KF PROJECT PAPER

NUMBER 47

PLANNING FOR PEOPLE

Developing a local service for people with mental handicap

1. RECRUITING AND TRAINING STAFF

Linda Ward

King Edward's Hospital Fund for London is an independent charity founded in 1897 and incorporated by Act of Parliament. It seeks to encourage good practice and innovation in health care through research, experiment, education and direct grants.

The King's Fund Centre has a particular role in promoting advances in policy and practice in relation to problems of health and related social care. It offers a forum for informed debate, provides an information service and organises a range of activities designed to support local strategies for service development.

One important focus for the Centre's work in recent years has been the practical steps necessary to develop comprehensive community-based services for people with mental handicaps and their families. The Centre has already published four project papers relating to this subject: **An Ordinary Life** (Project Paper No 24, reprinted July 1982, price £1.50) describing the philosophy and planning of local residential services; **Bringing Mentally Handicapped Children out of Hospital** (Project Paper No 30, November 1981, price £1.00) describing the alternative services in the community required to relocate the remaining children and young people in hospitals; **Better Services for the Mentally Handicapped? Lessons from the Sheffield Evaluation Studies** (Project Paper No 34, August 1982, price £1.50); and **An Ordinary Life: issues and strategies for training staff for mental handicap services,** edited by Ann Shearer (Project Paper No 42, 1983, price £2.50).

A series of complementary shorter papers is also being produced, including to date:
Short Term Care for Mentally Handicapped Children (King's Fund Centre Discussion Paper, February 1981, 75p)
The Portage Model of Home Learning Services (King's Fund Centre Discussion Paper, April 1982, 75p)
Mentally Handicapped People with Special Needs (King's Fund Centre Discussion Paper, July 1982, 75p)

All these papers are available from the Centre, Prices include postage and packing.

PLANNING FOR PEOPLE

Developing a local service for people with mental handicap

I. RECRUITING AND TRAINING STAFF

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PLANNING FOR PEOPLE

Developing a local service for people with mental handicap

PLANNING FOR PEOPLE is a series of pamphlets designed to share information gained from the experience of setting up and running a comprehensive community service for adults with mental handicap in South Bristol, using ordinary local housing. The pamphlets are being produced in response to a demand for information on how to go about establishing such a service. They are intended to give an account of the Bristol development, and some discussion of its apparent strengths and weaknesses, based on initial experience. The pamphlets are presented as working papers only, not as a definitive blueprint for the development of services elsewhere: a full appraisal of the successes and failures of the service will not be possible until it has been operational for some years. In the meantime, we hope that the pamphlets will help to stimulate comment, criticism, debate and ultimately, the development of better community services for people with mental handicap everywhere.

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CONTENTS

1. INTRODUCTION

When Avon Area Health Authority decided, in 1980, to allocate funds for the development of a new community based residential service for adults with mental handicap in South Bristol, there was little practical experience of this kind of service provision in Britain on which local planners could draw. Some ideas about how such a service might operate in theory were available from writings about the ENCOR scheme in the United States (Thomas, Firth & Kendall, 1978), from the just published pamphlet "An Ordinary Life" (King's Fund Centre, 1980) and from the detailed plans for NIMROD - a comprehensive service which was then about to be launched in South Glamorgan (Report of a Joint Working Party ..., 1978). At a practical level, there was some limited evidence from two new schemes for severely handicapped children at Skelmersdale, Lancashire and Ashington, Northumberland, that ordinary housing was a realistic residential option for mentally handicapped people who might normally be accommodated in hospital. To a large extent, however, the Project Team, established by the Health Authority to oversee the development of the South Bristol service, was on its own.

Four years later, after the inevitable quota of setbacks, frustrations and mistakes, the Wells Road service is in operation - albeit on quite a small scale. Six adults with mental handicap now live in two ordinary, staffed houses in the community where they are learning new skills and preparing to move on to permanent homes in the same neighbourhood at a later stage. Another two adults are now living on their own in a council house nearby, with visiting support from Wells Road and Social Services Department staff. About thirty-five other mentally handicapped adults and their families in the area are also in contact with the service, receiving help and support of other kinds. As time goes on, the number of people housed or supported by the scheme will, of course, increase substantially.

Setting up the service has inevitably brought its share of problems along with success. Not the least difficult has been the absence of precedents for the Project Team to draw upon as they embarked on the still (for the health service) novel plan of offering accommodation in ordinary houses in the community to any mentally handicapped adults in the area who wanted it, however severe their handicap or disturbed their behaviour. Now, as more and more authorities move towards the establishment of this kind of service, it seems appropriate to share the experience that has been gained from Bristol to ensure that the lessons that have been learned are not wasted but may be utilised in the development of improved services elsewhere.

ABOUT THE WELLS ROAD SERVICE

1. History

Traditionally, adults with mental handicap living in South Bristol have had their housing needs met in one of three ways:

(i) by **their family** - until the death or illness of a parent, or some other crisis has precipitated admission to-

(ii) the local **mental handicap hospital** - situated some miles from the South Bristol community, outside the city, and difficult to reach by public transport.

or (iii) a **hostel** - run by the local authority social services department, but able to accommodate only a small number of more able individuals.

More recently, a small number of less handicapped people have been accommodated in **minimum support group homes** or **supported lodgings** organised through the social services department or health authority.

In the late 1970's, the health authority decided that further residential

provision for mentally handicapped adults should not be built on the local hospital campus, but nearer to the community in South Bristol which it served. In line with the thinking current at the time, a 24 bed hostel was proposed.

In 1980, however, the publication by the King's Fund Centre of the influential pamphlet "An Ordinary Life" and the conference which accompanied it, convinced some health authority officials that the use of existing ordinary housing in the community would be more appropriate than the hostel previously proposed. A revenue allocation of £96,000 per annum was made to finance a community service.* The use of a 50-roomed property already owned by the health authority, on a site some distance from the South Bristol community was recommended as a possible base for the new service.

In 1981, a steering group (a sub-committee of the local Mental Handicap Health Care Planning Team) met to draw up plans for the proposed new service, and a job description for its co-ordinator. At this stage, a "community unit" model, embracing both day and residential, permanent and respite care, resource centre, meeting place and office space for staff was envisaged. (For a critique of this model, see Ward, 1982). The proposed 50-roomed base was successfully rejected, on the grounds that it was neither 'ordinary' nor 'local' and that its repair and running costs would be prohibitively high.

By the autumn of 1981 a pair of semi-detached houses on the busy Wells Road in South Bristol had been identified as more appropriate accommodation for the

*A separate report on the costings of the Wells Road Service will be available at a later date.

new service. At the same time, it was agreed that the service should be run along the lines originally adopted by the ENCOR scheme in the United States, and explored by the "Ordinary Life" working group of mental handicap professionals in this country.

By January 1982, a multi-disciplinary **Project Team** - comprising representatives from the health authority, the social services department and a parent from the service's catchment area - had replaced the earlier steering group. Its task was to oversee the establishment of the new service.

In March 1982, a **Project Officer***, whose brief was to develop and co-ordinate the new service, took up her post. Three months later, she was joined by the **Home Leader** - whose remit was to take charge of the details of refurbishing and equipping the first houses, and to manage them and the six staff who would work there once the residents moved in.

In November the same year, the six **support staff** started training with the service. In February 1983 three residents moved into the first house; a further three residents moved into a second house six weeks later. In April, two **Community Support Workers** joined the Wells Road team. The service was in full operation.

2. Aims and Structure of the Service

The new scheme aims to offer a comprehensive service to any adult with mental handicap living within a one mile radius of the first staffed homes - a densely populated urban area of three square miles, with a population of 35,000.

* Now retitled **Service Coordinator**

The service has two components:

(i) a **residential** component, offering housing and support to any mentally handicapped person in the area, appropriate to their particular needs.

(ii) a **domiciliary** or **community** component, offering a range of support and practical help to mentally handicapped people, who are living at home with their families, or who have moved on to homes of their own.

The **residential** service is based entirely on the use of ordinary housing in the community, adapted where necessary to meet particular individual needs (e.g. a physical handicap).

The first **staffed homes** are a pair of semi-detached houses. Three residents live in each house, with varying degrees of help from the support staff working there. The time they stay there will depend on their individual needs. Some may move on after a year or so to establish a different home in the locality; others may continue to live there on a permanent basis with some degree of staff support. All residents will be helped to learn new skills to enable them to begin to live more independently than in the past. They will also decide, with the help of family, friends and staff, what kind of permanent home they want to live in eventually.

The **cluster** is the network of different residential options which is gradually being established by the service for mentally handicapped adults in the area - group homes, placement with a family, an independent bedsit or flat, supported lodgings, a staffed house, or a home shared with other non-handicapped tenants or a live-in volunteer.

3. Features of the Service

The service has a number of key features:

(i) It aims to be **comprehensive** - no-one will be excluded on account of the severity of their handicap or behaviour disturbance.

(ii) It is aimed at **adults** (over 16). Priority is given to supporting adults who are already living with their families in the locality. The idea is to draw up plans for them so that a sudden admission to the local mental handicap hospital is avoided if there is a family crisis. Where resources permit, the service is also offered to those adults who originate from the area, but are currently living in hospitals elsewhere.

(iii) It relies on **ordinary local housing** (though this will be adapted as appropriate if someone has an additional physical handicap). With the exception of the initial staffed homes, this will be **rented**, from the local authority or a housing association.

(iv) It is **client-centred.** Each mentally handicapped person in contact with the service is offered the opportunity of drawing up an **individual programme plan** with their family, staff and other professionals. The plan sets out the client's current needs, and short and long term goals, and the steps which need to be taken by different people to ensure that these are met*.

(v) It is **flexible.** More able residents within the network, for example, may

* For information on individual programme plans see p. 74

receive just a few hours' support a week. A very severely handicapped or disturbed person might - at least initially - live alone with two staff members or volunteers. As people change and develop, staff support will be adjusted or withdrawn to match their needs. The individuals themselves are not expected to move to a different kind of home as a result. Just as important, is the need for staff to be flexible. Since the Bristol service is new, staff have understood from the outset that as the service expands and develops, they may well need to adapt their roles accordingly.

(vi) It is committed to the principles of **normalisation.** Clients are being helped to live as normal a life as possible in the neighbourhood, to mix with non-handicapped people, and be treated as ordinary, valued members of the community. The service aims to build on, not supplant, the **ordinary** existing resources of the neighbourhood. Wherever possible, residents and clients use the same resources - doctors and dentists, shops, pubs and cinema, adult education and leisure facilities, as anyone else - rather than specific, segregated facilities provided for "the mentally handicapped".

EVALUATION

When the district health authority decided to allocate funds to set up the new service in Bristol, there was little knowledge in this country of how feasible or effective it would be. The authority was understandably keen that the service should be evaluated before any decisions were made to replicate it in other parts of the district. A grant from the Joseph Rowntree Memorial Trust has meant that developments in the service have been observed and documented since its

inception.* These pamphlets - each on a different, but apparently important aspect of the service - are one outcome of the evaluation, designed to help others contemplating the establishment of similar schemes elsewhere - whatever their size, however they are funded. More detailed reports from the evaluation will be available at a later date.

MAKING USE OF THIS PAMPHLET

This pamphlet does not attempt to present an exhaustive, step-by-step account of how to set up a community service. Local conditions, funding arrangements and the particular agency responsible for the new development vary too widely for this to be a sensible possibility. Instead, only those lessons which have emerged from the Bristol experience which seem to have widespread relevance to a whole range of services and circumstances have been included. In using this pamphlet, therefore, a number of points should be borne in mind:

1. Retraining existing staff for work in community services

Some authorities in this country are now moving towards the gradual replacement of long-stay hospital provision for people with mental handicap, by community residential services, based on the use of ordinary housing. These services will be run mainly by staff transferred from their current work in institutions. Retraining existing staff, who may have extensive experience of work with mentally handicapped people in an institutional setting, but little experience of the issues involved in working in more intimate community situations, poses a significant challenge to the new services. Some of the training needs of this group of staff will be similar to those addressed by services employing new staff, as at

*For more details of the evaluation see p. 99

Wells Road. Section Four of this pamphlet may be helpful here. Other retraining needs are more complex, however. Additional help and advice on these points may be obtained by contacting direct those services which have already begun to wrestle with these problems in their own area (see pp. 78- 80).

2. **Training replacement staff**

Most of the training section of this pamphlet is written out of the experience of providing appropriate induction and initial training to staff at the establishment of a new service. As schemes develop, however, and initial staff move on to other jobs or further training, providing appropriate induction programmes for replacement staff will become an important issue. Many of the points made about training in this pamphlet will, of course, still be relevant. Other issues, however, to do with easing the entry of a new staff member into an already existing staff "team", and making available an adequate period for their induction, while managing to keep service and houses adequately staffed meanwhile, pose a new challenge, which services like Wells Road are only just beginning to address. It is hoped to provide some ideas and information on these points at a later date.

3. **After the induction is over**

Although the emphasis on the importance of providing good initial training for staff is well-founded (see pp. 40- 42) what happens when this period is over is of equal significance. Adequate support for staff once they are in post (to help them deal with difficult problems like coping with aggression); supervision or positive monitoring of their work (see p. 74); regular space for discussion of current issues at staff meetings, and a commitment to on-going in-service training are vital if the benefits of the initial training period are to be consolidated. Again, a separate report on these aspects of the service will be available later.

4. Beyond this pamphlet

This pamphlet sets out to share the lessons learned in Bristol with others engaged in developing similar services elsewhere. Since the provision of services in this way is a relatively new venture in this country, the Wells Road Service, like others of its kind, is - to a great extent - learning as it goes along. Other services have tried things in different ways. In deciding the best course for your service, borrow freely not only from the information in this pamphlet, but from the rapidly accumulating and varied experiences of other schemes elsewhere (see pp. 73 - 80).

2. WHAT STAFF DO YOU NEED?

INTRODUCTION

The number and type of staff employed will obviously depend on the size of the area to be served. The catchment area for the Wells Road Service covers 3 square miles, and has a population of 35,000. 70 adults with mental handicap live in this area, and are, thus, potential customers of the new service. A further 40 mentally handicapped adults who originate from the area now live in hospitals or hostels elsewhere. Some of these too will become consumers of the service at some stage.

