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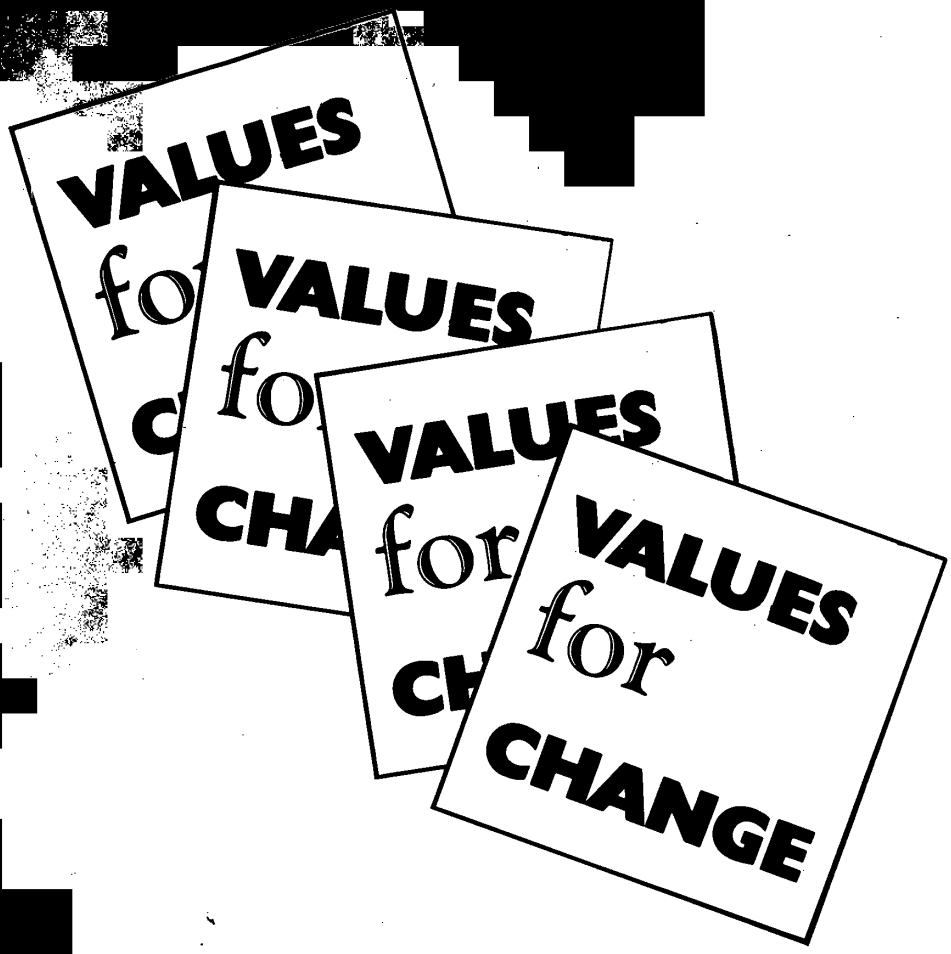

Values for Change

Su Kingsley & Helen Smith

~principles and approaches in designing a local training strategy

KING'S FUND CENTRE FOR HEALTH SERVICES DEVELOPMENT

COMMUNITY LIVING DEVELOPMENT TEAM

The King's Fund Centre for Health Services Development, which dates from 1964, is in purpose-built premises in Camden Town. Its aim is to support innovations in the NHS and related organisations, to learn from them, and to encourage the use of good ideas. The centre also provides conference facilities and a library service for those interested in health care.

The Community Living Development Team has a particular interest in the development of high quality services for people with long-term disabilities, including people with learning difficulties, physical disabilities and people with mental health problems. In common with other groups in the King's Fund Centre, the team's approach to service development is to support innovations in service organisations, to learn from them and to encourage the use of good ideas and practice.

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VALUES FOR CHANGE

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Training and community mental health services

A time of change

We are at a time of change in services for people with mental health problems. Increasingly, hospitals are being run down or closed and new community services are being set up . What effect does all this have on staff? What sort of people are required for the new community services? What sort of training is required to help ensure that the new services help the people who use them?

Training and better services

There is a great deal of interest in the part training has to play in building new, better services. At the King's Fund we get many requests from managers and professional training staff for help in devising local strategies. Through our contacts with staff and people who use services we know that there is much to be done in setting up good, local training schemes.

One of us is involved in helping a health district to develop its training strategy around the closure of a large mental illness hospital and the move to local services in three other districts. We both have an active interest in developing effective local services.

Good practice

As part of this work we carried out a survey of health authorities and social services departments, hoping to identify examples of good training schemes. We did find some good practice and give some information about these schemes. However the overall picture was a gloomy one: trainers on the whole felt under pressure, without sufficient resources and isolated, not knowing about other training schemes.

A framework

This paper gives a framework for thinking about the new sorts of training needed for community services. We start in **chapter 1** by describing what a good community service would look like. We need to know what we are training people for before we decide the types of training they will receive.

In **chapter 2** we look at what people need to learn about if they are to provide effective help to people with mental illness in the community. This means looking further than traditional training schemes. We need to find ways of helping people to change their basic attitudes and beliefs and of making sure that the service organisation supports them in this change.

Chapter 3 sets out an approach to local training. We suggest some important questions to ask and ideas to think about.

In **chapter 4** we describe a possible training strategy which could be adapted to the needs of a local service. The way it is used will vary from district to district and will also change over time, as people gain more experience.

Appendix 1 gives some examples of good practice, found in our survey. We outline the main features of each scheme and tell you who to contact for further information.

We have added a reading list, suggesting books and papers which might help you further in designing your own training strategy.

Training is not a magic answer. We want to stress that training is only one of the activities involved in setting up an effective community service. It is sometimes easy to think of training as some sort of 'magic holy grail'. "If only we could just get our staff to think and work differently, then everything else would fall into place". Our experience and that of others suggests that this is a myth which needs to be dispelled. Training is an important piece of the jig-saw puzzle, but it is still only one piece, and on its own can never be a substitute for effective management which ensures that the right people are involved and supported and the right resources are available at the proper time.

Over to you

We hope this paper will be of value to many people who are trying to devise better training methods. You may be looking at the needs of staff moving from hospital into the community, or you may be looking for ways to improve your community-based service. We think that what we have to say will be of help. It may also be of relevance to people with a wider interest in adult education.

If you are a member of staff or belong to a community or user group, we hope this paper will help you to ask the right questions and make suggestions about how training could be used to improve your local service.

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1 Training For A New Service

Introduction

This chapter looks briefly at new ways of providing mental health services in the community for people with long-term mental health problems and emphasises the links between training and the planning of a service. For a more detailed discussion of planning or service design, we would refer readers to the references in this Chapter. (1)

The implementation of community care will require innovative and radical shifts from established ways of working. Mental health workers will be called upon to deliver a service in very different circumstances to that of the psychiatric hospital and training is essential if staff are to meet this challenge in a competent and creative way. Not only will the nature of the work change; relationships with other disciplines and other agencies will be different too. One of the most striking changes will be in the relationship between staff and people receiving services. The transition then, to community-based mental health services requires new and different skills and the forging of new partnerships to meet the exciting changes that lie ahead.

What are we training for?

To be effective, a training strategy will need to reflect the values and aims of the service and a sense of how it will develop over time. Equally, the desired characteristics of a new service should be reflected in the training that staff receive. If the new service aims to be comprehensive, coherently planned at all levels, and responsive to the changing needs of people who use it, then a training strategy should also be aiming for comprehensiveness, coherency, and responsiveness to the changing work environment and needs of staff.

So how might a new service be structured? We have found the following fundamental principles and values helpful when thinking of service aims and objectives: they are derived from the work on normalisation by Wolfensberger, O'Brien, and others. (2)

Fundamental Principles	Service Principles and Objectives
People with disabilities:	**Services should:**
* have the same human value as everyone else regardless of their degree of disability	* provide appropriate support to every person regardless of their degree of disability or dependence
* have the same right and need to live like others in the community	* be provided in a way that does not exploit family or friends
* have the same varied human needs - physical, social, and emotional as everyone else	* support not supplant social networks of people with disabilities
* have a need and a right to a lifestyle which other citizens would value	* be local
	* be flexible
	* be provided in the least restrictive setting possible for each person

Issues in developing new services

An important task facing planners and managers is to create with staff and service users a shared sense of what a community service will look like. There needs to be agreement on the values and principles underlying the service and on the aims and objectives of the service. It may seem prescriptive to state what we think the principles and aims should be, but we do so to emphasise the desirability of services making their principles and aims explicit - and reaching a consensus with all concerned. In practice the principles outlined above might create a service which aims to:

1 actively promote community integration by ensuring that people live and spend their time in ordinary settings;

2 maintain people's existing abilities and enhance their capacities through a co-ordinated programme of skill learning and other activities;

3 provide relief and stabilization during times of crisis, including respite care if necessary.

