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TRAINING for CHANGE

Staff training for 'An Ordinary Life'

Reports from two conferences held at the King's Fund Centre

Edited by Linda Ward & Julie Wilkinson

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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 eight 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); **People First - developing services in the community for people with mental handicap** (Project Paper No. 37, October 1982, price £6.00); **An Ordinary Life; issues and strategies for training staff for mental handicap services** (Project Paper No. 42, 1983. price £2.50); **Planning for People: developing a local service for people with mental handicap** (Project Paper No. 47, April 1984, price £4.00). **An Ordinary Working Life: vocational services for people with mental handicap** (Project Paper No. 50. 1984, price £2.50); and **The Employment of People with Mental Handicap: progress towards an ordinary working life** (Project Paper No. 55, July 1985, price £4.50).

TRAINING FOR CHANGE

Staff training for 'An Ordinary Life'

Reports from two conferences held at the King's Fund Centre on 23 November 1984 and 16 April 1985 to discuss issues, strategies and experiences in providing appropriate training for staff in new community services for people with a mental handicap.

Edited by

Linda Ward and Julie Wilkinson

University of Bristol

Department of Mental Health

June 1985

ACKNOWLEDGEMENTS

Special thanks are due to the Joseph Rowntree Memorial Trust for financially supporting the research on the Wells Road Service, and encouraging the active dissemination of its results.

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FOREWORD

Since of the publication of An Ordinary Life in 1980, the King's Fund has shared with a large and growing network of people across the country in efforts to develop comprehensive community-based services for people with mental handicap. Much of the early work in this initiative concentrated on clarifying the nature of residential and, subsequently, day services required to meet the principles of An Ordinary Life.

Increasingly these ideas are being reflected in local joint plans and in some places at least there are now good services on the ground, although typically still on a modest scale. As the authors of An Ordinary Life anticipated, experience has underlined the importance of staff training in its broadest sense as a fundamental contribution to the successful implementation of community-based services.

Three aspects of this training may be particularly worth emphasising. First, while there is no substitute for high quality planning, new services are only going to work as intended and be sustained if the staff involved have a clear sense of purpose and are committed to the principles upon which the plans have been based. As an earlier paper in this series emphasised, therefore, an important part of any educational strategy is the provision of opportunities for staff to explore the values essential to the development of these services (Issues and strategies for training staff for community mental handicap services).

Second, staff are of course the main resource in any service and the performance of front-line staff in particular is critical in shaping the daily experience of clients. Put simply, new services will not be any better than the traditional arrangements they replace unless front-line staff behave differently. It is vital therefore that investment in their recruitment and training is recognised as central to successful implementation.

Third, we also need to recognise that community-based services put quite new demands on managers. The way they exercise their responsibilities will be the main determinant of whether front-line staff are able to perform in different ways. Indeed in many situations managers are going to be the main source of training and support for service providers. Training strategies must also give careful attention therefore to managers' requirements.

In addressing each of these aspects of training, the current state of local service development and limitations in centrally- or regionally-organised training arrangements, means that innovative services must typically invest in tailor-made training and development programmes for people they employ to do new jobs.

One excellent example of a local initiative designed to do just this comes from South Bristol (the Wells Road Service). With the help of the staff involved, the experience of this service is being evaluated and written-up by a University research team. The King's Fund has already published the first in a series of papers by Linda Ward arising from the evaluation. This paper on Recruiting and Training Staff together with reports on other local training initiatives was the basis for two workshops held at the King's Fund Centre in late 1984/early 1985. What follows is a distillation of contributions and discussion at these workshops,

very helpfully edited by Linda Ward and Julie Wilkinson, a colleague in the University of Bristol's Department of Mental Health. We hope that the ideas and experiences reported here will be of wider value in local efforts to make optimum use of the human resources upon which good services depend.

King's Fund College
June 1985

David Towell

References

King's Fund Centre (1980): An Ordinary Life: Comprehensive locally-based residential services for mentally handicapped people (King's Fund Project Paper, No.24, reprinted June 1982).

Shearer, A. (1983 ed): An Ordinary Life: Issues and strategies for training staff for community mental handicap services (King's Fund Project Paper, No.42)

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DEVELOPING A LOCAL SERVICE: WHAT KIND OF TRAINING DO STAFF NEED?

Linda Ward

I would like to share with you some of the lessons that have been learned over the last two years in the service that I am involved with in Bristol.

The Wells Road Service is a community based service for adults with a mental handicap living in one part of South Bristol. The service has been guided in its development by the principles set out in the King's Fund Project Paper, An Ordinary Life. Any adult with a mental handicap living in the area is eligible for the service, however severe their handicap or additional problems. Residential accommodation is provided entirely through the use of ordinary housing, with differing degrees of staff support available according to individual needs. There is a detailed account of staffing issues in local services like Wells Road in Planning For People. Today I would like to focus mainly on aspects of staff training not included there.

I would like to start by putting the question posed in the title of my contribution "What kind of training do staff need?" into some kind of context. You cannot provide staff with an appropriate and useful training experience in a vacuum. You need to go through a number of vital steps beforehand.

If we were to think of staff training as a ladder, it might look something like the drawing on p.4.

Before you can answer the question about training at the top of the ladder, you have to address all the questions that come on the rung below. You have to decide:

1 What are the aims and principles of the service?

2 Who are the clients? What are their needs?

3 How many staff (are needed to help meet those needs)?

4 What kind of staff (are needed to help meet those needs)?

5 What kind of tasks (will they do to help meet these needs)?

6 What skills (do staff need to do these tasks)?

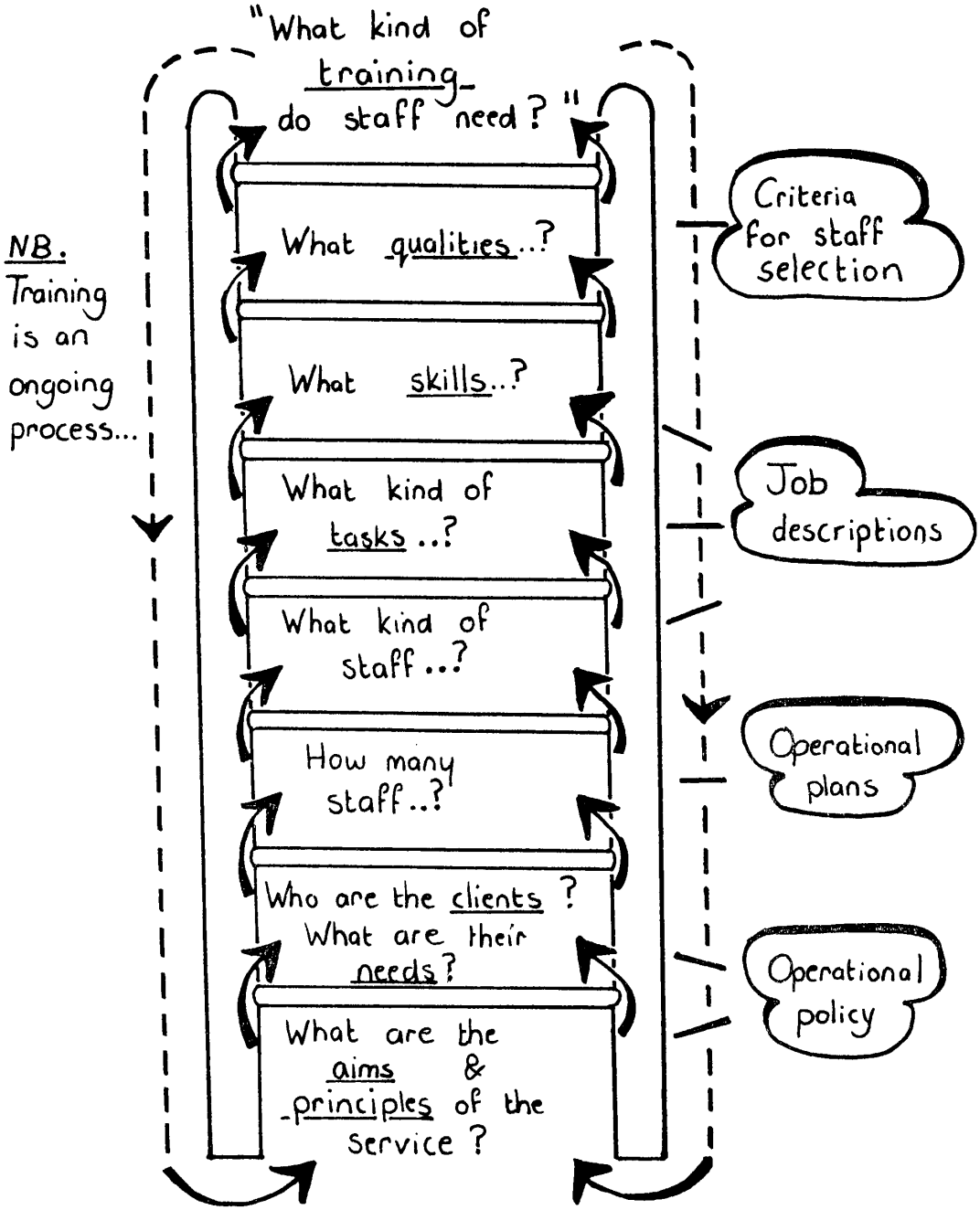
7 What qualities (do staff need to do these tasks)?

8 Therefore,

WHAT KIND OF TRAINING?

To answer these questions, you will need to spend a lot of time in discussion with all those involved with the service. You will also need to draw up an operational policy, operational plans, job descriptions for staff and the criteria to be followed in staff selection.

Staff training : first steps...



Of course the list of questions is not exhaustive. There are no doubt other steps which should be included. The point is that if you do not sort out Nos. 1 - 7 on the list adequately, then you cannot hope to succeed in No.8.

For instance, if a central aim of your service is to help clients and residents become more a part of their local community, mixing with predominantly non-handicapped people, then part of the staff training must be to acquaint them with community facilities and resources, and the different ways in which they may be able to help clients make use of them. (For example, through relatives, leisure volunteers, "befrienders", etc.) If this aim is not spelt out explicitly then there is a risk that staff training will neglect this in favour of more traditional but perhaps less practically relevant areas (e.g. "the causes of mental handicap").

Having successfully got through steps 1 - 7, step 8 is the organising of initial training, which itself breaks down into a number of further questions which look like this:

INITIAL TRAINING ..... SOME QUESTIONS

*OBJECTIVES?

What are the objectives of the initial training period?
What do we expect staff to be able to do by the end of this period? What skills do we expect staff to acquire?

*WHERE?

Where will the training take place?
Finding a suitable venue may be difficult. It will be easier for staff to learn domestic skills etc in the actual houses they will be working in but these houses may not be ready at the time of training, or this may be inappropriate for other reasons (e.g. if the house is small or if there are already residents living there).
Hospital space may be available but may not seem an appropriate place to learn about working in community services. Other training venues (like adult educational facilities) may be too expensive to book for an extended period.

*WHEN? HOW LONG FOR?

This may depend on when houses are ready for staff to work in, and residents ready to move in; this may not be known for certain when training is being planned.
A long enough period to cover all essential content will have to be balanced against questions of cost and once the service is operational, the question of how long temporary or other staff can cover while other staff are undergoing training.

*WHO FOR?

The same induction/training for all members of staff, or different packages for different staff groups?
Should training be shared with staff from other agencies, e.g. nursing assistants, local social workers, home care assistants, even administrators/service managers?
(At Wells Road the new unit administrator participated in the normalisation workshop organised for staff to the benefit of everyone.)

*WHO BY?

A training officer? - as in large agencies, social services departments etc.
A local psychologist?
The service's coordinator? Does s/he have the experience/expertise/time to do this?
An outside "trainer"? This was the solution adopted at Wells Road for part of the initial training of the residential staff.

*HOW MUCH?

Training can be expensive.
Make sure there is an adequate allocation for it in the budget!

..... and, most important, the questions of "WHAT" and "HOW" in organising an initial training package.

AN INITIAL TRAINING PACKAGE

Different staff at Wells Road had different induction training. (Details are given in Planning For People.) However, four broad core elements were common to them all.

1. Workshops (or other input) on: normalisation
   individual programme plans
   goal planning
   skill teaching
   for staff who did not already have expertise in these areas.

2. Information and contact with local services and agencies
   e.g. ATC, sheltered workshop, 'special needs' units, etc.

3. Details of community facilities and resources
   e.g. shops, post office, doctor, dentist, pubs, clubs, bus routes, swimming baths, fish and chip shops, costs, opening times, etc.; housing, employment, etc.

4. Philosophy/aims of service and their role within it.

Different staff had additional elements in their induction programmes, as follows:

1. SERVICE COORDINATOR & HOME LEADER (RESIDENTIAL MANAGER)

* Contact with similar services elsewhere
For our coordinator, sharing experiences with other new services (like Ashington- and NIMROD) had very important benefits, both practically and emotionally. This was especially important when the coordinator was being told "things cannot be done that way.....".

