Therapeutic recreation in social work practice for special needs groups

This item was submitted to Loughborough University’s Institutional Repository by the/an author.

Additional Information:

• A Master’s Thesis. Submitted in partial fulfilment of the requirements for the award of Master of Philosophy at Loughborough University.

Metadata Record: [https://dspace.lboro.ac.uk/2134/33783](https://dspace.lboro.ac.uk/2134/33783)

Publisher: © J.H. Jeal

Rights: This work is made available according to the conditions of the Creative Commons Attribution-NonCommercial-NoDerivatives 4.0 International (CC BY-NC-ND 4.0) licence. Full details of this licence are available at: [https://creativecommons.org/licenses/by-nc-nd/4.0/](https://creativecommons.org/licenses/by-nc-nd/4.0/)

Please cite the published version.
Please note that fines are charged on ALL overdue items.
THERAPEUTIC RECREATION IN SOCIAL WORK

PRACTICE FOR SPECIAL NEEDS GROUPS

BY

JAMES H JEAL

A MASTER'S THESIS BY DISSERTATION

Submitted in partial fulfilment of the requirements for the award of

M.Phil of the Loughborough University of Technology

June 1995

copyright by J H Jeal, 1995
ACKNOWLEDGEMENTS

Many people both in the UK and the USA have encouraged me to undertake this study which was supported by my employers, the Social Services Inspectorate of the Department of Health. Some, met during the course of my daily work, have, often unwittingly, challenged me to pursue it. Others have been supportive in offering criticism, advice and guidance including my supervisor Professor Adrian Webb, now Vice Chancellor of Glamorgan University, and his former colleagues, particularly Dr Jill Vincent at Loughborough University. To all go my thanks.

Thanks must also go to both Barbara Gordon, my personal secretary in the early stages of writing and typing, and to Lynn Watson, who was to subsequently assume the role and the attendant responsibilities. Through their willing and efficient discharge of all my demands the burden of producing the written material has been significantly lessened.

Unless specifically indicated in the text, or referenced as those of other authors, the views expressed are attributable solely to myself.
This thesis charts developments in the UK in relation to work with people with physical and/or learning disabilities and the manner in which recreational and leisure activities are increasingly utilised. Consideration is given to how the therapeutic value of recreation and leisure facilitated by social services departments with these groups can be significantly enhanced by the development of knowledge and applied skill in staff. The manner in which recreation and leisure could assist the achievement of service and professional objectives and the possible working arrangements which could be adopted in day centres are discussed. Consideration is also given to lessons which could be learned from the USA where therapeutic recreation has been promoted through, among other things, the formation of a new profession. The thesis highlights that while lessons may be learned from the USA, a new profession will not be a requisite of either sustained development or visibility of therapeutic recreation in the UK; it concludes that this will come only if a commitment is made by central government, employers and professional associations to policy formulations which brings therapeutic recreation into the mainstream of service activity, supported by formalised operational strategies and funding.
# TABLE OF CONTENTS

**Introduction and Method** ................................................................. Page 1

**CHAPTER 1:**

National and Historical Perspectives in Relation to Welfare, Sport and Recreation ................................................................. Page 12

**CHAPTER 2:**

Therapeutic Recreation Perspectives in the USA ................................ Page 37

**CHAPTER 3:**

Service Developments in the Fields of Learning Disabilities and Physical Disabilities ................................................................. Page 48

**CHAPTER 4:**

Findings and First Considerations ....................................................... Page 64

**CHAPTER 5:**

Processes and Functions of Assessments in SSDs ................................ Page 76

**CHAPTER 6:**

Further Considerations, Applications and Conclusions ...................... Page 86

**APPENDIX A:**

Blank Questionnaire ............................................................................. Page 106

**APPENDIX B:**

Completed Questionnaire ..................................................................... Page 110

**APPENDIX C:**

List of Activities .................................................................................... Page 116

**BIBLIOGRAPHY** .................................................................................. Page 117
In 1992 the Department of Health indicated its intention of using the term "learning disability" to describe what had previously been called "mental handicap". Both terms are used in this text, as are even more outdated ones. Use is generally determined by what was conventional during the period under discussion.

Abbreviations, all identified in full on their first use are as follows

- ATCs: Adult Training Centres
- BSAD: British Sports Association for the Disabled
- CCETSW: Central Council for Education and Training in Social Work
- CSS: Certificate of Social Service
- DES: Department of Education and Science
- HA: Health Authority
- HRSARS: Hospital Section of the American Recreation Society
- ICC: International Co-ordinating Committee
- LA: Local Authority
- LEA: Local Education Authority
- NART: National Association of Recreational Therapists
- NCTRC: National Council for Therapeutic Recreation Certification Inc
- NCVQ: National Council of Vocational Qualifications
- NDT: National Development Team
- NHS: National Health Service
- NTRS: National Therapeutic Recreation Society
- OTs: Occupational Therapists
- PHAB: Physically Handicapped Able Bodied
- RAAs: Regional Arts Associations
- SCU: Special Care Unit
- SEC: Social Education Centre
- SSDs: Social Services Departments
- SSI: Social Services Inspectorate
- TRs: Therapeutic Recreators
- TRUK: Therapeutic Recreation, United Kingdom
INTRODUCTION AND METHODOLOGY

Introduction

Recreation and leisure is utilised throughout Social Services Departments (SSDs) with children and families (in family centres) adolescents (intermediate treatment; residential care), and the elderly (residential and day care provision) and in a wide range of day and residential services provided for adults with learning or physical disabilities, or mental health problems.

As an inspector of the Department of Health, Social Services Inspectorate (SSI), my work has focused very largely on the fields of physical disability and learning disability. In the course of my work (which has included visits to and inspections of services for people with physical and learning disabilities, much of which is discharged by SSDs through day centre provision) I discovered that the considerable utilisation of recreation and leisure had never been systematically explored and developed. This raised the question of whether it was used as effectively as it might be and in a manner which would facilitate the achievement of the service and professional objectives of SSDs.

It was in order to facilitate my own understanding of the value and potential of utilizing recreation and leisure effectively in SSDs that in the early 1980s I established links with organisations committed to the development of recreation activities. Initially these included the British Sports Association for the Disabled (BSAD) and the Regional Sports Council, and it was through the former that I was first informed of the concept of therapeutic recreation and how this had been developed in the USA. As a result I met in this country staff from the University of Columbia-Missouri and subsequently visited it on a number of occasions, together with Indiana University, to explore not only the concept but to examine some of its practical applications. Both USA universities carry bachelor and master degree programmes in therapeutic recreation and in the case of Indiana, PhD programmes also exist.
My knowledge gained through visits to the universities and service agencies was also extended by attendance at multi state conferences where I from time to time presented papers at seminars. These conferences attended by over 500 personnel from service agencies, universities and both state and federal government provided a pot-pourri experience of therapeutic recreation being practised in a wide range of fields and very often pushing out the boundaries of creative thinking and practice. Particularly remembered were presentations on the therapeutic use of magic with people with disabilities and the function and use of puppets in providing socially sensitive education for children.

After having observed and had demonstrated to me during the course of my visits to America the validity of the use of recreation as a therapeutic tool I was particularly interested in how this dimension of recreation might be rooted, fostered and developed by and in SSDs in the UK. It was apparent to me in this respect that effectively used recreational activities could significantly support the growing commitment in SSDs to promote optimal independence for individuals in its service provision for people with physical and learning disabilities. My continuing interest was further sustained and extended through an invitation by the University of Columbia-Missouri to develop opportunities in SSDs in the UK for American undergraduates undertaking therapeutic recreation "practicums" and to co-ordinate and supervise their placements. This work occurred for some five or more years until regulations concerning placement supervision changed and practice supervision could no longer be undertaken by unqualified or unregistered supervisors.

Most of the work that occurred in the UK took place in one local authority (LA) which was in close proximity to my office. The placements occurred in the first instance in day centres for people with physical disabilities and subsequently in day centres for people with learning disabilities. While I was not responsible for the day to day work and supervision of students I provided support to staff undertaking it. This and the episodic supervision I generally provided for students presented a valuable means of exploring not only the concept of therapeutic recreation but the potential of its multifarious applications in social services settings in the UK.
At this time I was also instrumental in facilitating the agreement by the Central Council for Education and Training in Social Work (CCETSW) that a student on a Certificate in Social Service (CSS) should undertake a placement in the USA at an outdoor centre which functioned under the auspices of Indiana University; therapeutic recreation was the main focus of its activity. The student on his return to the UK was appointed to commission and then manage a day centre for people with learning disabilities. In view of the particular focus on the use of recreation it became known as a social recreation centre. During this same period faculty staff from both universities were intermittent visitors to the UK and I generally facilitated staff training opportunities for the SSD staff. All these factors generated in the SSD a commitment to the wider utilisation of recreation across a range of fields. However it did not promote a more rigorous analysis of its specific functions and significance for clients.

In view of the creative links which had been fostered over a number of years with both universities, in 1987 the SSD was invited and agreed to co-host with them the first international conference on therapeutic recreation. It was held in the UK in 1989 and SSI agreed that I should be fully involved. In view of my interest and involvement over some years, I was largely responsible for determining the professional inputs to the conference. They emanated from a wide range of agencies operating in a number of countries. A second international conference was held in Puerto Rico in 1991 and a third in Canada in 1993; the fourth is planned for the USA. A direct result of the conference in the UK was the formation of TRUK (Therapeutic Recreation, United Kingdom) an organisation committed to increasing the visibility and utilisation of therapeutic recreation in the UK. Membership of TRUK reflects a wide constituency, not unlike the UK attenders at the first international conference which included social workers, probation officers, OTs, remedial gymnasts, recreational and leisure personnel and representatives of a range of voluntary organisations and educational institutions.

Through the course of my interest and work, contacts have been established and sustained with other organisations which foster wide ranging recreational activities, including arts development agencies. As a result of my links with the latter and during the National Special Olympics held in the region in 1989 I was invited to join the
Committee to initiate a participative arts dimension to the Games in collaboration with a local arts development agency and SSDs in the region. It provided people with no commitment to the development of sporting prowess with the opportunity to be participants in the Games rather than just spectators.

The duties and responsibilities of the SSI, as a professional and inspectorial arm of the Department of Health, always require that it reacts and responds to both the political and government imperative of the day and times. While my particular interest in recreation and leisure has been acknowledged as proper within the SSI the practical and professional applications have been given scant consideration and in view of my extending knowledge I am regarded as having specialist expertise. In this context I have presented a paper on therapeutic recreation to an interdepartmental committee on disability co-ordinated by the Department of Health which has shown growing interest in the subject. It is an interest which is also mirrored in other government departments and reflects a need throughout government to find ways of utilising all of the community’s resources to meet demands on services which are fast outstripping resources. A new imperative to look at the issue is slowly being generated.

**Methodology**

The research had two main aims:

The first aim was to extend my observations and expand my knowledge about the effective use of recreation and leisure. As a result of my work with and observation of SSDs over a number of years I recognised that the widespread use of recreation and leisure should be systematically examined and placed in the context of the professional aims and service commitments of SSDs. The effective use of recreation and leisure will only occur as their function is rooted in policy commitments at both central and local levels and resourced (budgetary and workforce) in a suitable manner.
The second aim of my research was to examine and compare developments in the USA and Britain, and to explore the current and potential applications for therapeutic recreation in assisting and supporting SSDs in fulfilling both their professional aims and service commitments as they are now or as they might develop in the future.

The nature of the methodology of the research was determined by the need to discover the extent and scope of recreational activities in day centres run by SSDs and the purpose for which they were made available; and whether the purpose was achieved effectively. My experience within the SSI had informed me that the utilisation of recreation and leisure was in no way a systematic feature of service functions within centres and that what went on in one was often no guarantee of what would go on in another. Given these circumstances it seemed that the adoption of a quantitative style of research, while providing me with detailed data on the availability of recreational opportunities would provide no means of exploring and assessing its function and validity. However my purpose might be more effectively targeted by the adoption of a methodology which while providing me with some raw data also provided the means to identify the breadth of perceptions and views of senior staff (Bryman 1988). The methodology was designed to address both issues. Data was collected which confirmed the extent and scope of recreation activity; and the views and perceptions of managers were sought through investigative interviews concerning recreation and leisure and its function in relation to the wider aims of day centres.

The research was of necessity undertaken on a part time basis. It was based on a small scale empirical study in the SSDs which while limited in a number of respects was added to by the breadth of my experience gained over a number of years. The associated background reading I undertook and the observations I was able to make and reflect upon in supporting students undergoing placements in the UK counterbalances any limitations of the value of a small scale empirical study and also enhances its validity. However, in order to limit the impact of my subjective views influencing the outcomes of the study and to ensure a proper level of objectivity the investigations occurred in two authorities where I had had no previous contact or responsibility.
These were in a county authority (C) and an adjoining large metropolitan authority (M) in the West Midlands.

A significant factor which also impacted on the research and which should be signalled at this junction was the development of a social model of disability as opposed to a medical one. Community care legislation, the crystallisation of pieces of earlier piecemeal social legislation and the operational requirements and strategies flowing from it, reflects a distinct commitment to a social model. Unlike the earlier medical model which was often characterised by fostering in individual disabled people the quiescent accommodation of their physical or mental limitations and the concomitant emotional and social implications, the social model requires the refocussing of services to expand a repertoire of support, which while sometimes interventive should always attempt never to be interventionalist, to assist people to face and address the challenge of their individual lives. The locus of "the problem" is thus moved from the individual's impairment to the social context in which their lives are enacted.

It is a model which is far removed from the earlier medical model of care which was often determined and sustained through the views and authority of people other than disabled people themselves. The social care model properly marshalled and utilised provides the mechanisms by which people with disabilities take far greater control over their lives and the decisions which affect the systems which contribute to the support they chose to receive or require in their daily living.

**Methods**

The purpose of undertaking the empirical work relates to the first aim of the research. It was to test the observations I had made over the years in the authorities in which I had worked in the UK. These were that while recreation was extensively used it was not used as effectively as it might be because no systematic thought had been given to its value, validity and function and the manner in which it might assist SSDs in achieving their service and professional aims.
A first step in determining the organisation of the research was to meet senior managers in both authorities to explore whether policy commitments concerning recreation and leisure existed (or otherwise), and if these were in place in relation to the two client groups, what significant differences there were between them. With the early identification that no formal policy statements existed in relation to recreation and leisure in either authority the decision was taken to investigate single service provision in each authority. This considerably simplified the structure of the study and obviated the need to consider how differential organisational arrangements or policy commitments between client groups might impact on and influence the research findings.

On the basis of these first findings which informed the structure of my study the research was organised to be undertaken in authority (C) in three of the six social education centres (SECs) which existed in the county for people with learning disabilities and in the metropolitan authority (M) in three out of four of its social welfare centres for people with physical disabilities.

In order to adopt a common approach in the two authorities and between the two client groups a single questionnaire was designed for use across all centres (Appendix A). It was required that managers of day centres should be interviewed and this almost invariably occurred. One deputy manager acted up in a manager's absence. The questionnaire was designed not only to elicit information on recreational activities undertaken in or facilitated by centres but to explore the perceptions of managers and their views on the function of recreation and leisure in the wider context of the services provided by their centre.

All interviews were undertaken by me during the course of a day long visit to centres. All answers to questions were noted by me and these were subsequently typed and forwarded to respondents to confirm factual accuracy of the information given, and that my record of their views and statements concerning recreation and leisure within the context of their service responsibilities reflected accurately the views they held. A 100 per cent response occurred in this respect and where inaccuracies occurred these
were corrected When finalised and agreed completed questionnaires were returned to respondents for information as well as to the senior officers of the authority with whom I had had first contact. The nature of the feedback provided the means of ensuring that accuracy was established in relation to information data. Confirmation of the statement of views as marshalled by me also established a high level of reliability in this respect.

During the course of my visit to centres opportunities were also provided for me to observe centre based activities and meet both staff and participants engaged in them.

Five issues were addressed in the questionnaires. These are detailed below. Findings are addressed in a later chapter

(a) THE EXTENT, CHARACTERISTICS AND FREQUENCY OF RECREATIONAL ACTIVITIES:

Managers were asked to list all recreational and leisure activities and also to comment on whether each activity was regarded as either a planned regular, planned episodic or unplanned opportunistic event. Managers were also asked to indicate their perceptions of the characteristics of the activity and whether they saw it as serendipitous (for pleasure), occupational (to mitigate boredom) or diversionary (to inhibit perceived undesirable activity). Further they were asked to indicate whether they could identify any other perceived values in the activity (the development of physical or social development).

(b) THE ORGANISATION AND MANAGEMENT OF RECREATIONAL ACTIVITIES

Managers were asked to indicate whether they considered that recreational activities in their unit were the result of the policy determinations of the wider SSD, the perceptions of the centre staff, or the wishes of clients facilitated or limited by the particular skills of staff.
c) THE PERCEPTIONS OF CENTRE IN RELATION TO RECREATIONAL ACTIVITY

Managers were invited to make judgements concerning the perceived value of recreational activities within the wider context of their primary functions and to produce what evidence was available to support their views.

d) THE FUNDING OF RECREATIONAL ACTIVITIES

Information was elicited in relation to funding. This provided one indicator of wider management perceptions of the significance and value of recreational activities as a means of facilitating the achievement of the SSDs primary objectives.

e) POLICY IN RELATION TO RECREATIONAL ACTIVITIES

Managers were invited to identify written policy documents which addressed the utilisation of recreational activities in SSDs.

An example of a completed questionnaire, suitably anonymised, is reproduced at Appendix B. It indicates the range of activities undertaken and the view taken of their function and purpose.

Appendix C provides an aggregated list of activities available in all centres visited.

The second aim of my research had two aspects. The first was to examine and compare the policy and practice contexts in the USA and Britain in relation to therapeutic recreation. The second was to explore the current and potential applications within the British social services scene.
Both aspects were significantly informed by my visits to and contacts in America. Whenever visiting Columbia-Missouri or Indiana opportunities were always made for me to meet faculty staff to discuss a range of issues which focused not only on the academic and professional development of therapeutic recreation but its political impact on a range of social issues in the USA. In this regard an issue of particular significance has been its contribution to raising access issues and answers in relation to people with physical disabilities. Opportunities were also provided for me to visit a wide range of agencies where I was able to observe therapeutic recreators (TRs) in action and also had the opportunity to explore practice issues with them. These visits included hospital based rehabilitation services for recovering alcoholics and drug dependent persons, outdoor challenge activities for physically disabled young people in a residential camp setting (which also provided educational programmes for staff accompanying their charges), a correctional institution for young people; hospital based services for people with mental handicaps and day nursery provision for under fives.

Other modes of investigation were also used in addition to the empirical studies. In particular policy documents, government reports etc from the UK were consulted in both the welfare and recreational fields to trace and compare developments in the use of leisure and recreation. These documents are identified in subsequent chapters. In relation to the professional development of and the use and management of therapeutic recreation in the USA literature and professional commentaries were explored and considered. References to these are also to be found in subsequent chapters.

While the organisation of my research was clearly informed by the knowledge I had gained over years of working within the SSI, its structure provided the opportunity to expand my knowledge of issues within the social welfare and recreation and leisure fields with particular relevance to physical and learning disabilities. Additionally through tracing historical developments in both fields, insights emerged which threw light on the lack of current developments; and also the sighting of new opportunities now presenting themselves in the UK which might address these and provide the means to begin to devise a model of recreation and leisure which specifically utilises the therapeutic values of leisure as a basis for facilitating personal growth which fosters and
sustains optimal independence. The time is ripe for this to happen particularly in view of the very significant move from a medical model of disability to a social one which has gathered pace in recent history and gained a robust identity which is being sustained through legislative changes and government policies.

These additional elements of my work together with my visits to USA clearly enhanced the empirical study, of necessity small scale, which I was able to undertake. While any element of this research, if standing alone, would be insufficient to support the research in its entirety, standing together each supports the validity of the other and significantly enhances the wider reliability of the research.

**Summary**

This research examines the conditions under which recreation and leisure, while increasingly acknowledged as an important element of service provision are ineffectively utilised by SSDs in England and Wales. It consults policy documents and the literature to trace and compare developments in the USA with England and Wales. It identifies recent legislation which requires the re-sculpting of service and professional objectives of SSDs and which will affect the delivery of services. A new potential for the use of recreation and leisure will thus be generated. This research also examines what lessons can be gained from the USA where recreation and its therapeutic use is more systematically ordered and whether these lessons might be suitably incorporated in England and Wales and also the wider UK scene; it will also consider what elements need to be in place before recreation and leisure can be successfully grafted onto the "welfare tree" and how its potential impact might be effectively targeted, utilised and managed.
CHAPTER 1: NATIONAL AND HISTORICAL PERSPECTIVES IN RELATION TO WELFARE, SPORT AND RECREATION

This chapter is devoted to charting and reflecting upon starting points and respective general developments in the fields of welfare and sport and recreation with particular reference to the provision of services for people with disabilities. It also identifies the point of balance and potential common focus between developments in recreation - which initially promoted individual excellence in sport and the arts and has moved to facilitating services “for all” - and to changing developments in welfare - which are moving away from services “to all” and towards services geared to assessed individual need.

WELFARE

The "Welfare State" was finally established in the United Kingdom in 1948 in the aftermath of an earth shattering world war with the passage into law of the National Assistance Act. The Act and a tranche of welfare legislation passed during the war and following its cessation heralded a future characterised by hope and aspiration to achieve a fairer and more equitable society which would challenge and overcome the "giants" of "want", "disease", "ignorance", "squalor" and "idleness". The architects of the new and radically different future were not sanguine about the nature of the challenges before them and were mindful that the task of "social reconstruction" would be both arduous and monumental. They saw a world which had been devastated by the destructive forces of war and a future underpinned by the history of which they were a living part and "laboured" to establish foundations on which the new welfare edifice would be solidly built. The task was gargantuan and during the parliamentary years between 1944/48 267 pieces of legislation, of which some 33 related to welfare concerns, passed through the legislative chambers and committees of the Palace of Westminster and received Royal Assent. Not one of the "giants" was left unchallenged and specific legislation was enacted to address the problems they raised within the country.
A significant plank of the founding legislation of the Welfare State was that specific benefits payable to individuals during periods of temporary hardship would be derived from their payments of contributions in previous periods of relative security. It was acknowledged however that additional provision was also required for those who for a range of reasons might be unable to meet the requirements of a contributory scheme and The National Assistance Act 1948, provided for the "assistance of persons in need by the National Assistance Board and by local authorities". Although much of the Act has been superseded by subsequent legislation, it is still extant in parts. It continues to be the basis of present bipartite arrangements with central government generally, with rare exceptions, dispensing only financial benefits and assistance and LAs generally providing only services in kind. A significant departure occurred however in 1993 with the full implementation of the National Health Service and Community Care Act 1990 when central government vested in LAs the total responsibility to assess individuals with social needs for residential or community support Those in need and eligible for services will receive these directly from the SSD, or increasingly through independent providers, commissioned and contracted by SSDs to provide specific services.

