King's Fund Centre

MENTAL HANDICAP PAPERS

5

EDUCATION FOR CARE

Experiments with in-service training for health and social service staff.

Price : £0.30

The events described in this report all took place before 1 April 1974, when the re-organisation of the National Health Service, and of local government, became effective. Thus the reader will find many references to organisations and designations which no longer exist in that form. However, in preparing the list of people who helped in the project, we have as far as possible listed organisations and designations in post-re-organisation terms.

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EDUCATION FOR CARE

Experiments with in-service training
for health and social service staff

KFC Reprint No. 875

SUMMARY

This is an account of six experimental courses of in-service training, designed to help existing mental handicap staff to adapt their work-processes and attitudes in order to respond more readily to the challenge of the newer mental handicap strategies and attitudes which are now developing throughout the world.

All the courses involved collaboration between statutory and voluntary agencies, and they permitted experiment in the use, for in-service training purposes, of the general educational system.

A narrative account of the first three courses is given, together with an objective evaluation of the second three. In addition, a specially-contributed paper describes the vital role of general educational establishments in helping to meet the growing need for in-service training and education amongst staff of the health and social services.

Whilst the staff who attended these six courses were mainly mental handicap workers, the report is equally applicable to staff in other fields of health and social service work.

Although the King's Fund has financed the project, and has permitted the publication of this discussion paper, the views expressed are those of the Working Party which saw the project through, and not necessarily those of the Fund itself.

* * *

INTRODUCTION

1. The first thing to note about the training experiments described in this report is that they originated from the field: the need was brought to the attention of the King's Fund Centre by the training project officers who had been specially appointed by their regional hospital boards to help improve services to the mentally handicapped. Late in 1970, at a time of great division and stress in the mental handicap world, they reported the need for existing staff to be helped by re-orientation to the newer strategies of mental handicap. Experiment was needed, with a special regard for collaboration between statutory and voluntary agencies, and the King's Fund agreed to finance six experimental courses.

2. Early in 1971 a Working Party was formed for the project, made up of representatives of the three major voluntary societies in the mental handicap field - MIND, the Spastics Society, and NSMHC - together with the training project officers of the three chosen regions - Birmingham, Manchester and South West Metropolitan. Later, they were joined by representatives from the then Council for Training in Social Work, by the Royal College of Nursing, and by a psychiatrist working in the mental handicap field.

3. The first three courses began late in 1971, each to run for about three months, after which progress was reviewed in July 1972. That meeting included not only the Working Party, but also course tutors and some invited course members. As a result, the second series was planned somewhat differently, and arrangements were made for an evaluation, which had not been feasible for the first series. The second series of courses ran from November 1972 to March 1973, and this time the review meeting was aided by the independent evaluation by David Boud which occupies a prominent part in these pages.

4. The report begins with an account of the first series by Joan Rush, Project Officer at the King's Fund Centre: this is not an evaluation, but a simple narrative. There follows a compressed version of David Boud's evaluation, the full version of which is published separately as Training for Change: An Evaluation.(1)

5. In framing its conclusions, the Working Party has not attempted to lay down a list of hard and fast recommendations: each situation differs, and each of the six courses is unique in its own way. Instead, we have tried to identify some of the concepts which have to be weighed in the balance when in-service training is being planned, and to share some of the insights which have been gained in steering these very experimental courses. We hope readers will draw their own conclusions from the experiences we describe. Nevertheless, the Working Party endorses the five guidelines suggested by David Boud and listed in paragraph 124, the importance of which emerged as the lessons of the pilot courses were learned.

6. As a pendant to the report, we are given a view of the broader educational setting of training, as seen by David James, Director of the Centre for Adult Education, University of Surrey. Just as David Boud enables us to see mental handicap training as part of a larger scheme of in-service training, so David James shows us in-service training as part of general adult education.

7. As things turned out, the courses included staff from the NHS and from social services, and could well have included staff of voluntary societies. And the Working Party included representatives from all three sectors. However, the courses originated through the hospital service and in this report they are seen mainly as an instrument for improving hospital care. The Working Party did not feel competent to express views on the social services training scene, which is itself undergoing complete re-appraisal by the Central Council for Education and Training in Social Work. But although, because of this, the Working Party's conclusions relate mainly to the hospital service, many of the ideas expressed apply equally well to social services, particularly those relating to the integration of training activities as between health and social services and the education service.

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THE FIRST THREE COURSES

Joan Rush, SRN, Dip.Soc.
Project Officer, King's Fund Centre

8. Following the recommendation of the Working Party it was decided that each of the first three experimental courses should be linked with an educational establishment in the region chosen; be open to all grades of care staff in hospital, with the possibility of involving local authority staff; follow roughly the same timetable - that is, start with a three-day block and then follow a day release pattern for eight to twelve weeks; and be allowed to develop differently according to local resources and local need, although following the broad aims and principles laid down by the Working Party.

9. The three hospital regions selected were Birmingham, Manchester and South West Metropolitan, and in each case the training project officer was to be the link man. This is what happened in the three regions.

THE AIMS OF THE COURSES

Birmingham

10. The emphasis was placed on re-orientation training in residential care, and it was decided to base this on the development of a new hostel, all the staff of which attended the course. The aim was to develop interpersonal skills amongst staff in a new situation. The two tutors were from the Spastics Society and they arranged the syllabus to cope with the teething problems of a new hostel: the syllabus was practical rather than academic in emphasis, and was based on discussion groups rather than lectures.

11. Staff from local authority hostels for the mentally handicapped attended the course, as well as some in administrative and field work positions. The final composition of the course was five members of staff of the new Consterdyne Hostel, five participants from other hospital groups in the region, and eight participants from the local authority social services department.

Macclesfield

12. It was decided that in the Manchester region the course would be centred on Cranage Hall Hospital group. The former training project officer from Manchester moved to this hospital as Chief Nursing Officer and was able to follow the scheme through from its early stages. Fifteen nurses from the Cranage Hall Group attended, made up of ten charge nurses, one nursing officer, one student nurse, and three state enrolled nurses.

13. The aims of the course were to explore modern concepts of residential care for the mentally handicapped and to assist staff to adjust to the demands of these, with an examination of the nature of, and the problems associated with, the nursing situation. The other major part would be concerned with alternative forms of care in the community and with a discussion of the problems associated with these alternatives. There would also be practical sessions on such topics as art, drama and play.

Surrey

14. The broad aim of this course was to explore a method of in-service training which would enable staff to fulfil a new role in the care of the mentally handicapped. The course was self-directed by the participants and used learning methods of an experiential nature, directed by staff of the Human Potential Research Project at the Centre for Adult Education, University of Surrey.

15. The course participants came from four hospitals for the mentally handicapped in Surrey. They included: one staff nurse, two student nurses, two charge nurses from industrial training units, two ward sisters, three nursing officers, a physiotherapist, an occupational therapist, a co-ordinator of voluntary services, a principal psychologist and a teaching auxiliary.

COURSE VENUE, STAFFING AND CONTENT

Birmingham

16. The Spastics Society's Castle Priory College furnished the two tutors to the course, Joyce Knowles and Ray Johnson; these were helped by staff from Kidderminster College of Further Education and by outside speakers. The course started with a three-day block, two days of wh ich were spent at Kidderminster College and the last day at Lea Castle Hospital. This was followed by eight single days at weekly intervals. Half of those days were spent at Kidderminster College and the remainder at Consterdyne Hostel.

17. The syllabus included sessions on growth and development; home-making in its widest sense; living in groups; individual topics such as sheltered employment; and visits to interesting units. In all, there were 35 sessions in the course. Of these, ten sessions were given directly by the course tutors from Castle Priory, while fifteen were provided by staff from Kidderminster College. Three sessions were shared by course tutors and Kidderminster College staff, and there were six outside speakers. In addition, four afternoons were taken up by visits to hostels, sheltered workshops and village communities.

