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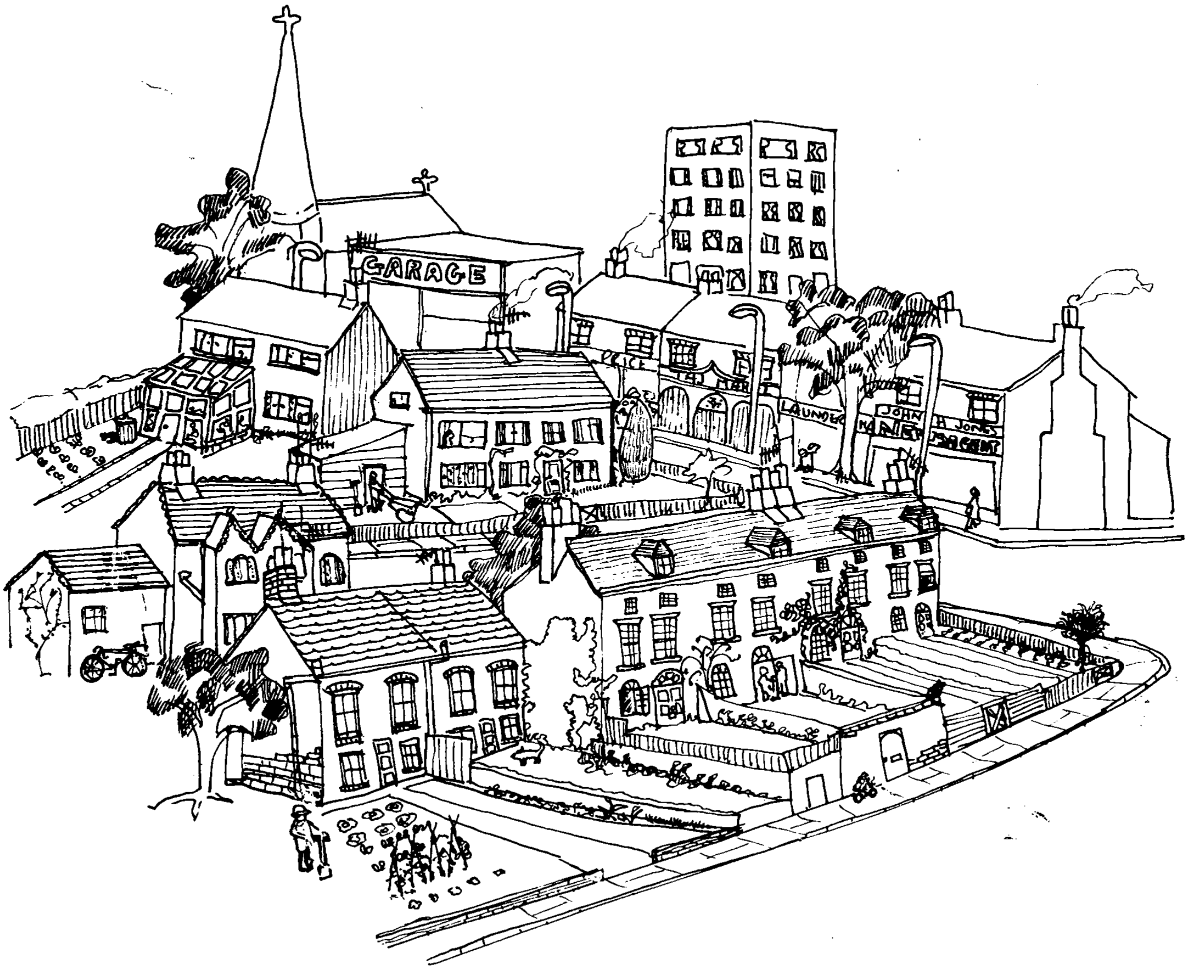

AN ORDINARY LIFE

Issues and strategies for training staff for community mental handicap services

edited by Ann Shearer

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 'An Ordinary Life' initiative. This project paper is one of a series which includes:

An Ordinary Life (Project Paper No 24, reprinted July 1982, price £1.50) an account of the principles involved in developing comprehensive locally-based residential services for mentally handicapped people and a guide to planning such services;

Bringing Mentally Handicapped Children out of Hospital (Project Paper No 30, November 1981, price £1.25) describes 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, 1982, price £1.50); and

People First: developing services in the community for people with mental handicap (Project Paper No 37, October 1982, price £5.00) A comprehensive and up-to-date review of the British literature on community-based mental handicap services.