* Management and administrative skills
Particularly if you want to recruit professional staff with extensive experience in direct client contact (e.g. nursing, ATC, hostel) rather than those from a background in management or administration.

* Staff support/positive monitoring skills (see p.27)

At Wells Road the last two of these three areas were not given as much attention as they should have been.

2. COMMUNITY SUPPORT STAFF (COMMUNITY CARE WORKERS)

These are the staff who give help and support to people living at home with their own families. For them, we found it was important to allow space in their induction period for:

* Getting to know each other since they were to work so closely together.

* Getting to know other professionals in the area e.g. the local psychologist, community mental handicap nurse, social workers, health visitor, home care assistants, etc. Monthly liaison meetings were established to discuss ways of working and agree responsibility for different clients.

* Getting to know clients and their families.

3. RESIDENTIAL SUPPORT STAFF (CARE ASSISTANTS)

The diagram on p.8 shows the other elements included in the initial training provided for the residential staff. The programme was fuller than for the other staff because some of them were less experienced.

Going clockwise through the picture:

* Parents' experiences and perspectives were emphasised so that staff would understand why some parents might react to the new service without enthusiasm but with suspicion and even hostility.

This was done in three ways:

- by different local parents coming to talk informally about their experiences.
- by staff reading different biographies about people with handicap and then making charts to present to the group, sharing what services had or had not been available to the families in question at the time.
- by staff role-playing a parent in the neighbourhood being told about the new service. How did they react and feel? Why?

* outside speakers, e.g. different local professionals talking about what they did.

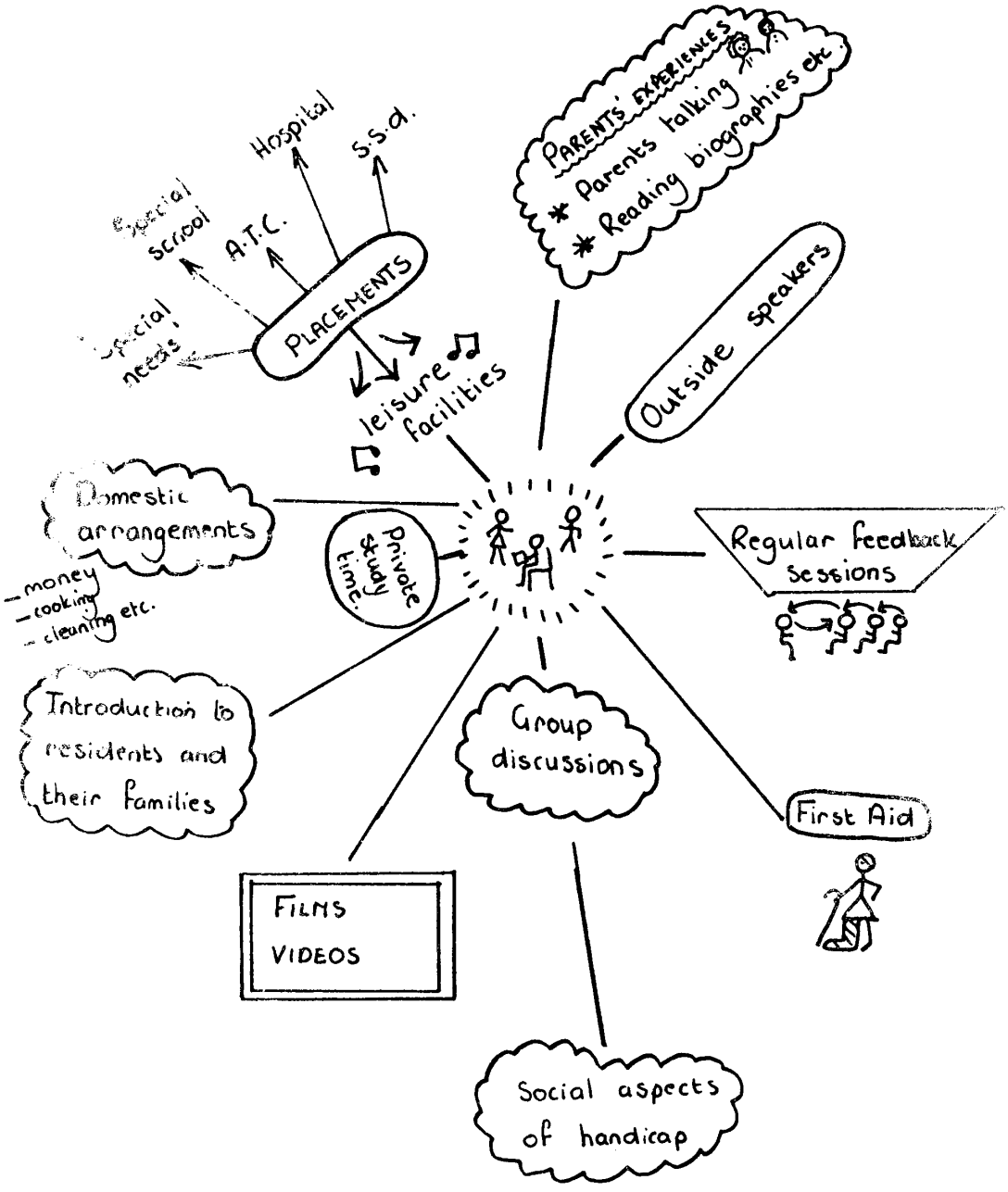
* regular feedback sessions, where staff could say what they thought of the training so far and what else they would like to cover or change.

* a series of first aid sessions

* regular group discussions

* sessions on social and medical aspects of handicap

Additional Elements included in the Induction/Initial Training of Residential Support Staff (care assistants)



* films and videos, some of them shared with nursing staff at the local mental handicap hospital.

* private study time, a day a week to give staff the space to do reading and other set work (e.g. in connection with biographical studies and placements).

* domestic skills and arrangements

* introduction to residents and their families

* and lastly placements. Since we recruited staff from a wide variety of backgrounds this was an important vehicle for staff to learn about different local agencies. (Staff each had two placements. Placements during the day were at ATCs, hospitals, special schools, social services department district offices, or 'special needs' facilities. The evening placements were at local clubs.)

HOW RESIDENTIAL STAFF FELT ABOUT THEIR TRAINING

To find out how the residential staff felt about their training, I asked them to fill in a brief form each day. In addition, I met with them several times as a group, and separately with each individual midway through and at the end of the training period.

This was how they felt about the programme:

They liked:

Group discussions led by the group tutor, where they discussed their placements, their biographical studies and so on. They were important because they were a fixed slot in the week where staff knew they would have the chance to come together and discuss what happened that week and tie it all together.

The normalisation workshop which had a big impact, particularly on staff who had previous experience of more restrictive services and settings than Wells Road.

The six sessions on social and medical aspects of handicap because they were so well presented, concentrating particularly on the social context and implications of handicap rather than the more usual, but far less relevant to staff, "causes of mental handicap" approach common in traditional training programmes.

Most popular of all were the sessions where parents talked and the first aid sessions which were not only reassuring but fun and seemed to contribute to the development of a "team feeling" (since they involved a good deal of body contact between staff).

There were mixed reactions to:

The skill-teaching sessions, partly because it is so hard to teach skills when staff do not have residents or clients to work with. In fact, staff did learn a lot about the principles involved, but the more practical input had to be repeated once they were working with residents in the houses through in-service training.

Evening placements in local clubs. Some staff who had had little previous experience with people with mental handicap enjoyed the opportunity to relax

with them in an informal setting. Other staff, drawing on the normalisation workshop, were unhappy that the clubs were so segregated and that activities were not appropriate to the members' actual ages.

Outside speakers, the quality and relevance of whose contributions varied greatly.

Private study time. This was valued by staff with children and other domestic responsibilities who could not otherwise have carried out the reading and other individual work.

Other staff with more free time had mixed feelings. It was noticeable that people valued it more, the more work that was set.

Staff did not like:

the venue (noisy, cold, dirty, did not blackout properly) and

the unexpected extension of the training programme (which resulted in a less coherent programme in the last few weeks).

HOW DID THE TRAINING ORGANISERS FEEL?

Their views corresponded closely to those of the staff as regards the successes of the training period (group tutorials, placements, normalisation workshop, etc).

Two areas that they felt had not gone as well as hoped were:

the community resources study. Staff had gone 'walkabout' in the local area and acquired a vast amount of useful information about services and facilities in the neighbourhood but this had not got written up on index cards as a permanent information bank before residents moved in.

Practical work/domestic skills, which they felt had not been prominent enough in the training period (for practical and other reasons). This had to be remedied later once there were actual residents to work with.

AFTER THE INITIAL TRAINING

Finding out how staff and training organisers felt about the training programme was, of course, interesting but not as important as discovering whether the programme had actually been useful to staff in their day-to-day work.

After the training period was over, I visited the staffed houses regularly to see how things were going and staff completed daily sheets for me about events in the houses. Six months later, I interviewed them to find out about their experiences and any training needs they felt they now had.

This was the list they came up with:

* Teaching skills

* Numeracy/literacy work

* Domestic skills/household arrangements

* Achieving consistency (between staff)

* Handling aggressive behaviour

* Emotional/sexual problems

PLUS

* How to reconcile/balance teaching skills with "an ordinary life" ....

Most of these areas had actually been touched on in the induction but could not be adequately dealt with before staff were actually working on the job.

Some of them, particularly balancing the twin areas of helping people learn skills and allowing them the right to live an ordinary life and do nothing in the evenings but watch television are never going to be entirely resolved; they are perpetual challenges in a service of this kind. (Though as we get better at offering people the opportunity to learn skills they want to acquire in ways that are interesting to them or to enjoy different experiences, this dilemma certainly diminishes.)

RESOURCES TO HELP STAFF AFTER INITIAL TRAINING

Fortunately we had a variety of resources to call on to meet the training needs of the staff once they were on the job.

* Psychologist - a psychologist joined the team part-time and helped keyworkers with: regular skill-teaching sessions in the house; goal plans and with drawing up strengths/needs lists etc for their residents' IPPs.

* A speech therapist helped out with MAKATON sessions for residents and staff.

* A local sex education agency, specialising in counselling in relationships and sex education, ran a 6 week evening class in personal relationships, attended by several residents and a residential worker, some community clients and the two community staff. (The understanding was that if the course needed to be repeated for other clients the community staff would have acquired sufficient experience and ideas to run it themselves.)

* Support group. A regular support group was established for the residential staff to talk through difficulties, e.g. their feelings about aggressive behaviour.

* Staff meetings/reviews were held regularly to agree procedures and plans.

* In-service training. Monthly in-service training was started to cover issues as they arose, e.g. how to handle mental illness problems etc.

I would like to end by summarising the main lessons learned in organising the residential staff's training at Wells Road and the issues and challenges that remain to be confronted.

THE MAIN LESSONS TO BE LEARNED WERE:

1. It is possible to organise one training package suitable for a staff group who are:

   qualified/unqualified
   experienced/inexperienced
   from different (professional) backgrounds

2. 'Team' feeling seems to be helped by:

   workshops
   practical first aid course
   regular group discussions

3. Early planning is essential.

4. Outside speakers can be a mixed blessing, especially if they are not adequately briefed, if they are not themselves familiar with, for example, ideas about normalisation, or if they are not carefully slotted into the training programme at an appropriate time (rather than when there happens to be a gap and they happen to be available).

5. Feedback sessions from staff are valuable (both for staff and service organisers).

6. Flexibility in the programme is vital, so that ideas expressed by staff can be acted on.

7. Lastly, that there is not one right way to do staff training. Different services and staff need different packages .... the ideas followed at Wells Road, and suggested in Planning For People are a starting point only, not a blueprint. We are changing things all the time and would expect others to do the same.

STAFF TRAINING: MORE ISSUES AND CHALLENGES

Finally to round off with some of the issues that have exercised us since the initial wave of staff training was over ...

* 1. Training for new staff, as original staff leave and the service expands... (which means going back to square one, with the additional problem once the service is operational, that someone has to cover the houses, or support clients in the community while the new staff are undergoing training).

* 2. Training for relief staff, that is the staff who work on an 'as and when' basis for the service, covering the houses when permanent staff are on holiday, sick, etc. Their most important contribution may be to provide cover so permanent staff can attend in-service days, which means that their own needs for training cannot be met this way.

* 3. Training existing staff for changes in services, not only hospital or hostel staff who are to start working in small community services but also staff already working in services like Wells Road which may shift fundamentally over time in response to changing local and client needs.

* 4. Training or help for managers/service planners as well as frontline staff.

* 5. A career structure for staff ...?

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King's Fund Centre (1980): An ordinary life. Comprehensive locally-based residential services for mentally handicapped people. London: King's Fund Centre.

Ward, L. (1984): PLANNING FOR PEOPLE. Developing a local service for people with mental handicap. I. Recruiting and training staff. London: King's Fund Centre.

