Alternative Roles for Clinical Psychologists: Working as a Residential Social Worker

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I have spent almost the last two years working as a residential social worker in a new community service for people with a mental handicap. With the job title of "house coordinator" I firstly ran a halfway house for seven people with mental handicaps leaving hospital and then a house in the community for four of these people.

The Rationale

When I first applied for the job most people, whether psychologists or members of other professions, expressed surprise at my decision. They wondered, I think, about my motivation for taking a cut in salary and moving into a job perceived to be of lower status. I had, of course, doubts myself, but, at a relatively early stage in my career and without family responsibilities, I felt that if I didn't do it now I never would. At the time I had spent three years as a clinical psychologist in a large institution for people with mental handicaps. While it had been instructive and often exciting to be involved in the growing movement towards community resettlement, I felt that the opportunities for developing my clinical skills were limited. The traditional psychologist's role of addressing individual problems seemed meaningless, futile and dangerously supportive of the shortcomings of the overall service provided, since it encouraged the idea that the problems and inadequacies of the residents were purely a result of individual rather than service deficiencies. Suggesting that a resident's problematic behaviour is attention-seeking may be technically correct, but if the person lives in a situation where social attention is an extremely limited commodity and we accept its legitimate claim by the resident, it seems ethically dubious to attempt to remove a successful strategy for obtaining it. Even substituting a more "appropriate" method of gaining attention is not the solution - the cake needs to be bigger if one resident's benefit is not to be another's loss. The only coherent role in such a situation seemed to be to work for service rather that individual changes. The widespread weight given to psychological involvement in community resettlement suggests that many psychologists have reached similar conclusions. I had been so involved for some time but felt the need for a role that would give me more, but justifiable, involvement with handicapped individuals. I was looking for an opportunity to gain further "hands-on" experience, with people with mental handicaps, with a view to increasing my personal competence in those areas of work where, as a clinical psychologist, I was expected to provide staff with advice, consultation and training. Without getting into the argument about the role of the consultant, it has always seemed to me that clinical psychologists, in services for people with mental handicaps, often have too little, if any, experience of hands-on work and, consequently, cannot hope to be very good consultants.

In fact my behaviour was not the surprise to me that it was to other people in that I had unsuccessfully applied for a similar post immediately after completing my clinical training and had been thinking, throughout my time as a clinical psychologist, about such options.

The Role

In retrospect I can see that my new boss took a calculated risk in employing me. I brought knowledge, skills and commitment with me from my clinical psychology background but I also had to be relied on to pick up those aspects of the house coordinator's job for which I had no training or experience. I have found it useful since to consider the major competencies necessary to do this job well.

A knowledge of normalisation principles seems absolutely essential. It is as easy to run a four-bed institution as an eight hundred-bed one. If the new services are not simply to become small-scale community-based institutions they must be rooted in very different values. Fortunately I had a fair knowledge of normalisation and was committed to putting it into practice. This sometimes got me into trouble with my staff, as when I objected to a cinema trip on the grounds that it was'nt very good for the residents' image - the film was "Morons from Outer Space"! This brings me to the second competency required, one which I did need to pick up as I went along.

I was required to manage up to seven residential social work staff. Some of these had nursing qualifications, some had substantial residential social work experience, some were unqualified and completely lacking in relevant experience. I had the power, which clinical psychologists often lack, to make things happen but I also was accountable for what my staff did and had to deal with their sickness, their holidays, their personal grievances and so on. The successful house coordinator, like any successful manager, has to influence staff without losing their goodwill and motivation. In my situation staff often worked alone and had, therefore, to be empowered to take decisions and use their judgment without this having disastrous consequences. I felt a responsibility to manage staff in a way which could be imitated in their interactions with the residents since it seemed likely that my management style would influence this. Above all I had to limit, or at least camouflage, any tendency within myself towards authoritarianism.

Before taking this job I thought "Imprest" was a misspelling of "Impressed". I found out, to my "cost", that it was the kind of account which I had to manage for the running of the house. So receipts had to be obtained, records kept of stamps used, columns of figures added until they balanced, or until I pulled my hair out - whichever came first. In addition there were all the forms to be filled out and signed - top copy to treasurer, second copy to personnel etc,etc. Such forms were a continual reminder of the presence of the surrounding bureaucracy which must apply the same rules to all its units however large or small. There seems a need for consideration of alternative systems which will protect residents, against e.g. fraud, while interfering as little as possible with their lives and reducing the amount of time spent by the person in charge on administrative duties. One such system might involve the funding organisation in an accreditation rather than management role with continued funding being dependent on the standard of service (including administration) provided.