A series of complementary shorter papers is also being produced, including to date:

Short Term Care for Mentally Handicapped Children (King's Fund Centre Discussion Paper, February 1981, price 75p)

The Portage Model of Home Learning Services (King's Fund Centre Discussion Paper, February 1981, free – please send large SAE)

Mentally Handicapped People with Special Needs (King's Fund Centre Discussion Paper, July 1982, price 75p)

Bringing it All Back Home: getting mentally handicapped people out of hospital (King's Fund Centre Discussion Paper, June 1982, price 75p)

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

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Foreword

In 1980 the King's Fund Centre published *An Ordinary Life* – a paper which set out to identify the principles and processes involved in developing comprehensive locally-based residential services for people with mental handicaps. The working group which produced *An Ordinary Life* stated the goal of these services as being 'to see mentally handicapped people in the main stream of life, living in ordinary houses in ordinary streets, with the same range of choices as any citizen, and mixing as equals with the other, and mostly not handicapped members of their own community'.

As I described in the foreword to the 1982 edition of *An Ordinary Life*, this initiative led to a continuing programme of work at the Centre. It also contributed to a growing range of local efforts to provide services which seek to achieve this goal. In turn, these efforts now offer a more informed basis for identifying issues which need to be resolved in the further development of community-based services and suggesting ways forward for policy and practice in other localities.

From the outset, the authors of *An Ordinary Life* recognised that the definition of roles and the recruitment and training of staff to perform those roles would be essential for the success of new services. Subsequent experience around the country has emphasised the importance of this theme. At national level, of course, the debate which followed the publication of the *Report of the Committee of Enquiry into Mental Handicap Nursing and Care* has still not led to very much progress in establishing a common framework for statutory training relevant to the needs of community-based residential services. In any case, the paucity of appropriate practice opportunities, even for better trained staff, means that innovative services must invest heavily in tailor-made training and development programmes for people they employ to do new jobs.

Accordingly, in November 1982, the Centre brought together some thirty people (listed in Appendix A) to examine the ways this challenge is being tackled in different local services. The participants started from a common commitment to the philosophy and service principles set out in *An Ordinary Life* and tried, on the basis of a series of previously commissioned contributions, to identify key concepts and methods.

Such workshops always have 'lives of their own' and it is difficult afterwards to capture all of value which took place for another audience. However, both the quality of the contributions and the wider interest in these issues has encouraged the King's Fund to produce this project paper. We are particularly grateful to those who presented material at the workshop (identified in the text) and to Ann Shearer (words) and Don Braisby (pictures) who have distilled in their different ways the essence of what took place.

As readers already familiar with *An Ordinary Life* would expect, an important concern of the workshop participants was the educational strategies through which staff can explore the values essential to the development of community-based services. A complementary interest was to find methods for involving parents more fully. Other key foci of discussion included the ways in which the tasks of managerial and front-line staff can be unambiguously defined and the training requirements which follow from these definitions.

Throughout the workshop there was recognition that with current levels of knowledge and practical experience, local services may need to review and revise procedures as more is learnt about their effectiveness. As in the whole of the *An Ordinary Life* initiative, participants also recognised the importance of joining with others to extend existing knowledge, strengthen the networks linking people engaged in innovation and find ways of encouraging further local enterprise. So comments, enquiries and suggestions arising from this project paper – addressed to Joan Rush at the King's Fund Centre – will be very welcome. There remains a great deal to be done to ensure that the people who as staff serve mentally handicapped people and their families have their contribution effectively used. We hope that the ideas in this paper and their development in wider discussions will go some way to enhancing this vital staff contribution.

David Towell
1983

WHAT DO WE MEAN BY TRAINING?

Training is an event
Training is a process

Events happen 'on Thursday'.
They often bring in outside trainers, with an independence and an energy that we can use.
Events offer a context for manipulation:

people are away from their phones;

the chance of new groupings for participants;

the chance of meeting people who think as we do;

the chance of new perspectives.

Process happens all the time.
We all learn every day of our working lives, and courses should be a backing to that positive experience.
Process offers a changed pattern of relationships and builds networks of people working together.

Training happens in an organisational and political context

We need to be aware of this context — which can be hard for people who work in statutory services.

Training is about the opportunity for change

National workshops are much less likely to lead to change than local ones. To bring a token member from 14 different areas is much less likely to lead to the implementation of what is learned than the building of a critical mass of people from one area or agency.

Training is about specific skills

The importance of skill-training shouldn't be underestimated. Achieving skills leads to success which changes expectations which leads to change in services. But people are often offered too much training in what they can't apply and too little in what they could. There's a muddle between 'training' and 'giving people a licence to practise'. We need to ask 'What does A need to work with B?' and offer it.