Macclesfield

18. The course tutor was John McAuley, a lecturer in sociology at Macclesfield College of Further Education; other staff from that establishment undertook special sessions. The course, which was held at Cranage Hall Hospital, consisted of ten study days over a period of three months and concluded with a weekend residential block at a local hotel. There was no initial residential block.

19. The course tutor attended the course throughout, and also contributed ten sessions on sociology. There were four or five sessions each on psychology, art therapy and play therapy by speakers from Macclesfield College of Further Education. There were four outside speakers from the world of special education, nursing, and the social services.

Surrey

20. The course was held at the Centre for Adult Education, University of Surrey. The tutorial staff were John Heron, Director of the Human Potential Research Project, with three project associates.

21. The course started with a three-day non-resident block, and a similar block was held at the end, with eight single days at weekly intervals between these two blocks. The first two days were spent in highly participative exercises in order to enable participants to communicate more freely, and the third day was spent calling upon the resources of participants to plan the remainder of the course in co-operation with the staff. The staff gave no formal lectures. Their role was to introduce a variety of group training methods and to facilitate the adoption of these methods and their application during the course to the topics which had been chosen on the third day by the whole course, or learning community.

22. Each day of the course was from 10.00 a.m. - 5.00 p.m. with four periods of 1 hour 20 minutes each - a total of 56 periods. 34 periods were devoted to a variety of team development exercises involving staff and participants only: these occupied the whole of the first five days and all but six periods of the last five days. 22 periods were spent with outside special contributors who gave talks and engaged in discussion for 16 periods, and participated in group tasks and other activities for six periods. The outside resource-people consisted of workers in the social service field, staff who work with autistic children, drama therapists, and professionals concerned with the development of future services for the mentally handicapped.

THE OUTCOMES

Birmingham

Comments from tutorial staff

23. It was felt that there had been some problems in communication between the numerous bodies involved in setting up the course, which led to organisational difficulties. Nevertheless, both the Castle Priory tutors and the Kidderminster College staff felt that the course had been a useful learning experience both for themselves and the participants, and that they had built up links which would be useful for future courses.

24. The range of experience among the participants made it difficult to decide at what level to pitch the lecture or discussion: the three-day block helped here as it tended to integrate the group.

Comments from course participants

25. The main criticism from participants seems to have been that the course was too short, and that they would have liked to have been able to put more ideas into practice while the course was still in progress.

26. Local authority hostel staff welcomed the course, partly because it reduced their sense of isolation from other mental handicap workers. The inclusion of social services participants was found to be helpful by nursing members who welcomed this opportunity to learn about community resources.

27. Some members felt that the mix of trained and untrained staff caused difficulties until they had established a common understanding.

Macclesfield

Comments from tutorial staff

28. Mr. McAuley reported that the course displayed four main features. Firstly, members needed practical help in the field of art, play and music therapy, and this was provided in a direct and relevant way. Secondly, theoretical inputs in the psychological and sociological field were appreciated by the course members, although sociological sessions did not evolve as the tutor had expected because of his involvement in the overall work of the course. The third feature was discussion with other disciplines in the field such as the voluntary services, the medical services, and educational services. Lastly, there were sessions which directly concerned communication inside the nursing hierarchy.

29. In these last two areas, inter- and intra-disciplinary, John McAuley felt the course tutor played a valuable role as an 'outsider', enabling course members to convey ideas they might have been reluctant to express to senior colleagues, thus avoiding some of the inevitable political involvements in the hospital.

30. In the opinion of the liaison officer from the hospital there was a noticeable improvement in the life of the residents, both in the environment of the ward, and in the commencement of art and music therapy. He also felt there was an increase in the confidence of course members and an improvement in their skills of communication.

Comments from course participants

31. Most members would have liked a more multi-disciplinary group, and more contact with social services staff. But a small section would not have wanted other disciplines involved. The practical sessions were enjoyed by most members. The broader issues discussed were valued more after the course had finished: the relevance had not always been apparent at the time.

Surrey

Comments from tutorial staff

32. John Heron and his staff considered that the course was modestly successful in achieving the four subsidiary aims which were: to help participants develop communication skills; to help participants innovate patterns of care; to create within the group a self-directed learning community; and to help participants plan for organisational change. This view was based on staff observations, on participants' questionnaire responses, and on informal exchange of views between staff and participants.

33. Staff identified the following constraints within which the course had to operate: to some extent they were overcome as the course progressed:

(a) The gap created by difference of background and training was most effectively closed on Day 3, by the act of co-operatively designing the rest of the course.

(b) Some participants were "sent" on the course in a way that left some residual resentment. This feeling was made explicit and was worked through at a relatively early stage. The nature and purpose of the course was not made sufficiently clear to some participants, as not everyone had had a pre-course briefing, and the programme was too technically stated to be clear without further discussion.

(c) The absence of any senior administrative and medical staff on the course was a definite constraint. It created a strong sense of authoritarian distance between participants and senior staff and underlined feelings of participants that their ideas for significant change and innovation could be blocked at the top, whatever happened on the course.

Comments from course participants

34. The experiential exercises were the most challenging and controversial part of the course. On balance the consensus of opinion was that this had been a valuable experience although it was found difficult at the time. The group discussions with visitors were found to be most enjoyable: what the group most disliked was being talked at.

CONCLUSION

35. No objective attempt was made to measure the effect of these first courses on the participants, other than by means of the somewhat subjective comments cited under the section Outcomes. The courses had been put on urgently to meet an urgent service need and there had been no time to make proper arrangements for evaluation, though this would take place on the second series. Nevertheless, all the training project officers involved felt that useful links had been established with the educational establishments involved and that this resource would be developed further in the second series.

36. The tutorial staff working with the courses welcomed the opportunity to work in areas which were new to them and felt this had been an interesting educational experience for them. They also felt they could build on experience gained with the first course, to develop further with the second course.

THE SECOND THREE COURSES

**AN EVALUATION

David J. Boud

37. The course tutors had all undertaken a brief review of the first series of courses but no systematic evaluation was undertaken. It was decided that the second series should be independently evaluated: this work, which started in October 1972, before the start of the second series, is described below.

38. The aim of the evaluation of the courses was to provide information which would aid decision-making about future courses. The problem was: what were the important factors, and how could they best be illuminated? A simple model for the evaluation was adopted viewing the courses in three parts:

The Aims: what did the courses intend to do?

The Content: what happened on the courses?

The Outcomes: what effects did the courses produce?

The report is divided into these three sections. A final section includes a discussion of some of the issues raised by the study, and a personal statement by the author. Attention is given not to the specific worth of any particular course, but rather to the general usefulness of courses of this type.

39. Information was obtained in four ways:

(a) Prior to the start of the second group of courses, the course organisers were asked about the aims of the course, the particular emphasis and important strategies that they hoped would be followed.

(b) Each course was visited by the evaluator at least once, so as to establish contact with the staff and participants, and to observe the types of relationship that were being developed between them.

(c) In the light of the aims of the courses, and discussion with staff and participants, a questionnaire was designed to assess participants' opinions concerning the courses. This was administered by post two weeks after each course had ended.

(d) Documents relating to each course were studied.

** Owing to pressure on space, this important chapter is an edited and reduced version of David Boud's original evaluation report "Training for Change - An Evaluation". See references - page 4.

THE AIMS OF THE COURSES

What was the aim of the King's Fund?

40. The aim of the Fund was "to find out what methods of training are best suited to the purpose of re-orientating existing care staff, whether hospital-based or not, towards modern concepts of residential care". Each course organiser interpreted this brief differently.

What were the general aims of each course, and how did each course interpret those aims?

