of the visit was simple; to provide an opportunity for clients to spend a day away from the Centre. The Wheatsheaf was chosen as a destination as it was far enough away from the Centre (8 miles) for the clients to feel they were going to a different town and yet it was close enough for travel costs to be low. There was a visit every day of the week with a maximum of twenty clients going each day. The cost was £1.50 per client to cover travel and lunch at the Wheatsheaf. Clients were selected on a 'first pay, first come' basis. Although no records were kept, it is probable that demand exceeded the places available by some thirty per cent. The organisation of the visit was informal. Two Centre ambulances left Suilven House at 11 am with the clients and two members of staff in addition to the ambulance crews. Drinks were served on arrival at the Wheatsheaf and the clients then sat down to lunch. Lunch was a slow meal and, after it was finished, clients were driven back to the Centre.

Two reasons may be advanced for the Wheatsheaf visit not having the same impact on Centre life as the Christmas parties. First, the Christmas party was part of wider, societal celebrations and the Suilven House party surely captured some of its excitement from that generated elsewhere. The Wheatsheaf visit was an isolated social event with nothing outside the Centre (nor the build up of Christmas decorations and fringe activities within the Centre) to reinforce it. Secondly, the Wheatsheaf visit was only attended by a minority of the Centre's clients whereas the Christmas parties received almost one hundred per cent support. Most of the clients who regularly took part in activities went to the Wheatsheaf. They were the first people to put their names on the list of clients wanting to go and, as demand was so great that all places were filled without the staff having to try to encourage less enthusiastic clients to go, the more retiring or isolated clients were not encouraged in the way some of them were encouraged at Christmas.

Before leaving the subject of activities, one question to which the writer frequently returned during the participant observation should be raised. That is, in what ways were the activity-groups similar and in what ways different, from groups engaged in similar activities but in different social settings. How, for example, did the basketwork class differ from the basketwork class at an evening institute? This is not a question that can be properly answered without research. However, the writer's impression was that there was a great similarity between the activities at the Centre and those in other organisations where the participants voluntarily engage in activities which involve some instruction. The pace may have been slower with the participants spending a higher proportion of time talking to each other instead of 'working' and they may have spent more time sitting and watching the world go by. Nevertheless, the activities essentially involved instruction with the social relationships that implies.

Client interaction

It has already been shown, in the context of activities, that many clients regularly took part in the same activity week after week. In doing so, they inevitably interacted with other clients who chose to take part regularly in that activity. However, little has been said of the relationships between clients who did not participate in activities or of the ways in which groups were formed and maintained. It became apparent at an early stage in the research that there were regular groupings of clients and that they invoked strategies to make it difficult for unwanted clients to join them.

It is possible to identify two different kinds of client groups; 'settled' and 'roaming' groups. 'Settled' groups comprised clients who associated closely with each other throughout a day and whose membership was similar from one week to another.

These groups were often activity-based in that four or five clients who took part regularly in (for example) woodwork classes sat together in the lounge on arrival in the morning, went to the woodwork class together, talked to each other while working, lunched together, sat together after lunch and worked together during the afternoon woodwork session. However, a 'settled' group was not always activity-based. Some groups of men or women clients associated regularly but spent the morning or afternoon session talking together, playing dominoes or sewing rather than being members of an organised activity group. Equally, there were clients who regularly took part in the same activity but who were not members of a settled group. Such members may have talked with one association of clients on arrival, taken an active part in the morning session of the woodwork class without talking to other clients, joined a different association of clients during the afternoon woodwork class.

A 'roaming' group was an association of clients who did not form the same group every week or necessarily the same group during both morning and afternoon sessions. Roaming groups formed and reformed into new formations two, three or more times a day. A roaming group may be distinguished from an association of clients by the degree of social interaction between its members. Roaming groups of members were formed through members choosing to group together or because they had a common purpose. However, a roaming group may be distinguished from an association by the fact that members remained together through choice and interacted with a shared purpose. This may have been a discussion of something that was of common interest, the playing of a game or participating in an activity. An 'association' comprised a number of clients in close geographical proximity but whose social interaction was limited to occasional interchanges rather than discussion.

In addition to the two kinds of groups and the associations there were isolates who spent a high proportion of their days alone but joined associations for part of the day (for example, lunch) and possibly roaming or even settled groups for part of the day. The last possibility was rare and the majority of isolates were never members of either kind of group.

The distinctions between settled groups, roaming groups, associations and isolates were not readily quantifiable but may be illustrated by following three clients on separate days at the Centre.

The first client, Mrs Lily Jones, was a member of a large settled group of six/seven members:

10 15 am

Arrived. Sought out other members of the group. Two had already arrived and were sitting at a table in the lounge drinking tea and talking. Mrs Jones joined them. **Settled Group**

10 25 am

Two other members of the group arrived by the same ambulance. They joined Mrs Jones and her two friends. **Settled Group**

10 50 am

All five members proceeded together to the basketwork class. They sat and talked together while they worked at the basketwork. **Settled Group**

11 50 am

Mrs Jones and two other members of the group went to lunch together where they sat in neighbouring chairs. **Settled Group**

12 40 pm

Mrs Jones left the other members of the group and moved to sit in a chair in the lounge with two other ladies she knew by name but to whom she had not spoken during the morning. They sat and discussed the Centre, the news and local gossip. **Roaming Group**

1 30 pm

Mrs Jones left the lounge to rejoin the basketwork class which was about to resume. She rejoined the clients she was with during the morning and remained with them for the rest of the day. **Settled Group**

The second client is Mr Faulkner:

10 am

Arrived and sat at a table alone. **Isolate**

10 10 am

Mr Cotterill arrived, saw Mr Faulkner and joined him. The two men knew each other and talked, on Christian name terms, about the previous night's football. **Roaming Group**

10 30 am

Mr Owen arrived and joined Mr Cotterill and Mr Faulkner. The subject of the previous night's football was re-opened. **Roaming Group**

10 50 am

Two men at a neighbouring table were about to play dominoes. They looked round the room for someone to join them and saw Mr Faulkner. One of them invited Mr Faulkner to play. He accepted and moved to their table. The three of them played dominoes for the remainder of the morning. **Roaming Group**

12 pm

The three men went their different ways for lunch. Mr Faulkner took the last place at a table. He appeared not to know any of his companions at the table and engaged only in polite conversation. **Association**

12 34 pm

After lunch Mr Faulkner sought one particular client with whom he sat and talked in the lounge. **Roaming Group**

1 30 pm

A care assistant announced that it was time for the play-reading class to meet. Mr Faulkner was a member of this and he joined it for the remainder of the afternoon. **Roaming group**

Finally, Mr Caldwell:

10 40 am

Mr Caldwell arrived and sat with two women at a table. The two women took little notice of him and he did not attempt to join their conversation. **Isolate/Association**

11 10 am

Mr Caldwell went to the toilet and, on return to the lounge, chose a seat in the corner. He sat alone. **Isolate**

12 pm

A care assistant told Mr Caldwell that it was time for lunch. He moved to a table and sat down without appearing to choose it on the basis of which other clients were seated there. He engaged in polite conversation only. **Association**

12 30 pm

Mr Caldwell returned to the seat he had occupied immediately before lunch. Other clients sat in neighbouring chairs but they did not engage in any conversation. Mr Caldwell stayed in the chair for the rest of the afternoon without speaking to anyone other than a volunteer when she brought him a cup of tea. For a high proportion of the afternoon Mr Caldwell was asleep and his only change of environment involved two visits to the toilet. **Isolate/Association**

It was stated in the discussion of activities that the same individuals took part regularly in the same activities. As one might expect, these individuals were often members of settled groups. As such they invoked mechanisms to maintain the group boundaries and to exclude unwanted clients from joining the group. In some groups there were one or two central members and their decisions were the major factors in determining the movements of the group. Mrs Lily Jones, who was quoted in an example above, was one such member and two examples demonstrate her influence on one group:

> At 9 45 one morning four members of the group had arrived at the Centre. Two members (Mrs Livingstone and Mrs Taylor) were sitting talking together at one table while the other two (Mrs Gill and Mrs Boot) were talking together at another table. Mrs Jones arrived later than usual at 10 50 am. She went to the table occupied by Mrs Livingstone and Mrs Taylor. Immediately, Mrs Gill and Mrs Boot picked up their cups of tea and belongings and went across to join the other three women. They then remained together in one group for the remainder of the day.

And:

> After leaving the morning's craft class Mrs Livingstone, Mrs Taylor, Mrs Gill, Mrs Boot and Mrs Jones moved towards lunch. Mrs Jones stopped off to go to the toilet and, when she reached the dining room, there was no vacant seat at the table occupied by the other women. Mrs Jones sat at another table. Despite the fact that the other four women finished their meals before Mrs Jones, they remained at their table until Mrs Jones finished and rose from the table. As she walked across to take a seat in the lounge area, the other women rose and joined her. The five remained together for the afternoon.

Settled groups adopted mechanisms to discourage unwanted outsiders from joining the group and these were often quite crude:

> Early one morning, while clients were still arriving, all four members of a settled group were sitting together at a table which was close to the door. One of the group (Reg) saw another man enter the room.
>
> Reg: 'Morning, Francis. Not a bad day.'
>
> Francis: 'Good morning, Reg. Very nice.'
>
> Francis interpreted this greeting as an invitation to join the group and he walked towards their table. As soon as he saw that Francis was going to join him, Reg turned round so that his back was towards Francis. Another member of the group pushed away the one vacant chair at the table and all four men adjusted their chairs so that there was no room for an extra chair at the table. The members of the group continued their conversation totally ignoring Francis. Francis stopped, looked at the group for a few seconds and went to sit at another table.

On occasions, a settled group had to accept the presence of an outsider but often the outsider was ostracised:

> A settled group of five women was seated at a table in the lounge. One of the women (Nancy), who was confined to a wheelchair, left temporarily to speak to someone at another table. While she was away David, the Caretaker/Care Assistant, wheeled another woman (Mrs Williams) in a wheelchair across to the space vacated by Nancy. One of the women in the group protested: 'That's Nancy's place, David.'
>
> David: 'It doesn't matter. First come, first served. Mrs Williams is lonely; nobody talks to her.'
>
> The other women at the table 'tutted' in annoyance and David left. The group members resumed their conversation without involving Mrs Williams.

Ten minutes later Nancy returned. The two members of the group either side of Mrs Williams pushed her chair backwards so that there was room for Nancy to rejoin the group. This she did and Mrs Williams left.

It was not always necessary for the group to demonstrate so forcefully that an outsider was unwelcome. Sometimes outsiders were aware of the existence of a group and of its membership and, consequently, they chose not to risk being positively excluded:

At 10 am, Nancy and Daisy were the only members of a settled group to have arrived at the Centre. They sat at a table talking to two other clients, David and Flo, who were not members of the group. At 10 20 am, two other members of the settled group arrived and were welcomed by all four of the clients seated at the table. Flo immediately rose and left to move to another table and as soon as the new arrivals sat at the table David also moved.

On other occasions, members of established groups invoked Centre rules to prevent unwelcome clients from joining them. A rule that was often invoked concerned the numbers of clients that were allowed to sit at a table in the lounge. As a consequence of clients moving chairs in order to form large associations which prevented movement around the lounge, the Officer-in-Charge introduced a rule that no more than six clients could sit at a table. The rule was rarely enforced by staff although it was invoked by client groups when it suited their purpose but was ignored when it did not:

A settled group of six women were at a table when a seventh (Mary) approached. Iris, one of the seated group, said 'You can't sit here. There's already six at this table.' Mary accepted the statement and went to another

table. Some twenty minutes later, Molly, another member of the settled group entered the room.

Iris called across to her 'Hello, Molly. Come and sit here.'

Molly: 'I can't. There's six here. You can't have more than six at at table.'

Iris: 'Oh, don't worry! That doesn't matter. Come and sit down.'

Iris pulled up an extra chair and joined the group.

However, settled groups did not always reject outsiders. Sometimes they were allowed to be peripheral members of the group. This was often the case if the settled group was very coherent and as long as the outsiders were prepared to recognise their peripheral positions and react to the group rather than try to launch initiatives. For example:

Win, Annie and Ida were the members of a settled group who stayed together throughout their time at the Centre. At 10 15 one morning the three were sitting together at a table when a fourth client arrived and joined them. The fourth member was politely greeted and remained in the group but did no more than support the comments made by the other members. A fifth client joined the group and was treated/behaved in the same way as the fourth. There were now no vacant chairs at the table. After some twenty minutes the fifth client left and his place was immediately taken by a sixth client. A few minutes later the fourth client left and his place was taken by a seventh client. Both the newcomers were treated/behaved in the same way as the other peripheral clients. At 11 am Win, Annie and Ida decided to go to the pottery class. The peripheral clients remained in the lounge but went their separate ways.

Thus, settled groups were sufficiently stable to be able to re-form weekly. Roaming groups, however, by definition, lacked this stability. Three distinct ways by which they formed, and sometimes developed into settled groups, may be identified:

1 The staff directed clients into groups. This often took the form of a member of staff suggesting to a client on arrival or to a client who was sitting alone 'Why don't you go and sit with x?' This more commonly happened when the member of staff was able to identify an acitivity in which the client was interested. For example:

> Mrs Hall was sitting alone in the lounge when Anne, a care assistant, saw her. She walked across to Mrs Hall: 'Are you on your own, love?' Don't you want to do some sewing this morning?'
>
> Mrs Hall: 'I don't mind.'
>
> Anne: 'There are some ladies downstairs making some toys and aprons for the sale. We'll go and join them, shall we?'
>
> She picked up Mrs Hall's bag and accompanied her to the sewing room where she found her a seat.
>
> Anne: 'Here you are, love. You sit here with Mrs Ashbridge and Miss Garner.'
>
> Mrs Hall sat down and the three women spent the rest of the morning working and talking together, went to lunch together and continued to work together in the afternoon.
>
> The following week the three women did not again form a group. Mrs Ashbridge and Miss Garner again sewed but with different partners.
>
> Mrs Hall did not take part in any activity and spent most of the day on her own.

The greater the degree of a client's immobility, the greater the influence staff may have had on the formation of a group. Some clients were wheelchair-bound and had difficulty in propelling their own chairs. Other clients moved with the aid of a stick but required further help from a member of staff if they had to move more than a

few paces. The relationship between staff and immobile clients is examined later, but it is important to suggest here the influence that staff had on immobile clients in the formation of a group. There was, for example, a settled group of three men who played dominoes together every week. Two of these were elderly, one was not, but all three were chair-bound. Each week, David (Caretaker/Care Assistant) wheeled the three men to the same table without asking whether or not they wished to play dominoes that particular week.

2 In some cases, staff did not encourage clients to join groups in the manner discussed above but the presence of a particular member of staff at a certain activity led to clients forming a group around that particular member of staff. This was similar to the process popularly thought to take place in schools where pupils choose to follow one subject rather than another because they prefer the teacher, not because they have a greater interest in the subject. For example:

Anne, a care assistant with expertise as a knitter, entered the room where a sewing/knitting class was being held. She stopped and sat next to Mrs Hughes who was having difficulty with a pattern. Miss White, at the far end of the room, saw that Anne had arrived and called to her 'Will you help me Anne?'

Anne: 'All right. As soon as I've finished here, darling.'

Anne moved to the end of the room to help Miss White and was followed by Mrs Hughes who took her possessions with her and occupied a seat next to Anne. While helping Miss White, Anne and the two clients held a conversation.

A few minutes later Mrs Swetman entered the room. She could not see Anne at the far end and asked a client seated by the door 'Is Anne here this morning?'

On being told that she was, Mrs Swetman went to join her. She knitted and joined the conversation of the other women. Although Anne left some twenty minutes later the group remained together for the rest of the morning and re-formed for the afternoon session.

3 In many instances, roaming groups were formed through the initiative of one or more clients. This may simply have been through one client occupying a free chair and initiating a discussion with a neighbour. On other occasions, positive efforts to form a group had to be taken by more than one client. For example:

> Mrs Jones was sitting alone cutting old material to be used as stuffing for toys. She was joined by Mrs Edwards who had been directed to the table by a care assistant. The two worked together sharing equipment and discussing various topics. Later, Mrs Jones saw that Mrs Riley was sitting in an association at a table nearby. Having attracted her attention, she called across to her 'Come over here'. Mrs Riley agreed and joined the other two women. Although she did not do any cutting of material, she stayed and talked with Mrs Jones and Mrs Edwards for the remainder of the afternoon.

Membership of roaming groups was not always won easily and, on occasions, roaming groups members rejected outsiders as brusquely as did settled groups. For example:

> Jean, who was knitting, and Hilda were sitting together. The two had been engaged in conversation for some twenty minutes when Flo sat down with them. Jean and Hilda ignored her for a few minutes. Then Jean became aware that Flor was watching her knit and said 'What are you staring at?' Flo looked at Jean in bewilderment and then lowered her eyes. A few minutes later, Jean turned again to Flo (who had no knitting with her) and said 'Get your own out of the bag and do yours.' Flo again lowered her eyes and then, when Jean resumed her conversation with Hilda, Flo quietly got up and walked away.

Associations included both clients who had been rejected by settled and/or roaming groups and clients who had no wish to associate with other clients at all but who were forced to sit in such associations by the physical limitations of the building which prevented their finding places to sit away from all other clients. Associations were thus comprised partly of clients with whom many other clients did not want to interact and clients who chose not to interact. Consequently, discussions were stilted or limited to polite exchanges as many of the 'rejected' clients in the association had not the social competence to maintain a conversation[1] while many of those who chose to be isolated had no wish to engage in a conversation. It was thus possible to be as socially isolated within an association as it was when one was geographically isolated. The social isolation was reinforced by the failure of the staff to be as involved with the isolates and associations as they were with the groups. This theme has been referred to earlier and will be returned to later. However, three points may be made following the discussion above.

1 One can only assume that in the majority of cases this competence existed in younger days but had been lost with age. However, in some cases, the individual may never have had this competence. One might speculate on a cycle of social incompetence with a higher proportion of socially incompetent people at the Centre than one would find in the general population of elderly. In such a cycle, the socially incompetent would be more likely to be socially isolated within the community without regular contact with relatives or friends. This social isolation would be one of the reasons for the person's referral and admission to the Day Centre where the incompetence which resulted in her isolation in the community also resulted in her isolation within the Centre.

First, groups were more likely to be involved in activities than were associations and isolates. As staff spent most of their time engaged in activities (partly through choice, partly a consequence of the staffing policy of employing instructors) it follows that they were more likely to interact with groups than associations or isolates. Secondly, groups were better able to put pressure on staff to interact with them when they wanted them to. This was partly a consequence of the combined strength of group members and, possibly, partly a consequence of the social competence of the members which resulted in their being able to attract the member of staff to the group originally and then to retain him. Thirdly, many isolates had no more wish to engage in conversation with staff than they had with other clients. They discouraged staff advances as they discouraged client advances.

In the literature on the social organisation of different kinds of institutions, there is often reference to one dominant group which defines the norms of the institution. (See, for example, Polsky 1965.) At Suilven House, there was no evidence of the existence of one such dominant group. There are many possible reasons for this including the possibility that clients who only attend a partial institution one or two days per week are less likely to be able to establish dominance than full-time members of total institutions. At Suilven House, not only was there no dominant group, but the members had very little knowledge of any other clients apart from those who were members of their own settled group or who were frequently members of the same roaming group. This extended to ignorance of the most basic knowledge of another client; her name. One frequently heard one client refer to another as 'that lady' rather than 'Mrs X'. Despite the size of the daily membership, many clients did not know whether other people at the Centre were clients or visitors. This even applied to the Discussion Group representatives chosen by the Officer-in-Charge in part at least for their ability to represent the views of all the

clients who attended on the same day as themselves. One example illustrates both this and the self-attributed status of clients engaged in activities:

> Mrs Robertson was one of the two members representing clients who attended on Wednesday. She had been attending the Centre since April 1978. On Wednesday 21 January 1981, Mrs Robertson was leaving the dining room when she met Mrs Williams. Mrs Robertson stopped and addressed her: 'Hello dear. Are you new today?'
>
> Mrs Williams (a member since March 1979): 'No. I've been coming a long while.'
>
> Mrs Robertson: 'Oh! That's what comes with working. I'm always busy next door' (indicating the sewing room) 'so I don't seem any of the people who stay in here.'

And:

> Mrs Lil Jones had been a client since October 1978 and represented the Tuesday attenders on the Discussion Group. On 6 January 1981, she commented to another member of her settled group on the number of 'new clients that are in today'. In fact, owing to the policy of suspending admissions over the Christmas period, there had not been a new client admitted for four weeks.

Some clients, notably those who were noisy or had noticeable idiosyncracies, were superficially known to many other clients but rarely by name. Settled groups of clients devised nicknames for themselves and for some of the other clients. These names permitted the discussion of the other clients but maintained a social distance between the discussers and the discussed. For example, Mrs Lil Jones, referred to above, introduced herself to the writer:

> 'I'm Clean Lil. Everyone calls me clean Lil to distinguish me from Dirty Lil. Even the ambulance driver calls me Clean Lil.'

And:

> One client was walking past a table at which sat an elderly man. She stopped and spoke to him: 'Scrounger's not pestering you today?'
>
> Elderly man: 'No. I've seen him but he's not been over for any cigarettes yet.'

And:

> I was sitting drinking tea after dinner with a group of five elderly men and women clients. One of them stated 'I haven't seen Scallywag today.' Other members of the group agreed that Scallywag had not been seen. The original speaker turned to me: 'Do you know who we mean?' I confessed that I did not and all five clients roared with laughter. It emerged that Scallywag was the nickname give to a spastic client who was unable to speak coherently or quietly and whose arms moved vigorously as she spoke.

Although the knowledge clients had of each other was limited and nicknames were invoked to identify certain clients, ther was no evidence that this was in any way sex specific. In fact, an analysis of sexual interaction suggests that most associations and groups of clients contained a sexual mix except for groups involved in activities that are traditionally sex specific. For example, no men took part in the sewing class and no women in the woodwork class. However, despite the sexual mix of clients the greatest interaction took place between clients of the same sex. Interaction between sexes was rarely overtly sexual and then only in a light-hearted manner and often with the initiative being given by a member of staff. For example:

> Ann, a care assistant, helped an old woman to a table at which a male client was seated. Ann, to the man: 'Here's your girl friend. I've brought her across to see you.'
>
> Old woman: 'I've got another boyfriend as well. They're both my boyfriends.'
>
> Old man: 'Oh! I'll give up then!'

Old woman (to Ann): 'I'd marry him if I was younger. But I'm old enough to be his mother.'

Ann: 'How old are you? 91?'

Old woman: '93.'

Old man: 'Well, I'm 84.'

Ann: 'Oh, that's much too young.'

The very little physical contact that existed between clients was usually a desire for physical contact with another person; not for physical contact with a person of the opposite sex. This was evidenced by the regular attempts to kiss, cuddle or hold the hands of members of staff. Some, but not all staff, were willing to have their hands held by clients but all staff were unwilling to allow the physical contact to go beyond hand-holding. Client attempts at other forms of physical contact were resisted:

> Flo, a wheelchair-bound client, was talking to Joe (Care Assistant). She unexpectedly reached up, put her arms round Joe's neck and tried to kiss her. Joe immediately forced herself free and said 'Don't put lip-stick all over me. It's like an orgy, this.'

Only on two occasions was there any physical contact between clients that could be regarded as sexual. On both occasions, this drew comment from other clients:

> The ambulance was on its morning round collecting clients. Grace got in and sat next to Mr Ellis, an elderly blind man. Mr Ellis greeted her: 'Here she is. Here's my girl-friend.' Grace held his hand and they sat holding hands for the remainder of the journey. Neither the driver nor the assistant commented but every client who got on made an observation: 'None of this!' or 'What's all this?'

On the other occasion staff commented as well as other clients:

> Cyril and Freda were sitting in neighbouring chairs in the lounge after lunch. Although they had not been engaged at all in conversation Cyril reached for Freda's hand and they sat holding hands. They took no notice of comments from other clients such as 'Aye, Aye!' and 'Surely not here' or from a passing care assistant who commented 'Well! I am surprised at you at your age.'

With both pairs of clients the contact was an isolated incident. Although Grace and Mr Ellis travelled together weekly and spoke to each other on the journey, they did not associate with each other at the Centre and the researcher did not again see them in any form of contact. He did not see Cyril and Freda speak to each other on any other occasion.