These aims could be achieved by providing people with a range of housing options, using ordinary housing stock dispersed within a natural community. Support could be provided by a flexible staff team working with people from the base of their own homes. Rather than using segregated services (such as day hospitals/centres, lunch clubs, etc.), workers would look to

ordinary community resources, (such as adult education classes, leisure centres and employment services) to help people learn new skills and build new lives. [3] Services might nominate a resource manager for each individual user who would ensure that a co-ordinated, individualised package of care is delivered when and where it should be.

Individuals who use or work in the service together with the wider community, need to know about and be involved in developing these plans. This meaningful involvement in planning the service will help carry people through the difficult process of change and help create a "climate of acceptance" for the change .[4] Collaboration between voluntary organisations, user groups and the local and health authorities is crucial in building a shared vision - a vision which is paramount in providing a "marker for our destination" along what is often an uncharted and obscure path. [5]

The process of simultaneously running down one service and building up another will be challenging for all involved. Service providers will have to work with the tension between long term service aims and short term goals; that is, they will have to balance what is desirable in the long-term with what is necessary in the present. Everyone needs to ensure that the information needed to develop and implement the plans passes undistorted through the system; a clear picture of progress must also be communicated. Management need to receive feedback from all levels, but especially from the point where individuals use the service in order to respond appropriately to changing needs and circumstances. [6] So, plans must be flexible, not written in tablets of stone.

Involving users in change

For the new services to offer what is needed and wanted by those who will use them, the views of service users should be sought and acted upon at every stage. This involvement of people who use services has been explored in some places, especially in relation to planning, but apart from a few notable exceptions (e.g. Survivors Speak Out; Nottingham Patients Council Support Group; Glasgow LINK), user groups, or individual users have rarely been involved in staff training. To effectively participate as trainers, users will need training and support - something which has often been viewed as a 'luxury' by hard-pressed trainers. But if staff are to reassess their relationship with users and focus on delivering what they really need, then users must be involved if training is to make any sense at all. There is very little literature on how best to approach this issue, but the work done on user involvement in planning may be of relevance.[7]

Meeting the needs of minority ethnic groups

A particular focus in training should be the delivery of a culturally sensitive service. Staff will need to learn what factors influence mental health work in ethnic communities; for example, the effects of racism on individuals; the higher level of social deprivation experienced by many ethnic groups; the possible conflict between dominant white values and the particular cultural and religious values of a minority ethnic community; the stress of migration; the effects of stricter immigration laws (leading to separated families and reduced chances of marriage within the social sub-group); and so on.

In particular mental health workers need to be aware of how language is embedded in a culture and how this might lead to language being misused and misunderstood by workers and users. The structures of our society are in many ways essentially racist, even though this is often unintentional, and workers need to explore how this can limit their professional competence. Training needs to deal with defensive manoeuvres such as being "overcaring"; saying all people are the same and ignoring differences of race, gender and class; being "over-polite"; or passing individuals on to workers/voluntary organisations of the same race as a matter of course, rather than it being the most appropriate option.

Working with other agencies

New patterns of service delivery will mean new partnerships in the planning, financing and managing of community care projects. Collaboration will help to ensure the most effective deployment of all available resources to provide a range of services matching the varied needs of users. The recent Draft Circular 'Collaboration between the NHS, Local Government and Voluntary Organisations' focuses on the importance of this issue, emphasizing the role of service users and carers and recommending their membership on Joint Care Planning Teams.(8) The "total resource" approach to planning advocated in this circular implies that services be seen in their totality; a comprehensive assessment of an individuals needs would include, for example, housing and education needs as well as health and personal social services.

The implication of these recommendations is that staff at all levels will need to familarise themselves with the structures and ways of working of other organisations; they will need to be encouraged to make links with groups they have not traditionally worked with - such as adult education and housing depts. For minority ethnic groups it might also be important to work with the institutions which maintain the culture and religion of the community, such as temples, mosques, etc.

Working across traditional organisational boundaries will also require more flexible, financial arrangements. This in itself presents a challenge to planners, managers and finance staff who will need to find creative ways of working together to resource new schemes. Other sources of finance to joint funding need to be exploited, including urban programme money, housing associations (for capital finance), voluntary sector grant funding and social security payments. There are already some instances where the management of finance is adapting to more complex situations as, for example, in the development of consortia. (9)

Working in teams

We have briefly discussed how the pattern of service delivery might change in response to the transition to the community; clearly there are also implications for the ways in which staff work together.

Effective community care implies teamwork or a multi-disciplinary/ multi-agency approach. The needs of people using the mental health service are so varied that no one person, profession, or agency can provide all the necessary help and support, and drawing on a wide range of

professional and personal abilities increases the chances of an individual receiving appropriate help and support. The problem with most existing professional training is that focussing on a particular profession can create impermeable boundaries around each discipline, perpetuating the idea that each discipline has knowledge and skills inaccessible to other disciplines. This is not a good basis for developing new services which require inter-professional working and collaboration. Indeed it may lead to increased opportunities for conflict and rivalry, and sometimes also provoke difficulties in working with non-professionals, such as users and volunteers. At worst it can limit the options available to individuals, and restrict their access to other types of help and support.

Working in a team is a skill that needs to be learnt and developed. Staff who have traditionally felt their primary loyalties were to their profession may find it difficult to work effectively in a multi-disciplinary team. Professions who have tended to be in control, such as psychiatrists, may also find it difficult to share their power.

Teamwork will probably best be encouraged by the development of joint training focussing on shared issues. The Audit Commission's report on community care noted the importance of new working practices and recommended that "the concept of a core of community health skills could be developed for all those involved in community-based care, based on shared training". [10] The report proposed initial training for basic grade care workers who would provide general support and act as the main contact for people in the community. This first level of training could then be supplemented with the acquisition of specific skills, enabling workers to become more specialised in particular aspects of community care, or in the needs of specific client groups. These proposals would complement multi-disciplinary working by encouraging the growth of a generalist approach to mental health work, based on meeting individual needs rather than working from particular professional perspectives. This approach may also highlight personal abilities as equally important aspects of doing the job, such as good negotiating skills and keeping calm in a crisis.

Training then, for those who work in new community services, will need to focus more on what is really needed at the point of service delivery, and less on professional distinctions.

2 New Ways of Looking at Training

As noted in Chapter One, effective training must grow from and be founded in the principles and aims of service development. Training will help ensure that the services people use; (i) come as close as possible to the goals jointly agreed by users and providers; and (ii) ensure that these goals are open to continual challenge.

In this way services will continue to move forward. But there are also some key values and principles which need to underpin the way in which training takes place. Previously most training in the caring professions has been based on the acquisition of knowledge developed within specific professional disciplines (e.g. nursing, social work, medicine, psychology, etc.) For many workers training has been concentrated at the beginning of their careers, with rare subsequent opportunities for 'time out' to acquire some particular practice skill.

Many people currently working in psychiatric hospitals will need re-training opportunities - to equip them with new skills to work in community settings and to assist them in successfully negotiating what will be a major life change. This means paying attention to both the skills required and the emotional implications of change.

There is a danger that if training is based too heavily on traditional models of knowledge transmission this will leave learners in a dependent relationship with the trainer/teacher. If not encouraged to take the initiative in learning they may not know how to transfer their knowledge to new and complex situations outside the "classroom". The emotional components associated with change - anxiety, uncertainty, fear - also may not be addressed. This could be prevented if participants themselves took more responsibility for defining what and how they learned; and if training focussed as much on experiential as well as on knowledge - based learning (eg. formal lectures). An example is the particular training initiative associated with the Housing Support Team which helps people make the transition from being homeless to householder status.[11] The courses start by brainstorming the sorts of changes participants anticipate, and continue with building the training programme around the needs that these changes will bring with them.[12]

In other settings, 'learner centred' approaches to training have been used to develop participants' ability to carry over learning to new situations and to learn from experience, so becoming independent of the teacher/trainer. Key features include an orientation which stresses the present and the future, rather than concentrating on what can be analysed from the past; objectives set by the learner; a focus on questioning rather than on knowing the correct answers; and the exploration of feelings and anxieties which may help learners to take risks in new settings.[13] Rather than acquiring knowledge and skills which relate to a specific area of practice, this approach aims to develop people's skills in learning from experience.

