

AFTER INDUCTION — THEN WHAT ? ¹⁾ Providing on-going staff training for 'An Ordinary Life'

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INTRODUCTION

Four years ago a local service for people with severe learning difficulties (mental handicap) was established in South Bristol. The service — called the Wells Road Service after the main road which cut through its catchment area — was set up by the local health authority along the lines suggested by the publication **An Ordinary Life** (King's Fund Centre, 1980). It aimed to meet the needs of the seventy adults with learning difficulties already living in its catchment area of three square miles (population, 35,000), and, potentially, a further forty who originated from the area but were currently living in hospitals, hostels or other accommodation elsewhere. The idea was to set up and support a variety of different residential options in the area with varying degrees of staff support for different individuals, and to provide a range of help, advice and opportunities for others in the community not seeking residential support.

The service was staffed in the initial years (before expansion in 1987) by a coordinator, a home leader and six residential staff (with back up relief available) and of two community staff, with advice and support also available from a senior clinical psychologist. Service staff worked in close cooperation with local social workers, community nurses and other professionals where appropriate, and, wherever possible, in conjunction with non-specialist agencies and individuals — local churches, adult education facilities, community centres, volunteers and 'leisure workers' recruited through a local Manpower Services Commission community programme.¹⁾ (A more detailed general account of the service is given in Ward, 1986b).

When the service was established, the role of its staff was seen to be crucial. It was largely through them that the goals and philosophy of the service, outlined in its operational policy would be realised. It would be their job to provide, wherever possible, 'support' rather than 'care', working alongside individuals in their pursuit of 'An Ordinary Life', fostering opportunities for them to develop new skills and relationships and enjoy new experiences, 'mixing as equals with the other, and mostly not handicapped members of their own community'. (King's Fund Centre, 1980).

Because the role of staff was seen to be so crucial, the unorthodox decision was taken to grade all posts in the new service on National Health Service administrative and clerical (rather than nursing) scales. This would permit the employment of individuals with a wide range of appropriate qualifications and experience — for example, in Adult Training Centres, education, residential social work — rather than restricting the field to nursing staff only. Great emphasis was placed on the provision of appropriate induction training for the varied group of staff thus appointed. This would, it was hoped, provide them with a good grounding in areas which were fundamental to the philosophy and success of the new service — the principles of

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normalisation, individual programme plans, skill teaching and so on. It would also enable staff both to learn from each other's past experience and make good – through placements and other training opportunities – particular gaps they recognised in their own personal experience. A detailed review of the initial training programme was published in a previous article in this journal (Ward, 1985b).

From the outset, however, it was recognised that even a fairly extensive induction training programme of the kind undertaken at Wells Road would not be enough. To ensure a high quality service which was responsive to users' needs would require **ongoing** training opportunities for staff. Some things simply could not be learned in abstract before staff were actually involved on a day-to-day basis with particular individuals. Many issues would arise, and need to be dealt with, once staff were on the job. Moreover, in a rapidly developing field like mental handicap, new approaches and ideas would become available **after** staff took up *their posts*. The body of knowledge and approaches available at their induction would need to be 'topped up', expanded, updated and revised as time went on. Accordingly, a sum of money was set aside in the service's annual budget specifically for on-going training purposes. (£2,000 per annum, at 1983/84 prices). A policy commitment was made both to organise an in-house programme of monthly in-service training days, and to enable staff to participate in other, externally-organised, training opportunities (courses, conferences, workshops) as they arose.

The purpose of this article is to describe and review both kinds of in-service training opportunities experienced by the initial complement of Wells Road staff over a two year period from summer 1983 to 1985. The article will look in turn at the in-house, in-service training programme, and the external courses and workshops which individual staff members attended, and conclude with a brief discussion of some lessons that can be learned by other services from the Wells Road experience in this area.