Subjects of conversation

The most popular way for clients to spend their time was to talk to other people; clients, staff or visitors. The subjects of their discussions provide insights into the interests of old people and the issues that concern them. These insights are of value to persons working with the elderly. For example, they may help the staff of a Centre decide which activities to introduce, the ways in which the organisation might support the clients or create structures that will help allay their fears.

At Suilven House, the clients talked about each other, their activities and what they had read in the newspapers. They had a particular interest in newspaper articles which referred to events of the past. Several clients regularly cut from the local paper the weekly feature 'From 25 and 50 years ago' which they showed to, and discussed with, each other. Apart from the emphasis on the past, these articles focussed on subjects that one might expect to be frequent topics of conversation amongst social groups of any age. Four themes were returned to so regularly by Suilven House clients that it is an unescapable conclusion that these themes were of particular concern to the clients. The themes, which will be considered separately, were being old, health, death and the need to be needed.

In the literature review at the start of this work, various sociological approaches to old age were discussed. Rose's (1965) view of old people developing a sub-culture with a shared set of beliefs was discussed. Wilson's (1973) criticism of Rose that, in general, the old disavow their status as elderly by retaining youthful self-images was also discussed. In providing Suilven House as a specialist facility for the elderly, Westshire Social Services Department helped legitimise the sub-culture of old age. However, the way in which they legitimised them was formally to identify them with the physically handicapped by providing a joint usage facility. Little support for

Wilson's criticism is available from the discussions the present writer heard at the Centre. In fact, only one comment (a complaint from a ninety-three year old woman that she had been placed in a geriatric ward during a stay in hospital) could be interpreted as indicating that an elderly person had retained a youthful self-image. Conversely, conversation regularly indicated an acceptance of old age and the physical limitations that accompany it. For example:

> Mr Done was sitting at a table alone when Mr Edge joined him. Mr Edge sat down with some difficulty and exhaled in a manner that indicated that sitting down had tired him.
>
> Mr Done: 'Are you not so well today?'
>
> Mr Edge: 'I'm well enough. I'm not so young as I was so why should I try to pretend I am?'

And:

> Two women were about to leave the sewing room at the end of the day. Although their sewing equipment and materials had been on the tables in front of them since they arrived from lunch nearly two hours earlier, they had been asleep most of the afternoon and, when they had been awake, they had spent their time talking to each other or watching the other clients. One woman (Flo) laughed and said to the other (Molly) 'Fat lot we've achieved today!'
>
> Molly replied: 'We're not here to achieve things. Not at our age. We're here to enjoy ourselves.'
>
> Flo: 'That's right. We've achieved enough in our time. We'll leave that sort of thing to the youngsters.'

The Centre staff reinforced the clients' views of themselves as old. For example, one of the care assistants had a special talent as a cartoonist. Two of his cartoons were prominently displayed in the entrance hall. One showed two very old horses in a field. The horses were taking no notice of a nearby filly and one was saying to the other 'At our age we have less and less trouble resisting temptation'. In the other

cartoon, two very old men were standing beside a snooker table. Both men had very long beards, were bent almost double and required walking sticks to remain standing. One man was asking the other 'You going to play, Old Joe?'.

Whilst there was a general acceptance of old age and the limitations that accompany it, there were various responses to the second subject of conversation - health. Some clients were pre-occupied with aspects of their health. Mr Caldwell was one such client. He was a fit-looking man of eighty-four who normally sat alone. He was mentally alert but was incontinent, a fact which he immediately told anyone who talked with him. The following conversation is typical of the many that the researcher had with him:

> Mr Caldwell was sitting alone at a table at the back of the lounge shortly after lunch. I stopped to talk to him.
>
> M Taylor: 'Hello, Basil. How are you?'
>
> Mr Caldwell: 'I'm OK but I'm incontinent as you know.'
>
> Mr Caldwell then explained how he first became incontinent and the difficulties he had with doctors who had failed to correctly diagnose his complaint and then to provide him with the correct medication.
>
> M Taylor: 'I'm going downstairs to the woodwork class. Are you coming down with me?'
>
> Mr Caldwell: 'I'd like to but it's too far from the lavatory. That's why I sit here. I have to be at the back of the room so that I can get to the lavatory very quickly. That's why I can't walk anywhere. I'd like to walk here but I have to come in the ambulance so that I'm not away from the lavatory for very long.'

Ill-health was often put forward as a justification for not taking part in activities. Other clients volunteered details of their illnesses in similar manners to Mr Caldwell. Often the client was suffering from only a very minor complaint. For example:

> After lunch, Mrs Douglas was sitting in the lounge as a member of a group of four clients. When the other three clients variously went to sew or sing, Mrs Douglas remained alone. I asked her whether she intended to take part in either of these.
>
> Mrs Douglas: 'I'd like to but I have trouble with my eyes. They run with water sometimes and I just cannot see what I'm doing.'
>
> Mrs Douglas's problem with her eyes certainly inconvenienced her when her eyes were running but this was infrequent and there was nothing to suggest that participating in activities brought on the problem.

And:

> Mrs Holbrook was a member of a stable group whose members regularly cooked in the morning and sewed in the afternoon. Mrs Holbrook was the exception in that she moved with the members of the group although she neither cooked nor sewed. She talked to the other members of the group while they participated in an activity. The instructors often asked Mrs Holbrook if she would like to take part but she always refused on the grounds of her migraine. One morning she did not wait to be invited: 'It must be nice to be able to do your own cooking. I used to be able to but my migraine's too bad now. It's only come on during the past few years but if I flit about at all it comes on. I just have to sit still. It's terribly annoying because I used to be so active. I keep going back to the doctor but he's no help. He just tells me it's my age. Well, that's wrong isn't it? There must be something he can do about it.'

While some clients saw their own poor health as a limiting factor and a subject which they introduced frequently into conversations, other clients took the view that physical deterioration was something that was inevitable with old age and their conversations reflected such acceptance. A frequent topic of conversation was the increasing difficulty in using their hands that some members suffered as a consequence of complaints that reduce dexterity. This phenomenon was accepted as part of becoming old. For example:

> I was discussing the attractions of basketwork with Mrs Livingstone, an elderly woman who took part in the class every Tuesday. She explained the advantages it has over some other activities: 'It's the one thing most of us can do with our hands now. We can't sew, it's too fiddly. Most of us can't even thread a needle! But we can do basketwork. It's difficult some days but we can hold the cane.'

A similar theme was developed by Mr O'Reilly who had tried to do some basketwork but gave up and spent his time at the Centre assembling wooden bird boxes:

> 'I had a go at basketwork for two or three weeks but I gave it up. You have to have awfully good hands to plait the weaving.'

There was an implicit assumption in Mr O'Reilly's comment, as in Mrs Livingstone's, that good hands are not the norm amongst the elderly. There was the same assumption in a comment made to another client by Mrs Lil Jones, a regular basketworker, about some of the members who were not taking part in any of the activities. She said:

> 'Look at them doing nothing all day. Most of them could do basketwork if they wanted to; their hands are still good enough. They just can't be bothered.'

Given the centrality of health as a topic of conversation, the number of members who had been seriously ill at some time in their lives and the visits made to the Centre by occupational therapists and district nurses, it is probably not surprising that, if a member was absent, other members assumed that this was because she was unwell. For example:

> Two elderly women were sitting together. One turned to the other and asked 'Is Mrs Connolly in today?'
>
> 'I haven't seen her.'
>
> 'She can't be well. I wonder what's wrong with her.'

Similarly, there was an assumption among clients that it was inevitable that they would have to enter hospital at some time:

> Miss Wright was the youngest client at the Centre. She had suffered from brain tumours which had necessitated several operations. On her return to the Centre after one operation she was talking to a group of elderly clients. One of these (Mrs Quinn) commented to Miss Wright on her loss of weight.
>
> Miss Wright: 'If you had to eat Walton's (a reference to Walton Hospital) food you'd lose weight.'
>
> Mrs Quinn: 'You're not giving a very good impression of Walton for when one of us goes in are you?'

The response of the Centre staff to the clients' major concern with health was, essentially, to ignore it. Members comments about their own health were greeted with non-commital comments such as 'not to worry' or 'what did the doctor say?'. There was a notice board headed 'Members in Hospital' but this was not used at all and throughout the period of the research no names or messages were posted on it.

The third regular subject of conversation was death. This was a subject which the writer heard discussed only following the death of a member but, as this was inevitably a frequent occurrence, the subject was discussed frequently. Although, without exception, everyone who spoke about death did so with a calm acceptance of its inevitability, the death of another client was greeted by some members as an opportunity to explore the subject. It was as if the subject were taboo at other times but the death of a client allowed a welcome opportunity to discuss the subject for a limited period. Some clients took the opportunity to demonstrate to other members that death was something they did not fear. Often, however, to the non-participating observer, there was the impression that the speaker was as much taking the opportunity publicly to explore her own feelings and to demonstrate her calm acceptance to herself as to others. For example:

> Two elderly women were sitting together at a table. Earlier in the day they had learned of the death of one of the clients. They had been sitting without talking for some time when one of them turned to the other.
>
> Mrs Williams: 'I'm not scared of dying, Ada.'
>
> Ada: 'Neither am I.'
>
> Mrs Williams: 'Well, if you've lived a good life, why should you be?'
>
> Ada: 'That's right. I've never done anything wrong.'
>
> Mrs Williams: 'I'm sure you haven't. You were a nurse for all those years helping people night and day.'
>
> Ada: 'That's right. No; dying doesn't worry me.'
>
> Mrs Williams: 'No. It doesn't frighten me either, Ada.'

And:

> The news of Mrs Holbrook's death the previous evening spread amongst the clients. In its telling the manner of her death (peacefully in her chair) became extremely distorted. Mr Harris broke the news to Mrs Chesters when she arrived. She appeared unconcerned at it.

Mr Harris: 'Did you hear that Mrs Holbrook died last night?'

Mrs Chesters: 'No. What happened?'

Mr Harris: 'Fell down the stairs. All the way from top to bottom. They found her lying there when they called for her this morning.'

Mrs Chesters: 'Well, when you're dead, you're dead. Doesn't make much difference how you die.'

Mr Harris: 'It's not going to matter to me when I'm dead.'

Mrs Chesters: 'Doesn't matter much to Mrs Holbrook now, does it? She's dead and that's all there is to it.'

Mr Harris: 'That's how I feel. You can only die once so it doesn't make much difference how it happens. It doesn't matter much to me how I die. I'm sure one way's as good as any other.'

Although many clients took the opportunity presented by the news of death to discuss their own positions in this way, other clients accepted deaths without comment, in many cases giving the impression that they had not heard the news. For example:

David (Caretaker/Care Assistant) took cups of tea to two elderly women and a man who had just arrived in the morning.

David: 'Did you know that Hilda has died?'

Miss Albert: 'No.'

David: 'Yes. Yesterday.'

Miss Albert: 'She was nice.'

David left the tea on the table and left.

The three people at the table started talking about a completely different subject. Miss Albert's had been the only comments on Hilda's death.

The example quoted above is typical of many in that one member of the group was just polite in her questions while the others took no notice at all of the death. Nobody asked how she died, when the funeral was to be or any of the other questions that are usually asked in such circumstances.

It was evident that for clients in the former category (those who explored the subject of death) the topic was frequently in their thoughts. The research diary includes many passing comments such as 'We'll have to make the best of it with what we have left,' and 'We'll be dead for an awfully long time'. One woman wanted to make a rug. She was shown how to make it but insisted on progressing inwards from the two ends. She explained that this was 'in case I'm not here next week'. In fact, she died before completion of the rug.

Given the client interest in death it was inevitable that staff would become involved in the subject. Their position was difficult but they did not always appear to appreciate how carefully the subject had to be handled. Even a sympathetic response by a member of staff sometimes led to alarm instead of peace. For example:

> Ann (a care assistant) was passing a group of five clients who were discussing the death of Mrs Frances Jones. One of the group asked Ann if she had heard the news. Ann replied: 'Yes, darling, I heard. Maybe it's for the best. She suffered an awful lot, didn't she? And she lived to quite an age. She was 82.' Ann moved on leaving a chorus of comments from the clients (four of whom were in their eighties) to whom she had spoken. One said: 'Eighty-two's not old.' Another: 'What does she mean, "quite an age"?' A third said: 'Was she only eighty-two?'.

Meals

Meal-times have important social functions in many organisations. They may allow people to meet with different social constraints from usual or allow people who would not otherwise meet to come together or allow subjects to be discussed which would otherwise be taboo. At Suilven House, meal-times ensured that clients who were socially isolated sat in close enough proximity to other clients for long enough that it was possible for them to engage in conversation. Meal-times also provided the only opportunity for certain selected clients to impose their authority on others with the formal sanction of the Centre staff. At meal-times, clients sat in groups of eight per table. Food for eight was brought to a table on serving dishes by care assistants and instructors. The dishes were in the charge of a monitor, who was responsible for serving the food. Monitors were chosen by the Officer-in-Charge and, although other clients could sit where they wished, a monitor was required to sit at the same table every week. The power that monitors gained from their position was jealously guarded. For example:

> Four dishes were simultaneously presented to the monitor at one table for serving. She had difficulty in serving from all four and one of the other clients offered to help.
>
> Freda: 'Would you like me to put the beans out?'
>
> Monitor: 'No. I'm dinner monitor. I'll do it.'

And:

> Warm dinner plates and dishes of food were put before the monitor at one table. A new client, unfamiliar with the procedure, picked up the plates and started to pass them round the table. The monitor, who had previously been handling them without any signs of discomfort, immediately collected up the plates and put them back in front of herself. She scolded the newcomer: 'Don't touch the plates. They're hot.'
>
> The newcomer was taken aback: 'I'm sorry. I thought I was helping.'
>
> Monitor: 'Well your're not. I'm the monitor. I'm the only one who's allowed to touch the plates.'

The Officer-in-Charge recognised the power that monitors had and she defended them. At the February 1981 meeting of the Discussion Group, disquiet was expressed by one client at the way in which the monitors carried out their duties:

> Client: 'I've been asked to see whether something can be done about some of the monitors. They take ages and by the time the last clients get their food, it's cold.'
>
> Officer-in-Charge: 'When I looked at the list of people who had volunteered as a monitor, I was surprised at the number of people who could have been a monitor but didn't volunteer. Now, if you don't volunteer yourself, you can't complain at the way someone else does it.'

Relations with the handicapped

At meal-times, it was common for handicapped and elderly clients to be seated at the same table. The relationships were not always happy for either party:

> Neville, a slightly disabled stroke victim aged fifty, approached David (Caretaker/Care Assistant) just before lunch.
>
> Neville: 'Can you move me from that table?'
>
> David: 'Which table?'
>
> Neville: 'You know which table!'
>
> David: 'I'll put you with the men.'
>
> Joe (Care Assistant), who had been listening: 'Don't you like sitting with the ladies?'
>
> Neville: 'I always have a cold dinner. "Pass me this, Neville. Pass me that, Neville." They're so old they can't do anything for themselves. I do everything for them and get a cold dinner for my trouble.'

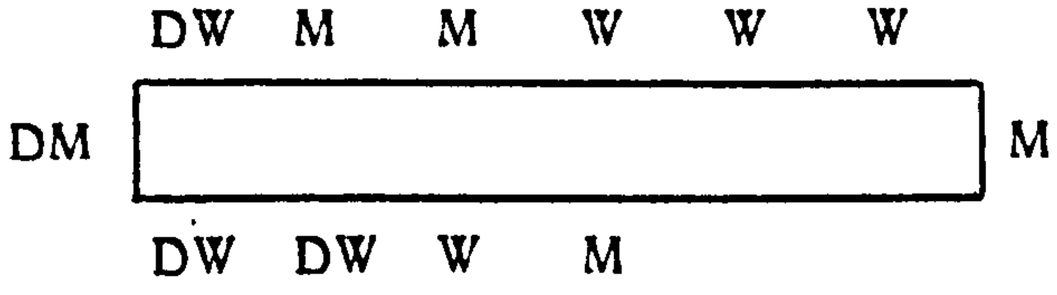
The present work is a study of the elderly in day care and the above is the one of the few statements of a handicapped client quoted. Relationships between the handicapped and the elderly were not always close and this example is included to illustrate that some of the handicapped were unhappy at being placed in the same centre as the elderly.

It has already been stated that the Centre was built with the dual role of providing day care for both the elderly and the handicapped. Many of the elderly were themselves physically handicapped with several being confined to wheelchairs during the day. Nevertheless, there was a social division between the elderly and the young physically handicapped. When they took part in the same activities they tended to sit in separate parties and, if they were not taking part in activities, they sat at separate tables or otherwise grouped themselves separately. This may be demonstrated by showing the seating arrangements at 2 30 pm on three successive days in the lounge and in the basketwork class (Diagrams 2 and 3). The three consecutive days were chosen in order to ensure that the population was not the same in each sample. Two-thirty was a time when clients were settled having chosen for themselves where they wished to be (compared, for example, with early morning when they were more likely to be seated at places where they had been directed by care staff and likely to be only temporarily located in that place). Basket work was chosen as it was the one activity that was engaged in by both men and women, handicapped and non-handicapped in large numbers.

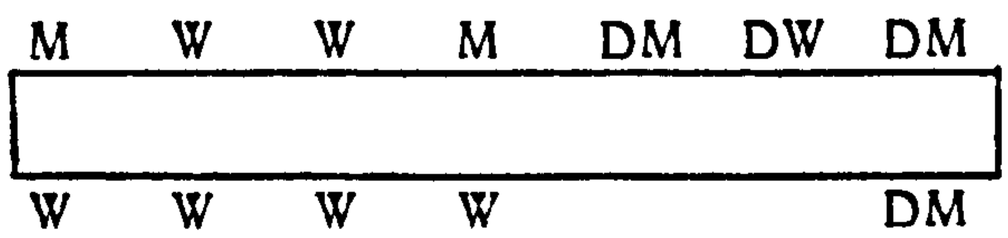
DIAGRAM 2

The seating of non-elderly handicapped and elderly clients at basketwork classes on three days

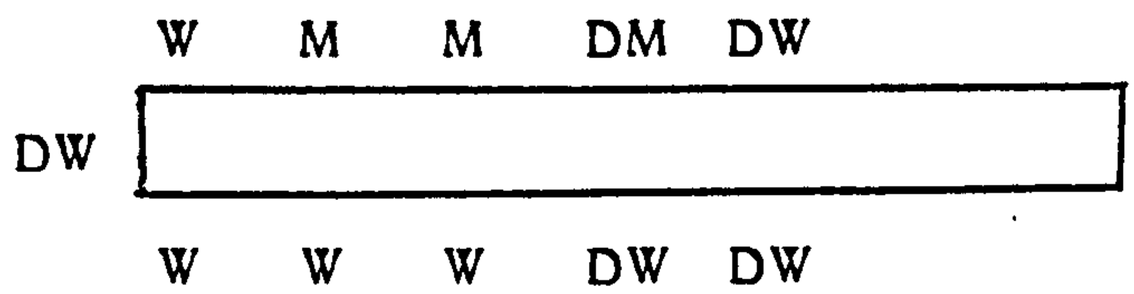
a. At 2 30 pm on 9 March 1981




b. At 2 30 pm on 10 March 1981




c. At 2 30 pm on 11 March 1981



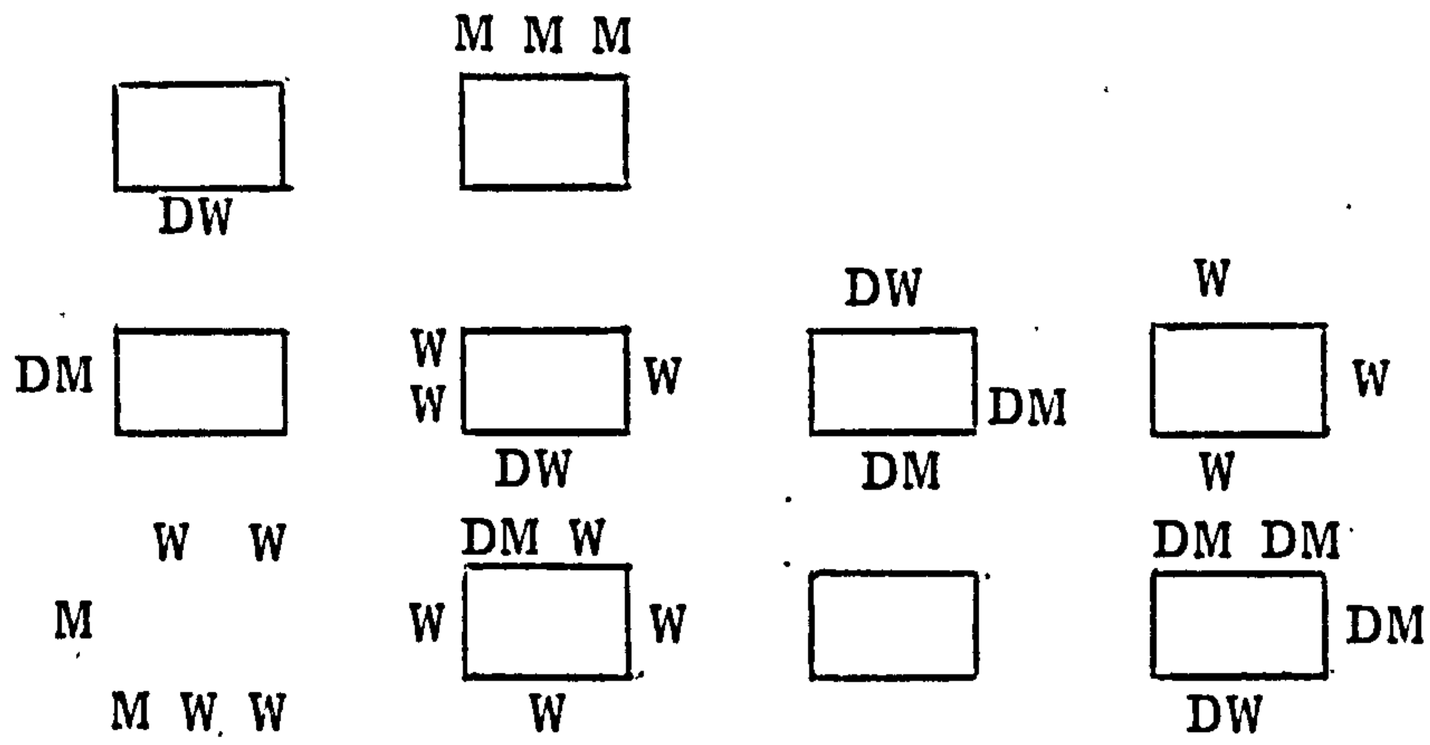

KEY

| | |
|---|---|
| DM | Non-elderly handicapped male client |
| DW | Non-elderly handicapped female client |
| M | Elderly male client |
| W | Elderly female client |
| ☐ | Table |

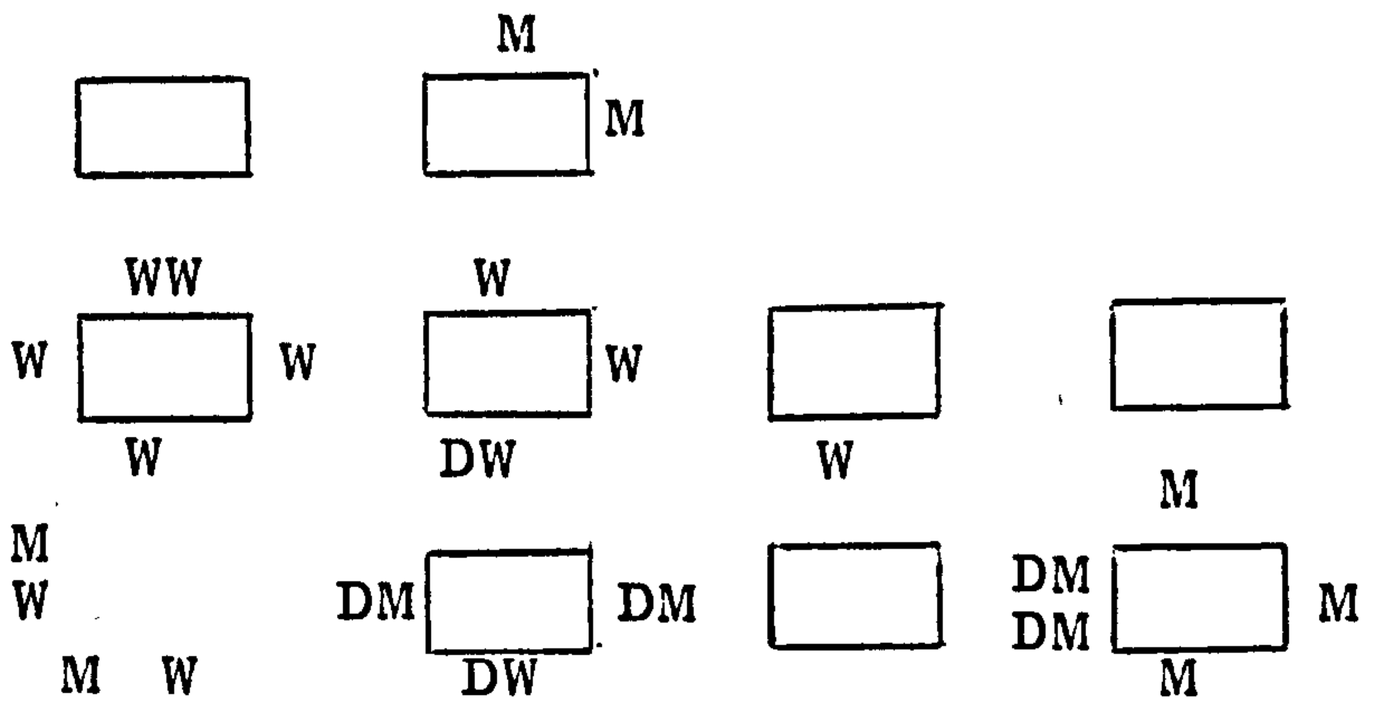
DIAGRAM 3

The seating of non-elderly handicapped and handicapped clients in the lounge on three days