To operate a comprehensive community residential service for this area **ten full-time** staff have been employed initially as follows:

PROJECT OFFICER (SERVICE COORDINATOR)

Main Responsibilities (at outset of service)*

- to develop, co-ordinate and manage the service overall
- to assist the project team (steering group) to draw up an operational policy for the service
- to make contact with potential clients and their families, and prepare individual programme plans with them
- to build links between the service, other professionals and agencies working in the area and the local community
- to supervise the induction and training of staff and ensure that staff are appropriately supported in their work
- to oversee the establishment of the first staffed houses and network of permanent homes.

*As the service has developed, main responsibilities have shifted in emphasis.
For current job description, see Appendix 1, p. 81

HOME LEADER (SENIOR CARE ASSISTANT/PERSON-IN-CHARGE)

Main Responsibilities (at outset of service)*

- to oversee the refurbishing and equipping of the initial staffed houses
- to be involved in the selection and training of support staff
- to manage the initial staffed houses and supervise and support the six staff working in them
- to establish (with the help of the Service Coordinator and project team) appropriate policies and guidelines for day to day life in the staffed houses
- to help plan individual residents' programmes and monitor and record progress on these plans
- to work within the initial staffed homes, carrying out the same duties as the support staff (see below)

COMMUNITY SUPPORT WORKERS (DOMICILIARY CARE ASSISTANTS)

Number: Two

Main Responsibilities (at outset of service)*

- to make contact with new clients and help to organise individual programme plans with them and their families if appropriate
- to help set up and coordinate networks of domiciliary support and help for:
  - (a) clients who are still living at home with their families in the catchment area, and intend to carry on doing so in the forseeable future
  - (b) clients preparing to move away from the family home into a home established through the service
  - (c) clients now living in homes established through the service
- to work towards meeting the variety of needs of clients and their families,

*As the service has developed, main responsibilities have shifted in emphasis. For current job description, see Appendix 1, pp. 83 - 87

e.g. for literacy and social skills classes, sitting in services, transport, daytime activities, respite care etc., either themselves or through other agencies, professionals and volunteers .

- to liaise with relevant agencies and individuals to establish a wide range of cluster homes - supported lodgings, bedsits, minimum support group homes, flat with live-in volunteer - as and when required
- to help individual residents in the initial staffed homes make an informed choice about the kind of permanent home they would like to live in
- to train and support volunteers who want to befriend individual clients in the area

SUPPORT STAFF (CARE ASSISTANTS)

Number: Six

Main Responsibilities*

- to work in the two initial staffed houses on a rota basis, with two people on duty in the daytime, and one "sleeping in" each night
- to actively support and help residents learn to do as much as possible for themselves, so that they may gradually lead a more independent life in the local community
- to foster and maintain relationships between residents and their families and with neighbours and others in the local community, and to encourage residents' use of local facilities
- to help draw up, and implement, residents' individual plans, and record progress made.

*For current job description, see Appendix 1, pp. 88 - 90

OTHER PROFESSIONAL STAFF

A comprehensive local service also needs input from other specialist staff. The amount of input will vary from service to service.

1. CLINICAL PSYCHOLOGIST

Input from a clinical psychologist is crucial in the early stages of planning and setting up the new service, to ensure that appropriate procedures are established from the outset. The psychologist also has a vital role once the service is in operation (see below).

At Wells Road, this input is provided by a community psychologist (employed by the District Psychology Service through joint finance) who divides her time between the Wells Road Service and other community needs in the wider South Bristol area.

Main Responsibilities (once service is established)*

- to sit on the Project Team (which oversees the development of the service)
- to attend meetings of the Service Advisory Group (a sub-group of the Project Team, formed to advise service staff on the detailed operation of the service)
- to advise and help service staff on the organisation and implementation of individual programme plans, goal plans, skill-teaching programmes and resident reviews
- to help identify, and meet, staff in-service training needs.
- to make recommendations on the eligibility of new clients referred to the service.
- to initiate, in conjunction with community staff, innovatory community

* For fuller details, see job description in Appendix 1, p. 91

schemes e.g. leisure activities; work with volunteers.

to play a supportive role in relation to service staff, as appropriate.

2. SPEECH THERAPIST, OCCUPATIONAL THERAPIST AND PHYSIOTHERAPIST

Input will vary according to the needs of individual clients.

At Wells Road, about one session a week is available to the service from the therapists based at the local mental handicap hospital. (To date this has proved to be more than adequate).

3. PSYCHIATRIST

Residents of staffed houses and other clients in the area should be able to call upon specialist psychiatric services as and when they are required, just like anyone else in the community. Residents of houses in the Wells Road Service do not automatically come under the care of a Consultant Psychiatrist when they move in, but are registered with a local GP for their day to day medical needs (e.g. prescriptions for drugs etc).

4. OTHER PROFESSIONAL SERVICES

Clients and residents use the same local resources and facilities as anyone else in their neighbourhood so far as possible. They use local GPs, dentists, opticians, social workers, home helps and community and district nurses as and when the need arises, in the same way as their neighbours, rather than separate specialist services.

VOLUNTEERS

Volunteers have an important role to play in this kind of service, befriending individual clients and residents (and their families) and helping them to make use of

ordinary leisure, and other facilities in the community. Later volunteers may also play a vital role in providing living-in support for adults in the cluster homes, through Community Service Volunteers' (CSV) Independent Living Scheme*.

COMMENT

A fully operational service will require more staff to live and work alongside severely handicapped adults than are currently employed at Wells Road because:

(i) more than two permanently staffed homes are likely to be needed in the long term

(ii) housing adults with profound handicap or very severe behaviour problems will demand a higher staff ratio

(iii) a pool of part-time relief workers may be needed to provide temporary cover in staffed houses on an 'as and when' basis (e.g. at times of staff sickness)[1].

(iv) as the service becomes established and accepted in the area, increasing numbers of families will wish to make use of it. (It may take a while before families - particularly those with a profoundly or multiply-handicapped member - can believe that the new service really will be able to accommodate their relative on a permanent basis).

Additional and alternative sources of funding to meet possible increased staffing needs in the future are currently being explored by members of the Wells Road Project Team and service staff. (A separate report on finance, funding and costings of the service will be available at a later date).

*See pp. 74 and 78

[1] Such a pool was created at Wells Road in March 1984.

3. RECRUITING THE RIGHT STAFF FOR THE JOB

WHO ARE THE "RIGHT" STAFF?

Firm criteria for selecting the right staff for a community-based residential service are hard to lay down. Ordinary housing schemes which cater for people with severe mental handicap are a new, and still rare, phenomenon in this country. There is limited experience available to provide guidance to those anxious to recruit the staff who will be able to run such schemes successfully. However, some general points relating to staff selection have emerged from the experience of appointing staff to the Wells Road Service. These are given below.

PROJECT OFFICER (SERVICE COORDINATOR)

1. Allocating Responsibility for the Appointment

(i) Setting up new appointments to a service which has yet to be established can take a long time. This is particularly true if:

- the posts are at all unusual
- the service is innovative
- the service steering group is multi-disciplinary

All these are likely in the establishment of an ordinary housing scheme.

(ii) It is a good idea to allocate overall responsibility for the appointment to one particular individual who has the authority to push the appointment process forward and deal with any problems as they arise. The Chairperson of the service management team or steering group may be the most appropriate person to take this role.

2. Advertising

(i) Some time will elapse between submitting an advertisement and its ultimate

appearance in a journal or newspaper (particularly if it has to be processed by a health or local authority's personnel department before submission).

(ii) When drawing up advertisements, make sure there is plenty of time for applicants to obtain forms and make informal enquiries before the closing date.

3. Job Description

(i) Draw up as detailed a job description for the post as possible*.

(ii) In a new service there will naturally be some uncertainty about the precise nature of the job to be undertaken. All job descriptions should state that duties will be subject to review and may be amended according to the needs and development of the service.

(iii) Make sure that the job description is accompanied by an outline description of the planned service (updated as the service develops).

4. Length of Contract/Secondment

(i) It is unwise to appoint a service co-ordinator or development officer on a short-term contract. As the service expands and develops the need for a service co-ordinator and manager will continue.

(ii) Appointments should be made on the same (permanent) contract basis normally employed for other health (or social services) staff.

*See Appendix 1, p. 81 for example

(iii) The possibility of secondment to a new service for a fixed term will only be appropriate where the post in question is a pump-priming position, the duties of which can be properly undertaken and co-ordinated by other service staff at the end of the contract.

(iv) Secondment is not an appropriate option for a service development/project officer post, since management and co-ordination responsibilities will extend beyond the initial development phase.

5. Grade*

(i) It is important to ensure that the co-ordinator/development officer of the service is placed on an appropriately senior grade, commensurate with the wide-ranging responsibilities of the post (see p. 81). This may be difficult however:

- if appointments are being made on an unusual scale for the kind of work being done (e.g. at Wells Road all appointments are on the administrative and clerical rather than nursing scales, see p. 93).
- if posts are new or unusual in any way (this applies to most of the current posts in the Wells Road Service).
- if applicants with particularly appropriate experience or ideas rather than traditional qualifications are encouraged to apply.

(ii) It may be slightly easier to ensure placement on an appropriate grade if the service is to be run by a voluntary organisation. Within health or local authority services, it may be harder to do this because of anxieties about comparability and precedents within the Authority.

*see also p. 93

(iii) If the post is not graded at an appropriately senior level, it may prove difficult to attract applicants of the right calibre and experience. It will also be difficult for the co-ordinator, once in post, to counter the obstacles and opposition inevitable during the establishment of an innovative service of this kind.

6. Accountability, Supervision and Support

(i) Clear lines of accountability are essential.

(ii) Appropriate supervision and support is also vital for staff working with mentally handicapped people in the community. Make sure that appropriate sources of supervision and support are clearly identified for all staff working in the service including the service co-ordinator/project officer. (Her/his needs for support will be as great if not greater than other staff members).*

7. Interviewing for the Post

(i) A multi-disciplinary interview panel is essential for an appointment of this kind.

(ii) The opportunity for panel and candidates to meet informally over coffee for an hour before the fomal interviews commence, gives a useful chance to break the ice and to see how well candidates cope with this kind of (stressful!) situation. Such a situation - meeting unknown others, often of superior official status and with different professional backgrounds, for whom the new service may be totally unfamiliar in its basic principles - will be a commonplace event for the coordinator, once in post. It is important that candidates, however apprehensive

*A separate report on staff support will be available at a later date.

they may - understandably - be feeling, should be able to cope with this successfully.

8. Criteria for Selection

(i) The following qualities are important in a co-ordinator/project officer post:

- Understanding of the ideas of normalisation and commitment to the development of community based services along these lines.
- Experience in the field of mental handicap
- Knowledge about services for people with mental handicap.
- Maturity
- Good interpersonal skills - personal warmth and an ability to relate well to others.
- Diplomacy and tact.
- Administrative experience.

(ii) Clearly, no one person will embody all these qualities! In making an appointment, prioritise important personal qualities which are more difficult to 'teach' (e.g. clear commitment to the fundamental ideas behind the service, interpersonal skills and diplomacy), over others (e.g. administrative and management skills) which can be acquired once in post (e.g. through members of the service management team or short 'management skills' courses).

HOME LEADER (SENIOR CARE ASSISTANT/PERSON-IN-CHARGE)

1. Fixing an interview date

(i) Progress in making an appointment can be severely delayed by problems in agreeing an interview date convenient to all members of a multi-disciplinary

interview panel. This problem will be exacerbated if panel members are:

- less committed to the new service than to the demands posed by existing services for which they are responsible.
- of superior official status to the project officer co-ordinating the appointment process.

(ii) Make sure shortlisting and interview dates are agreed well in advance - at a time that advertisements and job descriptions are first drafted.

2. Grade

(i) If possible, offer the post on a scale which will enable applicants from a wide variety of professional backgrounds to apply (e.g. on an administrative and clerical scale rather than a nursing scale).

(ii) Offer the post at a point on the scale that carries a salary and status appropriate to the responsibilities involved, and is likely to attract applicants with the skills, maturity and experience required.

3. Accountability, Supervision and Support

(i) The home leader should be directly accountable to the project officer/co-ordinator who has overall responsibility for the entire service.

(ii) Make sure appropriate sources of supervision and support for the home leader are clearly identified. The project officer is probably the most likely person to perform this role. (A clinical psychologist closely involved in the service might be an alternative).

4. Job Description*

(i) The job description for the home leader post will have to be drawn up before any staffed houses are in operation.

(ii) Borrow freely from job descriptions already drawn up by existing schemes where possible, adapting them as appropriate to the needs of your particular service[1].

(ii) Make it clear that duties will be subject to review according to the needs of the service as it develops.

(iii) Review the job description periodically to ensure that it reflects changes in the job as they occur.

(iv) Make sure that the job description is accompanied by an outline description of the planned service (updated as the service develops).

5. Timing of Appointment

(i) It is very likely that there will be uncertaintly as to the precise date on which alterations and decorations to accommodation within the service will be completed, ready for residents to move in. It is very common for actual completion dates to be significantly later than initially anticipated. It will often be difficult, therefore, to decide precisely when a home leader (and other house staff) should be appointed.

*See Appendix 1, pp. 83 - 85 for example.

[1] See addresses on pp. 78 - 80

(ii) In deciding when to make the appointment, bear in mind the following tasks, which the home leader will need to embark on well before the houses take in their first residents:

- an induction period in which to get to know relevant local agencies and individuals (see p. 49).
- overseeing adaptations and decorations necessary to the houses.
- ordering appropriate furniture and equipment.
- helping the service coordinator in recruiting and training home support staff (see pp. 31 - 39 and pp. 58 - 72).
- helping the service coordinator make contact with the first potential residents and their families.
- drawing up detailed guidelines for procedures in the houses (e.g. on drugs, repairs, financial matters etc.), and negotiating these through the relevant health and local authority and/or other channels.

(iii) If the home leader is appointed some time before the house is open, to carry out the tasks above, make sure the division of labour and authority between her/him and the project officer is clear. If it is not, confusion over their respective roles and responsibilities is likely to persist both inside and outside the service, long after the houses are operational.

6. Interviewing for the post

(i) Give candidates an opportunity to visit the service and the proposed staffed house (if this is appropriate) before the interview date, so that they can learn about the service in some detail.

(ii) On the interview date itself give candidates and members of the project team or steering group (not all of whom will be on the interview panel) a chance to meet

and chat informally over coffee before the formal interviews commence.

7. Criteria for Selection

(i) The following qualities are important in a home leader post:

- Maturity (over say, 28 years of age?).
- Experience - in the field of mental handicap and residential work.
- Flexibility - ability to look at fresh ideas.
- Ability to lead/manage a small residential group.
- Understanding of, and commitment to, ideas of normalisation.
- Commitment to work in a staffed home - rather than an ambition to play a wider role in the service overall.
- Likely compatibility with the service co-ordinator.