Evaluation

The review of in-service training at Wells Road on which this article is based was part of a much wider evaluation of the service overall, which included, in addition, a study of the 'quality of life' and social integration of residents, the costings of the service compared with other residential services and an appraisal of the development and operation of the service generally.

The examination of in-service training formed the second half of a study exploring staffing issues, the first half of which had focussed on selection and initial induction training. (Ward, 1984; 1985 a & b).

To gain information for this study, a number of complementary research methods were employed. For the first six months, staff were asked to complete a simple evaluation sheet at the end of each in-service training session. This written evaluation was subsequently replaced by a short (ten to fifteen minutes) group discussion at the end of each training day. The discussion was logged by the researcher on a flipchart, and focussed in turn on what staff felt had been the positive and negative aspects of each part of that day's programme, how the sessions might be useful to them in practice, and ideas for improvement in the future. As a *participant-observer at each training day* the researcher was able to document how each subject was tackled, the kind of teaching approach adopted and to observe how well different parts of each session seemed to work in practice. Information about the origins and preparation for each training day were collected as part of the routine monitoring of the service.

As part of the overall service evaluation, all staff were interviewed individually by the researcher every six months, and on leaving the service if they did so. This yielded detailed information from staff about the value of particular training sessions, and of the perceived effectiveness of the in-house training programme overall, at different points in time. Finally, information on the attendance of staff at externally organised training ventures (short courses, conferences, workshops) was collected by written questionnaire administered in 1986.

IN-HOUSE TRAINING

The in-house, in-service training programme started in July 1983, about six months after the end of the residential staff's induction period, and three months after the two community support staff had taken up their posts. The training days were organised on a 'whole establishment' basis (Whiffen, 1984), that is, for all the staff employed by the service, from coordinator downwards, and including both residential and community support staff. The training sessions were planned to take place from 9.30 – 3.30 on the last Thursday of each month (a fixed day so that residential rotas and other staff commitments could be pre-arranged to encompass this) at a local mental handicap hospital.

The training days were largely organised by the service coordinator, in conjunction with the clinical psychologist, to address particular issues and needs within the service as they arose, with outside contributors and specialist input brought in as appropriate. From July 1983 to June 1985 twenty in-service training sessions were held. For the first eighteen months – until the end of 1984 – they lasted all day (fifteen sessions); the remaining five sessions alternated between half and full days, depending on their subject matter.

Content

Figure 1 shows the content of the in-service training programme over the two years under review, with an indication of the number of sessions devoted to each topic. The sessions are listed more or less in the order in which they were held, although occasionally some time elapsed between different sessions devoted to similar themes. For example, there was an interval of several months between the first session on skill-teaching and a later session focussing more specifically on 'changing inappropriate behaviour', and a similar gap between the first two sessions on mental health/illness issues (which ran consecutively) and a third, follow-up session, six months later. The four sessions reviewing and evaluating the service in relation to its original goals and principles and the particular needs of the individual residents and clients it aimed to serve, took place at intervals throughout the two year period.

The content of the training programme was arrived at in three, sometimes overlapping ways. Most commonly, the coordinator or clinical psychologist (who played a key role in helping staff to maintain and improve the operation of individual programme plans, goal planning and skill teaching in their everyday work) became aware of particular problem areas – for example, when staff were initially getting to grips with drawing up strengths/needs lists and goals in the individual programme plan process. Sometimes, particular difficulties were highlighted by front-line staff themselves as a result of specific issues or dilemmas with which they were grappling at the time. The two sessions on 'working with families' and the three on 'mental health issues and problems', for example, were organised in direct response to acutely felt and strongly expressed staff needs. Finally, certain training sessions

(most obviously, the two devoted to self-advocacy and citizen advocacy) were organised to ensure that the service and its staff continued to keep abreast of new developments and approaches in the mental handicap field.