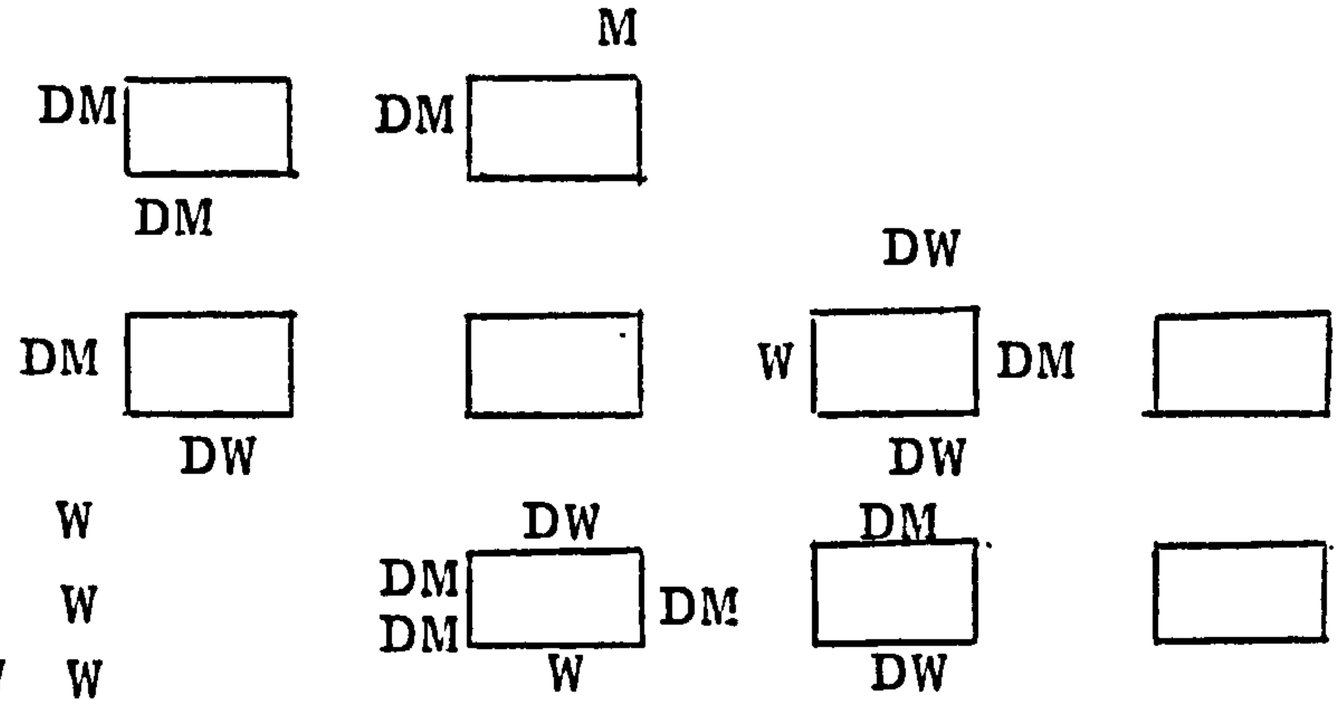
a. At 2 30 pm on 9 March 1981




b. At 2 30 pm on 10 March 1981




c. At 2 30 pm on 11 March 1981




KEY

| | |
|---|---|
| DM | Non-elderly handicapped male client |
| DW | Non-elderly handicapped female client |
| M | Elderly male client |
| W | Elderly female client |
| ▭ | Table |

Many elderly clients failed to understand the handicapped members and their problems. This may not be surprising. During their lives many elderly have seen handicapped people only at a distance and have not associated socially with handicapped people at all. The first day at Suilven House may therefore have been the first time that an elderly client spoke to a blind, crippled or spastic person, the first time she sat at the same meal table or the first time she had been in the same room. The failure of many elderly to understand the handicapped was demonstrated through their language. For example:

> Mrs Northcott and I were sitting alone together. She watched a disabled client with a slight limp walk across the room with the aid of a stick. She turned to me and said 'Look at that poor boy. There's some awful cripples here today. More than I usually notice.'

And:

> Mr Crosswell was delayed in leaving the lounge by two young handicapped men who were wheeling themselves through the corridor outside the lounge in their chairs. Mr Crosswell, who walked with the aid of a Zimmer frame, said to the elderly man he was with 'It's wrong that these people should be in the same room as us. They should have a building to themselves.'

And:

> A young disabled woman, Miss Faulkner, was about to move from a lounge chair with the aid of her two sticks. Mrs White, an elderly woman, who, owing to her frailty, was less mobile and less self-reliant than Miss Faulkner, rose from the table next to her to help her. 'Come along, love' she said. She then addressed me: 'She doesn't like me out of her sight. They say everybody loves someone, don't they?'

There was, however, one category of disabled people for whom the elderly at Suilven House had a very positive attitude; the blind. Elderly clients helped blind people to move about the building by opening doors, taking their arms, operating the lift and guiding them to their destinations. The same help was not provided for clients with other kinds of handicap. One frequently heard clients commend the blind for their efforts to overcome their handicap, especially when they were seen to engage in Centre activities. Sometimes the comments were made in formal meetings:

> At the November 1980 meeting of the Discussion Group, the activities being offered on Wednesday (the day on which blind clients attended the Centre) were being discussed.
>
> Officer-in-Charge: 'You must remember that there are a lot of blind clients here on a Wednesday.'
>
> Representative (Mrs McGrail): 'I know. I think it's marvellous the way people do all these activities when they're blind. A lot of people wouldn't bother and would let themselves go.' The other members present echoed this with comments including: 'They're wonderful', 'You've got to admire them', 'I don't know how they do it'.

At times it was possible to contrast the treatment of a blind client with that of a client with other handicaps. For example:

> Molly and Joan started at Suilven House on the same morning. Molly was blind and Joan was paralysed from the waist down. Both women were in their fifties. Molly was helped from the ambulance by the driver who took her to Joe, the care assistant with responsibility for the induction of new members. Joe took her to the lounge where she was given a cup of tea and introduced to some of the other clients. Joe left her at a table with two elderly women. They introduced her to other clients as they came in and got her another cup of tea.

At 10 30 am the two went to the basketwork class. They asked Molly if she would like to accompany them but she declined, preferring to stay in the lounge. The two elderly members were concerned that they should leave Molly in the hands of an experienced client. One of them called across to another client 'Mary! I've got a blind friend over here. Her name's Molly. If I bring her over, will you look after her? Basketwork's starting now and I've got to go.' Mary: 'Of course. Bring her over.' Molly continued to be accompanied in this way for the rest of the day. She was never on her own and anyone who left her ensured that she was introduced to someone else before moving away.

Joan arrived on the same ambulance as Molly. The ambulance assistant wheeled her into the building and left her at a table alone in the lounge. One of the volunteer staff who was organising the teas took her a cup of tea. She remained alone at the table until 11 25 am when she wheeled herself away from the table and started to explore the building. She stopped at the sewing class and sat at the table there until lunch-time. The sewing instructor introduced herself at 12 05 pm as the clients were going for lunch. She wheeled Joan to lunch. After lunch Joan sat alone until the sewing class recommenced. Joan returned to it and the instructor spent some time helping her and introduced her to other clients. At no point during the day did any client initiate interaction with Joan.

Outside the lounge, at the top of the stairs, is a large landing and on those days when several wheelchair-bound non-elderly men were at the Centre they congregated in this area, often spending most of the day there. They said that they sat there in order to enjoy peace away from the elderly members although, in fact, being a passageway between the lounge and the toilet as well as between the stairs and all

upstairs rooms, it was less quiet than the lounge. These disabled men may be regarded as having opted out of the Centre for part of the day and this status was implicitly recognised. For example:

> At the March 1981 Discussion Group meeting, it was decided that a working party which comprised two wheelchair bound men and one elderly woman should formulate proposals for a phone-in service. When a meeting place was raised, the elderly woman volunteered 'I'll come to you.' This was agreed.

There was no clarification in this example as to where in the building the meeting would be held. This was clearly understood by all present at the Discussion Group, including the staff. There was no other group at the Centre who were identified with a particular location.

If the elderly treated the blind with sympathy and the paralysed with indifference, they may be seen as cruel in their treatment of the spastic and the stroke victims whose speech had been affected. Two examples illustrate the relationship between the elderly and the two severely spastic clients. Both were confined to wheelchairs and could not eat or drink without considerable assistance. They had no speech although they were able to make noises to attract attention and could then make themselves understood by spelling out what they wanted to communicate through pointing to letters on a printed alphabet.

> At the Christmas lunch, Paul, a spastic member, was shaking and making grunting noises as he tried to draw the attention of staff to his wish for more wine. A care assistant noticed him and poured him some wine. An elderly woman sitting opposite Paul called across the table to someone sitting next to Paul 'That's the way to ask. If I ask like that do you think I'll get some more?' The two women laughed at the comment which Paul must have heard.

And:

> Jean, a spastic client, was wheeled into the lounge on arrival in the morning. The two elderly clients at the table where Jean had been placed moved to another table. After a few minutes Jean tried unsuccessfully to attract David's (Caretaker/Care Assistant) attention. One of the women at a nearby table called David on Jean's behalf: 'David what's-her-name wants you.'
>
> David: 'Who's that?'
>
> Women Client: 'Her,' pointing at Jean. 'The one that shakes.'
>
> David: 'Oh! You mean Jean.'

There were several stroke victims at Suilven House. Some were middle-aged men who spent two or three days per week at the Centre for a short rehabilitation period. Some, however, were not going to recover and they spent one or two days per week at the Centre. A few of these members had major speech defects. As a consequence, they were difficult to understand and took a long time to say what they wished. This required a degree of patience on the part of the listener which many elderly clients did not have. Many just chose not to become involved with such members while others demonstrated a lack of sympathy. For example:

> One of the members of the Discussion Group (Mr Rogers) had a major speech defect as a consequence of a stroke. At the November 1980 meeting, Mr Rogers tried on four separate occasions to contribute to the discussion. On each occasion, the other members did not allow him long enough to make his point before one or more of them entered the conversation and drew the attention of the other members. At the end of the meeting, the Chairman asked for

nominations for the post of Chairman for the next meeting. One of the elderly representatives (Mrs McGrail) nominated Mr Rogers.

Mr Rogers: 'I couldn't because of my speech.'

Mrs McGrail: 'Of course you couldn't. I was only pulling your leg.'

One may recall that, in an example quoted earlier, Mrs McGrail had been praising the blind members for their efforts to be involved in the Centre's activities. One further example:

> Mr Currie was a forty-eight year old man with a serious speech difficulty which was a consequence of a stroke. He was sitting at lunch one day with two elderly women (Mrs Gill and Mrs Johnson) either side of him. Mrs Gill to Mr Currie: 'Will you pass the salt, please?'
>
> Mr Currie was unable to reach the salt and had to ask, very slowly, for Mrs Johnson to pass it to him. When Mrs Johnson understood what was required, she passed the salt across Mr Currie to Mrs Gill.
>
> Mrs Johnson to Mrs Gill: 'He's a bit slow' indicating Mr Currie and tapping her forehead. 'If you want anything else ask me. Don't bother about him. Your meal 'll be cold by the time he gets round to doing anything.'

It may be possible to cautiously suggest a hierarchy of the most common client disabilities on the basis of the response of the elderly clients to the victims of the handicap. The hierarchy may be:

| HANDICAP | | ELDERLY CLIENT RESPONSES |
|---|---|---|
| Blindness | | Sympathetic. Helpful |
| Partially paralysed requiring wheelchair | | Indifference. Often ignored |
| Spastic | ) | |
| | ) | Unsympathetic. Often hostile. |
| Major speech defect | ) | |

It is difficult to understand why different handicaps should have drawn such different responses. It may be that blindness was understood by elderly clients and, merely by closing their eyes, they could understand the limitations and difficulties it imposes. Spasticity and major speech defects, however, were more difficult to understand and the limitations they impose on the victim were more difficult to imagine while the inconveniences to the non-handicapped members were greater than those posed by the blind. Another possibility arises from the Deputy Officer-in-Charge's particular interest in the physically handicapped (which is where his previous experience lay). He made a point of spending some time each day talking with the physically handicapped members; an experience which only a few elderly members enjoyed. It may be that, as a consequence, the elderly members felt disadvantaged compared with the physically handicapped who they saw as enjoying favoured treatment.

The former view receives some support and the latter some discredit, from the case of Eric. Eric was a man in his late forties who had fallen at work and suffered severe head injuries. As a consequence, he was able to walk with the aid of a stick but was only able to say 'Yes' and 'No' which were random responses to any question or comment put to him as he appeared not to understand anything that was said. He had, however, a very friendly, almost babyish, disposition and he waved and called out 'Yes' to anyone who passed him. He was liked by all the clients, many of whom went out of their way to help him and to talk to him.

As the Officer-in-Charge paid Eric as much attention as he did the other physically handicapped clients, Eric's case lessenes the support for the second postulated explanation for the elderly clients' attitude towards the disabled.

It may, however, lend support to the first explanation. It may be that elderly clients not only failed to understand the problems and conditions of spastic and speech defective clients but were also a little frightened by them and it was this that drew the hostility. Someone with a speech defect who also had a friendly disposition and was clearly simple (such as Eric) was not greeted with hostitility because they recognised that there was no reason to be frightened of him. He was obviously dependent upon others for all but his mobility.

However they were regarded, the presence of the disabled was important to the elderly. They made a more positive contribution to the Discussion Group than the elderly. Some of them were able, interested and had the patience to make items that the elderly were unable to make. For example, the model village made from wood and paper mache had items made by the elderly and the handicapped. However, the handicapped made the more complicated, detailed items while the simpler items were made by the elderly, often with the assistance of the staff. Without the involvement of the handicapped, the village would have been a very simple model. At the Christmas party, the atmosphere at the after-dinner concert was dictated by the handicapped. It was they who led the clapping, booing, cheering and jeering while a few of the elderly joined them in their responses, some slept but the majority smiled and laughed as much at having captured the mood of the handicapped, as at the performance. Without the handicapped, the concert would have been performed in almost total silence.

Staff-client interaction

While discussing the clients at Suilven House, passing reference has been made to the staff and their responses to particular situations. Interaction between clients has been described but interaction between staff and clients has been mentioned only

peripherally. In this section of the study, the interaction between staff and clients is examined in more detail. First, the ways in which staff spent their days are described. This includes a description of the daily activities of staff and their view of their own roles. Secondly, three particular aspects of the ways in which staff viewed clients and interacted with them are discussed. These are the hierarchical view staff had of clients, staff physical contact with clients and staff influence on client groupings. Thirdly, client perceptions of staff are examined. Finally, consideration is given to the ways in which distance between the two sides was maintained and tensions managed.

The different categories of staff at Suilven House have already been described (page 183). It has also been stated that the demarcation boundaries between staff in different job categories were blurred. The overlapping of the roles of care assistant and instructor, care assistant and cleaner, care assistant and driver have been mentioned.

In order to establish the ways in which staff spent their days, the activities of each member of staff were recorded on three separate days. The days chosen were different on each occasion as the activity programmes, part-time staff and clients differed from one day to another. These were considered possible significant variables that might have influenced the daily pattern of activities. In fact, the data obtained does not suggest that any of these variables was significant.

TABLE 22

Activities undertaken by staff at fifteen-minute intervals on three days

a. On Tuesday 5 May 1981

b. On Wednesday 13 May 1981

c. On Thursday 21 May 1981

TABLE 22 a. ON TUESDAY 5 MAY 1981

| Time | Officer in Charge | Deputy Officer in Charge | Instructors | | | | Care Assistants | | | | Care Assistant/ Caretaker | Cleaner | Hairdresser | Volunteers | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | 1 | 2 | 3 | 4 | 1 | 2 | 3 | 4 | | | | 1 | 2 |
| am 9.30 | Paperwork in office | Paperwork in office | Preparing work in craft room (1) | | Preparing materials for clients | Instructing clients | | | Paperwork in office | With CA/C on maintenance tasks | With CA4 on maintenance tasks | Cleaning | | Preparing tea | Preparing tea |
| 9.45 | | | | | | | | | | | | | * | Serving tea | Serving tea |
| 10.00 | | | | Talking with CA1 CA2, CL | | | Talking with I2 CA2, and CL | Talking with I2 CA1 and CL | | Alone on maintenance tasks | Talking with clients | Talking with I2, C1, C2. | Cutting hair | | |
| 10.15 | | | | Talking with CA1, CL | | | Talking with I2, CL | Repairing broken furniture | | | | Talking with C1, I2 | | | |
| 10.30 | | | | Instructing clients | | | Instructing clients | | Collecting dinner money | | Drinking tea alone | Cleaning | | | Taking orders for shopping |
| 10.45 | Walking round checking activities | Talking with clients | | | Instructing clients | | | Serving at shop | | | * | | | Washing up | |
| 11.00 | Paperwork in office | Paperwork in office | | | | | | | | | Maintenance tasks | | | | Shopping |
| 11.15 | | | | | | | | | Paperwork in office | | | | | | |
| 11.30 | | | | | Washing up (client utensils) | | | Restocking shop | | Preparing tables for lunch | Preparing tables for lunch | | | | |
| 11.45 | | | | | Supervising cooking (no clients) | | | | Preparing tables for lunch | | | | | | Distributing shopping |
| pm 12.00 | * | Supervising lunch | * | * | | | Supervising lunch | Supervising lunch | Supervising lunch | * | Supervising lunch | * | | | |
| 12.15 | * | | * | * | | * | | | | * | | * | | | |
| 12.30 | * | | * | * | Talking with CA2 | * | | Talking with I3 | | * | | * | | | |
| 12.45 | * | | * | * | | * | | | | * | | * | | Volunteers | |
| | | | | | | | | | | | | | | 3 | 4 |
| 1.00 | Talking with clients | * | | Talking with I4, CL | * | Talking with I2, CL | * | * | * | Talking with clients | | | Talking with I1, I4 | Preparing tea | Preparing tea |
| 1.15 | | * | | | * | | * | * | * | | * | | | | |
| 1.30 | Paperwork in office | * | | Preparing materials for clients | * | Preparing materials for clients | * | * | * | * | * | Cleaning | | Serving tea | Serving tea |
| 1.45 | | * | | | * | | * | * | * | * | * | | | | |
| 2.00 | | Paperwork in office | | Instructing clients | Instructing clients | Instructing clients | Talking with clients | Talking with clients | * | Maintenance tasks | * | | | Washing up | Washing up |
| 2.15 | | | | | | | Talking with CA2 | Talking with CA1 | Paperwork in office | | * | | | | |
| 2.30 | | | | | | | | | | | * | | | | |
| 2.45 | Talking to canteen staff | | | | * | | Instructing clients | Instructing clients | Talking with clients | | * | | | | |
| 3.00 | | Talking with clients | | | Instructing clients | | | | Talking with canteen staff | | * | | | | |
| 3.15 | Paperwork in office | | | | | | | | | | Talking with clients | | | | |
| 3.30 | | Paperwork in office | | | | | | | Talking with clients | | | | | | |

1. One day per week this instructor did not work with clients at all but spent the day preparing work and materials.

TABLE 22 b. ON WEDNESDAY 13 MAY 1981

| Time | Officer in charge | Deputy Officer in charge | Instructors | | | Care Assistants | | | | Care Assistant/ Caretaker | Cleaner | Hairdresser | Volunteers | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | 1 | 2 | 3 | 1 | 2 | 3 | 4 | | | | 1 | 2 | 3 | 4 |
| am 9.30 | Paperwork in office | Paperwork in office | | | | | | | | | Cleaning | | | | | |
| 9 45 | | | | Talking with I3 | Talking when I2 | | | | Mainten-ance tasks | | | Talking with I2, I3 | Preparing tea | Preparing tea | | |
| 10.00 | Talking with CA2 | | | Talking with I3 | Talking with I2 | | Talking with OIC | | | | | Cutting hair | Serving tea | Serving tea | | |
| 10.15 | | Talking with CA4, CA/CL | | * | Instructing clients | | | | Talking with DOIC CA/CL | Talking with DOIC CA4 | | | | Instructing clients | | |
| 10.30 | Showing visitor round centre | Paperwork in office | Preparing materials for clients | * | | Instructing clients | Serving at shop | Manicuring clients | Talking with CA/CL | Talking with CA4 | Drinking tea alone | | Washing up | | | |
| 10.45 | | | | Instructing clients | | | | | Mainten-ance tasks | Mainten-ance tasks | Cleaning | | | | | |
| 11.00 | Paperwork in office | | Instructing clients | | | | | | Talking with HD | | | Talking with CA4 | | | | |
| 11.15 | | | | | | | Talking with CL | | Mainten-ance tasks | | Talking with CA2 | | | | | |
| 11.30 | | | | | | | Restocking shop | | | Preparing tables for lunch | Cleaning | | | | | |
| 11.45 | | | | Wheeling client in chair | | | | | Wheeling client in chair | | | | | | | |
| pm 12.00 | Supervising lunch | * | * | Supervising lunch | * | * | Supervising lunch | Talking with CL | * | Supervising lunch | * | | | * | | |
| 12.15 | | * | * | | * | * | | * | * | | * | | | * | | |
| 12.30 | | * | * | | * | * | | * | * | | * | | | * | | |
| 12.45 | * | Talking with clients | * | Talking with a client | * | Preparing materials for clients | | * | * | | * | | | * | | |
| 1.00 | * | | Talking with CA3 CA4, CA/CL | * | Preparing materials for clients | | * | Talking with I1, CA4, CA/CL | Talking with I1, CA3, CA/CL | Talking with I1, CA3, CA4 | Cleaning | | | Instructing clients | | |
| 1.15 | * | | | * | | | * | | | | Talking with clients | | | | | |
| 1.30 | * | | | * | | Instructing Clients | | | | | Cleaning | | | | | |
| 1.45 | * | | Instructing clients | * | Instructing clients | | * | Talking with clients | * | * | | | | | Preparing tea | |
| 2.00 | Talking with canteen staff | * | | Preparing materials | | | * | | Mainten-ance tasks | * | | | | | Serving tea | Serving tea |
| 2.15 | | Paperwork in office | | Instructing clients | | | Talking with CL | Instructing clients | | Mainten-ance tasks | | | | | | |
| 2.30 | Paperwork in office | | Preparing materials for clients | | * | | | | | | * | | | | Talking with V4 | Talking with V3 |
| 2.45 | | | | | Instructing clients | | Talking with CA3 C3 | Talking with CA C2 | Talking with clients | | Cleaning | | | | Washing up | Washing up |
| 3.00 | | | | | | | | | Mainten-ance tasks | | | | | | Talking with a client | |
| 3.15 | | Talking with ambulance driver | | | | | | | | Playing cards with clients | | | | | | |
| 3.30 | | | Instructing clients | Preparing materials for clients | | | | | | | * | | | | | |