The last two considerations may seem less obvious, but are essential to the smooth running of the service.

(ii) No candidate is likely to possess all these qualities. Some of the characteristics may in fact be incompatible, e.g. someone with relevant experience and leadership ability may want to stray beyond the confines of the staffed home into wider concerns of the service overall.

(iii) Some of the qualities are difficult to assess or predict, e.g. likely compatibility with project officer; good interpersonal skills with staff and ability to lead/support a small residential group.

(iv) Someone with the maturity, experience and other qualities required may not be prepared to work at the salary level on offer.

COMMUNITY SUPPORT WORKERS (DOMICILIARY CARE ASSISTANTS)

1. Number of Staff Needed

(i) The number of community workers you employ will depend on:

- the resources available to your service
- the size of the catchment area to be served by the scheme
- the number of clients within that area (if known)
- the support available to them already through other services:

e.g. Are there adequate day services for all clients, even those with profound or multiple handicaps?

Is the area served by community mental handicap nurses? If so, what kind of services are they providing, and to how many clients?

How many clients in the area are already receiving social work help?

Are local social workers in a position to meet any increases in demand from mentally handicapped clients or their families?

What clinical psychology services are available in the community?

(ii) In working out the number of community staff you need to employ, the experience of existing schemes (NIMROD, Wells Road) may be of help (see pp. 79 - 80). Bear in mind, however, that:

- schemes in other areas may be covered by services not available in your own (e.g. community mental handicap teams). There may be a need for <u>more</u> community workers in your area to compensate for this.
- existing schemes have often had to guess how many community staff to employ, since they have had no precedents to draw on.
- schemes may have had to tailor their staffing to initial resources available, rather than to actual community needs.
- existing schemes have found that demands for their service from clients and their families have increased as the service becomes more

established in the area.

In some services, therefore, community staff are greatly overstretched and community needs cannot all be met, unless additional staff can be employed.

2. Grade and Salary

(i) It is a good idea to offer the post on a scale which will enable candidates from a wide range of backgrounds to apply (e.g. if the scheme is within the health service, on an administrative and clerical rather than a nursing scale).

(ii) Deciding the appropriate grade on the scale will be difficult, for the reasons already outlined above (p. 19).

(iii) Within existing services, there has been a tendency to appoint community support workers on grades which do not match up to the degree of responsibility, initiative and experience expected of them. Community support workers have frequently taken a substantial drop in salary when moving to these posts. Other promising applicants have withdrawn because of the low salary offered.

(iv) It is important to match grade and salary level to the requirements of the post, if staff of the right calibre, skills and commitment are to be attracted and continue to work in the service.

(v) If the initial starting point of the salary is low, ensure before the selection process starts, that candidates with appropriate qualifications and/or experience can immediately receive additional increments as a result. Decide beforehand (with the relevant administrator, personnel officer or whoever else may be appropriate) what kind of experience and qualifications will be considered relevant.

(vi) Make it clear in advertisements whether additional increments for relevant experience may be available so that candidates concerned about the salary level may still decide to apply. (N.B. This is especially important in health authority schemes, where candidates may otherwise be informed that new entrants to the health service must normally start at the bottom of the scale).

(vii) If overtime payments are available, or enhanced rates of pay for evening and weekend work, make sure candidates are aware of this. (If possible, work out a rough estimate of the likely value of these payments so that at interview candidates may have a clear idea of their likely take home pay).

3. Payment for overtime/time off "in lieu"

(i) Community staff will inevitably need to work in the evenings, e.g. to visit clients and their families who are not at home in the daytime, to meet with volunteers involved with clients, to set up evening classes etc.

(ii) Make sure your community workers will be able to take back any time owing to them at other times in the week. If there are likely to be occasions when this is not possible (e.g. if the service is fully stretched during the daytime meeting other needs) make sure that overtime payments are available for excess hours worked.

(iii) If overtime payments are not budgeted for, and claiming time back is not feasible without damage to the service offered, staff will become overstretched, tired and understandably resentful.

4. Job Description and Guidelines

(i) A detailed job description is essential, since the post carries a wide variety of duties (see pp. 86 - 87)

(ii) It may also be helpful to draw up (in consultation with other professionals working in the area) guidelines specifying:

- the broad areas of work of community staff
- the division of labour and responsibility between them and other professionals in the area, (e.g. community mental handicap nurses, social workers, clinical psychologists)
- a commitment to regular liaison meetings for all professionals active in the area, to ensure that duplication and confusion are avoided and that there is a shared understanding of respective roles in meeting individual client needs. (At Wells Road, these are held bi-monthly and attended by relevant social workers, community mental handicap nurses, clinical psychologist, health visitor, home care organiser).

5. Accountability, Supervision and Support

(i) Community support workers should be immediately accountable to the project officer/service co-ordinator.

(ii) Support and supervision is also essential in a post of this kind where staff are:

- working alone in the community
- providing a new kind of service (but in cooperation, not competition, with existing agencies)
- reliant on their own initiative and judgement
- expected to provide support (and training) of an appropriate kind to clients with a wide range of handicaps, behaviour problems and domestic circumstances
- expected to provide (in a sensitive and sympathetic manner) appropriate support to families who have been coping with very difficult problems over a number of years

- themselves providing support and training to volunteers involved in befriending clients and their families
- encouraging clients and their families to take risks and/or make changes in their lives (some of which will be more welcome, more obviously successful or more easy to adjust to than others).

(iii) Support may be provided by:

- the service coordinator
- other community support workers
- other members of the service's community team, if such exist, e.g. clinical psychologist, social worker.

6. Timing of Appointment

(i) When setting up a new service, it is a good idea to appoint community staff at an early stage before any staffed homes are operational. Community staff will be able to:

- make initial contact with clients in the area
- draw up individual programme plans with them and their family
- help identify which clients would like to move into homes organised through the service
- help prepare these clients (and their families) for the move ahead.

7. Criteria for Selection

(i) The following considerations are important in appointing community staff:

- relevant experience, especially of skill-teaching and working with families
- ability to work on their own initiative
- ability to "come over" well to families and relate sensitively to them

- ability to relate well to other professionals
- likely compatibility with service coordinator (particularly important if the service is small and community workers and project officer will be working closely together) and with each other (if employing more than one community worker)
- possession of current driving licence and car. (Clarify beforehand whether a car loan will be available to enable purchase of a car and on what terms).

(ii) If you are employing more than one community worker, you may decide to try to appoint workers of different ages, sexes and experience.

(iii) Existing schemes have found it hard to recruit suitably qualified men.

SUPPORT STAFF (CARE ASSISTANTS)

1. Number of Staff Needed

(i) In working out the number of staff you will need, contact existing schemes and learn from their experience. (Addresses on pp. 78 - 80).

(ii) You will almost certainly need more staff than you originally think necessary.

(iii) If you employ too few staff to cover the house(s) adequately during crises or times of staff shortage, make sure you will be able to:

- pay them overtime for excess hours worked

or

- draw on a pool of back-up/reserve staff who can be called on in an emergency. (N.B. This will need to be carefully organised and budgeted for).

(iv) If you employ too few staff for the duties required of them (e.g. if they are all expected to attend weekly staff meetings or monthly training days in addition to normal duties), and you have not budgeted to pay them overtime, they will build up vast amounts of "time owing" which will be difficult for them to claim back.

(v) In working out staff numbers, you will need to decide what kind of cover is required in the house(s):

e.g.
- will residents be at home during the day?
- what level of support do residents need?
- are staff required at night? If so, are "waking" or "sleeping" night staff needed? (see below)
- are staff expected to regularly attend:
  - resident reviews?
  - staff meetings?
  - in-service training days?
  - individual programme plan meetings?

  If so, how will the house(s) be covered in their absence?
- will staff be able to "claim back" extra time worked?

2. "Waking" v. "Sleeping" Night Staff

(i) Deciding whether to employ "waking" or "sleeping" night staff may depend on:

- the severity of residents' handicaps or behaviour problems (e.g. if they habitually wander at night)
- whether residents are used to waking night staff (e.g. if they have previously lived in hospital).

(ii) Different schemes have made different choices.

Those services that have employed **"waking"** night staff (e.g. NIMROD, Weyhill Road) felt that they were necessary, for the reasons outlined above.

Those services that have employed **"sleeping"** night staff (e.g. Ashington, Wells Road) argue that:

- once the precedent of "waking" night staff is accepted, a service is likely to go on using them.
- there is a real incentive for "sleeping-in" staff to encourage normal sleeping patterns.
- night staff can easily get involved in inappropriate activities at night, e.g. washing, ironing, preparing food - which is not ordinary living.
- residents' sleeping patterns have dramatically improved when they have moved from hospital into an ordinary house without waking night staff - after initial settling-in difficulties.

(iii) Contact existing services to decide whether waking night staff are necessary in your scheme (see pp. 78 - 80).

(iv) If you decide on "sleeping-in" staff, try to ensure that:

- an adequate sleeping-in allowance can be paid
- at difficult times (e.g. where residents are particularly restless) an additional staff member can sleep in to offer support. (This contingency will need to be budgeted for).
- in cases where staff members are actually awake through the night with residents, cover for the house the following day can be provided by another (relief) staff member.
- staff have access via the telephone to additional support and advice in an emergency.

3. Full-Time v. Part-Time Staff

(i) The advantages of employing part-time staff are:

- it is easier to ensure staff support is available at appropriate times, e.g. early morning, evenings and weekends, rather than during the daytime when some residents may not be at home.
- some people who are not able to consider full-time work (e.g. because of domestic responsibilities) may be attracted to apply. They may well have useful experience to offer, and are likely to live locally.
- there is a larger pool of staff employed by the service, who can be called on to provide support at times of staff shortage or in an emergency (again this will need to be budgeted for).

(ii) The advantages of employing full-time staff are;

- it is much easier from an administrative point of view, e.g. in the organisation of staff training, in recruitment, etc.
- residents are exposed to fewer staff changes.
- it may be easier to create a "team" feeling with a smaller (full-time) staff group, and to ensure staff are adequately supported and monitored in their work.

(iii) Some services (e.g. NIMROD) employ a mixture of full and part-time support staff.

(iv) If in doubt, contact existing services to find out what their experience has been.

4. Grade

(i) It is difficult to decioe on an appropriate grade for staff who may be carrying

much greater responsibilities than they would in a more traditional service, with less immediate access to back-up and support. This is a particular problem if:

- the new service is a health or local authority venture, since there will be concern (from the personnel and administrative viewpoint) to ensure that salaries and grades offered are comparable with other posts within the authority.
- if (as at Wells Road) posts are being offered on the administrative and clerical (not nursing) scales. (Deciding the appropriate position on an administrative and clerical scale for posts which are entirely non-clerical is likely to be the subject of intense debate).

(ii) Fixing an appropriate grade will depend on:

- the budget or resources available
- precedents created by other schemes or services
- the degree of responsibility staff will be expected to take (e.g. in the absence of the home leader, will individual staff members be responsible for the home, or is a deputy to be employed?).

(iii) In deciding on a grade, you will probably have to compromise between offering a salary likely to attract staff of the calibre and commitment required by the service, and ensuring that salaries and grades offered are compatible with others in the health or local authority. (Schemes run by voluntary organisations seem to have greater flexibility in this respect).

5. Hierarchy or Team?

(i) You will need to decide whether to employ all direct care/support staff on the same grade, or whether to opt for a two-tier system of senior and other support staff.

(ii) Within a small staffed home, it may be better to appoint all staff (bar the home leader) on the same grade (as at Ashington and Wells Road) if:

- all staff will be expected to perform the same duties
- it is felt that a hierarchical structure will not be conducive to flexible ways of working
- a two-tier system will force care staff on the bottom tier down to an unacceptably low starting salary.

6. Job Description*

(i) The initial job description for support/care staff will have to be drawn up before the house(s) are in operation.

(ii) The points made regarding the job description of the home leader (see p. 23) apply here also.

7. Accountability, Supervision and Support

(i) Support staff should be immediately accountable to the home leader.

(ii) Sensitive supervision and support is vital since:

- staff will not necessarily have extensive formal training or experience to fall back on
- staff will have to cope with crises and problems in the house as and when they arise, often without any other (senior) staff member present to give advice
- staff may be working with residents who are aggressive or who become

*See Appendix 1, pp. 88 - 90 for example.

ill or disturbed, or in other ways cause staff to feel they have somehow "failed" in their task

- staff may be working with residents in every area of their life - personal care, cooking, cleaning, laundry, shopping, skill-teaching, leisure activities etc. - without ancillary staff (e.g. cooks, cleaners) to help them
- staff may sometimes be working intensively for prolonged stretches of time (e.g. if a resident is ill or particularly disturbed during the night, staff may be actively on duty for up to 24 hours without sleep or a break)
- where there has been scepticism in the area as to whether the service can succeed (e.g. comments that individuals with particular problems or handicaps will not be able to survive in the community) staff are likely to feel anxious when things "go wrong", in case the critics are proved right.

(iii) Supervision and/or support may be provided by:

- the home leader
- other support staff (either informally or at staff meetings)
- in some circumstances, the project officer/service co-ordinator.

(iv) It is a good idea to specify sources of support in the job description, and to ensure that time is clearly set aside for each staff member to receive regular supervision and support.

8. Timing of Appointment

(i) Timing of the appointment of support staff is difficult, particularly if there is doubt as to when the house(s) will be ready for occupation. Adequate time must be

allowed for staff training before the house(s) are open (see pp. 58-72),but too long an interval between taking up posts and the first residents moving in will result in staff frustration, however good the training has been.

(ii) Balancing these two considerations is not easy and in the event may be beyond your control (e.g. if alterations to the house(s) are delayed by bad weather).

9. Shortlisting

(i) A large number of people can be expected to apply for the posts, particularly if it is clear from the advertisement that those without formal qualifications, or even experience, may be considered.

(ii) Candidates who are shortlisted may usefully be invited to visit the (unopened) house(s) and talk with the home leader before their formal interview.

(iii)Making a shortlist from application forms alone will be difficult, even arbitrary. It will help if:

- applicants are encouraged to make informal contact with the service beforehand (though this is very time consuming for the home leader)
- a list of criteria for selection is made at this point.