TRAINING EXISTING STAFF FOR CHANGE - EXPERIENCES OF JOINT TRAINING IN EAST SUSSEX

Jan Alcoe

In the following account I will be outlining the development of joint training in East Sussex from the perspective of a Social Services trainer and Ken will go on to discuss the experiences of Joint Training for a major Health and Social Services "Ordinary Life" scheme - the Foremost Project.

The Social Services Department in East Sussex has gone through a major organisational change over the past few years. All services - fieldwork, domiciliary, residential and day care - have been decentralised into a patch-based system, with the aim of bringing them closer to users and of achieving fuller collaboration with local communities. One of the benefits to emerge from this change has been the healthy development of joint planning and joint working with other agencies.

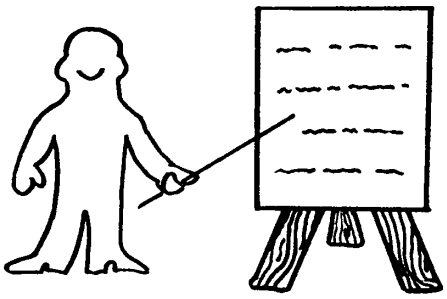
These developments have been important ones in encouraging the growth of more comprehensive services for people with mental handicaps based in ordinary settings, including better use of generic services in the neighbourhood in providing for individual needs. Working closely with local Health Authorities, Housing Departments, Housing Associations, Education, voluntary and community groups, we have been able to agree a service philosophy and set of service principles based on normalisation and to begin to develop real options for people with mental handicaps.

For example we now have established Community Mental Handicap Teams across the County, several new employment projects, long and short-term fostering schemes, and a widening range of residential services based on ordinary housing. Residential developments have ranged from large-scale projects like Foremost, which is moving children with profound and multiple handicaps into ordinary housing and family provision, managed jointly by Health and Social Services, to the development of housing for adults with mental handicaps by individual patch teams, supported by an appropriate mix of home helps, family aides, social workers, community nurses and housing wardens.

The changes I have briefly outlined have a profound impact on staff working within these developing services, whether managers, direct care staff or ancillary workers. They challenge all workers to take on more responsible roles, to work more closely together, and to develop shared values, and new skills and knowledge in working with mentally handicapped people. Such changes in attitudes and practice cannot be expected to follow automatically but must be encouraged and cultivated. Thus the development of joint training across the County has been a crucial one in supporting staff through change, and equipping staff across the various authorities involved, for new forms of service provision. In fact, joint training has, in itself, begun to play an important role in oiling the wheels of change.

Before I go on to outline some of the particular developments in joint training, there are three features of the training structure within Social Services in East Sussex which I feel have proved to be important levers in propelling us beyond our own Departmental boundaries in the provision of training.

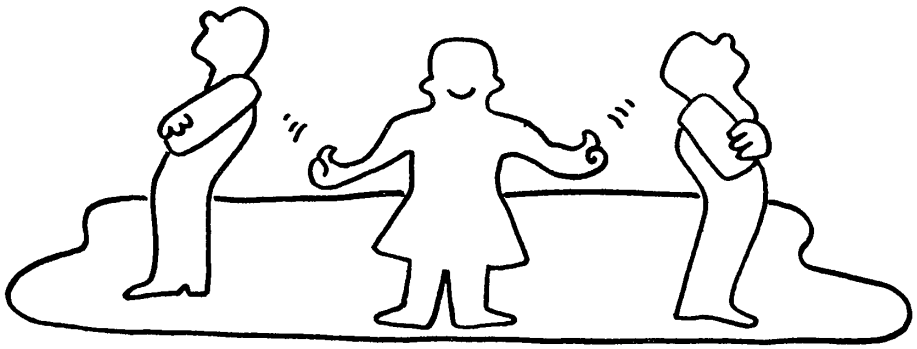
1. THE AREA-BASED TRAINING AND DEVELOPMENT OFFICER



THE AREA-BASED TRAINING & DEVELOPMENT OFFICER

As the Social Services Department decentralised, so did the training unit, and a training and development officer was located in each of 11 geographical areas across the county. Each officer works alongside the Area line managers in developing local services, and in making plans for staff training which can support such developments. In the case of mental handicap services many of the emerging schemes have involved nurses, housing staff, and volunteers, in addition to a range of workers from Social Services. It has therefore been the job of the Area training officer to create links with other agencies locally to provide joint training opportunities.

2. JOINT TRAINING AND DEVELOPMENT OFFICERS

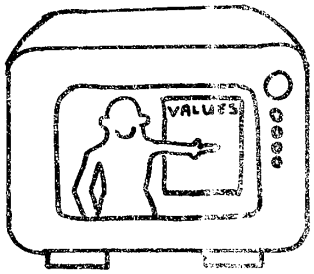


JOINT TRAINING & DEVELOPMENT OFFICER

Last year Social Services appointed its first joint training and development officer, from joint finance, to work with Eastbourne Health Authority in assessing training needs and developing shared training. Already, this appointment is proving highly successful in opening up opportunities for staff in mental handicap services to train together. It is now being followed up by two further appointments to promote joint training between the Department and the two remaining health authorities - Hastings and Brighton.

In addition the Foremost Project appointed its own Training and Development Manager who will plan and coordinate the joint training of over 100 nursing and Social Services staff involved in the scheme.

3. ESCATA (East Sussex Consultancy and Training Agency)

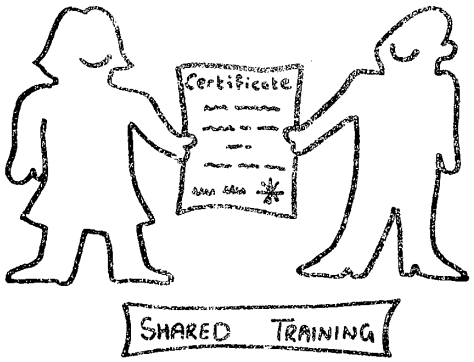


ESCATA

Decentralisation also brought about the formation of a professionally staffed media unit whose role was to provide high quality video materials to assist training in a variety of fields. The success of this unit led to the establishment of ESCATA which is able to market both materials and consultancy to Health and Social Services organisations. Increasingly ESCATA has been able to provide materials specifically designed for joint training in a number of fields, particularly in mental health and elderly services. This work is now being extended to mental handicap and I will briefly describe our plans later.

So these are some of the mechanisms which have proved valuable in engineering a wider range of joint training experiences. Finally, I would like to summarise what kinds of experiences we have been able to make possible through close collaboration between all concerned in providing services to people with mental handicaps.

1. PROMOTION OF JOINTLY PLANNED TRAINING

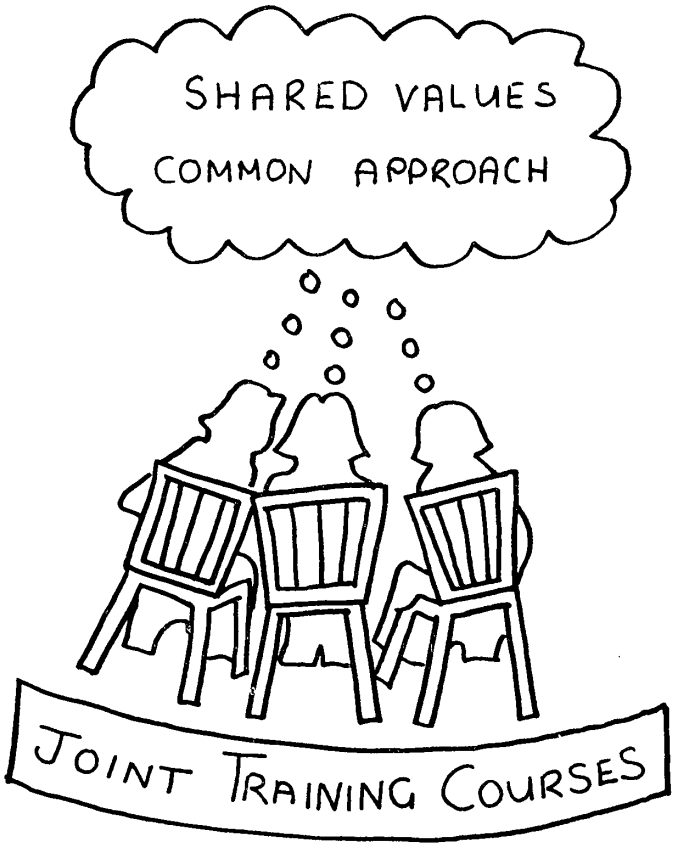


SHARED TRAINING

The development of opportunities for staff from various agencies in East Sussex, in particular Health and Social Services, to come together in a range of training situations has become an increasingly conscious process. The need for shared induction training and for shared qualifying training have received particular attention, since these are seen as being vital if we are to achieve more flexible movements of nursing and Social Services staff between separately managed services, and indeed to encourage the growth of more integrated provision.

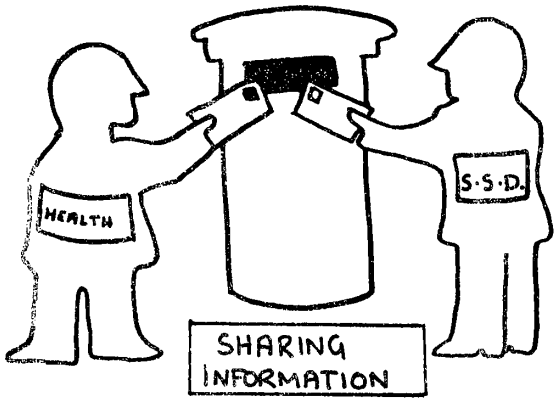
In the case of qualifying training, we already had the benefit of an excellent CSS Mental Handicap Special Option run by the West Sussex Institute of Higher Education, and this had been gradually attracting nursing staff in addition to those from Social Services and voluntary organisations. Out of a clearly expressed local commitment to shared qualifying training across Health and Social Services, representatives from all the authorities concerned established a joint working party which is now preparing detailed proposals for a shared CSS/RNMH pilot training course in East Sussex. These are shortly to be considered by CCETSW and the ENB.

2. DESIGN AND CONDUCT OF JOINT TRAINING COURSES



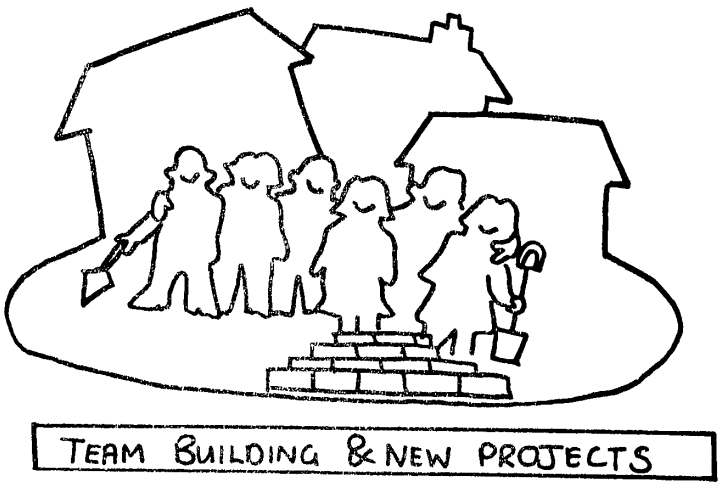
We have also seen a growth in the number of training courses, seminars and workshops being jointly devised and run in the County. One of the shortcomings of training in the mental handicap field in the past has been its over-emphasis of "technical skills" and its lack of concern with values and attitudes. It is now encouraging to see staff from different professional backgrounds who are involved in establishing community-based services to mentally handicapped people, coming together on residential normalisation workshops, and attending local seminars to explore values-based issues such as sexuality, approaches to further education, working with parents and so on.

3. FACILITATION OF JOINT TAKE-UP OF COURSES ORGANISED BY HEALTH, SOCIAL SERVICES OR VOLUNTARY ORGANISATIONS



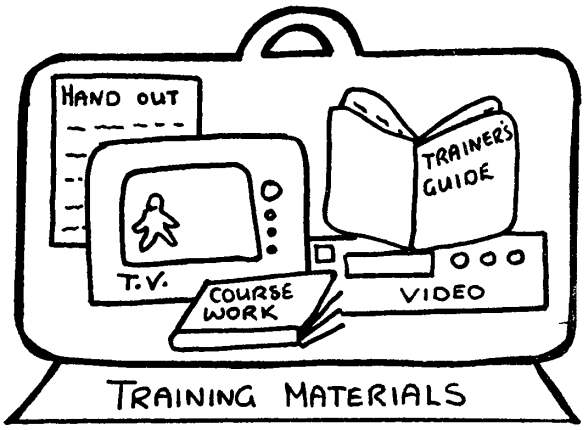
It is obviously important that existing training opportunities in any one authority or organisation are made as widely available to staff working in the field as possible and it has also been encouraging to see the development of better communication between trainers and managers across agencies to ensure that this happens. The recent formation of a Regional special interest group for trainers from local agencies is already proving helpful in disseminating and sharing information.

