TRAINING STAFF FOR 'AN ORDINARY LIFE' EXPERIENCES IN A COMMUNITY SERVICE IN SOUTH BRISTOL

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INTRODUCTION

The Wells Road Service

The Wells Road Service is a community service catering for adults with mental handicap living in one part of South Bristol. Its catchment area covers three square miles and has a population of 35,000 people, 70 of whom are adults with a mental handicap. A further 40 mentally handicapped adults who originate from the area, currently live in hospitals or hostels elsewhere. All are eligible for the service, however severe their handicap or disturbed their behaviour. The service comprises two main elements — community and residential support. Three community workers coordinate networks of support for clients living at home with their families or in homes of their own. Six residential workers and a home leader currently provide residential support to clients in the first staffed houses run by the service.

The service has been guided in its development by the principles set out in "An Ordinary Life" (King's Fund Centre, 1980). Thus, it aims to meet the needs of all mentally handicapped clients living in the area, in conjunction with other statutory and voluntary organisations as appropriate. This will eventually entail the provision of a wide range of residential options locally — group homes, placement with a family, an independent bedsit or flat, supported lodgings, staffed houses or homes shared with other non-handicapped tenants or a living in volunteer — according to the particular needs and choices of each individual, with varying degrees of staff support. In this way it is hoped that clients will be able to learn new skills, achieve more independence and continue to live in their own neighbourhoods, even when support from their own families breaks down. (For fuller information on the service, see Ward, 1983; 1984).

Evaluation

When the district health authority decided to allocate funds to set up the new service in Bristol, there was little knowledge in this country about how feasible or effective it might be. The authority was keen that the service should be evaluated before any decisions were made about replicating it in other parts of the district. A grant from the Joseph Rowntree Memorial Trust made it possible for the author to observe and document the service from its inception. A particular focus of interest from the outset has been the selection and training of staff.

In this article, the training organised for the first group of residential staff working in the Wells Road Service is reviewed, in the hope that lessons learned from this particular experience may be of use to others involved in training staff for similar services elsewhere.

The initial training of the first six residential staff took place between November 1982 and January 1983. In order to encourage flexibility of recruitment all posts in the new service had been graded on National Health Service *administrative and clerical* (rather than nursing) scales. Staff with a diversity of experience and qualifications — in education, social services and voluntary organisations as well as nursing — could thus be appointed. The six residential support staff, whose training is discussed here, had the following range of backgrounds: age — from 18-51 years; relevant experience — from extensive hospital,

hostel and Adult Training Centre experience to none at all; qualifications — from Registered Nurse in Mental Subnormality and teaching qualifications to none. Five of the staff were women, two were parents and half came from the local area. (Details of the criteria used in selecting staff are given in Ward, 1984).

Information about the training was collected in a variety of ways. Prior to the training period structured interviews were conducted with each member of staff, to learn about their backgrounds and experience, their feelings about the new job and expectations of the initial training, and with the training organisers, to discover the objectives, content and format proposed for the course. Once the training programme was underway, the support staff individually evaluated each day's training sessions, using a standardised form. This information was supplemented by regular group meetings between the staff team and researcher to discuss the training programme in more detail, and by structured interviews with each member of staff midway through the programme. Regular meetings were held with training organisers to get their views on progress and problems in the course as it proceeded. Once the initial training programme had ended, further interviews with the organisers were conducted to obtain their verdicts on the training programme overall and suggestions, on the basis of this experience, for setting up future training programmes of this kind. Six months later, individual interviews were carried out with the staff to discover any gaps in the initial training which they could now identify on the basis of their practical experience of working with residents in the staffed houses.

The possibility of evaluating the training by pre/post test measures relating to specific training inputs (for example, skill-teaching sessions), or by reference to particular aspects of subsequent staff performance in the houses was considered, but for technical reasons was rejected in favour of the detailed, descriptive appraisal outlined above.

THE TRAINING PROGRAMME

Planning the training

In the summer of 1982, when the training was being planned, the Wells Road Service was still in its infancy, with only two full-time members of staff in post: a service coordinator (appointed in March 1982), whose task was to set up and coordinate the service overall, and a home leader, appointed in June, to oversee the establishment of the first staffed houses and manage the staff group who would work there. Neither had extensive experience in staff training. Both had substantial work commitments besides the training programme. A key decision made at this time therefore was to involve an outside professional with experience in both staff training and mental handicap to act as group tutor to the support staff throughout the training period, and as advisor to the coordinator and home leader in designing the training programme. Several planning meetings resulted in a list of objectives for the course and a note of the particular skills and knowledge which staff needed to acquire in order to carry out their work as specified in their job description. (See Ward, 1984).