Birmingham

41. "To consider the generic aspects of residential care for the mentally handicapped. To consider in greater depths the specific problems of the multiply-handicapped, the adult and the adolescent."

Macclesfield

42. "To give to staff working with the mentally handicapped the opportunity to assess their own role in the caring process: in particular to consider their attitudes and values and how these affect their role performance and hence their patients.

To provide information about modern developments in residential care, and ways in which these can be used to provide a fuller and more satisfying life for mentally handicapped people."

Surrey

43. "To re-orientate existing staff towards the organisational and interpersonal implications of the educative concept of patient care."

What more specific aims were intended for each course?

Birmingham

44. "Through explanation, demonstration and participation, to give a greater insight into the problems associated with residential care, and an outline of the methods and approaches which can be used to meet these problems."

Macclesfield

45. "To enable course members to assess, in a group learning situation, whether the perspectives which they have developed are helpful for providing the best possible care for the mentally handicapped.

To provide training in the development of interpersonal skills, particularly to improve skills in communication and sensitisation to the needs of others, especially in the context of a multi-disciplinary institution."

Surrey

46. "To help participants develop skills in communication, tolerance, understanding, co-operative planning and self-direction.

To help participants actualise more of the potential of the handicapped: by developing a climate on the course that encourages the imaginative innovation of patterns of care to bring out the social, practical and cognitive skills of the mentally handicapped.

To create a self-directed learning community by using methods that require a high degree of participation and involvement.

To facilitate participant-planning for organisational change."

What were the common elements in the course aims?

47. It was intended that each course be composed of a multi-disciplinary mix of participants, drawn from a wide range of staff in the caring professions which have contact with mentally handicapped people.

48. An emphasis on the attitudes of the participants was a major focus. It was agreed that the important changes in patient care could be facilitated more by changes of staff attitudes, than by greater staff knowledge.

49. Interchange amongst participants was agreed to be of great importance. It was felt that the care staff had much to learn from each other in addition to any outside experiences arranged by the course tutors.

Where did course aims differ?

50. In the emphasis they placed on working directly with the attitudes of course members. Surrey and Macclesfield stressed the development of inter-personal skills of the course members. Birmingham stressed knowledge of new developments and of developmental psychology.

51. In the emphasis placed on control by course members. Great emphasis was placed by the Surrey and Macclesfield courses on participants choosing their own activities. Surrey in particular intended to allow the course participants to control the content of the course entirely, after the first three days.

52. In the ways in which the tutors facilitated interchange amongst the participants. Surrey and Macclesfield felt it appropriate to work directly with the feelings and attitudes of course members and to use these as a focus for discussion or other interpersonal activity. Birmingham attempted to encourage the participants to mix and interchange ideas by arranging what could be called the 'background variables': for example, providing open time during the residential periods.

53. These differences can be summarised by making a distinction between the type of course that was predominantly participant/interpersonal in orientation, namely Surrey, and the one that was predominantly content/ideas orientated, namely Birmingham. Macclesfield takes its place somewhere in between.

COURSE VENUE AND STAFFING

54. Each course allocated its time in a different way depending on the type of course and local circumstances. All three courses made extensive use of outside experts in particular areas, and in some instances visited hospitals and hostels for special purposes.

Birmingham

55. Beginning with a residential block at Castle Priory College, Wallingford, on 13th November 1972, the course continued one day a week for eight weeks at the Teachers' Centre, West Bromwich. It ended with a two-day residential period at Castle Priory College. Joyce Knowles, Principal of Castle Priory College, and Ray Johnson, Senior Tutor at the college, alternated as course tutors during the day release periods at West Bromwich, and were both present during the residential sessions. In addition, Mr. L. Lopes, Head of Residential Services, Social Services Department, West Bromwich, attended the course and offered assistance to the tutorial staff. Mr. W. Bailey, Bromsgrove College of Further Education, led sessions on Human Growth and Development, during the day release periods.

Macclesfield

56. The course started on 13th October 1972, with a two-day residential period in a hotel at Macclesfield, and continued for eight days once a week at Cranage Hall Hospital, Holmes Chapel, closing with a two-day residential period in the hotel. David Richards, Lecturer in Sociology at Macclesfield College of Further Education, acted as course tutor throughout.

Surrey

57. There was no residential period. The whole course was held at the University of Surrey, Guildford. It began with an introductory three-day block on 28th November 1972, and continued one day per week for eight weeks, closing with a three-day block. John Heron, Director of the Human Potential Research Project, acted as course tutor throughout. He was assisted by Steve Brown and Russ Brown, Associates of the Human Potential Research Project.

COURSE PARTICIPANTS

58. All three courses aimed to be multi-disciplinary and they included a wide range of participants. But the majority of members were either practising nurses, or had been trained originally as nurses. A very wide range of length of service was present in all three courses, from $1\frac{1}{2}$ years to 38 years. Details of participants in each course are as follows:

Birmingham (15 participants)

59. Two hostel wardens, one deputy warden, from hostels for mentally handicapped adults; one matron, one superintendent, one deputy matron, one assistant matron, one care assistant from old peoples' homes; one senior social worker and one social worker from a social services department; one study supervisor for residential staff, one nursing officer, one charge nurse, one staff nurse, one state enrolled nurse, from different hospitals.

Macclesfield (15 participants)

60. A group supplies officer, a physiotherapist, a physical training instructor, a senior social worker, an adult training centre instructor, one nursing officer, one staff nurse, five charge nurses and three state enrolled nurses. They were drawn from three hospitals and a social services department.

Surrey (12 participants)

61. A group liaison officer, a voluntary services organiser, two senior nursing officers, a ward sister, a student nurse, a teacher, a speech therapist, a member of the League of Friends (also a parent), two charge nurses, and a member of the hospital management committee. They represented a "diagonal slice" through one hospital organisation, namely, the Royal Earlswood Group.

COURSE CONTENT

Birmingham

62. The first residential period acted as an introduction to the rest of the course and a chance for the participants to meet each other informally. Most of the activities that took place in later days were established during this time. These included the series of lectures by Mr. W. Bailey of Bromsgrove College of Further Education on "Human Growth and Development"; and also the series of lecture discussions "Living in Groups" by members of the Bromsgrove staff and guest speakers. Also in the first residential period were talks by outside speakers on "The 'Our Life' Weekend", "The Parents' Point of View", and "Arts and Crafts - some ideas for mentally retarded children and adults". A talk was given on the work of the Social Services Departments, with special reference to residential care. The Castle Priory tutors linked these activities together and stimulated discussions on the topics raised. A visit to Borocourt Hospital was arranged to see some new wards there.

63. The day release section of the course was arranged around a core of lectures on "Human Growth and Development", taking the participants through the various stages of normal development from infancy to death: this occupied eight sessions. Another core subject, "Living in Groups" took topics on "Role and Role Play"; "Adaptation to new group roles - the stresses, demands and tensions created by group life"; "understanding people in groups"; "group dynamics"; and "styles of leadership and climates of organisation". This part of the course ended during the final residential period with a group project based on the problems associated with establishing a new residential hostel for the mentally handicapped. Other activities in the day section of the course were on "Occupying Handicapped Children"; "Home making"; "Music as a creative activity"; movement and physical recreation, and a film. There were also three visits to hostels, hospitals and training centres.

64. The closing residential period included a film about a spastic couple, a talk about the physical care of the severely handicapped; much discussion; and an evaluation of the course.

Macclesfield

65. Much of the course was organised relatively informally with the course tutor acting as a facilitator for group discussion for about half of the total time of the course. Aspects covered with the course tutor concerned skills in communication; sensitivity to the needs of others; institutionalisation; involvement in decision-making; key-tasks analysis; role-identities; and conflict of expectations.