Using this framework it is possible to draw up a set of objectives which training for transition to community services should be aiming to achieve. These include:

- identifying the needs of those who will use the services, including those from minority ethnic groups;

- extending opportunities for service users to participate as equal members in developing plans and running training events;
- enabling workers to acquire the specific skills to meet these needs: ways of planning with individuals, ways of helping people to become more independent, record- keeping, resource management, dealing with the public, and so on;
- helping staff and service users to accept and be involved in service changes;
- maintaining morale and ensuring that staff continue to feel valued;
- communicating all relevant policy decisions;
- enabling people to cope better with uncertainty, ambiguity and the fact that there will be no "right answer";
- creating a vision of the new service which provides a purpose and a framework for identifying new skills which will be needed, such as knowledge of welfare benefits, housing regulations, counselling skills, working with people in crisis, and so on;
- helping people to identify and use their own skills and existing resources;
- and to identify, cope with and turn to advantage the constraints to change;
- restructuring and learning from past experience, in particular the effects on the lives of users and workers of past services, enabling people to overcome past experiences and prejudices;
- providing an opportunity for people to explore their own and others' attitudes, values and feelings, and increasing their awareness of the effects of these on their own and others' behaviour;
- clarifying roles within the new services, with an emphasis on team building and enhancing co-operative problem solving;
- creating a plan of action that is connected with the wider service developments. (14)

In designing new services which increase opportunities for growth, development and improved quality of life in the lives of service users, similar opportunities need to be made available to staff. Training is an important vehicle for opening up such opportunities. However, training will only be effective if individuals feel that their effectiveness is improved - when this happens, training is felt to be empowering. For this to happen staff need opportunities to explore feelings, attitudes and personal values, as well as skills and knowledge: in other words training which is empowering has to include personal development, as well as the transmission of knowledge.

Different dimensions of learning

Personal change in working practices or skills is, we believe, dependent upon an individual's knowledge, understanding, basic beliefs, and attitudes. Training will need to take account of all

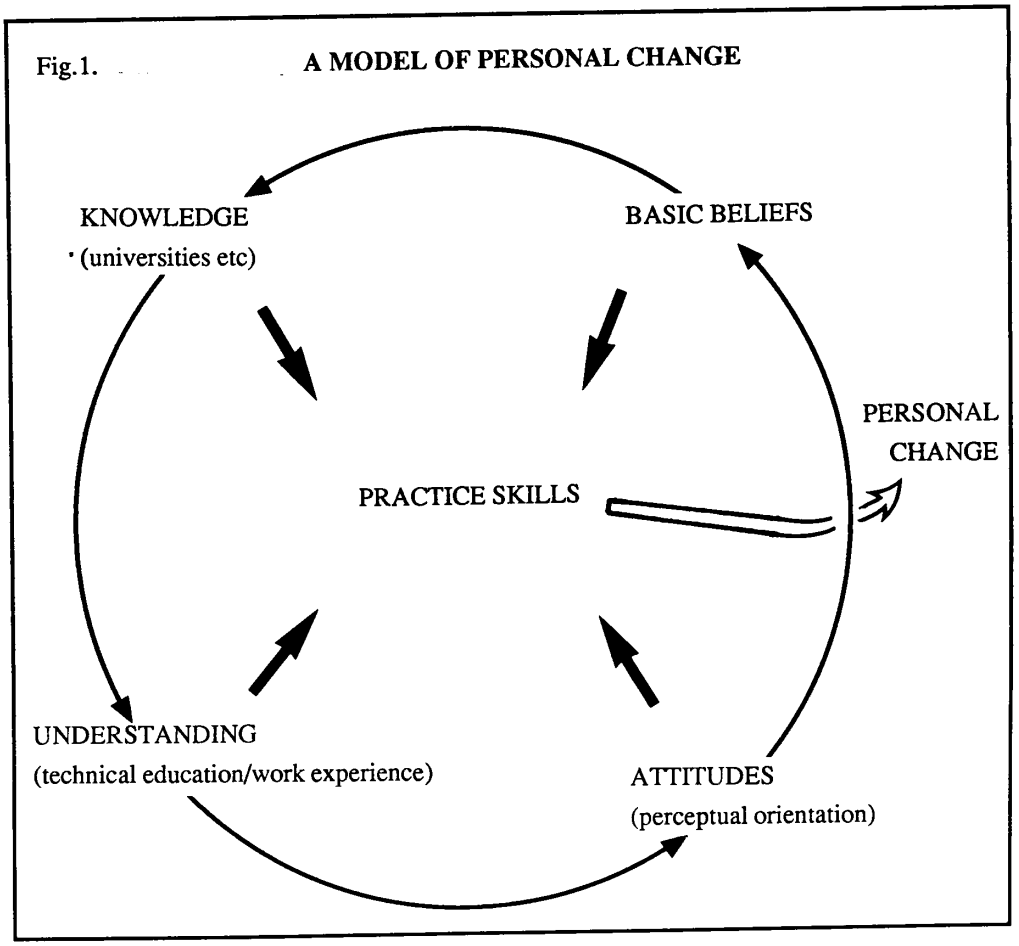
these, providing a balance of activities which allow people to develop an increasingly greater sense of their own competence. The possibility of feeling de-skilled when working in the community leads to lack of confidence, low self-esteem, and the erection of barriers to further learning and development. Hospital rundown or closure and the need to move into the community means that many staff currently working in mental health services are facing this fear. Acquiring competence in new skills (such as working with families in their homes) enhances self-esteem and motivates people to gain further competence.

The model of staff training and development proposed in this paper is based on four key elements in the acquisition and exercise of new skills and changes in working practices:

knowledge, understanding, basic beliefs, attitudes.

Fig. 1 illustrates this model. It is presented as a circular model to emphasise the interaction between the different elements. Each term has a specific meaning here and to help readers, these meanings are elaborated below, together with an explanation of how each aspect relates to the others. We would like to emphasise that this is an interactive model; even though we have separately defined the key elements for ease of explanation, in practice it may be hard to separate them out.

Fig.1. **A MODEL OF PERSONAL CHANGE**



Knowledge concerns the acquisition and mastery of formal information. It may be arrived at by generalising from experience, but is usually learnt formally (books, lectures, observation, etc.). Knowledge is often transmitted in concepts which link with theories about the world and, as such, is not value-free. For example, notions about the cause of schizophrenia differ from the medical model (based on an understanding of an individual having no control over what is perceived as an invasive or inherited disease process), to a dynamic, inter-personal model (based on an understanding that early childhood experiences are of primary importance).

Treatment of schizophrenia will depend upon what is defined as 'knowledge' about the cause; in the examples above, treatment would range from phenothiazine medication to psychoanalysis or family therapy. The choosing of a medical or inter-personal conceptualisation of schizophrenia is influenced by other more general theories an individual might hold; for example, someone who believes in fate and pre-destination is more likely to view schizophrenia as a disease over which they have no control; someone who sees him/herself as an 'active agent' in the world might believe that the resolution of their mental distress lies within their own power. This is a rather crude distinction, but serves to show how knowledge is expressed in concepts which link with many other notions individuals may have about themselves and the world in which they live.

Theories about how knowledge is constituted are rare. However, Terry[15] usefully suggests that there are nine levels. The first is "absolutism", where people believe there is a right and a wrong solution to a problem. Midway is "relativism", where people believe that all different approaches have equal viability or validity. The final level, and the most sophisticated according to Terry, is "relativism with commitment", this is where an individual believes there are different ways of looking at a problem, but chooses an approach which suits them best.

In training staff it is important to uncover their theories of knowledge in order to help them understand the nature of the training; if staff are waiting to be told the "right answer" (i.e. Terry's "absolutism") then they are unlikely to benefit much from training, nor to perform effectively in a service where few right answers are to be found.

Understanding is the application of knowledge - an ability to act appropriately on the basis of knowledge. For instance, solving problems or contributing to discussions using knowledge which has been gained, both involve understanding. Understanding is the difference between just repeating knowledge and using it to extend the range of things one can do. For example, a worker may know what questions to ask when assessing an individual, yet the ability to choose appropriately from a range of treatment/action options depends upon an understanding of why these particular questions are asked and the implications of the answers. Understanding often develops through experience of putting the 'knowledge' into practice.

Basic beliefs (or values) are a moral dimension, informing our attitude to the world; what we accept as right and wrong, and consequently how we act in different situations. Basic beliefs may also make us more receptive to some aspects of knowledge - and more resistant to others.

For example, if we believe that long stay hospital residents retain basic citizenship rights we are more likely to support efforts to rehouse people in the community than if we believe that they have lost their ability to be a contributing member of society.