10. Criteria for Selection

(i) The following criteria may be helpful in shortlisting and selecting a small number of staff from the large number of applicants likely for the posts:

- interest in, and apparent commitment to, the ideas behind the new service (normalisation etc.)
- warm personality and interpersonal skills
- flexibility and initiative

- familiarity with the local neighbourhood (staff who are themselves resident in the area will be in a better position to help residents become integrated in the life of the local community).
- likelihood that they will be able to work as a team and complement each other in various ways:

  e.g. range of ages

  both sexes

  variety of personalities (some quieter staff to complement more outgoing members)

  range of backgrounds

  range of experience and skills

(ii) In selecting staff, existing schemes have found:

- recruiting suitable men for posts is often difficult, but a mixed sex staff group is desirable, if it can be achieved. (It may be worth thinking how you might attract more male applicants for posts).
- applicants without formal training or even relevant experience are often just as suitable as those with more traditional qualifications and experience.
- it is good to select some local staff where possible.

4. INDUCTION AND INITIAL TRAINING

INTRODUCTION

1. Providing a good induction/initial training period for staff newly appointed to a community residential service is important because:

(i) The service will differ in many fundamental ways from traditional mental handicap services. The induction/training period will give staff an opportunity to become thoroughly familiar with the basic principles underpinning the service (e.g. normalisation) and the practical implications of these principles for their particular jobs (e.g. 'working with' not just 'caring for' the mentally handicapped person).

(ii) Posts within the service will differ from traditional mental handicap posts. The induction/training period will give staff an understanding of the key elements of their particular posts (as set out in their job descriptions) and how they will carry out these particular responsibilities in practice.

(iii) Posts will be open to staff from a wide range of personal and professional backgrounds. The initial training period will give different staff a chance to make up for different 'gaps' in their particular backgrounds.

(iv) The service will be working with a variety of different organisations, authorities and agencies. The induction period will give staff an opportunity to become familiar with the work of different agencies (e.g. the DHSS, the social services department, the community nursing service) and to meet key people from them, with whom they are likely to have contact once they are actively in post.

(v) Certain techniques, skills and methods of working (e.g. goal-planning, skill teaching, individual programme plans) will be fundamental to the organisation, operation and success of the new service and the progress of its clients. The initial training period will give staff an opportunity to become familiar with these techniques.

(vi) Good relationships with clients and their families will be essential to the service. The induction period will give staff the opportunity to learn and understand something about "the consumer viewpoint". It should encourage staff to be respectful and sensitive to the needs, views and feelings of clients and their families in their subsequent relationships with them.

2. A carefully planned induction period will generate and sustain enthusiasm and commitment to the new service. It will give staff a chance to get to know each other and feel part of a team. If it encourages staff participation, critical comment, the voicing of any anxieties or doubts (about the service or their role within it), if it encourages mutual help and informal contributions from different staff members according to their particular interests, ideas and experience, it will establish a positive model of working which will outlive the initial training period.

3. Once staff are actively in post, they will never again have the same amount of time and energy to think and learn about the service and their role within it. It makes sense to plan their induction with care, to ensure that the time spent on it is spent wisely.

4. Deciding on an appropriate induction package for staff of community services is not easy. There is, as yet, little practical experience in this country or knowledge of which elements of a training package are significantly related to

good subsequent staff performance to draw upon. Moreover, the specific details of any particular induction/training package will need to vary according to:

- the nature of a particular service or project
- the area which it is to serve
- the composition, and particular backgrounds and experiences of, its staff group

5. Some broad points relating to the induction and initial training of staff have emerged from experiences at the Wells Road Service. These are given below.

PROJECT OFFICER (SERVICE COORDINATOR)

PLANNING THE INDUCTION PERIOD

1. It is a good idea to allocate responsibility for the project officer's induction programme to one person. This may be the Chairperson of the project's Steering Group, or the person to whom the project officer is directly accountable (e.g. the unit administrator - mental handicap services, if it is a health authority project). She/he can then canvas all members of the project's Steering Group for their views on the appropriate content of the induction programme. This should ensure that key individuals and contacts within all the different agencies and professions involved with the service will feature on the programme.

2. A list of useful contacts, meetings etc. based on these ideas can be drawn up and circulated to members of the project team as a framework for further discussion and comment.

3. A draft induction programme can then be drawn up before the project officer

is appointed.

After the appointment is made, emphases within the induction period may need to be shifted to take account of the successful candidate's particular areas of experience and expertise (e.g. someone from a nursing background may need more time spent with local authority social services personnel, and vice versa).

CONTENT OF INDUCTION PROGRAMME

The precise content of the induction programme will vary enormously from one service to another. The following broad areas will, however, need to be covered in some form.

1. **Principles of normalisation**

   To enable the project officer to gain a thorough understanding of normalisation principles and what they mean for a service in practice.

(i) By attending 2 day normalisation workshop or 5 day PASS workshop (See p.77)

(ii) By reading O'Brien and Tyne's pamphlet (1981) which provides a useful introduction to normalisation principles and their implications for services in practice. (See p. 74).

2. **The local service - principles, details and history to date**

   To familiarise the project officer with the background and underlying philosophy of the local service, and details of how it will operate on a day to day level.

(i) By talking to those involved in establishing the service so far (e.g. Project

Team members).

(ii) By looking at existing papers on the service (including Project Team minutes).

(iii) By studying the (draft) operational policy of the service. This should outline the principles and practice of the projected new service.

3. **Information about similar services elsewhere**

To give the project officer information about the experiences of similar schemes elsewhere, useful precedents and potential sources of help, support and advice for the future.

(i) Information on **the location of other services** can be obtained from the King's Fund Centre or the Campaign for Mentally Handicapped People (see p. 78).

(ii) Detailed information about **particular local services** is best obtained by

- attending "information days" run by some individual services (e.g. NIMROD, Wells Road Service, see pp. 78 - 80)
- attending conferences/workshops on different aspects of running such services organised by:
  - The King's Fund Centre
  - APMH (Association of Professions for the Mentally Handicapped)
  - CEH (Centre on Environment for the Handicapped)
  - BIMH (British Institute of Mental Handicap)

  Contact them at the addresses on p. 77 to find out about forthcoming events of interest.
- reading (see pp. 73 - 76)
- phone calls/letters on specific points to particular agencies (see p. 78)

4. **Contact with key individuals and agencies likely to be involved with service**

To give project officer the opportunity

- to meet those she/he will have contact with in future
- to learn about the work of their agency
- to explain to them the nature of the service.
- to find out how they see the service and their relationship with it in future

(i) This may be achieved via "one off" meetings.

(ii) In some cases, it may be helpful for the project officer to spend longer with an individual or agency, e.g. a mini-placement of several days with the community mental handicap nursing service, or a week spent learning about the work of the local social services department, and meeting the different officers and social workers within it who have involvement in mental handicap services.

(iii) It may be helpful to prepare a leaflet outlining the aims and function of the new service, to circulate to individuals and agencies beforehand so that contact between them and the project officer is of maximum mutual benefit.

(iv) Make sure that the list of individuals and agencies for the project officer to meet includes:

- voluntary groups
- parents
- client groups

5. **Administrative arrangements, management skills, budgetary & financial procedures**

Some time will need to be spent acquainting the project officer with budgetary, financial and administrative information and procedures (e.g. timesheets, expenses, mileage allowances, time off in lieu etc.) This will be particularly necessary where the new service is part of a much larger

authority (e.g. health authority, or social services department) with a large number of set procedures to be followed.

Where the project officer has had little previous management experience, attending a short course on management skills (e.g. one organised internally by the local health authority) may be useful.

6. **Getting to know the local 'patch'**

To give the project officer a chance to make contacts with the local neighbourhood and generally "get a feel" of the area, by leaving some slots in the induction period free for the project officer to "walk about" the patch, use local shops, notice local facilities, talk to local clergy, police, community groups etc.

LENGTH OF INDUCTION PERIOD

1. This will vary from service to service.

2. At Wells Road, about one month was set aside for the induction period. However, some of that time was spent "doing work" for the service (e.g. working on the draft operational policy, and plans for the first staffed home), and some initial meetings with key individuals took place after the first month was over.

3. Clearly, any induction period will merge, more or less gradually, into "doing the job".

4. When deciding the approximate length of time for the induction period, bear in mind that:

- once the induction period is over, it may be difficult for the project officer to find time to read and think about the service, so time made

available now for this purpose is well spent

- if the induction period is too long, she/he will inevitably begin to feel anxiety about all the things to be done in the service which the induction activities may prevent from being done.

COMMENTS

1. Try to let the project officer have a copy of the outline induction programme before she/he starts work so she/he has some idea of what she will be doing in the first weeks.

2. Make sure there are gaps in the programme for reading, walking about the patch or making contacts of her/his own choosing.

3. Try to balance the need for the project officer to meet a large number of individuals within different agencies, with an awareness that meeting so many different professionals with different opinions about the service is likely to be quite overwhelming to someone newly in post.

4. See that the project officer has a base of her/his own from the outset, to which she/he can retreat to read, think, make phone calls etc.

5. Try to ensure that she/he has a chance to meet regularly with someone throughout the induction period to review and discuss what she/he has been doing. (The person to whom she is accountable may be the most appropriate).

6. If it is possible to draw up a leaflet outlining the new service for prior circulation to local agencies and individuals she/he is likely to meet, this will help

overcome some of the inevitable misunderstandings about what the new service should be doing. The leaflet should include any criteria for eligibility for the service, its catchment area (if appropriate) and an indication of when the service is likely to be operational for clients. This will help the project officer when she/he is confronted with the inevitable (often inappropriate) referrals to the service, during the first weeks of her induction.

7. Setting up a new community service can be an isolated and stressful task. Experience at Wells Road suggests it is extremely valuable if the project officer can attend any conferences or workshops early on in the appointment where she/he can meet others in a similar position elsewhere.

8. At the end of the induction period, ask the project officer to note down her/his feelings about it. Which parts were most/least interesting or useful? Why? The information may help in planning a better programme next time.

HOME LEADER (SENIOR CARE ASSISTANT/PERSON IN CHARGE)

PLANNING THE INDUCTION PERIOD

1. The most appropriate person to co-ordinate arrangements for the home leader's induction, is the service co-ordinator, in consultation with members of the project team.

2. An outline programme for the induction period should be drawn up before the home leader is appointed. The draft programme can subsequently be amended to take account of the successful candidate's background and experience, and any particular training needs.

CONTENT OF THE INDUCTION PERIOD

1. The precise content of the induction period will vary according to:

   - the background and experience of the new home leader
   - his/her responsibilities, as set out in the job description for the post
   - the nature of the service and the particular stage of its development

2. The points made on pp 43 - 46 above (on the content of the project officer's induction) apply equally to the induction programme for the home leader. (Some details within the two programmes may need to vary to take account of their different tasks and areas of responsibility within the service).

3. It will be particularly important for the home leader's induction programme to cover the following areas, if his/her practical experience of them is limited:

   - **goal planning**
   - **skill teaching**
   - **individual programme plans**

Help in these areas may be obtained from:

   - a local clinical psychologist or other interested professional with experience in these fields
   - one day workshops (see pp.77 - 8).
   - handbooks on these subjects (see p. 74)

It may make economic sense for your service to host specific, relevant workshops (e.g. on the three areas mentioned above, and/or on normalisation) in your own area, rather than pay for staff to travel to attend them elsewhere. In this case, it may be sensible to defer them until after the home leader's induction period is formally over, until all the service staff (including support staff) have been employed, so that everyone can attend and benefit together.

4. A number of **"mini-placements"** - lasting perhaps three days each - with different local mental handicap agencies may be worthwhile. Useful placements might be with the local

- Adult Training (or Social Education) Centre
- community mental handicap nursing service
- "special needs" unit
- school leavers unit/special school

The choice of useful placements will be heavily influenced by the nature of the agencies in your particular area.

The advantages of "mini-placements" of this kind seem to be that they provide:

(i) a 'practical' balance to other, more desk-based aspects of the induction period

(ii) an opportunity to make contact with, and work alongside, agency staff with whom the home leader will need to liaise in the future

(iii). a chance to understand more fully about the working of that agency than would be possible through a 'one off' visit

(iv) a source of contact with potential clients. This is likely to be of particular importance when the service is just being established.

The disadvantages are:

(i) a number of 'mini placements' even of three days must mean a longer induction period than some services will feel able to provide

(ii) the contacts/knowledge gained in three days can only be fairly superficial. (However, they greatly exceed that obtained through isolated visits to an agency).

(iii) the home leader may find it frustrating to be on placement particularly towards the end of the induction programme, when she/he is aware of the

growing amount of "real work" waiting to be done. (Hence the decision at Wells Road to have two days a week - even during placements - spent "back at the office").

5. In between mini-placements, and other fixed parts of the induction programme, it is a good idea (and to some extent, a practical necessity) to allow space for the home leader to start thinking about priorities in his/her work.

(i) At Wells Road, the home leader spent some time during his induction beginning to think about the following issues, in consultation with the project officer, individual members of the project team, and relevant health authority officers:

- alterations/decoration of the first homes acquired by the service
- the cost of furnishings for the houses
- possible rotas for staffing them
- the recruitment of support staff
- guidelines and policies for day to day life in the houses
- arrangements for decentralising the service's budget to enable house finances to be handled directly by staff and residents there
- making contact with potential clients/residents

(ii) Where the home leader is joining the service after some homes have already been set up (i.e. where she/he is not the original home leader appointed by the service at the outset) then much of the emphasis of the induction will need to be on:

- existing patterns, policies and routines within the homes (including details of assessment checklists, goal plan and individual programme

plan procedures)

- getting to know support staff and residents
- learning about the current stage of development of the service overall and plans for its future (especially in relation to the establishment and support of future homes)
- financial procedures within the houses

LENGTH OF INDUCTION PERIOD

1. This will vary from service to service.

2. At Wells Road, the induction programme for the initial home leader was spread over a six week period, several mini placements (of 3 days each) being sandwiched between "real work", particularly towards the end of the period.

3. The induction programme for the second home leader - who replaced the first home leader after 18 months - was scheduled over a shorter, three week, period. A longer induction (which might have included mini placements) was not possible because:

(i) the longer the induction continued, the longer the residential service had to operate without an immediate manager

(ii) it would have been difficult (for financial reasons) to have arranged for the home leader's shifts in the houses to be carried out by a temporary worker for longer than a month.

NB. The home leader himself felt a further week's induction (making one month in total) would have been ideal.

4. For both home leaders, "induction" merged into "real work" well before the

induction period was formally over.