Section 29 of the National Assistance Act is of particular significance to the topic of this research. When enacted it identified the range of welfare arrangements LAs had the power to make for specifically defined groups of disabled people (generally excluding groups with mental handicaps for which other legislation applied) and those others who might subsequently be so prescribed by the Minister The services, reflecting the horizons of the day included rehabilitation, provision of workshops and employment both in and out of the home, the sale of artefacts produced, and recreational facilities at home or elsewhere.

In 1970 with the passing of the Chronically Sick and Disabled Persons Act, most of the general responsibilities of LAs in relation to disabled people were elevated to duties. The duty to provide "recreational facilities" (Section 1) was significantly extended to include holidays which LAs could provide directly, or indirectly, through the provision of financial assistance Other recreation opportunities could also be supported through direct and indirect arrangements Assistling a person's capacity to "take advantage" of
educational facilities was also specifically identified and reflected to some extent the
growing acceptance of the re-creative value of further education pursuits

The subsequent enactment of the Disabled Persons (Services, Consultation and
Representation) Act 1986 initiated through a private members bill, as was the 1970
legislation, established no new duties in relation to recreational facilities. The tenor of
the legislation, some aspects of which have not been implemented as they are seen to
be subsumed by the NHS and Community Care Act, was to provide "for the
improvement of the effectiveness of, and the co-ordination of resources in, the provision
of services for people with mental or physical handicap and for people with mental
illness, to make further provision for the assessment of the needs of such people; to
establish further consultative processes and representational rights for such people; and
for connected purposes". The legislation established a novel departure from all previous
legislation and one which is likely to be of increasing significance in service
development in the future by making no distinction in its citation between, or separation
of, the nature of service functions which are made available to people with either mental
or physical handicaps. It also highlighted "representational" rights.

The formulation of welfare legislation is particularly susceptible, quite properly, to the
range of opinion marshalled through statutory and non-statutory committees, ad hoc
government committees and working parties. The establishment of the Royal
Commission of 1954-57 on the law relating to mental illness and mental deficiency 3
signalled for the first time a radical change of policy direction in recommending the
breaking down of segregated services established through earlier legislation and a move
towards community care Government commended its recommendations to health and
LAs, while at the same time effecting changes through legislation where these were
required 4.

Working groups, no matter how eminent or, conversely, undistinguished they are, do
not act in a vacuum and their commission to sit will invariably have been influenced by
changing perceptions and attitudes of what is publicly proper, scandalous (in the case
of enquiries) and professionally acceptable In a world made small by
telecommunications and fast accessible travel, these influences increasingly take on international perspectives. This is certainly true in relation to aspects of welfare services.

**Welfare and Mental Handicap**

The work on institutionalisation in America (Goffman 1961)\(^5\) the early evaluative study of residential care for elderly people (Townsend, 1962)\(^6\) and the findings concerning ill treatment and other irregularities in mental handicap hospitals in the UK\(^7\) & \(^8\), generated and fuelled a commitment to de-institutionalisation. In 1971 a DHSS White Paper set target dates for the implementation of a move from hospital to "community care"\(^9\). In 1980 an evaluation of progress made since 1971 occurred and subsequently a handbook was published in 1987\(^10\). This, with its focus on the essential elements to be incorporated in locally based services, together with the publication of an earlier green paper\(^11\) furthered the move away from institutional to community care.

In 1983 the "All Wales strategy for the development of services for mentally handicapped people" was published\(^12\). The strategy shared the commitment to facilitate the developmental thrusts and service requirements first identified in the 1971 White Paper to de-institutionalise hospital patients. It also focused on the development of service strategies which would successfully sustain mentally handicapped people in local communities regardless of whether they had been "decanted" from institutions or had always lived outside of them. In addressing this feature of its work the All Wales strategy reflected, without specifically highlighting it, the growing commitment to the adoption of the principle of normalisation. First enunciated and systematically explored in the 1960s it is described as "the use of culturally normative means (families, valued techniques, tools, methods) in order to enable persons life conditions (income, housing, health services etc) which are at least as good as the average citizens, and to as much as possible enhance or support their behaviour (skills, competencies etc) appearances (clothes, grooming etc) experiences (adjustment, feelings etc), and status and reputation (labels, attitudes of others etc)" (Wolfensberger, 1973)\(^13\).
A commitment to the principle of normalisation will quite properly emphasise different normative values over periods of time, and have far reaching implications affecting both service provision and the professional practice of those engaged in work with people with learning disabilities. Since its conceptual formulation, normalisation has impacted significantly and in different ways on the service policies and developments in SSDs. Much of this has been facilitated through the work of the National Development Group, a government funded body which was established in 1975 to accelerate the development of policy and practice in the field of mental handicap. Now defunct as an advisory group, the team formed to provide it with professional support continues to function. Since its inception, the work of the team has contributed significantly to developments across the whole field of mental handicap and has done much to encourage the service and practice applications of normalisation.

Another piece of formative work resulted from the study of a Kings Fund Centre working group on comprehensive locally based residential services for mentally handicapped people and the subsequent publication of its project paper "An Ordinary Life".14

The successful and effective implementation of radical policy change is dependent on a wide range of factors. In particular it is facilitated only when the commitment is shared between a range of interdependent political, professional and social institutions which are secure in the knowledge that their properly held vested interests are protected. In view of the de-institutionalisation thrust and the consequent closure of wards and hospitals, and the growing concern about the appropriate deployment of nursing staff in community settings, a committee was established to report on the future of mental handicap nursing and care. Reporting in 1979 it stressed the importance of moving away from segregated services and of developing a local model of care characterised by multi disciplinary functioning. Over time different models of care have been developed incorporating multi disciplinary functioning and new features of effectiveness sought. Research indicates however that aspirations are not easily translated into commonly held practice, and both organisational and professional blocks continue to exist which undermine effective multi disciplinary joint work (Brown and
The committee's proposal that unified training for nursing and social services staff should be established was not taken up and subsequent changes in regulations in relation to nursing and social work training makes this increasingly unlikely at the qualification stage.

Legislation of particular significance in the education field resulting from a changing philosophy influenced by a growing awareness of normalisation was passed in 1970 and implemented in 1971. The Education Act 1970 required for the first time that severely mentally handicapped children previously classed as "ineducable" were brought into the education system. The legislation required a response to a very significant challenge on teaching philosophy and practice as teachers addressed the need to provide educational programmes which engaged the minds, and explored the development of educational programmes which would facilitate the realisation of learning and life potential, of children previously described as ineducable.

Impetus for development and yet more demands were generated with the subsequent formation of the Warnock Committee of Enquiry into the education of handicapped children and young people. Its work was to have far reaching consequences. Reporting in 1978 it recommended amongst other things the abolition of a previously established categorisation system of handicapped children, the identification through assessment of special educational needs and the plans to meet them and the increased integration of children with such needs into mainstream schools provided with the resources to address their extended responsibilities. The recommendations were to be enshrined in the Education Act 1981 and implemented in 1983. The change, again reflecting the impact of the principle of normalisation, was further buttressed in the Children Act 1989 which stressed the importance of seeing children with disabilities as children first rather than as a person characterised by a disability calling for segregated treatment, care and support.
Welfare and Physical Handicap

In the field of physical handicap a parallel developmental track was not pursued to that of mental handicap. This was largely because of the limited perceived need to provide welfare services for children with physical disabilities who were almost invariably the concern of education authorities providing specialist services, often through boarding education, and of health authorities (HAs). However, with the increased commitment to support children to remain at home and attend mainstream schools, welfare services which support parents in their nurturing and training functions will clearly take on an increasing visibility. This will impact more significantly on the development of services of the SSDs; the awareness of this new dimension is only slowly dawning on them.

In the field of physical disability the work of SSDs has (very generally) been confined to adults with physical disabilities mirroring little more than the general responsibilities of Section 29 of the NHA and the Chronically Sick and Disabled Persons Act 1970.

Services provided "in the home", a feature of the 1948 legislation and a pattern common in the 1950s for disabled adults, resulted in a lack of provision of day centres. When in the late 1960s and early 1970s capital building programmes provided opportunities for SSDs to build day centres, those which did often adopted the design features of adult training centres (ATCs), and this to some extent pre-determined the nature of services provided by them. However, an unseen and potent element of the development was that for the first time greater opportunities existed for disabled people to leave their homes and to meet together with peers experiencing similar disadvantaged circumstances. The contemporaneous provision of residential accommodation by LAs and their links with day centres (not infrequently on the same sites) also added to the numbers of disabled people brought together. With the changed pattern of contact the potential was created for disabled people to consider with others in similar situations, their own needs and how they might be more suitably met.

Developments that have occurred in SSDs which most closely relate to disabled people achieving greater levels of independence and autonomy have resulted largely from a
requirement to respond to the increasingly vocal demands for services from groups of people with disabilities. Professional associations, pressure groups, and coalitions of disabled people themselves, formed for the purpose of advancing particular concerns have played no little part in creating a climate of demand in which change follows. In this connection The Year of the Disabled Person (1981) both raised the visibility of disabled people and also generated its own impetus in challenging for change. The earlier appointment of a Minister for the Disabled (since changed to Minister of the Disabled) and the successful establishment on the statute book of two private members bills, the Chronically Sick and Disabled Persons Act 1970 and the Disabled Persons (Services, Consultation and Representation) Act 1986, has done much to gain political ground which might otherwise have been lost. The 1986 Act was born out of a commitment by organisations to ensure that SSDs took their responsibilities seriously and were both consistent and rigorous in the discharge of their duties in relation to people with disabilities. Section 5 of the Act, now fully implemented, required for the first time that SSDs should assess the needs of all school leavers who were disabled and had previously been subject to a special needs assessment under the Education Act of 1981.

The National Health Service and Community Care Act 1990 is without question the most significant piece of legislation since 1948. It concerns itself with the management, organisation of the services and discharge of the duties of the NHS and welfare responsibilities of LAs. Of greater significance to this research is the Community Care aspects of the Act which embrace much of the work undertaken and recommendations made by the Griffiths Report. It particularly impacts upon the statutory responsibilities of LAs in relation to community services and the manner in which these are discharged both administratively and professionally.

The Act, as is often the case with welfare legislation, is a legislative formulation promoting the ways and means by which the growing philosophical commitment existing in both government and non government circles to reduce institutional care in all fields of welfare concern and expand community provision, can be translated into policy, development and practice. Fully implemented since April 1993 the Act requires LAs
to provide to central government community care plans jointly agreed with the HAs to which the authority relates; to ensure that direct provision to clients is consumer-focused and needs-led, rather than service determined; and to ensure that services allocated come from the most efficient and effective service provider regardless of whether they are from the public or independent sector or whether they are institutional or community based. LAs have also been required to establish formal complaint procedures and authority wide inspectorates which will ultimately be expected to inspect both residential stock and assess qualitative aspects of service delivery which they either provide or purchase.

Within the field of social and welfare services, community care plans will, dependent upon the political temperature of the day, extend central government's range of mechanisms to control, guide or direct policy and service objectives. This situation is not new. In 1948 LAs were required to submit welfare "schemes" to the Minister of Health for approval and once approved to act in accordance with the approvals. During local government reorganisation in the 70s procedural arrangements changed, reflecting a "hands-off" government view, and LAs were expected to develop services within "broadly formulated arrangements" without first seeking ministerial approval. Ministers did continue to have default powers, but rarely used them. The 1990 legislation conveys a more complicated picture. On the one hand is a new departure in the transfer to LAs of central funds to sustain people in the community which had previously only been available to support people in residential care; on the other hand, the powers and autonomy of action delegated to LAs in 1974 have also been reined in with the introduction of community care plans. Of even greater significance than changes in delegated responsibility, however, is the manner in which the legislation reflects and confers an altogether more radical change in the nature of the relationship between central and local government. Increasingly, central government is demanding far greater accountability from LAs in the discharge of all the duties which are delegated to them. Fiscal mechanisms are being established, some hotly contested in law, and increasingly LAs through their respective service departments are permitted to function only within strictly defined financial parameters laid down by central government, with no power or authority to raise additional local funds.
While the political patina evident in the 1990 legislation may in the fullness of time take on a different hue, the need to utilise efficiently and effectively the finite national resources available for all aspects of welfare provision becomes of increasing importance as demands on services increase. The requirements of the Act for LAs to plan strategically and to monitor more effectively the delivery of its services and discharge of its duties is a reality within grasp, given the explosion of knowledge in the field of information technology. As the current yawning gap between knowledge and application skills narrows, LAs will have the potential within shorter time scales to marshal information more strategically and develop the means to re-order priorities to ensure that finite resources are utilised to maximum effect. However, no amount of technological sophistication and application will ease hard decisions on prioritising the utilisation of finite, and scarce, resources.

The Act also mirrors a desire to provide services which are not grounded in historical perceptions of welfare but which heighten and protect the contemporary view of the right of individuals to exercise control over their own lives and to be able to choose the services within the community they wish to utilise. In time it may herald a move away from more traditionally held views of welfare and embrace an expanded view of other services which are seen increasingly to enhance life opportunities.

**Welfare and the Social Model of Care**

As changes in social legislation are properly susceptible to the opinions formulated through working groups, committees, etc, so equally are the models of care which determine professional practice and the discharge of service responsibilities. The social model of care, a model now generally adopted, albeit without necessarily a full understanding of all its implications, must always, like all models that are generally accepted and establish credence, reflect something of the primary social philosophy of the day. Asylums in an early Victorian Britain struggling to manage its move from an agrarian to an industrial society were, when first conceived and established, a humane and contemporary response to the needs of people made vulnerable through mental illness. The proper commitment to de-institutionalisation in our present age reflects,
amongst other things, the failure of society to re-gear its institution based services appropriately in light of the growing knowledge and understanding about the etiology, treatment and management of mental ill-health in the society we had become.

The social model of care, largely reactive to an earlier medical model in which treatment and care regimes were determined by those identified as having particular knowledge and skills, generally but not always underpinned by qualification and demonstrable competence, (doctors, nurses, OTs, social workers, care managers/assistants) now places far greater emphasis on the centrality of decision making and choice by the person receiving the treatment and/or care. It reflects not only a crystallisation of issues in relation to contemporary commitments to individual rights and the legitimacy of these being made manifest in multifarious ways, but the growing awareness of the manner in which the lives of disabled people are determined by the physical and attitudinal environments in which they are required to live.

Those engaged in providing systems of support and care, are properly exhorted from many quarters to adopt the social model of care. Much of the current legislation and government guidance emanating from it, underpins the model and groups of disabled people representing the views of their fellows are vocal in their call for its application. The translation of a philosophical, and also (in this particular situation), a political commitment, to a new system is, however, no easy task, not least because acceptance of its principles and tenets are no guarantee that individual applications will be finely tuned and that the interests and aspirations of people, as perceived by themselves, will be best served. Nor can the change in social and physical environments be guaranteed. In all new systems a potential exists to develop services that are more suitably geared to contemporary need and perceptions of need, the potential if realised, is invariably hard won (Morris, 1993) 19
SPORT AND RECREATION

LAs are the major public providers of sporting opportunities and facilities and it is estimated that in 1993-94 English and Welsh councils spent £1,786m on sport and recreation.

The development and promotion of sporting and recreational opportunities is however the responsibility of a wide range of statutory authorities, voluntary and ad hoc bodies and in the 60s central government established three major advisory groups, the Sports Council, the Arts Council and the Countryside Commission, to promote the development of services in collaboration with other statutory and voluntary agencies in their respective fields of activity and concern. While the nature of their responsibility, accountability and areas of influence have changed, reflecting both the commitment and direction of government and the relative influence of pressure and institutional groups, both Councils and the Commission remain extant.

Prior to the establishment of the Sports Council in 1965 all organisational, developmental and promotional work had been undertaken by the Central Council of Physical Recreation which worked under the sponsorship of the Department of Education and Science (DES). In 1972 the status of the Sports Council changed when it became an executive body with its own Royal Charter with the requirement to have regard to any general statements of policy issues by the Secretary of State.

In 1974 a significant change occurred when the Minister of State for Sport was designated Minister of State for Sport and Recreation. The extension of the Minister's functions was a direct result of the work of the Select Committee of the House of Lords on Sport and Leisure, which published a report in 1973 and the subsequent government review of policy and publication of the White Paper "Sport and Recreation". Amongst other things the White Paper announced in a Prime Ministerial statement the extension of the Minister's role indicating that the change was made to facilitate the co-ordination of the outdoor recreational aspects of the government's policies which ranged across a number of government departments.
With the change of status in 1972, its functions were also extended to promote increased participation in sport, to encourage and support the provision of sports facilities (with LAs primarily) and in co-operation with governing bodies of sport to raise standards of performance and to provide information and advice. By the early 1990s some 133 governing bodies of sport existed all of which save two (Tennis and Rackets and Ballooning) were core funded by the Sports Council: in existing to regulate and administer, develop coaching and promote participation and excellence in the particular sport which they represent, they take on a high profile in the politics of their own activity and sport generally, both nationally and internationally.

**Sport, Recreation and Disability**

In the specific field of disability no such governing body exists but the BSAD was established in 1969 to co-ordinate activity over all disability groups although at that time only two groups, the British Deaf Sports Council (1930) and the Paraplegic Endowment Fund (1948) which in 1972 became The British Paraplegic Sports Society, had been formally established. However between 1976 and 1982 five further national groups were formed. These were, British Blind Sport (1976), the British Amputee Sports Association (1978), the United Kingdom Sports Association of People with Mental Handicap (1980), Cerebral Palsy Sport (1981) and the British Les Autres Sports Association (1982). All these groups, now in association with the BSAD, seek through the networks they foster and within the parameters of limited budgets to develop opportunities for and excellence in a wide range of sporting activities in the particular field of disability with which they are concerned.

Although not providing a mirror replication of the national disability groups, six international disability sports federations have been established and each national group provides a representative on the International Co-ordinating Committee (ICC). The ICC takes the lead in organising the paralympics and co-ordinating links with the British Olympic Association. This small but highly visible aspect of sport for people with disability focuses by its very nature on the training and development of excellence in sports personnel for international competition. The recent formation of the British
Paralympic Association will further this commitment. It will also add force to the growing impetus to achieve the integration of competitions between people with disabilities into mainstream events in international championships. It is a commitment which is not shared by all sporting organisations by any manner of means. While only a small part of the total concern of promoting sport for everyone, the very visible and acclaimed achievements of individuals in both national and international competitions have made a significant contribution in helping the wider community acknowledge the value and importance of sport for all those who participate in it, whether in competitive or non-competitive fields.

Alongside the growth of disability-specific groups, a wide range of sports-specific organisations has also emerged. They provide opportunities for disabled people to participate in sporting activities at both competitive and non-competitive levels. Two such are The Riding for the Disabled Association (1969) and the British Ski Club for the Disabled (1974). Similarly, many other local single or multi activities groups have been formed and are frequently associated with wider national or regional groups eg PHAB (Physical Handicapped Able Bodied, an organisation formed to foster joint activity). Some other national organisations are geared to providing a range of sporting and recreational opportunities for people with disability focusing less on competition and more on serendipity, with degrees of emphasis on challenge eg the Calvert Trust and the Fieldfare Trust.

The growth and development of the range of organisations which now exists to foster opportunities for people with disabilities to participate in all sporting and recreational activities is evidence of the value that participants place on this feature of their life experience. It is also evidence of a growing awareness of those able bodied people who may have facilitated the formation of such groups in the past, and may continue to do so in the future, of the rights of individuals to participate in whatever activities they choose to enjoy and to be challenged by. The relatively short history of the development of sporting and recreational activities which are both physically and psychologically accessible to people with disabilities is rich in evidence of the ingenuity
of making the seemingly impossible, possible to those who are committed to meeting their individual and particular challenge.

In publishing the White Paper on Sport and Recreation in 1975 the government of the day acknowledged and accepted the view of their Lordships on the work they undertook in the select committee that "recreation should be regarded as one of the community's everyday needs" and that provision for it is "part of the general fabric of social services". The government shared the view that had underpinned the deliberations of the work of the select committee and stated that "sport and recreation provide enormous benefits for the individual in society and recognise the part which they can play in the enhancement of personality.... where the community neglects its responsibility for providing the individual with opportunities and choice in the provision of sports and recreational facilities, it will rarely escape the long term consequences of this neglect. When life becomes meaningful for the individual then the whole community is enriched" (paras 66-67).

While acknowledging that the then current economic difficulties were likely to inhibit the immediate development of services, the government stressed in its White Paper that the overriding responsibility of all public authorities was to ensure that the limited resources available to them were employed with "discrimination and in the most cost effective manner possible" (para 7). It commended to LAs as a basis for their planning for the longer term future a "comprehensive philosophy for sport and recreation" identifying six priority areas which should be addressed. Recreational opportunities for disabled people was one such and, in identifying this particular area of need, the government expressed its belief that "for many (disabled people) the development of skill in some physical activity is an invaluable means of acquiring social confidence and sense of fulfilment which their disability may make it difficult for them to discover otherwise" (para 61).

Some 10 years later a working party of the Association of Metropolitan Authorities produced its own report on leisure services focusing particularly on the need to make such services accessible to disadvantaged groups of which "disabled and/or handicapped
persons" were identified as a specific group. The report acknowledged the function of leisure as a means of enriching the quality of life and stressed the importance of collaboration between leisure, social services and education in adopting flexible working arrangements to ensure that services became both accessible and acceptable to disadvantaged groups. No attempt was made however to identify or analyse the value of collaborative working in facilitating the achievement of the primary professional aims of the respective departments.