66. The first residential period included sessions in which members' problems of organisational communication were explored, largely by free-ranging

informal activities using case studies. Role-playing situations were staged on such themes as the closure of a therapeutic-community-type adolescent unit. Also included was a lecture discussion on types of care in France, USSR, USA and Britain.

67. The remainder of the course was devoted to informal lecture discussions: topics in psychology by a lecturer from Macclesfield College occupied four periods; sessions aiming to provide material giving practical help to course members on art and sound therapy, took up four periods; two periods were devoted to play therapy and invited guest speakers discussed "The Role of the Volunteer", "Research into Patient Needs", and "Future policy for the mentally handicapped". A seminar on personalised clothing was also arranged.

68. The final residential period included a feedback meeting with members of the hospital administration.

Surrey

69. This course was innovative not only in its content and in the selection of staff, but also in the learning methods and course design. The basic principle of the course design was that the course members and tutors formed a self-directed learning community of peers and adopted the notion that "staff resources, participants' resources and external resources are made available, and distinctions between a trainer and trainee dissolve".

70. The strategy that the tutors adopted was that during the first two days of the course, the community of tutors and students engaged in a variety of community building exercises. These took the form of activities to "stress our common humanity by differentiating the person from the professional role". A discussion of some of the techniques used appears in the report of the course "Training for Change II" by Steve Brown.(2) In essence, they comprised activities that would build a group from the individual course members in such a way that they would see themselves as individuals but with professional roles outside the course, and would have knowledge and experience of some of the skills and resources possessed by other group members. The third day was spent by the whole group, in designing the structure, content and strategy of the rest of the course.

71. The time on the rest of the course was divided up into three main activities. Firstly, outside speakers on the 1974 reorganisation; the Briggs Report; parents' views; and assessment, treatment and therapy. These sessions were arranged so that the speakers would be invited to join the community temporarily, in the hope of generating maximum interaction between the speaker and the community. Four half-days were devoted to this.

72. Secondly, senior people from the Royal Earlswood Group, including the director of social training, a senior doctor, the chief nursing officer, the clinical psychologist and the group secretary, participated in the exploration of one or more of the following topics: organisational change; leadership styles and the use of power; use of resources; constraints within the organisation; areas of conflict; needs of patients; staff-patient attitudes; hospital morale; objectives and policies of the Royal Earlswood Group. Five half-days were devoted to this.

73. Finally, eleven half-days were devoted to Community Sessions. The purpose of these was to develop skills in interpersonal awareness, decision-making, interviewing, creative-thinking, action-planning, team-building, appreciation of each other's jobs. Many of the novel methods used to bring about these results are listed in Training for Change - An Evaluation. Part of the final block was taken up with a visit to the Royal Earlswood Hospital and an evaluation of the course by participants.

What was the major difference between the activities of the courses?

74. There was a great difference in the amount of participant-initiated activity. At Surrey, most of the course content was chosen by the course members: the tutors were there to facilitate self-directed learning. To a lesser degree this occurred at Macclesfield where participants had the opportunity to initiate activities, but where much of the course was prescribed in advance.

75. At Birmingham, most of the course was prescribed in advance. Course participants only had the opportunity to direct the activities during discussions after lectures, and in the occasional periods set aside by the tutors for this purpose. However, this strategy did allow the Birmingham course to present a very large amount of information to the course members, and allowed a much greater exposure to outside speakers.

THE OUTCOMES

76. The replies in this section of the report are mostly taken from the post-course questionnaires. In some cases these have been extended or amplified by personal comment. It is important to be cautious about questionnaire responses as they are open to many recognisable biasses and errors. The design of this particular questionnaire aimed to minimise some of these by asking questions which were open-ended, and which had to be answered by a phrase or short sentence.

How were the participants selected to attend?

77. In the previous series, participants who were 'sent' on the course produced a much less favourable response to the course than those who chose to attend. In this second series, nobody said that he had been 'sent'. Everyone spoken with had chosen to attend. Little, if any, pressure appeared to have been applied. In particular, the Surrey course organised a pre-course briefing at which potential participants met the course tutor and were told what the course involved.

How did the participants see the purpose of the course at the outset? Did the organisers see it the same way?

Birmingham

78. Almost all the participants expected that the course would deal primarily with residential care. Many expected knowledge of new developments in this field and particularly about hostels and care within the community. A minority expected that the course would help them in improving their care for the mentally handicapped.

Macclesfield

79. Some participants expressed expectations of dealing with problems related to their discipline, particularly nursing. Others saw the aims of the course in terms of generally improving life for the mentally handicapped and understanding new ideas of care. A minority had expectations of modifying their own attitudes and feelings towards their work.

Surrey

80. Despite the pre-course briefing, some participants at the outset were unsure of the purpose of the course. Others saw it in terms of team-building within an organisation, concerned with management studies or similar to first line management courses; an understanding of roles; to improve communication; and to learn about each other's attitudes and problems. A clear consensus did not appear.

81. Except for Surrey, these expectations are not too different from those of the course tutors. In the case of the Surrey course, it is likely that the novelty of the approach was difficult to explain in advance.

What did the participants finally see to be the aim of the course?

Birmingham

82. Residential care remained the focus of the course as before, though slightly less so. A minority saw the aim of the course as providing a meeting point

for staff involved in caring for the mentally retarded to share ideas and how to implement them. Three participants made comments that were a reflection of disappointment with the aims of the course; one of these said the aim was "to examine existing patterns of care and established methods of dealing with the mentally retarded".

Macclesfield

83. There was a change of emphasis towards the idea of meeting other disciplines, understanding the problems of others and improving communications. There was also greater stress on changing attitudes: two participants mentioned that they now saw the course in terms of improving life for the mentally handicapped. However, one still saw it simply as a "training course for nursing staff".

Surrey

84. The post-course responses were far more articulate than the pre-course statements. Many saw it in terms of team-building within an organisation, in improving working relationships and bringing together people in conflict. A large proportion of the rest saw the aims in terms of interpersonal benefits, of an understanding of the self and of others. Two participants commented that the aim of the course was to benefit the course tutors and the Human Potential Research Project.

What activities did the participants find to be most valuable?

Birmingham

85. A wide range of activities was found valuable by individuals, particularly the opportunity of meeting and discussion with others, the visits to different establishments, and getting the parents' point of view. Some were particularly affected, as they began to realise more clearly the outlook and difficulties of parents.

Macclesfield

86. Half the course members rated art therapy and play therapy as most valuable. A high rating was also given to the opportunity to learn of the difficulties of other participants in their job situation.

Surrey

87. The two most valuable activities were said to be the frank and open discussions amongst the community of members, and the interactions with senior staff from Royal Earlswood hospital. The meeting with parents and relatives of mentally handicapped patients was also felt to be valuable, and some of the course members found this a moving experience: experienced hospital staff discovered that they

still had a lot to learn of how deep can be the distress of parents, and how difficult the problems of acceptance.

88. All these diverse reactions highlight the fact that the course members are multi-disciplinary with a wide and diverse range of concerns. The problem for course organisers is: how can they handle this diversity?

What activities did the participants find to be least valuable?

Birmingham

89. The series "Human Growth and Development" was thought to be least valuable by four people. Two did not like the emphasis in the course on the growth of children, as they were working with the old and dying. The hospital visit was felt least valuable by those who had worked in a hospital previously.

Macclesfield

90. No event was found to be the least valuable by more than one person. Play therapy and art therapy were found of least value by two people who had had previous experience of them. Two people thought that the personal clothing seminar was of little value.

Surrey

91. Six people commented that the first two days of the course, spent in community-building, were either unnecessary or could have been considerably reduced.

What effects did the participants consider the course had on them?