Figure 1

Content of in-house training programme over 2 year period

Individual programme plans and goal planning (2)
Taking risks and moving on
Working together (communication between staff)
Skill-teaching techniques (2)
Working with families (2)
Mental health issues and problems (3)
Self-advocacy
Citizen advocacy
Normalisation (a review)
'A thoughtful look at ourselves' (4)
(periodic review of where service was going and evaluation of how well it was meeting particular individuals' needs).
Counselling skills

(Numbers in brackets indicate sessions devoted to each topic).

Approach

In devising each training session, the training organisers had several goals. First, the information/skills presented should be **accessible** to all staff present, including a number without an academic background. Second, material should be **relevant** wherever possible to real issues being confronted by both sets of staff, those working in the residential service and those working out in the community. Third, the training should be a **participative** process – all staff should be able to contribute freely according to their own needs and experiences. Finally, each session should have **practical** outcomes: that is, staff should be able to use what they had learned to improve their subsequent practice, and to address particular problems experienced in their work.

To achieve these goals, certain methods of teaching and of structuring training days were favoured over others. Experience over time made it clear which approaches were more successful and these were increasingly adopted as the training programme advanced. Regular use was made of **small, task-based, group work**, with each small group made up of a mix of residential, community and other staff, and feeding back the fruits of their labour (logged on large sheets of paper) into the wider group for discussion. The tasks given were **case-studies or pen pictures** of people and problems which drew directly on the kinds of issues staff were confronting in their daily work. The sessions were organised and presented by professionals familiar both to the staff group and with the realities of their work situations. Most commonly, this was the service coordinator or psychologist. Where other **specialist contributions** were required – for example, on mental health issues, working with families, counselling – these were sought from interested professionals on the service's steering group (consultant psychiatrist, social worker, clinical assistant) rather than 'outside' professionals who were less likely to be able to tailor their input to staff's specific needs. Where appropriate, **handouts** (for example on 'Medication and mental handicap' or 'Guidelines for Keyworkers') were distributed for easy, future reference.

The emphasis was on a mix of teaching approaches and activities in different size groups throughout the day, with staff of all levels engaged as active participants and equal contributors rather than passive observers and recipients of others' wisdom. Staff were seen as the best judges of how well particular sessions had worked for them. At the end of each session, their views and comments on the day were always sought, including whether they would like some kind of follow-up session, or further input on that particular topic to consolidate what they had just learned.

Teaching approaches which were gradually rejected as less productive in this in-service context were:— the straight information-giving lecture where staff were passive listeners; the use of outside speakers who were not familiar with the service and its goals; the use of abstract issues (not related to staff's everyday experiences) for teaching and discussion purposes, particularly if this was at the expense of staff having time to apply what they had learned to specific situations they were actually encountering in their daily work. Staff, while valuing the training opportunities presented to them felt that time 'taken off' from their 'real work' to attend in-service days was precious. The sessions had to feel and be relevant to their work to be seen as worthwhile.

Staff views on in-service training

Immediate reactions to the in-service programme (sought at the end of each training day) were largely positive. Staff found most sessions interesting and useful.

Favourable comments tended to be sparked by sessions that related directly to current staff dilemmas or difficulties, which gave adequate space for discussion of these and for planning future strategies and which allowed staff to work in small groups and really grapple with the issues. Sessions which were particularly successful in meeting all these requirements including an early one on communication between staff entitled 'Its all right if its not all right'. The session drew heavily on a case-study of an organisation (not the Wells Road Service) where there were problems in communication channels between different staff. People found working on the case-study in small groups useful because it posed pertinent questions without forcing them to talk about specifics of their own work situations if they did not want to. However, it did help them to clarify their ideas and think through how potential conflicts might be handled in the future. They reported that the session would be useful in their work because they would have more confidence about bringing problems to each other, they would be more alert to potential communication needs which were not being met and they would be more aware of colleagues' feelings.

The three linked sessions on mental health and illness issues, the session on 'taking risks — and moving on', the day on counselling and the sessions where service staff took 'a thoughtful look' at where the service was going were also amongst those most valued for their interest, usefulness and stimulation.