TABLE 22 c. ON THURSDAY 21 MAY 1981

| Time | Officer in Charge | Deputy Officer in Charge | Instructors | | | | Care Assistants | | | | Care Assistant/ Caretaker | Cleaner | Hairdresser | Volunteers | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | 1 | 2 | 3 | 4 | 1 | 2 | 3 | 4 | | | | 1 | 2 |
| am 9.30 | Paperwork in office | Paperwork in office | | | | | | | Talking with CA4 | Talking with CA3 | Talking with CL | Talking with CA/CL | | Preparing tea | Preparing tea |
| 9.45 | | | | | | | | | | | | | | Serving tea | Serving tea |
| 10.00 | | | Preparing materials | * | | Shopping for materials | | | Paperwork in office | Talking with CA/CL | Talking with C4 | Cleaning | Cutting hair | | |
| 10.15 | | | | Preparing materials for clients | | | Serving tea | | | Talking with a client | Mainten-ance tasks | | | | |
| 10.30 | | | Talking with CA1, CL | | Talking with client | Instructing client | Talking with I1, CL | Drinking tea alone | Wheeling a wheelchair bound client | | | Talking with I1, CA1 | | Washing up | Washing up |
| 10.45 | | | | Instructing clients | | | | Talking with CA3 and CA4 | Talking with CA2 and CA4 | Talking with CA2 and CA3 | Talking with CA2 and CA3 | | | | |
| 11.00 | | Talking with CA2 | Preparing materials for clients | | Wheeling a wheelchair bound client | | * | Talking with DOIC | Collecting dinner money | Talking to client | Mainten-ance tasks | Cleaning | | Taking orders for shopping | |
| 11.15 | | Talking with a client | | | Instructing clients | | Pushing wheelchair bound client | Talking with CA3 | Talking with CA2 | Mainten-ance tasks | | | | Shopping | |
| 11.30 | | Paperwork in office | Instructing clients | | | | Talking with a client | Serving at shop | Collecting dinner money | | | | | | |
| 11.45 | | | | | | | | | | | Preparing tables for lunch | | | Distributing shopping | |
| pm 12.00 | | Serving lunch | Serving lunch | | Reading magazine | | Supervising lunch | Restocking shop | Supervising lunch | Supervising lunch | Supervising lunch | | * | | |
| 12.15 | * | | | * | * | * | | * | | | | * | * | | |
| 12.30 | * | | | * | * | * | | * | | | | * | * | | |
| 12.45 | * | | * | * | * | * | | * | | * | | * | * | | |
| 1.00 | Talking with clients | * | * | * | * | * | * | * | * | * | * | * | Cutting hair | | |
| 1.15 | | * | * | Talking with CA2 | * | Instructing clients | * | Talking with I2 | * | * | * | Cleaning | | | |
| 1.30 | Paperwork in office | * | * | Preparing materials for clients | * | | * | Serving alone | * | * | * | | | | |
| 1.45 | | * | Preparing materials for clients | Instructing Clients | Reading magazine | | * | | * | Mainten-ance tasks | * | | | Volunteers | |
| | | | | | | | | | | | | | | 3 | 4 |
| 2.00 | Talking with visitor in office | Talking with clients | | | | | Instructing clients | | Paperwork in office | | Maintenance tasks | | | Preparing tea | |
| 2.15 | | | | | | | | | | | | | | Serving tea | Serving tea |
| 2.30 | | | | | | | | | | | | Talking with I1 | | | |
| 2.45 | Paperwork in office | Paperwork in office | | | | | | | | | Playing cards with clients | Cleaning | | | |
| 3.00 | | | | | | | | | | | | | | Washing up | Washing up |
| 3.15 | | | | | | | | | | | | | | | |
| 3.30 | | | | | | | | | Talking with clients | | | | | | |

KEY

| | |
|---|---|
| OIC | Officer-in-Charge |
| DOIC | Deputy Officer-in-Charge |
| I | Instructor |
| CA | Care Assistant |
| CA/CT | Care Assistant/Caretaker |
| CL | Cleaner |
| HD | Hairdresser |
| V | Volunteer |

— Continuation of activity category (although not necessarily the same activity with the same persons - eg. a care assistant may be shown as 'talking with clients' at consecutive time intervals - these may or may not be the same clients)

* Not on duty. (This category includes staff who were having a lunch break, in the toilet or it was impossible to locate them)

..... First time interval after the arrival at the Centre of the member of staff

..... Last time interval the member of staff was at the Centre before leaving.

In addition to this key, some further explanation of the Table is necessary. The times at which activities were recorded were limited to the period 9 30 am to 3 30 pm as this was the period when clients were present. Outside these times there were a few clients at the Centre but staff were almost entirely engaged in routine preparation, clearing up and maintenance tasks. It was felt inappropriate to include an analysis of these activities in what is, essentially, an exposition of staff involvement with clients. The staff included in the Table are all of those who worked voluntarily or in a paid capacity during the day at the Centre, with the exception of the canteen staff who are excluded as they did not interact with clients. Ambulance drivers do not appear as they did not work with clients during the day. Conversely, the Cleaner was in a job which involved interaction with the clients as she cleaned rooms while clients were present.

The Table refers to posts instead of names. This is partly because the posts were not necessarily filled by the same person each day (thus, the post of Instructor 1 on TABLE 22a may not have been filled by the same individual who filled the post of Instructor 1 on TABLE 22b, for example) and partly because one of the purposes of the investigation was to examine the ways in which categories of personnel were occupied.

The terms used in the Table are as concise as compatibility with accurate description allows. However, elaboration of some terms may be necessary. 'Instructing clients' appears where a member of staff was either directly instructing or demonstrating to a client but also where she was talking to a client within an education context although the talk may not have been about the activity in which instruction was being given. For example, a care assistant who was talking to a client while they were both involved in a cookery class is categorised as 'instructing clients' while the interaction is described as 'talking with clients' if either party entered the cooking area without being involved in the class. 'Maintenance' includes such diverse activities as working in the Centre's laundry and changing light bulbs. 'Supervision of lunch' includes helping clients to tables, carrying trays of food from serving hatches to tables and clearing tables. 'Preparation of materials for clients' includes such tasks as soaking cane, cutting needlework patterns and preparing ingredients for cookery.

The number of occasions on which staff are identified in TABLE 22 as engaged in different activities are grouped in eight categories and totalled (TABLE 23a). The recordings in each of the eight categories are totalled in TABLE 23b. In the main, the thirty-two different activities recorded in TABLE 22 fall logically into one of

the eight categories. In these cases the selection of categories is self-evident and explanation is unnecessary. However the categorisation of some activities requires justification. Although some of the activities (eg. collecting dinner money) might be regarded as management tasks, the way they were carried out makes it more appropriate to categorise than as 'service-orientated with clients'. Conversely, supervising lunch involved so little involvement with clients (normally only passing them serving dishes although some help was given in the feeding of two physically handicapped clients) that it is appropriate to categorise 'supervising lunch' separately.

TABLE 23

Analysis of activities undertaken by different categories of staff at fifteen minute intervals in three days

a. As recorded in TABLES 22a, 22b, and 22c.

| | OFFICER-IN-CHARGE AND DEPUTY OFFICER-IN-CHARGE | INSTRUCTORS | CARE ASSISTANT | CARE ASSISTANT/ CARETAKER | CLEANER | HAIR-DRESSER | VOLUNTEER | TOTAL |
|---|---|---|---|---|---|---|---|---|
| Management tasks | | | | | | | | |
| Paperwork in office | 82 | - | 16 | - | - | - | - | 98 |
| Talking with visitor in office | 3 | - | - | - | - | - | - | 3 |
| Showing visitor round centre | 2 | - | - | - | - | - | - | 2 |
| Walking round checking activities | 1 | - | - | - | - | - | - | 1 |
| Routine Staff jobs | | | | | | | | |
| Repairing broken furniture | - | - | 2 | - | - | - | - | 2 |
| Preparing materials for clients | - | 54 | 3 | - | - | - | - | 57 |
| Shopping for materials | - | 2 | - | - | - | - | - | 2 |
| Preparing tea | - | - | - | - | - | - | 18 | 18 |
| Washing up | - | - | - | - | - | - | 15 | 15 |
| Restocking shop | - | - | 5 | - | - | - | - | 5 |
| Maintenance tasks | - | - | 37 | 19 | - | - | - | 56 |
| Preparing tables for lunch | - | - | 3 | 5 | - | - | - | 8 |
| Cleaning | - | - | - | - | 39 | - | - | 39 |
| Shopping | - | - | - | - | - | - | 5 | 5 |
| Washing up (client utensils) | - | 1 | - | - | - | - | - | 1 |
| Supervising cooking (no clients) | - | 3 | - | - | - | - | - | 3 |
| Supervising lunch | 11 | 6 | 25 | 12 | - | - | - | 54 |
| Informal staff activities | | | | | | | | |
| Talking with staff | 8 | 18 | 44 | 7 | 8 | 2 | 2 | 89 |
| Drinking tea alone | - | - | 1 | 1 | 1 | - | - | 3 |
| Sewing alone | - | - | 4 | - | - | - | - | 4 |
| Instructing clients | - | 104 | 38 | - | - | - | 18 | 160 |
| Client-orientated interaction | | | | | | | | |
| Talking with clients | 16 | 1 | 13 | 6 | 1 | - | 1 | 38 |
| Playing cards with clients | - | - | - | 6 | - | - | - | 6 |
| Service-orientated interaction with clients | | | | | | | | |
| Serving tea | - | - | 1 | - | - | - | 24 | 25 |
| Cutting hair | - | - | - | - | - | 21 | - | 21 |
| Manicuring clients | - | - | 6 | - | - | - | - | 6 |
| Pushing wheelchairs | - | 1 | 3 | - | - | - | - | 4 |
| Serving at shop | - | - | 8 | - | - | - | - | 8 |
| Taking orders for shopping | - | - | - | - | - | - | 3 | 3 |
| Distributing shopping | - | - | - | - | - | - | 2 | 2 |
| Collecting dinner money | - | - | 6 | - | - | - | - | 6 |
| Not on duty | 25 | 41 | 49 | 16 | 14 | 5 | 5 | 155 |
| TOTALS | 148 | 231 | 264 | 72 | 63 | 28 | 93 | 899 |

b. Grouped in eight categories

| | OFFICER-IN-CHARGE AND DEPUTY OFFICER-IN-CHARGE | INSTRUCTORS | CARE ASSISTANT | CARE ASSISTANT/ CARETAKER | CLEANER | HAIR-DRESSER | VOLUNTEER | TOTAL |
|---|---|---|---|---|---|---|---|---|
| Management Tasks | 88 | - | 16 | - | - | - | - | 104 |
| Routine staff jobs | - | 60 | 50 | 24 | 39 | - | 38 | 211 |
| Supervising lunch | 11 | 6 | 25 | 12 | - | - | - | 54 |
| Informal staff activities | 8 | 18 | 49 | 8 | 9 | 2 | 2 | 96 |
| Instructing clients | - | 104 | 38 | - | - | - | 18 | 160 |
| Client-orientated interaction | 16 | 1 | 13 | 12 | 1 | - | 1 | 44 |
| Service-orientated interaction with clients | - | 1 | 24 | - | - | 21 | 29 | 75 |
| Not on duty | 25 | 41 | 49 | 16 | 14 | 5 | 5 | 155 |
| TOTALS | 148 | 231 | 264 | 72 | 63 | 28 | 93 | 899 |

TABLE 23 shows that, of the 899 recordings, staff were not on duty for 155. These were mainly lunch breaks. A member of staff was entitled to a one hour lunch break per day (four recordings) and 37 staff were entitled to lunch breaks over the three days of recordings. Thus, lunch break entitlements alone may account for 148 recordings. The remaining recordings may have been absences for entirely legitimate reasons such as visits to the toilet or cleaning of clothing. It may therefore be regarded as legitimate to disregard the 155 'not on duty' recordings as not being part of the working day and to consider only the use of time during the remaining 751 recordings (ie. 899 recordings minus 155 when staff were not on duty).

Of these 751 recordings, 279 (those in categories 5-7, ie. instructing clients, client-orientated interaction and informal interaction with clients) involved contact with clients. These represent 39.15 per cent of the 'on duty' recordings. Of these, 160 recordings are categorised 'instructing clients' and 75 are categorised 'service-orientated interaction with clients' in which the provision of a service (tea, hair-cutting, manicuring, wheelchair pushing, shopping or collecting dinner money) was the reason for the contact between staff and client with any social interaction being incidental. For example, in some cases, the staff member and client stopped and talked when the former was on duty in the mobile shop but in other instances there was just a financial transaction without any discussion. There were only 44 recorded instances of 'client-orientated interaction' in which social interaction with the client was the major or only reason for the contact. The high number of recordings of 'instructing clients' reflects the importance of formal activities which has already been identified and discussed. However, the Tables analysing staff interaction with clients do not differentiate between interaction with elderly and with handicapped clients. A much higher proportion of the handicapped than the

elderly engaged in activities. Further, as stated earlier, the Deputy Officer-in-Charge had a particular interest in the physically handicapped and he made a point of talking with them every day informally in small groups or individually. He alone accounted for 11 of the 44 'client-orientated interaction' recordings.[1] One may reasonably assume that, although 39.15 per cent of the recordings involved staff interaction with clients, a disproportionately high percentage of these were recordings of staff interacting with handicapped clients and that staff spent much less time with the elderly than this figure might suggest.

One must be careful in interpreting the 96 recordings in the 'informal staff activities' category. Although 89 of the recordings were of staff talking with other staff, it would be wrong to assume that this interaction was only casual, social discourse. Much of it was but some of it involved informal (but important) staff discussion on clients and the Officer-in-Charge or her deputy passing on instructions to other staff. Without transcripts of the conversations (many of which might not have taken place if the participants had thought that they would be recorded) it is not possible to categorise this interaction more accurately.

1 It would have been valuable to be able to differentiate between elderly and handicapped clients in this analysis. However, this was impossible for at least two reasons. First, they were often in mixed parties and it was not possible to identify whether a member of staff was (for example) instructing an elderly client, a handicapped client or a combination. Secondly, it was not always possible to know by appearance alone whether a client was elderly or disabled. Unless the observer knew the name of every client it was not possible for him to accurately categorise them as elderly or handicapped.

The Tables show that 315 recordings were in the categories 'management tasks' and 'routine staff jobs', ie. those that involve manual and non-manual administration and maintenance duties without client contact or involvement. These represented 41.94 per cent of the recordings made while staff were on duty. This is 2.79 per cent more than the number of recordings that involved staff contact with clients.

The analysis of staff activities shows the ways in which different categories of staff were deployed during the three days of recordings. Some categories of staff were deployed consistently throughout. The Cleaner spent most of her time cleaning, the Hairdresser cutting hair. Of the 190 recordings of instructors on duty, 164 (86.3 per cent) were of them instructing (104 recordings) or in associated routine jobs, ie. preparation of materials, shopping for materials, washing up client utensils or supervising items that clients had left cooking (60 recordings). The Caretaker/Care Assistant's activities reflect his dual role; daily supervision of lunch (12 recordings), some client-orientated interaction (12 recordings) and some routine staff jobs (24 recordings). Volunteers were used in a variety of ways and these were dependent partly on the skills and inclinations of individuals. Although all volunteers prepared and served early morning or post-lunch cups of tea, some went shopping for clients and one, a skilled needlewoman, instructed clients.

It may be said of the role incumbents identified in the last paragraph that they were spending the majority of their time undertaking the functions that their titles suggest. It may not be so easy to associate the duties of the care assistants, the Officer-in-Charge and her deputy with their titles. The multi-faceted role of the care assistants is demonstrated by the care assistants' appearance in all the categories of TABLE 23b. Indeed, of the 31 activities identified in TABLE 23a, care

assistants undertook 17. The 'paperwork in the office' was undertaken by one care assistant who had responsibility for collecting dinner money and the associated clerical duties. Another care assistant was responsible for the shop. One may therefore identify certain tasks with an individual care assistant. However, one may also suggest that it is difficult to identify a 'care assistant role' in the way that it is possible to identify an 'instructor role', 'cleaner role' or 'hairdresser role'. The activities of the care assistants overlapped with those of the Officer-in-Charge and her deputy in the 'management tasks' category, of the instructors (23.75 per cent of the instructing of clients was undertaken by care assistants), and of the Caretaker/Care Assistant (the sole male care assistant was recorded undertaking routine maintenance tasks almost twice as often as the Care Assistant/Caretaker; 37 recordings compared with 19). These figures may be interpreted as suggesting an uncertainty of the role of care assistants, or that they were being deployed inappropriately, or that they were being deployed in ways that utilised their individual personal skills.

The Officer-in-Charge and her deputy are shown in TABLE 23b to have been undertaking paperwork in their office on 82 of the times when they were on duty (66.6 per cent of recordings). They were recorded interacting with clients on only 16 occasions (13 per cent) and on eight occasions they were talking with other staff. The Centre was designed with a small office off the entrance hall for the Officer-in-Charge and her deputy. However, the Officer-in-Charge found that this was not large enough for the amount of time they were spending on administration and they were being 'disturbed in our work by clients and staff' (Officer-in-Charge), so they moved to a larger room at the back of the building where they were less accessible to clients and staff. The original office was then used by the care assistant with responsibility for dinner money and housed a couch along with first aid equipment for clients taken ill.

This discussion of staff roles has been analytical rather than critical. In common with other parts of this chapter, the intention is to record and describe the Centre; conclusions are drawn later.

The staff views of their roles reflected the above analysis with the care assistants being less certain of their roles than the others. Every member of staff was informally asked 'How would you describe your job at the Centre?'. The Cleaner was quite sure of her role:

> 'I clean, of course. What a daft question. What did you think I do? It's not like a normal cleaning job, though. There's always people to talk to and I like to think I can cheer them up. They need some cheering up, some of them, don't they?'

The Hairdresser, on the other hand, saw her work entirely in terms of self-benefits:

> 'It's a job that suits me. I leave home after John (her husband) so I can clear up before I come out. I start and finish at times to suit myself. There's always enough work to keep me busy. I could earn more outside but I'm my own boss here and I enjoy the company of the old folk.'

The instructors all saw their role as being wider than just instructing. Sheila, the basketwork instructor, gave one of the more articulate, but typical, responses:

> 'I'm obviously employed to instruct. But I'm as much a social worker as a teacher. Teaching a skill cannot be divorced from the person. If learning doesn't bring a greater understanding of one's life the teacher should give up, shouldn't he?'

Although Sheila was the only person to mention social work, all the instructors viewed their role as having both instructing and caring elements. Ron, the only male instructor, said:

'I'm here to teach some woodwork, jewellery, pottery; things like that. But that's not really the most important thing. If I can give the old folk and the handicapped some purpose in life, keep them occupied, make them happy - that's what really matters.'

The volunteers gave similar answers. They all said that they had spare time and wanted to devote some of that spare time to helping a deserving group. Margaret, a farmer's wife and the volunteer who gave some needlework instruction, was typical:

'It gives me a welcome rest from lambing! I wanted to help some people who are less well off. A friend of mine's mother was a client here and suggested I might like to come along. I can't quite remember how I started but began just helping with the teas and branched out from there. I've gradually spent more and more time here.'

The care assistants, however, were much less clear as to their role. Some saw the post as offering a variety of work but none was able to offer a clear explanation. Most appeared unsure. Anne, for example said:

'Well, I'm not an instructor. That's for sure. But I do a lot of instructing, if you know what I mean. That sounds daft, doesn't it?! On the other hand, I do more than an instructor. I make sure all the darlings are happy and have what they want.'

Joe and Eric were less sure. Joe said:

'Now you're asking me. What does the job involve? A lot of hard work for a start. It's difficult to describe really. I'm all over the place. Sometimes I'm in the shop, some of the time I'm doing their nails. I don't know. It's difficult to describe.'

Eric:

'I'm the dog's body. Anything nobody else will do - I get. Sometimes it's working in the laundry, othertimes it's wheeling clients about. All sorts of things.'

It should, perhaps, be recorded that these three answers were all good-humoured. None was as harsh when said as it reads here.

The Officer-in-Charge was quite sure what her job was:

'I'm responsible for everything that goes on here. That means that first and foremost I'm a manager. I make sure the staff know what's expected of them and I have supervision sessions with them every two months. It should be more often really but there isn't enough time. The staff include the canteen staff as well, of course, and I have to spend a lot of time with them. Then there's the paper-work. Ordering for the canteen takes a lot of time. There are lots of forms for the office (Westshire Social Services Department) and there are client records and transport although Colin (Deputy Officer-in-Charge) looks after them. There are often a lot of people from outside to see - social workers, people from the office, relatives. In the time that's left I try to be with the clients but there's not as much time for that as I would like.'

Unfortunately, the Deputy Officer-in-Charge entered the room during the conversation with the Officer-in-Charge and his comments only supplemented hers.

Some observations have already been made on the ways in which staff influenced the daily lives of the clients. Here this is developed by suggesting, first, that in the same way that elderly clients had a hierarchical view of handicapped clients, staff

had a hierarchical view of elderly clients. Secondly, the ways in which staff influenced client groupings are discussed. The two are, of course, closely linked in that the ways in which staff grouped clients (either consciously or otherwise) were likely to be dependent upon their views of the status of the clients concerned.

It was apparent at an early stage that some clients received far more attention from staff than others. It seemed that these were not necessarily clients who demanded attention in the sense of initiating interaction with the staff. The characteristics of the clients with whom staff spent their time were recorded as were those of clients who had less contact with staff and those who had no contact at all with staff. Over a period of time the lists of characteristics became more sophisticated until it became possible to suggest ideal-typical models of high, medium and low status clients. High status clients were the few with whom the majority of staff interacted through choice. A member of staff was likely to stop and talk to a high status member as he passed her chair, conversations were jovial, the relationship appeared to be that of dependent friend and depended upon. The client received assistance with any activity that she undertook when she required it.

Staff rarely stopped to talk to medium status clients unless the client initiated the interaction. Conversations were more formal with the client addressed by her title, 'love', 'darling' or a similar term rather than by her forename. The subjects of the conversation were more matter-of-fact than humorous, and the relationship appeared to be that of dependent client and professional. The client received assistance with any activity she undertook but usually had to wait her turn or request assistance. The majority of clients fell within the medium status category.

Low status clients had very little interaction with staff. Conversations they did have were usually initiated by the clients and curtailed by staff. They were almost always addressed by their surnames and any discussion with staff focussed upon the immediate administrative affairs of the Centre such as changes in transport arrangements and payment of dinner money. The relationship appeared variously similar to that between hotelier and guest, school teacher and pupil or even gaoler and inmate. The nature of this relationship varied considerably according to the nature of the particular client. Some clients in this category were very confused and were treated differentially by different members of staff in ways they individually thought would achieve a measure of understanding by the client. Other clients were perceived as 'troublesome' and treated in ways the staff though appropriate. David said of one such client 'You have to sit on her firmly or she'll cause all sorts of trouble.' The few clients in this category who took part in activities received very little assistance from the instructors unless they asked for help. However, the majority of low status clients did not take part in activities. They were nearly all isolates although some joined roaming groups. None were members of settled groups. It is probable that they had low status among the clients as well; a correlation that probably did not exist in respect of high and medium status groups.

The characteristics of the members of the three categories may be summarised in an 'ideal-typical model':

<u>High status clients</u>

1 Outgoing (but not dominant) personality.

2 Not temperamental (ie. predictable). Possibly possessed some 'anti-social' traits but these were due to handicaps (eg. spasticity) and were consistent from week to week.

3 In need of considerable assistance.

4 Mentally alert to the extent of understanding jokes but not so alert that she could 'give as good as she got'.

Low status clients

1 Dominant personality.
2 Prepared to challenge the staff on points of detail: appeared argumentative to staff.
3 Demanded assistance.
4 Rarely took part in activities.
5 May have been mentally less alert than other clients.

Medium status clients

1 Outgoing (but not dominant) personality: often initiated discussion with staff.
2 Took part in an activity.
3 Did not require or demand special assistance.
4 Willing to fit in with whatever arrangements staff made.
5 Understood jokes made by staff at her expense and often responded in like manner.

In additon to clients in these three categories there were a number who were without status because the staff did not interact with them sufficiently to categorise them. These were the statusless.

Statusless clients

1 Reserved personality: rarely initiated discussion with staff.
2 Did not usually take part in activities.
3 Did not openly challenge any aspect of the Centre although she may have done so to other clients.