Training starts with awareness

And that's mostly what this workshop was about. . . . .

Education in values (1)

Alan Tyne

Ideas, beliefs and values

The *ideas* people have to work with, and on, are a very important resource for any service. Ideas are how people make sense of what they are doing. They come from personal experience, the wider society and the explicit statements of a service system. Ideas are a kind of knowledge.

In a scientific world, much knowledge is subject to various 'tests' of validity – information and evidence, for instance, or support by scientific communities. *Beliefs* are bits of knowledge which aren't seen to need this external validation (though some scientifically-validated knowledge achieves this stature, too).

Values are one kind of belief, and are concerned with the relative importances of people, things and ideas. 'Philosophies' or 'ideologies' are simply systems of inter-related ideas, usually based on explicit beliefs and values.

When people are short of information, they are much more reliant on values and beliefs. We are short of well-validated knowledge on the provision of services to mentally handicapped people. We have very little knowledge of the causes of handicap. We have very few powerful techniques of intervention.

When service systems don't explicitly support values and beliefs, people are left to discover their own from personal experience, which includes their professional, training and work environments. These values can be precarious and easily challenged by societal values and structures.

How do ideas get formed?

People's ideas get shaped and formed in several ways, which we need to understand if we are to intervene effectively.

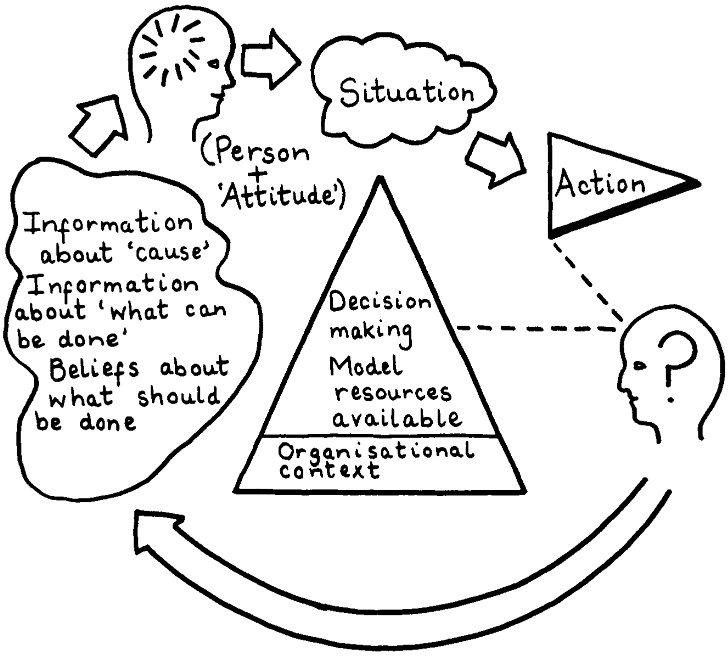
The attitude which a person takes into a given situation can be modified by what he or she finds in that situation (see first illustration, page 8)

Attitude is a product of the action that comes out of a situation (see second illustration, page 8).

A whole lot of factors help form organisational philosophies and personal values and beliefs – and are in turn modified by them (see illustration, page 9). (Remember organisations, just as much as individuals, have commitments to notions of 'What is the problem?' and 'What can be done about it?'.)

How can we change ideas?

Changing beliefs and values means not just trying to influence individuals, but paying attention to the structures they work in. 'Trainers' may have little access to these.