Negative comments at the end of particular days tended to be prompted by sessions which, conversely, had failed to meet the requirements outlined earlier — for example, where days had been structured or set up in such a way that staff did not feel they could relate what they were being told to their own work situations, or else could not see how particular approaches or strategies could be integrated in practice into their everyday working life. For example, staff were left uncertain at the end of the sessions on 'working with families' as to **how** or **when** they would be able to fit in detailed discussions about possible approaches with particular families into their everyday work — particularly within the residential service. Their experience

was that the time which could be regularly allotted to review each individual resident's life and progress was already extremely limited because of other competing demands on time. Using any of that time to plan in detail concerted approaches to work with families where there were difficulties would be to sacrifice the attention due to other important aspects of the individual resident's life. Similarly, the session on 'self-adequacy' (based around a video on this theme) was valued in some ways ('very encouraging'). However, not enough time was allocated for small group discussions at the end, and the training organisers had not thought through in advance how lessons from the video could be incorporated into the service in future. As a result, *the overall outcome of the day was less satisfactory than hoped*. Staff were moved by what they saw, but not all were able to see how it could be applied in practice in their own work.

Subsequent comments by staff on training

In later interviews with staff the particular value of many in-service sessions was confirmed. Other comments about the in-house training programme also emerged. For example, after the monthly in-service programme had been going about a year, some staff began to wonder whether such a heavy input of time was worthwhile. For community staff, stretched to the limit in devising ways of meeting a variety of different needs in the community (see Ward, 1986a) a whole day 'away from work' sometimes seemed a little self-indulgent. For residential staff, who might face the prospect of returning to work after the training session ended, 'sleeping in' and then working through until 3.00 p.m. the next day, the resulting fatigue set a premium on in-service days being clearly relevant to work issues to be worthwhile.

Gradually, a consensus emerged that bi-monthly (or half day) sessions would be preferable for a while. This change coincided with much wider changes affecting the service overall at that time. Community mental handicap teams were being introduced locally and there was uncertainty about the future of community support services of the kind established at Wells Road.²⁾ There were successive changes in management higher up the health authority's mental handicap hierarchy, as Griffiths-style general management was introduced.³⁾ The coordinator who had helped set up the Wells Road Service departed and was not replaced for a number of months. Decisions were taken locally to 'hand over' health authority mental handicap services, including Wells Road, to the local social services' department but there was confusion about when this would be or what it would mean in practice for staff and residents alike.⁴⁾ As a result of all these inter-linking changes, only two in-service days were organised in the Autumn, Winter and Spring of 1985/6 and in-house training was abandoned entirely from May to October 1986 when the service was without a direct manager.

When some staff (those who were about to take up different posts within the health authority or elsewhere) were interviewed again in 1986 about their experience at Wells Road generally, all commented on how valuable, with hindsight, the in-service training programme had been, not simply in terms of developing skills and gaining confidence and knowledge but also in securing time for all staff employed by the service to meet together and discuss issues common to all. ('We were more like a team together again then. Once a month we were all there'. 'We learned things which wouldn't have been available to us otherwise. They were good'.) Certainly, after the in-service training lapsed, there was a sharp increase over the months that followed, both in staff sickness and staff turnover and the proportion of staff actively seeking other jobs. All these phenomena were undoubtedly related in

turn to the widespread and continuing uncertainties and insecurities for Wells Road staff in the prolonged absence of an immediate service manager, the lack of access to clear information about plans for the service in the future and their implications for staff's own jobs and clients' lives. Additional casualties of the lapse in in-service training (and declining staff morale) seemed to be a slip in the frequency and intensity of skill teaching and goal planning for individual residents and a general feeling that 'things were drifting' somewhat. Again, this too could be attributed to the absence of a service coordinator who, in the past, had been committed to fully involving staff in discussions about future developments in the service, and had been in a good position to offer constructive feedback to all staff on how they were doing in their day to day work. In the absence of a coordinator, the home leader took on increasing responsibilities and ensured, with the residential staff team, that life in the staffed houses continued positively regardless of other uncertainties.