Although this ideal-typical model is rather crude, some space has been devoted to staff categorisation of clients in view of the potential importance for a client of her being categorised in this way. One aspect of this is staff influence on group formations. Earlier, the formation of groups was discussed with passing reference to staff involvement. However, staff were important agents in influencing who interacted with whom. For example, staff directed clients to seats on arrival:

> Anne (Care Assistant) was sitting just inside the door of the lounge one morning when Flo walked cautiously in with the aid of her stick. Anne saw her: 'Come in

dear. Nancy's at the far table.'Anne took her arm and led her to the table at which Nancy was sitting.

In this case, both Flo and Nancy were members of a settled group and it may have been that, if she had been offered a choice, Flo would have sat with Nancy anyway. However, Anne's action may have helped reinforce group solidarity and endow it with staff legitimacy. In some cases, though, staff directed arrivals to sit with other clients who were not members of the same group. For example:

Mr Burgess walked across to the tea trolley on entering the lounge one morning. The Volunteer who was serving tea did not like clients to carry their own tea across the lounge for fear of their spilling it. She said to Mr Burgess 'I'll bring your tea for you, love.' As a cup was already poured she picked it up, walked across to a table where two other men were seated and put it down for Mr Burgess. 'There you are, love' she said, pulling a chair out for him.

Mr Burgess sat at the table until he had finished the tea, then walked across to another table.

Thus staff, intentionally or not, assisted in the formation or maintenance of a group and they sometimes placed a client with people with whom she did not want to interact. In other cases staff were instrumental in isolating a member from a group. For example:

Mrs Green was sitting at a table in a craft room with three other members of a roaming group. She was experiencing difficulty with her knitting and this was noticed by Anne, a care assistant who was instructing. Anne said 'Come over here, Mrs Green, and then I can help you.' Mrs Green moved round the table to

join Anne. As she did so, her chair among the other members of the group was taken by another member, Mrs Wyatt. This was noticed by Mrs Green who made no comment at the time. When she left Anne, Mrs Green moved back to her original place: 'Can I have my chair back, now?' she asked Mrs Wyatt. A brief altercation took place which resulted in Mrs Green moving elsewhere. She did not rejoin the group for the remainder of the day.

Although the staff influenced the groupings of all members, those most affected were wheelchair bound clients. Sometimes staff asked non-ambulant clients where they wished to sit:

> Ron (Craft Instructor) took Reg, a wheelchair bound client, into the lift and into the dining hall for lunch. As they went through the door, Ron asked 'Anywhere special?'
>
> Reg: 'No. Nowhere special, Ron.'

Very often, however, non-ambulant clients were not presented with a choice. For example, earlier in this Chapter, Mrs Sarah Jones' first day at the Centre was described. This included the following incident:

> Mrs Jones was sitting alone at a table at 9 50 am. David (Caretaker/Care Assistant) wheeled in an elderly client in a chair. He introduced her to
>
> Mrs Jones: 'This lady comes from Saughall as well, Dora.' He left her at Mrs Jones's table.
>
> Mrs Jones: 'What part of Saughall do you live in?' Dora did not reply.
>
> Mrs Jones: 'This is my first day here.'
>
> Dora: 'Yes.' After a few further minutes Dora wheeled herself away to another table.

On another occasion:

> Three wheelchair bound clients arrived at the Centre at the same time; two by the same ambulance, the third by private transport. David (Caretaker/Care Assistant) wheeled two of them into the building in short relays and Eric, (Care Assistant) helped the third. One was a young, physically disabled man, the others were elderly women. On arrival in the lounge all three were taken to the same table which was otherwise occupied and left together. David and Eric moved away.

Wheelchairs were often used to fill spaces. It was common for dining tables to have single vacancies and for staff to fill these by pushing wheelchairs into the vacancies. In most situations, little thought was given by staff to the placing of non-ambulant members and they were often taken to a place that was easily accessible to staff. The social position of the non-ambulant would have been difficult even if staff had given more consideration to their placing. By being in a wheelchair they were socially isolated. By virtue of the size of the wheelchair, its occupant was often sitting slightly backwards of other clients in a 'circle'. It was not possible to place a wheelchair as close to a table as an ordinary chair. Thus it was sometimes difficult for a non-ambulant member to interact with the other members of the group. Being physically slightly outside the group she may have found it difficult to hear what the other members were saying, to make eye contact with them, to obtain natural openings into the coversations. It was often impossible to fit a wheelchair into an established group whereas it may have been possible to fit in another member on an ordinary chair.

Thus, at the Centre itself, the non-ambulant disabled were often on the periphery of a group rather than in a group. The position was similar in the ambulances that had been modified to take wheelchairs. These had 'tail-lifts' in order to admit such chairs and had been fitted with clamps which prevented the chairs moving about within the ambulance. One or more conventional seats had been removed to allow a wheelchair to be admitted and fitted to a clamp. Although a modified ambulance was able to carry at least six wheelchairs, it was common for only one or two members to be carried in wheelchairs and the remainder of the occupants to sit on conventional ambulance seats.[1] Ambulant members entered the ambulance via the front and filled the ambulance from the front seat backwards. Non-ambulant members entered via the back door and, presumably because it was easier for the driver or to prevent additional ambulant passengers entering from the front having to step past wheelchairs, the driver normally clamped the wheelchairs in the positions at the very rear of the ambulance. As the ambulances were rarely more than half full, there was often a considerable space between the ambulant and non-ambulant passengers with the latter physically isolated.

Having discussed staff classification of clients, reference must be made to client perceptions of staff. For two reasons it is not possible to construct an ideal typical model of centre-based staff in the style of the ambulance driver model. First, the staff roles were very much more complex and clients had different expectations of different aspects of the staff roles. Secondly, client expectations of staff were themselves more varied than were their expectations of drivers.

1 Several non-ambulant members preferred to move to a conventional seat once they were in the ambulance.

It was, however, possible to identify two groups of clients with consistent perceptions of staff; these are categorised as 'the entitled' and 'the deferential'. The entitled regarded day care as a right. They adopted the role of hotel guests and expected hotel service. They expected food and facilities to be of a high order and staff to be available to satisfy their requirements at a moment's notice. Some clients had higher expectations of the quality of service than others. Mr Washbrook was a client in the entitled group:

> Mr Washbrook was sitting in the lounge playing dominoes. He complained of the cold to a fellow player and then turned to a care assistant who was standing behind him and talking to an instructor: 'Ere; while you're not doing anything, get me my coat from the hall.'

On another day, Mr Washbrook was sitting at the same lunch table as the observer;

> After eating a mouthful of chips Mr Washbrook made a noise which indicated his displeasure. He called to one of the care assistants: 'You, Anne! Over here!'
>
> Anne came across.
>
> Mr Washbrook: 'These chips are soggy. I can't eat these. Take them back to the kitchen and see what they can do about them.'
>
> He turned to me: 'If they were from the chippy you'd throw them back. They think they can serve up anything here. I'd complain to Fitzpatrick (the Officer-in-Charge) but she'd just think I'm a trouble-maker.'

An elderly client, Agnes, was another in the entitled category:

> Agnes was sitting in the lounge shortly after arriving at the Centre one morning. She was talking with another client, Mary.
>
> Agnes: 'Well, I don't know what has happened to my tea. She (a volunteer) said she'd bring it over a long while ago and it's still not arrived. It's too bad.'

Agnes spelt out her expectations quite clearly when talking to the writer about the need for a cookery class:

> 'They offer basketwork, needlework, French; all these things. I really don't see why they can't offer cookery as well. When we first come they tell us they can offer all sorts of activities and that's the basis on which we agree to come. If they can't provide cookery they should have said so in the beginning and then we'd have known where we stood. If they want us to keep coming they'll have to start providing what we want.'

A final example is from a third entitled client, Mrs O'Neill, who was talking about the Officer-in-Charge:

> 'She's bossy. I've had to tell her off more than once. On one occasion I'd just had my hair cut and she came and told me to sweep the hair up off the floor. She then stood over me. Well! I've never done a job in my life when someone's had to stand over me to make sure I was doing it. I had to tell her off about that and she's not done it since.'

The truth of Mrs O'Neill's story may or may not be disputed. What was important was her attitude which was behind her interpretation of the event.

The deferential clients took a very different view. They regarded day care as a privilege rather than a right. They adopted the role of honoured guests and regarded any service that was provide as a bonus for which they showed considerable gratitude. The deferential position was put by Mrs Wright:

> 'We're ever so lucky to be here. When I look round at the number of people who have nothing and then think of how well looked after we are here. I get mad at the people who complain.'

Examples illustrating the deferential clients behaviour are, by nature of their expectations, less dramatic than those of members of the entitled group. For example:

> Miss Graham had been sitting in her wheel-cahir for more than twenty minutes waiting for someone to help her into the lift and then to lunch.
>
> David came along on his way somewhere else and saw her: 'Are you still waiting to go to lunch, Miss Graham? I thought Eric was going to take you. I'll be back for you in a minute.'
>
> Miss Graham: 'Don't hurry David. I'm quite alright here.'

And:

> Mrs Phillips was knitting as a member of a class. She finished her wool and, despite there being a care assistant and an instructor in the room, she crossed the room herself to collect some more wool. In doing so she fell but was fortunately unhurt. Joe (Care Assistant) helped her back to her seat: 'You shouldn't have tried to do that, love. Why didn't you ask Ann or me to get it for you?' she scolded gently.
>
> Mrs Phillips: 'You're busy enough without having to run little errands for me.'

Although most clients may be categorised as either entitled or deferential, it must be emphasised that these are very broad categories with clients variously displaying extreme or moderate characteristics of their category.

In view of the different expectations of individual members of staff and individual clients, and of the very different personalities at Suilven House it was inevitable that, as with any large social group, the nature of the relationships between individual clients and staff members varied considerably. Put crudely, some people got on well together while others did not. Thus the definition of acceptable client behaviour differed not only from one member of staff to another but, also, an individual member of staff's position differed according to who was the particular client concerned. Similarly, client expectations of staff varied. For example, the same client may have interpreted a 'playful pat on the back-side' from one member of staff very differently from that administered by another member.

Although these may be characteristics of any large social group there were two aspects that were unusual at Suilven House. First, there are few institutions at which all of the staff are younger than the clients for whom they are responsible. Secondly, apart from the two offices occupied by the Officer-in-Charge with her Deputy and by the Care Assistant who had responsibility for dinner monies (both of which were private territory which other members of staff entered by invitation for business purposes only) and a craft workshop there was no room or area set aside for staff use. This arrangement ensured that staff had to talk to each other, eat, drink tea and coffee within the same rooms as clients. Nonetheless, there were socially defined boundaries between staff and clients. Some of these were sociospatial. There were, for example, seats in one area of the lounge that were not formally set aside for staff but which were always occupied after lunch by staff members eating their own food or relaxing. The writer did not see anyone but the staff sit in these seats after lunch although before lunch they were readily filled by clients. At the Christmas concert, there were performances by staff and by clients but no performances by mixed acts of clients and staff.

A division beteen staff and clients that was particularly interesting concerned the initiating of activities. It was very unusual for the staff to initiate an activity either in the morning or in the afternoon. It was normal for clients to decide when a class would begin. For example:

> At 10 30 one morning a large number of clients were sitting in the lounge. Instructors and care assistants were variously talking in groups or preparing materials. No activities had commenced. Mrs Taylor stood up and announced to the other ladies at her table 'Come on! It's time we started some work'. She walked to the sewing room, followed by other clients and the instructor.

Although it was normal for the clients to decide when to start an activity, it was, conversely, normal for the instructor to determine the nature of the activity. This was true both of group activities such as cookery or singing where all participants had to bake the same food or sing the same song as each other and of individual activities such has sewing or basketwork where the individuals were working on separate projects. Even dominant clients were willing to allow the staff to decide what they would make. Despite the enthusiasm with which the active clients engaged in the activity they displayed an almost disinterested passivity in the selection of the activity itself. For example:

> Mrs Groom was an influential member of a stable group whose members sewed or knitted every week. At the end of one afternoon Mrs Groom finished knitting a small jacket. The next week she took her place at the sewing class but made no attempt to start knitting anything. Ann (Instructor) approached her: 'What are you going to do, love?'
>
> Mrs Groom: 'What is there?'
>
> Ann: 'Do you want to knit or sew?'
>
> Mrs Groom: 'I don't mind?'

Ann: 'You can make a teddy or a dishcloth.'

Mrs Groom: 'I don't mind. Whatever you like.'

Ann: 'OK, sweetheart. I'll get a teddy out for you to sew.'

Ann produced the teddy and Mrs Groom worked enthusiastically on it for several weeks.

Centre management

Reference has already been made to the status differential between care assistants and instructors, to the duties undertaken by different categories of staff and the extent to which they overlapped. It has been noted that the Officer-in-Charge and her deputy devoted their time almost exclusively to administrative functions. However, they were the only members of staff to have management duties. There was no formal hierarchical management structure beneath the Deputy Officer-in-Charge. However, as shown in TABLE 23, the Officer-in-Charge and her deputy spent nearly all their time engaged in paperwork in their office. They had little contact with the staff throughout the day. The formal hierarchical structure may thus be described as one that was concertinad but one in which the two managers were physically separate from the remainder of the staff for much of the day. There was no line management structure among the latter. The hierarchical structure may be presented schematically as:

Officer-in-Charge

|

Deputy Officer-in-Charge

|

Care Assistants/Instructors/Cleaner/Ambulance Crews/Caretaker

Power was held by the Officer-in-Charge and her deputy. The remainder of the staff tried to influence neither the policy of the institution (for example, such aspects as the activities undertaken, the hours the Centre was open, the clients) nor the roles of other categories of staff.[1] The Officer-in-Charge and her deputy both spoke highly of their staff when asked directly and, as illustrated by the following examples, in voluntary comments:

> The Deputy Officer-in-Charge was discussing meal arrangements with me while David (Caretaker/Care Assistant) was preparing the tables. The Deputy said to me 'You don't always appreciate staff qualities as you should but when you see what David does you see the importance of skills you'd never see written down in any job description for a day centre post. For example, setting tables and operating a printing press.'

And:

> While discussing the arrangements for the Christmas pantomime, the Officer-in-Charge said 'Everyone contributes to the Christmas party. The extroverts contribute to the pantomime but the quieter staff also contribute with some very hard work behind the scenes. I'm very lucky with my staff here.'

1 One possible exception must be recorded. The extent to which different categories of staff carried out the same jobs (particularly care assistants and instructors) has already been noted as has the perception, without rancor, of care assistants that instructors had higher status. Although the writer did not hear a single comment suggesting that the division or overlap of duties was inappropriate, one minute from the staff meeting held on 28 November 1978 hinted that there had been some past difficulties. The minute read: 'The matter of who does what was brought up by David (Caretaker/Care Assistant) who felt that care assistants were being used as lackeys by the craft instructors, who had also said that the care assistants were not doing their correct jobs but were doing the office work instead. Mrs Fitzpatrick said that it was in everybody's terms of contract to take clients to the toilet and generally help out and the care assistants were supposed to help in the craft classes when needed. Also David wasn't supposed to do anything for the clients and what he does is his own goodwill.' Both Mrs Fitzpatrick and David stated that they did not recall the minuted discussion with David adding 'I'm quite happy with things as they are'.

It may be regarded as trite to state that all the staff appeared happy but this is true. The researcher was aware of no personal animosities, clashes of personalities, arguments or anything else to suggest that the staff were anything but happy. One must thus ask why it was that they did not try to influence change. Contentment, apathy or lack of sufficiently broad experience to be aware of alternatives to present practice may be put forward as possible explanations.

The absence of a line management structure may have been one of the reasons why staff were poorly informed about Centre policy and decisions. The fact that Admissions Panel decisions were not passed on to staff has already been commented on. Another example of staff ignorance concerned the possibility of charges being levied on clients. Clients paid for their meals but there was no charge for transport or the day care service itself. During the period of the research Westshire Social Services Department considered the possibility of making a charge to clients for the service. Although this possibility was eventually rejected, it remained under consideration for several months. Apart from the Officer-in-Charge and her deputy, none of the staff was aware of the nature of the issues being considered by the persons and committees concerned or of the present stage in the discussions. They knew only what was in the press and would ask the researcher what he knew.

Although there was no line management structure within Suilven House, there was a clear structure designed to encourage participation in decision-making. Four aspects are important and are discussed separately. These are staff meetings, staff supervision, the Discussion Group and the Review Panel.

Staff meetings

Staff meetings, which were attended by all Centre-based staff, ie. excluding drivers and their assistants, were held once per month at 4 pm. The reason for the drivers' exclusion was explained by the Officer-in-Charge:

> 'I'd like them to be there but the only time we can have the meeting is at the end of the day and that's when the drivers are working. If I was to hold the meeting earlier to allow the drivers to attend, some of the other staff would have to look after the clients so they wouldn't be able to come. Whatever I do, there are going to be some people who cannot attend so I decided it would have to be the drivers.'

The meetings were chaired by the Officer-in-Charge, there were no agendas or terms of reference although the meetings were minuted and any member was able to raise items. The first meeting was held on 7 April 1978 and an analysis of the items discussed at the meetings between then and the end of the research period indicates the range of concerns. The items are listed in TABLE 24.

TABLE 24

Analysis of items discussed at staff meetings

| | NO. OF TIMES ITEM DISCUSSED | | NO. OF ITEMS RAISED BY JUNIOR STAFF [1] |
|---|---|---|---|
| Fund raising activities | | 74 | 2 |
| Administrative arrangements for clients | | 68 | |
| Arrangement of social events | 52 | | - |
| Buying Christmas presents | 5 | | - |
| Carol service arrangements | 3 | | - |
| Accompanying clients Christmas shopping | 8 | | - |
| Arrangement of social events for staff | | 8 | 3 |
| Administrative arrangements for staff | | 10 | |
| Payment of wages | 2 | | 2 |
| Staff holidays | 2 | | 1 |
| Price of staff lunch | 1 | | 1 |
| Craft course for instructors | 1 | | - |
| Staff duties | 1 | | 1 |
| Complaint that Centre opened on day of NALGO strike | 1 | | 1 |
| Supervision of staff | 1 | | - |
| Staff behaviour | 1 | | - |
| General Centre administration | | 29 | |
| Announcement of purchases of equipment | 15 | | - |
| Arrangements concerning visitors | 5 | | - |
| Timing of tea | 4 | | 4 |
| Fire drill arrangements | 2 | | - |
| Use of car park | 1 | | 1 |
| Student placement at Centre | 1 | | - |
| Announcement of introduction of Discussion Group | 1 | | - |
| Client issues | | 2 | |
| Complaint that a dirty client was serving dinners | 1 | | 1 |
| Problems faced by the blind | 1 | | - |
| TOTALS | 191 | 191 | 17 |

1 Junior staff are defined for the purposes of this Table only as all staff except the Officer-in-Charge and her deputy.

Several features of the analysis are worthy of mention. First, the meetings were concerned almost exclusively with administrative matters. Only two items (the complaint that a dirty client was serving dinners and the problems faced by the blind) involved discussions of individual clients. The emphasis given to administrative matters may reflect the importance of these to the Officer-in-Charge. Certainly, the Centre's activities, social events and fund raising promotions operated very smoothly; a feature that is important but which is not highlighted elsewhere in this study. Secondly, the analysis illustrates the importance of fund-raising at the Centre. Without the support of the comforts fund, clients would not have received Christmas presents, drinks at parties, would not have enjoyed subsidised trips or such a range of craft materials. Money was raised by selling the goods made by clients either privately to clients themselves or at public sales including sales of work at the Centre and stalls at events organised by other bodies. There were also fund-raising events not connected with items made at the Centre. These included cheese and wine evenings and jumble sales. Thirdly, it is notable that only seventeen of the 191 items minuted were raised by a junior member of staff. This reflects the lack of attempts by junior staff to influence change; a feature of the Centre discussed above.

Staff supervision

The second aspect of the management structure, staff supervision, was introduced by the Officer-in-Charge in October 1979. Plans for its introduction were announced at the September 1979 staff meeting. The relevant minute stated:

> 'Susan (Officer-in-Charge) stated that a lot of Centres had tried "supervision", the Officer-in-Charge and Deputy Officer-in-Charge seeing all the members of staff individually, and discussing any problems that have arisen.'

Owing to the personal nature of supervision, the writer was not present at any of the supervision sessions and has to rely on staff accounts of what they involved.

The Officer-in-Charge was doubtful about the success of supervision:

'Colin (her deputy) and I divide the staff between us. We try to see everyone once a fortnight but we don't manage anything like that. There just isn't the time and its more like once every five of six weeks. I talk about the work that the member of staff has done since I last saw them and we discuss ways that they can change. I'm not sure how successful it is; I've not got it right yet and I'd like to be able to spend more time on it.'

The staff were consistent in their views of supervision which reflected those of the Officer-in-Charge. The statements of Joe (Care Assistant) and Ron (Instructor) were typical. Joe said:

'We only started a year or so ago and I haven't really had that many sessions. When we started it was going to be every fortnight but it's not been anything like that. I don't know what we'd have found to talk about if it had been ... '

M Taylor: 'What do you talk about?'

Joe: 'Anything really. It's supposed to be about the clients and what I'm doing with them but it finishes up with us talking about anything.'

M Taylor: 'Anything?'

Joe: 'Anything to do with the Centre.'

Ron said: 'It's difficult to say what supervision has achieved because there's not been as much of it as there should have been. I've found it useful. We've talked about my work with clients but I think the most useful thing is that the supervision has made me think myself more about my work.'

Discussion Group

The third aspect of the management structure is the Discussion Group. The Group was established in February 1980. Its formation was announced at the February 1980 staff meeting by the Officer-in-Charge. The minute stated:

> 'The clients discussion group are having their first meeting on 12 February and hopefully they will come up with some ideas on what the clients would like to do when they are at the Centre.'

In fact, the Discussion Group was not as narrowly focussed as this minute would suggest. The Officer-in-Charge positively encouraged the Group to discuss a wide range of issues concerning the Centre including administrative matters, social events, fund-raising events, and activities. Further, each client delegate was required to make a short verbal report on any matter her constituents wished her to raise.

The Group had fifteen members; ten clients and five staff including the Officer-in-Charge and her deputy. The staff members were appointed by the Officer-in-Charge. Ten clients represented the clients attending each day of the week (two representatives of each day's population). Originally, clients willing to sit on the Group were asked by the Officer-in-Charge to volunteer and she undertook to draw names of successful volunteers from a hat. In fact, she selected from the list of volunteers those she thought most appropriate for the task. In order to emphasise the importance of the clients' contribution to the Group, the Officer-in-Charge required clients to occupy the posts of both secretary and chairman, the latter on a rotating basis. The client membership comprised four elderly women, one elderly man, two disabled women and three disabled men.

At the meetings, the Officer-in-Charge made major efforts to involve clients in a wide range of issues at an early stage. These included early notification of trips, of plans for the installation of a phone-in system for sick clients, requests for ideas for social events. Some subjects were client initiated and these were almost exclusively concerned with the day-to-day operation of the Centre such as changes in activities and arrangement of the cloak room. The client representatives, the Officer-in-Charge and her deputy all contributed fully to the discussions although the other staff members said very little.

The Discussion Group often established working parties and the membership of these suggested reluctance on the part of the Officer-in-Charge to allow them to meet without her being present. For example:

At the January 1981 meeting of the Discussion Group, the possibility was being considered of installing a phone-in system to allow clients who were unwell to contact other clients at Suilven House. After a lengthy discussion, the Officer-in-Charge suggested that a small working party should be set up to consider the matter. Two clients and a staff member were appointed to the working party and a date fixed for its first meeting. One member of the working party asked what its terms of reference were to be. The Officer-in-Charge replied 'Perhaps it would be best if I were to join the working party and then we'll work those out amongst ourselves.'

Although the elderly clients claimed to be pleased with the operation of the Group, some of the younger handicapped members interpreted the unwillingness of the Officer-in-Charge to allow working parties to meet without her being personally

involved as indicating that the Discussion Group was no more than a gesture of democracy while the Officer-in-Charge retained control of the important issues. Frank and Dennis, two handicapped clients, chose a discussion at the February 1981 meeting to support their argument. There had been a lengthy discussion of a proposed visit to Runcorn. Frank and Dennis had offered to organise this but the Officer-in-Charge had only been willing for them to organise the associated raffle while she made the rest of the arrangements.