4. PROVISION OF TRAINING IN JOINT PROJECTS AND EXISTING MULTI-DISCIPLINARY NETWORKS



The FOREMOST Project presented the need for a major joint training initiative in the County and our response to this is discussed later. However, alongside the development of big new schemes, we have needed to strengthen effective working between staff from a variety of professional backgrounds. Joint training has been able to provide important team-building opportunities for such staff, and the chance to examine and clarify individual's roles in emerging new services. In addition, managers have been making increasing use of secondments to give their staff first hand experience of different service settings.

5. DEVELOPMENT AND DISSEMINATION OF LEARNING RESOURCES AND TRAINING MATERIALS



The development of new forms of service provision and new approaches to training can be greatly supported by effective training aids and learning resources. The development of ordinary housing for people with multiple handicaps is something about which many staff - whether planners, managers or carers - can have grave reservations. Unfortunately, because of the small number of schemes in operation across the country and the level of intrusion which visits to them would incur, it is difficult to provide staff with any first hand experience. The production, therefore, of good video-based material which depicts such schemes and raises key issues for working in such settings can be of invaluable help to the trainer.

Next year ESCATA is hoping to collaborate with local Health Authorities and Region on the development of a range of video-assisted training packages which will help staff to develop attitudes, knowledge and skills relevant to working in ordinary life schemes. These will be designed for use by planners, managers and care staff across agencies. In the meantime we have just published a small training package called Lifestyles for People with Mental Handicaps for use by all such staff. We hope that the exercises in the package will enable people to come together in joint training situations to examine the impact of their own values on the lives of people with mental handicaps, and to identify ways in which they can work to improve the services they provide.

References

Brown, H. and Alcoe, J. (1984): Lifestyles for People with Mental Handicaps. A staff training exercise based on normalisation principles (ESCATA).

THE FOREMOST COMMUNITY PROGRAMME

Ken Whitehouse

Introduction

In a number of ways the design of the FOREMOST Programme and the initiatives for creating change that Jan Alcoe has identified owes much to developments in the role of training in East Sussex Social Services Department. Much valued knowledge has also been gained from the major organisational changes that the department has undergone in decentralising its operations: in devolving management responsibilities to high localised patch based teams.

There have been numerous parallels in this learning experience with those programmes aimed at the replacement of large institutional facilities by small community based residential provision. For example, the key role of local managers, and the development of their skills in integrating services into the infra-structure of the local community.

A critical factor has been the extensive investment in team building as a basis for enabling staff to support each other in acquiring new skills and responsibilities based on their interpretation of local need. Staff have needed support, through training, to move away from stereotyped "professional roles" towards the development of partnership relationships with the communities they serve.

Resources for Training

In this organisational change the department has acknowledged that to create new service initiatives adequate resources must be found to enable staff to acquire the desired skills. The department ensured that the FOREMOST Programme built into its budget a recurring sum of £20,000 for training existing and new staff, in addition to access to the already well developed department training programme.

Trainers and Managers as Partners

In the reorganisation the placement of trainers as equal partners in local management teams recognised the role they have in the identification of new service goals and the importance of their contribution in the translation of organisational goals into needs and objectives.

Trainers are seen as managers of significant resources and as such, are expected to commit these in the most effective ways. To enable this to happen requires trainers to forge effective day to day working relationships with front line managers. It equally demands that managers must increase skills and knowledge of training processes and methods of evaluating their effectiveness.

Within the planning team in this Programme trainers are expected to contribute to the management of change as a total process. We all contribute to Training Package design. We expect to act as trainers and facilitators in these programmes as much as we expect the Training Manager to influence and contribute to the overall management strategy.

Joint Planning

The FOREMOST Programme is planned jointly by Brighton Health Authority and East Sussex Social Services. Jan Alcoe in her role of trainer worked closely to enable the senior managers of both agencies to successfully identify jointly agreed principles from which managers could develop their service initiatives.

The Programme attempts to provide a range of services from direct family support initiatives to long term residential facilities for those people who require a permanent home of their own. Whilst the Programme probably has many features similar to your own I suspect it may have some unique characteristics which have had an impact on the design, sequencing and implementation of our training programme.

Handover to Social Services

In setting up this Programme, the two authorities decided that within three years joint management would be phased out and Social Services would take over total management responsibility. This has meant jointly agreeing service principles in the various components of the Programme. It has also meant ensuring that the major day to day management processes within the two facilities would enable a successful handover of managerial responsibility, so that Personnel, Finance, Staff and Service Management processes would be indistinguishable between the two.

This requirement forced us to review in more detail the existing management arrangements in the two Authorities. There were major differences in manpower resources, skills, backgrounds, training experiences and the impact of present working environment on attitudes and values. As a result of this review we were forced to recognise that we would need to develop a range of highly individualised programmes. It highlighted the need to underpin these programmes with additional training inputs, and to beef up such activities as staff development and appraisal, reviews, supervision practice. We also had to focus on existing line managers' leadership skills and commitment to the proposed changes.

Experience in the Health Service

We became acutely aware that for staff in the Health Service whose working experience has been in the more traditionally organised hierarchical setting, there were more accentuated differences in status between trained and untrained staff. In addition, these staff had had very limited opportunities for developing policy initiatives from within their staff groups. This required us to develop different approaches to work organisation within existing settings to provide these experiences for them. This we felt to be important as a preliminary phase before joint training initiatives would succeed, since the expectations then would be that staff would be heavily involved in designing localised service objectives requiring a highly participative approach.

This meant the re-scheduling of many of our original training timetables. These were further lengthened by our under-estimation of the time it would take to carry out the extensive personnel consultation and discussions required in securing individual and union agreement to changes in conditions of service etc. We learnt the lesson the hard way. Until we had established a real sense of job security for staff, it was not easy for them to develop trust in our commitment

to help them develop new skills to make the transition successfully. Any training initiatives were unlikely to be successful.

Managers as Trainers

The experience in the Social Services Department of the move to highly decentralised locally managed services highlighted the increasing need to equip front line managers with new skills as "trainers". We suspected from talking to other programmes that much of the real learning only begins to take place for staff once they are confronted in situ with the reality of day to day practice. Using the experience in training Patch Team Managers we included in our training for Home Leaders skills in structuring group learning situations, team building, a clear understanding and commitment to the values, principles and policies underpinning the Programme, and the need to draw heavily on local community resources. We work with the managers to design an educational experience which enables them to take a critical part in the training, induction and ongoing work with their own teams.

Timescales for Training

As with many programmes the availability of capital and revenue resources are subject to the success or otherwise of negotiations with the variety of funding agencies. This means that managers are having constantly to rejuggle timescales within the programme. This will mean providing training opportunities for staff who may have some time to wait before becoming involved in induction and preparatory programmes prior to moving into a house. Again for the trainer and project staff this means ensuring heavy face to face contact for these staff and using the opportunities within existing services to identify valuable related learning opportunities. Our main approach is the development of Individual Programme Plans, firmly rooted in the principles of normalisation. This has the added advantage of both improving the present life experiences of the residents and of taking staff away (in pursuing these programmes) from the narrow confines of the institutions.

Models for Parents and Staff

The Programme's main focus is in providing staffed housing for a number of profoundly handicapped young people where the existing model of care is highly medically orientated and where staff have been recruited to service this model. The lack of practical examples across the country adds to the scepticism of some staff that the alternatives proposed will be appropriate. Even in situations where we have identified similar people with major handicaps in other programmes living in the community, staff and many parents find it very difficult to identify with them when seen in ordinary community housing. For many staff, we have not been particularly successful in helping them feel confident about the proposed changes. We have yet to find a way of providing the right experiences for both these staff and parents who can be as much in need of help as are residents in going through the painful process of change. Perhaps we may have to resign ourselves to the fact that this is a situation which will only resolve itself once a local example is there for staff and parents to experience. Some staff and possibly parents may, of course, choose to vote with their feet.

Involving Staff in Change

In common with many programmes we have found that targets can only be secured by continual adjustment. At a time of such change staff need secure

boundaries, but also some space and open-endedness so that they can effectively contribute to the design and implementation of their own service. They can end up feeling a sense of ownership. I think we have sometimes underestimated the need for project staff to spend extensive periods of time working alongside, leading and demonstrating their commitment to this process whilst offering day to day reassurance and support. Trainers, because of their role in the Programme, have provided other managers with an important feedback in these situations. We have been helped considerably in modifying our more traditional management approaches to this problem by adopting some of the change strategies embodied in the PASS approach to service design.

I suppose like most programme managers and trainers you will have experienced the problems of sequencing training and also, in the limited space available alongside the day to day working commitments of staff, the task of prioritising training activities. We have established that one of our major priorities must be in ensuring that staff understand, are committed and own a certain set of values which will influence their day to day activities with the people they work for. We can then ensure that the helping skills required are less dictated by prescribed models of care, that personal interaction with residents is less dictated by personal attitudes etc. and that the help offered is close to that desired by the receiver. How these values can be translated into day to day living experiences for handicapped people through Individual Programme Plans, opportunity plans and specific skills learning programmes is therefore another key part of the training strategy.

We have found useful the idea of prioritising training by considering what people need to know on day one of opening the unit, what they need to know after six weeks etc.

I am conscious of one major strategy we have failed so far to develop. That is the role of the service receiver as potentially the most powerful influence on our behaviour. That must be something we seek to rectify.

Conclusion

To conclude, key points from our training strategy are:

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

- The use of training experiences to enable staff to identify with and own the service objectives for their resource.

Reference

Wolfensberger, W. and Glenn, L. (1975): Pass 3. Program Analysis of Service Systems. (Toronto National Institute on Mental Retardation. 3rd Edition.)

A STRATEGY FOR REGIONAL INITIATIVES IN STAFF TRAINING

Peter Wakeford

Peter Wakeford outlined the training initiatives promoted by the South East Thames Regional Health Authority, with particular reference to the planned closure of Darenth Park Hospital, and the provision of residential services for its former residents in the community. These initiatives are summarised in Bringing People Back Home a new publication from the South East Thames Regional Health Authority (1985), as follows:-

Bringing People Back Home

South East Thames Regional Health Authority is committed to developing local services to replace large institutions for people in the priority care groups (mental handicap, mental health and services to elderly people). It is determined that these new services will provide an acceptable amount and quality of care and is working towards this goal in partnership with local authorities and district health authorities.

Bringing People Back Home is the staff training initiative designed to support this policy. It builds on the success of work started in 1983 and 1984 in mental handicap and aims to provide a range of training options which really lead to effective service development in each of the priority care areas. It involves three linked approaches:

1. The integration of training with other aspects of setting up new services (Training for Service Development). This involves working with front-line staff, managers and planners from different agencies as a single team throughout the planning, setting up and operation of services, so that all decisions can be clearly related to the kind of lifestyle service users will have once the service is operational. The major example of this approach is the course Developing Staffed Housing for Priority Groups.

2. The recognition that new services do not represent a static ideal. As services develop, part of the training function is to encourage more creative or adventurous solutions that achieve higher standards of care. This implies that the best investment to assure standards of care is that staff are enabled always to look beyond existing solutions and to explore new models at the 'leading edge' of service provision. This is particularly reflected in the use of Programme Analysis of Service Systems (PASS) to critically examine existing and planned services.

3. The development of a partnership between local training staff (in health, social services and other agencies) and regional staff to develop local self-sufficiency in basic in-service training and to ensure effective and responsive use of regional resources. A Trainers' Special Interest Group provides a forum for this work and about 20% of regional staff time is devoted entirely to helping local training staff.

Bringing People Back Home comprises five separate brochures, each of which gives details of one aspect of the training initiative:

Developing staffed housing for priority groups
Workshops for community mental handicap teams

Developing local staff training initiatives in mental handicap
Special services for people with severe mental handicap and severe behaviour problems
PASS: Program Analysis of Service Systems

Further Information

Copies of Bringing People Back Home and further information about the different areas of work in the initiative can be obtained by contacting the regional staff involved:

MIRIAM SALMON, Course Secretary (Priority Care)
PETER WAKEFORD, Education and Training Officer (Mental Handicap)
PETER LINDLEY, Education and Training Officer (Mental Health)

at David Salomons House, Broomhill Road, Southborough, Nr Tunbridge Wells, TN3 0TG. Telephone 0892 38614.

JIM MANSELL, Lecturer in Mental Handicap at the University of Kent at Canterbury and Co-ordinator of Staff Training in Mental Handicap for South East Thames Regional Health Authority

at Social Psychology Research Unit, University of Kent at Canterbury, Beverley Farm, Canterbury, CT2 7LZ. Telephone 0227 66822 extension 7679.

Reference

South East Thames Regional Health Authority (1985). Bringing People Back Home

AFTER INITIAL TRAINING, THEN WHAT?
IN-SERVICE TRAINING, POSITIVE MONITORING AND STAFF SUPPORT

Jan Porterfield

Staff are a valuable resource!

but, often .....

* Little attention is given to defining staff roles, supporting staff efforts and recognising staff achievements.

* Service planning and management often revolve around:

That is, the buildings, the contents and money.