In 1982, some 10 years after receiving its Royal Charter and mindful of the priorities which had been identified by government, the Sports Council committed itself to developing areas of special need. Having regard to the evidence of the General Household Surveys of 1977 and 1980 which showed that participation in indoor sport more than doubled in the 1970s it wrote in the forward to its publication "Sport in the Community .. the next 10 years" of "the sports franchise (being) greatly extended but the suffrage (is) far from universal" It went on to indicate that the "handicapped" was one group who "take no part (in sport) often because of barriers of access, cost and lack of information" Beyond the acknowledgement and identification of special areas of need the document made no commitment to specific groups but more to potential strategies which might begin to address the needs. However, in raising the profile of sport in a society in the throes of significant demographic change in which sporting participation had grown in popularity and frequency, the document also identified, in the context of demand outstripping current public and private resources, the need selectively to concentrate developments, a theme first raised in the Government White Paper of 1975.

In 1986, in preparation for the mid term review of its ten year strategy, the Sports Council produced a paper for consultation. It invited responses to a series of questions, supported by summarised facts, which addressed issues of population and demography, partnerships in developing mass participation, developing excellence and the resources and roles of the public sector. Specific questions were put to explore accessibility to facilities and programmes for people with disabilities.
The formulation of the responses to the consultation paper of 1986 was published in 1988 under the title "Into the 90s . . A strategy for sport 1988-93". The report reflected both the wide range of issues initially identified in 1982 and changes that had occurred over the intervening period. In relation to promoting "mass participation" it indicated its intention of giving greater emphasis to young people and women and particularly those "who may be ... disabled in all its programmes" (pp2). In bidding for those resources which the Council considered might properly come from central government the Council stressed the significance which sport and recreation has played in the past five years in supporting healthier life styles and in contributing to the alleviation of social deprivation.

In identifying the function of sport and recreation in relation to personal development the report states "Last but by no means least, the Council reaffirms its belief in the value of sport and recreation to the personal development of men and women, boys and girls. From the youngest child, using sport to develop the physical co-ordination necessary in all aspects of life to the oldest pensioner for whom the sport itself may be almost incidental to the friendship and social network it brings, the function of sport and recreation in developing the human mind and body is invaluable. It is impossible to measure in any objective way such intrinsic benefits. Even here there will be economic spin offs to the nation such as reduced accidents and fewer calls on social services" (para 6.9)

Given this statement and the role played by SSDs in the lives of many adult men and women across the range of physical and mental abilities, it is surprising that they were not identified amongst the list of statutory authorities, government departments and voluntary organisations with which the Council feels it is important to collaborate. Evidence would seem to suggest that their absence in the list is because SSDs have yet to acknowledge consistently and formally the value and significance of the function of sport and recreation in the context of their clients' developmental needs, and are failing to utilise it effectively. This issue will be discussed in a subsequent chapter.
Much of the specific development in relation to sport and recreation for disabled people funded by the Sports Council has occurred through various agencies (BSAD, as well as sport specific organisations). Some directly funded development has also been made (for example, Demonstrations Project Everybody Active NE England) within the Council's broad strategic commitments while the identification of the need for and the establishment of such projects has occurred through the work of a range of groups working for disabled people. These groups were particularly evident in contributing to the work of the Minister of Sport's Review Group 1988-89

In the forward to the report of his Review Group 27, published in August 1989, the Rt Hon Colin Moynihan, then Minister of Sport, indicated that while the Review Group had been established to consider the many aspects of sport for people with disabilities the work had to some extent been spurred on by the proposed reorganisation of representative bodies at international level and the thrust towards the assimilation of sport for disabled people with that of able bodied sport. A number of recommendations related to this particular concern but very many more related to the wider canvas of providing sporting and recreational opportunities for people with disabilities. The Sports Council was urged to allocate more of its resources to sport for people with disabilities, to appoint officers to promote work in the regions and to fund organisations undertaking specific work. The governing bodies of sport were asked to accept in principle that "they will ultimately assume responsibility for disabled people in their sport (as opposed to the current situation where this is the responsibility of the seven national Disability Sports Organisations) and should set a timetable to achieve this" (ppv). Statutory authorities and agencies, voluntary organisations and other government departments were also invited to address and implement those recommendations that impinged upon their functions

The recommendations were far ranging. HAs were invited to review their sports provision for those in long term care and devise a strategy for extending opportunities for increased participation and LAs were asked to assume responsibility for the provision and co-ordination of sport for people with disabilities at local level and to access information about provision through traditional and new outlets. They were also
asked to formulate a statement on sport setting out their agreed aims and policy and appoint a senior officer to assume responsibility for its implementation supported by nominated officers in each of the authority's departments: and to undertake an access audit of their sports facilities as a basis for spending money on providing access as money became available.

In relation to education services a range of initiatives were identified by which the DES could provide better guidance to LEAs on the development and utilisation of sport, particularly in mainstream schools, with children with disabilities.

SSDs were invited to publish a detailed policy plan drawn up, implemented and monitored in consultation with disabled athletes, the disability sports organisations and the Sports Council, and were also asked to consider grant aiding voluntary organisations where this was not occurring. These latter recommendations in all probability reflected the fact, not identified, and certainly not quantifiable against the services contributed by others, that SSDs provide by far the most community based day services for those adults with disabilities who need them. A noteworthy and somewhat unusual characteristic incorporated in the text of the report was the specific invitation to a professional association, the Association of Directors of Social Services, to consider the recommendations of the report. This research will indicate the timeliness of the invitation. The validity of the creative use of sport and recreation in work with adults with disabilities is however an issue which needs to be addressed by a wide range of personnel in SSDs together with elected members in their role of policy making and budget allocation.

THE ARTS

The founding structure of the Arts Council of Great Britain, reflects some similarities with the Sports Council. Established by a Royal Charter of Incorporation in 1946 it assumed the functions of the previously established Council for the Encouragement of Music and the Arts (CEMA). In 1965 funding arrangements previously administered by the Treasury were changed when its grant became administered by the DES.
Minister of State for the Arts was appointed to promote the Arts and in the process oversee the work of the Council. In 1967 a new Charter was granted and its objectives, which remain unchanged, are:

a. to develop and improve the knowledge, understanding and practice of the arts;

b. to increase the accessibility of the arts to the public throughout Great Britain,

c. and to advise and cooperate with departments of government, LAs and other bodies on any matters concerning the foregoing objects whether directly or indirectly. (ACGB 1967).

The Arts Council was quick to establish working relationships with Regional Arts Associations (RAAs) whose genesis resulted from an impetus of LAs to provide a common focus for the interest and involvement in the arts of individual LAs both at district and county council levels. The nature of the working relationships between the Council, and the Associations reflected circumstances of the time in the Arts world and its changing political fortunes (Hutchison, 1982). In recent years both the RAAs and the Arts Council have undergone significant restructuring with Associations being re-established as Boards during 1991/2 and the Arts Council reconstituted in 1993 when it became the Arts Council of England with separate arrangements for Scotland, Wales and Northern Ireland. These changes are unlikely to affect significantly the patterns of work and relationships which had been established between the Council and the Associations, and the Boards will continue to discharge the responsibility of the former Associations as regional allocators and managers of earmarked central funding. The changes may however raise the profile of the advisory functions of the Council and provide it with the impetus to formulate a more visible regulatory role, which while existing in some respects in the past had been lacking in definition.
The Arts and Disability

Arts and disability had been on the agenda of the Arts Council of Great Britain since the early 80s. In 1982 the Carnegie UK Trust established a Committee of Inquiry to "look into the extent to which existing facilities enable people with disability to involve themselves in the arts whether as artists or audience and to make recommendations to encourage development and improvement". The Committee under the chairmanship of Sir Richard Attenborough reported in 1985.

The work of the Attenborough Committee and the wide ranging recommendations of its report has informed work that has been undertaken in a number of quarters and not least in both the Arts Council and the RAAs. One outcome was the formulation of a Code of Practice on Arts and Disability produced by the Arts Council in October 1985 and subsequently the publication of an arts and disability check list which provided a quick reference guide for arts officers on arts and disability issues. In October 1989 an Arts and Disability Action Plan was published. This latter document identified "measures to be undertaken by the Arts Council, the RAA and all Arts Council clients in furtherance of the code of practice" and "additional measures to be undertaken by the Council as a pledge of commitment to this area of provision and as an example to other major arts providers".

Much of the work undertaken by the Attenborough Committee and its sequelae has focused on the physical accessibility of arts venues for people with disabilities and, for those who so wish them, opportunities to develop and extend their artistic skills and employment prospects both as artists or in the management and technical fields related to the arts. In promoting a policy on Arts and Disability the Arts Council and the RAAs were challenging and requiring their grant receiving clients to address the problems of the wider access of employment and participation which might previously have been considered insuperable. Put within a historical context of change, significant advances have been made in providing opportunities for the arts for people who might not necessarily have had them. Seen from the perspective of a person who is handicapped by both physical environments and social attitudes towards disability too
little has occurred too slowly. This most certainly is the message of self advocacy groups which are establishing themselves throughout the country and becoming increasingly vocal and demanding.

A range of factors have facilitated the establishment, increased visibility and impact of self advocacy groups for people with disabilities in a society which generally has scant awareness of the physical and psychologically handicapping environment it provides. The utility of sport and recreation in facilitating a sense of self confidence and validation for individuals has often played no little part in giving them the confidence to speak out about wider issues which concern their lives. The expansion of opportunity for people to engage in the participative and creative arts has also been a significant feature in this process in the wider context of recreation. Much of this work has been promoted through the formation of Art Development agencies which resulted from the growing awareness and conviction of the value of active participation in the arts for people who are disadvantaged for a range of personal and social reasons (Levete, 1987).  

The raison d'etre of Art Development agencies is generally to provide active participation in the arts for people who might otherwise be prevented from doing so by a range of personal or social circumstances. Many such agencies exist and address the wide range of "disadvantaged groups". The Shape Network is a national federation of those arts organisations which are generally more specifically geared to promoting participation in the arts for people with disabilities. The first Shape group was founded in 1976 and from its early beginnings it has attracted artists from all backgrounds who generally share a common commitment not only to explore and extend their own artistic creativity but develop skill in facilitating the artistic and personal development of those with whom they work. Although sometimes providing a direct service, Shape organisations more often function as an intermediary between artist and agencies wishing to engage artists' services. In this context Shape organisations have often facilitated work undertaken in day centres in SSDs; not infrequently they have also negotiated grant aid from external funders without which the work could not take place.
In this respect SSDs have clearly benefited from the policy commitments of the Arts Council, RAAs, other LA departments (Leisure and Education) and charities.

The more general reluctance or unwillingness of SSDs to support arts inputs very likely indicates that they are failing to acknowledge the importance of their contribution in facilitating self actualisation in clients and its importance as a basis for sustaining the development of levels of functional independence which lessens dependency on statutorily provided systems of social supports.

**RECREATIONAL WELFARE**

The provision of LA leisure services is not underpinned by any statutory requirement to provide, unlike welfare services; nonetheless, both services are on a continuum of provision in which the middle ground has many similarities. Whereas welfare services were initially required to develop services into which "clients" requiring those services were slotted (services for all in need) providers and managers in SSDs are now struggling to establish equitable policies and operational strategies which address the shaping of services to individual need and choice. On the other hand leisure services, at the behest and requirement of national funding organisations but also in response to the increased demand for leisure from all sectors of society are expanding services which provide opportunities for all who choose to participate in them rather than only for an elite with aspirations to excellence.

In a study of the rationale of public leisure policy sponsored by the Sports Council and the Social Science Research Joint Panel on Recreation and Leisure Research, the authors (Coalter et al, 1988) identify the changing ideological stances of the Sport and Arts Councils and to a lesser extent the Countryside Commission, to a commitment to the generalisation of services and the provision of leisure opportunities and access "for all". The authors also identify that whatever the range of strategies devised to achieve a significant populist commitment, a philosophical tension will always exist when the underlying founding principle of the Councils and the Commission since inception
derived from elitism (a commitment to the best and in the case of the Countryside Commission, conservation which almost invariably limits access).

In further exploring the tension in the field of public service leisure providers which have no statutory requirements to provide services, the authors identify the political and managerial conflicts which are generated in determining how services are geared. Services may be geared predominantly to market forces and providing what the public demand and pay for; this position is opposed by the concept of "recreational welfare" whereby services are made available to disadvantaged groups with little or no power to "purchase" leisure opportunities or finance recreational pursuits.

The authors also identify that a significant determinant in the functions and professional direction of staff in LAs engaged in providing leisure services has been the national policy direction in leisure. As a result of an underpinning commitment to the maximisation of efficient market forces the development of management skills has been of first importance in expanding and subsequently sustaining services. In these circumstances neither LA providers nor their staff have placed a priority on exploring policy positions or professional stances, separately or in association with others, on recreational welfare. For example, the question whether recreational welfare is no more than an institutional mechanism to exercise social control over disadvantaged or disaffected groups or whether it has a function in facilitating personal and social growth in individuals has not been debated. Clearly the latter view would be of particular significance in terms of collaborative endeavours between recreation and welfare services.

Given the development agendas generated, assumed or necessarily adopted within the respective fields of leisure and welfare it is little wonder that no more than a passing nod of acquaintance has occurred, or rhetoric been heard, which acknowledges the intrinsic and common qualities to be found in both leisure and welfare services when these are geared to foster personal and social growth of individuals whatever the level of challenge, achievement or engagement. The therapeutic function of recreation in sport, the arts or other leisure activities, is a resource largely untapped in England and
Wales (and also in the wider UK). It is a resource which has applications in all fields of personal and social development and certainly echoes both the aspirations and commitments of services for everyone which are tailored to meet individual need and choice.

**SUMMARY**

This chapter explored the respective and different developments in welfare, sport and recreation, including the arts, and the emergence of shared objectives. Often unrecognised by virtue of the working context in which different service providers have engaged (market as opposed to welfare forces) changing welfare legislation and service activity has created the potential to develop new perspectives in which recreational activities may be utilised to foster social well-being and competence in both general terms and where specific needs have been identified and targeted.
CHAPTER 2: THERAPEUTIC RECREATION: PERSPECTIVES IN THE USA

In this chapter some important elements in the development of therapeutic recreation in the USA are identified. Consideration is also given to the interrelatedness of the influences which have impacted on both academic and practice developments particularly in relation to the establishment of a discrete profession. Further consideration is also given to lessons which might usefully be learned from the experience of the USA in establishing a more visible and effective use of recreation as a therapeutic tool in the UK.

In America the utilisation of recreation as a therapeutic tool began to take on a systematic form as a result of the voluntary work undertaken by Red Cross personnel in hospitals treating medical, surgical and psychological conditions of returned soldiers from the theatres of war in Europe and Asia in World War II (Sylvester, 1989)\(^{35}\). They worked under the direction of medical staff and alongside nursing staff, and the relatively few para medical groups that existed in hospital settings at the time, including occupational therapists (OTs). OTs had become a visible working group in America during the 1914-18 European War and later informed and influenced the early developments of occupational therapy in the UK in the 30s. Occupational therapy in the UK became better recognised and valued during the Second World War (Colins, undated)\(^{36}\).

The achievements attending the specific work of the volunteer Red Cross workers in providing recreational activities for patients in hospitals gave them the impetus to establish, in 1948, the Hospital Recreation Section of the American Recreation Society (HRSARS) to address issues of recreational activities in institutions. It was from these beginnings that efforts were made to formulate the distinctive nature of the work the Red Cross workers undertook in the recreational field and which separated it from others, not least occupational therapy. It has been suggested that this early work born out of a belief in "recreation for all" was the forerunner of the emergence of a "civil rights" perspective in this field of activity (Austin, 1989)\(^{37}\). Much has occurred since.

37
Another significant early development was the emergence of recreational therapy as a specialist function of Parks and Recreation personnel who spearheaded it as a means of accessing recreational environments, services and opportunities to people with disabilities. This work and its rising profile was clearly fostered through the Federal Rehabilitation Agency which, committed to promoting rehabilitation through recreation, funded therapeutic recreation programmes (therapeutic recreation is a term which came into common usage in 1966) at both undergraduate and post graduate levels at universities. These were predominantly located in Parks and Recreation Departments. Over years the "civil rights" perspective has been more closely related to this work and wider considerations of access. This and the nature of academic developments in the universities is very likely the reason why on first acquaintance Europeans visiting America see therapeutic recreation as largely concerned with people with physical disabilities and access. The reality is very different and the wide range of posts held by delegates at conferences is evidence of that fact. Therapeutic recreation specialists can be found working across all client fields in both institutional and community settings though work within institutions has continued to focus on treatment programmes, health promotion and rehabilitation.

In professional development terms and until the mid 60s, the different emphases of treatment in institutions and the accessing of leisure activities to people with disabilities were fostered through two associations. Reference has already been made to the formation in 1948 of the HRSARS which was the first of its kind. The National Association of Recreational Therapists (NART) was formed in the 1950s to address issues identified by the growing number of Parks and Recreation personnel. Their work did much to foster a greater awareness of access issues far beyond the context of recreation and some of this work was to bear fruit in political lobbying which was to increase from 1966 when both associations disbanded and reformed as one joint association, the National Therapeutic Recreation Society (NTRS). Notable work occurred in relation to the Rehabilitation Act 1973 (amended 1978) and the Education for All Handicapped Children Act (PL 94-142).
It was in 1966 and at the foundation of the NTRS that the term "Therapeutic Recreation" was adopted to embrace the two positions which had previously been fostered by the two different associations. It also identified a founding issue which was to become of mounting importance: "leisure ability" was to be the ultimate goal for therapeutic recreation rather than "health restoration".

Throughout this period, subject options which addressed the therapeutic dimension of recreation and leisure were becoming available on degree courses in American universities. Almost invariably located in Parks and Recreation Departments of wider faculties, the content of these courses often reflected no more than the philosophical commitments of the staff teaching them. A corpus of academic knowledge was developed, however, and this established academic and working concepts. These, as may be expected, identify and reflect the philosophical tensions of the different working practices found in institutional and community settings in which recreation and its therapeutic functions are seen to have a significant place.

A foundation construct of therapeutic recreation, proposed by Peterson and Gunn (1984) and which continues to be seen as valid today, identified a continuum of client need (treatment, leisure education, recreational participation) related to levels of dependence/independence. Points along the continuum of need and the levels of dependence/independence were matched to styles of practitioner intervention (service provider, educator, enabler) (see Figure 1).
Figure 1
Recreational Activity Participation Model

(TRS supports clients in their leisure)  
Enabler  
Facilitator

(Leisure experiences are co-managed between clients and TRS)  
Educator  
Instructor  
Advisor

(Leisure experiences are managed by the TRS)  
Direct  
Service  
Provider

To improve functional ability & adaptive behavior. (Treatment is viewed as an essential precursor to recreational activity involvement)

To develop leisure awareness, enhance social skills, & identify recreation & leisure (Acquiring these skills & knowledge is necessary to optimize leisure decision-making capacity & leisure choices)

To achieve satisfying leisure experiences with self & others (The ability & desire to participate voluntarily in leisure pursuits enriches clients' leisure well being)

Treatment related to high levels of dependency is generally seen to be of a prescriptive nature geared to improving functional ability or fostering adaptive behaviour of the client, with practitioners making judgements (alone, together or with the oversight of medical supervision) and providing suitable activity for the purpose. Treatment is viewed as an essential precursor to involvement in recreational activity. When a client moves away from a total or significant dependence on activities marshalled for him or her, the intervention of the practitioner is perceived to reflect their changing role of educator, motivator and adviser to the client in fostering his/her capacity to develop leisure awareness, enhance social skills and identify recreation and leisure activities. As the client moves towards increased and functional independence the role of the practitioner is perceived perceptibly to change again to that of enabler, broker and facilitator to the client in achieving satisfying leisure experiences which enrich their leisure well being.

This construct (with all the limitations of a diagrammatic representation of a dynamic process) mirrors to a large extent, albeit crudely, some of the significant stresses within the practice of therapeutic recreation in America today. These focus on whether therapeutic recreation is primarily an element of a wider treatment "modality" with the therapeutic recreation specialist working with a multidisciplinary team and not infrequently under supervision, or whether it is a free standing specialist activity with therapeutic recreation specialists functioning as "leisure counsellors" with a formulated value base, "proven" principles of practice and a battery of skills all specific to the promotion of therapeutic recreation (Peterson, 1989).

These dilemmas, far less evident during and immediately after the war when the US was providing free rehabilitating services to its returned veterans, have become much more marked as the impact of war receded in a society where access to health and social care provision, beyond crisis life saving interventions, is determined by individuals' private insurance arrangements. In the context of the soaring costs of health and social care provision in the USA, the effectiveness of cost limited purchases of care become important to both service funders (almost invariably insurance companies) and service receivers (the patient) alike. In these circumstances the
efficiency and cost effectiveness of recreational activity as part of a "restorative" programme must stand alongside all other interventions which are seen as appropriate and necessary. Current research, clearly important in this regard, is attempting to demonstrate the validity of the function of therapeutic recreation both quantitatively and qualitatively and a major research programme on the efficacy of therapeutic recreation financed by the Medical Sciences Division of National Institute on Disability and Rehabilitation Research, a branch of the United States Department of Education, has recently been completed at the Temple University, Philadelphia. In 1991 a conference focusing on the outcomes of the research brought together "over 80 of the country's researchers, educators and practitioners to debate and come to agreement on the outcomes or benefits, of therapeutic recreation in rehabilitation" (Coule et al, 1991). The conference was the culmination of a year of extensive work undertaken by working groups focusing on service areas in which therapeutic recreators work. These were physical medicine, psychiatry, gerontology, paediatrics, chemical dependence and developmental disabilities. Each group systematically examined the literature and research in their particular field, produced a paper for conference delegates and subsequently a formal response to the summary paper and the views expressed at the conference.

In its work each group addressed itself to identifying from within the USA seminal work which will inform the development of future theoretical concepts of therapeutic recreation and analytical studies or research work which demonstrates its known or believed efficacy. In the field of developmental disabilities the research identified that involvement in therapeutic recreation improved social skills, socialisation, co-operation and interpersonal interactions.