COMMENTS

1. The comments made on pp. 47 - 48 above, on the project officer's induction, apply to the home leader's induction also.

2. It is helpful to offer a structured programme at the beginning of the induction, with flexibility for the home leader to shape later parts of it as she/he sees fit.

3. If the home leader is appointed some time before the first homes are opened, it is vital to allocate time early on in the induction for him/her to discuss with the project officer their different areas of responsibility within the service, both now and in the future.

4. It is important to ensure that the home leader has a breathing space of, say, a month of "nine to five" days for his/her induction programme. Not everything she/he needs to know in this period can be learnt just by being "on the job". Make sure that his/her shifts in the houses are covered during this period to make a proper induction programme possible (e.g. by the employment of a relief or temporary member of staff).

COMMUNITY SUPPORT WORKERS (DOMICILIARY CARE ASSISTANTS)

PLANNING THE INDUCTION PERIOD

See p. 48 above, "Planning the induction period of the home leader".

CONTENT OF THE INDUCTION PERIOD

This will depend upon:

- the background and experience of the particular community staff employed
- whether community staff are employed before, after or at the same time as the support staff recruited to work in the staffed houses. (In the latter case, you will need to decide whether the community staff will participate in exactly the same training programme as the home support staff - see pp. 58-72 - or only some aspects of it).

The induction programme should, in any event, include the following areas:

1. **Introduction to the service - its history and structure; their role within it**

(i) Through meetings/discussion with:

- the service co-ordinator
- members of the project team (if appropriate)
- other service staff (e.g. the home leader, if she/he is already appointed).

(ii) Through visits to any homes already operated by the service, and meeting their residents and staff*.

(iii) Through study of the operational policy of the service and their own job descriptions.

* This was relevant at Wells Road since the community staff were employed after the first homes were set up. With hindsight, it would be preferable to employ community staff much earlier so that they would be responsible for making the initial contact with potential residents for the first home.

2. **Principles of normalisation**

See p. 43 above.

3. **Contact with key individuals and agencies locally with whom community staff may be working in the future**

e.g. community mental handicap nurses

clinical psychologist

speech therapist/physiotherapist/occupational therapist

mental handicap hospital

special school/school-leavers unit

Adult Training (Social Education) Centre

Sheltered workshop

Pathway officer

social workers

home care organiser and assistants (home helps)

voluntary work/volunteers organiser

sitting-in services (if such exist)

mental handicap information service

health visitors

technical/further education colleges

community centres

housing department/housing associations

sex education/personal relationship counsellors

parent groups

client groups

NB (i) It is vital that adequate time is set aside for meetings with local community nurses, social workers, health visitors and clinical psychologist(s) to agree their respective areas of responsibility and activity. (At Wells Road bi-monthly liaison meetings betwen these

groups have proved helpful for good working relationships beyond the induction period).

(ii) It is important that community staff have a chance to meet the actual fieldwork staff of other agencies with whom they will be in routine contact when they are working, rather than just their managers.

4. **Getting to know the local patch**

See p. 46 above.

This will give community staff the chance to begin to collate information on local resources, e.g. sympathetic dentists, opticians etc.*

LENGTH OF INDUCTION PERIOD

1. At Wells Road, the induction period for the community support workers lasted about a month.

2. Towards the end of this period almost half their time was spent "doing the job", i.e. gradually making contact with clients and their families.

3. The community support workers recruited to Wells Road had extensive experience and contacts in the field. Less experienced staff would probably require a more structured programme for the full four weeks.

COMMENTS

1. If you are appointing more than one community support worker, the induction programme will need to take account of differences between them in existing experience and expertise. However, you may find that this means they can be

*For more details on collating this kind of information see p. 65

useful as resources for each other (and the service) in suggesting helpful contacts and sharing personal knowledge and skills.

2. If you appoint community workers without substantial prior experience of skill teaching and goal planning, then these areas will need to be covered in the induction. They may also need some input on individual programme plans. (See p 49)

3. It is very important to leave adequate space in the induction period for the community workers to spend time together and with the project officer, getting to know each other and working out effective ways of working together in the future.

4. It is useful to leave gaps when arranging the initial programme, so that the community workers can fit in any extra visits/meetings etc. that they feel are necessary.

5. If it is possible to arrange for community staff to meet with others doing similar work elsewhere, this may be helpful, given the infinitely wide scope of their role*.

6. In view of the apparently limitless nature of their job and the lack of comparable posts elsewhere, it is important to ensure regular support/supervision is available to community staff from the outset. The service co-ordinator is probably the most appropriate person to provide this.

*At the time of writing, the only roughly comparable posts seem to be the domiciliary care assistants employed at NIMROD (see p. 79).

SUPPORT WORKERS

PLANNING THE INITIAL TRAINING PERIOD

1. It is best if one person has responsibility for co-ordinating arrangements and planning the support staff's training.

2. The most appropriate person to do this will vary from service to service. The service co-ordinator, home leader or a clinical psychologist involved in the service might take on this role in different projects. In large scale projects or services, there may even by a designated "training officer" with this responsibility.*

3. Discussions about the length and format of the training period need to start early, to ensure that speakers, placements, workshops etc can be booked to take place at an appropriate stage in the training, rather than organised on a fragmented, ad hoc basis.

4. Preliminary discussions about the training should involve:

- the service co-ordinator
- home leader
- clinical psychologist
- other members of the project team (if appropriate)
- any professionals working locally in the field of training, who have a relevant contribution to make (e.g. those involved in nurse education, social services training, WEA etc).

*e.g. In some Welsh counties as part of the All-Wales Strategy

5. It will pay dividends to consult with people who have run, or advised on, other staff training programmes elsewhere before deciding on the final format of the training period. (See names and addresses on pp. 77 - 80).

6. At this early planning stage, you need to decide upon:

i. the approximate length of the training

ii its overall objectives

iii particular skills that it is important for staff to acquire

iv an appropriate co-ordinator/chairperson/tutor for the group throughout the training period

v an outline plan of the structure, content and methods of training to be adopted

vi the staff who will attend

vii potential venues

viii the budget available

i. **The approximate length of the training**

In many schemes this will not be known for certain when the initial training is being planned. It will often depend on when the houses in which the staff are to work finally become ready for habitation. Since completion dates for alterations/decorations to houses are notoriously unreliable, you will probably need to agree an ideal length of training (say 6 weeks), with contingency plans available should the opening date of the houses be delayed.

ii. **Objectives**

Detailed consideration of the job descriptions and responsibilities of the staff once in post should help in the identification of the overall objectives of the training. They should be agreed by the relevant professionals involved in planning

the training and recorded in as precise and specific wording as possible. Try to indicate by the side of each listed objective, how it will be achieved, (e.g. via placements, visiting speakers, the home leader etc).

iii **Particular skills**

Consult the job descriptions of the staff to identify particular skills you expect them to need once they are in post. Again, indicate by the side of each listed skill, the way in which you intend it should be acquired.

iv **Co-ordinator/chairperson/group tutor**

Staff experience of the training period will obviously benefit if there is a constant co-ordinator/tutor present throughout, who is able to draw together the different elements of the training programme for both staff and visiting speakers. The presence of a constant co-ordinator/tutor will also facilitate staff feedback on the training as it progresses, and enable the planned programme to be modified as appropriate.

In some services, it will <u>not</u> be feasible for a senior member of staff (say the service co-ordinator or home leader) to be constantly available throughout the training period because of other demands on their time (e.g. overseeing alterations to, and equipment of, houses; making contact with clients and their families etc). In this case, it will help if they can:

a. arrange for someone with skill and experience in staff training to act as a group tutor to the staff on a regular basis (say once a week for a two hour period) discussing their experiences of placements, any reading and individual work they have been set and any other topics agreed with

training organisers.*

b. set up regular feedback sessions themselves with the staff throughout the training period.

c. be present during training whenever possible so they are informally available to staff without difficulty.

d. ensure visiting speakers are thoroughly briefed beforehand

- on the exact nature of the service in which the staff are employed and the kinds of duties they will fulfil
- their backgrounds and training so far
- the likely extent of their knowledge in the speaker's field
- the desired focus and format of the speaker's contribution

v. **An outline plan of the training**

It will encourage a more coherent structure to the training if an outline plan or timetable is agreed at an early stage, and speakers, films, visits etc. are slotted into this overall framework. A possible outline plan might be as follows:

Mondays - domestic areas/topics to do with the house and the service (led by service co-ordinator/home leader)

Tuesdays - **am** discussion group (group tutor)
pm outside speaker on related theme

Wednesdays & Thursdays placements or workshops (e.g. normalisation, goal planning, individual programme plans, skill teaching)

Fridays - private study day (for staff to do reading and individual set work)

*This proved to be a very successful arrangement at Wells Road (see p. 98).

vi. **Who will attend?**

Might your training programme be of interest to other agencies working locally in the mental handicap field? If so, try contacting them to see if you might share resources, venues, workshops etc.

Advantages

- contact between your staff and their colleagues in other related fields
- an increased awareness of the work and viewpoint of different professionals
- possibly, material benefit (e.g. with resources, equipment, venues etc)

Disadvantages

- the programme may have to be re-thought (to take account of the different staff needs) to such an extent that the needs of your staff are not well met.

vii. **Potential venues**

If you do not have suitable premises of your own, try community/resource centres, technical and adult education colleges, or other facilities owned by health, social services, education authorities in the local area. Ideally, you will need one comfortable room which is "yours" throughout the training period, which will "black-out" for slide shows etc and where things can be left on the walls overnight and at weekends; access to kitchen facilities (for coffee and tea, and preferably for working on domestic teaching methods and skills) and the use of an additional room for workshops.

In practice, locating suitable venues for a prolonged (six week) period is extremely difficult, particularly in term time. Good venues are often very expensive.

It makes sense to start looking early for the kind of venue you require. An uncomfortable environment will detract from the positive aspects of your training programme and make learning far from easy for your staff.

vii. **The budget available**

Putting on extended training programmes is not cheap. Your budget will need to cover:-

- hire of your training venue
- costs of special workshops (e.g. normalisation, goal-planning)*
- payment of group tutor (if used)
- hire of films, videos etc.
- teaching materials (flip charts, felt tip pens etc)
- any expenses to speakers

7. You will need to strike a balance in your planning between ensuring that the training programme has a coherent structure and is well organised in advance, and that it is sufficiently flexible to respond to the expressed needs of the staff as it progresses. Leaving a few slots in the time-table free after the first couple of weeks should give sufficient flexibility for this purpose.

CONTENT OF TRAINING PERIOD

The exact content of the initial training period will be determined by:

- the objectives agreed (see p. 59)
- the support staff's job description (outlining tasks and responsibilities)

*Contact addresses on pp. 77 - 78 for quotation of likely costs.

- the skills identified as necessary in this work (see p. 60)
- staff backgrounds and experience

However, experience suggests that the following should be included.*

1. **Introduction to the service (its history, philosphy and structure) and their role within it**

(i) through discussion with service co-ordinator/home leader

(ii) through reading/discussion of operational policy for service

(iii) through discussion of their job description

2. **Normalisation workshop**

Lasting 2 - 3 days, preferably in the second or third week of training. (Contact CMHERA, see p. 77 for details).

3. **Goalplanning/individual programme plan workshop**

One day workshop(s), towards the end of the training period. (See pp. 77 - 78 for details).

4. **Placements in other local mental handicap services/agencies**

(i) Proper preparation (e.g. on what staff should be looking for, what they are expected to feedback to the whole staff group later about the service etc) is essential, as is thorough feedback and discussion afterwards, so that staff can share their perceptions and experiences with each other.

(ii) Host agencies also need adequate preparation by those organising the training to ensure that staff are given the opportunity to experience work in that situation rather than simply a "guided tour".

*For the actual time-table followed at Wells Road see p. 94

(iii) Placements need to operate for 2 - 3 days a week for several weeks, to give staff the chance to share and learn from their experiences in their weekly group discussions, as the placements progress.

5. **Skill Teaching**

A series of sessions, led by a clinical psychologist, in consultation with the home leader, on how to approach skill teaching with residents.

6. **Mental Handicap Services**

Information on different mental handicap services, their development and how they link up locally. Different aspects may be contributed by visiting speakers (e.g. local community nurse, social worker etc.), provided that they are well briefed (see p. 61 above), and by the group tutor, drawing on staff's past work and current placement experiences.

7. **Community Resources**

Detailed information on the local community, e.g. bus routes, early closing day, different churches, doctors, dentists, opticians and other services, leisure facilities (costs and opening hours), location of supermarkets and different kind of shops (including take-away meals), pubs, post offices, banks, parks, schools and other education facilities, local social service and social security offices, clubs, social groups and so on. Also, information on the social make up of the area, the kind of housing in different localities, any industrial development or factories.

(i) Most of this information can best be obtained by dividing up the catchment area into segments and giving staff time to go walkabout, collecting details on their segment.

(ii) The material collected can then be shared at the weekly group discussion and

individuals given the responsibility of transferring the information on to separate index cards, so that it is available as a permanent resource for staff once they are in post.

(iii) A system for updating information in the future also needs to be agreed at this time.

8. Social and Medical Aspects of Mental Handicap

The distinction between impairment, disability and handicap and the secondary effects of institutionalisation and "over protection"; psychological and psychiatric problems; different medications and their effects; common syndromes.

(i) These may be covered in a series of sessions, either by a senior member of the service (e.g. the service co-ordinator) or a local psychiatrist with a good understanding of the service and a social rather than a medical perspective on handicap.

(ii) The ability to present material in a lively and interesting way is vital if these sessions are not to degenerate into traditional lectures on the 'aetiology of mental handicap'.

9. Parents' Experiences and Perspectives

Relating to parents will be an important area of activity once support staff are in post. An understanding of parents' experiences with their handicapped relative and with mental handicap services in the past is vital if staff are to carry out this part of their role effectively and with sensitivity. Useful ways of increasing staff awareness in this area are:

(i) reading and discussion of biographies (see below)

(ii) talking with 2 or 3 local parents

(iii) role playing a parent in the catchment area who is contacted with news of the service that is just about to begin operation. How would you feel/react? Why?

10. **Study of Biographies**

Careful reading and discussion by staff of various (auto)biographical studies about the lives of different mentally handicapped people and their families will give them valuable insights into this area.

(i) Staff should be asked to read one book each (preferably during time specially allocated to them for such private study).

(ii) They can then be asked to prepare a chart from the book, depicting the various key events in the life of its subject and his/her family, and the support services that were (or were not) available to them at the time.