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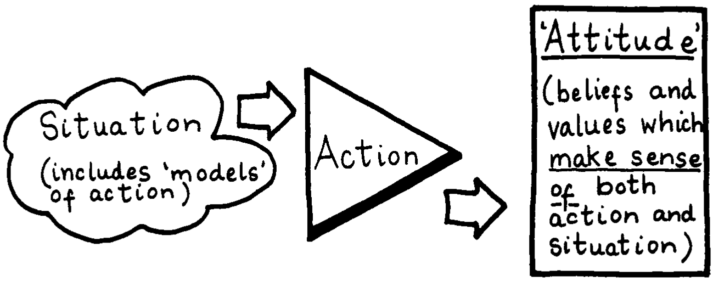
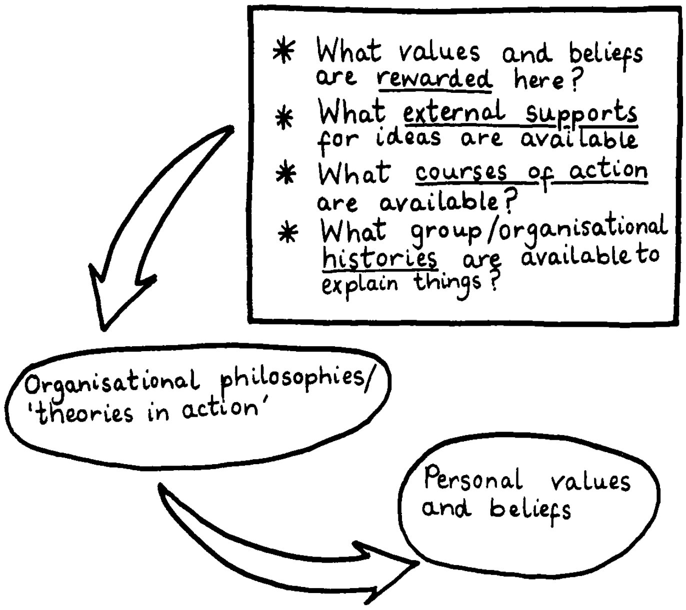


By now, CMHERA (Community and Mental Handicap Educational and Research Association) has held more than 40 workshops on normalisation and related issues, as well as nine five-day workshops on PASS, (Program Analysis of Services Systems), the evaluative tool developed in the United States by Wolfensberger and others and based on the principles of normalisation.[1] CMHERA has worked with 18 health and local authorities in different parts of the country. As well as running workshops, it has done some field work and follow-up.

In CMHERA workshops, we look at *'what is the problem?'*

We try to 'ground' the learning, through exploration of the experiences of devalued people, encouraging participants to adopt a viewpoint and develop a commitment, using presentations and setting tasks which lead to a group exercise or a PASS evaluation of a service.



We look at *'what can be done?'*

Here we examine the principles of service-response, working through a definition of normalisation and a statement of beliefs and values, service goals, and a programme of action. We look at 'images of possibility' – as at *An Ordinary Life* conferences.

We make an *analysis of key issues*

We look at dignity and respect, age-appropriateness and participation as 'problems' in the lives of mentally handicapped people, and work out practical programmes of action in these areas. We look at the 'value themes' which run across these areas. People need to make up their own minds about segregation, the developmental assumption, and issues of imagery and 'interpretation'.

We work on *ways of supporting people in their work on values and beliefs*

We look for ways of reducing the sense of confrontation in working with these ideas – because confrontation hurts and people seem to learn better without it. We use normalisation as an *active principle of enquiry*, not as a dogma. We stress the developing nature of ideas, the agenda of questions rather than solutions. We encourage people to explore the impact of value-systems by explaining one to them in detail. The task is to learn the ideas, not to change their own. We try to support people who *do* undergo traumatic re-examination of their beliefs.

We do all this through workshop techniques and participative learning. The trick is to set up structured times, spaces and groupings in which people can share their learning; we try to make the work their own as far as possible. We use group posters and feedback, because these are things that groups can own.

From our work so far, we have concluded that external intervention can have only limited impact. The important next stage is to help people develop networks of mutual support to reinforce their learning and enable them to continue to grow and innovate.

Reference

1 Wolfensberger W and Glenn L. Programme analysis of service systems (PASS 3). National Institute on Mental Retardation, Toronto, 1975.

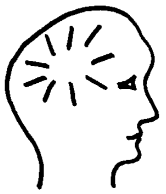
WHERE DO OUR IDEAS ABOUT MENTALLY HANDICAPPED PEOPLE COME FROM?

Think of the very first person you ever met whom you now know to have been mentally handicapped. (A child in your school? The child of friends of your parents? A child you didn't really know but was part of your childhood landscape?)

How did you describe them ?
How did you think they got to be the way they were?
What did you think should be done with them?
What did you think would be their future?

Take your time. . . .

And now turn up the page for some common answers that people give to the questions. . . .