All groups in adopting both values and position statements and signalling the outcome of analytic work (not infrequently single study projects) highlighted the urgent need for a significant expansion of research programmes which are both systematic and rigorous in analysis and which identify measurable outcomes of effective intervention.
The research work undertaken and facilitated by Temple University has provided many rich seams for examination in the future and the paucity of work which identified measurable as well as demonstrable evidence of the efficacy of therapeutic recreation in all fields is one which will tax researchers for many years to come.

In reviewing recent research directions in the field of therapeutic recreation and in emphasising the growing need in the future for the profession to develop sophisticated research programmes, Compton (1989) has expressed some encouragement at emerging trends of continuity in research and the expansion of longitudinal studies which embrace a wide range of philosophical and practice issues and facilitate the foundation of new, and refinements to and extensions of old, knowledge bases.

An area of enquiry which is also highlighted by Compton (and others) and will be more easily addressed than some is the continuing analysis of the specific skills required by therapeutic recreation specialists in discharging their educational and counselling role in assisting people to maximise their leisure potential. Such an analysis of therapeutic recreation would clearly resonate with the accepted purpose of its function as declared by the NTRS and reflected in the Peterson and Gunn model which sees therapeutic recreation as a means to "facilitate the development, maintenance and expression of an appropriate lifestyle". It would clearly also facilitate the journey towards establishing a professional status which is perceived by those outside of the profession as credible. It would almost certainly be a surer path to tread than some others in a country which lays great theoretical stress on the inalienable rights of all its citizens and which is rich in, and generally committed to, the purchase and utilisation of a wide range of therapeutic systems as a means of achieving and sustaining life enriching goals of both individuals and groups.

The formation of a new profession is a long and wearisome road for those engaged in the process. It is a journey therapeutic recreation specialists have commenced. A first and proper concern is the establishment of minimum standards of knowledge and practice, the manner by which members are registered and the code of ethics and conduct to which the accredited membership will adhere and be governed. In 1981,
after 25 years of voluntary credentialing of practitioners, an activity which was the responsibility of a number of self governing groups functioning in association with each other, a new governing body, the National Council for Therapeutic Recreation Certification Inc (NCTRC) was established. Since 1981 it has become increasingly influential in determining not only the standards, but also the future direction of therapeutic recreation. It is likely to be the major force in establishing the formal public profile of the profession in the USA for the foreseeable future. It is unlikely to ignore a concern which is increasingly felt that the "all embracing approach important in 1966 to bring two disparate groups together is now a hindrance rather than a strength in the quest to establish a distinctive self directing and visible professional identity for therapeutic recreation".

With the perspective of history it is possible to identify how war affects the social structures of the societies engaged in it and the emergence of therapeutic recreation in America is but one small facet of the impact of war on that country. In this context it is interesting to reflect on the development of therapeutic recreation in the USA in the post war years. The Red Cross volunteers who engaged in the early work of recreational therapy saw the value of it and were sufficiently committed to establish an association to sustain its visibility and maintain its influence as the first impact of the work diminished. It is not surprising that as veterans returned from the war and reintegrated into home communities which showed no signs of the ravages of a war waged in distant parts, rehabilitation work, particularly when related to the physical and psychological consequences of war on individuals, largely sank out of sight. The situation provided many of the ingredients which came together and the chemistry required to fight for recognition through the classic route of moving towards professional status of which the establishment of associations is a major part. With the amalgamation in 1966 of the two associations involved in recreational therapy contemporary issues of shared concern were identified, defined to a large extent through a commitment of a federal agency to fund academic and professional development which served its objectives. It is not unreasonable to suppose that with such a signal of validation from a federal agency a new authority was born in dealing with government, and, sustained and nurtured through a renewed visibility of rehabilitation work with
casualties of the Vietnam war an impetus generated to establish a higher professional profile which could influence government policy in those areas in which its voice was considered to be of growing importance.

While the process of "reconstruction" of social change since World War II had been very different in the UK, certain similarities existed in the emergence of new working groups. One example was the development of state subsidised domiciliary services which was born out of the war time work of the Women's Voluntary Service and at the war end the acknowledgement of LAs of the growing importance of providing domiciliary support to the elderly. As a result, war time volunteers were, after the war, formally employed as Home Help Organisers to organise this particular service which in the wider welfare services of the day was seen to be of low status. This status was further diminished in the early 70's with the expansion of social services and with it the growing status of social workers. While Home Help Organisers had attempted to realign their status through the formation of an Institute, membership of which was eligible through examination, little progress was made. It is interesting to note however that, through a widespread commitment and development of community care systems now underpinned by legislation which has reflected on their organisational status by the increasing enhancement of their managerial tasks, the impetus for formal and discrete professional status is no longer seen to be of importance particularly in a service department which is needing to become increasingly multi disciplinary in context.

In the USA the utilisation of the therapeutic value of recreation and leisure has had an increasingly visible impact on service developments across a range of fields and both federal and state governments acknowledge its value and place in both institutional and community fields (Patrick et al., 1989). This development has clearly been enhanced through the heightened profile of the profession gained through its successful lobbying and advocacy work. In the UK while a generalised acceptance is held of the value and importance of recreation and leisure as a therapeutic tool no discrete political agendas or lobbying activists exist, nor have formal policy directions or strategies been identified at central or local government level. We need to ask the question therefore whether an effective policy thrust can only be facilitated by adopting the American course of
establishing a new professional group which commits itself to developments in this particular field. While there might be many lessons to learn from the American experience it is unlikely that the most speedy and effective result in the UK will be by replicating the same journey. We should be careful therefore to take the most suitable route which best suits the manner in which our services have been established in the past and the direction they are likely to take in the future.

In the context of developing professional knowledge there is very much to share however. The Peterson and Gunn matrix developed to demonstrate recreational activity participation and the movement from dependency to independency promoted by maximum to minimal direction has common characteristics with "best" work adopted by staff in the UK. This facilitates the social training of clients being prepared for moves from institutions to community supported living arrangements, or programmes devised for clients over dependent on formal support systems to develop optimal independence, thus reducing levels of formal support.

The diagrammatic linking by Peterson and Gunn of the differential functions of a therapeutic recreation specialist with changing needs of clients as dependency diminishes, mirrors the manner in which skilled workers, (nurses, social workers, day centre staff) adjust the nature of their support to clients as their social skills are extended and become established. In the UK situation the structure of the matrix might also be used to provide a crude picture of patterns of "best" service provision found in day centres in SSDs. At the highest level of dependency, services are provided "in house" by staff, moving through at the middle level to supported activities occurring externally, with or without the assistance of other agencies/volunteers, and ultimately to the highest level of independence where the nature and character of activities and attendant support/association are determined solely by the individuals themselves.

In the fields of learning and physical disabilities in the UK shared patterns of work are increasingly characterising nursing, social services and education practice amongst those who are engaged in facilitating functional levels of independence and managing community care support systems. While the use of recreation and leisure is increasingly
visible in this work, its effective utilisation is unlikely to be facilitated through the establishment of a new profession. It will not occur however until its value as a therapeutic tool and aid to independence is firmly rooted and adopted as policy (as was the case with domiciliary services) with a commitment made effectively to marshal and co-ordinate resources which are the responsibility of different statutory authorities, departments and agencies. In a society where need is fast outstripping finite resources a new imperative exists to move out of traditional patterns of service response to provide innovative patterns of support which reflect the needs, wishes and aspirations of the users of services. In requiring a greater use of the independent sector in providing services which are tailored to individual need the government through the National Health Service and Community Care Act also provides a new legislative framework to foster greater collaborative work across statutory and independent agencies. It most certainly provides the opportunity for SSDs to explore the more effective use of recreation and leisure in their primary aim of promoting independence. With this will come the acknowledgement of the value of recreation and leisure and the importance of setting its use firmly in policy, so making available funding to discharge the work effectively with other agencies either collaboratively or as purchasers to the best and desired ends of clients.

**SUMMARY**

This chapter was used to explore the academic and practice developments of therapeutic recreation in the USA and their impact on the establishment of a discrete profession. Consideration was also given to lessons to be gained in the UK from the experience. It also identified that a wholesale transfer of the developments in the USA is unlikely to be effective in SSDs in the UK; and that arrangements to establish a visible and effective use of recreation as a therapeutic tool in SSDs will need to flow from the political and organisational structures relating to welfare services which are germane in the UK.
CHAPTER 3: SERVICE DEVELOPMENTS IN THE FIELDS OF LEARNING DISABILITIES AND PHYSICAL DISABILITIES

In this chapter the changing pattern of developments in the discrete fields of learning disabilities and physical disabilities is explored. The growing congruence is identified in shared working objectives in education, health and welfare and service responses which are attempting to move away from providing support systems which foster dependency and towards interventions which assist people to optimise functional levels of independence. Consideration is given to the increasing utilisation of recreation and leisure in both the learning and physical disabilities fields and reflections are made on its limited impact in supporting the professional objectives of SSDs

LEARNING DISABILITY

The Legislative Context

Tracking the historical development, the changing range and inter-relatedness of responsibilities of statutory agencies (health, welfare and education) in the field of mental handicap requires no little skill in orienteering. Legislation provides some compass markings, although true north cannot be assumed unquestioningly.

To all intents and purposes LAs were first required to assume some welfare responsibility for mentally handicapped people with the passing of the Mental Deficiency Act 1913; it called for the statutory supervision of "ascertained defectives" which definition encompassed both children and adults.

The enactment of the Mental Deficiency Act 1927, made no major change to the statutory duties of the LAs although it expanded the nature of supervision to include the training and occupation of "defectives". Subsequent legislation and notably the National Health Service Act 1946 transferred to the National Health Service (NHS) those institutions which local HAs had established to provide care for mentally handicapped
adults who were not, and could not be, suitably cared for at home. However, as a result of the recommendations of the Royal Commission and the implementation of the Mental Health Act 1959, the Minister of Health laid a duty on LAs to again provide residential accommodation as well as a full range of community services for both mentally ill and handicapped adults. The situation in relation to children established by the 1913 and 1927 Acts did not change however until 1971 when a radical departure from previous practice occurred following the implementation of the Education (Handicapped Children) Act, 1970 the Act required that staff and premises were transferred from local HAs to Local Education Authorities (LEAs) who became vested with the responsibility to provide specialised forms of education for children who had previously been regarded as "ineducable". This change in relation to children crystallised a perceptible shift of philosophy and policy from a health to an education and social care model.

The potential for adding impetus to the policy shift in relation to adults which had become visible in 1959 came in 1971 with the publication of the White Paper "Better Services for the Mentally Handicapped". While LAs had begun to develop community services for mentally handicapped people not entering hospital, resources often precluded pro-active developments for patients discharged from long stay hospitals and HAs themselves provided a range of community based services for their former patients. While some of this work has occurred in collaboration with LAs much has not, resulting not infrequently in the fragmentation of services which are less than efficiently geared to the provision of community support services which are adequate to both need and demand.

**Care in the Community**

In 1993 and the full implementation of the National Health Service and Community Care Act 1990 LAs have again resumed the major responsibility through their own services, or through commissioning the independent sector to provide services for the provision of community support including the accommodation of patients discharged from hospitals. It is anticipated by government and fervently hoped by others that the
legislative requirement that LAs produce jointly agreed care plans in consultation with HAs will ensure that service developments will be characterised by a coherence rarely present in the past. Recent history provides few examples, if any, on which confident hope can be established and hope alone will not buttress the new legislative requirement or feed genuine commitments to the process. Collaboration on specific programmes and the promotion and delivery of services by providers, jointly or individually, which are acknowledged to be effective by providers and receivers alike will be important early features to identify and replicate in facilitating a functional level of collaboration in relation to the more global joint concerns with which separate authorities must begin to engage.

The Review of Mental Handicapped Services in England (Progress, Problems and Priorities) published in 1987 and referred to in chapter 1 highlighted that while services by regional HAs were variable the pace of change identified in 1971 had not been achieved. Nonetheless, children resident in hospital over the intervening period had been reduced by 74 per cent exceeding in a remarkable way the targets set in 1970. According to the review this had resulted in the increased availability of a range of educational and welfare services to support parents or substitute carers to undertake care in the community; and also the decision by some hospitals not to admit young children. The picture was very different in relation to adults where over the same period no more than a 16 per cent reduction had been achieved (from 49,584 residents to 41,552). It is not really surprising that the rate of change was so different. Support systems that are required to assist those caring for dependent children are very different from those needed by adults whose dependency needs resulting from their disability have been compounded by years of institutionalisation.

Reduction of patient numbers do no more than indicate one measure of success or failure in a hospital closure programme. They do not measure the qualitative aspects of alternative care systems which must be provided in the community. These are ultimately determined by their capacity to respond appropriately to individual need, the deployment of necessary and integrated community resources often managed by different authorities and agencies and the effective skill mix of staff engaged in the
work. They will be significantly impeded if fiscal measures are not in place which ensure that money is directed to where it is needed.

The 1984-85 House of Commons Select Committee on Community Care which focused wholly on services for the mentally ill and mentally handicapped heard evidence from many quarters and were far from sanguine in believing that arrangements current at the time could be suitably re-jigged to ensure that the financial resources required to implement the policy were available where they were wanted. As well as hearing evidence about the funding and planning infrastructure the committee also heard wide ranging concerns in relation to service and professional developments which it was felt would be required to ensure the implementation of community care progressively and successfully. In wholeheartedly supporting a policy of community care, which it acknowledged would be costly, it highlighted that in the final analysis the judgement of its success would be determined largely by the quality of care available and the extent to which individual need was catered for. Wide ranging recommendations were made including those which indicated that hospital provision should not be reduced without demonstrably adequate alternative services being provided beforehand (paras 30,40); that new fiscal arrangements should become available to assist in the creation of alternative services for people who left institutional care or never entered it (para 116), that social security payments to individuals were comprehensively reviewed and geared to promote the development of supported care in the community, (para 147); that redeployment of staff should be facilitated (para 178); and that mutually compatible training programmes in mental handicap care were developed through CCETSW and the National Boards for Nurse Training (para 197). In the context of mental handicap the committee signalled its belief that in the long term it considered it logically desirable and sensible to "envisage all social care mental handicap services, .. financed and administered by local authorities." (paras 67-69).

The growing discontent with the financial arrangements which were becoming increasingly inflexible to meet the radical changes which were slowly and imperfectly gaining ground were taken up in different quarters. Professional and allied associations were increasingly voicing, not infrequently tendentiously, the need for services to be
the responsibility of a single agency and took the opportunity to provide evidence to the select committee (para 69).

Following their research academics were similarly exercised and in 1986 the Audit Commission, addressing all aspects of community care, recommended that the responsibility for community care should rest with LAs and where necessary funds should be transferred from the National Health Service. In 1988, the Griffiths Report was expressly commissioned by the Secretary of State of the Department of Health and Social Security to undertake an overview of community care policy. In acknowledging the work of the select committee and the Audit Commission and in concurring with their general recommendations Griffiths went further than any previous report and recommended that benefit payments made by the Department of Health and Social Security for residential care should be transferred to LAs to provide and arrange care for people assessed and eligible for care in either residential or community settings who could not make adequate provision for themselves through lack of financial resources.

The National Health Service and Community Care Act 1990 provided new fiscal arrangements which were implemented in 1993. These largely reflect the recommendations made in the Griffiths Report and LAs have had transferred to them funds previously disbursed by central government which met the needs of those living in the community who required long term residential support. However no new formal or statutory arrangements have been made in relation to the transfer of funds from the National Health Service whose patients are leaving long term hospitals to live in community based settings. While the new legislative requirements and fiscal arrangements have created new potentials for service developments these will largely be realised or impeded by the nature of the cost ceilinged budgets which will be controlled by central government. It is feared also that what developments do occur will be impeded further if central government chooses not to earmark the funding indefinitely and it becomes an unspecified element of the standard spending assessment which determines and controls the total annual budgets available to LAs to discharge all of their delegated responsibilities.
Both HAs and LAs have continued since the review of 1980 to explore, develop and extend the range of options open to their patients and clients who have accommodation needs and who will also need levels of service and personal support ranging from very high to minimal. While planning strategies required to establish patterns of care and support appropriate for individuals who have particular needs in common might be identified and generalised, each scheme and the individuals involved in it will make it unique and set the pace at which it achieves an optimal level of operation. In view of the diverse and wide ranging personal and service needs required, suitably tailored responses and service developments will often seem painfully slow. It is unlikely that it could be otherwise.

**Day Services**

The importance of providing day services which support people with learning disabilities to live in the community is critical and was emphasised in the White Paper of 1971. These were not seen to emanate wholly from welfare services but from a number of sources. The value of assistance from services provided by the Department of Employment was identified for those able to move or be supported to move into remunerative employment (the youth employment service, sheltered workshops; industrial rehabilitation and resettlement). However, it was acknowledged that the function of ATCs was crucial. These were seen to facilitate the means of providing special training for "mildly" handicapped school leavers who were not able to go directly into open or sheltered employment and also to provide for "severely" handicapped people some permanent form of work or occupation specially geared to their limited capability. The purpose of "special training and work or occupation" was seen to "develop work habits and to increase self reliance generally, so as to help each handicapped person to live a more independent life. The programme should include further education and facilities for social and recreation activities" (para 155)

The White Paper called for a substantial expansion in day centre places from the 23,000 available in England and Wales in 1969 to a tentatively identified target of 74,900 places in 1991. (55,897 were available in 1990) Twenty years on, the rhetoric of
community care provides some harmonious resonances to the earlier preoccupations of government even although emphases may have changed In the 90s educational services will become increasingly important. More clearly defined than 20 years earlier is the importance of the work of housing agencies in providing suitable housing for people prepared for, requiring and desiring semi or unsupported accommodation

Prior to 1971 statutory welfare services were provided by three (sometimes two) separate departments of the LA but with the implementation in that year of the Local Authority Social Services Act 1970, one SSD was created which assumed the duties of the previous children’s, mental health and welfare departments This major reform based on the Seebohm Report of 1968 pre-dated by some two years the restructuring of LAs when some smaller authorities became part of larger ones. It was a period of major activity and expansion in SSDs and capital stock was increased considerably Many ATCs were built at the time and in the waning glow of post war full employment, these were not infrequently designed, often with the direct assistance of civil servants informed by guidance notes issued by central government to promote employment training, or in the absence of basic skill, occupation in work activity of an industrial nature. Some centres were built on industrial estates. The emphasis clearly reflected the views expressed in the White Paper "that special training and work or occupation is to develop work habits and to increase self reliance generally so as to help each handicapped person to live a more independent life". Regimes at centres were established to further these objectives and staff were appointed who could foster a work ethos and discipline which might enable mentally handicapped people to move into full time employment. Seen primarily as instructors, a practice that continues to apply in many centres today, formal training for ambitious staff generally consisted of the Diploma for Teachers of Mentally Handicapped People. In very recent years the diploma has effectively become defunct and formal training has been generally routed through the work-based CSS. It was subsequently recognised as a social work qualification and has since 1992 been subsumed into the Diploma of Social Work, the sole qualification (for social work) now available in the UK.
With the changed economic climate and employment opportunities significantly diminished for people with no more than basic skills many SSDs have attempted to develop a new "social" focus in their work with clients in ATCs. This changed direction assisted by the continuing evaluation of services for people with mental handicap by the National Development Team (NDT) reflects changing professional and social attitudes in relation to mentally handicapped people. Through their publications the NDT has addressed a range of policy and practice concerns. Pamphlet 5 focuses specifically on "Day Services for Mentally Handicapped Adults" of which the provision of day centres continues to be seen as an important element. The document addresses not only the needs of people with a mental handicap in the context of independence, individuality, education, personal relationships, leisure, recreation and work but also their rights. With its re-ordered emphases on social development as opposed to industrial and employment training and the emerging one of "rights", the document is reflective of the manner in which the issue of rights is being articulated in society at large. It adds support to the need tomarshal services which address wider concerns in connection with the personal and social development of individuals. The pamphlet has become the basis of government guidance to LAs in this specific area of their responsibilities.

Many ATCs though by no means all, have become known as Social Education Centres, a term coined and popularised by the NDT in Pamphlet 5. This change of title is in itself generating a slowly changing pattern of operations as staff increasingly attempt to facilitate both formal and informal education programmes and a range of social activities often against the odds of budgetary and staffing restraints, and buildings ill designed to cope with changing philosophy and practice.

In attempts to develop collaborative work with other agencies and to utilise the wide range of community and professional resources that can be tapped to foster the capacity of a person with learning disabilities to live a life characterised by independence, activities may often occur "off campus" in mainstream facilities with attenders being bussed, accompanied or helped to travel without supervision to colleges of further education, leisure centres etc, and other social venues. The development of off campus
activities many of which are of a recreational nature is clearly becoming an important feature of work of day centre staff committed to breaking down attitudes which buttress segregation and impede the promotion of social functioning in people with learning disabilities which allows for living with support determined by need rather than former practices of care.

Without formal commitments to this work articulated and formalised in policy statements by SSDs the utilisation of education and recreation is often haphazardly managed thus reducing its impact and value. This will not change until SSDs explore the manner in which education and recreation, properly marshalled, can assist it in achieving its primary and proper social work and service aims.

Intellectual and attitudinal acceptance of change can be difficult but the physical or action changes which must be identified, implemented and applied as a result of a commitment to a change in philosophy are often far harder to manage. This fact was clearly evident in the first "national" inspection of day services for people with a mental handicap undertaken by the SSI in 1987 when services provided by or accessed through LAs were inspected in a representative sample of 13 LAs.

The inspection focused on the development and management of services emanating from day centres. Stress was laid on the importance of having systems in place which facilitated the developmental and social growth of those individuals to whom centres provided a service. The report identified that while SSDs "claimed" to be committed to current departmental guidance (government Department of Health) which advised "that LAs should organise their services in the light of principles expressed in Pamphlet 5 of the NDG (it) seemed not to be fully understood or implemented" (pp vii) In not a few of the SSDs inspected, policy documents were fragmented and the basis on which coherent services could be developed had not been established. While "islets" of very good practice were evident in most authorities, a transfer of knowledge and good practice from one centre to the next was by no means automatic. However the quality of staff was frequently commented upon by inspectors who found many highly committed to their work, with a capacity to conceptualise about the nature of their
work, and a sensitivity to and awareness of the needs of their clients and to the needs of their own further learning.