(iii) Presenting, and discussing their charts at the weekly group discussion will, with appropriate planning and leadership, lead staff to an increased understanding of families' experiences of mental handicap services in the past, their attitude to and expectations of them in the present, and the development of services generally.

11. **Domestic arrangements, skills and procedures in the house(s)**

Working out procedures for shopping, budgeting, cooking, cleaning and other day to day routines in the houses; how to cope with emergencies, aggressive behaviour etc; how to promote consistency between staff in their approaches to work with residents.

These issues can be worked out with the home leader towards the end of the training period. (Possibly in the house itself in the time before residents move in, when staff are taking deliveries of furniture, hanging curtains etc).

12. **First Aid**

A series of practical sessions on basic first aid.

This was included in the Wells Road training as an afterthought, at the specific request of the support staff, and was a great success.

13. **Introduction to residents and their families**

Information about (potential) residents and their families will need to be made available to staff as training progresses, and contact between them gradually established.

14. **Speakers**

Visiting speakers may be a useful source of information for staff on local services etc. It is vital, however, to ensure that:

- they are well briefed (see p. 61)
- they are interesting speakers (not only competent practitioners)
- they are slotted into the training period at an appropriate point (i.e. their contribution should complement other areas being studied by the support staff at that particular time).

15. **Films and Videos**

Well chosen films or videos, slotted into the timetable at an appropriate point, make an enjoyable change for staff in their training programme, and provide a useful stimulus for discussion.

Sharing films with other mental handicap agencies in your area will reduce hire costs and, if the films are shown to an audience of mixed professionals, should make for more interesting discussion afterwards.

16. **Private Study Time**

If possible, make sure some time is allocated each week for staff to read or carry out other individual work set for them by the home leader or group tutor (e.g. see 10 above). It will not be feasible for staff to do work of this kind in addition to a full week's training programme unless time is made available for this purpose.

17. **Group discussions/group tutor**

Regular weekly discussion sessions led by a skilled group tutor with experience in staff training will provide a good forum for staff to share placement experiences, present individual work, learn more about mental handicap services and pool information about community resources. The advantages of a fixed, weekly group meeting of this kind are discussed above (p. 60).

18. **Regular feedback sessions**

Regular feedback sessions between support staff and training organisers are essential to draw different threads of the training together, and to ensure that any gaps identified by the staff in their training programme are filled appropriately. They also provide a good opportunity to find out how different parts of the training are going. Such feedback sessions are particularly important if group discussions of the kind described above are not possible.

LENGTH OF TRAINING PERIOD

1. About 6 - 8 weeks seems reasonable. This is long enough to include placements, individual set work, regular group discussions, a couple of workshops and input from speakers and films. It is not so long, however, that staff will start to chafe against continuing training, feeling that they are just "marking time" until they can really "start work" with residents. (See also p. 98, note 5).

2. In practice, fixing the exact length of the training period in advance is not easy, if the house(s) in which staff are to work once their initial training is over, are not yet completed. It is wise to draw up contingency plans in advance, in case the opening of the houses is delayed and the training period therefore prolonged. If your service already has houses in operation, it may be feasible for some of your staff to help out in these. Otherwise, staff might work individually with clients and potential residents in their own homes, in local day services, or in the community, perhaps helping them to make use of ordinary leisure and other facilities.

COMMENTS

1. Early planning is essential - if planning is delayed it becomes impossible to stick to a firm, coherent, overall structure for the training. Speakers and workshop organisers will have to be slotted in when they are available instead of when they would be most appropriate. A fragmented programme will result which staff are more likely to experience as "filling in time".

2. Planning takes time - it will be difficult for the service co-ordinator or other training organisers to carry out all their usual duties (e.g. contact with clients) in addition to organising training, booking and briefing speakers, workshop leaders etc., and being available for feedback and other sessions throughout the period.

3. Briefing speakers - in some detail pays dividends in ensuring that their contribution to the programme is useful to staff (see p. 61).

4. Finding an appropriate venue may be a headache. Start looking early.

5. If the training programme is intended for community staff as well as home support staff, make sure it is equally relevant to both. Where there are areas of relevance to one group only (e.g. working out domestic details in the houses), plan alternative options for the others at that time (e.g. visits to local agencies, see p. 55). Avoid making staff sit in on sessions that are irrelevant to their own future work. They will only feel resentful that the training has been designed to meet other people's needs rather than their own.

6. If you set up evening placements (e.g. at a hostel or Gateway Club), make sure that training finishes early on some days to compensate.

7. Make sure that the programme is flexible. Leave some gaps so that you can take account of staff suggestions made during feedback sessions.

8. Collect as much feedback from the staff during their training as you can, through regular feedback sessions and/or simple evaluation sheets for them to complete.

9. After the training period is over, and staff have been at work for some months, ask them to identify gaps in their initial training on the basis of their experiences "on the job". Their ideas will be useful when you plan future training programmes.

10. The relative intensity of the training period may leave staff with a feeling of anticlimax once they start work in the houses. This is particularly likely if residents move in only gradually, so that staff are initially under stretched. It will help if you can:

- prepare staff beforehand for possible feelings of anticlimax at this stage
- make sure that space (and support) is available for them to voice these feelings
- ensure that they have plenty to do (e.g. completing the community resources information bank, see p. 65).
- reassure them that they will not remain under stretched for long!

11. Not everything staff need to know can be learned during initial training. Some things will have to be learned "on the job"; others through later training days which can build on experience gained in post. A commitment by your service to ongoing in-service training is, therefore, essential.

5. WHERE TO GO FOR MORE INFORMATION

I. USEFUL READING MATERIAL

1. DEVELOPING COMMUNITY RESIDENTIAL SERVICES

Centre on Environment for the Handicapped (1981): Housing projects for mentally handicapped people. Seminar report (London, CEH)

Firth, M. and Firth, H. (1982): Mentally handicapped people with special needs (London, King's Fund Centre)

Gathercole, C.E. (1981): Residential alternatives for adults who are mentally handicapped (4 pamphlets).

1. The resettlement team
2. Group homes - staffed and unstaffed
3. Family placements
4. Leisure, social integration and volunteers

(Kidderminster, BIMH)

Heginbotham, C. (1981): Housing projects for mentally handicapped people (London, CEH)

Heginbotham, C. (1983): Promoting residential services for mentally handicapped people (London, CEH)

King's Fund Centre (1980, 1982): An Ordinary Life. Comprehensive locally based residential services for mentally handicapped people. (London, Kings Fund Centre)

Shearer, A. (1981): Bringing mentally handicapped children out of hospital (London, King's Fund Centre)

Ward, L. (1982): People First. Developing services in the community for people with mental handicap. (London, King's Fund Centre).

2. SELECTION AND TRAINING OF STAFF

Allen, P. (1983): "Training direct care staff" in Shearer, A. (See below), pp. 34 -40.

Felce, D. (1983): "Selection, recruitment and promotion" in Shearer, A. (See below), pp. 31 - 3

Felce, D., Jenkins, J., Mansell, J., de Kock, U., Toogood, S., Pomfrey, A. (1982): Staff induction training (University of Southampton, Health Care Evaluation Research Team)

GNCs/CCETSW (1982,83): Cooperation in training. Report of the joint working group on training for staff working with mentally handicapped people

Part 1: Qualifying training
Part 2: In-service training

(London GNC/CCETSW)

Shearer, A. (1983 ed): An Ordinary Life. Issues and strategies for training staff for community mental handicap services. (London, King's Fund Centre)

3. JOB DESCRIPTIONS

Mathieson, S., Wilson, C., Jordan, P., Rowlands, C. (1983): "Defining tasks: from policies to job descriptions" in Shearer, A. (See above)

4. POSITIVE MONITORING/SUPPORT FOR STAFF

Houts, P.S. and Scott, R.A. (1975): How to catch your staff doing something right (Hershey, Pennsylvania: Hershey Medical Centre)

5. GOAL PLANNING/INDIVIDUAL PROGRAMME PLANS

Blunden, R. (1980): Individual plans for mentally handicapped people: a draft procedural guide (Cardiff, Mental Handicap in Wales - Applied Research Unit)

Felce, D., Jenkins, J., Toogood, S., Mansell, J. and de Kock, U. (1982): Individual programme planning. Handbook for Keyworkers (University of Southampton, Health Care Evaluation Research Team)

Houts, P.S. and Scott, R.A. (1975): Goal planning with developmentally delayed persons: procedures for developing an individualised client plan (Hershey, Pennsylvania: Hershey Medical Centre)

Jenkins, J., Felce, D., Toogood, S., Mansell, J. and de Kock, U. (1982): Individual programme planning. Handbook on chairing the meeting (University of Southampton, Health Care Evaluation Research Team)

6. NORMALISATION

O'Brien, J. and Tyne, A. (1981): The principle of normalisation: a foundation for effective services (London, CMH)

7. COMMUNITY SERVICE VOLUNTEERS (CSV): INDEPENDENT LIVING SCHEME

Shearer, A. (1982): Living Independently (London, CEH and King's Fund Centre)

8. PARTICULAR LOCAL SERVICES (EXISTING OR PLANNED)

i. **Ashington, Seaton Delaval & Berwick Houses - Northumberland Health Authority**

- **small homes for children and young people previously in long-stay hospitals**

Allen, P., Brown, F., Carruthers, P., Robson, I. (1983): "Getting severely mentally handicapped children and young adults out of hospital to live in ordinary housing" in APMH: Mental handicap: Care in the Community (London, Association of Professions for the Mentally Handicapped)

ii. **Burnley Project - NW MIND, in association with Calderstones Hospital, Lancashire.**

- **small homes for profoundly handicapped young people, previously resident in Calderstones Hospital**

Brandon, D. (1983): "Settling in Burnley". Open Mind, No. 2, April/May, p.7

iii. ENCOR

- **pioneering, comprehensive service for people with mental handicap in Eastern Nebraska.**

Thomas, D., Firth, H., Kendall, A. (1978): ENCOR - a way ahead (London, CMH)

iv. **Foulkes House - MENCAP Homes Foundation**

- **home for eight mentally handicapped young people/adults in South London**

Murray, Nicholas (1983): "A permanent home" Community Care, October 13th, pp. 16-17

v. **Lewisham & North Southwark Health Authority**

- **detailed plans for comprehensive local services in South East London**

Guys Health District (1981): Report of the development group for services for mentally handicapped people (London, Lewisham & N. Southwark Health Authority)

vi. **INTEGRATE, Preston & Chorley - voluntary organisation, in association with NW MIND**

- **residential service in Preston for adults previously in hospital.**

Brandon, D. (1983): "Hard journey home" Social Work Today 25.01.83, p.13

vii. **NIMROD - County of South Glamorgan**

- **comprehensive service for people with mental handicap in South Glamorgan**

Humphreys, S., Lowe, K. & Blunden, R. (1982, 1983): Long-term evaluation of services for mentally handicapped people in Cardiff 1. Annual Report for 1981 2. Annual Report for 1982 (Cardiff, Mental Handicap in Wales - Applied Research Unit)

Murray, N. (1984): 'A chance to develop' Community Care, April 26, pp. 18-19

Welsh Office (1978): NIMROD: Report of a joint working party on the provision of a community based mental handicap service in South Glamorgan (Cardiff, Welsh Office)

viii. **North West Regional Health Authority**

- **plans for comprehensive local services in the North West**

NWRHA (1982): Services for people who are mentally handicapped - a model district service (Manchester, NWRHA)

ix. **Skelmersdale Project - Barnardo's North West Division**

- **small homes for children with severe mental handicap**

Wolfarth, P. (1982): Barnardo's Skelmersdale Project (Liverpool, Barnardo's NW Division)

x. **Wells Road Service - Bristol and Weston Health Authority**

- **comprehensive community service for adults with severe mental handicap in South Bristol**

Ward, L. (1983): "An Ordinary Life". Community Care, November 10th, pp. 15 - 18.

xi. **4 Weyhill Road; 8 Wolversdene Road, Andover - Winchester District Health Authority**

- **staffed homes for adults with severe/profound mental handicap**

Mansell, J., Felce, D., Jenkins, J., de Kock, U. and Toogood, S. (1983): "A Wessex home from home" Nursing Times, 03.08.80 pp. 51-6

II. USEFUL CONTACTS/ORGANISATIONS

1. For information about **conferences/workshops on aspects of setting up/running community residential services,** contact:

ASSOCIATION OF PROFESSIONS FOR THE
MENTALLY HANDICAPPED (APMH)
Greytree Lodge
Second Avenue
Greytree,
Ross-on-Wye
Herefordshire.