92. This question could only have been effectively answered by observing and interacting with participants in the job situation before and after the course: this would have been a lengthy and costly process. So the following changes are those which participants themselves report as having happened to them, in answer to the question: "Looking back on the course, what changes in your behaviour or outlook, no matter how slight, could you attribute to your attendance at the course?". Different categories of change were provided - connected with patients, connected with your immediate colleagues, etc.. Aside from individual comments, one of the most illuminating results was the number of participants who replied that they had experienced some change as a result of the course. The table shows the number of course members who said they had changed in each of the various categories.

	Birmingham (15 participants)	Macclesfield (15 participants)	Surrey (12 participants)
Changes connected with:			
Patients	8	12	2
Immediate colleagues	6	9	10
Staff in other disciplines	9	5	12
Junior and senior staff	8	6	8
Personal changes	10	6	9

93. These results give an interesting profile on the relative emphasis of each course. Surrey's effects are mainly concerned with changes in relationship between staff in other disciplines, with immediate colleagues and with staff adjacent in the hierarchy. Personal changes are also important. Macclesfield's effects have quite a different profile: main changes are connected with the patients themselves and with immediate colleagues. Birmingham is different again. Much fewer changes are associated with immediate colleagues than the other two courses. There the main emphasis is on personal changes, and with staff other than immediate colleagues, and with patients.

The following is a précis of statements illustrating some of the changes reported.

94. Birmingham

Connected with patients

More relaxed; realise that tension in the job is not caused by other staff or residents but by administrative system
Aware that handicapped persons are not 'patients', but 'people in care'

Connected with staff in other disciplines

Realise that most residential workers feel isolated: intention to visit other establishments
Encouraged by knowledge that all disciplines share the same problems: less feeling of isolation
More sympathetic and tolerant with staff involved in residential care of the mentally ill.

Personal changes

Awareness that staff can be 'institutionalised'
Gradually throwing open family's doors to residents
More questioning about personal attitudes to mentally handicapped

95. Macclesfield

Connected with patients

More aware of the mistake of setting inappropriate limits on a mentally handicapped person's capacity for social and emotional growth
Greater recognition of handicapped person's social and emotional needs

Connected with immediate colleagues

More sure that nursing officers are sympathetic to ward problems

96. Surrey

Connected with immediate colleagues

Emphasis on need for team work
More able to talk directly and honestly to colleagues
More relaxed attitude to new colleagues

Connected with staff in other disciplines

People within other disciplines seen as individuals rather than as stereotypes
Aware of need to know more about other disciplines
More able to discuss problems with seniors and juniors in all disciplines
Realisation of manager's duty to bring out creative ability from all levels of staff

Personal changes

More confident: less concerned about criticism
More able to speak up

Did participants consider there were any undesirable effects?

97. The vast majority of participants on all courses felt that there had been no undesirable effects on the course. Most of those which were mentioned were connected with an increased awareness of the difficulties and problems concering their jobs or those of other people in the caring service: one participant thought the course demonstrated how inherent and deep are attitudes of authoritarianism in the hospital. Another said that the course spotlighted the many inadequacies in the residential care at present being provided, and the disturbingly low standards at all levels.

Would participants recommend colleagues to attend a course of this type?

98. This can be regarded as a question which summarises their evaluation of the course: the answers reveal whether they feel it is good enough for their colleagues to spend time attending.

Birmingham

Four would not recommend their colleagues to go. They say that it was concerned too much with residential care. Two, who are not working with the mentally handicapped would also have reservations.

Macclesfield

Three participants, not nurses, would not recommend their colleagues to go. They say that it was too much orientated towards nursing and hospital care.

Surrey

All participants would recommend their colleagues to go. A few have reservations, but they are all different from each other.

99. Would participants have liked the range of participants to have been increased?

Birmingham

Most thought the range about right. Twice as many said it should be broader than said it should be narrower.

Macclesfield

Seven said that the range should be broader and should include disciplines other than nursing, especially doctors and psychologists. Yet five thought it should be narrower and be restricted mainly to nurses.

Surrey

A majority said it should be broader; no-one thought that it should be narrower. Seven people said that it was important to include doctors.

100. Did participants think it important to have course members drawn from different points in the hierarchy?

Birmingham

All except one member thought it important.

Macclesfield

Everyone thought it important, although they were slightly less emphatic in their statements.

Surrey

Everyone thought this to be very important, many thought it essential.

101. Did participants think that course members should have greater control over the content of the course?

Birmingham

No-one claimed to have had sufficient control of content, but two people pointed out the difficulties involved if they were to have a say in content.

Macclesfield

Slightly more than half the members said they did have sufficient control over content, but some mentioned that this was not particularly relevant.

Surrey

Most participants said they had sufficient control over the content of the course, though within a general direction provided by the tutor. A few commented that they did not have enough control over the methods that were adopted.

102. What additional activities would participants have liked to have seen included in the course?

In all these courses, many suggestions were made, but nearly all were mentioned by one person only. At Birmingham, many comments were made about the lack of sufficient discussion time on nearly all topics.

103. What changes would participants like to see if the courses were run again for a different group of people in the same field?

Birmingham

The greatest reaction was for more choice and flexibility in the running of the course: "A chance to discuss what the group wanted instead of running a tight schedule of lectures". Also suggested was a greater time to be spent on group dynamics and other forms of group work, and greater attention to the selection of participants to attend. Two mentioned that it would be preferable to have the course residential, or at least spread over a much shorter time span.

Macclesfield

A majority would like the course to be held away from the hospital. A rather smaller number would prefer a two-week course continuous and residential. Three would have liked a hospital-orientated tutor.

Surrey

The predominant suggestion is that there should be a full 'diagonal slice' through the hierarchy for participants in the future. In this, participants are drawn from different levels in different disciplines through an organisation. For example, a committee-member, a senior doctor, a middle-line administrator, a ward sister and a junior volunteer would form such a diagonal slice through the hierarchy of a single hospital. The idea of a more compressed course, in a non-hospital venue, received great support.

Did all the participants finish the course?

104. No, there were some 'drop outs' in both the Macclesfield and Surrey courses. Three participants at Surrey left the course in its early stages. No attempt was made to follow these up as the sensitive issues involved in 'dropping out' of a course need to be handled carefully. It was considered that the time required to pursue these would be outside the resources of the evaluation.

How did the course tutors evaluate their course?

Birmingham

105. The Castle Priory tutors recognised some of the problems in the course, particularly that of the selection of participants, which was outside their control, and of the "overloading" of tutorial staff at times. They point out "the criticism and comments of the group at the end of the course,(mentioned in paras 82 and 98) must be taken in context, as the needs of some of the group were not those the course aimed to fulfil".

Macclesfield

106. David Richards writes: "A major part of the course tutor's role was to consolidate and facilitate learning on topics presented by other staff and speakers, as well as on topics which he or course members introduced. This was important, as although not self-directed by participants (it was felt that institutional and organisational pressures would not allow this) the course did attempt to be flexible and to allow course members to present their own problems. However, I think that the course was too structured by the pressures already mentioned and not enough of a "self-directed learning community" was created. In informal terms, the course "worked" in the sense that contact between people of different disciplines and statures in the caring service managed to communicate on what seemed to be more than a superficial level, and to exchange, assess and re-assess their perspectives."

Surrey

107. The tutors felt that the style of course that they had adopted was successful. Steve Brown writes: "A distinctive feature of the course was the frank exchange of views and experiences between community members. The gains from this kind of interaction are typically the enjoyment of the concomitant atmosphere of trust, a sensitivity to others views and needs, a willingness to use the support of the community to take risks as part of a process of innovation". He goes on to suggest that the growth of this openness was in large measure due to the radical methods used on the first two days, and points out "the construction of a self-directed community of peers requires the dropping of role defences; it is precisely this action which causes embarrassment and uncertainty". He feels that the emphasis of the course was towards the process rather than the task, and cites his feedback information from participants to discount fears that they were not getting any visible work outputs from the course.