Some readers may be concerned about our inclusion of basic beliefs in this model. Training methods have been promulgated in the last 20 years which appear to rely heavily on breaking down defences and shattering basic beliefs - for example, EST Training. These methods are akin to - and often experienced by participants as - brainwashing techniques. That is not at all what we are proposing. We do believe however, that it is important to examine and make explicit the basic beliefs of the trainer and the learner, since these will influence people's receptivity to new knowledge. Research has shown that the results of children's I.Q. tests are influenced by what the teacher administering the tests has been told about individual children, especially regarding their social class. In other words, our assumptions and beliefs may limit the success of others - a pertinent lesson for mental health workers who may be unwittingly restricting the lives of service users through their (the worker's) beliefs about users' abilities.

Those concerned with addressing basic beliefs should examine the assumptions and attitudes inherent in existing professional training . This is important if trainers are to be clear about the beliefs underpinning their new training, otherwise those involved in re-training may remain unaware of the basic beliefs originally learnt when they became a mental health worker.

In developing new patterns of services for people traditionally seen as "patients" or passive recipients of care, it is crucial that staff in those services spend time examining their beliefs about service users, and their assumptions about users' needs, capacities, attributes and rights. Workers also need to explore their beliefs about people from different races and cultural backgrounds, this exploration may well reveal lack of knowledge about different lifestyles, and lack of understanding of certain aspects of the culture, such as the significance of religious rituals.

These basic beliefs about people who use services will influence how staff make sense of the move to the community and how they will respond to any training programme.

Attitudes concern emotions - the way we feel about new ideas in relation to our basic beliefs. Learning at this level focusses on adopting new perspectives. For instance, experiencing success in previously difficult activities brings the confidence and pleasure of exercising new found skills. Dealing with deep-seated prejudices (often related to a long experience of misinformation), can also improve our working and personal relationships with other people. For example, discovering that an individual, institutionalised for many years, retains a love of music, may give him/her something in common with a member of staff. The staff member may look to communicate with the person through music and will feel pleasure if successful. This experience may encourage the worker to seek different ways of communicating with other individuals on the ward and may change the worker's perception of the users as mute, severely damaged people, with nothing to contribute to others.

Practice skills constitutes the vehicle for action - the practice of new skills is a demonstration of competence in knowledge and understanding and may also indicate changes in basic beliefs and attitudes. For example, someone successfully facilitating a self-advocacy group demonstrates:

- *knowledge* of the concepts of self-advocacy and an *understanding* of the sensitive role of staff in this process;

- this may also indicate a shift in *basic beliefs*, i.e. that users have the right to exercise self-advocacy;

- any subsequent success of the group will serve to further develop staff's *practical skills* in supporting and encouraging users to take up self-advocacy;

- this will further reinforce a change in *attitudes*, i.e. that this is a good and positive thing to pursue.

For training to be effective, interventions must be planned which address each and every aspect appropriately. Simply teaching people new skills - anxiety management for example - will not be useful if they do not also have knowledge about when using such a technique will be appropriate, and the basic belief that this is a relevant practice to use with the people they work with. On the other hand, giving people knowledge without the means to use it in practice makes learning an academic exercise, which quickly loses all relevance to the real world.

Principles into practice

Appendix 1 describes some examples of good practice in training models which seek to incorporate many of the factors discussed above. At this point, we would like to take an established training exercise and look at how it fits the model we have outlined above. Programme Analysis of Service Systems (PASS) is a training exercise devised to enable people to evaluate services for people with disabilities.[16] It was originally developed for use in services to people with learning difficulties, but is now also being used by people working in mental health and in other services concerned with people with disabilities. We commend PASS as a good way to enable people to understand the impact of services on the lives of people who use them, and as a practical framework for service design. It is a complex tool which demands awareness and sensitivity from those who use it. In order to maintain its high standards PASS training materials are not available 'off the shelf'; PASS is taught through residential workshops, typically stretching over an intensive 5 - 6 day period.

The workshops are designed to familiarize participants with the theory of normalisation and its practical implications as developed by Wolfensberger, O'Brien, and others. [17] By the end of the workshop participants should understand how it can be used and applied in practice, and have had significant practical experience of doing this. They will have been challenged to examine their own underlying beliefs and value systems in the light of normalisation and will have had an opportunity to reconsider their attitudes at the points where they experience significant conflict. We will examine how these different aspects are addressed during a PASS training workshop.

Personal Change Working with PASS can lead to personal change through challenging and confronting beliefs and attitudes. As the workshop progresses, participants are required to interact with service users in a way which almost certainly differs from their normal working role. For a much longer period than is usual in professional contacts, they spend time with users, getting to know them and the way in which they spend their days and their lives. There is no structured brief and participants are encouraged to get to know users as people with likes and dislikes, a past history, aspirations and future plans. In this way the workshop often challenges the legitimacy of the knowledge and understanding gained through professional training. Previously held assumptions about users - about their capabilities, their life experiences, their potential to contribute to society - are questioned through meeting people outside the usual "staff-patient/client" relationship.

Basic Beliefs Participants on a PASS workshop are introduced at an early stage to the clearly stated beliefs and principles that form the value-base for the workshop. Normalisation (and PASS) is based on the essential premise that each individual is of equal human value, regardless of disability. This basic belief generates other fundamental principles and service principles based on human rights and dignity.* The rest of the workshop flows from these principles and participants are constantly reminded of their importance and asked to consider their implications for working practices.

Knowledge The theory of normalisation (that is the basis of PASS) is concerned with notions of what is typically valued by people in our society (eg. a house, job, good health, wealth, etc.). It shows how people with disabilities come to be devalued by losing these assets through their experience of their disability. Sociological theories, and in particular deviancy theory, are used to demonstrate how the 'good intentions' of many human service workers are constrained by attitudes and practices which are widespread in society at large. The workshop looks at how services themselves can become handicaps for people with disabilities. Contact with the service may restrict an individual's access to a valued lifestyle by actually controlling their lifestyle (e.g. through having to live in a long-stay hospital) or through the secondary stigma associated with service contact (eg. difficulties in finding a job because of having a psychiatric record).

Knowledge is transmitted in the workshop through written material (to be read prior to attending the workshop) and lecture sessions involving all participants, with extensive use of audio-visual aids. The workshop is structured so that these sessions for "transmitting knowledge" are interspersed over the five days, building on and contributing to the increased level of understanding that is intended to develop.

Understanding PASS workshops aim to develop an understanding of how services affect people's lives. Participants' understanding is helped by using newly acquired knowledge to undertake a practice evaluation of a simulated service. The effects of reaching agreement on the rating of an aspect of the service helps participants develop an understanding of how the beliefs, values, and theories may be put into practice. A major part of the workshop is a site visit to a real service where participants get to know the people using that service. This exercise serves to increase understanding about the impact of the service on people's lives, and helps participants focus more strongly on users.

Attitudes may be reinforced or changed by PASS. The training challenges workers' attitudes, not just towards the particular group of people they normally work with, but towards all disadvantaged groups, such as unemployed people, or those from different ethnic backgrounds. The small teams in which participants work provide a safe, intimate environment for people to explore what may be deeply held views about people who receive services. Attitudes are challenged in this setting through increased understanding and discussion and debate with other participants and the group facilitator.

Practice Skills PASS workshops do not directly address working practices. The aim of the workshops is to help people examine their beliefs and values, rather than teach them new skills. However, participants may well review the relevance of their existing work skills; in this way PASS helps individuals identify what sort of skills they need to learn, to work in a community service.

** These principles are similar to those defined in Chapter One.*

3 A Strategy for Training

If community psychiatric services are to provide significantly improved opportunities in the lives of service users, then staff will require considerable training input. Training programmes will have to address a range of different needs amongst different staff (in terms of both professional background and seniority in the organisation). Programmes will also need to support inter-agency working much more explicitly than "unidisciplinary" professional training is currently able to do. Training will need to be carried out at regular intervals throughout a worker's career: it will not be sufficient to create an initial 'blitz' and then assume that the job is complete, or will somehow continue without further input. Training should rather, provide continuing developmental support and so play an important role in the continuing evolution of the service, as experience provides lessons and examples from which to learn.

The multi-dimensional and long-term nature of such training suggests that to be effective, a strategic approach will be required. In this Chapter we seek to define the characteristics of a 'strategic' approach to planning and problem solving, and to see how this relates to developing effective training programmes to support staff during and after the move to community based services.

What is 'strategy'?