EXTERNAL TRAINING OPPORTUNITIES

In addition to the in-house training programme, staff were given regular opportunities to attend other training events organised by outside agencies, such as the British Institute of Mental Handicap, the Association of Professionals in Mental Handicap (APMH), Community and Mental Handicap Education and Research Association (CMHERA), Castle Priory College (Spastics Society), King's Fund Centre and the local Workers' Educational Association (WEA). These events spanned a wide variety of subjects. Residential staff attended a number of workshops which focussed specifically on working in small staffed homes; an introductory six week course for local staff in the mental handicap field run on a one day a week basis by the WEA, a similar twelve week course on profound handicap, and a range of events on drama, crafts, sign language, stress and burnout, and groupwork. The annual APMH conference – focussing each year on a different theme – was also regularly attended. Additional events attended by community staff (and the service coordinator) reflected other aspects of their particular roles – citizen and self-advocacy, daytime alternatives and employment, adult and further education, and workshops on teaching normalisation to other people. Attendance at particular events was decided by staff themselves. All were circulated regularly with information about forthcoming events and were free to indicate to the coordinator any they wished to attend. Staff then decided amongst themselves who should attend particular events if there was competition to do so, on the basis of whose 'turn' it was to go on a course and whose particular interests specific events best suited. On average, staff participated in two or three different courses or workshops a year, varying in length from one day events through weekend workshops to a one day a week course lasting twelve weeks. Two staff who joined the service some time after it was set up, attended slightly more events in their first year of work to compensate for their less organised induction period.

Staff views on external training opportunities

The questionnaire completed by staff in 1986 asked for general information about access to external training events overall, and more specific information about each particular event they had attended.

General comments

On the whole, staff had found it easy to attend outside events of interest to them ('the opportunity to attend courses was very generous') and were satisfied with the number they had attended, though one or two commented ruefully that sometimes everyone had wanted to attend a particular event, or two events had

clashed. Several volunteered comments about the particular value of outside workshops and conferences as a source of support and inspiration, in meeting people from other services, 'keeps your interest going and gives you the feeling you are part of something happening all over the country', and that going on outside courses increased the individual's sense of worth and status. Only one person commented that the in-house training programme was more useful. The only other mildly negative comments were that it had been difficult to find appropriate courses or workshops on counselling and management.

Specific comments

Staff were asked to state for each event they had attended: whether it had proved useful, whether they had given feedback about it to colleagues, and whether it had had any practical effects on their subsequent work practice.

Almost every event attended was judged useful by the staff member involved, suggesting that not only had the events been well run but also well chosen by the staff as being appropriate to their particular situations and experience. Exceptions (not found useful) were an annual conference which had proved disappointing one year; a course on sign language run at the local university which the staff member and resident who had attended together had found difficult to keep up with; a workshop on teaching normalisation to others, which staff had hoped would have had a more practical outcome; a residential workshop on representation of people with learning difficulties in the media which had been poorly organised.

In order to maximise the benefit to all staff when individual members attended external training events, feedback to colleagues – usually at the start of the next *month's in-service training day* – was encouraged. Most people commented on their questionnaire that some kind of feedback to colleagues had been given in this way, although a few noted that their feedback had either been too short, or not well enough organised for maximum benefit. One person, in particular, commented 'If feedback is not (a) as soon as possible after the event, and (b) carefully prepared, then learning is not shared and can be forgotten/wasted'.