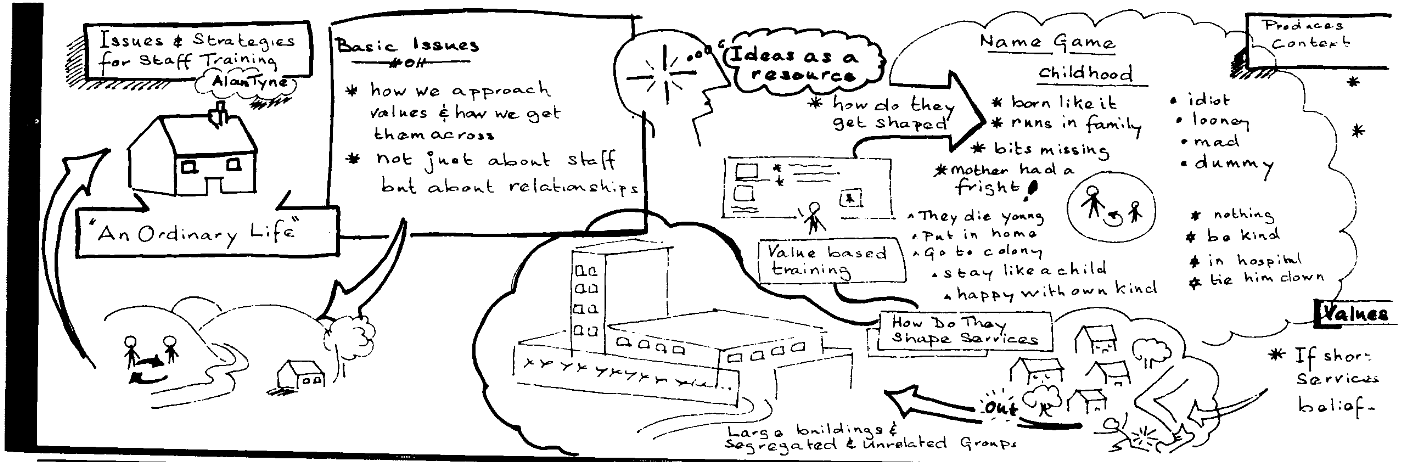
OUR IDEAS ABOUT MENTALLY HANDICAPPED PEOPLE COME FROM VERY DEEP DOWN

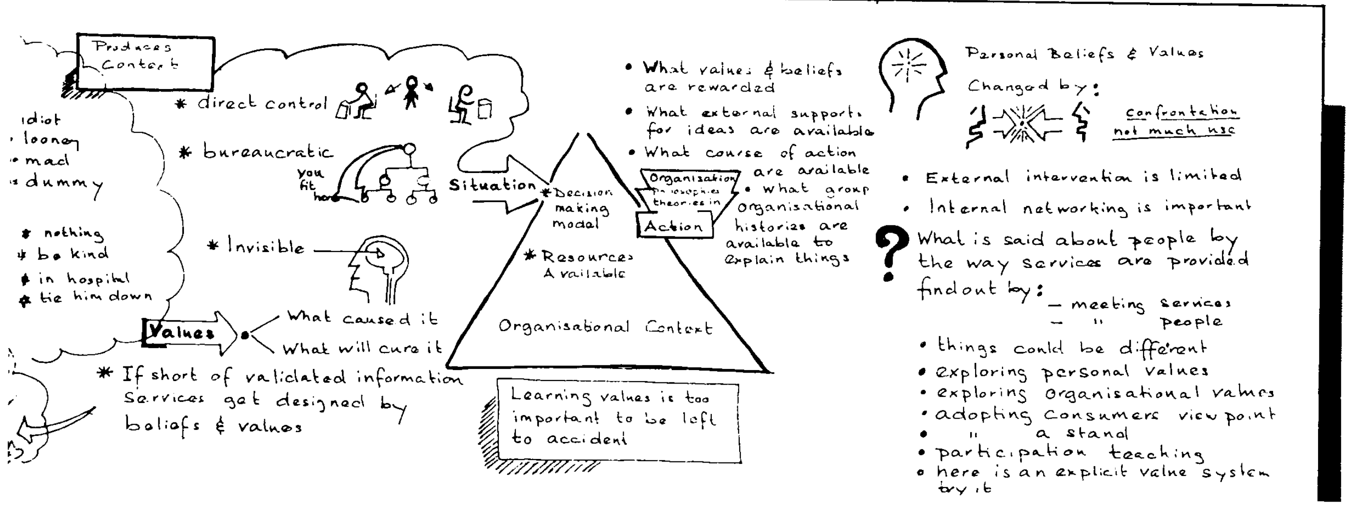
How did you describe them?
Idiot? Looney? Mad? Dummy?

How did you think they got to be the way they were?
Born like it? Runs in the family? Bits missing? Mother had a fright? Parents did something wrong?

What did you think should be done with them?
Nothing? Be kind? Put them in hospital? Tie them down?

What did you think would be their future?
They die young? A place in a home or colony? They stay like children? They're happy if they're with their own kind?