I was responsible not just for the psychological aspects of resident care but also for ensuring that food was bought, the house was kept clean, people saw the doctor when they were sick, and so on. Most of these skills I possessed but they were **personal** rather than professional skills and I found it difficult to see myself as working when I was using them. Paradoxically, the personal and ordinary nature of such skills makes them liable to abuse. Different members of staff perform such skills differently and are liable to resist attempts to make them conform to a common resident-centred pattern. Thus, how the cleaning is done may depend on the member of staff on duty - not an ideal set-up for residents to learn either the skills involved or that it is their, rather than the staff's, house.

As a behaviourally-oriented psychologist I brought with me skills in teaching and the management of behaviour which I was able to put to good use. People with mental handicaps do, of course, have individual deficiencies.

Putting the service on a more reasonable keel makes it clearer what these are but does not, by itself, overcome them. Some problems may even worsen or at least appear to worsen. A resident's aggressive behaviour may pale into insignificance by comparison with his fellows in an institution and may be easily managed by some combination of p.r.n. medication, seclusion, large male staff and even larger male residents. In an ordinary house it can become dangerous, attract undue attention from neighbours and require coping with, without the assistance of staff from the villa next door. Similarly, a resident's behaviour of throwing unwanted items out of the window becomes more problematic when they drop into the neighbour's garden! The need here is for behavioural analysis and intervention which does not interfere with the residents' rights nor conflict with normalisation principles.

The Results

I actually feel that I did not make a particularly good job of being a house coordinator. I was and am aware of the ways in which residential services, even community-based ones, often fail people with mental handicaps. Typically, people do not have enough to do - they are "done to" rather than being actively engaged. Even where modern techniques, such as individual programme planning, are used, they are often used mechanically rather than creatively and are reflected in additional paper production rather than in what actually happens to the people who live in the service.

In fact the service I ran failed, to an extent, in just these ways. Clearly, knowledge is not equivalent to successful implementation. While I already "knew" this, I feel it is particularly important to have this insight confirmed by experience. It operates against the all too frequent professional tendency to "blame" service staff for a poor service. This can occur, even while adopting a normalisation-based analysis of mental handicap to the effect that mentally handicapped people are limited by our expectations, by the roles we ascribe to them and by the lack of appropriate supports and opportunities. Residential (and, no doubt, other direct-care) staff are also confined by such expectations and roles - it is often these that need to be changed, not the staff. Thus, as a clinical psychologist, and in my job since leaving residential social work, I have worked all sorts of hours outside the standard 9-5. However as an R.S.W. shift times were more important so that even if I did work late I felt unhappy and aggrieved that I had to. Changing such feelings and their associated behaviours requires not different staff or better and different staff training. Rather, it requires changing the contingencies applied to staff - better pay, more self-determination, higher expectations and so on.

The Lessons

The above discussion of roles and expectations represents my attempt at capturing what seems like one of the most important learnings from my experience as a house coordinator. I was amazed at what the job did to me. One example of this occurred in the context of a discussion I was having with a G.P. about one of the residents. I found myself steering the conversation in such a way as to make it clear that I was not just a residential social worker - in a previous incarnation I had been a psychologist! What's more, it worked! The doctor treated me with much more respect from then on, an outcome that served to make clearer the lack of respect that he had been showing previously. There are a couple of other subjective learnings which I would like to mention.

Personally I found the experience both demanding and stressful, more so than my former post. While undoubtedly this was partly due to the particular

match between me and the job, I think it also represents a reasonable assessment of the nature of the work. It is demanding and stressful, probably more so than its equivalent in institutional services. Institutions successfully dilute personal responsibility by having separate night shifts, two- manager systems, multidisciplinary teams, assistance at hand and so on. It is very rare for institutional staff to have to stay on beyond their shift and even rarer for them to be called at home about a problem at work; both were frequent occurrences as a house coordinator. I would not argue for building such dilution of personal responsibility into new services as, in institutions, it has been a frequent contributor to inadequate resident care. We need, however, to recognise the issue, particularly in the early days of new services when support and management systems may not be well developed.

The job competencies described earlier are rather different to those that we can expect potential house coordinators to possess. This has major implications for staff training both at qualifying and post-qualifying levels. If psychologists are to provide effective consultation or management to new services, they too must develop new competencies. Perhaps the recent enthusiasm for service planning needs to be tempered with the continued practice of the psychologist's clinical skills, as the agenda shifts in emphasis from a need for service change to a need for skills which will facilitate individual change. This is perhaps particularly the case if high-quality new services are to be provided for mentally handicapped people having special needs where considerable work is required to identify, develop and transmit the necessary staff competencies.

After just under two years I moved on to a job whose primary emphasis is the teaching and training of staff for work in the new services. I have to say that moving on was something of a relief, almost like the removal of a physical weight from my shoulders. Despite this I feel I have had an immensely valuable experience and one which makes my current job both more meaningful and easier to perform. I would encourage other psychologists whether pre- or post- clinical training to consider taking similar jobs. I would not want to reduce further the shortage of psychologists in the mental handicap field, but feel that it is the kind of experience which can significantly increase the quality of later psychological work.

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