Most staff were able to give some examples of how different training events had affected their practical work, either in general terms ('renewed enthusiasm') or more specifically – buying musical instruments for residents to play, using different drama techniques and games (especially on holiday), recognising stress in themselves or others and being able to do something about it. Another tangible outcome of outside training events attended was the subsequent organisation of in-house, in-service training days for the whole staff group on particular subjects. The sessions on self-advocacy and a later session on employment all originated in this way. Even more concrete was the formation of a local group of people (including some involved in the *Wells Road Service*) who became interested in citizen advocacy after attending a workshop on the subject. The group eventually secured funding and established an independent citizen advocacy office in the local area.

DISCUSSION

From the preceding accounts, the values of on-going, in-service training opportunities for staff working in a developing community service are clear. They are manifest in both tangible and less tangible ways, with an observable outcome in improved staff practice (new strategies for tackling particular problems, better skills in, say, goal-planning or skill-teaching, different approaches to creating better opportunities for clients) and in increased staff confidence and morale.

Some difficult issues are, however, also clear. Organising good, relevant, staff training takes time, space, commitment and money. It requires an identified person with that specific responsibility, if in-service training is not to take a back seat when apparently more pressing issues or crises – inevitable in a flexibly developing service – also need to be addressed. Training cannot be effective in a vacuum, without an infra-structure of organisational back-ups of other kinds. At Wells Road these included separate weekly staff meetings for residential and community staff, monthly service meetings for the whole staff team, weekly skill-teaching sessions organised by the psychologist around particular staff/resident needs, monthly reviews of residents' progress (in addition to six monthly individual programme plans), fortnightly support group sessions for residential staff, individual staff supervision sessions, occasional opportunities for the whole staff group to share ideas and experiences with equivalent staff teams working in similar services elsewhere and staff involvement and consultation in future service plans. Together these created – during the period under review – a working environment where staff generally felt supported in the challenges they faced.

Inevitably, some aspects of the training programme were less successful than others. Plans to share in-service days with local social workers and nursing staff were seldom realised in practice. Only a few sessions were run jointly in this way. Nursing staff, for example, often found they were called upon to cover staff shortages elsewhere in the hospital just as they were about to attend a training session. Another problem which was never satisfactorily resolved was the use of relief workers to support the staffed houses during training days. By definition, this meant that relief staff (who had not undergone an extensive induction programme of the kind organised for staff when the service was first established) were not able to benefit from the in-service programme. A more crucial flaw in the training programme was evident as plans were made, both to establish similar services on a district-wide basis and also to ultimately hand them over to the local authority social services department. Although the Wells Road staff were now a highly trained, skilled team, their training was not a nationally recognised one. In comparison with traditionally qualified local authority or health authority staff, Wells Road staff proved not to be well placed necessarily in competition for other posts as they became available in locally developing services, despite the relevance of their experience and training. By the time of writing, a number of staff were, reluctantly having to apply for CSS (Certificate in Social Services) and CQSW (Certificate of Qualification in Social Work) courses in order to secure their future careers.⁵

CONCLUSIONS

As to the shift towards 'community care' for people with learning difficulties accelerates, increased emphasis is being placed on the importance of good induction training for staff taking up these new community posts. This concern is now reflected in practice and in written resource materials describing different initiatives in this area (Allen, 1984; Felce, 1982; Shearer, 1983; Ward, 1984; Ward & Wilkinson, 1985). Surprisingly, however, very little attention has been paid hitherto – in plans, practice or written materials – to the need for on-going in-service training once staff are in post. Yet experience in community services, like that described here, suggests that on-going, in-service training has an enormous role to play in ensuring that the new community services move forward rather than stagnate, and that staff are confident, competent and imaginative about ways in which their services can develop for the benefit of all concerned. Sound management practice – the involvement of staff in service planning and a commitment to flexibility as experience

within a service grows – and training practice are clearly interlinked. Without one, the efficacy of the other is drastically reduced. Where the two co-exist, there are continuing opportunities for staff to develop alongside residents and clients in their pursuit of 'An Ordinary Life'.