Frank was an articulate man who had strong views on the Discussion Group:

> 'It's useful as a means of communication but it discusses things which the management should be sorting out. The proposed public address system is a case in point. It should have been thought through by the management first but it wasn't. They put it to the Committee at too early a stage because they hadn't thought it through. The Committee's a good idea but it's just turned into the manipulative machinery of management.'

The Officer-in-Charge's interpretation was different:

> 'On the whole, I'm pleased with the way it's developing. I'm responsible for what's happening at the Centre so I cannot allow the Discussion Group to take decisions that commit me to things I don't agree with or cannot get support for from the office. But as a means of letting the clients make a contribution to the running of the Centre, I think it's coming on quite well.'

It is interesting that, in the same way as active clients regarded themselves as having higher status within the Centre than the non-active, some of the Discussion Group members saw the Group members as an elite of the Centre. One example

illustrates this as well as demonstrating the efforts made by the Officer-in-Charge to encourage delegates to involve their constitutents in the running of the Centre.

At the December 1980 meeting, members were discussing the possible involvement of Discussion Group members in the manning of the pay-phone in the entrance to the Centre. Mrs Robertson, an elderly representative said 'Why is it always just the Committee who are involved in these things?'

Officer-in-Charge: 'You should look to the people outside this room. There are people out there with a lot to contribute.'

Mrs Robertson: 'Yes, and they just sit there.'

Officer-in-Charge: 'It's up to you to go out and get them involved.'

Mrs Robertson: 'It's not that easy. Most of them just aren't interested. They want everything done for them. It's only those of us in here who really take an interest in the Centre.'

Although Mrs Robertson's statement exaggerated the position, many members did show an apathy towards active involvement in shaping the development of the Centre. There were two Centre publications which were intended to keep the clients informed of developments. The Discussion Group minutes were published shortly after each meeting and 'The Towpath Times' was published approximately monthly. The latter was typed by a client, edited jointly by a client and the Officer-in-Charge. It contained twenty or more pages of Centre news, articles on Elgol, brief extracts from national newspapers and magazines, poems, prayers, cartoons, recipes and jokes submitted by clients and staff. Both publications were free. They were actively distributed by Discussion Group representatives and copies were placed on a table for members to collect if they wished. Although these publications were designed to provide an effective communications system in the Centre, some clients did not even make the gesture of taking a publication:

Mrs Crosland was moving round the lounge distributing copies of 'The Towpath Times'. She reached the table occupied by Mr Black and Mr Caldwell.

Mrs Crosland: 'Do you want one, Mr Black?'

Mr Black: 'No.'

Mrs Crosland: 'No? It's good reading. What about you, Mr Caldwell?'

Mr Caldwell: 'No.'

Mrs Crosland: '"No?" Got the TV licence to pay, I suppose?'

She walked off shaking her head, leaving the two men perplexed by the joke.

Review Panel

Review Panel meetings were held once per month. The purpose of the meetings was to review the progress made by a client at Suilven House and to determine any changes that should be made in her programme. A client was reviewed after she had been at the Centre for six months and thereafter as necessary. It was extremely unusual for a client to have a further review after that at six months.

There were two types of review. An internal review was the common kind. One instructor, Joan, who volunteered for the job, collated written comments on the client to be reviewed. She obtained these from all members of staff who wished to comment and from social workers, occupational therapists and any other relevant community-based worker. The people present at the internal review were the Assistant Principal Officer, Officer-in-Charge, and Deputy Officer-in-Charge. Appropriate other professionals (eg. social worker, health visitor) were invited to the review but very few attended. Less than one in three of the Review Panel meetings the writer observed were attended by anyone other than the three people mentioned above. The second type of review was referred to as a 'full-blown' review. These were rare and none was held during the research period. A full-blown review was held if the Centre staff had special concerns about a client. The client was invited to attend and more detailed written reports were required.

A meeting of the Review Panel was normally very short. Twelve was the approximate number of clients reviewed at a monthly meeting, the exact number being determined by the number of clients admitted six months previously. A client who was thought to be benefiting from day care, who was not represented at the meeting by an external agent and for whom no recommendation was made by a member of staff, was dealt with in three or four minutes. Clients with special problems were considered for up to twenty minutes.

The review of each client took a similar form. The Officer-in-Charge or her deputy gave a verbal report on the client under consideration, written reports were read out, if an external agent was present his views were heard. A decision was then made. The decision was normally 'to continue as at present' but sometimes it was decided to offer additional days to a client, rarely to reduce the number of days and, on one occasion, 'to ask staff to monitor her progress carefully'.

Decisions to offer clients additional days at the Centre were based on various grounds. It has already been stated that it was normal practice to offer a new client just one day per week initially and to consider increasing this later if a case was made. At all the Review Panels the observer attended, the cases for additional days were made exclusively by the external agent. This was thought appropriate by the Officer-in-Charge as 'They are the people who see the clients at home and can tell what they need. We only see them here and so it's often difficult for us to tell whether they are really getting as much benefit from being here as we might think.' On every occasion a request for additional days was granted although sometimes for less days than were being requested. In other words, on some occasions a case was made out for a client to attend, say, an additional two days but the Panel agreed only to an additional one. It was much more common for additional days to be

requested for handicapped clients than elderly clients. It was suggested by the Officer-in-Charge that this may have been because of the suddenness of the episode that disabled a handicapped client and the drastic change in life style that the episode brought with it combined with the fact that, for some of the handicapped, day care was of temporary nature while they adjusted to the problems of being handicapped and, possibly, while sheltered accommodation was being arranged. For the elderly, the circumstances that led to day care were more likely to be gradual and day care was a long term provision ending either with death or institutionalisation.

The only two requests for elderly clients to be allocated extra days were made by social workers and have already been described (p 198).

Despite the statements of the Review Panel members, the truth is that the allocation of additional days was a haphazard process. There was no policy as to the circumstances that were considered appropriate or inappropriate for the allocation of an extra day. The whole Review Panel process was problematic. It existed because there was agreement that client progress should be reviewed periodically but there was uncertainty as to how the review should be conducted. This was reflected in the comments submitted by staff. Three examples of comments on clients considered by the March 1981 panel were:

'She enjoys sewing but her stitching is erratic.'

'She is now taking more interest in her appearance.'

'He has become more involved and gained an interest in life. He used to be very drab but is now a lot brighter.'

SUB-SAMPLE

The sub-sample comprised the total intakes from the October, November and December 1980 Admissions Panels. The data obtained from the sub-sample suggested new lines of enquiry during the study. However, owing to the size of the sub-sample and the single methodological way in which the data was collected (ie. by an interview with the client) all the evidence has been treated with caution and supporting evidence sought from the main sample and from secondary sources. Consequently, most of the evidence either suggested by or taken from the sub-sample has been discussed in the preceding pages. The only data from the sub-sample presented here is that which gives a new emphasis to a point already made, or which introduces an argument not previously presented.

The structure of the interviews has already been discussed in the chapter 'Research Methodology'. All members of the sub-sample were interviewed in their own homes within one week of the decision to admit them and again three months after admission. The sub-sample comprised 29 clients. Four of these dropped-out of the Centre a further three died before the three-month interview was held. The times for the interviews were arranged by telephone where possible although clients without telephones were normally interviewed without prior arrangements being made. Approval was obtained from the referral agent before an initial interview was held and in many cases this person had alerted the client to expect a call from the researcher. It has already been explained that each client was told the purpose of the interview, asked whether she was willing to take part and asked if she was willing for the interview to be tape-recorded. A feature of the interviews was that every client agreed to these requests.

Even the four clients who dropped-out were willing to be interviewed at the three-month stage.

The majority of clients said specifically how pleased they were to have been visited. Twenty-two of the 29 made such observations at the initial interview and 14 of the 22 at the three-month stage. Typical statements were:

Mrs Quinn: 'Thankyou for coming to see me.'

Mrs Woodworth: 'It's very kind of you to call, love.'

Mr O'Reilly: 'Good of you to come.'

One might suggest that this was just politeness or, more cynically, that it reflected a willingness to engage in an interview with someone who may have been perceived as having some influence at the Centre. From the sincerity and warmth with which these comments were made, the writer is sure that they were genuine and that a more accurate interpretation would focus on the lonely lives led by the majority of the subjects and the pleasure they obtained from an occasional visitor, especially one whose purpose was to sit and listen to them talk about themselves.

Only 17 of the 29 clients could remember how they came to hear of the Centre. The distribution of role occupants from whom they heard of the Centre is interesting:

| | |
|---|---|
| Home help | 9 |
| General practitioner or hospital doctor | 4 |
| Occupational therapist | 2 |
| Social worker | 1 |
| Daughter | 1 |

Although one would not wish to place any great reliance on these figures, they present at least two features of interest. First, all but the social worker and daughter had contact with the client as a consequence of the client's ill health or physical disability.[1] These role occupants have a major professional interest in health and it may well be that concern for their client's health was a major reason for them drawing attention to Suilven House. Secondly, the figures emphasise the importance of the home help in the lives of many elderly people. It is rare to find an occupation held in such high regard by clients. Again, the writer is sure that the favourable comments made by clients were sincere and not a consequence of any such factor as fear that the service would be withdrawn if the client was not seen to value it. The observation made by Mrs Samuels was representative of those made by other members of the sub-sample:

> 'I first heard about it (Suilven House) from Mrs Johnson. She's my home help. She's marvellous. I don't know what I'd do without her. She's the third one I've had and I don't know which is the best. I really don't. She does much more than she has to does Mrs Johnson. Do you know, she's here until one o'clock some days and she's supposed to finish at twelve. Nothing's too much trouble. And her husband; he brings my shopping round for me in the car every Friday.'

Both the clients who had heard about the Centre from an occupational therapist had been taken to Suilven House by the therapist for a preparatory visit before being considered by the Admissions Panel. Only two other clients had been on such visits. It is evident that the decisions whether or not to arrange a preparatory visit and the form such a visit should take were made by the referral agent. From the evidence

1 It is possible that the social worker may have become involved for similar reasons.

of the sub-sample and the researcher's participant observation of the whole population it appears that the agents who arranged preparatory visits were mainly those who visited Suilven House for other purposes. These may have been to attend Review Panels or because it was more convenient to visit several clients at Suilven House than to call on them at their own homes. The preparatory visit reflected this. The client was usually given a tour of the building by the referral agent and then left in the lounge to watch the clients while the agent went about his business.

The members of the sub-sample who had the clearest expectations of what the Centre would be like were those who had been on a preparatory visit. Even their expectations and impressions were unclear and bewilderment was a more notable feature of their response to the visits than clarity of expectation. This may not be surprising given the unstructured nature of their visits. Mrs Gill was representative of the clients who had been on preparatory visits. When asked for her impressions of the Centre and her expectations of what she would do there she said:

> 'There's a lot of people there I don't know. I'm surprised how much there is going on there. I can't say what I'll do there. I'll have to get to know people there.'

The members of the sub-sample who had not been on a preparatory visit had little idea what to expect. Examples of statements that reflected the lack of clear expectations were:

Mrs Brain: 'I expect it will be something like hospital.'

Mrs Hill: 'It's a converted house isn't it?'

Mr Graham: 'I don't even know where it is.'

Mrs Fuller: 'I expect it will be like a big sale of work.'

It is not surprising that the writer was asked to explain what happened at the Centre by many members of the sub-sample and some of them assumed that the purpose of his visit was to give such explanations.

Given their confusion as to what the Centre would have to offer it was perhaps inevitable that many clients had little idea what they would do at the Centre or what they wanted from it. Nonetheless, it is possible to identify three kinds of expectation that clients had. Eight of them saw membership as giving them an opportunity to engage in activities. Mr Graham, for example, saw it as 'work experience'. He had previously been an active wood-worker but was now less skilled than he had been and sought a new outlet for his talents. He though he would like to learn basketwork. Mrs Hill hoped 'there will be people there who will help me make things.'

Seven clients mentioned company as something they were looking forward to:

Miss Barnett: 'I want to get to meet other people.'

Mr Watson: 'Sociability will be the main benefit.'

Mrs Hill: 'It'll give me a break from the house. I can just drop everything and meet new people.'

The most prevalent hope (mentioned by twelve clients) was that there would be para-medical facilities:

Mr Watson: 'I want to have a bath with someone to help me. I've only got a shower here.'

Mrs Gill and Mrs Fuller: 'Will there be a nurse?'

Mrs Wordsworth: 'Will there be a chiropodist there to help me with my knee?'

Mrs Jones hoped it would make her walk better.

Mr Farndon wanted someone to cut his nails while Mr O'Reilly thought it might help him with his 'toilet problem'.

In view of these confused expectations it may not be surprising that nearly all members of the sub-sample were fearful in some way. These fears took many forms. Several clients were concerned about the transport as they thought they would not be able to cope with the tail-lift or that the journey would be too long and uncomfortable. Several were just concerned about the unknown:

> Mr Farndon: 'There's nothing hard is there?'
>
> Mrs Quinn: 'Do you think I should go? I'm scared of making an awful hash of it.'
>
> Mrs Wordsworth: 'I don't want to fill in forms.'
>
> Mrs Gill: 'They won't leave me alone, will they?'
>
> Mr Graham: 'Are you sure I won't have to do homework?'

Several clients made it clear that they had been persuaded to allow their names to go forward for admission. In some cases they had been told how difficult it was to obtain a place as a form of pressure. Mrs Courtenay made a comment echoed by others:

> 'It's very difficult to get in, isn't it? I don't know very much about it, only that there's a lot that gets put forward and don't get in. My doctor said to me, "Don't you let them see you hesitate, Mrs Courtenay. It they offer you a place, snap it up. You won't get a second chance."'

Others decided to accept places for the reason nicely stated by Mrs Hill: 'just that they were good enough to let me go'.

It was to be expected, perhaps, that, as a consequence of these fears and confusions, it was common for clients to hope that the interviewer would be at Suilven House to greet them. In all but one case, no prospective client was aware of knowing

anyone who was already at the Centre and the interviewer would at least be someone to cling to and a link with home, albeit a tenuous one. Some comments were:

Mr O'Reilly: 'I'll see you there, won't I?'

Mrs Woodworth: 'Will you be there on Tuesday?'

Twenty-one of the 29 clients referred, at the initial interview, to the possible presence of the researcher at the Centre.

It was possible to interview fewer relatives than had been hoped. This was a consequence of the logistical difficulties of arranging to interview both client and relatives between the formal decision to admit the client having been taken and her first day at the Centre. The only relatives interviewed were six siblings and two spouses who lived with the clients. Each of them emphasised the importance to the client of her having a chance to leave her house and, either as a secondary reason or as the main attraction, the opportunity for the relative to have a break from the client.

Some space has been devoted to the initial interviews in order to adequately represent the views of members of the sub-sample at this stage in their Centre careers. The three-month interviews added little that has not been discussed earlier in this chapter and less space is devoted to them here.

Four members of the sub-sample had dropped out of the Centre during the three months since they were admitted. Although none had formally withdrawn from the Centre they had stopped attending between two and four weeks after admission. (These figures are based on the clients' own statements and the writer's own records as the Centre did not have appropriate records). The ambulance drivers had stopped calling for them. All four were quite clear why they had stopped attending. Two

indicated that they were left alone: 'Nobody spoke to me' (Mrs Brian), and 'I didn't know anybody' (Mrs Griffiths). One was upset by the irregularity of the transport. The final client, Mrs Jones, said she had left because she 'wasn't getting any better'. None of the four had been on a preparatory visit before admission to the Centre.

Of the remaining 25 clients, seven had been absent on five or more of the possible attendances since admission. The actual number of possible attendances varied from eleven to thirteen. These five clients had such different responses that it may be worth summarising their views separately;

1 Mrs Fuller said that she enjoyed going to the Centre but she wanted a nurse there. Unless she felt very well she didn't go.

2 Mrs Jones thought that she ought to keep going because 'I said I'd go in the beginning'. There was nothing for her to do there and most of the clients were not her type.

3 Mrs Quinn had suffered ill health but she enjoyed going and had attended regularly except for the period she had been bed-ridden.

4 Mrs Wordsworth was not very enthusiastic at all. 'It gets me out of the house' she said 'but I don't know when the ambulance is coming from one week to the next. When it does come I'm bumped all over the place'. Her other concerns were lack of opportunity to be bathed and 'not knowing anyone'.

5 Mr Farndon enjoyed going to the Centre for the company. However, he had faced problems with the ambulance tail-lift and only attended when he felt 'at my best'.

The remaining 15 clients had been absent on three or less occasions. All thought that the Centre had lived up to or exceeded their expectations. Twelve of them specified social reasons for their enjoyment with 'companionship,' 'meeting new people,' 'sociability,' and similar phrases being used. Five clients said that the opportunity to get out of the house was important. Five mentioned the attractions of the activities offered at the Centre. This is interesting as eight had specified activities as an attraction when they were initially interviewed. Four of the five were among the original eight. Of the balance of the eight, one had died, one had found basketwork too difficult, one said her hands 'just aren't good enough any more' and the other 'couldn't find anything I wanted to do.'

Both the spouses originally interviewed were interviewed again after three months. Both stated that they had benefited from the break with their spouses and felt that the client had benefited as well although neither was very specific about the nature of these benefits. One of the six siblings previously interviewed was not available and the mother of one had died. Three of the remaining four siblings thought that their parents had benefited from the companionship at the Centre but the fourth thought that her mother did not enjoy going and she did not appear to get on well with the other clients. This accorded with her mother's statment. The fourth sibling though that the Centre had not made any difference to her father.

# CHAPTER 4

# IMPLICATIONS OF THE STUDY

## INTRODUCTION

This study has raised a wide range of issues which must be drawn together and some of their implications identified in this concluding chapter. The major foci of this chapter concern policy implications at a variety of levels; national, social services department, Centre management, individual staff and clients. These foci cannot be divorced from other issues concerning ageing (both theoretical and empirical), from sociological and social psychological work. Nonetheless, given the intention of the study and the nature of the research, it is appropriate that the conclusions should concentrate on the implications for Suilven House in particular and, where appropriate, for day care provision for the elderly in general. Doctoral theses are often criticised on the grounds of their remoteness from real life. The conclusions of the present work are intended to focus specifically on the issues identified in the research and possible ways of tackling some of these issues.

The issues that are brought together in this chapter are the purpose and aims of day care; the clients' career landmarks (Admissions Panel, induction, Review Panel); the Centre regime which includes the roles of staff, staff and client interaction, activities undertaken, issues of concern to the clients; the relationships between elderly and physically handicapped clients. Finally, some suggestions are made concerning the direction of Suilven House and future research.

In the following pages, the writer discusses strengths and weaknesses of Suilven House. It should be emphasised that none of his statements should be interpreted as critical of the care staff. They are caring, considerate and helpful. The problems that they have might be attributed to factors outside their control such as lack of training for their posts and not being told what is required of them.

## PURPOSE OF DAY CARE

One theme that has frequently emerged throughout the study has been the lack of clarity over the purpose of day care for the elderly. This was illustrated in the literature review, where some authors were shown as being uncertain about the aims of both residential and day care for the elderly. Other writers identified different justifications of different policies. It was stated in the literature review that, given the variety of expectations for residential care, it is not surprising that research has not focussed on an assessment of the effectiveness of one or more homes in achieving pre-set goals. This may be even more evident in the case of day care where there is greater uncertainty as to the goals.

In the literature review, the writer referred to the conclusions drawn by other authors that no fundamental philosophy exists upon which to base provision for all individuals needing care 'outside their own homes. Reference was made to the lack of clear and coherent policies for the provision of day care activity. Rather than there being a continuum of care which might have a Darby and Joan club meeting one afternoon per week at one end of the continuum and day hospitals operating all five days per week at the other, chance factors have influenced the provision of centres.

One of the more disturbing aspects of the present research has been the demonstration of the relevance of these conclusions to Suilven House. Differences of opinion between writers may be valued as reflecting open-minded academic debate; differences at national policy level may not be considered critical given the extent to which local government is responsible for policy formulation and implementation. In Britain, the autonomy of local government in formulating and implementing social policies is prized. A consequence of this autonomy is that there are inevitable variations in the forms and levels of provision between areas. It might justifiably be argued that, in a form of social provision such as day care, so little is known about the advantages and disadvantages of various forms of provision that it is desirable for there to be different sorts of Centre in order for comparisons to be made. However, this study has shown that in one local authority the justification for day care provision has not been thought through and this confusion is evident within Suilven House. Of further concern is the fact that there is no evidence to suggest that the staff are aware of this confusion and consequently there are no steps being taken to clarify the situation.

The extent to which clarity of the purpose of the Centre is lacking has been shown already. Briefly, the evidence relates to a number of different aspects of life in the Centre. At Admissions Panel meetings there are no clear criteria on which decisions to admit or not admit a client may be based. In the absence of a statement of purpose and, subsequently, of the criteria for admission, any reasonable criterion has become acceptable and no client has been refused a place. This was illustrated when Mrs Jones was considered for a place. She was offered a place on the grounds of her need for company although the Principal Assistant Officer had previously stated that 'the need for company or other social reasons are, on their own, not grounds enough for offering an applicant a place.'

A different emphasis is obtained from the evidence concerning the reasons for the availability of certain activities rather than others. Cost of materials, availability of space, design features of equipment, availability of instructors and popularity of the activity, as perceived by the Officer-in-Charge, were all mentioned as reasons. It was not suggested that an activity had been chosen because it would help achieve an objective of the Centre. Once a programme of activities has been determined, different instructors follow different policies concerning the way in which they structure those activities. It has been shown that some instructors attempt to match the task to the client's ability, some try to help the client improve her skills by providing a progressive programme while others allow a client a completely free choice in selecting a task.

There are several consequences of the lack of clarity over aims. Three appear to be of particular importance and are discussed here while other consequences will be returned to later in this chapter. First, without clear aims, the Centre lacks direction. The design of any tool must be dependent upon the purpose for which it is intended and it makes little sense to think that a tool is useful and subsequently to think of a purpose for it. In the same way, it is logical to base decisions at Suilven House on such issues as the skills to be sought and developed in staff, the facilities to be made available, or the activities to be offered on the purpose for which those skills, facilities or activities are being made available. If, for example, a major aim of the Centre is to counter the effects of social isolation, it is important that Centre staff should have appropriate social skills to promote social contact. If a major aim is to provide a health-orientated, physical welfare or remedial facility, then it would be important to ensure that staff have appropriate nursing or para-medical skills.

Similarly, decisions about the facilities to be provided and the physical setting should be largely influenced by the aims. So also should decisions on whether bathing, remedial gymnastics, manicuring, basketwork or reading are appropriate activities to be made available.

A second major consequence of the lack of clarity concerning the aims of the Centre is that clients are being admitted with unrealistic hopes concerning the potential of the Centre and, in some cases, are even withdrawing from the Centre because these hopes are not being met. In some instances it is obvious to someone who knows the Centre and what it has to offer that these hopes are unrealistic and yet client hopes and 'Centre' objectives are not matched.[1] This unrealism may be illustrated with reference to the clients who enter the Centre expecting or hoping that they will receive medical or para-medical treatment for some disability while the Officer-in-Charge may be unaware of the existence of this disability. Some clients may have unrealistic expectations as a consequence of their own, or their doctor's, prior experience with day hospitals. Several clients have been in hospital where they have seen or talked about day hospitals, have been day hospital clients, or have been referred by doctors whose own experience of day centres may have been shaped by day hospitals.

1 This is an issue which will be taken up again later.

A third consequence concerns the overall pattern of community-based provision for the elderly in Elgol. Suilven House is just part of a range of provision that includes a hospital-based geriatric day unit, secular and non-secular clubs. There is some evidence of clients belonging to more than one of these and of some clients being 'discharged' from the geriatric day unit when they become members of Suilven House. Dual membership and transfer from one organisation to another may be entirely appropriate. The point is that in order for optimum use to be made of each form of provision it is important that the purpose of each is clear.

A first and major recommendation from this research is that further consideration be given to the purposes of the Centre. This might involve many of the parties concerned with Suilven House; clients and their relatives, Centre and other Social Services Department staff, referral agents and others in 'caring' professions.

## THE EARLY STAGES IN A CLIENT'S CAREER

Three events in the early career of a client have been identified within this study as being of potential importance for the client. These are the Admissions Panel, the induction programme and the Review Panel. Although these are spread over a period which is often a little in excess of six months and although the two Panels are different orders of event from the induction programme (being short events rather than an ongoing programme) there is a clear link between the three that makes it sensible to consider them sequentially here.