'Strategy' is a much used - and misused - word, taking on many different meanings. The idea of strategy which we have found helpful is that of "an activity which combines a number of areas of work in a way which multiplies their individual effectiveness and gives clear direction." This activity needs to be based on clearly stated values which are reflected in the goals of the organisation. For example, a successful strategy to resettle people from a psychiatric hospital into the community will co-ordinate a range of voluntary, statutory and ordinary community services (housing, support in crisis, leisure, welfare benefit, etc) to offer a comprehensive service to individual users. It will only be successful if there is a clear, agreed-upon definition of what constitutes a good service and what is a desirable outcome. In this way a strategy helps an organisation, group or individual to achieve and improve their intentions (whether service, product, or profit).[18]

This definition demonstrates how 'strategy' must be explicitly related to the organisation's goals and values which are usually expressed through various policy statements. So, the organisational policy should provide the foundation for a training strategy;and the strategy for training should represent the organisation's plans for making its policies effective. The bestseller "In Search of Excellence" discusses the question of strategy in relation to successful private sector companies whose strategies and structures were driven by changing pressures in the market place.[19] The equivalent driving force in health service training should ideally be the organisational policy which reflects the needs and requirements of people who use services. In practice it can sometimes be based on organisational needs only, turning training strategies into instruments of management; that is, training improves the way the organisation runs and not the service offered to users.[20] In an 'ideal' training strategy there are likely to be at least two main streams of activity: one directed towards communicating the organisation's goals, policies and values and

encouraging a wider 'ownership' and understanding of them; and a second stream of training focussed on developing the practical capacities of staff in the organisation to achieve those goals. Management must ensure that training takes place, and that it is valued, supported, and adequately resourced. It is important to emphasize this last point: too often training appears to be seen as a substitute for managerial action, expected in itself to resolve problems within an organisation.(21) The reverse should be what happens; for training to be effective, management must keep pace with the organisational changes which training programmes are addressing. There is no in point training staff to work in community settings if the other aspects of building up a community service (securing finance, accommodation etc) are not also being pursued.

Developing a strategy

Key questions which need to be answered when devising a training strategy include:

- what is the purpose of training?
- how can training assist the fulfillment of the organisation's objectives?
- what kinds of training already exist?
- who is responsible for training?
- in what ways should training be delivered?

A strategy for training will need to be explicit about:

- why training is being undertaken;
- what resources it will require;
- the intended scope of the training programme - whether it will include different agencies, different professions, different grades, different service delivery settings, different individual needs;
- who is responsible for initiating the strategy and continuing to ensure support for training;
- who is trained and when;
- and how a favourable context for training will be created - especially in relation to service development plans.

This last point is particularly important. Training has often concentrated on improving individual skills with little reference to how or when these new skills can be practised:

"...training is usually too narrowly defined as improving the skills or attitudes of individuals, there is no guarantee that their performance in the work setting will change: this may be due much more to lack of resources, lack of help or lack of encouragement than to individual skills or attitudes. A restricted focus on individual change also often reflects and reinforces an artificial separation of planning and management from the reality of work as experienced by front-line staff, so that staff and their trainers are blamed for failing to meet unrealistic or improper expectations generated elsewhere.(22) "

The training strategy for the Wells Road service for people with learning difficulties (mental handicap) focussed on six conditions for creating a healthy context for training:

- The integration of training activities into the planning process and day-to-day management activities.
- The investment of real resources - a commitment to providing space and time in which learning can take place.
- The identification of where staff are starting from in their learning - 'Individual Programme Plans for Staff'.
- The key role of line managers, and equipping them with the appropriate skills as trainers within their own staff groups.
- Ensuring that the appropriate personnel and management support activities are taking place to underpin the training initiatives.
- Ensuring the appropriate inputs for the timescales of the programme, as they relate to different groups of staff.(23)

A value base for training

Our model of adult learning (see Chapter 2) suggests that we need to pay equal attention to identifying value systems and attitudes, and to inculcating knowledge and developing competence. The values which inform service plans and contribute to the goals of a service should be applied to every aspect of training. So, if service development is to be based on the principle of normalisation, an important value and goal for the service will be respect for each user as an individual. In the same way, training for staff must treat them with respect and value their individuality. If this does not happen then it is extremely unlikely that staff who have themselves felt devalued and discounted will be able to provide the respect and attention which the service is trying to achieve for its users.

Some key aspects of a training strategy for transition

1. Taking multiple interests into account

The development of community-based mental health services will depend upon the involvement of a wide range of service-providing agencies in the voluntary sector as well as on health and

local authorities, it will also require the services of staff from a broad span of different professional backgrounds and seniority. A training strategy will need to identify:

- all agencies - voluntary and statutory - likely to be contributing to the service in the future.

- the range of professionally trained people whose skills and expertise will be relevant training resources. For example, hospital-based staff will need help in developing community work skills; 'field' staff may need help in working with people in local residential settings; and so on. Staff from these areas of work could assist in training others from different settings.

- the different needs of different grades of staff. Unskilled and junior staff will need training to move into the community. Senior professional staff and managers will need training in new ways to support and manage the staff for whom they are responsible.

- the support which staff require to cope with the changes. The early stages of change may be easier for care staff if they are involved in planning the new services. The more complex forms of joint management and control of services which may evolve later will require managers to develop new ways of working with other staff and other agencies. Again, being involved in the planning process may help alleviate anxiety.

2. Meeting multiple individual needs

How can the individual needs of staff best be taken into account and individual training programmes be developed from a limited range of available resources? One solution would be to design an appropriate package for individual users using the range of available resources similar to the IPP System for service users - in other words, to adapt the concept of individual planning to meet staff training needs.[24] An individual plan will need to include an assessment of the individual's current strengths, areas in which they hoped to develop new skills and aspects of their performance for which they need support in order to improve: all this of course should be jointly worked out with the individual. The next section of the plan would identify how the individual could be helped through training, either within the organisation or using external resources; and would, finally, include a phased plan designed to achieve some specific objectives over a specified time period. Both the individual staff member and their line manager would need to agree the plan which could form an important aspect of a regular appraisal process.

In this way staff could be provided with opportunities to identify their interests - areas in which they want to develop - and also areas in which their competence needs to be enhanced if they are to participate fully in the new service. These individual training needs could then be met through a modular training programme, which might include some elements for all staff, some elements for selected or project-based staff, and some individual elements met through participation in further education or the use of 'distance learning' materials eg. Open University packages/course.

3. Using multiple locations

Training should not take place through a single course provided in a uniform way. The great majority of training officers who replied to our survey (described in the Introduction) stated that their major training resource was the provision of in-house programmes, but there was generally little use of other local and national resources. We envisage that a training strategy would consider using local and regional resources available through further education colleges, universities, and other training agencies. It would also include considerable elements of internal training: some of this would be in the form of "bought-in" courses run by outsiders; some would be seminars and specific skill-related courses provided locally; and some would relate to staff teams or individuals, working alongside other teams in their work settings to provide actual "on-the-job" training.

In addition to these activities we would expect people periodically to be sent on national workshops and seminars and for there to be supported access to individual learning packages, whether through the Open University, Open Tech, National Extension College or other bodies. Finally a local resource of literature, self-instructional material and videos would provide a valuable support to individual learning.

4. Ensuring continuity and responsibility

We have discussed how training needs to be related equally to the development needs of staff and the services they are working in, but neither of these areas stand still. Consequently training must be sustained over time, continuously identifying and meeting new needs which arise in response to new ideas and demands. In this way training can help the service remain alive and vivid rather than becoming ossified and stale. Maintaining and improving the quality of the service is closely related to training. So, part of a quality assurance strategy for new services should be the creation of a system of in-service training, which links continued service development with continuous staff development.

Training is as much a responsibility of the service managers as it is of the training department, and the two must work together to address the organisation's needs.

5. Resources for training

The training strategy that we have outlined is complex, requiring simultaneous consideration of the needs of different aspects of the service and different staff over an extended period of time. Training as a major element in service development will inevitably require resources, and any strategy must include careful consideration of the resource implications. Clearly training has direct financial costs, whether internal, external, or individual learning is involved.

Trainers need to be planners and managers of training programmes, as well as delivering direct training (for an example of how this might work in practice see SETRHA's 'Bringing People Back Home' programme).[25] The training programme will also need to indicate where training is to be delivered directly, and whether initial training will then enable the recipients to train other staff. A variety of local, regional and national "training providers" will need to be identified.

In order to make the best use of these various opportunities, training packages to meet individual staff needs will have to be carefully designed and supported through sensitive staff appraisal. Finally, for staff to benefit fully from 'off-the-job' training, adequate cover arrangements will be necessary to release them from their day-to-day responsibilities.