A finding of the inspection report, and significant to this research, is that "the range of activities provided by ATCs is almost infinite. Almost without exception every ATC or SCU (Special Care Unit - a specialised unit normally located in the main centre which provides support for profoundly mentally handicapped people) itemises one or two potentially interesting activities offered to its clients. Frequently a number are offered and some units provide a choice of classes and recreation facilities which must rarely be available elsewhere." (para 5.2). The report indicated that "inspectors also noted that leisure activities were seldom integrated within an overall programme" and rarely were they "based on up to date individual assessment of need" and were "most usually not part of a co-ordinated plan" (para 5.4)

During the course of its national inspection work the SSI sampled amongst other things the nature of the services in which attenders of day centres participated. This showed that of the sample (generated from the LAs being inspected) 61 per cent participated in recreational clubs (many would be centre based) and 25 per cent participated in further education courses. Surprisingly no attempt was made to identify the percentage of attenders engaged in centre based industrial activity but seen against the survey return of those undertaking sheltered work (7 per cent) and open employment (10 per cent) the figures signify that a high proportion of attenders are having some experience of education and recreation pursuits. It is likely that in addition a high proportion of attenders of further education courses also undertake recreational activities. Attenders from both groups may also be engaged in instructional training on activities.

In the context of these statistics it is noteworthy and appropriate also to indicate that the Review of 1980 identified that most people living in mental hospitals engaged in day time activities. An activity analysis of 8,521 patients, 10 per cent of whom were in LA run ATCs, undertaken on a particular day in 1977 indicated that half of the attenders were engaged in social training, handicraft or full time education. With the increasing need for day places in either LAs or health settings to support the very many patients
who have now moved into the community, or will do so in the future, the need to facilitate educational and recreational activities seems bound to increase. It is likely that a very similar picture in relation to education and recreation will be found in centre services which are geared to the needs of people with physical disabilities.

**PHYSICAL DISABILITY**

The development of welfare services within LAs for people with physical disability has not followed a parallel track to those for people with learning disabilities, largely because the services which existed in the past focused on the needs of adults, with education authorities responsible for those of school age. Section 34 of the Education Act 1944 laid upon LEAs a duty to ascertain which children in their areas required special education and to provide it; the Act also laid down procedures for medical examinations of children and the DES over the years provided regulations and guidance which reflected current thinking and practice. Education occurred almost invariably in special schools, many of which provided full or joint day and boarding facilities; segregation from peers without disabilities and isolation from networks of friends at home was almost inevitable, even in those situations where every effort was made to mitigate the problem. Given these arrangements it was a commonplace occurrence for SSDs to become aware of young people with disabilities only when they had formally left school and returned to live with their parents; and very often only when the stress of changed living circumstances within families had become intolerable.

The Education Act 1971 in requiring LEAs to provide education for children previously deemed ineducable had no significant impact on education for physically disabled children but its downstream consequences most certainly did.

Following the enactment of the legislation the Warnock Committee was established in 1974 to investigate the whole range of special education and its future developments. The Warnock Report (1978) laid great stress on ending segregated education for children with disabilities and with that commitment, subsequently enshrined in The Education Act 1981, generated an impetus in service changes which it will take years
effectively to address and handle particularly in health, social services and housing
terms. The 1981 Act implemented most of the recommendations of the Warnock
Committee, it abolished previous categorisation systems and required the identification,
assessment and planning for children with special education needs, with education to be
provided in mainstream schools contingent on certain considerations. Education
authorities were required to involve parents in special needs assessments and also to
inform both the HA and the SSD that an assessment was being undertaken on a
particular child. This requirement provided the first locus for SSDs formally to
contribute to the joint identification of educational and developmental programmes
which the assessment procedure had been established to address. However, few SSDs
have felt themselves sufficiently resourced to involve themselves unless other significant
factors have required their involvement with the child and family concerned.

The transition from life in school to life out of school, whatever form it takes, is not
without its stress for most young people and a range of services have been developed
in the past which facilitates this transition. It is a period of life which is particularly
stressful for young people with uncertain futures and doubly so for those with
disabilities moving into adulthood. With the introduction of the Disabled Persons Act
and Section 6 implemented in 1988 the SSDs were for the first time given the duty to
undertake assessment of all young people who were considered and regarded as disabled
by them, and to provide those services which it assessed as appropriate. It is interesting
to speculate whether this provision would have been called for and enacted if SSDs had
more actively involved themselves at an earlier stage with education authorities in
identifying and addressing wider social and family concerns in the context of assessment
for special education needs. Assessment work at whatever stage it occurs clearly calls
for considerable skills which reside in no one professional discipline.

In an inspection undertaken in 1989 in six LAs to assess progress made in the
implementation of Sections 5 and 6, inspectors found that while some progress had been
made priority needed to be given not only to "the establishment of effective inter-
departmental work and co-operation between the LEA and SSD" but also to the
"determination of departmental policies relating to this area of work ... and their
communication to staff to ensure that they are well understood and followed" In the summary to the report the inspectors indicated that they had no reason to believe that what they had identified in their work would not "hold true more generally" in all LAs. It is clear from the report that much effort is still required to foster multi disciplinary and multi agency work. This is only likely to occur as respective departments are confident about the purpose of their contribution, how they make it and with whom.

The general provision of welfare services to adults with disabilities originally emanates from Section 29 of the National Assistance Act. Powers also existed through the Disabled Persons (Employment) Act 1944 which enabled LAs to provide "sheltered workshops" and hostel accommodation for those engaged in work or training under the Act. In view of the permissive nature of the powers, prior to the Chronically Sick and Disabled Persons Act 1970 service development in LAs was largely dependent on the view of elected members of welfare committees and their senior officers working in their departments. As a result services were often low in priority and provided in a fragmentary way with little consideration of service objectives or strategic planning needs.

A permissive power often harnessed by welfare departments was the power to provide to people with physical disabilities suitable work in their own homes and to assist in the disposal of the "product of their work." This activity was facilitated by the appointment of peripatetic craft instructors who instructed people in their own homes in those particular craft activities, notably cane work, which might when completed be a saleable product, a not unimportant outcome at a time when social security benefits were minimal. This style of work changed as day centres were built and people had the opportunity to leave what was often an isolated home life to attend a day centre, which if suitably managed, could be both socially stimulating and challenging. The bringing together of people in this way was probably the first step in assisting disabled people to voice for themselves demands for the provision of better services.

Many of the early developments which occurred for disabled adults were initially linked with services for elderly people. While this situation has changed, joint day provision
for disabled and elderly people continues to exist in SSDs and where this prevails it significantly affects the provision of appropriately geared and related services for young people. In 1984 there were 177 day centres for physically handicapped people providing 9,363 places and 286 centres for mixed client groups providing places for 16,016. By 1990 there had been a reduction to 166 single group (physically disabled) centres catering for 8,482 and an increase to 356 joint centres catering for 17,794. Joint provision continues more often than not to be linked with services for elderly people, but it is not unknown also for it to be linked with services for people with learning disabilities and sometimes people who are psychiatrically ill, and occasionally for both. While joint usage may signal a current and necessary intention of using scarce physical resources efficiently, it demands an even greater need to establish a clear formulation of policy objectives and operational strategies which address both the shared, common and group specific needs of clients. What evidence exists suggests, however, that reality bears no relationship to intention.

No major national work similar to that which has occurred in the learning disability field but focusing solely on day centres for people with physical disabilities has been undertaken by the SSI. Regional work has however occurred, and very often it has resulted in the inspection of more than one establishment in a particular SSD. In one region, an inspection of personal social services for people with physical disabilities requiring substantial assistance with personal care occurred in 11 SSDs. While addressed in the context of comprehensive service provision, the inspection took some account of services emanating from, or facilitated by day centres, and identified that in "some parts of the region Further Education establishments (were) providing opportunities for people ... these ranged from swimming to sophisticated information technology projects". And again, "facilities included small one day a week craft sessions in local centres ranging to large multi purpose centres for all ages and needs". "Some staff spoke of a growth in outreach work by day services workers" which was described both as a "consequence of lack of field social work involvement" and "a natural development in the role of day services to become resource centres". The Report recommended a range of policy, organisational and practice issues the SSDs clearly needed to address in order to fulfil the three primary service tasks which had
been identified as "contributing to overall Council strategies for the improvement of opportunity for all people with disabilities, (providing) for the well being and welfare of people . ." and to "meet the individual needs of people . . to . . live a life which is like that of others and which meets their own wishes"

Inspection work undertaken by the SSI in a number of authorities throughout the country which has focused solely on day centre services has found a wide range of in and out of centre activities 57-60. The recommendations in all cases resonated with the wider issues referred to in the previous paragraph. All reports indicated the need for SSDs to identify an overall philosophy which would both inform the development of the SSD's policy and operational strategy and facilitate the development of coherent practice throughout the centres which each individual authority may provide and operate.

Without exception all reports referred to the commitment of staff. Not surprisingly they also indicated the need for training which would facilitate the achievement of centre objectives once formally identified.

**OVERALL SUMMARY**

Given the different starting points between services for mentally and physically handicapped people it is not surprising that parallel tracks have not been maintained over the early decades of the Welfare State. Service developments for one group clearly impinged on the other, however, and not least the initial character of day centres for physically handicapped people which was influenced by the early commitment to provide in ATCs experiences which were characterised by an industrial training or occupation ethos. With the developing awareness in both professional and government circles of the importance of adopting a changing philosophy which embraces a commitment to services which militate against segregation and dependence and facilitate normalisation, integration and independency, common patterns of service are developing. Similarly the practice skills of staff, which might nonetheless be applied in different work settings, are taking on common and shared characteristics. This is a
factor which not only applies in relation to SSDs but across other professional disciplines and particularly in the fields of health and education.

The development of welfare services in the past has always to a limited extent reflected prevailing attitudes, and significant shifts which are now occurring must also be taken into account in the re-gearing of future service developments. Leisure and its recreative opportunities, once enjoyed only by the affluent now has a much larger constituency, not only through force of economic change but also through a growing realisation of its value in terms of physical and mental well being. Inspection work in both the learning disability and physical disability fields has identified that a significant feature of the operations of most centres is their utilisation of a range of recreational pursuits and this likely reflects no more than the responses by staff to what is occurring in wider society. In the course of their work inspectors have also identified that recreational activities like other developments in centres are not part of a coherent policy formulation; and in the case of centres for those with physical disabilities because aims and objectives are usually only very loosely articulated and systematic formulations of policy and practice are generally absent.

**SUMMARY**

*This chapter considered the evidence that recreational pursuits, while used widely, will continue to have little impact until their functions are more fully understood and a policy adopted which facilitates their effective and target directed impact. It reflected on the continuing failure to acknowledge the importance of recreation in facilitating the achievement of service objectives which promote optimal independence in clients.*
CHAPTER 4: FINDINGS AND FIRST CONSIDERATIONS

This chapter is devoted to the examination of information gained from two SSDs about the extensive utilisation of recreation and leisure in day centres for people with learning disabilities and physical disabilities. It reflects on the absence of policy statements, funding commitments and coherent strategic planning and the consequential failure to use recreation and leisure effectively. Consideration is also given to the manner in which a coherent strategy once established could be discharged and the personnel who might be best placed both organisationally and functionally to undertake the work and extend its impact.

Reference was made in the introduction and discussion of methodology to the issues and questions raised with both senior officers of the departments and managers of day centres. The findings of those investigations are outlined below:

FINDINGS

a. THE EXTENT, CHARACTERISTICS AND FREQUENCY OF RECREATIONAL ACTIVITIES

All centres visited, regardless of client group, carried a wide range of activities and no managers questioned the validity of doing so. A list of all activities is appended at Addendum C; they have been categorised as Sport (competitive and non competitive), Creative Arts (painting, sculpting etc), Participative Arts, (drama, dance, music etc), Craft (woodworking, knitting etc), and Leisure (narrow boating, horse riding, theatre visits, etc).

It was evident that a number of factors determined the nature and frequency of the activities. Funding was significant and reference will be made to this factor subsequently; there were others also which were important. Physical environment and space constraints clearly limited or prevented certain centre based activities. Staff attitudes and aptitudes to activities and not least...
commitment, were also considered by managers significantly to affect the recreational or creative value of the activities pursued. Some activities had been established because of the skill of a particular member of staff and sometimes had to cease if staffing constraints required the staff member to undertake other duties or if for some reason they left the centre. Many other activities which might require the supervision of a qualified instructor took place outside of the centre, generally, but not invariably, at recreation and leisure centres or at FE classes.

All centres engaged in off-campus activities, ranging from outings to activity specific pursuits, and these were often used as a vehicle to address the negative effects of group segregation and to facilitate the process of integration into the wider community. Off-campus activity was also invariably seen as fostering social confidence and/or competency. However there was far less indication that staff had identified and were developing skills in applying a working understanding of the importance of utilising off campus resources with the potential for, or providing, opportunities for clients to self select support systems, thus diminishing the need to continuously provide and organise formal networks of support.

(a)

Recreation and Leisure as a Planned Activity

All centres expected to provide in-centre recreational activities during the course of their working week and in this respect pursuits were seen always to be planned. Organisation of on-campus activities varied considerably. At one extreme clients chose to engage in a self selected loosely assisted pursuit (in one centre for a time limited period because of space and client/staff ratio) or to respond to a rallying call to form two teams for uni-hockey, through to one centre in which recreation was regarded as a feature of the core curriculum and clients were expected to "sign up" to a number of a wide range of recreational activities. A higher level of planning existed in relation to off-campus activities. This was due to the nature of the activity and in
many circumstances to the need to arrange bookings, transport (a recurrent headache for staff) and so on through to major planning to organise overnight or longer absences from home. This factor may well have impinged on the apparent need for a greater level of commitment by participants to engage in off-campus activities.

The episodic incidence or regularity of activities was invariably underpinned by staffing and funding considerations but also reflected an ebb and flow of interest in certain activities. Some activities were determined by weather considerations and others, like fishing, by seasonal calendars. Yet others were geared to cultural and arts events and sometimes to specific projects (for example, a Waterways Photography Project).

Recreation and Leisure as an Unplanned Opportunistic Activity

Unplanned opportunistic activities occurred far less frequently. They generally focused upon visits to arts events or spectator sports events which were occurring in the locality. The promotion of opportunistic initiatives was largely dependent upon the willingness of staff to organise the event and attend "out of hours". When occurring, unplanned opportunistic work appeared to be largely due to staff knowing about opportunities which might provide a valued experience for attenders of the centre. User councils, where established, were slowly beginning to initiate events and in these circumstances staff attempted to undertake no more than a facilitating function.

THE ORGANISATION AND MANAGEMENT OF RECREATION ACTIVITIES

The three social education centres in the county authority were located in different geographical divisions and each centre was responsible to different operational managers. Although distinctive elements of development were evident in each centre, which probably reflected particular commitments or
skills of centre managers and possibly their line managers, a county policy statement existed concerning the overall and general development of work within the client group. Centres were expected to provide appropriate and suitable leisure and recreational pursuits for attenders and to develop services within broadly stated common objectives and commitments. As a consequence each centre was in the process of adopting individual planning which attempted to bring into balance the views of the attender, the staff and appropriate carers and others and the resources available to discharge responsibilities. Recreation and leisure was seen to be part of "shared action planning".

The three centres had adopted similar practices to manage recreational and leisure pursuits. No establishment existed for a staff member to be wholly responsible for the organisation of recreation and leisure; rather, some staff were expected to dedicate time to facilitate the work.

In the metropolitan authority, as in the county authority, the managers of the Social Welfare Centres worked to different divisional managers. Centre Managers were expected to act within a broad departmental remit which required that services were provided which facilitated rehabilitation. In the absence of detailed policy it appeared that idiosyncratic developments had occurred which reflected the working styles of individual managers and others who made up the centre's staff and their perceptions about the service they were employed to provide. There was no establishment for function-specific staff although all managers attempted to appoint staff to the posts of instructors or care assistants with particular skills that might be required or utilised in their centres. In one centre a recent appointment had been made of a person with skills in sporting activities with the expressed intention of developing these activities with younger attenders of the centre, at another, a person with arts and crafts skills had recently taken up a post.
c. **THE PERCEPTIONS OF CENTRE IN RELATION TO RECREATIONAL ACTIVITY**

In the county authority all managers of centres considered that recreational activity was a significant element in the totality of the centres' activities. This was demonstrated in a number of ways. All centres had adopted the mechanism of providing dedicated time to particular staff members to facilitate recreational work. Although recreation and leisure was featured as part of only one centre's curriculum, in practice it appeared to be an important feature of daily activity in all three centres; it was identified as a specific element of individual programme planning and review. Some specific funding had been made available for recreational activities and development.

In the metropolitan authority a manager of one social welfare centre considered that recreational activity was not significant in the totality of the centre's activities. Two centre managers considered that it was. No centre had established detailed or specific procedures of assessment and review and what arrangements existed were not consistently applied. Beyond a limited individual evaluation as a function of admission procedures little more occurred. It was considered that in the context of admission procedures the availability of recreation and leisure opportunities would become known to potential or admitted clients. The Pultibec medical assessment procedure adopted in one centre was generally administered at the point of or shortly after admission. Recreation and leisure was not a feature of the system. Funding for recreation and leisure activities was minimal although one centre had had made available to it a significant sum from an inner city underspend.

d. **THE FUNDING OF RECREATIONAL ACTIVITIES**

In the county authority a policy had been adopted to make each operational unit a cost centre. Differential progress was being made in each division and
only one was fully operational as a cost centre. It managed an "out of centre" budget of £2,500 and costs attaching to in-centre activities were subsumed under other budget heads. Another centre managed a divisional allocation of £3,850 which was said to cover both out-of-centre activities and "materials" for in-centre programmes. The remaining centre, while explaining that no identified budget existed, allocated £300 for staff managing particular portfolios across the whole gamut of the service activities of the centre. The overall budget approximated those of the others although different divisional accounting arrangements caused things to look different. It was very apparent however that the cost of the recreational activities far exceeded the budget that was available from the SSD. Staff had significantly "aggregated" their budgets (none of which could be costed) in a wide range of ways. This included utilising at no cost educational facilities, (it was not unknown for activities to be curtailed if the facility was expected to become fee producing); FE provision both on and off-campus, specialist volunteers (not infrequently teachers, who previously may have been on the pay-roll of the education authority to undertake the self same work with the self same people); grants from a regional arts council and grants known to an arts development agency working in the area. Centre amenity funds were also used in specific situations, generally to "top-up". Clients and carers also contributed where appropriate.

In the metropolitan authority two centres identified a "holiday and leisure" budget of £100 a substantial part of which was required to pay for a TV licence. One of these two centres also identified a "training and materials" budget of £2,400. Both these centres were well established in buildings which were purpose built c. 1960. The remaining centre was about to move into a newly built centre. It identified a "training and materials" budget of £7,000 which possibly reflected the department's view of the necessary budget required for start up costs of a centre which was to undergo a very radical change in the immediate future.
The range of activities undertaken within the centres could not have been sustained without considerable funding support from other sources and staff had successfully cornered other monies from charities, private funding of events by clients and well wishers, and the centres' amenity funds. One centre undertook fund raising activity for specific purposes. Two centres located in the inner city had also been able to find funding from the Government Inner City Partnership Initiative and on one notable occasion netted £25,000 as a result of an annual underspend.

**POLICY IN RELATION TO RECREATIONAL ACTIVITIES**

In the county authority, SSD policy existed which required divisions to provide a comprehensive service which fostered "normalisation" and the promotion of recreational and leisure activities was seen as part of this. All centres were being required to produce their own overall centre policy within the wider policy of the SSD for submission to the senior management of their respective divisions and formal ratification.

In the metropolitan authority it was indicated that no formal policy existed in relation to recreational activities nor did formal policy exist in respect to the wider objectives of social welfare centres. A centre policy was in the process of being formulated for the new centre which was to be commissioned during the course of 1990.

**SUMMARY OF FINDINGS**

From the evidence available a number of common issues can be deduced. Overwhelmingly managers and other senior staff members when interviewed expressed the view that recreation activity was a significant feature of the centre’s overall functions. One exception existed although this was not an indication that recreational activities were not utilised and facilitated regularly. Similarly recreational activity was acknowledged as important to the well being of clients and to a lesser extent that aspect
of their life experience in which the SSDs had a proper concern. While in the two service spheres examined very different stages of overall development existed, policies and service strategies in relation to recreation and leisure were said by senior officers of the SSDs to reflect no more than an acknowledgement of the legitimacy of promoting it. Senior officers of the SSDs saw no significance in the utilisation of recreation and leisure in policy and strategic planning terms nor were links made between its use and the achievement of the primary concerns of SSDs. This mirrored with a fair level of accuracy what was generally occurring in service units. Given these particular scenarios it is not surprising that neither authority had addressed realistically the issue of appropriate funding of recreation and leisure in the service field examined.

Policy and strategic development formulations exist in SSDs for a range of reasons. An important one is to ensure that the creative interplay between client need and the professional skills and service resources available to an SSD to meet these needs are maximised. Where a disfunction between policy and practice develops and is apparent, a clear need exists to examine what action should be taken to ensure that a new balance which renews the effective discharge of service responsibility is achieved. Such a situation now exists in relation to the utilisation and management of recreation and leisure in the SSDs visited during the course of this research. This very likely mirrors a common situation throughout the country. The inspection work undertaken by the SSD and referred to in chapter 3 supports this view. What is occurring in the fields of learning and/or physical disability is also very likely to exist in those other fields where recreation and leisure is adopted as a legitimate operational function.

The evidence of this research suggests that much time and energy is committed to the provision of recreation and leisure opportunities but that there is a failure, both at unit and the wider organisation levels, to see or utilise it as a function which can significantly interlock into the achievement of the primary objectives of SSDs. It is also evident that without a more informed, skilled and systematised use of recreation its impact will be far from maximised nor will this occur without the formulation of policy objectives and practice strategies to develop the work and the identification and application of appropriate funding to sustain it. How is it likely that this will occur?
CONSIDERATIONS

With the inception of SSDs in LAs in 1971, OTs who had previously almost invariably operated out of hospitals or NHS establishments were provided with an additional and appropriate locus for their work. It was an appropriate development in view of the increasing emphasis in their work on rehabilitation and the promotion of daily living activities to enable people to leave hospital and function with only limited or no domiciliary support. A survey undertaken in 1988 \(^6\) indicated that of 86 LAs surveyed and from a 74 per cent response rate, 1,669 established whole time occupational therapy posts existed filled by 31,999 workers (about two per cent of the total work force employed in both the NHS and LA).