A number of key ingredients of the programme were identified in this planning period. These were: a two day *normalisation workshop,* to be run by CMHERA (Community and Mental Handicap Education & Research Association); a six session *skill teaching workshop* to be run by a local clinical psychologist and the home leader; *placements* (two days a week for six weeks in a local mental handicap service; one evening a week for six weeks in a local leisure facility used by mentally handicapped adults); weekly *group discussions* with the group tutor (so that staff could learn from each other's experience, ideas and individual project work); one day a week *private study time* — for staff to read and do individual work; and a *'getting to know the local area' project,* compiling information on

community resources. These activities were supplemented as the training period progressed, and other interests and needs became apparent, by contributions from *local professionals* and *local parents; films and videos* on relevant issues; and a series of sessions each on *social and medical aspects of handicap* and on *first aid.*

To avoid the fragmentation so often evident in staff induction courses, a relatively stable framework for the training period was planned (Fig. 1), into which all these items could be slotted in a reasonably coherent fashion.

Figure 1

Planned weekly timetable, in outline

Mondays	—	domestic areas/topics to do with the house and the service (led by the service coordinator/home leader)
Tuesdays	—	*a.m.* discussion group (group tutor) *p.m.* outside speaker on related theme
Wednesdays &	—	workshops (e.g. normalisation, goal planning, individual programme plans, skill teaching)
Thursdays	—	or placements
Fridays	—	private study day (for staff to read and prepare set work)

(For details of the timetable for the whole training period see Ward 1984)

The role of the group tutor

The group tutor had a key role to play in the training period. First, she was influential in *planning the overall programme.* Thus, it was largely a result of her experience in staff training and her input to planning meetings that course objectives were defined, and the need for coherence and structure in the programme recognised. Second, her input was crucial to the success of staff *placements in other agencies.* The coordinator and home leader had thought about the possibility of mini-placements for the staff as part of their training. The group tutor provided strong guidance on important issues like the timing and length of placements; the suitability of different local agencies; what staff should look for, and record about their placements; and how each individual's placement experience could be shared with the rest of the group.

Finally, the group tutor was responsible for planning (in consultation with the service coordinator) the weekly *group discussion sessions* with staff. To begin with, staff were each asked to read a different account of the life of someone with mental handicap (for example, Boston, 1981; Cook, 1980; Deacon, 1974) and prepare a chart depicting key events in the life of its subject and his/her family, and the support services available to them at that time. Presenting and discussing the chart was designed to help staff towards a greater understanding of families' experiences of mental handicap services in the past and a better insight into potential attitudes to this new community service in the present.

Another focus of early group tutorials was *the 'jungle' of health, social and other services* (including education and voluntary agencies). Here, staff contributed their knowledge about different services from their own experience until, with the help of the group tutor, a wall chart was built up depicting the structure and responsibilities of the various services at a national and local level. *The development of mental handicap services* was gradually pieced together in a similar way, using information from the various biographical studies which they had read, their placements and their own past experience, supplemented and drawn together by the group tutor. Preparation for, and feedback from, *placements* also took place

during group tutorials. Individual staff members shared their experiences and gave detailed information about the agencies in which they had been placed, along guidelines suggested by the group tutor.

Finally, a study of local *community resources* was also planned for these sessions. Familiarity with neighbourhood facilities was seen as an important means of encouraging the social integration of clients and residents into their local community. Staff were, therefore, given time to get to know the different parts of the service's catchment area, and asked to compile information on resources available locally, e.g. 'bus routes, churches, pubs, shops, post office, banks, dentists, opticians, doctors, leisure and education facilities, social services offices, clubs and so on. This information was to be shared at the discussion group and transferred to index cards to give a permanent record of local resources, updated as time progressed.

EVALUATION OF TRAINING

THE VIEWS OF THE SUPPORT STAFF

Reaction to the *group discussions* and the contribution of the *group tutor* was positive. ("She presented us with a clear and comprehensive way of reviewing placements and the books we are going to read". "Thoroughly enjoyed them. The way she goes about it, you don't realise 'til afterwards what you've learned".) The *biographical studies* were particularly successful —as a means of both finding out about mental handicap services and their development, and of exploring parents' experiences. ("They tied in well with parents' talks"). There was also appreciation of the value of a constant slot in the weekly timetable, where reaction to different aspects of the course could be brought together. ("She has a knack of tying it all together. It's good to have an ongoing thing which does that").