* Staff are often left to "get on with the job".

Most staff enjoy many aspects of their work, including

- interacting with people
- helping people learn and use skills
- enabling people to become more confident and independent
- enabling people to live in the community

and most staff who work in "new" community services want to do this work because they are committed to the concept of providing services in the community and because they want to innovate and create better services.

Most are also committed to the people they are supporting!

It must be acknowledged that there are aspects of the work which make it difficult for staff to maintain their commitment and enthusiasm, for example:

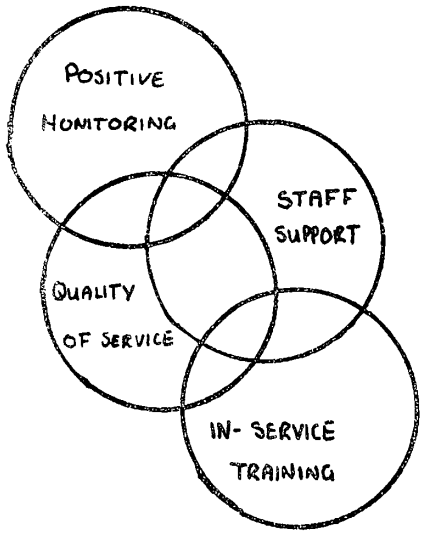
- low pay
- low status
- inadequate training
- unclear service aims and job descriptions
- inadequate material resources

- feeling of isolation
- pressure to prove that community services work
- resentment from some other practitioners
- tiring, physical work
- dealing with difficult behaviour of people they work with
- lack of support

etc, etc.

Because of these pressures it is ESSENTIAL for staff to BE supported and to FEEL supported.

In-service training and positive monitoring are two ways of providing staff with support.



Staff will usually do a better job if ...

-> they know what is expected
(clear service aims and job descriptions)

-> are trained to do it
(initial and in-service training)

-> are supported
(in-service training, positive monitoring, staff reviews, informal contact etc, etc)

1. IN-SERVICE TRAINING

* teaches people new skills (goal-planning, Makaton, first aid)
* gives people a new outlook
* makes people enthusiastic
* helps refresh people
* improves morale

IMPROVES THE QUALITY OF THE SERVICE BEING PROVIDED TO PEOPLE LIVING IN 

WHERE should in-service training take place?

- away from  ?
- at the  ?
- with  (colleagues)?
- with  (people from other services, disciplines)?

Staff need a good mix of in-service training opportunities. Going away and meeting people from similar services can be very stimulating and can improve morale. It is unlikely, however, to improve the service unless there is support from within.

Training as a staff group can result in more immediate service improvements but it is difficult to arrange (especially in residential services) and can be threatening to managers. One way round the first problem is to include the people living in the house in the training, and regarding the second problem a solution would be to involve the manager in planning and presenting.

2. POSITIVE MONITORING

Positive monitoring is a method which managers can use to help them support staff and improve the quality of the service.

Positive monitoring provides a structure which enables managers to ...

* maintain close contact with people using the service
* maintain first hand knowledge of the way the service operates on a day-to-day basis.
* identify problems while they are small and resolve them
* identify equipment and resources which are needed
* identify necessary changes in staff routines

* identify staff training needs

* receive comments and suggestions from staff

* maintain close contact with staff.

There are six components of POSITIVE MONITORING:

1. Defining service aims

2. Specifying clearly what staff should do to achieve these

3. Teaching staff to work in the specified way

4. Regularly watching staff work and looking at records and other aspects of the service

5. Giving specific feedback to staff on their work and getting staff comments and suggestions about the service

6. Reviewing individual job performance.

Positive monitoring attempts to reverse the common practice of ignoring staff when they are working well and giving them attention only when problems arise.

In order for positive monitoring to work...

- the manager and staff must want to improve their service

- they must want to work together

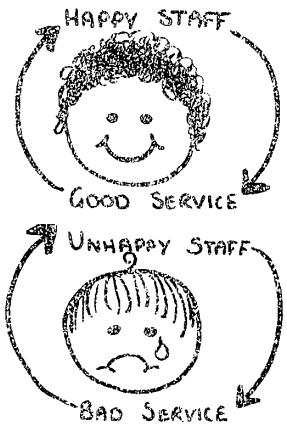
- the manager must have the respect of the staff

- the manager must have the inter-personal skills required to GIVE and ACCEPT feedback in a sincere way.

Positive monitoring helps the manager FOCUS on the work of individual members of staff. This helps the manager get to know staff as people and makes contact with them more genuine and personal.

The personal attention helps to establish and maintain good staff morale and encourages staff to do a better job.

Generally:



APPENDIX A - PAPERS AND REPORTS FROM WORKSHOP GROUPS

MORNING WORKSHOP GROUPS

Group I. IN-SERVICE TRAINING FOR CHANGING SERVICES
Leaders **Mary Phillips**
Jan Alcoe
Barry Gray

NOTES FOR WORKSHOP

What in-service training do we need to provide for existing hostel or hospital staff as services move towards "An Ordinary Life"?

1. Some services are moving purposefully towards an attempt to provide "Ordinary Life" situations; others are changing direction because of different factors. For example, units no longer needed for young children because of changing child care practice, converted to "homes" for children/adolescents with severe mental handicap. These changes make considerable demands on staff at all levels: some may have "irrelevant qualifications"; many have no training at all.

2. The purpose of in-service training for all groups is to help staff feel more able to understand and to contribute to the changing work situation and to feel more confident about their ability to learn new skills. At the same time management need help to improve their skills in relation to staff development and supervision/support to ensure that what has been learned during in-service training programmes can become part of everyday practice. (For example, putting into practice ideas about the importance of taking risks.)

3. Management at all levels also need help in understanding the link between providing a better service for residents and enabling them to develop their full potential and doing the same for staff. This applies particularly to unqualified staff (eg care assistant or nursing assistant) who have a great deal of day to day contact with residents, often without adequate preparation. They present a considerable challenge because many of them have had few or poor learning opportunities and their potential may be undervalued.

4. Whatever their previous work experience, most staff need help to understand how and why services are changing and what their own motivation is for working in this field in spite of considerable stresses involved. This applies particularly to staff working on wards where residents are not expected to move out in the immediate future. Discussions with staff on in-service training programmes demonstrate their commitment to providing "normal life" conditions, but these usually involve considerable organisational changes. This has important implications for the way the "trainer" works with the management.

5. Staff are often in closer contact with parents than in the past when visiting was less encouraged. This is particularly true when short stay care is given and parents often turn to staff for support in between admissions. Staff

need to learn about the total lack of support services experienced by many parents in the early years of the child's life, and of the gaps in services for the young adult and older person with a mental handicap.

To what extent is this increased contact with parents seen by management as part of the work responsibility of staff or incidental? If it is the former, there are considerable implications for in-service training and the development of skills involved in working with parents, many of whom have received very little help in the past.

6. The move towards providing smaller units may make it even more difficult than it has proved in the past to get staff released for in-service training programmes on a regular basis. Running short series at the unit can help to ensure continuity of attendance but the series has to fit in with school holidays, staff leave and the simple fact that the work of the unit has to take precedence. There are particular problems for the very small units run by voluntary organisations on a shared living basis. (The same reasons are given for not holding regular staff meetings.)

7. Much more attention should be paid to involve clients in developing the services, including the way staff training is organised.

NOTES FROM IN-SERVICE TRAINING WORKSHOP

A number of objectives regarding training for change were identified:

Objectives of training for change

* To maintain morale within existing services as people need to feel valued, and also need to identify existing skills in staff.

* To give staff a purpose and equip them with new skills, sharing a vision with them of what could be.

* To acknowledge the effects of past services and overcome past experiences and prejudices when considering how to change strategies.

* To have an awareness of the local policy and a knowledge of what resources are available.

* To explore own attitudes and values as well as those of managers and practitioners.

* To identify the needs of those being served and extend opportunities for residents to become involved in the training and change.

* To accept and participate in change (both staff and consumers).

* To put together a plan of action that is part of the wider service developments.

* Clarification of roles in the new service, with an emphasis on team-building.

Several problems that could be associated with training for change were highlighted. An awareness of these is important if the training is to be successful.

Problems of training for change

* Unclear ideas about jobs that will need to be done and a lack of policy, role definition, trust, information and communication about change and the related training.

* A lack of training strategy (insufficient identification of needs, appraisal and development of the system) and muddled expectations about what training can do, along with a narrow-minded approach to the training.

* Lack of time for training within the existing work and a lack of commitment in the training by both staff and managers.

* The fear of the personal effects of change held by staff and managers and also training not being seen as relevant to "our place".

* The demoralising effects that training can have if there is a difficulty with transferring it back to the actual work setting.

* Getting the right people to train and making sure there is adequate finance, follow-up and support.

* Bureaucracy can in practice inhibit change.

It was felt that in order to establish a clear "contract" details of training should be written into the job decription and the management be strongly committed to it before the training begins.

Points about training

Prior to the onset of the training phase an Action Plan containing clear training objectives should be drawn up. It is helpful if those involved work as a team to draw up aims and objectives.

It is necessary to build in a framework which allows for positive feedback by the trainer and manager to help maintain change. Examples of ways this could be done are:

- individual staff supervision
- feedback at working level and not just at management level
- project contracts

Finally, it is important to inform the staff of the training being done and the ways in which it might affect them.

MORNING WORKSHOP GROUPS

Group II. INDUCTION AND INITIAL TRAINING
Leaders **Peter Allen**
Shirley Lowe

NOTES FOR WORKSHOP

This workshop will consider who might be staffing these new services; how they should be selected and what would be the appropriate introductory training/orientation. Participants will, through the workshop, develop a training package and have opportunities to discuss the relevance of this to their own service.

1. The Selection of Staff
   - Service philosophy
   - Anticipated tasks
   - Staff backgrounds
   - Criteria used in making choice
   - Who interviews?

2. Devising a Training Package
   - Identifying aims and determining content
   - Training package "ground rules"

3. Let's Devise our own Package
   - Who co-ordinates/teaches
   - Content and rationale

4. Okay, but what Happens in Practice
   - Examples of initial training
   - Subsequent impact
   - What happens next?

NOTES FROM INDUCTION AND INITIAL TRAINING WORKSHOP

1. SELECTION OF STAFF

Staff Side

In the prospective staff members' eyes the selection begins with how the job is actually sold. For example, what the advertisements say and whether they are accurate? It may seem obvious, but on this rests the prospective staff's decisions to apply.

The other alternative may be prospective staff who are coerced/told/encouraged to join the 'new' service for people with mental handicap.

Service Side

Is it accurate to say that all people here are going to be providing ORDINARY HOUSING which is PART OF A LOCAL NEIGHBOURHOOD. If not, let us spend some time listing the type of services with which people are going to be involved.

Examples of service aims/philosophy

- Sometimes it is what we have been told to do
- The books/articles say it is time to change
- "Normalisation principles"
- Giving people an opportunity to develop full potential
- Individual needs

Practical applications

Might be

- move into 3-bedroomed houses/bungalows
- using "not quite ordinary houses"
- moving 5 children into one house
- moving 3 ladies into one house
- using two houses next door to each other
- developing 'family units' (up to 7 or 10 beds)
- building on hospital sites/former children's homes

2. THE STYLE OF SERVICE DETERMINES THE TASKS YOU WILL BE ASKING STAFF TO PERFORM

What will you be asking staff to do?

- Homemakers & housekeepers
- Take on an educational role
- Work together with neighbours
- Teach social skills
- Help with leisure time
- Support during transition
- Deal with residents as individuals
- Introduce 'dignity of risk'
- Work with a policy
- Plan
- Review
- Goal plan

- Interpret and facilitate
- Do life story work
- Define boundaries
- Go out and extend role
- Deal with finances
  - housekeeping
  - DHSS benefits
  - housing benefits
- Sleep/wake at night
- Reassure parents
- Act as Keyworker
- Fill in forms

Which ever task you or others choose must influence the way in which you select staff and the content of proposed training workshops but more of that later.

3. WHAT BACKGROUNDS MIGHT STAFF COME FROM?

Qualified	Health Social Services Education
Unqualified	Good wife/mother or husband/father People previously in voluntary work People with some experience of mental handicap Local people

For whom are you most likely to be looking?

HOW ELSE MIGHT THEY ENTER SERVICE? Be redeployed

4. INTERVIEWING

Who do you choose to do the interviewing, and on what criteria do you base the selection?

Remember, we are looking for people who are or will be proficient in these areas (refer back to the list in 2).

What is the relative importance of each of these tasks and is it possible to build up a rough profile of the type of person you are looking for?

Do the decisions you make - about which areas are important - determine who is best suited to do the interviewing?

For example, if 'Homebuilding' is important, then who best discovers if your prospective staff have those skills?

Should prospective staff meet the intended home residents prior to the interviews and if so in what context?

Who would you most like to do the interview?

- Residents themselves (this might involve a separate meeting, compatibility check)
- Other/existing staff (peer group)
- Head of the service/house
- Parents

Who would probably end up doing the interview?