The first movement of OTs out of institutional settings was an applied response to the recommendations of the Cope Report (1951) \(^7\) which signalled a changing professional and service objective of occupational therapy: "the promotion of daily living activities". It was a logical consequence of the early beginnings of occupational therapy in the UK between the wars which was initially facilitated informally by medical practitioners who believed in the value of therapeutic occupation in the process of "treatment". The first training programme was developed in 1929 at a residential psychiatric clinic in Bristol under the aegis of Dr Elizabeth Casson who was supported in this work by workers, one of whom had travelled to America and undergone the formal training for occupational therapy which had by that time become established in that country. The work initially focused wholly on the promotion of therapeutic activity. In 1951 when identifying the changing practice aspirations of "promoting daily living activities" the Cope Report was responding to the newly emerging concept of rehabilitation. It was to have an early impact on the training of OTs and a qualification was introduced which combined the physical and psychiatric specialisms, which had previously been separate qualifications. The earlier emphasis on craft activities was significantly curtailed.

Most OTs in SSDs now operate out of fieldwork offices. Their work is predominantly directed towards the support and maintenance of people in their own homes through the assessment for and provision of equipment and adaptations which foster optimal levels
of functional independence. Little or no emphasis is placed on facilitating occupational activities. In this regard their functions reflect the views signalled by the Cope Committee in 1951 and this will continue with even greater emphasis in the future as a consequence of the NHS and Community Care Act.

The new duties to be placed on LAs relating to the individual assessment of need for residential and domiciliary support will require that OTs in LAs have suitably geared organisational and practice strategies in order to tackle the increased work load in relation to assessment while at the same time fostering the promotion of daily living activities with many clients. This continuing emphasis on assessment and domiciliary support will distance OTs even further from their founding work of supporting treatment through facilitating occupational activities.

The professional direction of OTs in LAs informed by both philosophical and/or policy considerations which have impinged on the operational discharge of services in SSDs over time raises a question which clearly needs to be put. It is whether the extensive recreational and leisure activities which are being fostered by day centres should be seen as development of the early work of OTs and firmly lodged within that professional field, or whether they have a distinctive characteristic of their own which calls for a different knowledge and skill base and application. If the answer is neither, and I believe it is, how might this emerging and significant dimension of SSD work be facilitated by appropriate and properly supported staff in a manner which ensures that it is most effectively used.

In America with a social and welfare backcloth very different from the UK therapeutic recreation has become a visible and viable force through the formation of a profession which is identifying characteristics and marshalling skills which are seen to be distinctive to the profession (leisure counselling) and which separates it from its older cousin, occupational therapy. Will the formation of a new professional group be the means of ensuring that in the UK the therapeutic characteristics of recreation and leisure are more effectively utilised and managed. It is unlikely; nor would it be the most efficient course to adopt in the UK with its particular social welfare backcloth and
where the viability of professional groups in the welfare field is significantly affected by government policy and action. A comparison of the fortunes of OTs and domiciliary services officers in SSDs highlights the point.

At the inception of SSDs OTs with an established professional status and developing professional base shared very similar auxiliary functions in SSDs to those of home help organisers many of whom had no or very little training. Both were seen to act in a support function to social workers who were the main "professional" group of the new departments, as a result, they lacked organisational status. This situation has not changed significantly. However both OTs and domiciliary service officers, a title which home help organisers assumed over time and which reflects their expanded areas of responsibility, now contribute very much more to the capacity of SSDs to discharge the government's community care policy and strategy and are assuming greater visibility and importance in SSDs. With this has come a growing status. This will very likely continue as departments acknowledge that the successful discharge of their changing duties will increasingly depend on the collaborative interplay of staff from different working disciplines and backgrounds.

The potential for a similar situation developing in relation to recreation and leisure also exists. It will not come however until the function of recreation and leisure is seen as a significant contributory factor to SSDs achieving their primary function of facilitating optimal independence and it becomes a feature of welfare policy both at national and local levels.

Given the capacity to foster a commitment to change in SSDs which staff group might assume a greater level of responsibility to discharge the work? With the changing pattern of work and activity of OTs in SSDs it is unlikely that they will be appropriately placed organisationally to undertake the work. In any event greater impact will very likely occur if it is undertaken by those directly involved in work with clients.

In day centres for people with learning disabilities and physical disabilities, recreational activities are generally facilitated by staff very often junior in age, and almost certainly
junior in status within the wider context of SSD employment. Most will have been appointed as care assistants or instructors, or some such position, and some may head a small group of workers as a senior. Few staff will possess social work qualifications, though some will eventually undertake these. For those with few academic qualifications the emergence of the National Council of Vocational Qualifications (NCVQ) will provide a route to professional training in the social services field. Aptitude and commitment are clearly two important qualities for staff to bring to the whole range of their work and this is no different in the specific field of promoting recreational opportunities. There are indications however that some young people qualified, and sometimes highly qualified, in other fields are beginning to move into social services and not least into day services. Their contribution could be significant.

The successful and creative use of recreational pursuits will, as in other fields, depend on a blend of knowledge, skill and application. Not surprisingly, given the genesis of this work and in view of its lack of a policy base staff development opportunities which would assist staff to develop and refine a specific knowledge and skills base are generally not provided. None existed in the two authorities in which this work was undertaken. This is clearly a matter which will need to be addressed if staff are to identify the wider use of recreation and leisure as a therapeutic tool which can support SSDs’ professional and service aims of facilitating optimal independence.

SUMMARY

This chapter explained and considered information gained from two SSDs about the extensive utilisation of recreation and leisure in day centres for people with learning disabilities and physical disabilities. It reflected on the absence of policy statements, funding commitments and coherent strategic planning and the consequential failure to use recreation and leisure effectively as a therapeutic tool and means of assisting SSDs to achieve their professional and service aims. Further consideration was also given to the manner in which a coherent strategy once established could be discharged and the personnel who might be best placed both organisationally and functionally to undertake the work and extend its impact.
CHAPTER 5: PROCESSES AND FUNCTIONS OF ASSESSMENTS IN SSDs

This chapter is devoted to considering the changing and complex nature of assessment as managed in SSDs and the characteristics and functions of assessment when utilised in fostering the personal and social development of individuals attending day centres. Reflections are also made on the general absence, or where present the limited function, of recreational and leisure activities in assessment protocols. Consideration is also given to the outcome when recreation and leisure is predominantly seen to do no more than support other staff intensive work.

Since the inception of SSDs, assessment activities have been a feature of the range of service functions for which the departments have had both statutory and general responsibilities. Service groups within SSDs have almost invariably devised their own ad hoc systems of varying degrees of sophistication, sometimes with the assistance of published material, and these generally relate the aggregation of the perceived needs of the client group, to the nature of the service interventions, and the outcomes to which the service providers may aspire. Often procedures, sometimes described as assessment, might not move beyond an evaluation of whether a person fits the criteria of service provision (and in the context of this research, admission to day centres) and the level of priority they should command for the service, with little consideration given to the assessment of subsequent progress and the point at which the service may no longer be required.

Alongside the range of assessment procedures which relate solely to the professional and service activities of SSDs, there are also those procedures attaching to some services which are purely administrative and which examine the financial resources of intended recipients of services and their ability to make financial contributions. In recent years, financial assessment of clients has increased as SSDs have been required to pare their budgets and explore ways of ensuring that essential services can be maintained. In these circumstances a person adjudged eligible for a service may not receive it before a financial assessment has been made and the client agrees to pay the level of contribution required. At one time many SSDs organised their work in a manner which
separated out professional assessments from financial ones, with administrative staff being almost wholly responsible for the latter. This has changed as SSDs have resorted to charging service users able to make a financial contribution to a service and professional staff have been assuming more responsibility in certain, less problematic, tasks of collecting information for financial assessment. With the introduction of the Disabled Persons Act which required that all disabled persons should receive a full assessment and the full implementation of the NHS and Community Care Act expanding the requirement to provide a wider range of assessment activity, both professional and financial assessment will increase significantly.

An innovatory feature of assessment is also emerging within SSDs as a result of the NHS and Community Care Act and is currently commanding considerable time and energy of SSD staff. It relates to the need of SSDs to move from the role of sole providers to that of utilising and purchasing a range of services provided by the independent sector. In view of these changes many SSDs have restructured their departments with some personnel being given sole responsibility for assessing the utility, appropriateness and value of services provided by independent providers, purchasing through contract those considered most suitable and best and monitoring service delivery and the maintenance of quality. Over time this radical departure from previous patterns of service provision will significantly modify the service profile of SSDs. Inevitably, as SSDs prepare themselves for the wider professional and services applications of the changes, a new language has been spawned. Assessment will result in the preparation of "individual care plans" and subsequently staff will engage in "care management" which will almost invariably occur within identified and limited budgets. The extent of involvement of "care managers" with users will depend on whether "packages of care" are directly provided by the SSD or purchased from the independent sector. No reason, legislative or otherwise, exists why packages of care might not include both "purchased" and "provided" recreational activities (eg adventure holidays, attendance on a time-limited recreational programme).

Embarking upon a discussion of the principles and practice of assessment procedures particularly as utilised, or perceived as utilised, by SSDs across its field of service
responsibilities, has always been fraught with difficulty. With the recent changes it is not unlike a ship entering the Sargassa Sea and being hazarded by weed.

In an attempt to chart a navigable course and to assist SSDs in addressing the radical changes which they are to accommodate, a series of guidance documents addressing different aspects of the changes have been produced and published by the SSI. One such, which focuses solely on the professional identification of client need and the formation and management of packages of care admits to no more than the identification of "a set of principles which all care agencies are able to own as a common baseline for negotiating local arrangements". It stresses the importance of devising an assessment process which is as "simple, speedy and informal as possible" and adopting a level of assessment determined by an initial identification of need. The guidance suggests that a number of levels may exist ranging between simple and comprehensive. While acknowledging that assessment in certain situations may be no more than a single agency activity, it also stresses its importance as a multi disciplinary and multi agency function.

The guidance also addresses itself to the separate but interdependent issues which will need to be considered and dealt with by both managers and practitioners. Without a firm policy commitment by SSDs and the support, direction and assistance of senior managers to devise assessment systems which are geared to the aims and objectives of specific service activity within particular client groups, much of the diffuse and untargeted activity which currently occurs and is sometimes characterised as assessment when it clearly is not, will continue; and the hallmarks of an assessment process - the identification of targets, the charting and reviewing of progress and re-assessment - will be absent. The guidance highlights, as a pre-requisite of a programme of service and skills development in this field of activity, the need for SSDs to have in place specific policies for each of its service fields and operational strategies which facilitate the achievement of departmental policy within the context of individual service units (eg a day centre as part of a wider specific service activity).
The evidence found during the course of inspection work of the SSI of day centres for people with physical disabilities indicated that very little of this work has been done and an urgent need for it to occur existed. While SSDs may have achieved more in the field of learning disabilities, the evident absence of unit strategies found in the national inspection of the SSI has clearly impeded the comprehensive development of services which are task targeted and both efficient and effective.

The guidance also takes care to acknowledge that no one system, to whatever degree it might be graduated, can address the multifarious needs of people who, during the course of their adult lives, may have legitimate recourse to services provided by SSDs. Services for an elderly widow with a supportive family, but who needs adaptations to a domestic environment to inhibit a slide into dependency, has needs which are very different in degree and detail from a young woman with learning disabilities, inappropriately cosseted through childhood, who needs both support and challenge to raise personal aspirations, courage and social horizons to establish a functional level of independence; and the rehabilitative processes, levels and pace which the SSD may facilitate in collaboration with other agencies for a married family man disabled through a road or some such accident, is very different from the nature of rehabilitative work required to "move on" a youth to functional independence whose childhood has been characterised by significant and segregating disability. Given this scenario and the current commitment to move from a "service driven" provision to a needs led consumer centred service, assessment processes will need to embrace many things for different people.

The generalised statements of the SSI guidance produced for both managers and practitioners, primarily in SSDs but also in the wider context of "caring agencies", attempt to address the function of assessment across all adult client groups. In stressing a graduated system of assessment which is determined by needs, which SSDs have statutory responsibilities to meet, or policy commitments to deliver, the SSI implicitly signals the need to hasten the move away from the medical models of assessment which focus too closely on deficits and their management. These have often been utilised or modified for use in day centres in the past. Conversely, it underlines the importance
of devising systems which identify, promote and enhance behavioural competencies which facilitate an individual's capacity to function optimally within the context of their own social milieu.

In the field of learning disabilities, a wide range of comprehensive assessment procedures have developed over time. These have addressed educational, health and social aspects of development. An interesting study, not the focus of this research, would be to trace the changing emphasis of assessment procedures as services have begun to accommodate a philosophy which is committed to community provision as opposed to institutional care, and working objectives have begun to focus on the promotion of independence rather than on mitigating the negative aspects of dependency.

A situation which is commonly found in ATCs or SECs of SSDs is that staff groups have devised hybrid assessment procedures which they consider will best further their work. While little more than basic assessment might occur in determining whether a person once referred is a suitable candidate for placement in a particular centre, more detailed procedures may be adopted to ensure that the person is appropriately engaged in centre and out of centre activities. A fully comprehensive assessment may occur, however, only when it has been identified that a person is moving towards a life crisis. More often than not, this is seen to happen only when indications exist that a person's significant carers may no longer be able to care for them in the foreseeable future. This process and point of "intervention" is often born out of necessity. In ATCs and SECs with weekly "registers" often in excess of 200 and daily attendance over 100+, staffing/attender ratios very often preclude the means of providing for all attenders. consistent, targeted and reviewed services of intervention. This situation is inevitably compounded if staff, who may possess skills to undertake rudimentary assessment work, do not possess the skills for sophisticated procedures which embrace a range of multidisciplinary knowledge and practice.

A not dissimilar picture is found in relation to day centres of people with physical disabilities. Those assessment procedures which exist are almost invariably of a hybrid
nature and developed in the context of a manager’s perceptions of the services which his or her centre provides. Where it exists, the limited nature of the assessment process is often compounded by the fact that services emanate from a "welfare" base as opposed to the "training" ethos which has always pervaded service developments in the learning disabilities field.

The move away from assessment procedures which facilitated systems of support used in the past, which while often benign were often covertly directive, to those which embrace and are driven by the views and aspirations of the client will not be easily achieved. As well as the very real difficulty of staff moving towards a new point of balance in their working relationships with clients, the marshalling of "care packages" which are relevant to need and viable within cost limited budgets will add further to the difficulties of fostering services which are wholly geared to the development of optimal independence whatever that might be.

Another dimension of an historical nature that very often impacts on day centres for people with physical disabilities is that, until relatively recently, much of the work was often locked into services for the elderly. This is evidenced by the number of joint centres which continue to be provided by SSDs. The needs of elderly people whose lives may have become fractured through the diminution of social and family networks and frailty are very different from those of younger disabled people who require support and challenge to realise their potential to establish and live lives within achievable levels of independence 64. Day services for younger disabled people which are provided in day centres where the ethos is characterised by the social needs of the middle aged and elderly, are frequently unable to generate the rigour and challenge which young people require to facilitate personal and social growth. Where this situation exists changes are unlikely to occur and staff skills are unlikely to be extended until SSDs address some of the very real organisational difficulties which impede the delivery of targeted and pertinent services geared to individual need and development.

This is a matter which in the past has not been systematically addressed. It can no longer be put aside. The Disabled Persons Act 1986 required LAs to offer a
comprehensive assessment where a person "appears" disabled, under the terms of the Act, irrespective of the need that is initially presented. The solutions that are available will however not be found in SSDs alone but in the utilisation of an integrated range of services which are to be found in the community; the NHS and Community Care Act provides a new incentive for this to be vigorously pursued.

In the past the educational and health fields, both in the UK and abroad, have played a major part in the development and range of assessment protocols which focus solely on individual development or attainment, and the formulation of treatment or training goals. Many more protocols exist in relation to mental disability than physical disability but some common characteristics are likely to be evident in almost all. These generally relate to the functions of the assessment process and will include: an identification that the person is a suitable candidate for the particular assessment process, and a general or detailed assessment of levels of ability/disability so that these can be subsequently reviewed, tested or measured in the context of setting achievable personal and/or service goals. Much of the assessment process focuses around functional or social "domains". These, more often than not, include communication, physical development, self help, community orientation, vocational skills, academic skills and personality and behaviour problems. Considerable emphasis is placed on what an individual can or cannot do. Very little consideration appears to be given to what a person may wish to do or to the social contexts which enhance or, more likely limit, their lives.

Recreation and leisure is unlikely to be rated as a discrete domain but when sometimes identified as a feature of the protocol, is generally subsumed within a domain which the protocol authors consider appropriate. When featured, very little more than an identification of interest or involvement in specific activities occurs. Almost invariably assessment instruments are completed with the involvement of a number of personnel who play key roles in the life of the person being assessed.

A feature always present in assessment protocols which separates assessment from all other procedures which might do no more than determine eligibility to services, is the
capacity and requirement to test or measure progress or development from an established baseline. Assessment procedures also always need to be placed in the context of the service activity of a particular agency. This is not to say that certain aspects of assessment processes going on in different agencies might not have common features; in fact they will often share objectives, e.g. the development of life skills. Each agency needs, however, to adopt procedures which best suit client need and aspirations in the context of the service functions they are required to address and provide. At the same time they need to be mindful of the relationship of their work to processes being undertaken elsewhere.

With the growing commitment to common targets in educational, health and social services fields which focus on the promotion of functional independence, multidisciplinary assessment and multi-agency functioning will become increasingly important. Common targets are also increasingly characterising services provided in SSDs for people with learning disabilities and physical disabilities. While separate services continue, and this is almost invariably appropriate, much of the work undertaken by staff in its service units subscribe to common aims and objectives. Although working contexts in both settings may be significantly different it is increasingly acknowledged that staff in both require a range of common skills.

A procedure which has significantly informed SSDs in recent years attempts to adopt assessment procedures, both in the learning disability and to a lesser extent, in an adapted form, in the physical disability fields, is the Individual Planning Programme System. Initially developed in 1982 in Hampshire to facilitate the development of personal and social competencies of 15 users, and potential users, of a community based residential service for people with profound mental handicaps, it lends itself to adaptation; and the authors acknowledge the importance of adapting to local needs, and not least, the multi-agency networks which may exist in different situations. The procedure not only assesses the personal developmental and social needs of individuals, but identifies and facilitates programme plans geared to the development of both personal and social gains which are considered to be individually achievable and will foster optimal levels of independence. The process could not be other than highly staff
intensive, and often requires regular "training" interventions. To ensure success, these may also need to be carried out over protracted time scales. Further, the establishment of regular and episodic "top-ups" may also be required to sustain the gains a person has achieved. Because staff/client ratios in day centres are often geared to service objectives subscribed to in the past, it is a process which is usually limited to clients facing a life crisis which, unless tackled, could cause them to become increasingly or wholly dependent upon full time care.

A current feature of operational arrangements in day centres is the attempt to ensure that those requiring most support get it. The range of personal skill and social competence found in attenders of day centres, be they for people with physical disability or learning disability, is invariably wide. Some users (and their carers) may be dependent on day centre services to support domestic situations which require intensive care interventions, while others may be using the centre as a feature of a wider support network which sustains a functional level of independence.

Daily programmes are usually organised with the range of client need in mind. Clients with greatest actual or potential need undertaking specific tasks or learning directed programmes work to a better staff/users ratio. In order to support more staff-intensive work, programmes of group activities are nearly always available which can be supervised with limited staffing and sometimes volunteers. In these circumstances, recreation and leisure has been an important means of centre management. The success of its use has however also fuelled an extensive and often imaginative utilisation of recreational activities. It has also fostered the growing conviction that attenders of centres have equal rights to enjoy recreation, both in centres and increasingly through the wider services and facilities made available to the whole community, and provided by both private and public sectors. However, the use of recreational activities merely as a means of prioritising and managing workload and demand has apparently prevented SSDs considering its value in achieving the primary professional objective of facilitating the development of optimal independence. As a consequence recreation and leisure activities are rarely used to achieve professional objectives effectively as part of a coherent service strategy.

84
SUMMARY

In this chapter consideration was given to the changing and complex nature of assessment as managed by SSDs and the characteristics and functions of assessment when related to the personal and social development of individuals. Further considerations addressed the functions of recreation and leisure in day centres and its limitations when seen as little more than a means to manage demand-led work and to support staff to engage in other targeted staff intensive activity.
CHAPTER 6: FURTHER CONSIDERATIONS, APPLICATIONS AND CONCLUSIONS

CONSIDERATIONS

In both the USA and the UK the first commitments to use recreation activity (play, sport, etc) to facilitate both the physical and social development of individuals in their formative years was founded on a general belief of its value underpinned by theoretical concepts emanating from a range of intellectual disciplines, notably philosophy, psychology and psychiatry. Layman (1972) 69 said that modern analysis was based on four stages. The acceptance and applications of the mind/body unity, the use of play and sport in meeting a person's basic needs or channelling basic instincts and therefore contributing to healthy emotional development; the formulation of theoretical concepts bolstered by the results of clinical case studies, surveys and questionnaires; and finally the generation of hypotheses to be tested using experimental methods.

In reflecting on the validity of beliefs and the theoretical concepts underpinning applications in the education fields in the USA in the 1930s, and the arguments made to fund developments, Layman posited six propositions which generally informed the working assumptions made in connection with the links between play and sport and emotional health. These she related to the research in the field that she had knowledge of after a wide ranging and extensive search of the literature. It is interesting to note that one piece of unpublished research she identified was in relation to recreational therapy (Meyer, 1955) 70. It was highlighted as one of a few studies she considered to be "scientifically tenable" by its use of control groups. In calling for a more rigorous application of scientific research principles she acknowledged the difficulty of research in "real life" situations, she did not question the importance of establishing working assumptions upon which service developments can be based.