Tel: 0989 62630

BRITISH INSTITUTE OF MENTAL HANDICAP (BIMH)
Wolverhampton Road
Kidderminster
Worcs DY10 3PP

Tel: 0562 850251

CASTLE PRIORY COLLEGE
Thomas Street
Wallingford
Oxon OX10 0HE

Tel: 0491 37551

CENTRE ON ENVIRONMENT FOR THE HANDICAPPED (CEH)
126 Albert Street
London NW1 7NF

Tel: 01 - 482 2247

KING'S FUND CENTRE
(LONG-TERM & COMMUNITY CARE TEAM),
126 Albert Street
London NW1 7NF

Tel: 01 - 267 6111

2. For advice/information on **staff training and workshops,** e.g. normalisation, PASS (Program Analysis of Service Systems), goal planning etc. contact:

COMMUNITY AND MENTAL HANDICAP EDUCATIONAL AND
RESEARCH ASSOCIATION (CMHERA)
12a Maddox Street
London W1R 9PL

Tel: 01 - 492 0728

JAN PORTERFIELD
Service Development and Staff Training Adviser
10 Gordon Close
Old Marston
OXFORD OX3 0RG

Tel: 0865 241200

3. For information on **the use of volunteers** in community services contact:

COMMUNITY SERVICE VOLUNTEERS (CSV)
237 Pentonville Road
London N1 9J

Tel: 01 - 278 6601

4. For information on **the location of existing community services** in this country contact:

CAMPAIGN FOR MENTALLY HANDICAPPED PEOPLE (CMH)
12a Maddox Street
London W1R 9PL

Tel: 01 - 492 0727

KINGS FUND CENTRE
(LONG-TERM AND COMMUNITY CARE TEAM)
126 Albert Street
London NW1 7NF

Tel: 01 - 267 6111

5. For information **about particular existing services** contact:

i. The District Psychologist
Northgate Hospital
Morpeth
Northumberland

Tel: 0670 512281

- for information on **Ashington, Seaton Delaval and Berwick** homes (see p. 75)

ii. North West MIND
Suite 223
Miller House
Miller Arcade
Preston
Lancs PR1 2QA

Tel: 0772 21734

- for information on NW MIND's **Burnley Project** (see p. 75)

iii. CROXTETH PARK PROJECT
24 - 6 Cruchian Way
Croxteth Park
Liverpool

- for information on **Croxteth Park Project** - Barnado's Project for eight profoundly, multiply handicapped children previously in long-stay hospitals now living on an ordinary residential estate in the community.

iv. INTEGRATE
75 Garstang Road
Preston
Lancs

Tel: 0772 24755

- for information on **INTEGRATE** (see p. 75)

v. MENCAP HOMES FOUNDATION
123 Golden Lane
London EC1

Tel: 01 - 253 9433

- for information on **Foulkes House** and **MENCAP Homes Foundation** generally (see p. 75)

vi. NIMROD
The White Houses
40/2 Cowbridge Road East
Cardiff CF1 9DV

Tel: 0222 373002

- for information on **NIMROD** (see p. 76)

vii. ORDINARY LIFE PROJECT ASSOCIATION
c/o Allan Stephenson (Acting Chairman)
St. John's Hospital
Bradley Road
Trowbridge
Wilts

Tel: Trowbridge 63936

- for information on the **Ordinary Life Project Association** - part of a scheme to replace existing hospital provision with an entirely community based residential service for people with mental handicap within Bath Health District

viii. BARNARDO'S SKELMERSDALE PROJECT
110 Inglewhite
Birch Green
Skelmersdale
Lancs

- for information on **Barnardo's Skelmersdale Project** (see p. 76)

ix. WELLS ROAD SERVICE
Knowle Clinic
Broadfield Road
Knowle
Bristol BS4 2UM

Tel: 0272 710582

- for information on **Wells Road Service** (see p. 76)

x. Winchester District Unit Management Team
Silverhill
Winchester

or

Health Care Evaluation Research Team
45/7 Salisbury Road
The University
Highfield
Southampton
Hants SO9 5NH

Tel: 0703 583485

- for information on **Weyhill Road/Wolversdene Road homes, Andover** (see p.76)

APPENDIX 1 - JOB DESCRIPTIONS OF WELLS ROAD SERVICE STAFF

PROJECT OFFICER/SERVICE COORDINATOR*

GRADE: Senior Administrative Assistant (A & C Scale 4)

RESPONSIBLE TO: Unit Administrator, Mental Handicap Service

RESPONSIBLE FOR: Home Leader, Support Staff, Community Staff and Secretary

LOCATION: Portakabin, Knowle Clinic

SUMMARY OF RESPONSIBILITIES

The Coordinator will be principally responsible for the continuing development, administration and management of the Wells Road Service overall, as directed by the Unit Administrator. The Coordinator is expected to provide a focal point for the development of the service.

PRINCIPAL DUTIES

1. (a) Be available to provide regular support and supervision to the Home Leader in leading the Support Staff team.

   (b) Assist the community support staff in the development of their work and provide regular support and supervision.

   (c) Be responsible overall for the management of the service, and monitor levels of support within the service.

2. To meet regularly with the project team and to assist the team in drafting operational policies for the service and keeping these under review.

   (a) Under the direction of the Unit Administrator, to implement decisions of the project team.

3. To be involved in gaining knowledge of a wide range of housing options and making these available to the clients of the service.

4. In conjunction with the joint funded psychologist, be responsible for the development of the IPP system with clients of the service and their families.

5. (a) To recruit staff for the service, and be responsible for organising induction and in-service training.

   (b) With the psychologist and clinical assistant, provide staff training to meet current needs.

*Current (not original) job description, revised 1984, to reflect shifts in emphasis of responsibilities since post was established.

6. Be responsible for the development of voluntary involvement with the service, and supervise the community support staff in their work with volunteers.

7. Disseminate information about the service. Attend and contribute to workshops, training courses, conferences and seminars as required.

8. Liaise with locally based agencies to promote an understanding of the service i.e. Local Authority Day Centres, Educational Establishments, Residential Services, Social Services etc.

9. Meet with clients of the service and their families when necessary either to establish contact or to ensure standards of support.

10. Liaise with locally based Health and Social Services personnel to negotiate the setting up of support networks from appropriate agencies for clients of the service.

11. Cooperate with and assist the research team in its evaluation of the service.

12. Ensure effective standards of employment procedures - recruitment, induction and training, employment documentation, terms and conditions of service, disciplinary procedures, coordination of annual leave, monitoring of attendance and sickness levels etc.

13. As a member of the administration staff of the Mental Handicap Unit, to contribute towards the development of services for people with a mental handicap within the Unit as required by the Unit Administrator, depending upon the requirements of the Wells Road Service.

TERMS AND CONDITIONS OF SERVICE

Staff will be employed under the Terms and Conditions of the Admin. and Clerical Whitley Council.

The main duties are as outlined above, but these will be subject to regular review and may be amended according to the needs and development of the service.

HOME LEADER (Job Description)*

LOCATION:	Wells Road houses
GRADE:	Admin. & Clerical, Scale 3
HOURS:	Normally 37 per week, including some evenings and weekends, Bank Holidays and sleeping in duty
RESPONSIBLE TO:	The Home Leader will be accountable to the Coordinator, Wells Road Service
RESPONSIBLE FOR:	Support staff employed in the homes

JOB SUMMARY

i. The Home Leader will be expected to play a leading role in the establishment of care policies and in the recruitment of other members of the support staff. Applicants will, therefore, be expected to have had extensive experience in the residential care and management of mentally handicapped people. A professional qualification in nursing (RNMS) or in residential social work or other appropriate equivalent experience and/or qualification is necessary.

ii. The Home Leader will be expected to provide and maintain a quality of life and a warm supportive atmosphere in which relationships between individuals can be warm, affectionate and caring; relationships which, at all times, acknowledge and respect the individual's rights and personal dignity of the residents. The Home Leader will ensure that the homes provide an atmosphere which is conducive to growth, physically, mentally, emotionally and spiritually.

PRINCIPAL DUTIES

1. The Home Leader is expected to provide leadership for the Support Staff team and to provide a focal point for the development of the homes as directed by the Coordinator.

2. Specific Tasks

   (a) Be available to provide regular support and supervision to the support staff.

   (b) Welcome parents and relatives to the homes, to maintain relationships between the resident and the family, and to cooperate with them in the on-going support for the resident.

   (c) Relief Staff. Be responsible for relief support workers employed by the service to provide full cover for the homes. Contact relief staff when they are required, guide and support them in their work, and keep records of their hours worked.

*Current (not original) job description, revised 1984, to reflect shifts in emphasis of responsibilities since post was established.

(d) Develop close contacts with the local community. This will be done by making relationships with neighbours and friends through whom the residents can acquire a sense of belonging to the neighbourhood.

3. Residents' Development

(a) Be involved with support staff, parents and other relevant professionals in implementing individual programme plans with residents. Monitor and record progess with these plans.

(b) Be responsible for drawing up individual teaching programmes and assist the support staff with skill teaching sessions, and record progress with goals.

(c) Be responsible for the satisfactory chairing of staff and review meetings, assist the support staff in minuting and recording the business of these meetings.

(d) Liaise with professional staff, parents and other people involved with individual residents.

(e) Encourage participation of residents and their families in decision making and planning mutually agreed objectives.

(f) Assist the support staff to complete initial assessments with residents and subsequent regular assessments of their skills.

4. Working Relations

Maintain good working relationships with other professionals, general practitioners, social workers, ATC staff, psychologists and members of other professions, including voluntary agencies, also develop and maintain good relationships with relatives, neighbours and others in the local community.

5. Staff Development and Training

Advise Coordinator on staff training needs and be involved with organising and contributing to in-service training to meet these needs. Attend and contribute to workshops, training courses, conferences and seminars as and when required.

6. Residents' Care

(a) Ensure and maintain a high standard of personal health and hygiene by the provision of a healthy environment and encourage regular exercise and satisfactory diet and rest.

(b) Assist the residents to register with local dental practitioners and GPs and regularly monitor the state of residents' health.

(c) Participate in preparation and serving of food in an attractive and suitable form and in making satisfactory communal arrangements for staff and residents to take meals together, as appropriate.

(d) Ensure that residents are appropriately clothed at all times including repair and renewal, and personal dress, wherever possible, is of their own choice.

(e) Ensure that the residents are introduced to and encouraged to take part in a wide range of stimulating and creative activities, both indoors and out of doors. Help residents in choice, acquisition and use of recreational and leisure materials and encourage contact with local people and community facilities.

(f) Be aware of the importance of spiritual growth as part of the residents' total development and take appropriate action to make this a reality in the residents' life.

7. Administration

(a) Report mishaps, accidents and complaints to the Administrator, Mental Handicap Services, via the Coordinator.

(b) Supervise work of the support staff and introduce new members of staff to their duties.

(c) Ensure that adequate supplies of food, crockery, cleaning materials plus other day-to-day household goods are purchased from local shops.

(d) Draw up a rota ensuring adequate staff cover for the homes, including the sharing of responsibility for sleeping in on an agreed rotation, for which an appropriate payment will be made.

(e) Regularly monitor the quality of life within the homes available to the residents.

8. Research

This is a new service which is being monitored and evaluated by the University Department of Mental Health. Staff of the homes will be expected to cooperate with the research team in their study of the new service.

9. Terms and Conditions of Service

Staff will be employed under the Terms and Conditions of the Administrative and Clerical Whitley Council.

The main duties of the post are as outlined above, but these are presently being reviewed and may be amended according to the needs and development of the service.

COMMUNITY SUPPORT WORKERS (Job Description)*

LOCATION:	Knowle Clinic
GRADE:	General Administrative Assistant
HOURS:	Normally 37 per week. This will include evenings, weekends and Bank Holidays for which enhanced rates of payment will be made.
RESPONSIBLE TO:	The community support staff will be accountable to the Administrator of Mental Handicap Services via the Service Coordinator.

JOB SUMMARY

1. Two community support workers will be appointed to the service. They will share responsibility for providing domiciliary support to individual clients and families under the immediate direction of the Coordinator who has been appointed to develop this new service. They will be accountable to the Administrator of Mental Handicap Services.

2. The community support staff will play a leading role in the establishment and maintenance of appropriate levels of care and support for people with mental handicap living within the catchment area of the Wells Road Service. Applicants will, therefore, be expected to have had extensive experience in the domiciliary support and/or residential care of adults who have a mental handicap. A professional qualification in nursing or in social work or other appropriate experience and/or qualification is necessary.

3. Community support workers will be expected to liaise with families, volunteers, foster parents, landladies and other professional workers to enable people with a mental handicap to enjoy a variety of living situations within the local neighbourhood, (e.g. living in flats, or houses or lodgings etc.). The responsibilities of the post will include identifying individual needs for support, preparing individualised plans for people referred to the service, fostering helpful relationships with families, implementing individual plans, teaching clients new skills as appropriate, and monitoring the quality of care available to clients of the service.

SPECIFIC TASKS

1. Family Support: To meet with the families of clients referred to the service and negotiate individual plans for the future support, care, development and management of each person appropriate to his or her needs.

2. Liaison: To liaise and maintain good working relationships with local authority social workers, adult training centre staff, community nurses, teachers and any other relevant professional staff concerned with the care and support of individual clients with whom they are involved.

*Original job description, currently under review.

3. Fostering good relationships: To foster helpful relationships between the clients of the service and volunteers, foster parents, landladies, neighbours, professional workers and agencies and other potential supporters and befrienders.

4. Record Keeping: To maintain up to date records of all clients notified to the service and to note the contacts and support made available to each client by the service; to ensure that appropriate written reports are prepared as required.

5. Reviews and case conferences: To take responsibility for ensuring that regular reviews are arranged for each client in the service and that relevant personnel are informed in advance of their occurrence; to attend reviews and case conferences as appropriate.

6. Training of clients: To assist in the development of training programmes which will enable clients to achieve higher degrees of independence in their daily lives, to be involved in the implementation of these plans and to record progress achieved.

7. Recreation and leisure: To facilitate opportunities for recreational and leisure pursuits appropriate to the age of the client making the fullest use of available resources in the local neighbourhood, and to foster social contacts and relationships with non handicapped people in the community.

8. Work with volunteers: To assist in the recruitment, preparation and training of volunteers to befriend and support individual clients in the service, to help their integration into the local community and to provide on going support for these volunteers.

9. Cluster housing development: To assist the Coordinator to identify suitable houses, flats, bedsitters or lodgings or other homes for the clients of the service, and to play a leading part in the commissioning and furnishing of cluster housing acquired from housing associations, the local housing authority or the private sector for this purpose.

10. Monitoring the quality of life: To monitor the quality of life within the cluster homes; ensuring that the client's right to privacy and independence is fostered and safeguarded, but that appropriate action is taken where the client's well being is endangered.

11. Cluster homes: To ensure the provision of support for residents in the cluster homes and to maintain liaison between volunteers, professional staff and other agencies involved in supporting the residents.

12. Staffed homes: To work closely with the Home Leader and the support staff to provide continuity of care for clients moving into and out of the staffed homes.

13. Training courses: To attend and contribute to workshops, training courses, seminars and conferences as and when such opportunities arise.

14. Research: To collaborate with the research staff in keeping records of daily activities and such other tasks as are from time to time introduced as part of the evaluation of the service.

Terms and Conditions of Service: Staff will be employed under the Terms and Conditions of the Administrative and Clerical Whitley Council.

The main duties of the post are as outlined above, but these will be subject to review and may be amended according to the needs and development of the service.

SUPPORT STAFF (Job Description)

LOCATION:	Wells Road, Bristol
RESPONSIBLE TO:	Home Leader
GRADE:	Higher Clerical Officer
HOURS:	A 37 hour week including some evenings, weekends and Bank Holidays
SPECIAL DUTIES:	1. Be part of a team to sleep in on an agreed rotation, for which appropriate payment will be made. 2. Assume responsibility for the Wells Road houses in the absence of the Home Leader.

GENERAL

1. Support staff will be expected to provide a high quality of care in the Wells Road houses and a warm, supportive atmosphere in which they can establish friendly and caring relationships with the residents, and which at all times acknowledge and respect the residents' personal dignity and individual rights. Staff will, therefore, be expected to have a positive attitude towards working alongside mentally handicapped people and a commitment to helping them secure for themselves as normal and enjoyable a life in their local community as possible. Experience of working with mentally handicapped people though very desirable is not essential as appropriate training will be provided.