What changes would the tutors like to see if courses were to run again?

Birmingham

108. "Any future composition of the group should be known sufficiently far in advance to tailor-make some aspects or, alternatively, those people whose needs fall well outside the scope of the course should be withdrawn. A much more positive tutorial role should be allowed in order to bring the lectures together." The tutors suggest that future courses could well be taken over by the College of Further Education.

Macclesfield

109. "The location and timing need attention in future. The hospital setting for the single study days meant that hospital pressures were hard to avoid. Also the intensity of interaction and group learning was dissipated during the week. I would suggest that the ideal course design would be a two week period of residence in a hotel, followed by a period of approximately two to three weeks during which time on-going projects in the hospital situation would be set up and supervised by the course staff. These could serve as the basis for a feed-back session at the end of this period for a further five-day period. The course should, if possible, be self-directed and should certainly in any case be tailored to the individual needs of the course members which they are in the best position to know about, rather than institutional preconceptions about the 'real world' of staff."

Surrey

110. "The tutorial staff should assume responsibility for approaching outside speakers and inviting them to participate in selected sessions. The cross-section of the hospital organisation which participants represent should be extended to include group secretary, consultants, and other members of the professional executive. The use of 'block' periods should be increased, so that a structure might be three days + two single days + four days + two single days + three days. These blocks might be residential."

111. The formal evaluation concludes here. What follows are David Boud's own subjective views and interpretations. They are given here to help the reader judge how effectively the courses met the original brief, and to identify some of the problems which have to be overcome in ventures of this kind.

A PERSONAL INTERPRETATION

David J. Boud

112. In this concluding section I intend to give my own views and interpretations. I cannot always cite objective evidence, but I believe that this statement may help the reader to judge how effectively the courses met the original brief, and to identify some of the problems that remain to be overcome.

113. I think all three courses made an important contribution to the in-service training of the staff who attended them. It is instructive that the Birmingham course, which probably had the most difficulty in meeting its own aims and the aims of the participants, is the one which offers a number of important guidelines as to future courses.

114. Firstly, the aims originally stated of the Birmingham course were not appropriate for all the staff who were recruited to attend it, and by the time that enrolment was complete it was too late for the course organisers to re-plan the programme. This points to two important guidelines for courses of this type:

- the aims of the course should be appropriate to the needs of the actual participants; or alternatively, a careful selection procedure should be adopted so as to exclude participants from groups which do not fit in with the course design

- planning should not be so inflexible that a timetable of activities is complete before the needs and interests of the participants are known.

115. Secondly, the organisation of the course was complicated by a large number of different teachers being involved to varying degrees. This resulted, on occasions, in there being several people running a discussion without prior co-ordination between them, making it difficult for people to participate, and to recognise the main trends. This suggests that:

- a course development team should be established if there are many staff responsible for the course. The team should have a co-ordinator to see that no overlap or confusion takes place, and that all tutors and speakers are adequately briefed on their role within the context of the total course.

If the Surrey course model were adopted this team would also include all the course participants. Thus,

- if the course development team includes the participants, adequate procedures for dealing with group interactions and conflicts must be part of the repertoire of all course tutors.

116. Thirdly, many participants felt that the content and structure of the course was not in line with their needs and interests, and, more importantly, they felt that they did not have sufficient opportunity to work through this issue.

117. One of the visiting tutors said that the course members had much more experience between them than the tutors. If this is true, then it seems reasonable that courses should be run in such a way that maximum use is made of this expertise, and I think that there are strong reasons, both educationally and economically, why this should be done. The course is only a small part of the participants' working experience. Information about new developments can be taught to them, but it is likely that without additional stimulation this information will decay and be lost. I think that the best use of time on these courses was spent when participants were learning how to learn from each other. It is not sufficient for participants to be brought together to hear speakers, and then to discuss the subject. This is an artificial situation seldom found outside courses. It is important that they learn to develop interpersonal skills which they can use in other situations to learn for themselves. This leads to another guideline:

> courses should aim to develop interpersonal skills which can be used by participants to facilitate their own learning, both during the course and after.

118. Finally, the Birmingham course did focus attention on one quite considerable problem of concern to residential care staff. That is the problem of isolation. Many staff working in homes or hostels were immensely grateful for the opportunity that the course gave them to meet other people doing the same job. This seems a difficulty that will increase substantially with the policy of dispersal of residential units. It may become an increasingly important function for in-service courses to provide a venue where people may overcome the isolation of their job, meet with colleagues, and talk over common interests.

119. Considering the three courses together, there seem to be some common threads that emerge: they concern time-span, the range of participants, and emphasis. Tutors and participants alike comment on the long time-span. They would have appreciated the same number of days over a shorter period. They would also like to have seen more block periods, perhaps residentially. This proposal would have to be considered carefully for if one of the aims of a course were to encourage participants to apply what they learn in the work situation, then an intensive course would not necessarily be most appropriate.

120. The range of participants needs to be examined. There was overwhelming support for the idea that senior staff should take part in these courses, and there was substantial support for making the courses more multi-disciplinary. Both these proposals seem valid, and have great implications for the design of future courses. The main issues are twofold: whether senior staff can be integrated into the group without dominating it, and whether the emphasis of the course

should change in that situation. The first is obviously a question to challenge course tutors and make them consider whether their present role would be satisfactory. The second raises a more fundamental issue. It is: what should be prime focus for the course?

121. The three courses each had a different emphasis: Surrey concentrated on interpersonal and organisational problems; Macclesfield emphasised patient care and development, and Birmingham stressed changes in attitudes and skills needed for the move towards hostel accommodation. It would benefit senior staff to be involved in all three types of course.

122. Leaving course membership aside, the problem is: what is the priority area for attention? From my observation of some of the sensitive and difficult areas discussed on the three courses, I believe that the greatest attention needs to be focussed on inter-personal and organisational problems in the work situation. Surrey made a courageous approach to this type of course, using some distinctly novel methods which produced some very positive results. Unfortunately these methods require an expertise which is not at present widespread, and their use by teachers unskilled in this challenging approach could produce difficult situations. So the number of such courses possible at this time is bound to be limited. There is also a largely unmet need for courses aimed at patient care and development, as at Macclesfield, or at attitude changes and new skills, as at Birmingham. There is room for a multiplicity of provision, but in any course, whether of the type described or otherwise, it is crucial to give attention to interpersonal and organisational problems as they appear in the actual work situation.

THE CONCLUSIONS OF THE WORKING PARTY

123. Earlier chapters have made it clear that this is not an unqualified success-story. A need for in-service training was perceived in the field of mental handicap, and the King's Fund financed six varied courses which attempted to meet that need. Participants, organisers, tutors and evaluators have commented frankly on the mistakes and weaknesses of these courses, as well as on their achievements and strengths. Most of the new insights afforded by these six mental handicap courses are not specific to mental handicap, for they illuminate the general question of in-service training in the health service, and its relationship with the general educational system of our country. It is unlikely that the full lessons of the six courses would have been drawn out without the help of two people: David Boud, who used a magnifying glass to examine the precise nature of the six courses, and who reported objectively on what he saw; and David James, who, in a final section, uses a telescope to bring into our vision the landscape of general education. Without these two interpreters, many of the lessons might have been lost, for David Boud has given us detailed guidelines on the future construction of courses, whilst David James has given us a general overview of the way in which the health services might integrate with the education service.