With the emerging visibility in the USA of therapeutic recreation, (and an interesting and far reaching debate, but not the focus of this research, is the manner in which that particular concept was pursued and developed rather than recreational therapy), and its
established profile as a profession, the recent work at Temple University (see page 43) and its signals to the profession of the need to pursue an extensive, varied and detailed research programme is particularly noteworthy. Clearly new economic imperatives in the USA, in the 1980s and 1990s and particularly in relation to health care programmes require research programmes which are rigorous in data analysis and demonstrate decisively, effective professional outcomes, particularly in situations where commitment to programmes and the working assumptions underpinning them have largely resulted from people's belief in them. However, 25 years on from Layman's critique, much of which continues to be true and important, greater confidence has also been established in the academic rigour of research programmes which examine the qualitative aspects of both process and outcome of "real life" situations and are given greater credibility, particularly when protocols are adopted which can justify under rigorous examination their capacity to test or analyse what they intend to test or analyse, and to identify outcomes which are a legitimate basis for the service developments that are built on them.

Work and applications surrounding the relationship between physical well being and emotional health have been addressed in a similar fashion in the UK and research and theoretical propositions in this country, the USA and elsewhere have informed the wider debate.

Fox (1992) 74, in addressing physical education and the development of self esteem highlighted amongst much else the work of Campbell (1984) 72 who had declared as the First Law of Human Behaviour the desire to enhance self esteem, suggesting that motivation, beyond the basic biological requirements, could be explained by a human desire to experience good feelings about the self. It was clearly a declared position which resonated with much that was informing action and educational practice in the UK and Fox provided evidence for this by drawing attention to the theme often taken up by HMI of Schools who in their reports consistently called for greater consideration of the whole child and the promotion of self esteem, and to the circulars of the DES which actively encouraged it as an aim in educational programmes. It was also an issue
signalled by a working party in physical education in its submissions in relation to the development of the national education curriculum 73.

In identifying the considerable research work undertaken in assessing self esteem primarily in the USA, and not least his own in that country and subsequently in the UK, Fox acknowledged the relative wealth of research which focuses on physical activity and development. He noted, in comparison, the paucity of work which attempts to address the multi dimensional features of self esteem and the inter relationship between physical, psychological and social features of individual development and their impact on what has been described as global self esteem. Fox reported that following a series of studies Marsh and Shavelson (1985) 74 concluded that "each of the (multi dimensional) studies provided clear support for the multifaceted nature of self concept. The structure of self concept and the relationship between self concept and other constructs cannot be adequately understood if this multi dimensionality is ignored".

The considerable body of knowledge in relation to the development of self esteem in non disabled children and service applications based on these, has also informed understanding in relation to disabled children but to a much lesser extent. In 1972 Oliver 75 took the opportunity to explore the literature and research then currently available in both countries. Legislative changes in both the USA and UK in relation to handicapped children had at that time still to significantly impact on service developments and educational practice. He concluded that "if the contribution of it (physical activity) is important for normal children it is even more important for the handicapped". Highlighting the manner in which handicap prevents involvement in spontaneous activities he postulated that "systematic physical activity therefore is essential for handicapped children. Whether this is in the form of spontaneous free play, organised play therapy or highly structured physical education lessons is of no moment providing the activity suits the needs, interests and aptitudes of the children ... it would seem that unless we are prepared to offer opportunities for the handicapped to profit from physical activity their handicap may be much greater than their specific disability".
Given the early academic commitment to, and problems that researchers have encountered in establishing, scientifically reliable research protocols, it is not surprising that most work has been focused on physical activity with its greater susceptibility to monitoring and control. But what of the functions of the creative arts in the process of establishing emotional well-being and self-esteem? Its visibility, and accessibility to the vast majority was of course far less in the early decades of the Twentieth Century but few would now doubt its value even amongst those who do not see themselves as artistically focused. Service developments in the arts field both in the USA and UK have occurred, not surprisingly, on the basis of belief and theoretical concept with little in the way of research foundations, a situation which mirrors earlier developments in the field of sport and physical activities. Educational programmes which stimulate and encourage artistic ability and development are becoming increasingly visible as a legitimate vehicle to expand learning horizons and social development and particularly in relation to children with learning disabilities. In the UK this has become increasingly important since the 1970 Education Act after which children could no longer be deemed as ineducable.

Other developments of far reaching significance have also occurred. In the USA the development of Special Arts, a sister organisation to Special Olympics with similar aims and objectives, is another indication of the growing awareness of the role and function of the arts in establishing and sustaining emotional well-being and self-esteem. In the UK in the 70s, Gina Levete provided the spark which led to the formation of Shape a network of arts development agencies throughout the country. In more recent years a wide range of art specific groups and organisations have also been established for similar or allied purposes for example the Firebird Trust, Catch 27, Green Jam.

When Levete published "The Creative Tree" (1987), a practical guide to facilitating participation in the arts for disadvantaged people, Claus Newman, a consultant paediatrician wrote the forward based on his experience with handicapped children over two decades. He had observed that impoverishment of life experience in children and their families, often brought about by isolation, could lead to apathy and resistance to attempts to help their independence by special training in specialised centres. He had
also observed that the introduction of the creative arts could exert "a restorative effect on some children, elevating mood, improving the effectiveness of treatment and seemingly, their enjoyment of life", and that, "a breakdown of isolation and expansion of experience of life increases the motivation to use whatever independence is possible; and without such motivation, conventional treatment may lose much of its value".

These views, and the developmental activities occurring which were reflective of wider changes in society, echoed those of the past and in particular of Dr Casson, the driving force in the foundation of occupational therapy in the UK. At the outset of her medical career and as a clinical assistant working with adults at a mental hospital in 1930, she saw how purposeful occupation could counteract "bored idleness" and facilitate treatment.

Both the early work of Dr Casson and more recent developments have clear resonances with the founding philosophy of Dr Ludwig Guttmann of Stoke Mandeville Hospital. In his work with seriously disabled casualties of war he saw the value of challenge, targeted through sporting activity and competition, as a powerful force in rehabilitation. The Stoke Mandeville Games established in 1948 was the modest forerunner of much that has occurred since. While the very visible and extensive developments and successes in both the national and international field of sport in relation to people with spinal injuries had an early influence in generating sporting activities for many other people with disabilities, including learning disabilities, its influence has gone far beyond the specific field of sport. Although generally remaining untested much of the work with adults will mirror significantly much that has been established in relation to children and the formation of essential well being and self esteem. Also the personal achievements of a multiplicity of people with disabilities in overcoming individual and social handicapping circumstances to live fulfilling lives and which contribute to the wider society in which they live is yet more evidence. It is also fitting tribute to those in the past whose vision and commitment facilitated the means to make it possible. It is a tribute shared with those unsung others who, subscribing to their views and enthusiasms, assisted in the task - often against professional indifference and a failure by organisations to acknowledge the validity of the work. Yet the present situation
remains curiously unchanged from the past. While organisations may be quick to applaud the visible achievements of individuals, the lessons to be learned from the few and their more general applications to the vast majority of service users are almost invariably left unconsidered. In the context of SSDs this is amply demonstrated in the findings of this research.

The potential for change is considerable. Knowledge now exists which is a sufficient base for service and professional developments. The NHS and Community Care Act, with its commitment to individualised programme planning, and the need for SSDs to facilitate services on a more rigorously cost benefit basis, may be the imperative to strike new ground which opens up new horizons for service users where the promotion of optimal independence is both a professional and service objective.

Demands for change may also come from other quarters. The disability lobby in the UK, and particularly coalitions made up solely of disabled people, speak with a much more challenging voice than before. It is unlikely that this would have occurred without a process being engaged which gives disabled people more confidence in exercising control in their own lives. Recreational opportunities which provide choice, challenge, pleasure and the experience of fulfilment or achievement can be, and often are, significant first experiences in growth towards personal awareness, self autonomy and independence.

Will change occur and what factors will need to be in place and activated to facilitate it? Current legislative provision clearly enhances the potential for change but it will be realised only as the contribution of recreation and leisure is seen as valid in both professional and cost benefit terms. This will come, particularly in the field of day services for people with learning and physical disabilities, when staff can demonstrate empirically and systematically that pleasurable activity contributes significantly to personal and social development and to the achievement of overall day service objectives. It will be rooted only as SSDs establish policy and operational strategies and funding commitments to the process; its nurture and growth will ultimately be dependent upon the development of the skill mix which staff will require to utilise
recreation and leisure efficiently, effectively and in a targeted manner. The systematic analysis informed by relevant academic rigour of the particular advantages that emanate from change will also provide a sound basis for securing future and continuing developments.

APPLICATIONS

In earlier chapters the distinctive characteristics of day centre provision (for people with learning disabilities and those with physical disabilities) were identified as well as those changes which have occurred over time which have brought service functions closer together. Previous distinctions in professional training no longer exist and the skills base required for the work are shared. Centre activities often reflect common and shared goals and recreational pursuits are utilised widely.

Historically, rehabilitation has never been seen to be a primary function of day centres in either field of disability. The focus in relation to learning disabilities was, and still continues to be, that of training; centres for people with physical disabilities have always existed to provide a social support and/or care network for those who required it, and with needs which could not be met elsewhere. However, with the perceptible philosophical shift and political commitment to move people out of long term institutions, and to prevent them entering them, the resultant need to facilitate daily living skills as a means of fostering independence has become an important and valid centre function. With the change came the need to explore how best this could be progressed in an environment in which working objectives were changing but where the staff/user ratio continued to be based on earlier patterns of work.

The response adopted in many centres and mentioned earlier was the introduction of individual programme plans for those with greatest need, and the development of independence programmes which provided training opportunities geared to the development of daily living skills. Training programmes requiring a high staff/user ratio necessarily required other strategies to be evolved which were less staff intensive and recreational activities geared to the pursuit of pleasurable experiences and not target
oriented were extensively adopted. In the course of these arrangements however it was recognised that some recreational pursuits contribute significantly to the development and enhancement of social competence (mobility training/social interaction etc).

Recreational activities provided by day centres do not exist only as a means of ensuring that staff/user ratios are kept manageable. While staff and senior managers alike are not sanguine about the quality of some recreational opportunities provided for centre users, they generally acknowledge that - properly and actively provided - recreational activities can and do enrich the quality of life and as such are properly facilitated by SSDs. Staff in centres, their direct managers and senior managers in the wider SSD also often share the belief and express it that users have the "right" to engage in pleasurable pursuits. It is a belief which in all probability reflects the increasing visibility of "the right to leisure" in the wider community; but it is also beginning to be perceived as linked to "normalisation" the overall objective to which independence programmes are directed.

That recreational activities in day centres are utilised widely is in no doubt and the evidence found in this research reflects and supports the findings of extensive inspection work of the SSI. Given the permissive or encouraging climate which exists in SSDs over the use of recreational activities and the nature of the belief in its value and validity why are the activities often no more than peripheral to the increasingly central commitment to "normalisation" through the promotion of independent living skills and optimal independence? It is not unreasonable to suppose that if brought into the mainstream, centre objectives would be more effectively targeted. The generation of additional secondary gains to SSDs would also potentially reduce the level of extensive and high cost provision of formal community support networks to users whose hold on independence and community living are far from robust.

The pursuit of optimal independence for those who have for a range of reasons learned to be, or adventitiously have become, dependent is a long and arduous one. A multiplicity of individual needs will require to be addressed in the process. While for some the aggregation of need may be the relearning of skills once developed but since
lost, for others it will be the acquisition of new skills for the first time. A common basic foundation upon which success will be built however, and one which needs much early attention and continuing support, is the motivation and commitment of the person for whom the training is proposed. Suitably nurtured "trainees" will engage the challenge, manage the disappointment of failure and the challenge of further attempts, or the realignment of new targets. They will also develop the capacity to utilise whatever gains are achieved as a basis for life extension and enrichment and sometimes as spurs, to attain new levels of achievement. Learning new, or re-learning old skills, is however possibly no more than the tip of the visible iceberg of social rehabilitation and optimal independence will not be sustained unless other more fundamental factors are suitably addressed. These will include a range of psychologically rooted elements and will almost certainly include issues around identity, and social roles.

While many of the skills to effect psychological changes which are concomitant to social rehabilitation are not within the professional competence of many of the staff in day centres, much of their work has the potential to facilitate, sustain and extend it once started. These will include the processes by which individuals of low esteem establish a sense of higher esteem, begin through the validation of others to validate themselves and develop a sense of self and self identify with the capacity to make choices and decisions about daily living, which begin to foster or nurture self autonomy. This supporting work is important in a range of contexts but crucial in the facilitation of independent living programmes undertaken in centres which are geared to the specifically identified needs of individuals. Recreational activities are clearly a vehicle which has potential to be used in this way and some imaginative staff are utilising them in such a manner. It would appear rare however that this work is seen to contribute to targeted programmes of social rehabilitation. Information concerning recreational activities, when identified, does little more than indicate the activities in which a person engages and generally makes no attempt to link the potential or gains of the activities to wider assessment processes.

In looking at the manner in which recreational activities become less peripheral and more central to the working objectives of centres, a clear danger exists. It is, that in
attempting to identify the contribution which they may make to planned targeted training programmes, it will be considered that they should be an incorporated and assessed feature of such programmes. If it is a generally accepted belief that people with disabilities share the same right to leisure as all others, it should be categorically stated that day centres have no right to subvert these pleasurable and life enriching features by utilising them solely to their own service and professional ends. This does not mean however, that centre staff should not explore ways to capitalise upon the developmental and social gains which users realise through recreational pursuits. The following paradigm (Figure 2) attempts to identify what might be an appropriate process to adopt it is based on the premise that any user of a centre by virtue of their attendance is part of a transitional process which is concerned with fostering greater levels of, or sustaining, independence. The paradigm is illustrative of all users, be they people who are ultimately preparing for a move from the care of parents or others, to supported, semi supported or non supported accommodation, to those who, with high levels of disability and dependency, are unlikely to achieve more than an expansion of, or arrest of diminishing, self activated choice and independent action.
FIGURE 2

THE UTILISATION OF RECREATIONAL ACTIVITY AS A SUPPORT FUNCTION TO WIDER SOCIAL WORK AIMS MODEL

c J H Jeal (1994) - from an idea of M Doyle
Recreational activity should not be obligatory and the process by which users are invited to choose should be seen in the context of the wider working relationship between staff and users which reflects respect. Users should know that they have the right to choose and that their choice will be respected. A user's right of choice does not however preclude the responsibility of staff to consider what activities might be encouraged to facilitate both development and social gains. Staff will need to be aware of a whole battery of reasons why people may fail or refuse to choose to participate and handle each situation sensitively, encouraging involvement and stimulating interest where this seems appropriate.

Recreational pursuits should not be seen as part of a wider assessment process. However individuals suitably engaged in activities which are appropriately and purposefully organised will gain from the experience. Staff should assist users in these circumstances to garner all the benefits of the experience. Benefits and skills gained in one situation can, when suitably and appropriately applied, be the basis of new learning not only in similar but in very different situations. Staff should not only assist users in marshalling gains but to realise the potential of these being transformed into a foundation upon which new and different targeted programmes may be established and progressed. Activity facilitators, leaders and key workers will play an important role in helping users identify and apply all the benefits, and latent and developing skills. This clearly is a function which will call for a range of skills in staff.

A figurative paradigm which indicates the elements of a process can often reflect only poorly, if at all, the dynamic nature of the process or the interplay and interdependence of each of the elements on the others. The process which is proposed is not just about assembling activity (recreational and other where assessed as necessary) in a related schematic and progressive manner although this may on occasions be how it happens. Activities, both recreational and targeted, will often occur beside each other. What is all important is the utilisation and management of all the positive features which emanate from engaging in any recreational activity which supports the achievement of identified and agenda targets which are part of wider programmes of activity and training. Users who are engaged in recreational activity who are helped to plumb the
pleasure of it and also to identify its benefits and their application will be better equipped to utilise them effectively in the course of other targeted programme activity.

If it is acknowledged that a greater effectiveness in the utilisation of recreational activities will facilitate the more efficient achievement of the primary objectives of day centres, three questions have to be posed. They are: what distinctive task-specific skills are required? Are day centres staff the most appropriate staff in SSDs to undertake the work, or are other staff, either within the SSD or outside it already equipped or better able to accomplish it? What needs to be done by SSDs to facilitate the utilisation of recreation and leisure as a therapeutic tool and for it to become a significant function of its service activity?

Staff Skills

In Chapter 2 the development of therapeutic recreation in the USA was considered and reference and comment was made on the Peterson and Gunn paradigm "Recreational Activity Participation Model" (Figure 1, page 40). Amongst other things the paradigm relates the roles of therapeutic recreation specialists to the hierarchy of needs of clients in a recreational context and in so doing signals without identifying them the skills which staff require to discharge their roles. These leisure specific needs identified very generally, also reflect the nature of needs which could be identified in the wider context of the developmental and social needs of users of day centres in SSDs in the UK. Equally, many of the roles of SSD day centre staff share features with those of TRs and a detailed examination of the skill base would reflect many similarities.

A parting of the ways is clearly evident however. While the service objectives of SSD personnel clearly legitimise the utilisation of leisure as a support function of wider development and functional needs, it would be difficult to legitimate a leisure counselling function which was solely directed to the acquisition of a tailored leisure lifestyle. This divide highlights the distinctive skill which staff utilising leisure pursuits in day centres in SSD in the UK need to develop. The skill is intrinsically about the capacity of staff to assist users to identify whatever gains are acquired in the course of
pleasurable recreational activity, transfer their applicability and utilise them to address and support other developmental targets in the context of personal and social growth. In day centres much of this will occur in the course of training in life skills which foster optimal independence.

This work and the skill which is part of it will undoubtedly be most successfully discharged in a "counselling" mode. It will require a range of abilities. At the outset it will be necessary for staff working with users to foster interest and commitment to either general or specific activities and subsequently address with users the analysis of both seen and unseen gains, and their relevance and application to wider social needs. This work will clearly be "played out" in a context of a multiplicity of activities in which staff may participate in a range of roles (leadership, team, co-equal) or where activities occur under the direction or tutelage of others or are arranged by users, with support from centre staff, as facilitators. In this wide context a replication of the role of the TRs (as identified in the Recreational Activity Participation Model) will occur (Direct service provider/ Educator: Instructor: Adviser/ Enabler: Broker: Facilitator) and the graduation and change of role follow a similar pattern.

A high cost factor in sustaining the philosophical, political and legislative commitment of facilitative community care is, and will continue to be, the need to provide formal support networks for those who have established no more than a fragile hold on independence. It is a factor which could effectively impede a significant extension of services in the future as demand on formal systems of support rise, costs spiral and services become increasingly difficult to provide and manage. All support schemes will need to be careful in avoiding the establishment of new and inappropriate dependence patterns or formal support systems.

The contribution of recreational activities could in this regard be significant at two levels. At the first level an enriched life experience will at the least secure and potentially extend social functioning. On the second level and more importantly the formation of links with affinity groups has the potential to forge informal social networks which can provide a significant support function. The value and importance
of this should not be under rated. Informal support systems, generated through friendship networks which the "client" has played a large part in creating, may become of increasing importance. They have the potential to lessen the need for the maintenance of formal systems of continuous support. In developing and co-ordinating this work, in the context of their wider service concerns staff will clearly assume something of the functions adopted by leisure counsellors in the Peterson and Gunn paradigm

Staff Positions and Support

The manner in which recreational activities are being utilised in day centres with staff increasingly involving themselves in co-ordinating a wide range of recreational pursuits suggests they will continue to be central to service development. If providing this kind of service was critically reduced it is likely, by definition, that no further developments would occur, particularly as OTs, who might be regarded as appropriate personnel to assume a lead role, are unlikely to be given the responsibility in view of their changing functions in SSDs. To state however that day centre staff are central to future developments does not mean that other personnel both within and outside of SSDs may not be able to make pertinent contributions in formalising knowledge and identifying a skills base upon which more structured work can be established; nor contribute to and support therapeutic activity undertaken in different working situations.

The knowledge base is one which will require disciplined analysis and attention from a range of personnel. Remedial gymnasts in the health service, artists versed in the participative arts and working in association with voluntary organisations are two such groups which may have appropriate expertise. and from the health and social service fields, OTs with their grounding in the psycho social applications of therapeutic activity are clearly well placed professionally to assist in the task.

The extension of skills will require similar attention and much that has been identified and applied in America will be relevant. The emergence of the NCVQ could also provide an ideal vehicle for the identification of work based competencies which not
only begin to analyse the skill elements but also contribute to the consideration of the wider function of recreation and leisure in SSDs.

A potential area of conflict once a formalised pattern of work is established is the level at which recreation and leisure is pitched both in terms of its organisational importance and the status of those engaged in the work.

The adoption of a managerial pattern similar to those of domiciliary services would clearly buttress the organisational and professional validation of the work. "Recreational Services Officers" with responsibility for the management and development of recreational services could be located within an SSD to facilitate the development and co-ordinate the services across all client groups with senior staff, in discrete client groups or service units responsible for day to day management of services and with staff facilitating recreational activities. Staff functioning at the basic operational level would, as in effect generally happens now, be responsible to a senior member of staff whose knowledge and skill would be of a high order. It would be no different to current arrangements now operating in day centres where aptitude, ability and skills are factors taken into account in assigning work responsibilities. Clearly in the context of recreation and leisure the matching of staff aptitudes will be important but probably all centre staff could contribute much or something to a wide ranging programme of recreational activities unless other specific duties precluded it. While most staff suitably encouraged might see engagement in recreational activities as a legitimate working function some will have less potential to assist clients to incorporate social gains into wider developmental programmes. Those with the capacity to do so should however be provided with the opportunity to both extend and expand their skill and knowledge. This pattern of work organisation would also reflect the pattern of work which exists in occupational therapy services in SSDs with OT assistants being generally accountable to OTs for the work they undertake which calls for less knowledge and fewer professional skills.

Another positive feature of bringing into the mainstream the work of staff engaged in recreational activities and in so doing validating its function, is that rather than
searching for the recognition of their work possibly through a separate professional identity (as occurred initially in relation to home help organisers) their energy would be more effectively directed to the establishment of expertise in this field of work in the wider context of social services provision. It is a feature which would catch the tenor of the day when increasingly stress is being placed on the importance of multi-disciplinary work in SSDs.