- Director of Nursing Services
- Sector/Unit Administrator
- Consultant Psychiatrist
- Assistant Director of Social Services
- Personnel
- "Experts"
- Psychologist

QUESTION: Will the latter group necessarily select the best people for the tasks identified in (2) above?

5. TRAINING PACKAGES

Now, and only now, do we begin to think about how best to prepare staff, although the reality is that you will have had to make inspired guesses before this time.

Special points for consideration

It must make sense to those who make decisions about when staff are appointed and whether or not training takes place.

It must have a positive correlation with the philosophy upon which the service is being built.

You must decide who is going to
- plan
- co-ordinate
- administer
- pay speakers (Which budget?)
- welcome speakers

Do you have a specific
- project leader
- trainer

or will it be one/several members of the team? If so, what effect will this have on the team?

DECIDE

how long it is going to last

on a venue (Will this be a teaching establishment?)

on the main aims for teaching and how these will be evaluated

EXAMPLE

(a) To help people become part of the local community - FACILITATOR

(b) To teach and develop new skills - ASSESSOR/TEACHER

(c) To develop personal relationships - LISTENER/FRIEND

(d) Use of community facilities - 'WHAT'S ON' EVENT ORGANISER

(e) To budget/keep records - ADMINISTRATOR

(f) To make a home/household - A 'FAMILY MEMBER'

(g) To become a housekeeper - COOK/CLEANER

6. A POSSIBLE FRAMEWORK

It would seem to make sense to ensure that staff really get to know the people they will be living with. This may be despite claims that the "dependency level" of all patients in X hospital is already known.

Three things are important: first to get to know the people, second the place they are moving from and third their current/past experiences.

These observations could be aided by structuring the detective work, for example

- use a polaroid camera
- record what happened and for how long
- discover when the day starts/ends
- do the people go out to work (adults), or school (children)
- how many people live in each ward/dormitory
- who prepares meals and where are they eaten
- what happens in the evening/at night
- what differentiates each day/week/month

Use this information to paint portraits of the people coming to live in the new setting and the place they have moved from. Note typical experiences for a 'day in their life'.

In my opinion this approach supplies a phenomenal amount of information upon which the subsequent structure of the introductory training is built.

When writing individual portraits it is important to make decisions about how they might be used in the future. What uses can you think for them?

The framework of an initial training programme would probably include the following. (Here you are referred to the King's Fund Centre Project Paper No.42 Issues and Strategies for Training Staff for Community Mental Handicap Services.)

- Historical background and new service rationale
- Development of Language and Communication
- Physical development)
- Social development) Practical issues
- The development and teaching of skills) - lifting/eating etc
- Sexual/personal relationships
- Local facilities and services
- Day time occupations
- Relating to parents

Once these have been decided it should be possible to structure a timetable which includes relevant topics. If possible, try and employ local professionals in the teaching - people with whom staff will form a developing relationship - it acts as a good introduction.

Remember, the efficacy of your staff team lies in the summation of their strengths as individuals. You will be looking for people from a wide variety of skills and it is important to ensure they realise that they have their own strengths. It may be wise to spend time in the teaching, building a team identity.

Peter Allen

MORNING WORKSHOP GROUPS

Group III. MANAGEMENT FOR "CARE IN THE COMMUNITY"
Leaders Nan Carle
David Towell
Michael Libby

NOTES FOR WORKSHOP

THE TRAINING NEEDS OF PLANNERS AND MIDDLE MANAGERS OR "HOW TO REMEMBER THAT WHEN YOU ARE UP TO YOUR NECK IN ALLIGATORS - THE GOAL IS TO DRAIN THE SWAMP"

In the transition from hospital services into community services the main role of middle managers is to make sure that the service stays on course - that the vision of what "should be" remains intact. This is very difficult when there are four meetings in one day and there is a folder full of unanswered letters, but because of the turbulence and uncertainty it is even more important that as middle managers we know what we are striving for - that we understand our own ideas, values and the principles which guide our attention and decision making.

Within the context of an ordinary life there are at least five accomplishments that can usefully guide our design of services for mentally handicapped people.

* Presence in the community
* Promotion of individual interests and rights
* Progress towards continuous growth and development
* Promotion of a positive reputation for people with mental handicaps
* Participation in the community of people with mental handicaps with their non-handicapped peers

The task of maintaining our direction toward the accomplishments is clearly not an easy one. There are no existing models or management structures which can guide our actions. Every day we set new precedents. We are in the business of managing change. Living with that ambiguity can be very stressful and confusing. It can also be very challenging and rewarding. Some of the skills one might need to manage this transition into an ordinary life would include the ability to:

* Make relationships
* Think constructively and creatively
* Think in the long term
* Understand organisational structures and management
* Teach and counsel others
* Manage conflict

The training events and packages that would be useful in order to gain and develop these skills would include opportunities:

* To explore one's own philosophy, values and principles

* To work with various groups in order to explore roles one is good at and roles one is not

* To learn methods of creative problem solving

* To learn ways of identifying the performance indicators of oneself and others

* To develop ways of monitoring one's own performance and that of others

* To predict the effects of management structure and decisions about resource allocation

If the transition from institutional services to high quality services in the community is to be an honourable one - which is not dependent on government thinking or "flavour of the year" styles of policy making, then it is crucial that middle managers constantly look for opportunities that would challenge how well they are doing in maintaining the direction of the service. They will also need to learn how to cope with failure at a very early stage and still be resilient. Otherwise the swamp will never be drained and the danger for people with mental handicaps is that there will be a movement back into segregated institutions based on rejection from a community which does not have ways of accepting people who are different.

Nan Carle

NOTES FROM MANAGEMENT WORKSHOP

The group based its discussion on the following questions:

* Think about someone you know who is innovative
  - what are they like?
  - how do they differ from others?

* What, if anything, is special about the role of the middle manager?
  - what are the strengths of this role?
  - what are its constraints?

* How can we arrange training and support so that we can develop and sustain the innovations we want?

I. THE INNOVATORS: What are they like?

A broad range of characteristics were suggested as being important in someone who is innovative:

an exciting person with the ability to excite others

confident and stimulating

opportunists with a strong desire to achieve.

politically aware with a good understanding of organisations

'rule-benders' who are not afraid to challenge the status quo

a good sense of humour

perceptive; able to grasp the content of different situations

can express clear values and are constantly looking for other ideas

good at finding allies and also at being team members

possessing either a broad range of skills or else having specialist knowledge in one particular field

not afraid of change, but actually enjoy it

thoughtful about their professional and personal lives

Despite the above list it was felt that innovators are not all the same and are rather thin on the ground. More people are needed who will act as tireless campaigners in order to achieve their 'vision'.

II. MIDDLE MANAGERS: What, if anything, is special about the role?

The group divided this section of the discussion into strengths and constraints.

STRENGTHS	CONSTRAINTS
* Other people think that the middle managers have "power"	-> Unrealistic expectation by others of the middle manager to have real power
* They need to support people above and below themselves, therefore need inner strength	-> They are stranded in limbo and need support themselves to provide inner strength
* They are flexible and therefore have less clear roles	-> In times of uncertainty they are demanded to be consistent and need to be clear about their role
* Influential and mobile	* Limited in ability to allocate resources
* Have to challenge "the vision" and monitor progress; leading to adaptive change	* Limited in ability to make decisions
* Need to make an independent decision from an objective position	* Do not have first hand experience (as others see it)
* Have ownership of ideas	* Professional issues may be in conflict with management structures
* Need to work in a group, seen as a strength	* A role that is personally hard to take, i.e. eaten for breakfast and has to come back!
	* Need to work in a group, also seen as a constraint

III. DEVELOPING AND SUSTAINING INNOVATIONS:
How can we arrange training and support?

The following criteria were considered important regarding training and support:

* Need personalised development/support according to the unique characteristics of the person being trained, including:
  - opportunities to learn how to be confident
  - opportunities to learn how to listen

* Need to be clear who we are training and for what purpose
  - ie we need to know what are our training needs

* Need to use settings where the people being trained can exercise the skills they have

* Need to provide opportunities for the people being trained to
  - add to their strengths
  - compensate for their weaknesses

* Recognise that the skills needed to innovate are different from skills needed to maintain a "vision"

* Need to bring "maintainers" closer to the system they are maintaining

* Values/principles of the trainees and trainers need to be explored.

Additional criteria related to INNOVATORS:

Innovators are in the eye of the beholder; that is, they are different things to different people.

Innovators can be found at all levels.

They usually need to have others around them to offer support.

They usually build bridges between different components of a service or between different services.

They can use existing practices and situations to accomplish their "vision".

MORNING WORKSHOP GROUPS

Group IV. TRAINING FOR THE FUTURE
Leader Graham Lowe

NOTES FOR WORKSHOP

The problems about training for the future is that we are doing it in the present, and have to assume what the future will look like.

Even when, as at the present, we can identify a desired state we wish to reach, it takes time to change qualifying training and for the people who have gone through that training, to get into practice. If the assumption is correct, that changes of practice lead to changes in qualifying training rather than vice versa, then that training will lag behind practice as a matter of course. The more rapid and pronounced the changes in practice, the more obvious are the gaps in qualifying training reflected. Where there is more than one qualifying training and more than one profession providing an apparently similar service to a similar group of people, then there is concern not just about the conjunction between qualifying training and practice, but also between the different forms of qualifying training. This is currently the intention in training for work with mentally handicapped people.

The concern to develop a relevant training approach between the nursing and social work professions began with the Jay Committee report and continued through the two reports of the GNCs/CCETSW Joint Working Group. The Jay Committee took a radical approach by suggesting a single existing form of training (CSS), whilst the Joint Working Group considered co-operation between nurse and social work training, following the rejection of the Jay training proposal. When the majority of staff who have training specifically for working with mentally handicapped people are located in the nursing/hospital service, and the majority of clients requiring a service are located outside of the hospital setting, co-operation between nursing and social work is essential. The question is whether this must essentially be a short term strategy. If only a small minority of mentally handicapped people require primarily a nursing service, does it make long-term sense to continue to identify nursing as an appropriate form of training?

If nurse training were to be "re-located", the question must be how the existing client focus and status of that training is preserved. The 1982 RNMH syllabus attempted to do this "re-location" through community placements and an emphasis upon community care, thus retaining both the focus and status of training. This change does nothing to address the fundamental dilemma of maintaining a nursing qualification for what is primarily a non-nursing job, nor about the training base remaining within an institution setting.

If the long-term view demands a single form of training based upon the needs of mentally handicapped people living in the community, can existing social services training meet that need? Particularly when work with mentally handicapped people is seen to require specialised knowledge and skill, whilst both CSS and CQSW training is developed on a generic base, can and should CSS and CQSW training be developed in order to accommodate the specialist demands of mentally handicapped people? In this context CSS training does have specialist components which cater for a wide range of client groups including mentally

handicapped people, but the length of time devoted to particular client groups on CSS has been questioned.

Does this mean there is a need to seriously consider a professional training which is specialised and concerned only with mentally handicapped people? Would a move in this direction be unhelpful and paradoxical at a time when provision for mentally handicapped people is firmly towards integration and away from specialised resources as a matter of course?

As well as concerns about the location and structure of qualifying training for the future, there are also issues around the focus and content of a training programme. The shift away from institutional care brings with it a shift in how mentally handicapped people are perceived; instead of starting from a base-line of handicap and seeking to find out what an individual can do, the base-line is one of ability from which individual needs are established. Whilst this approach may be present in much current practice, it is open to questions about the extent to which it is present in qualifying training, particularly where the training is concerned with the provision of a service within an institutional boundary. As institutional boundaries become less relevant to service provision, so training content should become more concerned with facilitating qualified people to work across boundaries rather than be constrained by them. A better balance may need to be struck between training to provide a direct service to people and an indirect service on behalf of people. To facilitate community care perhaps greater attention needs to be paid on qualifying courses, to community work.

References

GNCs/CCETSW (1982/3): Co-operation in Training, Parts I and II. Report of the Joint Working Group on Training for Staff Working with Mentally Handicapped People (London, GNC/CCETSW)

Report of the Committee of Enquiry into Mental Handicap Nursing and Care: (The Jay Report, 1979); Cmnd 7468-1, (London, HMSO)

Other Reading

CCETSW (1979): Training for Work with Mentally Handicapped People. (London, CCETSW)

Graham Lowe

AFTERNOON WORKSHOP FOR ALL GROUPS

GROUP EXERCISE

The Story

The house at 43 Brunswick Road is the home of four adults who previously lived in a large mental handicap hospital. All four have been labelled as severely mentally handicapped. All need some help with dressing and bathing. James cannot speak or feed himself, is unable to walk and is sometimes incontinent. Rachel has limited speech. Simon occasionally attacks other people. Helen cannot speak and is usually quite passive.

Ten staff - some full and some part-time - provide 24 hour/day support to these four people. Staff are employed by the local authority but come from a range of backgrounds, training and experience. Prior to people moving into the house just over a year ago, staff had a 7 week period of induction. About three months ago two staff also attended a goal-planning workshop run by a national training organisation.