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NOTES

1. A government agency responsible for the creation of temporary employment and training initiatives.
2. The establishment of community mental handicap teams in Bristol was guided by traditional thinking about their composition, that is, a 'core' membership of one social worker and one community mental handicap nurse (Development Team for the Mentally Handicapped, 1978) with other part-time specialist members, for example, clinical psychologist, occupational, speech and physiotherapists and psychiatrist.

The community support service already established at Wells Road, by contrast, was operated by a new breed of professional called "community support workers" – who drew upon the skills of other professionals and non-professionals, and made use of a wide range of local resources and facilities to meet different individuals' needs as appropriate. Like the residential staff the community support workers had been appointed on NHS administrative and clerical scales, in order to permit the recruitment of staff to these posts from a variety of professional backgrounds and experience. (Appointment on more orthodox NHS scales – for example, nursing – would have restricted employment to one single professional group). The hope was that the community staff appointed would develop flexible and creative approaches and exploit new opportunities tailored to the particular individuals with whom they worked. Experience at Wells Road was positive. The use of this kind of frontline worker encouraged a flexible and creative approach, the development of individually-tailored opportunities, and the use of ordinary mainstream local facilities. After initial teething problems, relationships with existing local professionals, like community mental handicap nurses and social workers, developed well. Hence the disappointment when the decision was taken to abandon what had proved to be a successful method of working (the Community Support Service) in favour of one about which there was no practical experience locally (the Community Mental Handicap Team). For a more detailed discussion of the issues surrounding the development and maintenance of the Wells Road Community Support Service, see Ward, 1987.

3. The Griffiths Report into NHS management (1983) "recommended that general managers should be appointed at all levels in the NHS to provide leadership, introduce a continual search for change and cost improvement, motivate staff and develop a more dynamic management approach". (Ham, 1985). As a result of the implementation of the Report's recommendations management structures throughout the NHS were reorganised, with the appointment in 1985 of general managers at all levels: regional, district and unit. At a local level in Bristol, changes in management meant that existing managers within the mental

handicap unit (who were familiar with the aims and philosophy behind the Wells Road Service) were redeployed elsewhere.

4. Traditionally, responsibility for general mental handicap services in the U.K. has been divided between health authorities and local authority social services departments. Over the past fifteen years there has been increasing government pressure for local authority social services departments and health authorities to work more closely together in planning services for people with learning difficulties. More recently, that pressure has increased and it is now proposed that there should be a complete transfer of responsibility for services from health to the local authorities. In Avon, this handover is to be completed by 1995 although the precise timetable for handing over individual parts of services (like Wells Road) is not clear. (Initially – in 1986 – it had been proposed that this should take place immediately.)

Positive benefits of such a transfer of responsibility are, first, that people with learning difficulties are not, usually, 'ill' and their support is, therefore, more appropriately organised under the aegis of the social services department rather than a health authority, and second, that a transfer would avoid fragmentation and duplication of services.

Potential disadvantages of the proposed transfer which are commonly cited include: the possibility that the considerable experience and expertise accumulated by some health authorities and their professionals in working with people with learning difficulties may be 'lost' in the handover to social services departments; the haste with which decisions to 'hand over' services (and their staff and users) appear to be being carried out; the uncertainties facing health authority staff (especially nurses) in the transfer of employment to the local authority; and, particularly important, the severe economic restraints faced generally by local authorities both now and in the foreseeable future, and the possible implications of this – in the context of their other statutory responsibilities – for the provision of good community mental handicap services in the future.

5. "Reluctantly" because CSS and CQWS courses – the nationally recognised qualifications for local authority social services department staff – are generic rather than specialist social work training courses, with limited (if any) coverage of mental handicap. For staff who want to pursue careers in mental handicap, the attraction of the courses does not necessarily lie in acquiring directly relevant skills, but in the enhancement of future employment prospects as mental handicap services are 'handed over' from health to local authorities. (See note 4 above).

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