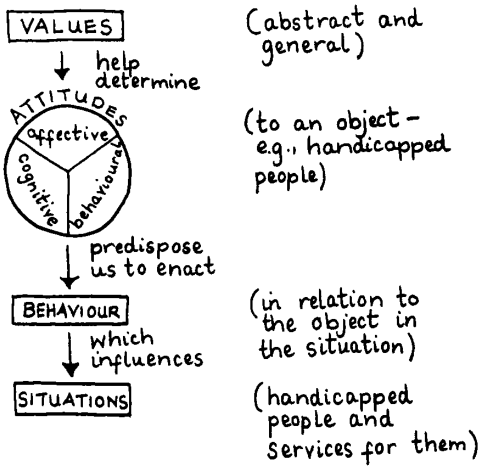

Issues & Strategies for Staff Training
Alan Tyne
"An Ordinary Life"
Basic Issues
#0H
* how we approach values & how we get them across
* not just about staff but about relationships
Ideas as a resource
* how do they get shaped
Value based training
Name Game
childhood
* born like it
* runs in family
* bits missing
* mother had a fright!
• They die young
• Put in home
• Go to colony
• stay like a child
• happy with own kind
• idiot
• looney
• mad
• dummy
* nothing
* be kind
* in hospital
* tie him down
Produces Context
*
*
Values
How Do They Shape Services
Out
Large buildings & Segregated & Unrelated Groups
* If short
Services
belief-


Produces Context
idiot
• looney
• mad
• dummy
* nothing
* be kind
* in hospital
* tie him down
* direct control
* bureaucratic
you fit here
* Invisible
Values
What caused it
What will cure it
* If short of validated information Services get designed by beliefs & values
Situation
* Decision making model
* Resources Available
Organisational Context
Organisation philosophies theories in Action
Learning values is too important to be left to accident
• What values & beliefs are rewarded
• What external supports for ideas are available
• What course of action are available
• what group organisational histories are available to explain things
Personal Beliefs & Values
Changed by:
confrontation not much use
• External intervention is limited
• Internal networking is important
?
What is said about people by the way services are provided
findout by:
– meeting services
– " people
• things could be different
• exploring personal values
• exploring organisational values
• adopting consumers view point
• " a stand
• participation teaching
• here is an explicit value system try it

Education in values (2)

Mark Burton

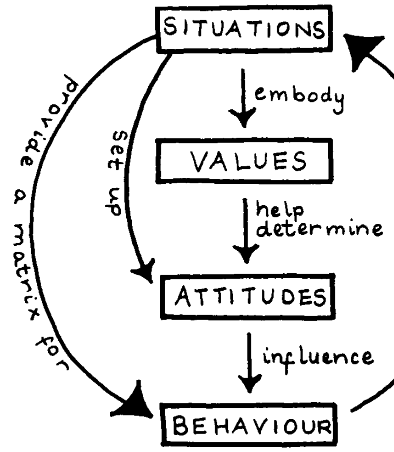
Much orthodox Anglo-American social psychology – summarising common sense – uses this model of the relationships between values, attitudes, behaviour and situations.



This 'unilinear' model is distinctly unhelpful. By conceptualising values as abstract, shadowy and in the head, it seems to rule out the possibility of changing them, or even of subjecting them to critical examination. In addition, it misses the 'out-thereness' of values.

Instead, values and value systems may be seen as concrete, as embodied within services for handicapped people and the practices that they determine.

So the model could be usefully revised like this:



The whole system also needs putting in a wider societal context, which changes over time through social policy, economic development and so on. That wider societal context includes society-wide assumptions about handicapped people and the way they are treated – like being poor and being segregated.

Implications for teaching about values

The revised model sees values, attitudes, practices and environments as a totality, as a system, in which each part is multiply determined by the others and by wider social forces. This has two major implications for changing services and teaching about values within them.

1 We need to intervene on several levels – for example, through teaching about values and through planning for and politicking about service environments.

2 We need sustained intervention of a continuing, supportive sort – because of the multiple determinations in the values/attitudes/behaviour/services system.

People who try to change things are often in a minority – whether in planning groups or in teaching environments. There have been two different approaches in social psychology to the problem of minority influence.

One says: 'Conform to the majority view at first, be nice, build up acceptance and status, and then use your position as a basis for arguing your radical proposals'. The major difficulties here come from the implausibility of achieving such a u-turn, and the danger of doing damage in the meantime – perhaps getting sucked into the majority perspective or at least watering down principles. The second approach says: 'Establish early on a distinctive minority position with clear arguments based on principles and, wherever possible, evidence'. There is research evidence[1] to show that this can be highly effective. This approach needn't be rigid or particularly confrontational. It can be consistent and flexible if use is made of an underlying pattern of tenets and themes. The consistent and principled articulation of *An Ordinary Life* arguments, flexible in the face of new evidence or conditions, may be clearly rooted in an explicit and recognisable value system: normalisation.