124. The members of the Working Party are under no illusion that by virtue of these few experiments they have suddenly acquired all the knowledge there is to be had on the subject. We have learned a lot from our participants and tutors, but other people have experience too. We would like to pass on to other workers some of the ideas we have gleaned, and in so doing we wholeheartedly endorse the five guidelines identified by David Boud - namely:

- the aims of the course should be appropriate to the needs of the actual participants; or alternatively, a careful selection procedure should be adopted so as to exclude participants from groups which do not fit in with the course design

- planning should not be so inflexible that a timetable of activities is complete before the needs and interests of the participants are known

- a course development team should be established if there are many staff responsible for the course. The team should have a co-ordinator to see that no overlap or confusion takes place, and that all tutors and speakers are adequately briefed on their role within the context of the total course

- if the course development team includes the participants, adequate procedures for dealing with group interactions and conflicts must be part of the repertoire of all course tutors

- courses should aim to develop interpersonal skills which can be used by participants to facilitate their own learning, both during the course and after.

125. It is essential that the aims of the course, the reasons for which it is being held, should be crystal-clear at the outset. Is the need technical, organisational, or attitudinal? With this known, attention can be given to structure and content.

126. In an understaffed service, no-one can easily be spared to 'go on a course': unless there is a feedback when he returns, his absence is regarded as a skive. The service's need to maintain staffing levels cannot be ignored, yet occasional one-day absences are not the best plan, educationally. Preference is for a centre-piece of a number of weekly study-days, bracketted by two 3-day residential blocks. None of the residential study should be in a hospital setting, and only such study days as specifically require a hospital setting.

127. Whilst it is easier to plan standard courses, and to fit participants into these, it is more effective to try to tailor the course to the needs of the actual individuals who participate in the course. If the design of the course is designed entirely by the participants, organisational problems are great, and the apparent lack of structure may demoralise or inhibit those attending. There seems to be a case for blending these two approaches, so that whilst a firm framework of main elements is planned in advance, scope is left for some participant involvement in deciding content and presentation. Unfortunately, the difficulty of obtaining release tends to increase when the employing authority cannot be shown a very specific programme.

128. The more that course members are involved, the more will develop those inter-personal skills which will encourage learning from one another.

129. The more that course members are involved, and the wider the scatter of resource-people, the more a course-development team is necessary. There should always be one tutor who will provide a continuity of referal and will act as a link man between, and interpreter of, invited speakers.

130. The greater the interpersonal involvement, the more skilled the tutors will need to be, with qualities of perception, empathy and sensitivity.

131. The greater the mix of professions, and of different levels of seniority, the better the course, but the greater the problems of course content and intellectual level: yet the response indicates that the effort to engender a course which meets these diverse needs is worthwhile, if only because it stimulates a recognition of the underlying unity of all mental handicap workers. In our opinion, if the only result of such a course were to reduce professional isolation, it would still be worthwhile.

132. Since there is a considerable lack of in-service training opportunities, and since so few qualified and experienced staff are offering courses, there is room for diversification and experiment in the types of course most suited to local need. Mental handicap workers need technical information about mental handicap; they need an understanding of the organisation of mental handicap services; and they need to develop interpersonal attitudes and human relationships which will help them to learn from one another. Technical and organisational learning should constantly be taking place at hospital level, and can often be specific to particular groupings of staff. What cannot so easily be handled inside the hospital is the development of those attitudinal relationships without which technical learning is of little avail. There seem to be two parallel needs:

(a) to train staff to handle courses which concentrate on interpersonal relationships, as exemplified at Surrey;

(b) to meet the urgent need for courses which combine technical and attitudinal training, as exemplified at Birmingham and Macclesfield.

133. We must add that even if the courses we describe do succeed in developing good attitudinal relationships, and in developing technical and organisational learning, little good will transpire unless the education of committee-men and top managers is handled in such a way as to lead them to develop a participative and collaborative climate of management for the whole enterprise. This leads us now to leave the question of training for change, and to consider education for change.

134. In-service training should not be insulated within the health service: it is a part of general education.

135. General education should not be asked simply to supply missing components in a hospital-organised course: nor, for that matter, should the hospital be expected to supply some missing components in a general education course. There needs to be a kind of osmosis, with each affecting the other.

136. General education has some significant advantages for health service education: resources, even the allowance per student, are vastly greater; the college or university offers a neutral base; the paths to general education are opened up to the health worker; understanding of health and social services by outsiders is improved.

137. For why does the health service tackle so many of its education and training problems on its own? Apart from in-service training, statutory training, including that of nurses, would surely derive rich advantage from closer association with the general educational system.

138. Service and professional antagonisms should not be allowed to hinder this interpenetration of services. In particular, health staff must learn to recognise that health service educational needs are extremely unlikely to be met effectively from within the financial and tutorial resources of the NHS. It is better that the education service should perceive more clearly its duty to health service education, and become more aware of the value which association with practical health and social service problems could have for general students.

139. Regional and area health authorities will have immense new responsibilities. All their services are labour-intensive: virtually all their staff need training: there will never be enough fully-trained professionals. Some of their staff will be already trained, but will need occasional refreshment and stimulus; many will never undertake full professional training, but will need good induction, and instruction in specific skills. There are few, if any, unskilled jobs in the delivery of health and social services. This being so, we find ourselves asking whether the health service possesses enough people with the real skills of training and education: teachers who understand how we learn, and how people behave in learning groups: we think not. The first priority is to train an increasing number of good trainers.

140. Equally important, every health service area ought to have an on-going day-to-day training relationship with its neighbouring college of further education. Every region, and most major areas, ought also to have a strategic educational relationship with the university or polytechnic: the aim is not only to produce better practitioners, but to produce individuals who are aware of the social context of their service.

141. It goes further than this: it is not just a question of getting specialised knowledge and developing special attitudes: staff need to be motivated to learn more; to organise their professional work and their personal life so that, to some extent, personal and professional goals do not conflict. They need to enthuse other people.

142. As we enter a new service, more labour-intensive than ever, there is a need for study and experiment in these new education and training dimensions, to answer such questions as:

- What are the underlying in-service training and educational needs of health care services?
- How far can and should general education meet those needs?
- To what extent should previously-specialised health care training now be brought within the ambit of general education?
- What should be the mechanics of collaboration?

143. It seems to us that health care education should draw on the considerable resources of the general educational system as well as on the relevant professional expertise. Greater involvement of the general educational system could bring great benefit to the health care system. Thus the message to any health authority is to start a dialogue with the neighbouring college of further education, and together to discover the extent and nature of service training needs and how they may be met. The adult education system is there, and will even expand, if the Russell Report (3) is implemented; it is waiting to be exploited by the organisation which has possibly the greatest variety and quantity of training needs in Great Britain - the national health service.

THE ROLE OF GENERAL EDUCATIONAL ESTABLISHMENTS IN IN-SERVICE TRAINING AND EDUCATION FOR THE HEALTH AND SOCIAL SERVICES

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Introduction

Traditionally, Government educational reports have concerned themselves largely with the needs and problems of young people. The last two years or so have seen the publication of a number of investigations into the educational needs of adult students. The Briggs Report on Nursing Education (4), the James Report (5) (and subsequent White Paper) (6) on Teacher Education and now the Russell Report (3) on general non-vocational adult education, are important examples. In each case these reports highlight the need for the initial and continuing education of the individual to be integrated and directed towards two broad goals:

(a) through training, to produce more competent and informed practitioners

(b) through education, to produce more socially aware and responsible individuals.

Professional educational needs

Analysis of these reports further suggests that there are five main groups of needs experienced by adult students which seem to me to be particularly relevant to the health and social service professions. These may be broadly summarised under the following headings:

(a) The need to acquire further knowledge and skills in one's own particular specialism

This may involve revising and updating previously learned material or making good the deficiencies resulting from inadequate earlier education.

(b) The need to develop attitudes and approaches appropriate to one's own particular specialism

This is particularly important if the individual changes his role within a group. A nurse promoted to senior management who runs the hospital like a large ward, or the surgeon who when teaching students demands the conformity and blind obedience more appropriate to coping with emergency operations, are obvious examples here.