The normalisation and skill-teaching workshops were attended by staff from a local mental handicap hospital as well as the support staff. The contact, and the exchange of ideas, was appreciated by the Wells Road service staff. Reaction to the two day *normalisation workshop,* held in the second week of training was particularly positive. People found it well presented and the exercises and group discussions enjoyable and thought provoking. ("It made me aware how to treat mentally handicapped people. Some ways I've been in the past have not been very good". "It has stayed with me and been influential. I look at things now with that in mind.") Criticisms of the workshop centred on the difficult conditions under which it was presented — no blackout for showing slides, noise from adjoining classes, a dirty, cold room for workshop groups.

Reaction to the Bereweeke *skill-teaching workshop* (Felce *et al.,* 1983) — six sessions spread over the third and fourth weeks of the course — was more mixed, improving as the sessions progressed. On the whole, staff valued learning how to break tasks into steps and enjoyed working in small groups. They were less keen on the 'lecture' part of the workshops. They were not sure that the particular system they were learning was necessarily going to be appropriate for work with their residents, and disliked some aspects of it. An obvious but important part that emerged was that learning skill teaching may be easier once staff have 'real' residents to think about. With hindsight, most staff felt it would have been more helpful at the end of their training.

Placements

Overall, staff felt they had benefitted from their placement experiences. The *evening placements* in a social club or leisure facility had a more mixed reaction than the day placements in local mental handicap settings. Some people enjoyed their time at a club, for the opportunity it gave them to relate to mentally handicapped people. Others who

already had extensive experience of such facilities found it less useful. Several staff were critical of the clubs themselves. Drawing on their normalisation workshop, they observed that the activities provided were not really appropriate for the age group of their clientele. Nonetheless, one or two staff were glad to have got to know more about the local social clubs which future residents might wish to attend.

Day placements had been selected by the staff according to particular individual interests, or 'gaps' in their own experience. On the whole staff felt they had gained a lot from them and that the contact they had established would be useful to them in their later work.

Outside speakers

A series of six sessions on *social and medical aspects of mental handicap* was one of the most popular features of the initial training. The sessions focussed on the 'social' aspects of handicap — how a 'disability' can become a 'handicap' in our society — and the secondary effects of institutionalisation and over-protection, as well as particular syndromes, psychological and psychiatric problems, different drugs and their effects. The sessions were appreciated for their lively and interesting style of presentation (the use of a variety of 'props' and aids, and the full participation of the group) and their intelligibilty to a 'lay' audience. A number of *talks by local parents* of people with a mental handicap were also highly rated by staff for the insight that they provided on the variety of families' experiences.

At different points in the training programme, a variety of *local professionals* — social workers, community nurses, clinical psychologist and so on — also talked to the staff group about their work and their potential role in the new service. Reaction to them although predominantly positive, varied, highlighting the importance of careful selection, briefing and timetabling of outside speakers. This should ensure that speakers are thoroughly aware of the needs of the staff group and the desired focus of their contribution; that they are interesting speakers, as well as competent practitioners and that they are slotted into the training period at an appropriate point, so that their contribution complements other aspects of the programme at the time.

A series of practical sessions on basic *First Aid* was also included in the training as an afterthought, at the specific request of the support staff. It was a great success. ("Excellent, fun, reassuring and useful".)

Private study time

One day a week was left free from the outset for staff to pursue general reading and individual work set them by the group tutor, e.g. reading and preparing a chart from their biographical studies; writing up material from their placements. Staff were grateful for this opportunity to work on their own. Most felt that they would not have been able to complete the reading or carry out set work in addition to a full week's training programme, if time had not been specifically allocated for this purpose. Later on, however — when the training was extended, because work on the houses was still not finished — the private study days were less valued. Staff felt that there was insufficient work set to do during them, and by now, they were understandably impatient to get on with the job they had been employed to do, rather than continue studying.

A number of other areas of the training programme were singled out by staff for positive comment. They enjoyed a session organised by the service coordinator, where they *role played a parent* from the catchment area being told of the new service being established, and explored how they would feel and react, and why. A discussion on *sexuality and relationships of people with mental handicap* was also enjoyed. *Feedback sessions* on how

the course was going, and ideas for the timetable ahead were also appreciated, as were most of the *films and videos* they saw on different issues in mental handicap. Overall, staff felt that the training had been well organised and that they had learned an enormous amount.