Admissions Panel

The Admissions Panel and its operation is an important feature of the Centre. It is here that the decision is made to accept or, theoretically, reject a candidate for a place. Decisions on transport, the day to attend and other relevant details are taken by the Panel. The candidate's admission form which is considered by the Panel is the first document to be placed on the client's file and the Admissions Panel is, for the majority of clients, the only occasion on which three of the persons professionally most responsible for her care at home and at the Centre meet together to discuss her case.[1]

One cannot but be impressed with the time that these personnel devote to the Admissions Panel. Documentation is carefully prepared and copied. The Assistant Principal Officer and Officer-in-Charge devote a full morning to the monthly Panel meeting and the referral agent has to attend even if he is referring only one candidate. For the referral agent this involves setting most of the morning aside. The structure has several important strengths. The involvement of the Assistant Principal Officer ensures that an office-based, management representative of the Social Services Department is involved in the decision-making which gives weight to the decision, ensures his familiarity with the types of client being referred and their problems, and provides potential for his making representation to, and links with, other sections of the Social Services Department as necessary. The involvement of the Officer-in-Charge ensures that the most senior officer within the Centre is familiar with the circumstances of each admission and is thus in a position to make the most appropriate arrangements for the client. The presence of the referral agent who, one assumes, is the carer with fullest knowledge of the client, allows the

1 These are the Officer-in-Charge of Suilven House, the Assistant Principal Officer and the referral agent.

client's case to be presented more fully than would be possible in writing, permits the Centre representatives to seek clarification from him on any relevant issue and ensures that the agent is able to accurately report back to the client. A further strength is that the Admissions Panel provides an opportunity for the various members to understand better each other's roles, aims, perspectives and problems. One would hope that this would lead to a better service to clients.

Despite these strengths, one cannot be entirely satisfied with the admissions procedure. Although an attraction of the Panel is the opportunity it provides for its members to explore further aspects of the client's case that are presented on the admission form, it has been shown that, in practice, this opportunity is not taken and the answers to the questions raised by the Panel are usually already provided on the form. One might argue that full enough information is provided on the form for it to be unnecessary for the Panel to meet.

Why is it that all candidates for places have been accepted by the Panel? There are several plausible answers to this question. It may be that there is such complete understanding between the Centre staff and referral agents that the latter only nominate candidates who have appropriate claims to places. One may argue either that in this case the Panel is now unnecessary or, alternatively, that the continued meeting of the Panel maintains this understanding and, consequently, the nomination only of appropriate candidates. It may be that referral agents know how to present their clients' cases in ways that maximise their chances of being admitted. The writer is of the opinion that there is truth in both these possibilities but that a more important factor is, again, the confusion over the purpose of the Centre. It has been shown that clients have been admitted to the Centre despite the fact that the only grounds upon which the client was recommended were grounds which had been stated previously to be insufficient on their own. If the aims of the Centre were made clear it would be possible to identify the criteria upon which the decision to admit or

not to admit a candidate would be based. At present, the aims have not been made clear and neither have the criteria. As a consequence it is not possible to reject a candidate on the grounds that she does not satisfy certain stated criteria. Similarly, a candidate is not accepted on the grounds that she meets specified criteria. Until these criteria are clarified, a referral agent will be successful in obtaining a place for his client as long as he is able to make out a plausible case for her to have a day away from her home or for her to benefit from a day in the semi-structured company of other elderly people.

The absence of policy is further apparent in the allocation of a day of the week to a candidate and in the allocation of a number of days. It has been shown that the allocation of a particular day is haphazard although ad hoc attempts are sometimes made to allocate a client a day that is thought to match her particular needs, interests or background. Apart from the policy that blind clients are catered for on Wednesdays there is no guiding factor in determining the day to be allocated. If there were a clear policy that all clients requiring x would attend on Thursdays when appropriate facilities for the attainment of x would be provided, the allocation of a day would be more rational. This would, of course, require a prior decision that the attainment of x is an aim of the Centre, methods of determining whether a particular client should aim at x and her chances of achieving it.

It has been shown that it is very rare for an elderly client to be offered more than one day per week at the Centre although it is more common for physically handicapped applicants. This may reflect an underlying, although unstated belief that the provision of a place for an elderly person is a permanent commitment (ie. until the client's death or transfer to residential care) whereas for some physically handicapped clients the provision is only short or medium-term. Some handicapped

clients, for example, some stroke victims, improve sufficiently to return to independent living and leave the Centre. There is a view that the provision of two or more days per week at Suilven House may accelerate the return to independence and aid the client in facing the problems of adjustment to handicap. Nevertheless, a few elderly clients attend for two or, in very rare instances, three days per week. Requests for more than one day are not granted until the need has been proved to the Review Panel's satisfaction. The inconsistency between this practice and that of immediately offering additional days to handicapped clients on the grounds of the importance of the early weeks at the Centre for adjustment does not appear to be recognised. The criteria upon which decisions to offer additional days are taken by the Review Panel are not clear and the most influential factor appears to be the strength with which the referral agent argues the case.

The one important person who plays no direct part in the formal admissions procedure is the candidate. The client probably does not know why she is being recommended for a place and her expectations are often different from those of the referral agent. This issue is pursued in the section of this chapter concerned with induction.

On important issue highlighted in the research has been that there are many fewer confused clients at Suilven House than one might have expected. The literature review reflected the prevalence of brain failure amongst the elderly and the writer was aware of this in his visits to elderly people's homes in Westshire. Yet there were very few confused clients at Suilven House. This was demonstrated by the writer's own subjective assessment of the population and by the fact that confusion was identified as a problem at entry in only 28 cases of which 15 were specified as

'mildly' confused. One of the failures of this study has been the writer's inability to identify the reasons for this small proportion of confused clients. There is no evidence that referral agents decide not to refer confused clients nor that they understate the extent of confusion on the referral form in case the candidate's chances of acceptance are reduced as a consequence.

Finally, consideration should be given to the possibility that the Admissions Panel is unnecessary as sufficient evidence on which to base a decision is already on the application form and the discussion only reiterates or amplifies the written points. Against this is the argument that the rules of the panel game are known to both service providers and referral agents. A basis of trust has grown up as referral agents know that their candidates will be accepted and the receivers have learned that the candidates are suitable. It may be that the game must continue to be played in order that the rules are maintained. In other words, if the face-to-face contact were to be lost so may be the trust. If the referral agent did not have to justify his recommendations, however superficially, he may not be so careful in deciding who to recommend.

Induction

Reference was made in the literature review to a number of works that have focussed on the effects of the early days of institutionalisation on elderly people. The seriousness of the consequences of institutionalisation varied from an increase in the death rate to changes in self-image to regressive behaviour. Various writers have stressed the importance of an induction programme in easing the transition to an institution. Although it has been suggested that moving into a partial institution such as Suilven House is unlikely to be as traumatic as moving into a total institution such as a residential home, the early days are still likely to pose difficulties for new

clients. For many, the Centre will be the first organisation that they have been members of for some years. For all, there will be the problem of learning the regulations of the Centre, adjusting to the norms and facing new situations.

The importance of induction is formally recognised by the senior staff at Suilven House. One care assistant has been given responsibility for the induction of new clients into the Centre. She is expected to welcome newcomers, show them around and support them during their first days at the Centre.

Despite this formal recognition of the importance of induction, this study has shown that new clients faced considerable difficulties. The induction policy outlined above has not been implemented. This study has shown that many clients are not greeted on arrival, are left on their own and are confused. Two of the four sub-sample clients who had withdrawn from the Centre during the first few weeks said they had done so because they knew nobody or because no-one spoke to them.

Two sorts of changes might be made to the system in order to aid the implementation of the formal policy. The first concerns the fact that communications within the Centre are not good enough. This is an important issue that extends beyond the question of induction and which is further discussed later. So far as induction is concerned, the requirement is for a formal channel of communication which ensures that members know when a newcomer is to be admitted. Could existing clients be informed that a newcomer would be joining them on a certain day? It is important that staff know when a newcomer is to join. They should know her name, something of her background and her interests. If the Centre is to offer a progressive programme to meet an individual's requirements, the Admissions Panel should state clearly the reasons for the client's admission and plan

a programme to achieve whatever goals have been set for her. The reason for admission, aims for the client and the programme should then be communicated to the staff formally and discussed with them. At present staff do not know when a new client is to join, and are not provided with information on her. It is necessary to improve communication with staff in general but even more important to ensure that the care assistant with responsibility for induction is provided with the sort of information just mentioned. At present, it is quite common for a new member not to be met at the Centre simply because no member of staff other than the ambulance driver has been informed that a new client is to join.

The second change that might be made within the present policy is to provide a clear job description for the member of staff with induction responsibilities so that she knows what is expected of her. The job description should be supported by providing her with training. She should know what is required of her practically. She should know when she should meet clients, what she should show them, what to provide for them and so on. She should also have a greater understanding of the difficulities faced by elderly clients in joining the Centre.

It may be that the Centre staff could think more imaginatively about the process of induction. It may be that induction would be better left to, or include the involvement of, another client. A client may be better able to help the newcomer to understand the Centre. She would have more time to devote than a member of staff. The newcomer may feel more relaxed with someone of her own age and in similar circumstances. There may be important benefits for the existing client concerning self-image and her role in the Centre. Another alternative would be for several staff to have responsibilities for induction with new clients being 'shared'

amongst them. Each newcomer could be attached to an identified member of staff who would be responsible for looking after her during the initial weeks. This 'pastoral' role could be continued even after induction is complete. A third alternative would be for group induction programmes. It might be appropriate for half the clients admitted one month to be allocated, say, Tuesdays and the other half Thursdays. Two groups of some six clients would begin together and remain together for the first day or two and for gradually shorter parts of subsequent days. This would permit a member of staff to remain with newcomers for a greater time and there might be advantages for new clients to be with others in similar situations. There might be disadvantages with all these possibilities but, given the significance of induction, it is important that experiments are undertaken.

The preceding paragraphs have focussed on the weeks immediately following a client's admission to Suilven House. Yet preparation should begin before a client is formally admitted. In the literature review it was noted that Lieberman (1969) found that many of the effects of institutionalisation on self-image were set in motion by the decision to enter the institution and occurred with maximum intensity prior to entrance while Pope (1978) refers to 'preparation' which lasts from the time of application to notification of the availability of a place as the first of four phases in the admission process.

The present research has shown the concern that clients have during the period between being offered a place and taking up that place. Many have very little idea what to expect and display emotions varying from concern of the unknown to fear. In common with studies of residential homes quoted earlier, this research has found that very few clients have an opportunity to visit the Centre before they are considered by the Admissions Panel. Most of those who had been on preliminary

visits had not been provided with a structured tour but had been left alone to observe what was happening. Nonetheless, there is some evidence that clients who had enjoyed a preliminary visit were better prepared for their Centre careers. Nearly all members of the sub-sample who had been on preliminary visits had clear expectations concerning the Centre when they were interviewed prior to admission, although these were unrealistic in many cases.

Some consideration should be given to involving all clients in the Centre prior to their admission. Each potential candidate for a place should undertake a visit to the Centre that is structured in such a way that she is familiar with the daily life of the Centre and should be able to discuss the Centre with a member of staff and/or clients. She should then have the opportunity to inform the Admissions Panel how she hopes to benefit from attendance at the Centre. This need not require her to attend the Centre as the referral agent could be required to represent the candidate's expectations. The client should in turn be informed of the sort of provision that the Panel has decided will be made available to her. This might ease the difficulties of the first days at the Centre for the client, reduce the possibility of her having unrealistic expectations about what the Centre may be able to offer her, and make it easier to devise a programme for the client that would help her achieve specified aims.

Review Panel

The functioning of the Review Panel has been described and discussed. Normally, a client is 'reviewed' just once, after six months at the Centre, by a Panel comprising the Officer-in-Charge, her deputy and the Assistant Principal Officer. In exceptional cases the referral agent is invited and, rarely, a client's case is reviewed on further occasions. Centre staff are notified that a client is to be reviewed by a care assistant with responsibility for this. She collates the verbal observations of staff and passes these to the Officer-in-Charge who reads them to other members of the Panel.

Again, one must admire the enthusiasm with which the Panel undertakes its task but ask its purpose. The only changes that were implemented at the Review Panels attended during the period of this research involved the allocation of an additional day. It is certainly important that the Centre should provide a 'safety net' in order to identify clients who have problems. That the Review Panel does not fill a more important role may be attributed to the absence of clearly defined Centre aims. At the risk of labouring the point, if the Admissions Panel were able to specify the grounds on which a client was admitted and to lay down a programme to assist the client in achieving goals, the Review Panel could ask for appropriate evidence to help it determine the extent to which the goals had been achieved. It could then suggest modifications to the client's programme. The evidence of the research is that comments made by staff for consideration by the Panel are less helpful than they might be as they are given no guidance concerning the purpose of the comments. Reviews should certainly continue but consideration should be given to implementing a structure that would ensure on-going reviews in place of the single review presently undertaken. This will become increasingly important as the Centre population becomes longer established. At the time of the research the Centre had

been open for less than four years and it follows that the maximum period between the six-month review and the present was less than three and-a-half years. Although this may be regarded as a long period without review, it is inevitable that in the future clients will have been at the Centre for many more years than this. It would not be practical to suggest that every client is considered by a Review Panel every six months. However, there are alternative ways of reviewing client progress that could be considered. If, for example, the earlier suggestion were to be implemented that a new client be allocated a member of staff who has pastoral responsibility for her, it would be possible for that responsibility to be continued throughout the client's Centre career. This member of staff would be responsible for on-going review of the client with periodic reports submitted to, or discussions held with, the Officer-in-Charge and the convening of a Review Panel including external caring professionals when deemed necessary. Such a system would ensure that every client is regularly reviewed without the review involving large numbers of staff.

## REGIME

The term 'regime' is used here in the manner of Pritlove (1976) identified earlier; the sum of the relationships involving both caring staff and clients. This research has identified a series of issues concerning the relationships between Centre members. Many of these have policy implications. It is appropriate to discuss some of the more important issues here. First, the role of the staff will be discussed, and secondly, the relationships between staff and clients.

Role of the staff

The importance of the staff in structuring client relationships and other social relationships was emphasised in the literature review. Various models of staff-client relationships and of staff roles were identified. Although none of these are directly applicable to Suilven House, they suggest ways in which these issues could be examined. Lipman and Slater's (1977) criticisms of the hotel manager and guest model; Pincus's (1968) multi-dimensional model; Miller and Gwynne's (1972) contrasting of horticultural and warehouse models; the Barclay Report's (1982) identification of refuge, control and learning, and growth and development approaches were useful.

An appropriate way in which to start examining the role of staff at Suilven House is to reflect on the ways in which staff are deployed. The participant observation showed that staff spend less of their time with clients than one might have expected. Analysis of recordings taken at fifteen-minute intervals over a three-day period showed that on only 39 per cent of the occasions when staff were on duty were they with clients. A high proportion of that time was thought to involve interaction with the handicapped clients, not with the elderly. In contrast, 42 per cent of recordings were in the categories 'management tasks' and 'routine staff jobs'. The other main finding concerning staff roles was the extent to which different categories of staff undertake the same duties. This is reflected in the confusion that exists amongst staff regarding their roles.

There are several reasons why one would wish to see the state of affairs reflected by these findings changed. First, the majority of staff are employed to work with clients. If care staff and instructors are not caring and instructing then it is reasonable to argue that clients are not enjoying the level of interaction with staff

to which they are entitled. Secondly, the various job titles should reflect the expertise of the staff employed in those jobs. The salaries attached to different jobs were, one assumes, determined according to such criteria as the skills and responsibilities involved in the execution of those jobs. If staff are not deployed in the way one might be led to expect from their job title, one must ask whether they are inappropriately deployed, whether the demarcation between jobs is appropriate or whether the balance between the number of different jobs is correct. The writer believes that the research suggests that improvements could be made in each of these aspects of the Centre.

The problem concerning the allocation of relevant tasks to prersons in different role statuses is largely attributable to the office-based roles assumed by the Officer-in-Charge and her deputy. It has been shown that, apart from lunch and short periods either side of lunch, they spend nearly all their time undertaking administrative duties in a room separated geographically from the rest of the building by a corridor and cloakroom. Most of the elderly clients and staff are on a different floor from this room. A consequence of this is that instructors and care staff in particular lack direction. Nobody tells them what to do, when or with whom. They do what they think appropriate when they think it appropriate. A significant observation was the extent to which clients initiate activities and are followed by staff. These comments should not be regarded as criticisms of the staff concerned who display commitment and concern for the clients. Rather, the comments again reflect the need for a decision on the purposes of the Centre, clear programmes for individual clients which are communicated to the staff and the involvement of at least one of the two senior staff in the rooms occupied by clients and staff in order to ensure that the programmes are implemented.

It may be desirable for senior staff further to clarify the roles of the different categories of staff. The Cleaner has been shown to spend the majority of her time cleaning and the Hairdresser cutting hair but the activities undertaken by the other staff show considerable overlap between role statuses. This may well be desirable. It maybe, for example, that it is appropriate that there is considerable overlap between care staff and instructors. If so, this should be stated and, possibly, the perceived status differential between instructors and care assistants ended. It may even be appropriate to dispense with the different titles. The staff recognised that instructing involves a pastoral role. Care staff spend a lot of their time instructing. The dispensing of the different titles for the two categories of staff would reflect this reality. It may make it easier for the Officer-in-Charge to deploy her staff and may eliminate the tendency for the present care staff to seek status through instructing. The last may, in turn, increase the time staff spend with clients who do not take part in activities.

The writer recognises that the changes suggested above could not be made easily. Comparability with other institutions, better paid staff wishing to maintain differentials, trade union views and similar factors would have to be taken into account.

The voluntary workers have not been mentioned so far in this discussion. Some of the voluntary workers fulfilled limited roles performing routine tasks such as serving tea. Others are indistinguishable from the instructors and care staff and all the comments made about these role statuses in this discussion are equally applicable to the voluntary workers. The 'routine' task of serving tea is not unimportant. Every client has a cup on arrival in the morning and after lunch. A voluntary worker is thus the one Centre-based role occupant that the clients must meet. She is cast in

an important role and the fact that clients are unaware who are voluntary and who are employed staff should be regarded as praise for the former. Their skills and central role might be used by involving them in client reviews and other forms of consultation.

One would certainly like to see consideration given to the role of the two most senior staff. It makes little sense for the two most senior staff to devote most of their time to routine administration involving completion of forms, statistical records, ordering materials and keeping financial records of payments for dinners and client purchasing of goods. Their skills and experience are essentially in working with clients. They would be more appropriately employed supervising staff,[1] working with clients and managing the Centre. It may be appropriate to employ an administrator with administrative skills to undertake the administrative work of the Centre.

Although the Hairdresser and Cleaner spend most of their time hair-cutting and cleaning, their duties have been shown to involve them in interacting with a wide range of clients including the isolates who do not interact with the care assistants and instructors. Their roles are wider than may at first appear and it would be appropriate to think of them as staff with caring roles.

1 Credit must be given to the Officer-in-Charge for trying to implement a system of staff supervision. Both she and the supervised staff have noted that the supervision has not been as successful as they would have wished. She is in need of guidance on the ways in which supervision should be undertaken.

It is thus a pity that the Hairdresser does not attend staff meetings. The same is true of the drivers whose importance has been demonstrated time and again throughout this study. As the only staff at the Centre who have contact with clients at their homes and at Suilven House, they are in a position to provide a bridge between the two contexts and have knowledge about clients that is not available to other staff and which could be important at a discussion of clients. However, it has been shown that the purpose of staff meetings is not to discuss clients but to consider administrative matters. The writer recognises the need for meetings at which administrative arrangements may be made in order to ensure the smooth running of the Centre. Given the importance of transport to clients and staff it is unfortunate that drivers are unable to attend meetings at which administrative matters are discussed. There is also a need for meetings at which clients may be discussed. Such meetings could help to ease the communication difficulties referred to earlier.

Before leaving staff meetings, reference must be made to the extent to which the Officer-in-Charge and her deputy raise items for discussion (174 of the 191 items raised). This may not be a very different proportion from that pertaining at meetings which are involved with administration at other institutions of many kinds. Neverthelesss, it does indicate that the junior staff play a smaller part than might be desirable in directing the Centre.

The senior staff have made a strong attempt to involve the junior staff in the meetings. The Discussion Group, attended by staff and client representatives, was set up recently and demonstrates a willingness to involve clients in decision-making although on a much more restricted basis. The research has shown that the Officer-in-Charge is prepared to consult the clients on certain issues but she is not

willing to do more than consult them. This is reflected in the title of the committee; 'Discussion Group'. This is what it does; it discusses, it does not decide or even recommend. This is not a criticism. The Group has only been recently established and the writer has sympathy with a policy of moving slowly towards fuller client involvement.

Staff and client interaction

It is to be hoped that the establishing of the Discussion Group reflects a move towards a greater autonomy for clients and relaxing of the control that the Officer-in-Charge exercises in some areas. Surely, for example, the term 'dinner monitor' is not appropriate in a day centre for the elderly. It suggests relationships between staff and 'monitor' and between 'monitor' and other clients that should not exist in an establishment for adults. Again, one can understand the reasons for the Officer-in-Charge selecting the client representatives on the Discussion Group. The selection of the clients she considers the more articulate and reasoning may help establish the Group. It is not so easy to understand or justify this selection while claiming to the clients that the names were drawn from a hat. Nevertheless, it is hoped that when the Group is established it will be possible to hold open elections for membership.

It is also hoped that the current proposals for a 'phone-in' system through which absent clients will be able to talk to their colleagues at the Centre will result in a more open exchange of information about clients. It is regrettable that there is presently no mechanism whereby clients are kept informed about illness and deaths of other members. The use of the existing noticeboard or, preferably, more informal announcements (possibly at lunch when all clients are assembled) might reduce the unfortunate rumours and distorted accounts that currently circulate.

Some evidence has been provided to suggest that some client members of the Discussion Group regard themselves as an elite. Although it has been shown that they are unable to determine Centre policy, they are in a position to help to shape it and, as a consequence of their being informed about or consulted on various issues, they are privy to information that is not disclosed to other clients.

The other aspects of client hierarchy that have been demonstrated in the research are first, the status accorded to activities and participants in activities and, secondly, the model of good and bad clients. With both these it is yet again necessary to refer to the lack of clarity concerning the purpose of the Centre. It has been shown that fewer than half the population take part in activities and that those members who are participants take part regularly from week to week. Activities learned at the Centre are not practised at home so it cannot be claimed that the Centre promotes new interests which are pursued during the rest of the week when clients are not at Suilven House. Some prospective clients are particularly attracted to the Centre by the possibility of taking part in an activity or learning a new skill. If a client is already proficient in an activity, she is likely to take part in that activity if it is available at Suilven House; if she is no longer proficient at an activity in which she was once proficient she is unlikely to take part in that activity although she may take part in another. A client who enters Suilven House without a predisposition towards any activity is more likely to engage in an activity if she follows a 'directive' induction programme than if the induction programme is 'non-directive'. A consequence of these findings is that, if the Officer-in-Charge wants to increase the activity participation rate, positive steps need to be taken with individual clients to find out what they would like to take part in and what they are prepared to try. A structured series of 'taster' sessions within an induction

programme might be worthwhile. While recognising the good intentions behind the Officer-in-Charge's action in transferring the basketwork classes to the lounge for a week in the hope that non-participants would be encouraged to take part, this action may not be sufficient. It is unlikely that clients who have not taken part will be motivated to go to the class and join in or will have the self-confidence to do so. If the previous suggestion that each client should be attached to a personal carer who has some responsibility for that client were to be implemented, the personal carer could give encouragement and help the client into a new acitivity. This one-to-one relationship is presently missing.

However, a prior question is whether it is important that clients should take part in activities. At present, the status given to participants by the senior staff is reflected by the clients. Non-participants have little involvement with staff. In a few cases two or three clients regularly engage in a hobby such as card-playing and they are happy to continue alone. Formalising the activity or staff involvement in it might reduce the enjoyment of such participants or lead them to abandon their game.

The Officer-in-Charge has justified the emphasis she places on activities on the grounds that participation gives members confidence. Other staff and active clients see non-active clients as lazy and failing to take advantage of the facilities that the Centre has to offer.