An issue which clearly goes hand in hand with the question of organisational status and one which could equally raise conflict is the professional level at which recreational work is pitched. The matter should be dealt with realistically having regard to the past history of innovative service development in SSDs and in the context of the changing pattern of service delivery in the future.

The raison d'être of the NCVQ is to provide those with insufficient basic academic qualifications access to formal training and qualification through the assessment of practical competency at pre-qualifying stages. Recreational work would lend itself very adequately to becoming an assessed module for those undertaking "hands on" work and this should occur. Those in senior positions should also be provided with the opportunity to acquire a high level of knowledge and expertise, particularly in the context of the developmental and wider therapeutic applications of recreational activity.

Equally those with overall managerial and service development responsibilities should have the opportunity to acquire knowledge and skill appropriate to the nature of their duties. Given a clear signal from LA associations that they acknowledged the importance and significance of developments, universities and other providers of higher and further education which have developed a range of specific modules in wider programmes of recreation and leisure unrelated to social services could fruitfully collaborate with educational institutions addressing social services needs. Both could provide courses which are suitably geared to the academic, educational and practice needs which potentially exist at a range of levels and have yet to be addressed.
The Role of Social Services Departments

Staff in SSDs, and particularly those in day centres who have utilised widely recreation and leisure in their daily work, have established a locus for their continuing involvement in the development of therapeutic recreation. Another question does however have to be asked. It is whether the professional viability of therapeutic recreation will, as in America be dependent on the formation of a new professional group. It is a factor which cannot be denied that in the USA the visibility of therapeutic recreation has largely occurred as a result of the commitment to and success in establishing the foundation of a discrete discipline. While much of the knowledge base attaching to therapeutic recreation in the USA may have relevance and application in the UK the very different nature of their welfare and care systems clearly requires an approach in the UK which will best root the currently unrooted therapeutic dimension of recreation and leisure into mainstream services provided both by SSDs and other agencies. The history of both policy and service developments in the welfare services since the inception of the welfare state would clearly indicate that a slavish replication of the USA approach would not be the best, most efficient or effective one to adopt.

Although considered in many quarters over almost as many years as community care, recreation and leisure and a growing belief in its therapeutic value has failed to attract or command the attention of senior managers, elected representatives and legislators. Consequently no strategic policy or coherent developments have occurred nationally. None such are likely until a catalyst is found to create an impetus which brings together professional groups with employing agencies in both the statutory and independent fields and provides a target to be achieved. LA SSDs are well placed to provide this.

With the operational requirements and arrangements flowing from the implementation of the community care legislation, a new opportunity is provided for SSDs to foster innovative service developments both within their own departments and from leisure providing agencies in both the statutory and independent sectors. The visible working commitments of staff will not, however, be enough. Successful rooting will depend on the unequivocal commitments which are declared by SSDs and both the early
formulation of policy and coherent strategies which marshal the financial and skill resources required to progress developments.

A clear first step for SSDs, their LAs, and others should be to undertake inter-departmental inter-authority recreational/leisure audits. These should identify not only facilities available in local areas but the range of opportunities that can be fostered through the effective use of skilled personnel in respective agencies. Consideration should also be given to the manner in which statutory and particularly voluntary funding could be utilised for the purpose.

Early work should be fostered clearly in a different and national arena, possibly through the LA associations, and in collaboration with other agencies (professional associations etc) to produce guidelines for service developments both in the statutory and independent sectors. These should identify both common features and others which are agency-specific.

At the same time work should be undertaken on the formation of multi disciplinary working parties to explore the training and developmental needs of staff. LAs should look to central government to partner its associations efforts in both these areas and canvas vigorously for the adoption of identified objectives.

While much clearly needs to be initiated and sustained nationally, LA SSDs should immediately commence to marshal their work in relation to the utilisation of recreation and leisure and rigorously consider how it might be more effectively applied. This is a matter of considerable importance as national developments will be fuelled and wider commitments gathered as belief becomes proven fact.

In a financial climate of constraint considerable managerial skill is required to marshall resources for essential work and initiatives, particularly those that may be of high cost and are consequently given low priority. It would be wrong however to consider that extended developments in recreation and leisure utilised in SSDs would necessarily be high cost. Much occurs already. What is called for is the utilisation and effective
application of recreation and leisure which is geared not only to the service aims of
SSDs but to their professional aims too. The current commitment to the promotion of
optimal independence in people with learning and physical disability will fail miserably
if alongside it no work is done to facilitate personal development and growth which
generates and sustains the capacity to order and manage the life choices with which a
person is confronted. The effective use of recreation and leisure, whether in a day
centre, a recreational facility or in whatever arena it is engaged has no small part to
play in the process of fostering both optimal levels of self autonomy and independence;
and for those who need a high level of support, recreation may significantly enhance
the utility of support systems which are self-determined and of lower cost and thus
reduce the need for continuous formal high cost systems of support.

This research has identified the need for developments and also the will required to
promote them. These developments cannot of course occur without funding, or in but
a few situations, the remarshalling of resources. Funding should be found from a
number of sources, and from a range of statutory authorities. However, developments
should not be seen solely against cost benefits accruing from more effectively
marshalled and target directed services, but also beside the measure of growth potential
they muster and sustain and the contribution they make to wider community care
policies.

In 1975 the White Paper on Sport and Recreation considered that economic difficulties
would impede the immediate development of general recreational services; 20 years on
while the economic situation is bleaker the therapeutic dimension of recreation has
increased in visibility and with the wider commitment to community care has the
potential to become an important dimension in facilitating people's capacity to establish
and sustain their roots in the community. The imperatives of the post community care
era are greater than they were in 1975 The challenge remains the same. Our
awareness has developed Both the imperative and the challenge require to be taken up.

105
A. EXTENT, CHARACTERISTICS AND FREQUENCY OF RECREATIONAL ACTIVITIES

1. What is the extent of all recreational activities from 1988 to the present day?
   List activities: in/out centre
   
<table>
<thead>
<tr>
<th>Activity</th>
<th>In/Out</th>
<th>*PR/PE/UO</th>
</tr>
</thead>
<tbody>
<tr>
<td>SPORT</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

   CREATIVE ARTS

   PARTICIPATIVE ARTS

* See explanation at Question A3
2 What are the characteristics of recreational activities:

- Sport (competitive/non-competitive)
- Creative Arts (visual ... painting, sculpting etc)
- Participative Arts (drama/dance/music etc)
- Craft (woodworking, knitting etc)
- Leisure (narrow boating, horse riding, theatre visits etc)

In all these activities attempt to distinguish extent to which the activity is seen as serendipitous, diversionary or occupational: also whether other intrinsic values are perceived (physical/social development etc).

3 What is the frequency of recreational activity?

- Planned Regular
- Planned Episodic
- Unplanned Opportunistic
Appendix A (continued)

B ORGANISATION AND MANAGEMENT OF RECREATIONAL ACTIVITIES

1 What activities are:
   Management (SSD) Determined
   Staff (Centre) Determined
   Functionally (Staff/Clients) Determined

2 Are function specific staff appointed by the SSD?

3 Are staff given specific tasks to perform by centre management?

C PERCEPTIONS OF CENTRE IN RELATION TO RECREATIONAL ACTIVITY

1 Is recreational activity significant in the totality of the centre’s activity

2 How is this demonstrated?

3 Is ‘recreation’ an element of individual programming where this exists?
Appendix A (continued)

4 Are any monitoring/assessment procedures adopted in relation to 'recreation'?

Ask for copies of any past or current assessment procedures used by centre or any 'audit reports'.

D FUNDING OF RECREATIONAL ACTIVITIES

1 Was there an identifiable budget for 1988 (April 1988-89)?

2 What was it?

3 List other funds which were tapped (education, agency, amenity, private)

4 Are figures available?

E POLICY IN RELATION TO RECREATION ACTIVITIES

1. Does a departmental policy exist?

2. Is there any written centre policy?
### A Extent, Characteristics and Frequency of Recreational Activities

1. What is the extent of all recreational activities from 1988 to the present day? List activities in/out centre

<table>
<thead>
<tr>
<th>Activity</th>
<th>In/Out</th>
<th>*PR/PE/UO</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SPORT</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Leisure Centre Activities (full range)</td>
<td>OUT</td>
<td>PR</td>
</tr>
<tr>
<td>Badminton/Soft ball etc</td>
<td>OUT</td>
<td>PR</td>
</tr>
<tr>
<td>Swimming (1) Profoundly handicapped</td>
<td>OUT</td>
<td>PR</td>
</tr>
<tr>
<td>(2) More able</td>
<td>OUT</td>
<td>PR</td>
</tr>
<tr>
<td>&quot;Personal Development&quot; local college of FE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Personal and social development through</td>
<td></td>
<td></td>
</tr>
<tr>
<td>physical activity ... team games, deportment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>etc occurs with other centres)</td>
<td>OUT</td>
<td>PR</td>
</tr>
<tr>
<td><strong>CREATIVE ARTS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pottery</td>
<td>OUT</td>
<td>PR</td>
</tr>
<tr>
<td>Art Sessions/Collage</td>
<td>IN</td>
<td>PR</td>
</tr>
</tbody>
</table>

*See explanation at Question A3*
PARTICIPATIVE ARTS

Drama (Local College of FE) IN & OUT PR
Music and Movement " IN & OUT PR

CRAFT
Woodworking IN & OUT PR
Dressmaking IN & OUT PR
(Skills obtained on outside courses are sustained in centre activities)

Embroidery/Knitting
(A "pre-retirement course") IN UO

LEISURE
Horseriding (2 ability groups) OUT PR
Ten pin bowling OUT PE
Cycling (bikes and trikes) IN & OUT PE
Gardening (community support group) IN & OUT PR
Gardening (skills development group) IN & OUT PR
Motor games (uni hockey/netball) IN PR
Country dancing IN PR
"Daily life" games (table games) IN UO
Yoga IN & OUT PE

In all these activities attempt to distinguish extent to which the activity is seen as serendipitous, diversionary or occupational; also whether other intrinsic values are perceived (physical/social development etc).

Occupational or diversionary elements are not considered to be reasons for introducing activities.

All activities are said to be purpose directed and the serendipitous element utilised to foster either physical or social development (sometimes both)
Appendix B (continued)

3 What is the frequency of recreational activity?

Planned Regular

Planned Episodic (See PR, PE or UO at Question A1)

Unplanned Opportunistic

B ORGANISATION AND MANAGEMENT OF RECREATIONAL ACTIVITIES

1 What activities are.

Management (SSD) Determined

Staff (Centre) Determined

Functionally (Staff/Clients) Determined

An open ended policy statement exists which expects Centres to provide appropriate and suitable leisure and recreational pursuits for attenders at Centres. Within the county a commitment exists to "Shared Action Planning" which requires that "action plans" are based on joint work of staff, the "consumer" and appropriate "carers" and others. It was indicated that in identifying recreational and leisure activities the interests of staff (and presumably skills which may not be perceived as a pre-requisite of their work function and possibly not sustained through staff training opportunities) play a large part in the discussions which occur in determining what opportunities may be made available. The "Student" Council is encouraged to make suggestions to Centre staff and to make choices. The OIC felt that some 50 per cent of choices made emanate from attenders and the remainder are staff motivated or determined.

2 Are function specific staff appointed by the SSD?

No function specific staff have been appointed by the SSD

3 Are staff given specific tasks to perform by centre management?

At the time of the visit 2 staff dedicated a percentage of their working week to the promotion and organisation of recreational and leisure activities
C PERCEPTIONS OF CENTRE IN RELATION TO RECREATIONAL ACTIVITY

1 Is recreational activity significant in the totality of the centre's activity

YES

2 How is this demonstrated?

(a) The Centre management has two staff undertaking "dedicated" responsibilities.

(b) Recreational and leisure is a specific element of the action planning that is undertaken with each attender.

(c) Resources and finance (see below)

3 Is 'recreation' an element of individual programming where this exists?

Yes. See C2b above

4 Are any monitoring/assessment procedures adopted in relation to 'recreation'?

Ask for copies of any past or current assessment procedures used by centre or any 'audit reports'.

Yes, copies have been made available The system has been informed by a series of publications See attached.

D FUNDING OF RECREATIONAL ACTIVITIES

1 Was there an identifiable budget for 1988 (April 1988-89)? - Yes

The Centre has now been designated and is functioning as a "cost centre" and an "out of centre" budget head exists

2 What was it? £2,500

3 List other funds which were tapped (education, agency, amenity, private)

(a) Centre's materials budget
(b) Attenders sometimes pay for "admission" to leisure centres etc
(c) Amenity funds
(d) Parents
(e) "Hidden" education funding, the specific course programming
(f) Work of "specific skill" volunteers
4 Are figures available?

These cannot be totally quantified but £1,600 has come out of the Centre’s materials budget.

E POLICY IN RELATION TO RECREATION ACTIVITIES

1. Does a departmental policy exist?

An overall departmental policy exists which is committed to "normalisation" and this acknowledges the importance of recreation and leisure.

2. Is there any written centre policy?

Centre management are being required to write a centre policy to be submitted to senior managers. It is expected that this will reflect the wider philosophy and written policy of the department.
REFERENCES

Teaching the Moderately and Severely Handicapped Volumes 1 and 2 - M Bender

In Search of a Curriculum - The Staff of Rectory Paddock School

The PATH Project (Hester Adrian Research Centre) - D Jeffree and S Chesldine

The Derbyshire Language Scheme - M Masidlover

Curriculum Planning for the ESN(S) Child - N B Crawford

Let Me Play - D Jeffres, R McConkey, S Hewson

Let Me Speak - D Jeffree and R McConkey

Record Sheets  Makaton Vocabulary - M Walker

A Prescriptive and Behavioural Checklist for the Severely and Profoundly Handicapped - Popovich

Portage Guide to Early Education - S Bluma, M Shearer, A Frohman and J Millard

An Experimental Curriculum for Young Mentally Retarded Children - F P Connor and ME Talbot

Physical Education for Special Needs - L Groves CUP
<table>
<thead>
<tr>
<th>LIST OF ACTIVITIES UNDERTAKEN IN OR FACILITATED BY CENTRES VISITED AS PART OF THIS RESEARCH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aerobics</td>
</tr>
<tr>
<td>Adventure Holidays</td>
</tr>
<tr>
<td>Art</td>
</tr>
<tr>
<td>Art Galleries</td>
</tr>
<tr>
<td>Badminton</td>
</tr>
<tr>
<td>Bangor Racing</td>
</tr>
<tr>
<td>Billiards</td>
</tr>
<tr>
<td>Bowls</td>
</tr>
<tr>
<td>Candle Making</td>
</tr>
<tr>
<td>Canework</td>
</tr>
<tr>
<td>Car Maintenance</td>
</tr>
<tr>
<td>Chair Making</td>
</tr>
<tr>
<td>Collage</td>
</tr>
<tr>
<td>Country Dancing</td>
</tr>
<tr>
<td>Craft</td>
</tr>
<tr>
<td>Crochet</td>
</tr>
<tr>
<td>Cycling</td>
</tr>
<tr>
<td>Dance and Movement</td>
</tr>
<tr>
<td>Darts</td>
</tr>
<tr>
<td>Day Trips</td>
</tr>
<tr>
<td>Drama</td>
</tr>
<tr>
<td>Drawing</td>
</tr>
<tr>
<td>Dressmaking</td>
</tr>
<tr>
<td>Embroidery</td>
</tr>
<tr>
<td>Fancy Dress Nights</td>
</tr>
<tr>
<td>Film Shows</td>
</tr>
<tr>
<td>Fine Art</td>
</tr>
<tr>
<td>Fishing</td>
</tr>
<tr>
<td>Flower Arranging</td>
</tr>
<tr>
<td>Gardening</td>
</tr>
<tr>
<td>Glasswork</td>
</tr>
<tr>
<td>Graphic Cut Out Art</td>
</tr>
<tr>
<td>Group Holidays</td>
</tr>
<tr>
<td>Horseriding</td>
</tr>
<tr>
<td>Horse Trap Riding</td>
</tr>
<tr>
<td>Horticulture</td>
</tr>
<tr>
<td>Indoor Hockey</td>
</tr>
<tr>
<td>Knitting</td>
</tr>
<tr>
<td>Leatherwork</td>
</tr>
<tr>
<td>Library Visits</td>
</tr>
<tr>
<td>Local Carnivals</td>
</tr>
<tr>
<td>Model Making</td>
</tr>
<tr>
<td>Mosaic</td>
</tr>
<tr>
<td>Music</td>
</tr>
<tr>
<td>Music and Movement</td>
</tr>
<tr>
<td>Narrow Boating</td>
</tr>
<tr>
<td>Nine Pin Bowling</td>
</tr>
<tr>
<td>Old Time Dancing</td>
</tr>
<tr>
<td>Painting</td>
</tr>
<tr>
<td>Paper Flower Making</td>
</tr>
<tr>
<td>Paper Work</td>
</tr>
<tr>
<td>Photography</td>
</tr>
<tr>
<td>Pin and Thread</td>
</tr>
<tr>
<td>Pool</td>
</tr>
<tr>
<td>Pop Concerts</td>
</tr>
<tr>
<td>Pottery</td>
</tr>
<tr>
<td>Pub Lunches</td>
</tr>
<tr>
<td>Pyrography</td>
</tr>
<tr>
<td>Quiz Groups</td>
</tr>
<tr>
<td>Relaxation</td>
</tr>
<tr>
<td>Role Play</td>
</tr>
<tr>
<td>Rushwork</td>
</tr>
<tr>
<td>Sedentary Games</td>
</tr>
<tr>
<td>Sewing</td>
</tr>
<tr>
<td>Shooting</td>
</tr>
<tr>
<td>Silkscreen printing</td>
</tr>
<tr>
<td>Snooker</td>
</tr>
<tr>
<td>Social Education Visits (eg pubs)</td>
</tr>
<tr>
<td>Soft Ball</td>
</tr>
<tr>
<td>Soft Toy Making</td>
</tr>
<tr>
<td>Split Cane Work</td>
</tr>
<tr>
<td>Stool Making</td>
</tr>
<tr>
<td>Swimming</td>
</tr>
<tr>
<td>Table Games</td>
</tr>
<tr>
<td>Table Tennis</td>
</tr>
<tr>
<td>Tailoring</td>
</tr>
<tr>
<td>Tapestry</td>
</tr>
<tr>
<td>Team Games</td>
</tr>
<tr>
<td>Ten Pin Bowling</td>
</tr>
<tr>
<td>Theatre</td>
</tr>
<tr>
<td>Tie and Dye</td>
</tr>
<tr>
<td>Video Filming</td>
</tr>
<tr>
<td>Weaving</td>
</tr>
<tr>
<td>Weight Training</td>
</tr>
<tr>
<td>Wheelchair Dancing</td>
</tr>
<tr>
<td>Wood Sculpture</td>
</tr>
<tr>
<td>Woodworking</td>
</tr>
<tr>
<td>Wrestling Matches</td>
</tr>
<tr>
<td>Yoga</td>
</tr>
</tbody>
</table>
BIBLIOGRAPHY


12 Welsh Office (1983), The All Wales Strategy for the Development of Services for Mentally Handicapped People, Cardiff, Welsh Office

13 Wolfensberger, W (1973), The Principle of Normalisation in Human Services, Toronto, National Institute on Mental Retardation


15 The Jay Report, (1979), Committee of Enquiry into Mental Handicap Nursing and Care, London, HMSO

16 Brown S, Wistow G, The Role and Task of Community Mental Handicap Teams 1990 (CRSP), Aldershot, Avebury Studies of Care in the Community


22 DOE (1975), Sport and Recreation, Cmd 6200, London, HMSO

24 The Sports Council, (1982), *Sport in the Community the next 10 years*, London


30 Arts Council of GB (1985), *Code of Practice on Arts and Disability*, London

31 Arts Council of GB (undated), *Arts and Disability Check List*, London


33 Levete G (1987), *The Creative Tree*, Salisbury (Wilts), Russell (Publishing) Ltd


119


45 Social Services Committee 1984/5 session, (1985) second report *Community Care with Special Reference to Adult Mentally Ill and Mentally Handicapped People*, London, HMSO


50 Ministry of Health, (1965), *Local Authority Building Note 5 Adult Training Centres*, London, HMSO

51 National Development Group (1977), Pamphlet 5 *Day Services for mentally handicapped adults*, London Department of Health and Social Security

52 Social Services Inspectorate (1989), *Inspection of Day Services for People with a Mental Handicap: Individuals, Programmes and Plans*, London, Department of Health


54 Social Services Inspectorate (1990), *Developing Services for Young People with Disabilities*, London, Department of Health

56 Brearley P, Social Services Inspectorate (1989), "A Quirk of Fate .. An inspection of PSS provision to people with physical disability needing substantial personal care", Leeds, Department of Health

57 Clarke P, Taylor S, Social Services Inspectorate (1991) "A Day in the Life" ... An inspection of day centre services for people with disabilities, North Tyneside, Gateshead, Department of Health

58 Clarke P, Cook A, Social Services Inspectorate (1989), Report of Inspection of Kendal Multi Purpose Day Centre, Cumbria, Gateshead, Department of Health

59 Clark P, Brown M, Social Services Inspectorate (1988), Inspection of Bedlington Day Centre Northumberland, Gateshead, Department of Health

60 Booth L J, Frazer J, Tait E, Stapley S, Clarke A, Social Services Inspectorate (1991), "A Day in the Life" ... An inspection of day centre services for people with a physical disability in Oxfordshire, London, Department of Health

61 Blom Cooper L, (Chairman) (1989), Occupational Therapy, ... An emerging profession in health care, London, Duckworth


65 Hogg J, Raynes N (Ed), (1988), Assessment in Mental Handicap, London, Helm

Mittler P J (Ed), (1970), The Psychological Assessment of Mental and Physical Handicap, London, Methuen


Campbell R N, (1984), The new science; Self-esteem psychology, University Press of America, Lanham, MD

British Council of Physical Education, (1990), Physical Education in the National Curriculum, (Interim report), London, Physical Education Association of Great Britain and Northern Ireland


Thomas D, (1982), The Experience of Handicap. London, Methuen