Negative comments centred principally on the cold, noisy venue, and — as the training had to be prolonged — on the resulting haphazard organisation of its later weeks. By the end of the training period, most felt that it had gone on too long and that some days they were "filling in... dragging our heels". "Really we're just waiting for the residents, the houses to open".

THE VIEWS OF THE TRAINING ORGANISERS

The training organisers — the service coordinator, home leader and group tutor — were also asked for their views about the training programme. On the whole, their comments echoed those of the support staff. They were agreed that the training period had been too long, through circumstances beyond their control. In particular, they regretted that it had been prolonged into the New Year, instead of terminating at the more natural Christmas break. Its extension had inevitably resulted in a more fragmented, ad hoc, programme in the latter stages than was desired. Overall, they felt extremely positive about how the course had gone, but selected out certain aspects which could be improved in the future. For example, the *community resources study* was not finally written up as a permanent information bank for the staff's future use, as had been hoped. An earlier start on the venture might have ensured its completion before residents moved into the houses and became the top priority for staff attention. There was also a feeling that the training period could have included more *practical work,* for example, more input on how goalplanning tied in with individual programme plans and how staff could teach practical skills to residents. The original idea that Mondays would routinely be "domestic" days, where staff would practise skill-teaching, and later work out practical issues to do with shopping, cooking, menus, household chores, and budgeting had proved difficult to adhere to in practice. These issues would have to be addressed in the first days in the houses, just prior to the residents moving in, and in later in-service training days, as necessary.

Most of the key features of the training programme, however — the group tutorials, the placements, the normalisation workshop and so on — were viewed as a success. The staff had acquired a good deal of knowledge and skills and a 'team feeling'. They were still enthusiastic about the new service and keen to start putting what they had learned in training into practice on the job.

LATER TRAINING NEEDS

Close contact between the researcher and the support staff was maintained once the staffed houses were in operation, to discover how well their training had prepared staff for their work in practice. For the first three months, a brief sheet was completed each day by the member of staff on sleeping-in duty, recording particular problems or high points of that day. Regular visits to the houses and informal chats with staff supplemented this information. After six months, each member of staff had a lengthy interview with the researcher, reviewing initial experiences in the houses and the adequacy of their induction training.

A number of further training needs became clear in a variety of areas. These included more help with teaching skills, numeracy and literacy work, domestic skills and household arrangements, and assessment — and on achieving consistency between staff in these areas. Dealing with aggression from some residents and with their emotional/sexual problems were also areas in which staff felt they needed more information and help.

The staff had received some grounding in most of these topics in the induction training, but felt that they neded some 'refreshing' or 'topping up' now that they were working with real residents and real problems. The service was already committed to monthly in-service training days, which were used over the next few months, to give staff further help and opportunity to do practical work on goalplanning, individual programme planning, skill teaching and "taking risks". The arrival of a new clinical psychologist with a part-time commitment to the service, meant that weekly skill-teaching and other practical sessions could also be held at the houses, geared directly to helping staff and residents with particular individual problems.

Later, practical training of this kind seemed, in many ways, to be more useful to staff now that they were involved with individual residents on a one-to-one living basis, than the more abstract input inevitable during the induction training programme. (Staff themselves, however, felt the initial input during their induction had provided an essential grounding for the later work).

The particular characteristics and needs of different individual residents led to demands for specific additional training inputs as time went on. For example, difficulties in communication for one person led to a local speech therapist organising a number of sessions on using MAKATON (sign language). Limited opportunities in the past for learning about personal and sexual relationships led to three residents attending a course on the subject organised by the service's community staff and run by a local professional specialising in this field. Aggressive behaviour from individual residents towards particular staff, and sometimes other residents, led to demands for some input on self defence, especially for female staff. Meanwhile, regular "support" sessions or group meetings for the house staff, run by a professional with skills in group- and counselling-work, helped staff to talk through their difficulties and anxieties in coping with this aggressive behaviour. Regular staff meetings and reviews facilitated agreement on how to handle these inevitably disturbing incidents. Later on, with the prospect of new residents with profound and multiple handicaps, staff expressed keen interest in appropriate training and guidance to help them meet these individuals' needs as sensitively as possible.

Some time after the houses opened, a further training need became clear. There were urgent requests for guidance in handling problems of a psychological/psychiatric nature to help staff cope with the difficulties of particular residents at different times. Three in-service training days were devoted to the subject over the next few months. Workshop material was directed towards particular problems residents and staff were encountering. Staff were enthusiastic about the sessions. One or two commented on the lack of input on mental illness in their initial training programme, though it was not clear that abstract sessions on the subject at that stage would have proved helpful to them in practice later on.