Checklist for a Training Strategy

- Will there be a conscious process of identifying the demands which new patterns of service delivery will place on staff?
- Will training reflect the same values and goals as those which underpin the service development strategy?
- Will ways of involving service users in training programmes be identified and utilised?
- Will the training strategy address the need to create a cultural shift within the organisation in order to reflect new values and goals?
- Will appropriate training programmes be planned for all grades of staff throughout the organisation?
- Will training specifically address how staff can deliver a culturally and ethnically sensitive service?
- Will training be geared to identifying and meeting individual staff needs through individual programmes built up from a range of resources?
- Will training plans provide for a continuing process of staff development and service evaluation?
- Will training be shared with other relevant agencies such as:
  - health authorities
  - local authority social services
  - housing associations
  - voluntary groups, in particular MIND, National Schizophrenia Fellowship, Richmond Fellowship, Mental After-Care Association (and many more local groups)
  - adult education service
  - black and ethnic minority voluntary groups/community leader

- Will training be an integral part of a strategy for managing change within the mental health service?
- Will the resource requirements for training be identified, and will there be ways of meeting these needs?
- Will the training strategy make use of a range of resources and locations both inside and outside the organisation?

4 Proposals for a Model District Training Strategy

Addressing the issues we have outlined above will demand a comprehensive initiative, which involves a broad range of interests, and which is innovative and experimental in the type of training which is made available. We believe that, above all, such an initiative needs to be developed with the participation of a wide range of people who are involved in and affected by the changes in services. The initiative should also be able to experiment with new approaches and to learn from these attempts. There are many ways in which training strategies which meet these criteria could be developed. However, we have created a model which we think is helpful and which suggests one way of planning a district strategy, based on the ideas discussed above.

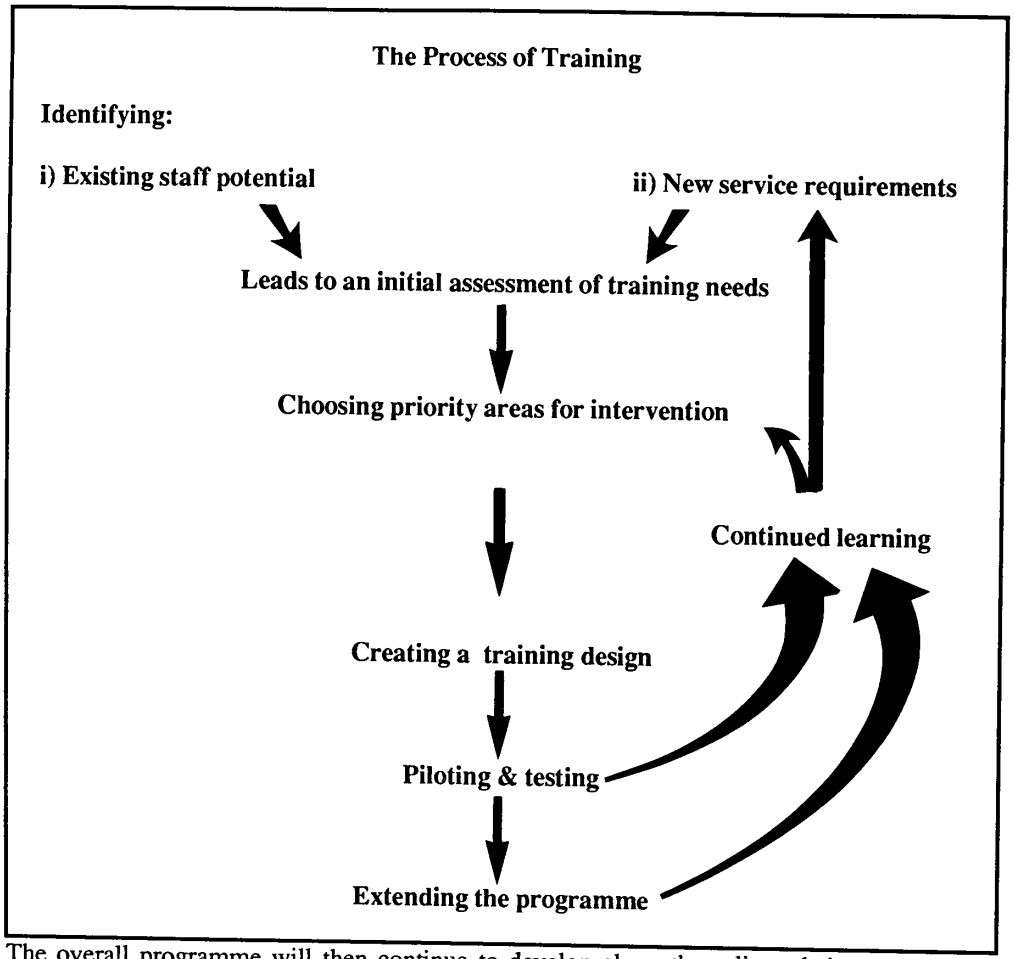
The model has several stages and starts with an assessment of:

i) new service requirements; and

ii) existing staff potential.

It is important to recognise that neither training needs, staff's abilities, or their expectations of what the service will provide are 'static' pieces of information. Rather they are likely to be in a state of flux, and will require checking and rechecking regularly in order to ensure that training is continually on course and is re-oriented to changing needs.

Having made some preliminary assessment of training requirements, the training strategy will need to determine where interventions are going to be targeted in order to have maximum impact. It is unlikely that all training needs can be met at once, and consequently the strategy will have to set priorities. Training needs should be prioritised to ensure that the most urgent requirements are addressed first, allowing staff to tackle other areas in order of significance. Piloting and testing are a further necessary stage in the process. This enables the design to be tested before extending it district-wide. Modifications and alterations should be made at this stage, possibly leading to a reassessment of service requirements, or another look at the training design. The stages of this model are represented in Fig. 2 which shows diagramatically the process of devising a training strategy. At the same time, of course, staff will be going through these experimental training programmes and should already be deriving benefit from them.



The overall programme will then continue to develop along these lines, being extended to different groups of staff, and to new projects. All the time, however, the programme should be responsive to feedback from participants, both during training and subsequently as they become better able to assess the relevance of training in their new work roles and workplaces.

Implementation of the training programme

We do not think it appropriate for a single individual or agency to take on the whole task of devising a training strategy. Training and future service developments will need to involve a range of interests. To assist this we suggest that the strategy is developed and implemented by multi-disciplinary and multi-agency groups, working together within a co-ordinated framework, and developing a shared ownership of the strategy.

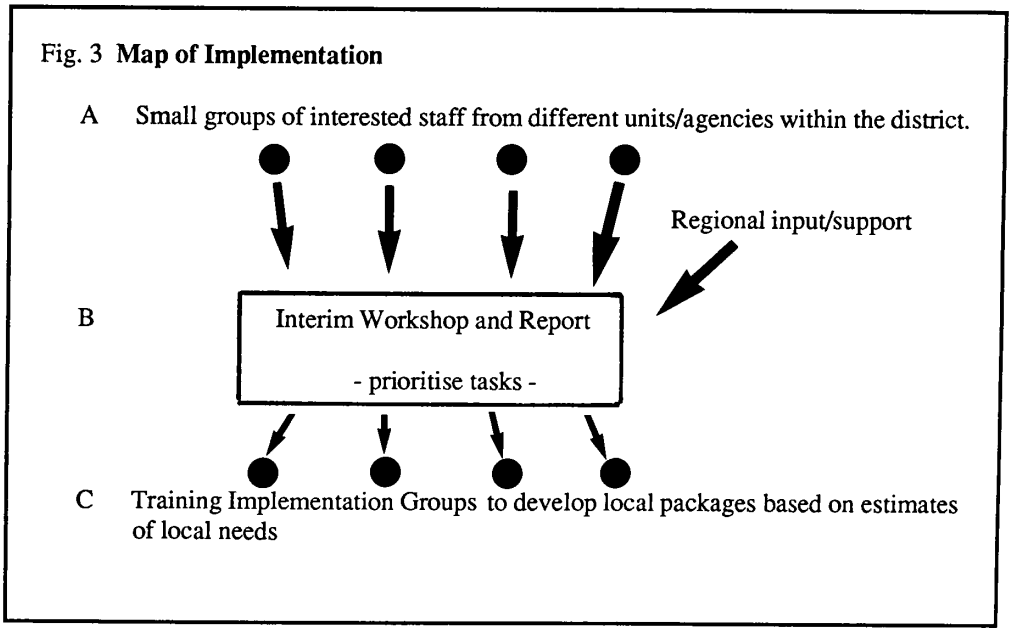
This will inevitably require energetic and sophisticated leadership, but we do not think that at this point it is important which agency provides such leadership. What matters is that whoever leads the process has the capacity to communicate a vision of the future, and is able to generate commitment to joint working, and joint problem-solving, from the different parties involved. We have devised a map (Fig. 3) which illustrates the implementation stages of the programme.