One aim of the service is to provide a "homely environment". This aim has been interpreted by various members of staff in different ways. For example, Ray thinks this means keeping the house clean and tidy. He spends most of his working hours doing domestic tasks. Jane, on the other hand, feels that it is more important to spend time chatting to residents and making sure they have lots of interesting activities. Ray resents Jane because he feels she is not doing her share of the work. The house is always untidy after Jane has been on duty - with toys and books scattered everywhere. Jane is annoyed with Ray because he spends so little time with residents. She feels that they are bored when Ray is on duty and blames him for being so insensitive to their needs.

Mary, the home leader, who works shifts like other staff, is not happy with the way things are going. She had hoped that staff would teach people new skills and include them in domestic work. She feels that Ray does too much for the residents and that Jane treats them like children. She has mentioned her concern, in a general way, at a few staff meetings but the situation has not improved.

Richard, the co-ordinator of community services who has overall responsibility for the house, agrees that residents should participate in more activities both inside the house and in the community. Richard and Mary meet about once a month to discuss the house. They have discussed the possibility of involving volunteers to help each resident develop friends and interests outside the house but have not yet had time to recruit these. Richard has attended three house meetings but at each he was called to the telephone and once he had to leave to deal with a crisis.

Issues for discussion

These questions are to stimulate discussion. Feel free to discuss other issues relating to this area. It is not necessary to answer all the questions.

1. How could in-service training, positive monitoring, staff support be used to improve the situation?
2. What difficulties might there be in introducing these?
3. How might these difficulties be overcome?
4. What advantages do you see in introducing them?

Jan Porterfield

NOTES FROM THE AFTERNOON WORKSHOP

Some problems inherent in the situation are:

1. unclear aims and a lack of organisation.

2. there appears to be an unclear job description; staff are committed but in apparently the wrong way. Also, the staff seem to be an incohesive group wasting a lot of energy because they lack direction and have different approaches to residents.

3. there is no specific monitoring of the staff or feedback to them regarding their work.

4. the training situation appears inadequate. Firstly, after the seven week induction period training seems to have ceased for staff. The Goal Planning Workshop was a "one-off", not continuing and not involving all staff. Secondly, it was felt that the manager needs management training in order to begin to function properly. The manager as the situation stands is not planning properly and seems short on commitment as well as not spending sufficient time with the whole group involved with the house.

5. the values and attitudes of the staff towards the people living in the house seem muddled. The activities that they are being offered by the staff might not be the most appropriate.

6. communication between individual staff members is lacking. They are not sharing ideas or learning and do not offer support to each other.

7. the system in the house does not seem to be addressing individual needs, neither of the people who live there nor the people who work there.

Suggested ways of tackling these problems

1 Service aims: they need to be clearer. A definition is needed of what a "homely" atmosphere entails. This probably means different things to different people but a joint decision could be made on the aims and organisation of the home, based on the residents' needs.

2 Following on from (1), Richard could be involved in the process of redefining staff roles and job descriptions on the basis of what the experiences of the residents should be. He needs to help them define any problems relating to the change.

Also the shift system makes team work difficult; "never the twain shall meet". Regular staff meetings are important to ensure the staff act as a cohesive group and aim in the same direction.

3 Regarding monitoring and feedback, which is obviously needed in this situation, it would have been useful to examine the induction course and see how staff reacted to it. What was missing? What was found to be useful? etc etc. From this feedback a follow-up training period could have been arranged to satisfy the staff's needs.

Also Richard and Mary should have meetings with staff members to praise them for the good parts of their work and offer guidance and direction on the weaker areas. Through this positive monitoring Richard is systematically informed about what is going on in the house and is able to listen to and assist his staff.

4 Mary, the homeleader, needs training in staff supervision, time organisation and management. Richard needs training in the techniques of positive monitoring.

The staff team appear to need regular in-service training days, including topics such as the best ways to work with people who have a severe mental handicap and how to cope with problem behaviour. Sessions on goal planning should be regular and progress reviewed periodically rather than featuring as one session and then the management expecting staff to cope. The staff should also be taught new skills and the appropriate way to use them.

5 Following on from (4), the in-service training needs to encourage staff to explore their own values and attitudes, as well as those of their colleagues. A workshop on normalisation would be useful, including age and culture appropriate activities based on a thorough assessment of each person's needs.

6 In order to enhance communication between staff members and between different levels of staff and management a monthly meeting of the home "team" would be useful. Basically this would develop a forum for interaction. Any issues could be openly discussed here.

More frequent meetings for the direct-care staff team may be needed to talk about more 'micro' issues related to the day-to-day life in the house. Once a week would probably be sufficient.

7 In summary, there needs to be an establishment of the individual needs of each resident and the training and development needs of the staff. Individual programme plans can be devised to ensure that the resident's needs are met and to ensure that the whole service is centred around an individual-orientated approach. Feedback from the staff to Richard and vice-versa will establish exactly what the training needs are and the best way they can be met.

Additional points

In the example given there might be a role for others outside the management structure to come in and be a part of the service. This could be in the form of volunteers to "befriend" a person who lives in the house and perhaps act as a "bridge" between home life and integration into the community.

It was debated how a service can combine the training and monitoring of staff with "ordinary" living in a home where people with a mental handicap live.

APPENDIX B - CONFERENCE PROGRAMMES AND LISTS OF PARTICIPANTS

"PLANNING FOR PEOPLE" IN THE COMMUNITY: STAFF TRAINING FOR "AN ORDINARY LIFE"

Friday, November 23, 1984

PROGRAMME

9.45 a.m.	Coffee
10.15	INTRODUCTION by Chairman for the day David Towell Fellow in Health Policy & Development, King's Fund College
10.30	DEVELOPING A LOCAL SERVICE: WHAT KIND OF TRAINING DO STAFF NEED? Linda Ward Research Fellow, University of Bristol, Department of Mental Health
10.55	TRAINING EXISTING STAFF FOR CHANGE - EXPERIENCES OF JOINT TRAINING IN EAST SUSSEX Jan Alcoe Training Consultant, East Sussex Consultancy and Training Agency Ken Whitehouse Project Manager, Foremost Project, Brighton
11.20	WORKSHOPS (see accompanying sheet for details)
12.45	Lunch
1.45	AFTER INITIAL TRAINING, THEN WHAT? - IN-SERVICE TRAINING, POSITIVE MONITORING AND STAFF SUPPORT Jan Porterfield Service Development and Staff Training Adviser
2.15	WORKSHOPS (see accompanying sheet for details)
3.45	TEA
4.00	GEOGRAPHICAL GROUPS - an opportunity to meet and discuss issues with others from your area/region
4.15	Close

"PLANNING FOR PEOPLE" IN THE COMMUNITY: STAFF TRAINING FOR "AN ORDINARY LIFE"

Friday, November 23, 1984

WORKSHOPS

There will be two workshop sessions - one at 11.20 am and one at 2.15 pm - with participants staying in the same workshop for both sessions. It will be helpful if you will please sign up for the workshop of your choice, before the conference starts.

The topics for the morning workshop session are set out below. Details of the afternoon session will be explained by your group leader.

Group I — IN-SERVICE TRAINING FOR CHANGING SERVICES
What in-service training do we need to provide for existing hostel or hospital staff as services move towards "an ordinary life"?

Leader: Mary Phillips
Rowntree Mental Handicap Staff Training Project,
Bristol Area

Group II — INDUCTION AND INITIAL TRAINING
What is an appropriate initial training package for frontline staff (with a variety of backgrounds) when they join new community services?

Leader: Peter Allen
Principal Clinical Psychologist, Newham Health Authority

Group III — MANAGEMENT FOR "CARE IN THE COMMUNITY"
What help or additional training do planners and middle managers need in the transition to locally-based services?

Leader: Nan Carle
Unit Administrator, Mental Handicap Services,
Lewisham & North Southwark Health Authority

Leader: David Towell
Fellow in Health Policy & Development, King's Fund College

Group IV — TRAINING FOR THE FUTURE
RNMA, CQSW, CSS ..... integrated and shared training ..... or what?

Leader: Graham Lowe
Social Work Education Adviser, CCETSW, SW Region

"PLANNING FOR PEOPLE" IN THE COMMUNITY: STAFF TRAINING FOR "AN ORDINARY LIFE"

Friday, November 23, 1984

LIST OF PARTICIPANTS

Mrs Marian ALLEN	Deputy Area Organiser	Social Services Dept, Chelmsford
Mr T J ANDERTON	Team Leader	Hulme Hall Close, Cheshire
Mrs Jane ARMSTRONG	Senior OT	Brentry Hospital, Bristol
Mr J ASHBY	Officer in Charge	SS Training Section, Coventry
Mrs Linda AVERILL	Information Officer	BIMH, Kidderminster
Mrs Patricia BALDWIN	Assistant Organiser	Ramsgate Community Centre
Miss Elizabeth BARKER	Group Manager	Clements Road, Essex
Miss Gill BATCHELOR	Social Worker/MH	Social Services Dept, Suffolk
Miss Jenny BECKINGSALE	Sen Nursing Officer-Training	Bristol & Weston HA, Bristol
Mrs Christine BLINCOE	Sen Clinical Psychologist	Ida Darwin Hospital, Cambridge
Mr Stuart BLINCOE	Nursing Officer/MH	Newham HA, Albert Dock Hosp, E16
Mr E J BOTLEY	Asst.Div.Nursing Director	St Margarets Hospital, Epping
Mr Eric LIVINGSTONE	Nursing Officer	Slade Hospital, Oxford
Mrs Margot CARNE	Deputy Warden	Mulberry Way Hostel, Essex
Mrs Sylvia COGLIATTI	Sen Clinical Psychologist	Borocourt Hospital, Berks
Mrs Suzanne COLLINS	Head of Psychology Services for People with MH	The Bell, Tooting, SW17
Dr C A COX	Sen Clin Medical Officer	Hounslow & Spelthorne HA, Hounslow
Mr Peter DAWSON	IPP Co-ordinator Derby City (East)	Derby NE Social Services Office
Mr Robert F DOLTON	Sen Lecturer	City of Birmingham Polytechnic
Mrs Jill DOWNEY	Social Worker/MH	Social Services Dept, Suffolk
Mr Paul ENNALS	Development Officer	'Sense', London WC1
Mr Stephen EVANS	Unit Admin/Rehab & Non Acute Unit	Milford Hospital, Godalming
Mrs Christine FABRIZIO	In Service Training Officer	Cranage Hall Hospital, Cheshire
Mr G FENNER	Dir Nursing Services	Hortham Hospital, Bristol
Miss Margaret FIELD	Officer in Charge	Jireh House, Maidstone
Mrs F FLETCHER	Senior Care Assistant	The Mount, Home for MH Children and Adults, Sheerness
Miss C FLIGHT	Person in Charge	Bereweeke House, Winchester
Mrs S FORSTER	Social Worker	Gloucester Centre, Peterborough
Mr K F FRANKS	Nursing Officer/Community	Middlefield Hospital, Solihull
Ms Rose FRANKS	Training & Development Officer	East Sussex SSD Eastbourne
Mr N J FRIZELLE	Dir Nursing Services/MH	Fieldhead Hospital, Wakefield
Miss Sue GARDNER	District Clin Psychologist	Upton Hospital, Berks
Mr John GARRARD	Training Officer	Diggle, Oldham
Mrs Anita GIBSON	Nursing Officer	Gloucester Centre, Peterborough
Mr Barry GRAY	Management Committee Member	Hawthorn Lodge, Dorchester
Mr W A K GRAY	Principal Consultant/MH	Social Services Dept, Reading
Ms Sheila GUNGAPHUL	Clinical Teacher/MH	Whipps Cross School of Nursing, E11

