

names of those who agreed to carry out actions and the date by which they are to be carried out. Monitoring is achieved by weekly action review meetings and new life plans are drawn up to regular intervals (for example six monthly) recording needs that have been met and those still unmet.

Procedures like Life Planning do not encourage the denial of special needs, for example the need for medication to treat a mental illness, the need to control the intensity or quality of social contact, or the need to be protected from sexual exploitation etc. Life Planning does not therefore negate the right of a psychiatrist to utilise the concept of efficacy for treating the illness itself. It does, however, look at more than the illness. It lists strengths, skills, personal assets and ambitions however meagre or mundane, and builds upon them.

The tight specification of such a process for meeting the needs of people whose very existence pays our salary, people with special needs of whatever origin, is more likely to establish the living of "valued lives" than attempts at direct attitude change. This is because the procedure specifies and guides staff behaviour irrespective of their attitudes.

We might, however, predict that life planning and procedures like it, could over time, affect staff attitudes. A behavioural requirement, that of completing Life Plan documents in full consultation with the patient, forces the keyworker to reorganise the way they store or categorise information about the patient. This is because the documents are actually templates for describing ordinary lives led by ordinary people. Discrepancies between the current life of the patient and ordinary life are categorised as needs on separate sheets. Staff might therefore come to respect the patient as an ordinary person but with very special needs, rather than a special person who is "an inspiration to others"! The patient will often have many special needs, some of which can be phrased as skill deficits requiring training, but others simply revealing weaknesses in the service he currently receives, for example basic material needs, or advocacy needs.

At the hospital where I am working we have been experimenting for some time with Life Planning for people with mental illnesses. Only a tiny minority of our patients have had Life Plan documentation drawn up but already the results have been of benefit to the patients concerned as well as illuminating to staff. We are starting to realise what can be achieved by naming people responsible for action. We are also beginning to realise what needs are not met and often cannot be met by our service.

To include Life Plan documents in patients' case files (which, as confidential documents is their proper place) is an act of bravery but also an act of honesty and respect towards the patient. Those few sheets constitute a snapshot of a person living a life within a service which we provide. The quality and comprehensiveness of that service is boldly described in terms of needs met and unmet. It could make embarrassing reading particularly if we would rather only advertise the needs that we can meet. If, however, we decide to take a more positive attitude, this documentation, by

revealing shortcomings in our service could guide us towards better service provision, particularly when planning future services, community based or otherwise.

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#### REFERENCE

<sup>1</sup>CHAMBERLAIN, P. (1986) *Life Planning Manual*, second ed. British Association for Behavioural Psychotherapy.

DEAR SIRS

Dr Boucherat is to be congratulated for her thoughtful review of the principle of normalisation as applied to individuals with a mental handicap, and some of this principle's shortcomings (*Bulletin*, December 1987, 11, 423-5). However, there a couple of points which I feel warrant further comment.

Firstly, many of Dr Boucherat's criticisms relate to the more recent writings of Wolfensberger, and the behaviour of his more fanatical adherents. I believe these criticisms to be well-founded, but it is important to distinguish between them and longer standing more fundamental concepts which underlie the normalisation ethic. The move towards deinstitutionalisation of people with a mental impairment, and their re-establishment as valued members of society within the community would probably not have progressed so fast and so far without the normalisation lobby. Furthermore, many of us, without a thought for Wolfensberger, and without the enlightenment of PASS workshop experiences, utilise aspects of normalisation in our daily life and work. Children with a mental handicap are seen now (educationally at least) as having "special learning difficulties" as opposed to being simply "educationally subnormal". Many of us make a deliberate effort to refer to "individuals with a mental handicap" rather than a "mentally handicapped person". Similarly, it must surely have greater adaptive use to advise somebody that they have epilepsy or diabetes, rather than being an epileptic or a diabetic. These comments may sound simplistic, but they remind us of the individual's many other attributes, and place his/her needs in context. They are more than pleasantries.

Dr Boucherat emphasises the failure of the normalisation philosophy to recognise the existence of peoples' internal world. Of course, Wolfensberger's exposition, along primarily sociological lines, does not *ipso facto* deny the presence and importance of other psychological factors—be they conscious or unconscious. What is more amazing is the volume of existing literature which has not been utilised in explaining the phenomena of stigma, dehumanisation, and discrimination. An illustrative example, which shows how far back you can search for relevant literature, is Hebb's early work on the nature of fear.<sup>1</sup> He demonstrates the importance of simultaneous perceptions of familiar and unfamiliar features in the generation of fear and avoidance. This research is rarely quoted yet it has important messages regarding the above social phenomena.