Stage One - training assessment groups

The first stage (A on Fig.3) is to establish small groups to work on identifying training needs. These groups are likely to include interested staff from all the appropriate units/workplaces in both health and social service agencies within a district, as well as professional and lay members of local voluntary organisations. There is also a strong case for including users, unpaid carers and other members of the community in these groups, including members of ethnic communities. Their tasks would include determining the skills needed in the new service, assessing the existing staff potential (retraining needs) and identifying alternative sources of staff (new training needs).

We suggest that the groups have three key tasks in this initial phase. Firstly, to assess the abilities and potential of the present staff group; that is, their skills, interests, latent skills and preferences. The groups should also be finding out how workers perceive their own development needs, and linking them to the district plans for the new service. Secondly, to look at what the new service will require in the way of training. We discussed in Chapter 1 the importance of using service development plans to identify the new skills that will be needed during the transition to community-based services and this will be a key function of the multi-disciplinary groups in this first phase. Thirdly, alternative and additional sources of skills should be explored. Individuals (existing staff and new staff) bring with them particular skills (such as knowledge of welfare rights) which are useful in the new service.

Fig. 3 **Map of Implementation**



In some districts it may be simplest to set up three 'task forces', each taking on one of the above functions; in other districts it may be better to have four or five groups, considering all the functions, but each covering a specific geographical area. There are likely to be a number of different ways of arranging this, and we do not think that at this stage one method can be identified as the 'best'. The most important thing is to ensure that whatever way is chosen,is that which best fits the local situation, both structurally and politically.

In summary, during the initial phase multi-disciplinary and multi-agency groups will be required to:

i) identify the underlying philosophy and tasks of the new service to be provided;

ii) define the skills and staff required to make this service a viable proposition; and

iii) explore available options for finding and training staff, including re-motivating existing staff and identifying potential new pools of personnel.

Setting up these groups may initially have to be done by one or two enthusiasts who can motivate others to join in drawing up a district wide strategy.

Stage Two - workshop and interim report

As the groups make progress on these tasks, the next stage (B on Fig.3) will consist of a joint workshop for all local 'stakeholders' in present and future services. The workshop will provide an opportunity to broaden participation and to strengthen local involvement. It will provide an early opportunity for those unable to commit time to the initial working groups to contribute to the design and development of the training strategy. The participants at the workshop should include representatives from voluntary organisations, ethnic communities and user groups. The workshop must be comprehensive both in content and range of people attending, otherwise the priorities that emerge may be skewed and unhelpful.

The workshop would aim to:

i) provide feedback to each of the small groups on the appropriateness and usefulness of their proposals, especially in the light of work done by the other groups;

ii) negotiate overall training aims and objectives for the district to pursue;

iii) decide upon training priorities; and

iv) prepare for further training activities by establishing the value of a strategic approach and reaching a concensus of approval and understanding of the proposed training programme.

Regional support may need to be sought at this stage and the use of regional resources discussed. A report stating the findings of the small groups and the agreed priorities would be useful to circulate to those unable to attend, and for future reference.

Stage Three - training implementation groups

Following on from the workshop we propose the creation of a new set of working groups. (C on Fig.3). These groups could be based on the previous small groups, but need not necessarily be. If not done already, membership should be extended beyond staff to include service users, representatives of voluntary organisations and other appropriate people in line with the priorities

set by the workshop. At this stage they are more likely to look like a task force network, and could be regarded as 'training implementation groups'. Their task would be to devise local ways to meet training needs based on:

(i) estimates of local need as assessed by the small groups; and

(ii) the overall direction and priorities decided in the workshop and mandated at Regional level.

Training implementation groups could take as their initial focus some new service development such as a specific project. Their task would be to identify and assess the training needs for staff coming to work in the project, both in terms of the skills needed in order to deliver the service effectively and the individual development needs of individual staff, (this latter task may not always be possible if staff are new and not coming from other parts of the service). They will need to design ways of meeting these needs and we imagine that this will require a variety of different interventions.

Some training will be needed which brings the whole project staff together (for example, a session to determine philosophies and modes of working together as a community mental health team); individual staff members may need to participate in district - wide training (normalisation workshops, for example); there may also be a case for seconding some staff on to existing training programmes offered by educational agencies (a community work course at a local college, or support on one of the Open University community care programmes are examples of relevant options); finally it may also be deemed necessary to improve the general professional competence of staff, through RMN/CPN nurse training, or ASW(social work) courses.Examples of training needs and possible service responses are shown in Fig. 4.

Stage Four - training network

The training implementation groups could form a district network both providing mutual support and anticipating future training requirements. Regular meetings of members of the network could be an exciting and creative forum for maintaining awareness of changing training needs, and stimulating new ways of meeting those needs. In this way an element of continual development would be provided for the service as a whole, offering a forum in which problems could be aired, and new ideas proposed.

Fig. 4

Examples of training needs and responses in a new service

Staff will need to develop new:	* relationships with colleagues * and with service users * attitudes and expectations * skills * knowledge about service users * and service models	
Managers will need to develop new:	* expectations of staff * planning & implementing skills * performance measures * leadership skills * development roles	
Some training needs:	* knowledge and information about new services * community/neighbourhood work skills * supporting learning from experience * team development * ability-focussed assessment * goal setting	
Some possible responses:	**Project Level:**	induction courses, teamwork support
	District Level:	values workshop, skill development
	Regionwide:	secondments to education programmes , management development

Appendix One: Some Examples Of Training In Action

In this section we return to the survey referred to in the Introduction and present some training stategies which seem to us to be examples of good practice.

Wigan Health Authority has created a training programme based on a multi-disciplinary approach. They are using line managers as trainers, which enables training to be closely related to the work - place and provides for individual development in conjunction with the staff appraisal system. There are three key principles underlying the training programme:

- it should focus on individual staff needs and individual development;
- skills to be learnt should clearly reflect client needs;
- training should stimulate staff to continue developing their skills, and enable staff to pass these on to other staff.

The programme spans the whole staff group, and includes: initial induction training; basic occupational training; training for individual performance appraisal; the development of training skills in staff; supervisor development; and management training. The content of training is clearly related to the need for new skills and increased awareness of what is required by the move to community-based services. It includes elements provided 'in-house' together with bought-in training.

South Lincolnshire Health Authority established a multi-disciplinary staff training group in 1985, focussing on the problems created by organisational change and the decentralisation of services. The aims of the group were: to help staff understand and cope with changes in both NHS management and in mental health provision; and to provide a means of minimising speculation and anxiety concerning the future of the mental service health service.

The group has organised an initial one day workshop, bringing together key staff in middle and first line management from health, social services, voluntary agencies, housing, the probation service and the police. This workshop was devised and run by external consultants, but similar events have since been organised by district staff. These local events are preceded by a questionnaire sent to participants which asks for their expectations of, and views on, prospective changes in the service. It also asks staff to speculate on the opportunities this could provide for them, together with their own assessment of their current training needs in order to make the most of these opportunities. The workshops are also being supported by training in managerial, technical, and job-related skills. In addition the group produces a regular news-sheet, giving details of training activity and resources.

Torbay Health Authority and **South Devon Social Services** have developed a joint strategy providing inter-disciplinary education for both professionals and volunteers involved with mental health services. The first two years of the strategy's in-service training programme included re-orientation courses for staff moving from hospital to community services;

development courses to improve existing standards of practice; specialisation skills for experienced practitioners, with an emphasis on the practical application of skills,(rather than just acquisition); workshops on topics of general interest in mental health; and special interest groups, providing an opportunity for small groups to develop particular aspects of their work and be supported in trying out new ideas. Volunteer counsellors and befrienders are trained to work alongside or independently of the statutory services. The present focus is on providing a psychotherapy course and more specialist education.

In addition **Torbay** has an innovative approach to basic RMN training, founded in adult education principles where learners take a major part in determining their learning needs. The key to this is the attachment of learners to existing staff (especially trained for the role) who act as 'mentors'. This enables much greater flexibility about placements and the pacing of learning, and provides a structure for individual support. The intention is that the approach will produce staff who are much better fitted for new roles in the developing community services.

Kirklees Partnership in Community Care is a collaborative group consisting of **Huddersfield** and **Dewsbury Health Authorities, Kirklees Metropolitan Council Social Services Department** and various voluntary organisations. One element of their work is represented by the Project Working Group on Training and Staff Development, which has set up a multi-disciplinary course to facilitate the development of community based mental health services. The course aims to enable participants to develop effective teamwork within inter-disciplinary teams. The focus is on developing 'helping skills', based on the belief that whatever roles people play in community services (seeking or giving help, or supervising) personal relationships are the key to success. Participants are encouraged to set their own goals for learning, and to evaluate whether they are being helped to achieve these as the course progresses. Themes covered include:

- exploring values and attitudes;
- problem-solving and decision-making;
- prioritising and consensus decision-making;
- conflicts of interest;
- role scanning;
- the progress of community care;
- reflection, evaluation and planning for the future.