Miss Grethe HANSEN	Training Officer	County Hall, Herts
Miss Ricky HASLAM	Project Worker	Derby Homes Foundation, Derby
Mr D HAYLETT	Community Charge Nurse	West Essex Health District, Harlow
Mr John HENDERSON	Administrator	Hawthorn Lodge, Dorchester
Mr John HOLLAND	Prin Clin Psychologist	St Richards Hospital, Chichester
Mr R HOLLAND	Social Worker	Gloucester Centre, Orton Longueville
Miss O M HOOKER	Management Committee & Secretary	The Mount, Home for MH Children & Adults, Sheerness
Mrs Judy JARMAN	Senior Physiotherapist	Gloucester Centre, Peterborough
Dr M JAYASENA	Consultant Psychiatrist	South Ockendon Hospital, Essex
Mr James JEAL	Social Work Services Officer	East Midlands Region, Nottingham
Mr Richard LEA	Specialist Social Worker /MH	London Borough of Harrow
Mrs F LEFEVRE	Person in Charge	Bereweeke House, Winchester
Mrs Marina LEWIS	Head OT	Gardiner Hill Unit, SW17
Mr E LICORISH	Senior Tutor	School of Nursing, Whipps Cross Hosp
Ms Anne LOCKWOOD	Nursing Research Co-Ordinator	Maternity Unit, Peterborough District Hospital
Ms Viktoria LOW	Social Worker/MH	Biggleswade Area SS Beds
Mr P MARTIN	Training Officer/MH	SS Training Section, Stone House, Coventry
Mrs Janet McCRAY	Senior Nurse-Post Basic Education	Royal Earlswood Hospital, Surrey
Mr H McCREE	Chief Nursing Officer	Winchester HA
Mr Peter McHALE	DNS/MH	Rugby, Warwickshire
Ms Christine McKENNA	Senior Lecturer	Stockport College of Technology
Mrs P M MARSHALL	Asst Area Director	Social Services, Beds
Miss Angela MERRYWEATHER	In Service Training Officer	Mary Dendy Hospital, Cheshire
Miss Stella NEWTON	Ward Sister	Cranage Hall Hospital, Cheshire
Mr D OOGARAH	Senior Nurse	Rosa Morisson House, East Barnet
Ms Jan PAHL	Research Fellow	University of Kent at Canterbury
Mr Ian PEARCE	Training & Development Officer	Islington Social Services
Mr Dennis Chan PENSLEY	Senior Social Worker	Social Services Dept, Chelmsford
Mrs Emma POE	Chairman Management Committee	Hawthorn Lodge, Dorchester
Mr Ken PUGSLEY	Nursing Officer	DHSS Elephant & Castle, SE1
Ms Allison QUICK	CHC Member	Haringey Community Health Council
Mr Robin RENNIE	Deputy Area Organiser	Social Services Dept, Chelmsford
Mrs Jill ROWE	Unit Sister	Cedar View, Barony Hospital, Cheshire
Dr Oliver RUSSELL	Consultant Psychiatrist	University of Bristol
Mr Terry SCRAGG	Principal Lecturer	Bognor Regis College, West Sussex
Mrs Magda SEREDA	Psychologist	Cell Barnes Hospital, Herts
Mr Santokh SINGH	Senior Nurse	St Ricnards Hospital, Chichester
Mr Chris STEVENS	Unit Admin/MH Unit	Solihull HA, West Midlands
Mr Ellis J THACKRAY	Dir Nursing Services/MH	Lenham Hospital, Kent
Mrs Maria THOMAS	Service Development & Evaluation Officer	The Warneford Hospital, Oxford
Mrs Jillian THORP	Teacher	Foreland School, Broadstairs
Miss Susan TONGE	Houseparent	Jireh House, Maidstone
Mr Paul WILLIAMS	Director	CMH, London W1
Mr S WADE	Clinical Nurse Manager	Royal Albert Hospital, Lancaster

Mr Geoff WALLIS	Head of Home	Bell's Piece Cheshire Home, Farnham
Miss F E WHITE	Care Officer	Lea Combe Hostel, DCC Hostel for MH Adults, Axminster, Devon
Mr J WHITE	Nursing Officer/Reh	Middlefield Hospital, Solihull
Mrs Judy WILSON	Chairman, West Dorset Family Support Service	Hawthorn Lodge, Dorchester
Mrs Vivienne WILSON	Staff Nurse	Aycliffe Hospital, Co Durham
Mr James R A WOOD	Prof Dev Officer/MH	c/o Dept Nurse Education, Maidstone
Mr A J WORTH	Assistant Officer	Cambridgeshire County Council
Mr Tom YATES	Head of Home	Hawthorn Lodge, Dorchester

"PLANNING FOR PEOPLE" IN THE COMMUNITY: STAFF TRAINING FOR "AN ORDINARY LIFE"

Tuesday, April 16, 1985

PROGRAMME

9.45 a.m.	Coffee
10.15	INTRODUCTION by Chairman for the day David Towell Fellow in Health Policy & Development, King's Fund College
10.30	DEVELOPING A LOCAL SERVICE: WHAT KIND OF TRAINING DO STAFF NEED? Linda Ward Research Fellow, University of Bristol, Department of Mental Health
10.55	A STRATEGY FOR REGIONAL INITIATIVES IN STAFF TRAINING Peter Wakeford Education & Training Officer, South East Thames Regional Health Authority
11.20	WORKSHOPS (see accompanying sheet for details)
12.45	Lunch
1.45	AFTER INITIAL TRAINING, THEN WHAT? - IN-SERVICE TRAINING, POSITIVE MONITORING AND STAFF SUPPORT Jan Porterfield Service Development and Staff Training Adviser
2.15	WORKSHOPS (see accompanying sheet for details)
3.45	TEA
4.00	GEOGRAPHICAL GROUPS - an opportunity to meet and discuss issues with others from your area/region
4.15	Close

"PLANNING FOR PEOPLE" IN THE COMMUNITY: STAFF TRAINING FOR "AN ORDINARY LIFE"

Tuesday, April 16, 1985

WORKSHOPS

There will be two workshop sessions - one at 11.20 am and one at 2.15 pm - with participants staying in the same workshop for both sessions. It will be helpful if you will please sign up for the workshop of your choice, before the conference starts.

The topics for the morning workshop session are set out below. Details of the afternoon session will be explained by your group leader.

Group I — IN-SERVICE TRAINING FOR CHANGING SERVICES
What in-service training do we need to provide for existing hostel or hospital staff as services move towards "an ordinary life"?

Leader: Mary Phillips
Rowntree Mental Handicap Staff Training Project,
Bristol Area

Leader: Barry Gray
Lecturer, Dorset Institute of Higher Education

Group II — INDUCTION AND INITIAL TRAINING
What is an appropriate initial training package for frontline staff (with a variety of backgrounds) when they join new community services?

Leader: Peter Allen
Principal Clinical Psychologist, Newham Health Authority

Leader: Shirley Lowe
Principal Social Services Officer, Mental Health Section,
South Glamorgan Social Services Department

Group III — MANAGEMENT FOR "CARE IN THE COMMUNITY"
What help or additional training do planners and middle managers need in the transition to locally-based services?

Leader: Michael Libby
Professional Adviser, Cheshire Foundation

Leader: David Towell
Fellow in Health Policy & Development, King's Fund College

"PLANNING FOR PEOPLE" IN THE COMMUNITY: STAFF TRAINING FOR "AN ORDINARY LIFE"

Tuesday, April 16, 1985

LIST OF PARTICIPANTS

Mrs Moira ANGEL	House Leader	Fareham
Mr A BAILEY	Project Co-ordinator	Neighb/hd Network Scheme, Bolton
Mr I BAKER	Comm Charge Nurse	Little Plumstead Hospital, Norwich
Mr S BAXTER	Res Reh Officer	Tameside SS Dept, Lancashire
Mrs Beryl M BENNETT	Deputy officer-in-Charge	Plaistow, E13
Mr R W BERRY	Senior Nursing Officer	Stoke Park Hospital, Bristol
Ms Sarah BRETT-JONES	Social Worker	London Borough of Hammersmith & Fulham
Mr David CLARK	Nursing Officer	Purdown Hospital, Bristol
Mr Nigel P COLES	Sen Officer Mental Health	Dorset SS Dept
Mrs Kathy COOKE	Deputy Officer-in-Charge	Plaistow, E13
Mr Brian K COOPER	Sen Nursing Officer M/H	Houghton Health Centre, Sunderland
Mrs Ingrid CRAIG	Administrator	Grove Park Hospital, London
Mrs Vera CRONIN	Nursing Officer Comm	South Ockendon Hospital, Essex
Mr Steve DAVIS	Manager	Stonebridge ATC, London NW10
Mrs N DICKIE	Secretary/Treasurer	Scottish Society for M/H, Cumbernauld
Ms Dorothy DUNN	Clinical/Psychologist	Community Team, S Southwark
Mrs Ellen DUNN	Principal Officer	Bexley Social Services
Mrs Mariann EVANS	Sen Training Officer	Avon Social Services
Mrs P FAIRHURST	Senior Nurse Manager	Chase Farm Hospital, Enfield
Mr Keith FAULKNER	Development Worker	London SE1
Mrs H J FILBY	Acting Unit Administrator	Highbury Hospital, Nottingham
Mrs Chritine FINCHAM	Clin Nurse Manager	Cell Barnes Hospital, Herts
Mr Bill FOSTER	Person in Charge	Banbury Community Unit, Oxford
Mrs R FRASER	Senior Tutor	Balderton Hospital, Notts
Mr M GALLOP	Nursing Officer	Little Plumstead Hospital, Norwich
Mr B GUPPY	Officer-in-Charge	Heathcroft Hostel, Reading
Ms Daphne GVOZDENOVIC	Training Officer	London Borough of Sutton, SS Dept
Mr C A S HADLER	Dir Nursing Services M/H	Bristol & Weston HA
Mrs M HALL	Res Social Worker	'Sunnyside', Corsham, Wilts
Mrs J HOYTE	Asst Dir Nursing Services M/H Unit	Chase Farm Hospital, Enfield
Ms Debbie ISAAC	Occupational Therapist	N Southwark CMH Team, London
Mrs Helen JAMES	Community Team	Slade Hospital, Oxford
Mrs Valerie JEFFREY	Project Co-ordinator	Key Housing Ass Ltd, Glasgow
Mrs K JONES	Officer-in-Charge	Neighb/hd Network Scheme, Bolton
Mr Peter KENT	Asst DNS	South Ockendon Hospital, Essex
Mrs F KIRKPATRICK	Nursing Officer	Hales Hospital, Norfolk
Mr R W M JONES	Unit Administrator	Comm Serv Hounslow & Spelthorne HA
Miss B M JORDAN	Asst House Leader	'Conifers', Fareham
Mr Robert LEAR	Prin Social Worker M/H	London Borough of Enfield
Miss Moira M LEITCH	Prin Officer Health Serv	Social Work Department, Glasgow
Mr Eric LIVINGSTON	Community Team	Slade Hospital, Oxford
Mrs Barbara McCLOUGHAM	Co-ordinator M/H Services	Seebohm House, Norwich

Mrs A McGUIRE	Committee Member	Scottish Society for M/H, Cumbernauld
Mr Alec McTAGGART	Officer-in-Charge	"Whiteacre" Essex SS Dept
Mrs Denise MILTON	Asst Supervisor	Social Day Centre, Portsmouth
Mrs Rinske MITCHELSON	Occ Therapist	Social Day Centre, Portsmouth
Mr Paul MUIR	Head of Group Homes Project Team	Greenwich Social Services
Mr Bill MURCER	Principal Officer	The Childrens Society, London
Mrs Z NADIRSHAW	Sen Clin Psychologist	Harperbury Hospital, Herts
Ms Helen NIGHTINGALE	Prin Clin Psychologist	Hammersmith & Fulham HA Comm Mental Handicap Services
Mr Michael O'LEARY	Prin Development Officer	Port Talbot, Glamorgan
Ms Sally PENNINGTON	Sen Support Manager	Lewisham & N Southwark HA
Miss Sylvia PETERS	Senior Nurse	South Bedfordshire HA
Mr James POWER	Support Manager	Central & N Lewisham CMHT
Mr Abaul PEERBUX	Senior Nurse Manager	Hammersmith & Fulham HA Comm Mental Handicap Services
Mrs S A E PROSSER	Senior OT	Hernes House, Oxford
Ms Allison QUICK	Member	Haringey CHC
Mrs Nancy H RADFORD	Research Fellow	Dept Educational Studies, University of Surrey
Mr Graham REES	Community Team	Slade Hospital, Oxford
Ms Carolyn REGAN	Administrator	Hammersmith & Fulham HA Comm Mental Handicap Services
Mrs Marion ROCK	Tutor/Training Officer	SS Dept, Lancaster
Mr Allan ROSS	Supervisor	Social Day Centre, Portsmouth
Mr Bill SAMPLE	Clinical Psychologist	Shropshire CMHT
Mr D SAVAGE	Training Officer	Neighb/hd Network Scheme, Bolton
Sister Mary G SHIELDS	Officer-in-Charge	Mitre House Centre, Glasgow
Mr Santok SINGH	Nursing Officer	New Lodge Hospital, Essex
Miss Jenny STANBURY	Deputy Project Leader of 'Sunnyside'	The Childrens Society, Corsham, Wilts
Miss Carol SUTTON	Res Social Worker	Plaistow, E13
Mr John TAIT	Prin Nursing Officer	DHSS, London
Mr Alan TUDWAY	Principal Officer	Social Services Dept, Sutton
Mrs J WALKER	Officer-in-Charge	Scottish Society for M/H Cumbernauld
Mr B WATSON	Senior Nurse Manager	Little Plumstead Hospital, Norwich
Miss Deborah J WEBSTER	Deputy Sister	Westwood Hospital, Bradford
Mr J D WESTON	Principal Officer	West Sussex CC
Mr John WOODS	Asst Divisional Director Mental Health	Bracknell SS Department
Mrs Dot WOOTTEN	Sen Support Manager	Lewisham & N Southwark HA
Ms Julie WILKINSON	Researcher	Dept Mental Health, Bristol

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