In teaching settings, the teacher is likely to have a dual role: a limited leadership and authority status, but the position of an outsider or minority figure. The arguments about minority influence and the considerations of the value/attitude/behaviour/situation complex suggest that these two roles might be used in combination as follows.

A distinctive position about the role, place and value of handicapped people should be made explicit from the start. This should be accompanied by a strategy of coalition, or network-building, to support and sustain people who are trying out new practices and exploring new value systems.

Reference

1 Moscovici S and Nemeth C. Minority influence. In Nemeth C, ed. Social psychology: classic and contemporary integrations. Chicago, Rand McNally, 1974.

SOME TYPICAL THINGS THAT PEOPLE SAY OR BELIEVE THAT AREN'T HELPFUL IN SERVICE SETTINGS

'There's no money so nothing can be changed.'

'The public won't tolerate mentally handicapped people in their community.'

'We tried it and it didn't work.'

'They are all perfectly happy as they are.'

'There's nothing you can do to help him/her.'

'We haven't the right to impose our ideas on them.'

'The other professionals don't understand.'

'It's what the *service* (not the individual) needs. . .'

'We haven't the authority.'

'We must be sure to take everyone with us.'

'We can't use the washing machines except for teaching purposes.'

'Mental handicap has had its turn, now we must think of the elderly.'

'We're already overprovided according to Regional norms.'

'We'll think of that tomorrow.'

WHAT KIND OF CHANGES IN PEOPLE'S LIVING OR WORKING SITUATIONS WOULD BE NEEDED TO SUSTAIN A DIFFERENT SET OF BELIEFS?

A willingness to look at the positives of any situation.

Comparing the rights we enjoy with those of mentally handicapped people.

Removing the levels of obstinate bureaucracy to give local control of resources.

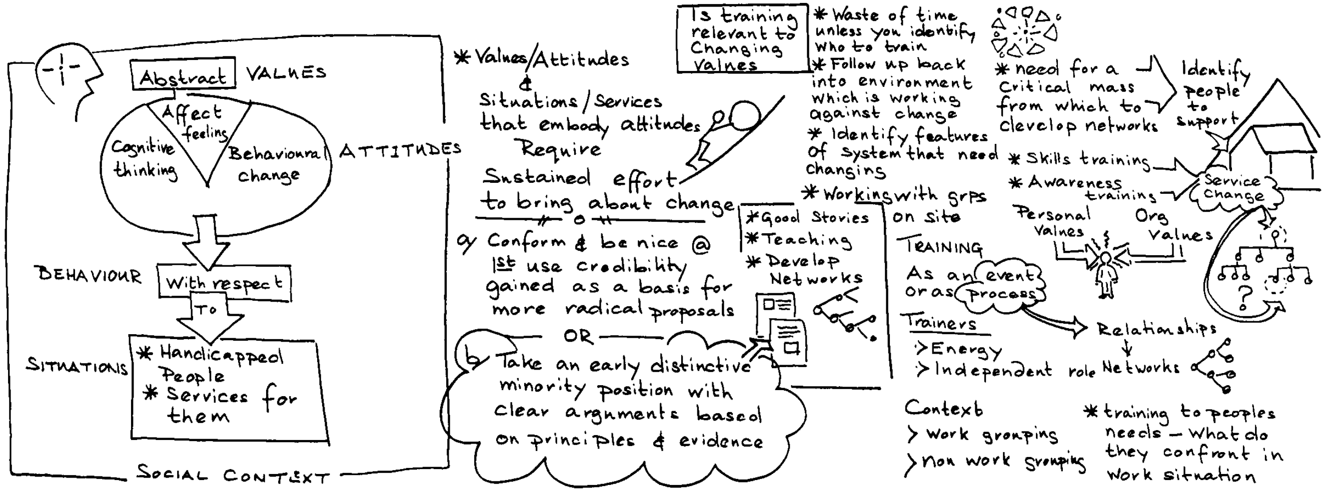
Demolishing buildings (to show we mean what we say).

Meeting mentally handicapped people rather than just talking about them.

Getting service managers to see their job as having to do with development and change and not just control.

Bringing in 'ordinary' people to do 'professional' jobs.

'AND WHERE ARE THOSE 'ESSENTIAL' NEW RESOURCES IN THAT LIST? Reassessment of our ideas and knowledge is just as important.