(c) The need to motivate people to learn and go on learning about their own particular specialism

Motivation is the basis of activity. So often the immediate pressures of the job make discussion and innovation appear of secondary importance,

even though lip-service may be paid to it. The problems here are exacerbated in professions which put great emphasis on 'experience', but which at the same time often seem to find it acceptable to be the amateur in all things non-clinical.

(d) The need to transfer these attitudes and enthusiasms to other parts of the individual's life

This is a difficult concept to identify but it seems to me to be bound up in statements like 'the need to educate the whole person' and 'proffesional education', which emphasise the integration and wholeness of the individual's life both personal and professional.

(e) The need to communicate these attitudes and enthusiasms to other people.

The reports cited above all imply the responsibility of members of professions to learn and teach, by example and in other ways, in spheres far beyond their own specialist contributions to society. If individuals are educated to think clearly, identify priorities, be self critical and constructively critical of others, then they surely have a responsibility to exercise these competences to the benefit of society. There can be few groups in our society with as much to contribute to the well-being of mankind as the health and social service professions. Do they, in fact, make a full and meaningful contribution to the on-going education and development of the human race?

There are, of course, many reasons why the answer to this question must be negative. The professions concerned are overworked to a greater extent than most groups in society. Some, like medicine, choose to recruit small numbers of individuals from potential applicants, either through governmental or professional direction: wastage is relatively low. On the other hand, the nursing profession recruits on a wider basis, and wastage is high. Student nurses find themselves essential members of the work-force, obliged to combine demanding physical work with equally demanding study. They comprise one of the few health care professions educated entirely by the employer: the connection between student nurse and employer is much closer than that between medical student and teaching hospital. But in either case there is the risk of a very specific vocational education, not sufficiently concerned with matters external to its own sphere.

It would of course be foolish to suppose that no other professions are in the same situation. The dangers, however, must be greater in those professional groups whose training and education do not intersect with the main stream of general education.

The involvement of general education

There is a good deal of antagonism in certain sections of the health and social services towards the involvement of general education in their programmes of activity. In large part I think this stems from a quite understandable feeling that the health and social services have to be patient- or client-orientated in a way which quite changes their educational priorities and needs. I think there is a danger, however, in putting too much emphasis on the speedy production of apprentice-type workers who can fulfil a role in a ward or community team at an early stage in their training.

workers who can fulfil a role in a ward or community team at an early stage in their training. Such a training demands conformity and predictability, rote learning and imitation because of the great amount of material which has to be acquired before true understanding is possible. I suspect that this type of training may attract the youngster who does not wish to think for himself, who likes to have decisions made for him and is prepared to conform without question. This is, however, a very broad issue beyond the scope of this paper.

Why involve general education?

There are many reasons why general educational facilities should be used by the health and social services for their in-service education. Firstly, general educational establishments are usually much more completely set up as resource centres than the majority of health and social service institutions. Moreover, they have expertise on many fronts gleaned from fields relevant to, but outside the health and social services - for example, libraries and other resources, specialists in management and education, and facilities for research.

They provide a neutral academically-respectable environment in which different professions from the health and social services can come together. This can make their contribution truly interdisciplinary and avoids the intellectual in-breeding which is characteristic of monotechnic establishments.

The environment that general education can provide is neither patient- nor client-centred. It tends much more towards research and innovation. This enables the course participants to think about the crucial fundamental issues confronting them without the distortions of historical tradition, economic pressure, political expediency, personal prejudice and all the other factors which tend to operate in a work situation.

The use of general education resources will improve public awareness and consequently also public image of the health and social service professions. This will be consolidated if some sort of equivalence is worked out between general education qualifications and those of the health and social services.

These are among the main reasons why general educational establishments should be involved with the health and social services.

How should general education be involved?

For efficient use of available resources some sort of hierarchical structure I think will be necessary. Universities and polytechnics, in line with the recommendations of the Russell Report, should probably concern themselves with researching into fundamental problems related to the pre-service and in-service education of these professional groups. They may also run pilot courses where this is appropriate. The bread-and-butter work of providing opportunities for study locally for members of these professions, however, must be provided through colleges of further education. These establishments are sufficiently widespread and

sufficiently well staffed on the whole to provide convenient, locally informed, easily available centres for further study. Indeed if there is implementation of the Briggs Report's recommendation that colleges of nursing and midwifery education should be established, one would hope that it would be a matter of policy to ensure appropriate links with local colleges of further education.

These links may be of a variety of kinds. They may be very loose informal contact where student-nurses and midwives have opportunities for using college libraries, joining students' unions, etc., and clearly, similar appropriate facilities should be available to qualified staff concerned with in-service education. On the other hand, organised visits, conferences and meetings of a variety of kinds might be provided for the health and social services by the local colleges. More formal short or longer courses in fields like management, educational methodology, research appreciation, etc., as well as in the social sciences and other disciplines supportive to these fields, might also be provided through the colleges.

The thorny question of courses leading to qualifications also needs to be considered. How appropriate for older students are traditional courses like A-level or first degrees? What particular problems have traditionally non-graduate professions in the field of further and higher education in this increasingly degree-conscious society?

In each of the areas outlined above it is essential that a close investigation of need in both content and method should be undertaken before any further developments are widely encouraged. The advantages of such collaboration could be enormous. The main stumbling block to these kinds of development in the past seem to stem from the fact that boundaries established for administrative and economic convenience have become barriers to communication, to the sharing of resources and to mutual awareness of one another's problems.

The way forward

In initial investigations of collaboration of the kind described above it seems to me that one needs to ask the following questions:

(a) Of the staff of the general education establishment:

Have they the intellectual competence to deal with the kinds of problems faced by the health and social services?
Have they experience relevant to the needs of those people?
Do they want to help?

(b) Of the health and social services staff:

Have they the ability to cope with the kinds of courses which would be provided for them?
Have they the appropriate past experience to enable them to make full use of the resources which will become available to them?
Are they motivated to learn from these sources?

In general, I think the answer to all these questions is positive. It is essential, however, that the practical needs of the situation are carefully taken into account.

From the point of view of health and social services staff, the courses and conferences must clearly be relevant and be firmly based on the needs of the group or groups with which they are working. They must demand appropriate rigour of thought. They must be appropriately timed, either on release-from-work basis or at evenings and weekends. Preferably there should be opportunities for obtaining qualifications which will have currency outside the health and social services. These qualifications must take into account professional examinations and experiences already possessed by the candidates. At the same time, the activities must lead to the personal advancement of the individual in some sphere or other.

As far as the educational establishment is concerned, it will clearly benefit from having the expertise and experience from these most relevant professional groups studying the problems of mankind. The ideas and contacts so obtained will help to strengthen the relevance of their other course-teaching at whatever level. Clearly, however, the establishment will need staff and other resources to meet these demands, and my own experience here suggests that the health and social services are generally unaware of the cost of appropriate professional educational facilities.

It seems to me that in the first instance the following practical steps need to be taken:

(a) Appropriate persons from the health and social services and from general education need to be brought together to discuss a relevant brief in relation to future collaboration.

(b) Their first priority should be to identify present and future problems which have been obscured by many traditional and now irrelevant issues.

(c) Advisory groups and pilot projects need to be established as quickly as possible to investigate possible areas of collaboration.

(d) Whatever the outcome of these pilot projects, the information they have gleaned should be widely disseminated before further time and money is spent by other groups duplicating this work in other parts of the country.

Only then shall we see real progress, real collaboration, towards the production of united, informed and articulate health and social service professions.

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The following people gave help at various stages of the project, and were given the opportunity to contribute to, or comment upon, the draft of the ensuing report

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Printed in England by 'Health and Social Service Journal,' 27-29 Furnival Street, London EC4A 1JR