In other areas, it was not felt that prior training would have been helpful in meeting individual residents' particular needs. One person, for example, suffered from an unexplained, but severely handicapping condition which recurred every few weeks and resulted in extremely disordered behaviour for its duration, rquiring one to one attention from staff. In the past, admission to the local mental handicap hospital from home had ensued. Within the new service, the resident was able to continue at home during these bouts of sickness. Over time, staff developed strategies, based on their accumulated experience of previous episodes, for managing them, so that the level of disturbed behaviour and distress was reduced. In this situation, a formal training input during the induction period would not have helped staff. Learning through familiarity and experience proved more fruitful.

DISCUSSION

Problems in organising training

A number of constraints operated during the initial training period, posing problems in planning and organisation. A major difficulty was uncertainty as to when the staffed houses would be ready to open their doors to residents. As delays occurred, the training programme had to be extended, since the service had no existing homes into which the staff could be deployed for the period.

Another problem was that the service coordinator and home leader had substantial other work commitments in addition to the training programme — making contact with clients and potential residents and their families and organising individual programme plans with them; liaising with contractors and suppliers about the decoration, adaptation and equipping of the houses and so on. The employment of the group tutor to help plan the course, and run weekly group discussions with the staff greatly assisted the coordinator and home leader in the task of organising and co-ordinating the training programme. Nonetheless, there were inevitably occasions when the three-way communication and planning systems broke down, and the structure of the course was less coherent than desired.

The venue for the course was also less than ideal. Other potentially suitable premises in the area, like the local technical college, were either too expensive, or not available for an extended period.

Finally the particular identity of the first residents was not known at the time the training started, so sessions could not be geared towards specific individuals and real issues and problems. As the training progressed, the first residents were identified and staff greatly valued the opportunity then to get to know them and their families before they moved in.

All except the last of these problems will be factors common to many training programmes. In addition, many developing services will need to gear their induction packages to re-orienting existing staff, who have inappropriate institutional experience or training, to work in ordinary houses in community services like Wells Road.

Lessons from experience

Definitive statements about staff training clearly cannot be made on the basis of one small-scale programme of this kind. However some general points do emerge, which have been borne out by the experiences of staff subsequently appointed to the service, and by later in-service training sessions which have been shared with local authority social services department field staff and nursing staff from the local mental handicap hospital. In particular, it has proved possible to organise training programmes which are relevant, useful and enjoyable both to staff without experience or qualifications in the field and those with extensive experience and training. Placements have been helpful in providing experience of particular mental handicap services with which staff are not already familiar. Workshops, practical first aid courses and weekly group discussions have helped staff start to feel, and operate, like a team.

Early planning is essential if a coherent overall structure for training (both initial and in-service) is to be achieved, and speakers and workshops are to be slotted in at appropriate times rather than when they happen to be available. Such planning takes time, which means the service coordinator or other training organiser will not be able simultaneously to carry out their full, normal workload. Briefing outside speakers in some depth on the service, the staff and the contribution expected of them will pay dividends; holding regular feedback sessions with staff to discover their reaction to the training as it progresses and particular requests for future training sessions, and ensuring the timetable is sufficiently flexible for such requests to be met are equally important points to be borne in mind.

Conclusions

When the training programme for the Wells Road support staff was being planned, there was little material available in this country to provide guidance on how to proceed. Existing training programmes were geared either to nursing staff, working mainly in hospital settings, or to social services staff, working in hostels or 'homes'. They were not directed to a staff group with a wide variety of backgrounds and experience, who would be working in ones and twos in ordinary housing in the community, alongside residents who might be extremely handicapped or disturbed, and without a traditional hierarchy or means of staff support immediately at hand. Now, nearly two years later, there is more experience in this field on which to build. Other new services have provided initial training for staff, some of which is now documented for the benefit of others venturing in this field. (Felce *et al.*, 1982; Shearer, 1983; Ward, 1984).

At this stage in the development of new patterns of service for people with mental handicap it is clear that no single centrally determined training programme will provide all the answers that are needed. Different areas, different services, different staff will require a range of training packages at each stage in their development. By sharing, and building upon, this diversity of accumulating experience it is to be hoped that a more appropriate staff training, and, hence a better quality of life for mentally handicapped people in the community will ultimately ensue.

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