2. The staff group will comprise, in addition to the Home Leader, six whole time equivalent support staff, of whom two will, on average, be present in the house in the daytime and one during the night. Staff will share all caring and housekeeping duties - there will be no cooks or domestic staff employed. Everyone will therefore share in:

(a) physical care - helping people living in the house to get up or go to bed, dress or undress, wash, use the toilet, eat at mealtimes, where they need assistance to do so.

(b) teaching - carrying out training sessions to develop residents' abilities, following written guidelines.

(c) arranging activities - working with people to engage them in purposeful activities as appropriate.

(d) housekeeping - cooking, cleaning, shopping, helping to look after residents' clothes etc. These activities will be arranged so that residents join in, although those who are very handicapped may only be able to do a little of each task themselves.

SPECIFIC DUTIES

1. Contact with relatives and the community

(a) Welcome parents and relatives to the house, to maintain relationships between the resident and the family, and to cooperate with them in the ongoing care and support of the resident.

(b) Develop close contacts with the local community. This will be done by making relationships with neighbours and friends through whom the residents can acquire a sense of belonging to the neighbourhood.

2. Residents' Care and Support

(a) Ensure and maintain a high standard of personal health and hygiene by the provision of a healthy environment and including regular exercise and satisfactory diet and rest.

(b) Assist the residents to register with local dental practitioners and GPs and regularly monitor the state of residents' health.

(c) Participate with the residents in preparation and serving of food in an attractive and suitable form, which staff and residents will eat together.

(d) Ensure that residents are appropriately clothed at all times, wherever possible in clothes of their own choice.

(e) Ensure that the residents are introduced to and encouraged to take part in a wide range of stimulating and creative activities, both indoors and out of doors. Help residents in choice, acquisition and use of recreational and leisure materials and encourage contact with local people and community facilities.

(f) Be aware of the importance of spiritual growth as part of the residents' total development and take appropriate action to make this a reality in the residents' life.

3. Residents' Development

(a) Be involved with the Home Leader, parents and any other relevant professionals in planning and implementing individual programmes geared towards promoting residents' development.

(b) Assist the Home Leader in monitoring and recording progress on the implementation of these individual plans.

(c) Assist the Home Leader in providing written reports on residents if

required.

(d) Attend reviews on the residents as appropriate.

(e) Liaise with professional staff, parents and other people involved with individual residents.

(f) Encourage participation of residents and their families in decision making and planning mutually agreed objectives.

4. Working Relations

Maintain with the Home Leader, good working relationships with other professionals, general practitioners, social workers, ATC staff, psychologists and members of other professions, including voluntary agencies, also develop and maintain good relationships with relatives, neighbours and others in the community.

5. Staff Development and Training

Attend staff training programmes organised within the home and attend and contribute to other workshops, training courses, seminars and conferences as and when required.

6. Administrative

(a) Report mishaps, accidents and complaints to the Home Leader.

(b) Assist in the introduction of new staff members to their duties.

(c) With the residents, purchase food, crockery, cleaning materials, plus other day-to-day household goods, from local shops.

(d) With the Home Leader, regularly monitor the quality of care within the house available to the residents.

(e) Attend staff meetings and act on decisions agreed there.

7. Research

This is a new service which is being monitored and evaluated by the University Department of Mental Health. Staff of the home will be expected to cooperate with the research team in their study of the new service.

Terms and Conditions of Service:

Staff will be employed under the Terms and Conditions of the Administrative and Clerical Whitley Council.

The main duties of the posts are outlined above but these will be subject to review and may be amended according to the needs and development of the service.

CLINICAL PSYCHOLOGIST (Job Description)*

GENERAL RESPONSIBILITIES

(1) To Chair Individual Programme Plan (IPP) meetings and share responsibility with Service Coordinator for implementing IPP system.

(2) To help identify and meet staff in-service training needs.

(3) To make recommendations to the Service Advisory Group on the eligibility of new clients.

(4) To attend the Wells Road Project Team meetings.

(5) To attend the meetings of the Service Advisory Group.

(6) To play a supportive role in relation to the Wells Road Service staff.

INVOLVEMENT WITH RESIDENTIAL SERVICE

(1) To participate in client review meetings and staff meetings, as appropriate.

(2) To develop and supervise skill teaching programmes for residents in conjunction with Home Leader.

(3) To act as consultant/supervisor for key support staff working with residents who require a specific management or therapeutic programme.

INVOLVEMENT WITH COMMUNITY SUPPORT SERVICE

(1) To act as consultant/supervisor for community support staff working with clients, and/or their families, for whom a specific treatment or management programme is required.

(2) In conjunction with community support staff to initiate innovatory schemes (e.g. leisure activities; work with volunteers) to facilitate/support living in the community.

TIME ALLOCATION

(1) It is recognised that the workload will vary throughout the three years and consequently it is not appropriate to stipulate a fixed number of sessions which will be allocated to this service.

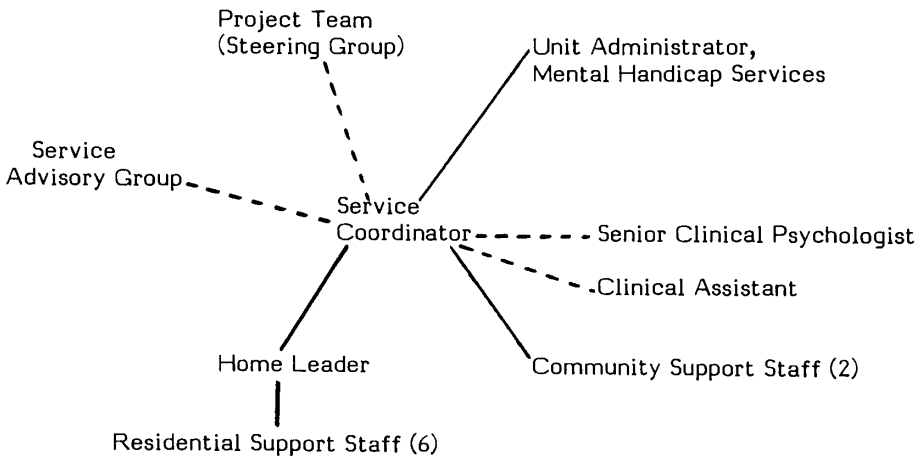
ACCOUNTABILITY

(1) While the post-holder will be expected to work in close consultation with members of other disciplines, he/she will be professionally accountable to the District Psychologist.

*Current (not original) job description, revised 1983.

SUMMARY OF STAFFING AND MANAGEMENT OF WELLS ROAD SERVICE

The staffing and management structure of the service is as follows:



—— = line of direct accountability

STAFFING

Coordinator, home leader, residential and community support staff - full-time posts, funded by the Wells Road Service, part of Bristol and Weston Health Authority.

Senior Clinical Psychologist - joint funded for 3 years. Employed through the District Psychology Service, to work both within Wells Road Service, and meeting other community needs.

Clinical Assistant - 2 sessions per week, funded by the Wells Road Service, on a trial basis to facilitate initial links with local GPs and provide support to the residential staff team as appropriate.

MANAGEMENT AND ACCOUNTABILITY

The service forms part of Bristol and Weston Health Authority's Mental Handicap Unit.

The **Coordinator** is directly accountable to the **Unit Administrator,** Mental Handicap Services.

The establishment and general policy development of the service has been overseen by a multi-disciplinary **project team.**

Guidance on more day-to-day issues is available to the service from a sub-group of the project team, the **Service Advisory Group**

GRADING OF POSTS

All ten full-time posts are on health authority administrative and clerical scales. This is to ensure that all posts within the service are open to applicants from as wide a range of backgrounds as possible, rather than being open only to those with nursing qualifications or experience. This decision was prompted by two considerations. First, the posts in question embrace a broader range of duties than those normally undertaken by nursing staff. (For example, within the houses there are no separate domestic or catering staff. Cooking and cleaning is shared by staff and residents as appropriate). Second, while some nurses might be suited to the innovative ways of working envisaged within the service, others might find their RNMS training and hospital experience of little relevance to supporting clients in the community towards more independent living. Since other professional qualifications or experience - e.g. in a social services setting or a voluntary organisation - may be more relevant to the new service, it is felt that applicants from these backgrounds should also be eligible for the posts. The ten staff appointed to the service do, in fact, come from a wide range of backgrounds, qualifications and experience - in nursing, education and residential work.

The different posts within the service are graded on the administrative and clerical scales as follows:-

SERVICE COORDINATOR
Admin. and Clerical, Scale 4
(Salary, £7,404 - £9,025 pa)

HOME LEADER

Admin. and Clerical, Scale 3
(Salary, £6,646 - £8,413 + £366 Hotel Allowance pa)

COMMUNITY SUPPORT WORKERS

General Administrative Assistant
(Salary, £5,670 - £7,404 pa)

RESIDENTIAL SUPPORT WORKERS

Higher Clerical Officer
(Salary, £4,686 - £5,670 + £366 Hotel Allowance pa)

Note

1. Salaries quoted are based on April 1983 salary scales.

2. **Coordinator/Project Officer posts** in services elsewhere are graded at a more senior level than at Wells Road. (Starting salary usually around £9,000 -£9,500).

3. **Home Leader and residential support staff posts** involve evening and weekend working which in practice enhances salary by around £1,200 pa.

APPENDIX 3 - SUPPORT STAFF INDUCTION:

OUTLINE TIMETABLE FOLLOWED AT WELLS ROAD

WEEK 1

Introduction - to each other - to induction	Introduction - to research and evaluation of training
Administration (time sheets/pay etc) TUTOR GROUP	Organisation of placements Family reaction to service (role play)
Origins of Wells Road Service Parent Talking I	Occupational Health checks
TUTOR GROUP	Visits to clubs etc (prior to early evening placements)
Choosing furnishings for houses	PRIVATE STUDY

WEEK 2

Psychologist - role in service Treating clients as 'People First' I	Individual Programme Plan
N O R M A L I	S A T I O N
W O R K	S H O P
Choosing furnishings for houses	PRIVATE STUDY

WEEK 3

"Accident of birth" "When the bough breaks" (Films)	SKILL-TEACHING WORKSHOP I
TUTOR GROUP	Choosing equipment for houses Social Worker - role in service
Aspects of mental handicap II Evaluation of induction (researcher)	SKILL-TEACHING II
PRIVATE	STUDY
SKILL-TEACHING III	Feedback on induction so far Treating clients as 'People First' II

WEEK 4

SKILL-TEACHING IV	Parent Talking II
TUTOR GROUP	Handling Violence
Aspects of mental handicap III	SKILL-TEACHING V
PRIVATE	STUDY
SKILL-TEACHING VI	Family therapy & mental handicap

WEEK 5

Family therapy and mental handicap (Cont) Complaints procedures	Parent Talking III
Aspects of mental handicap IV TUTOR GROUP	Community nurse - role in service
P L A C E	M E N T S
P L A C E	M E N T S
PRIVATE	STUDY

WEEK 6

Aspects of mental handicap V Evaluation of induction (researcher)	Planning remainder of induction and discussion
TUTOR GROUP	SKILL-TEACHING IV
P L A C E	M E N T S
P L A C E	M E N T S
PRIVATE	STUDY

WEEK 7

FIRST AID I	Avon Family Support Scheme
TUTOR GROUP	"Stepping Out" - (Film)
P L A C E	M E N T S
P L A C E	M E N T S
PRIVATE	STUDY

WEEK 8

"James is our brother" - (videos) "Adult placement"	Sexuality & mental handicap
Aspects of mental handicap V	PRIVATE STUDY
PRIVATE STUDY	GPs, families and mental handicap
Teaching interpersonal skills Visit to houses	Christmas party at ATC

WEEK 9

TUTOR GROUP	"Like us" (Films) "Mentally handicapped children growing up"
P L A C E	M E N T S
P L A C E	M E N T S
PRIVATE	STUDY

WEEK 10

Aspects of mental handicap VI Rights of mentally handicapped people	"Joey" - (film)
TUTOR GROUP	FIRST AID
P L A C E	M E N T S
P L A C E	M E N T S
PRIVATE STUDY	Choosing equipment for houses

WEEK 11

Community police service	Play Therapy
TUTOR GROUP	Health and safety at work First Aid III
P L A C E	M E N T S
P L A C E	M E N T S
PRIVATE	STUDY

WEEK 12

Planning first days in houses "Special Work Training Programme"(film)	Local people talking about area
TUTOR GROUP	Open afternoon at houses I (NB. Before residents moved in)
FIRST AID IV	Study of local area
Staff meeting and staff support	Volunteers - their role in service Open evening at houses II
PRIVATE	STUDY

NOTES ON SUPPORT STAFF INDUCTION

1. Tutor group sessions (see p. 69) covered the following broad areas:

   Discussion and presentation of material on biographies (see p. 67)
   Preparation and feedback on placement experiences (see p. 64)
   Collation of information on community resources (see p. 65)
   Different agencies involved in the provision of mental handicap services (see p. 65).

2. In addition to day placements (two days a week for six weeks), each member of staff had an early evening placement, in a club or other leisure facility for people with mental handicap (one evening a week for six weeks).

3. Experience at Wells Road, and at other services, suggests that some skills are more easily learned "on the job" than during an induction programme carried out beforehand. Staff may well need "refresher" sessions on techniques of goal planning, skill-teaching and individual programme planning, once they are actually engaged in working with residents in order to fully understand how to put them into practice. A commitment to providing workshops, in-service training or regular advisory sessions from a clinical psychologist after staff have taken up their posts is, therefore, essential.

4. The induction was originally planned to last six - eight weeks. Delays in work on the first houses to be established by the service resulted in the induction period being greatly extended.

5. Other schemes have organised induction programmes for their staff in other ways, often for much shorter periods of time. For some account of these, see pp. 73 - 4, or contact individual services as appropriate (see pp. 78 - 80).

6. A separate, and more detailed, account and evaluation of the induction programme organised for the support staff at Wells Road is in preparation.

APPENDIX 4 - NOTES ON THE EVALUATION OF THE WELLS ROAD SERVICE

The evaluation of the Wells Road Service is currently divided into five broad areas, as follows:

Study A - A detailed account and appraisal of the development, organisation and operation of the service.

Study B - Staffing - selection, training (initial and in-service) and support.

Study C - The "quality of life" enjoyed by clients and residents in the service.

Study D - The social integration and networks of clients and residents of the service in the local community.

Study E - Funding and costings of Wells Road (and other community services).

For further information on the evaluation, contact:-

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