Certainly one would wish to see a range of activities offered at the Centre. Whether or not participation does improve members' confidence is unknown. As it is known that many members want to take part and that activities give a focus to the Centre, they are justified. However, recognition should be given to the wish of many clients not to take part and they should be accorded the same status as activity participants

and should have similar opportunity for interaction with staff. Indeed, it may be argued that as they have less interaction with other clients they should have greater opportunity for interaction with staff. The real difficulty is that the staff do not know what to do with the non-active clients. It is relatively easy to identify a need for activities and to provide them. It is more difficult to identify the sort of provision to be made for clients who do not wish to take part in activities and any provision may require more advanced skills from the staff than those involved in instructing. To judge from other research that has been undertaken (see, for example, Peace, Hall and Hamblin (1979), and Hanson (1972)) staff should anticipate that, normally, many clients will not be active. The review of literature into old people's homes emphasised the extent to which passivity is the norm. At Suilven House passivity is accompanied by a reluctance by many clients to join the group activities promoted by staff. The staff feel frustrated and discouraged from making further special arrangements for clients by what they perceive as a poor response by the clients. It is to be expected that many clients at Suilven House will be passive for most of the day. One might ask why they should not be passive while wishing to see them encouraged to do more than sit and watch the world go by. Research findings referred to in the literature review have emphasised the difficulty faced by the elderly in learning new skills and in coming to terms with their inability to perform skills they had once mastered. The latter has been put forward in this work as one of the reasons why some clients at Suilven House are unwilling to take part in certain activities. However, many prospective clients look forward to taking part in all available activity at Suilven House but then do not participate when admitted. This may be a consequence of their own lack of confidence, the difficulty of entering the stable social groups that take part in the activity or possibly the way in which the activity is organised. All have been identified in this study as difficulties and in each case staff are in a position to make appropriate changes.

Not all activities require a high level of skill. There is potential for developing activities for which the clients themselves could be responsible. For example, there is a large empty greenhouse at the Centre. This has possibilities for client management and for the clients to help each other to develop the necessary horticultural skills. The sale of flowers and vegetables grown in the greenhouse could provide an income for the Centre and further interest for the clients.

In summarising some previous research, the writer stated (page 30): 'It may be that the difficulty of learning skills, a general feeling of tiredness which makes inactivity attractive and past-orientation form a vicious circle. If loneliness is included in such a circle it becomes formidable.' There are clients at Suilven House who are caught in such a circle and who are not being helped to break out of it. A first step in helping them would be to ensure that each client has some contact each day with a named member of staff - the personal carer suggested earlier. The personal carer could make use of the client's past orientation as the basis of discussions which would normally involve other clients. This in turn could be accompanied by activities or lead into them. These need not be entirely Centre-based. The Centre is located in a City with a history that dates back to the Romans. This provides a fine environment for past-orientated persons! The success of the Christmas party and occasional outings as unifying activities reinforces the view that, to be a success, an activity need not require a high level of skill. It would not be necessary to involve a client in a semi-structured programme for a full day; it is recognised that many elderly people require long rest periods. It is to be hoped that staff support might gradually be withdrawn as a client interacts increasingly with other clients and develops her own interests.

One returns to the position that, if the purposes of the Centre were better defined, the grounds upon which a client was admitted were stated, a programme or aims laid down for that client, certain kinds of provision might logically follow.

Some concern should be expressed about staff perceptions of 'good' and 'bad' clients. It was noted in the literature review that Brearley (1975) has suggested that the staff view of a 'good patient' is one who conforms, behaves, does not make demands and subordinates his own personality to that of the organisation. This is in contrast to the 'bad patient' who makes continual demands and is determined to remain an individual. In the present work a more complex model has been presented. The higher status clients have more contact with staff and this contact is more sympathetic. The low status clients are characterised by dominant personalities, willingness to challenge staff to whom they appear argumentative, demanding assistance, rarely taking part in activities and may be suffering a degree of brain failure. They are avoided by staff. The statusless clients are reserved, rarely take part in activities and do not challenge openly any aspect of the Centre. They are not avoided by staff but equally staff do not make efforts to initiate interaction. Consequently, they too are left alone. Both categories are disadvantaged by the lack of interaction with staff. They are likely to be segregated from groups of high and medium status clients as a consequence of the way they are perceived by staff and the influence that staff have in group formations.

This discussion raises questions concerning the extent to which staff should try to influence the mixing or grouping of clients and the extent to which they should themselves interact with certain clients. It has been shown that isolates and members of roaming groups find it very difficult to join the settled groups. Even

when staff attempt to introduce them, the settled groups often resist their joining. It may be that staff should learn which groups are closed to outsiders. Against this, one might argue that the settled groups contain more of the confident clients and more of the extrovert clients and that the isolates may benefit from interacting with them. Any deliberate staff attempts to group clients should be carried out carefully and the settled groups should be allowed to accept newcomers in their own time. If staff wish to encourage social interaction the earlier comments concerning inducting clients in groups are worthy of consideration. Indeed, it may be that staff should discriminate positively in favour of the roaming and isolated clients in the allocation of their own time. By definition, members of the settled groups enjoy social interaction. They may not benefit from interaction with staff to the same extent as other clients. It may be argued that in some cases, for example, the basketwork classes, clients would benefit from the absence of the instructor for much of the day as this might promote the independence of which most participants are capable but which is not encouraged by the permanent presence of the instructor. It is strange that these socially and physically competent clients should enjoy the company of a member of staff all day while many isolates do not talk with a member of staff all day. Hanson's (1972) research, quoted in the literature review, concerning the absence of conversation in old people's homes except that initiated by staff has been echoed here and is relevant to the present discussion.

As aspect of the Centre regime to which this study has frequently returned concerns the provision of transport for the clients. Some of the studies quoted in the literature review indentified transport as an issue of concern to clients and its importance has been emphasised by this work. The sub-sample interviews showed that even prior to their admission clients were concerned about travel arrangements.

The main sample had concerns that may be identified under two categories. The first set of concerns were structural. Difficulties of getting on and off the tail-lift ambulance and delays in the arrival or departure of the ambulance were the main structural problems. The second set of concerns focussed on the drivers. An ideal-typical model of popular and unpopular drivers was constructed. Popular drivers were characterised as driving smoothly, being reliable timekeepers, being predictable in their moods and undertaking odd jobs within clients' homes. Unpopular drivers were characterised as driving fast and jerkily, being unreliable timekeepers, unpredictable in their moods and having no contact with clients inside their homes. The importance of a driver lies not only in his role of driving the ambulance but also because the driver is the client's first contact with the Centre both when she first becomes a member and at the start of each day, he is the one link between the client's home and the Centre, he is the only member of staff with whom the client interacts without choice, and he has power concerning attendance at the Centre.

The Centre has no formal policies concerning transport and this is probably sensible. Decisions whether or not transport should be made available and, if so, the kind of transport are based on the merits of individual cases. The routes to be taken and the order in which clients are collected are determined by the drivers. These factors further increase the influence of the drivers and yet their importance does not appear to be fully appreciated by senior staff. For example, they are not represented at the Discussion Group and they do not attend staff meetings. In view of their importance in determining the extent to which a client enjoys her day at the Centre and the unique knowledge they have of a client it is desirable that they should be more fully involved. They should be consulted in reviews of client progress, be party to discussions on Centre policy and be made aware of the importance to clients of a good transport system including an awareness of the characteristics that clients expect of a good driver.

Just as drivers are not aware of their potential influence on clients, neither are the Centre-based staff. This research has identified their roles in several areas including influencing the activities that clients undertake, shaping group membership and promoting clients' self-images. They are certainly not aware of the extent of their power in these areas. If they were, it is probable that they would, for example, be more concerned about the placing of clients at lunch or when they wheel chair-bound clients into the lounge in the morning.

There are, perhaps, three issues that are of on-going concern to many clients about which staff might be made aware; bereavement, health and loneliness. Each has been identified within this work as being of major importance to many clients.

In the literature review it was stated that several writers have discussed the response of old people to bereavement. These writers have stated that most elderly people have experienced multiple bereavements during their lives and they have suggested that the grief response may be modified in older people. The present research has shown that staff are unsure how to inform clients of the deaths of their fellows. The clients themselves take the opportunities provided by such bereavements to explore their own attitudes towards death. There are two aspects of this subject to which the Centre may address itself. The first has already been mentioned and this is the need to improve the method of communicating the news of deaths to clients. The second is the extent to which the Centre staff should face the clients' attitudes towards death. One might ask whether the Centre should do anything. The writer's view is that it should. Miller and Gwynne (1972) were quoted earlier as referring to the role of a residential home for the terminally ill as bridging the gap between social death and physical death. A day centre for the elderly is not

in this extreme position but, nonetheless, most clients can expect to be members until death. As the Centre is expected to care for the clients and improve their quality of life it should take account of a subject of such importance to members. It is notable that as only 70 of the 241 clients were stated on their admission forms as adhering to a religion, the majority are unlikely to rely on religious support. If Suilven House does not provide the opportunity to explore feelings about death and offer appropriate comfort it is difficult to see where else most clients will get such help. Several authors have suggested that younger people working with the elderly are more concerned about death and its impact than are the elderly themselves. (See, for example, Peace, Hall and Hamblin (1979) and Brearley (1975).) Suilven House staff find it a difficult subject to handle and they would benefit from advice themselves before helping clients.

Finally, one might note that some clients have been admitted on the death of their own spouse. They refer constantly to their late partners but nobody at the Centre is sure how best to help them.

Health is a pre-occupation of many clients. The literature review earlier indicated that health deteriorates noticeably after the age of 75, that many elderly people have health problems of which they are unaware or which are not diagnosed, that many elderly people have difficulty estimating the extent of their ill-health and that many have difficulty in coming to terms with physical change. The present research has consistently shown that Suilven House clients are concerned about their health. The members of the sub-sample expressed their concern at the availability of health-related facilities and personnel when initially interviewed. Although comparatively few clients were referred by an agent in a health-related occupation, it was thought that the process leading to referral often had been initiated by a general practitioner, a hospital doctor or someone in a related profession.

Formally, the Centre has no role in improving physical health. This partly reflects the division of responsibility between social services departments and health authorities. Partly, it is just that the Centre's role is not clear. It has been stated already that district nurses and occupational therapists visit the Centre to treat their clients as this is an efficient way for them to organise their workloads. If clients were provided with an opportunity to tell the Admissions Panel what they expect from the Centre, medical, para-medical or health related facilities would feature high on their lists. This gap between client expectation and provision has been shown to be one of the reasons for clients withdrawing. Consideration should be given to the Centre's role in providing health care.

One difficulty is that most of the health problems of the very old are beyond cure. This was noted in the literature review when arthritis, rheumatism, difficulty with walking, forgetfulness, poor eyesight and incontinence were listed as the most common ailments. Although beyond cure, often they are not beyond allevation. The present clients' admission forms demonstrate the extent of ill-health among the population and reflect the above list showing arthritis, poor eyesight, confusion, disabled, heart disease and strokes as the most common problems. The Centre cannot cure these problems but the present staff could offer counselling, guidance and reassurance. All are necessary. If appropriate professionals were to visit the Centre those clients in need could be bathed, clinics could be held, treatment provided and tests undertaken. This would ensure that clients receive services they might be unable to obtain otherwise.

It has also been shown that informal staff-client interaction has led to the informal reporting of health problems to medical practitioners. Consideration should be given to extending and formalising this. As so many clients live alone and are socially isolated, the Centre staff are in the best position to detect and pass on this information.

This study has shown that ill-health is an often stated reason for some clients not taking part in activities while other clients accept that their physical deterioration is inevitable but do not allow it to detract from their enjoyment of the activity. The existence of the former group again emphasises the importance of counselling to aid those in the latter category.

## LINKS WITH THE HANDICAPPED

An important and, to the writer, unexpected issue that has been identified within the present research is the attitude of the elderly towards the physically handicapped clients. The attitudes of the elderly clients vary from ignoring the handicapped through condescension and friendliness to hostility. It has also been suggested that some of the handicapped are not happy to be in the same Centre as the elderly but as this work has been solely concerned with the elderly, this possibility has not been pursued. The study has shown that a handicapped client is more likely to attend the Centre on several days per week than is an elderly member. It has also been suggested that the senior staff interact more with the handicapped than with the elderly. If this causes resentment among the elderly it is not apparent and it is probable that the elderly are not aware of either of these factors.

Elderly and handicapped clients are geographically and socially separate in the Centre and it has been shown that even when they are in the same basketwork class they sit apart. Some elderly clients have been quoted as being sympathetic to the problems faced by handicapped clients while others have stated that the handicapped should occupy a separate Centre and some have been openly aggressive. It was concluded that elderly clients respond differently towards various handicaps and that a hierarchy of handicaps might be discerned. It was cautiously suggested that elderly clients may be sympathetic and helpful towards blind clients; indifferent towards the partially paralysed; unsympathetic and often hostile towards spastics and clients with major speech defects.

A subsequent literature search lends support to those findings. Other writers have suggested that attitudes towards the disabled are multi-dimensionable, measurable and a function of severity and type of handicap. Shears and Jenseman (1969), for example, found that amputees, wheelchair patients and the blind were most acceptable; deaf, stutterers and hairlip sufferers a second group; mentally ill and retarded the least acceptable. Cerebral palsy victims were a separate set between the second and third groups. The present findings are broadly similar to Shears and Jenseman's although not exactly parallel.

It is not suggested that the elderly and the physically handicapped should be separated into different Centres. The elderly have been shown here to benefit in various ways from the presence of the handicapped who, for example, were able to undertake the more advanced craft work in the making of a model village and who set the tone of the Christmas party. For these benefits to be maximised it is necessary to give thought to ways in which the elderly might be educated to understand handicaps and ways in which integration might be promoted. However, it

may be that such re-education of elderly people is not possible. In this case separate centres for the elderly and the handicapped may be necessary. The issue is a major one which requires further research.

The possibility of educating clients leads naturally into the training of staff. It must be reiterated that the staff are conscientious and very caring but that only two of them have enjoyed any form of training. They have not been asked to think about many of the issues raised in this research. They would benefit from training that would develop their natural skills, help them consider theoretical approaches and inform them of research findings.

## THE AIMS OF THE CENTRE

Suggestions have been made in these conclusions on ways in which detailed aspects of Suilven House may be changed. However, the writer has returned constantly to the need for clear aims for the Centre. If these were to be stated, it might be easier to identify the grounds upon which candidates for places might be accepted or rejected, to provide programmes for individual clients and to judge the extent to which individual clients might benefit from attendance at Suilven House. It is appropriate for the writer to suggest possible ways in which such aims may be developed.

If there were a wide range of co-ordinated facilities for the elderly in Elgol it might be appropriate to suggest narrow aims for Suilven House. For example, it would be possible for day hospitals, residential homes, day care, luncheon clubs and sheltered housing to be organised in such a co-ordinated and flexible way as to be able to specify the roles and aims for each. Clients would then be allocated to an appropriate form of care which would be determined by a team with knowledge of

the full range of facilities who would match the needs of the clients with the aims of a particular facility. As a client's needs change it might be appropriate to move her from one form of care to another. The forms of care in Elgol at present are not co-ordinated in this way. The writer believes that better co-ordination is desirable while he recognises the problems of co-ordinating services. In the absence of co-ordinated provision, Suilven House may have to admit clients with a broader range of needs.

An appropriate way in which to examine the role of Suilven House is to examine the needs of the elderly. The literature review showed that elderly people may be living in poverty, their health may have deteriorated, they may be lonely or isolated, they may have suffered brain failure, the skills they possessed may have deteriorated and they are likely to find difficulty in learning new skills. The participant observation in this work has shown that Suilven House clients display some of these characteristics.

Simmons has listed the needs of the elderly as to live as long as possible or until the advantages of death outweigh the burdens of life, to get more rest, to safeguard or strengthen any prerogatives acquired in mid-life such as skills and possessions, to remain active participants in the affairs of life, to withdraw from life where necessity requires it as timely, honourably and comfortably as possible. The disadvantages and difficulties of old age combined with the needs identified by Simmons provide a framework within which the aims for Suilven House may be listed. However, the Centre does not have the facilities, nor the staff the skills, to achieve all these aims. Nevertheless, for at least three reasons, the writer would

not wish to see Suilven House's aims restricted to meeting a limited list of client needs just because it does not have the facilities or staff to meet more needs. First, the literature review showed that many elderly clients have multiple disabilities. This is true of many clients at Suilven House. They require a facility that helps them meet all their needs rather than just one or two of them. Secondly, the Centre is not full. As there are vacancies it would be more appropriate to provide for a greater range of need than to restrict the range. Thirdly, all the clients have been identified as requiring care. Even with less fragmented care provision and fuller knowledge by placing agents of the facilities available, it is likely that there would be no alternative to Suilven House for the majority of clients. The writer would prefer it to be recognised that it is legitimate for the Centre to cope with all these problems but for staff, facilities and programmes to be provided that can cope with each.

In the literature review, some theoretical approaches to residential and day care were identified. For example, Miller and Gwynne (1972) write of horticultural and warehousing approaches; the Barclay Report (1982) suggests refuge, control and learning, growth and development approaches. The writers stress that the approach chosen must reflect the needs of the clients and that the approach adopted has implications for the level of client participation. If Suilven House is to meet the range of client needs that are suggested here, it must take different approaches with different sorts of clients. This is administratively difficult. However, it would be inappropriate to adopt the same approaches towards, say a client who has serious brain failure and for whom the most appropriate caring approach might be protective and towards a client who is active but lonely for whom the most appropriate approach might be developmental. The former client might be unable to take any part in decision-making and the main aims of care for her might be to prevent her

wandering away from the Centre and to satisfy physical needs by providing hot meals and baths. The aims for the latter client might be partially satisfied by helping her take an active part in decision-making, by providing tuition in new skills and by encouraging her to mix with different clients.

If the multi-aim approach suggested here were to be adopted, clear programmes for each client would be required. These would be established at the Admissions Panel, there would be appropriate induction, client progress would be discussed at staff meetings and there would be regular reviews. These aspects have been discussed earlier in the chapter.

In conclusion, the following list suggests aspects of client lives that could be assisted at Suilven House. Three broad need bands may be identified as justification for admitting clients. Some clients may fall into just one of these bands, others into two, some into all three. They are:

1 To reduce the incidence of failing health. This follows the evidence of the extent of deteriorating health in old age, the expectation of clients that there will be health-related facilities and expertise at the Centre and Simmons' identification of the need to maintain life as long as possible at as high a quality as possible. This aim refers to the needs of clients with brain failure as well as other forms of physical deterioration and ill-health.

2 To reduce the incidence of isolation. This follows from the identification of loneliness as a characteristic of old age. Loneliness may result from isolation, bereavement or other factors.

3 To provide a break for relatives. In this study frequent reference has been made to the care provided by relatives. The pressures placed on relatives who live with and provide daily care for an old person are often enormous. The provision of day care for the old person might improve the quality of both her life and those of her relatives.

It may be that a client admitted for any of these purposes might have her needs satisfied and day care might no longer be necessary. This would be the ideal. It is recognised that for many day care will continue until death while for others deterioration will continue and attendance at Suilven House will be followed by admission to residential care or hospital.

In order to meet these aims, six broad bands of provision might be identified. The exact form of provision to be offered must be determined according to the individual client's needs. However, there is likely to be a positive correlation between certain forms of provision listed below and certain aims listed above. The forms of provision are:

1 Health orientated care. The provision of such care would require few, if any, additional facilities. It is not suggested that the Centre would provide the same sort of care that one might find in a day hospital although there may be some overlaps. The writer would like to see more clients bathed, an extension of the manicuring service, clients provided with nursing services such as bandaging, some of the less intensive forms of occupational therapy and physiotherapy provided, and visits by opticians to provide regular eye-testing. These would provide levels of health care that some clients currently do not enjoy. It may be a more efficient use of their time for some health care professionals to visit several clients at the Centre at the same time than to visit the clients in their own homes.

The provision of such care has implications for the staffing of the Centre. It may be necessary to employ a full-time nurse or care staff with nursing qualifications. Co-ordination with the Health Authority would be an important aspects of health-orientated provision.

The present provision of a mid-day meal is an important aspect of health care.

2 Protection. For a few clients protection is a major aim. This applies particularly to those with brain failure who might leave the Centre or unwittingly take risks within the Centre.

3 Company. This study has shown that it is possible for an old person to be as lonely at Suilven House as in her own home. One does not necessarily eliminate loneliness by placing someone amongst other people. Some people will find friends by joining in activities and the provision of activities is mentioned below. Positive steps have to be taken to encourage some people to interact with others. The Centre's aims in some cases might be to promote relationships that continue outside Suilven House with clients visiting and going out with each other. In other cases, the opportunity to interact with other people at the Centre may be a sufficient aim. Staff involvement is important in achieving these aims. Staff may organise discussion groups or other structured situations in order to encourage people to interact. The personalities of some old people or the nature of their disabilities may result in the Centre staff being the only people with the skills or patience to interact with them.

4 Activities. The provision of activities is variously important as a means of promoting social intercourse, of preventing deterioration in health, of compensating for the loss of existing skills and for the promotion of new skills. The writer believes that the present activities cater for many clients. They do not cater for the less able client who might find it difficult to join an activity-orientated group and who might find it difficult to master the skills being taught. Provision should be made for the less able clients. The very able should be encouraged to undertake more advanced and independent activities. For example, some clients might be able to work in the greenhouse without supervision.

Within this category of provision should be included what Simmons refers to as 'active participation in the affairs of life'. The writer has welcomed the introduction of the Discussion Group. He believes that this should be extended in order that clients might play a greater part in the Centre management, and decision-making processes. There are other ways in which some of the clients might remain involved in the affairs of life. For example, some of them are able to organise activities within the Centre, to help other clients or to participate in activities outside the Centre. In this last respect the writer would encourage experiments involving clients in selling their own work and helping with community events.

5 Rest. It has been shown in the literature review that many old people require more rest than do younger people. The Centre staff should regard rest as being as important as activity. In some cases it might be undesirable for a client to rest all day at the Centre. In other cases, a client may have no opportunity to rest except at the Centre. For example, a client who lives in a small flat with her daughter and young grandchildren might welcome a quiet room and the opportunity to rest peacefully once a week.

6 Counselling and guidance. Different clients might benefit from counselling and guidance in different aspects of their lives. Counselling might be provided for the bereaved, help given to face death. A different form of guidance could be the provision of advice on social security benefits and other facilities available to the elderly.

The six bands of provision identified above require few additional facilities. It is important, though, that training be provided for staff in order that they have the necessary skills and understanding to implement these forms of provision.

## FURTHER RESEARCH

An analysis of the need for research into all aspects of the elderly is outside the scope of this work. As far as day care is concerned, the writer believes that there is a need for two kinds of research. The first is the in-depth study of more establishments. It has been stressed in this study that no claim is made that what happens in Suilven House is similar to what happens in other Centres. In order for there to be a greater understanding of day care, there is a need for further studies of centres in order for comparisons to be made with centres that have already been researched. Secondly, there is a need for action research. This would involve researchers going into Centres and implementing programmes, possibly of the kinds suggested above, in order to examine the effects of such programmes.

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**WESTSHIRE COUNTY COUNCIL**

Social Services Department

*RECORD OF BASIC BACKGROUND*

*INFORMATION AND INITIAL CASE PLAN*

**District:**

**Reference:**

**District of Origin (if different)**

**Name of Client:**

**Address:**

**Date of Birth:**

**Telephone No.:**

**Marital Status:** **Religion:**

**Referred by:**

**Address:**

**Telephone No.:**

**Date:**

**Details of Family**

**Name:** **Date of Birth:** **Occupation/School**

**Where applicable, details of other relatives**

**Name:** **Address** **Relationship**

**Clients General Practitioner:**

**Address:**

**Telephone No.:**

**If relevant Consultant:**

**Hospital:**

**Ward:**

**Date of admission:**

**Date of Discharge:**

**Type of Accommodation:**

**Landlord:**

**Specify involvement of other Agencies, and community support:**

## *SOCIAL HISTORY*

(Cover, in all cases, the reason for referral and presenting problems, chronological history, domestic and financial circumstances, family relationships, etc, and, where appropriate, medical diagnosis and prognosis, involvement of other Agencies and community support available, previous help attempted, etc.)

(Continuation Sheet available)

Signed:

Designation:

Date:

**Summary of current situation and problems (stating why case needs to become 'live'):**

**Objectives and Work Plan until first Review:**

**Signed:**

**Designation:** **Date:**

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**Team Leader's comments:**
(To include authorisation for: (1) case being made "live"; (2) inclusion on caseload (name worker) (3) any services to be granted:

**Date of first Review to be held**

**Signed:** **Date:**