We must be careful not to throw out the baby with the bathwater. The normalisation principle is essentially a good one which has enhanced our perceptions of, and support offered to, disadvantaged individuals. There is a need to relate existing data on basic psychological processes to the phenomena which Dr Boucherat describes. Then, hopefully, we can start to bridge the gap between Wolfensberger's observation of, and ideals regarding, society, and Clifford's statement regarding the importance of the individual's internal world, his feelings, and his general state of mind.

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#### REFERENCE

- <sup>1</sup>HEBB, J. (1946) On the nature of fear. *Psychological Review*, 53, 259–275.

### *Planning for bed needs*

DEAR SIRS

At some risk of being considered one of those doctors who hold entrenched positions, oppose necessary change and so on, I write in response to some of the points raised by 'Planning for Bed Needs and Resource Requirements in Acute Psychiatry' (S. R. Hirsch, *Bulletin*, December 1987, 11, 398–407). It was a laudable attempt to address a serious and difficult practical problem but I doubt if it is meaningful to quantify the value to a psychiatric service, on the basis of any statistical data at present available.

It may be naive to expect it, but there seems to be very little mention of *quality* in this debate. Some discussion of what constitutes 'quality' might indeed help to raise the standards of communication between ourselves, the general public, the 'media' and our political representatives.

Meanwhile I am puzzled by the Working Party's choice of 'activity' as the proposed sole criterion of the functioning of an active psychiatric service (since 'resource provision' and 'potential demand' are not characteristic of the service, but of the conditions within which it must operate). Obviously it is of some interest to any employer to know that an employee is active rather than idle; but it is *useful* activity, not activity *per se*, which an intelligent employer wants to maximise; that is, activity which contributes to the stated goals of the organisation.

From this point of view, what is required is, firstly, to define the goals of the acute psychiatric service in question; these may well vary from one community to another and indeed, probably ought to do so, since there are likely to be *qualitative* differences in the nature of the demand and how it is expected to develop in the foreseeable future. The next rational step would be an attempt to devise some way of estimating, quantitatively how far each unit of a given type of activity *contributes to those goals*. This would make it possible to estimate the 'useful activity output' of the service in question. To obtain a meaningful estimate of efficiency, this quantity should be *divided* by the total activity, which might be estimated broadly along the lines suggested by the Working Party (but more on that subject later).

This approach would be roughly analogous to the way in which efficiency is defined in other spheres, as 'useful work done' divided by heat or energy or work put in. It would not conflict with the queuing-theory approach so lucidly advanced by Dr Marjot (same issue of *Bulletin*). With respect, it makes little sense to define efficiency as 'work put in by the service' divided by 'money put into the service'. If an economic measure similar to productivity is what is required, then it should be defined as '*useful* activity output' divided by 'money input'.

With these general principles in mind the suggested activity 'algorithm' (sic) seems to be at odds with any sort of community-orientated policy. The given formula implies that one patient admitted and discharged adds two points to the 'activity' score, whereas one domiciliary visit which prevents an inappropriate admission by mobilising other methods of support (such as CPN visits, which do not count!) adds only half a point. In other words—prevent an admission and you are penalised one and a half points. The weightings used in the formula seem to illustrate with exquisite aptness the point that *useful* activity—not aimless activity, not 'statistical' or fictional activity—is what a psychiatric service should be producing from its resources. Almost any formula will tell an interesting story—but some stories are more relevant than others.

I write in the earnest hope that the College will not allow itself to be drawn into supporting any further proposals for reorganisation, from no matter what ideological source, which do not rest on a basis of very well considered performance criteria.

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*Professor Hirsch replies*

DEAR SIRS

I agree with the overall direction of Dr Thomas' argument, and many of the points he makes, which are very important. It would be helpful if he and other readers interested in the subject would read the full report to get a better feel of the problem we are dealing with.

Ours is a report of what we are able to achieve with the limited amount of data painfully extracted pre-Körner while Dr Thomas' letter largely concerns itself with the direction in which the argument should continue to develop. Criticisms he makes apply equally well to the Körner data sets and the 'performance indicators' which the DHSS is currently developing. We were, in fact, completely unaware of the development of Körner until we finished our report, but they are both working on nearly the same lines.

It is the spirit of Dr Thomas' letter with which I have to disagree. It suffers from what I might call the 'reification fallacy'—a tendency to equate a measure of a thing to the whole of a thing, forgetting that it is only a measure. Our working party started out on the journey to try to identify how many beds, later redefined how great a resource, a district needs for its particular psychiatric service. We realised there was no absolute answer but that we could talk in comparative terms within the overall context of the Health