South East Thames RHA in conjunction with the **University of Kent** has built up a Regional team of trainers, practitioners and researchers who are working with health and local authorities in the Region to support the transition from large institutions to local services. As well as working with individual authorities to develop local training packages the team has built up a number of special Regional initiatives, which address specific training needs, and which are pioneering and testing new ways to support service development. These courses and workshops are open to people working in health, social services departments, education services and voluntary agencies. They are intentionally multi-disciplinary, and stress the links between training and

service development through project work and supervised local training initiatives. Much of the work of the Regional team is designed to 'train trainers', strengthening local competence to deal with staff development issues rather than taking over that function.

Most of this work has focused on services for people with learning difficulties (for a full account, see ref 25), but they are now expanding into mental health services. The training strategy used in both areas combines organisational development with training targeted at individuals. In learning difficulties, the main areas of work include:

Defining exemplary service models

A special course "Developing Staffed Housing for People with Mental Handicaps" (1983-5) was able to draw on the available knowledge and experience of staffed housing services for people with severe and profound learning difficulties. More recently, a major initiative has involved the setting up of a Special Development Team to help local services develop a good quality of life for people with learning difficulties and challenging behaviour, by giving extra help through experienced staff with the time, knowledge and resources to provide practical help.

'Training the Trainers'

A framework entitled 'Joint Assessment of Local Training Need' has been set up to review local training needs across agencies and disciplines to produce local training strategies. A Trainers Development Programme is run each year to equip local staff with the skills to implement local training strategies. Six training packages for front-line staff have been produced to meet the need for materials which are effective and reflect the 'state of the art'. Special workshops have also been run on the organisation of community teams, sexuality policies and guidelines, and using Open University resources.

Individual training and development

A two-year part-time MA programme has been set up at the University of Kent designed specifically for people who will lead the development of community care. In addition, two proposals have been developed for shared qualifying training of nurses and social services staff and one of these has now received approval from the validating bodies. A post-qualification training for staff working with people who present special challenges or difficult behaviour, which will integrate course work and supervised practice to achieve "hands-on" competence, started in January 1989.

Quality assurance

200 staff have been trained in Programme Analysis of Service Systems (PASS), an evaluation tool focusing on the principle of normalisation (see Chapter 2). A training package in quality assurance has been drafted and some parts have been piloted prior to Region-wide introduction.

Evaluation and Research

Some evaluation of each of the training initiatives is an integral part of the work (for example, follow-up surveys on the impact of the staffed housing course have been carried out). Two larger projects are currently under way, one focussing on staff turnover in different types of mental

handicap service and the other on the quality of life of people living in services. These projects have been set up with the Special Development Team, using observational measures of individual activity before and after transfer.

Mid-Essex Health Authority have appointed an 'Employee Development Advisor', whose role will be to clarify the implications for staff of service planning proposals. General managers in the authority will be encouraged to give staff training a much higher priority than it has hitherto been accorded. In 1986 a strategy for change was developed from two workshops involving senior managers and medical consultants. It identified themes for organisational change to "make General Management work", including:

- the development of a corporate image and better public relationships;
- the need to be more user oriented;
- the development of a clearer understanding of the relationship between user needs and demands and the resources available to the Authority;
- improvements to quality of service;
- the encouragement of greater innovation in service delivery accompanied by optimum delegation of decision making;
- the need to build on organisational strengths against fairly pervasive gloom nationally about the N.H.S;
- improvements in internal communications and the development of better internal mechanisms for the resolution of conflict.

To implement the strategy for change successfully it was vital not only to equip managers for what were in many cases new roles, but also to ensure their commitment to, and knowledge about, the associated necessary organisational changes; it was important to provide clear linkages between planned organisational and managerial development.

Eighty-two per cent of senior and middle managers attended one of six "Core Workshops". The District General Manager, introducing each workshop, emphasised his commitment to management development and his expectations of managers. The rationale for personal effectiveness was that anyone who wants to improve the way they manage others must first learn to manage themselves.

Workshop outcomes were articulated in terms of personal and organisational action planning. The former process (personal planning) enabled individuals, on the basis of a diagnosis of personal development needs undertaken both individually and with their peers during the workshop, to opt into further workshops. The latter (organisational planning) involved the feedback of views on the nature and pressures of managerial roles as part of the continual evolution and implementation of the strategy of change. The latter data together with subsequent evaluation letters from participants enabled the Management Board to assess the degree to which the workshop's aims were met and to set further organisational change goals.

Six months later participants attended a half-day activity at which individual action plans were reviewed and further blocks to individual and organisational development identified.

The 3-day core workshop programme and the subsequent half-day follow-up cost approximately £10,000 plus about 25 days of senior management time. Administrative support was provided from within the organisation.

Kent County Council Social Services Department is establishing fifteen Community Mental Health Teams. They are working with consultants from **Birmingham** and **London Universities** to develop appropriate training programmes for these teams, which will include induction team workshops to establish a common philosophy, policy, and objectives and further training in management, practice and evaluation skills. Health service personnel and staff of voluntary agencies will also participate, and in addition the training programme will include public education sessions. The objective was to integrate planning and training from the beginning in a combined programme. A four day induction course was held which took as its theme the development of a comprehensive mental health service. Staff were then requested to begin thinking about the preparation of their area plans and the components of the service they wished to develop. (A survey had been carried out prior to the beginning of the training which had established the current baseline of existing services, so everyone knew the point from which they were starting.) The teams were issued with a common format for the preparation of their plans.

A block week of training then followed when staff brought back their embryo plans for consultation. They had to produce immediate, medium and long-term objectives within a specified framework. Running concurrently with this planning exercise was the training element designed to equip the new mental health managers with background knowledge and skills relevant to their management and development role.

After a further two months planning in the workplace, final plans were submitted to the development officer at headquarters. A detailed analysis of all the components contained in the six plans followed and were converted into the first draft of a county plan. Everyone had made a contribution to the overall plan and it was hoped this would achieve a sense of common ownership.

Central Norfolk Adult Education Department and **Norwich Health Authority** have devised a programme in which staff and patients work together on issues raised by the transition to community services. Although the programme has not yet started due to financial restraints, the ideas are interesting and worth describing here. For many people living in hospital this will have been the nearest thing they have known to home for much of their adult lives. As a result, people may experience a deep sense of loss when finding themselves in new and unfamiliar surroundings outside the hospital. Neither will staff be immune from the effects of such changes in their working lives. Many of them will identify closely with the institution to which they will have committed so much time and energy over the years. Everyone engaged in this change of style and pace will need a period for adjustment and reflection.

The training programme is innovative in that it seeks to link the process of redefinition of 'patients' as adult learners with the changing roles of nurses as facilitators of community living. The project envisages the adult education authority working initially with nursing staff on a joint project through which staff development will be promoted. Adult education tutors would work

with nurses and para-medical professionals to develop individual learning programmes for a number of long-stay residents identified by ward and clinical teams (the care group).

The objectives would be:

1. The creation of a climate in which residents and staff will be able to make a smooth transition to life in the community.

2. To assess those aspects of the daily living activities of members of the care groups and/or their personal interests which might provide the focus for the development of a learning programme.

3. To identify realistic learning goals and appropriate activities compatible with the assessment made in 2 above.

4. To encourage all staff working with members of the care group to see their own relationship with the residents from the perspective of the residents as learners.

5. To provide opportunities for staff to take part in off-the-job training with particular emphasis on the changing perspective of the work in which they are involved.

Alongside these examples a number of other districts are developing pioneer concepts in some aspects of their training for community based services. **Sheffield Health Authority** has a re-orientation programme for nursing staff, which is supported by organisational development work with the management group. **The Mental Illness Unit of North East Essex Health Authority** has created its own training plan which embraces basic and post-basic professional training; basic skills training; communication skills; induction and orientation sessions; an organisational development programme; management training opportunities; staff appraisal; and general education.

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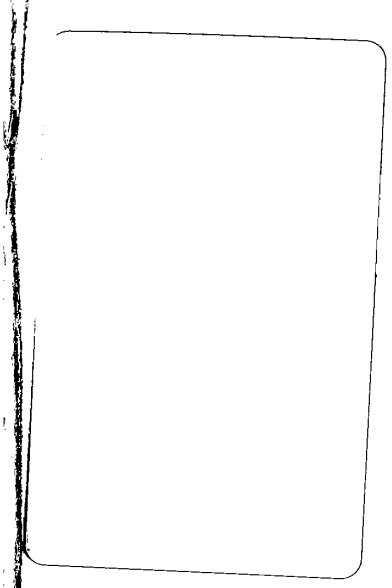

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