Abstract
VALUES
Affect feeling
Cognitive thinking
Behavioural change
ATTITUDES
BEHAVIOUR
With respect To
SITUATIONS
* Handicapped People
* Services for them
SOCIAL CONTEXT
* Values/Attitudes & Situations/Services that embody attitudes Require Sustained effort to bring about change
a) Conform & be nice @ 1st use credibility gained as a basis for more radical proposals
OR
b) Take an early distinctive minority position with clear arguments based on principles & evidence
Is training relevant to Changing Values
* Waste of time unless you identify who to train
* Follow up back into environment which is working against change
* Identify features of system that need changing
* Working with grps on site
* Good Stories
* Teaching
* Develop Networks
* need for a critical mass from which to develop networks
Identify people to support
* Skills training
* Awareness training
Service Change
Personal Values
Org Values
TRAINING
As an event or as process
Relationships
role Networks
Trainers
> Energy
> Independent
Context
> Work groupings
> Non work groupings
* training to peoples needs – what do they confront in work situation

Parents as part of the team

Sherry Noley

> 'For years, parents were described as anxiety-ridden, over-emotional and unable to take part in deliberations that affected the future of their child. With changes being brought about by the normalisation principle, the tables are being turned. Today, it is recognised that there is great value in allowing parents to participate fully in decisions involving their children.'[1]

> 'The challenge in the 1980s for both parents and professionals will be to find ways to carry out the legislative mandates for collaborative efforts to help children.'[2]

Parents are getting used to hearing about partnership with professionals, cooperative effort and multidisciplinary teams. But some very practical questions need to be answered.

> How *do* we integrate the expertise and perspectives of parents with those of people in the helping professions?
>
> How *do* we include parents in elements of decision-making that have traditionally been left to professionals?
>
> How *do* we determine ways for parents to help their sons and daughters in residences lead ordinary lives?

Parents have been in a 'no-win' situation for a long time. They meet assumptions:

> They are at such a crisis in their own lives that they can't possibly be objective.
>
> Any family with a handicapped member is a handicapped family.
>
> Parents don't care because they don't come to PTA meetings.

Where parents *are* involved, it's usually at the toothpaste and buttons level. Their involvement consists of choosing the first and sewing on the second – while staff get on with the really important decisions, like where their child goes to school. Or they may be presented with a package and asked 'Do you agree with this or not?' – without any chance to look at its separate elements.

So how do we achieve real involvement for parents?

As with any change of philosophy, there is a lag between the time of verbal commitment to that philosophy and the time when it is implemented and integrated into our everyday lives. This process is a 'human, psychological and educational [one] that must begin with people learning about one another.'[3]

Let's begin this process by considering how the lives of parents might be changed when their sons or daughters go to a residence.

Residential placement has been identified as a crisis point in the life cycle of a family with a handicapped child. It forces parents to deal with a major transition in their role as parents; and *any* transition, whether positive or negative, chosen or imposed, will create some degree of stress and strain.

This is how it seemed to one mother in Nebraska when her multiply-handicapped daughter went to live in a community-based residence at the family's request.

> 'The thing about being a parent of anybody is that your life is so daily. It's all sort of fluoride toothpaste and missing buttons and should we ask about a change of medicine since she's having a lot more seizures – things like that. So when we had a crisis in the family and decided it would be best for her to live in a residence, we missed *her* of course, but we hadn't realised how much time and energy all that ordinary stuff took. I felt kind of like I had lost my job. It was hard to get used to.'

What eventually happened in this situation was probably not unique. The mother was quite pleased and relieved to discover the quality of the staff members at her daughter's residence and the genuine warmth of their relationship with her child. But she also felt that she had been 'replaced' in her role as mother since they performed the tasks which had always been *her* responsibility before that. At first she saw only their ability to cope well with the time-consuming task of feeding her daughter – and forgot that she always had to juggle this task with meal times for her two sons and husband. Though it wasn't clear to her just then, questions began to form in her mind – questions about her image of herself as a 'good' mother, questions of self-esteem.

This led to conflict with staff at the residence over seemingly trivial things like how her daughter's hair was fixed or whether she should be wearing her sandals instead of her tennis shoes. It took a while for the mother to become aware of her feelings and to take the risk of expressing them to the staff.

Parents of people who live in residences may also experience the feeling of being an 'outsider'. I felt something of this myself, when my own children were living with their father during one academic year. On one particular visit to them, I was standing outside the front door waiting for someone to answer the doorbell when I was struck with the awkwardness of the situation. I had to wait to be invited into the place where my own children lived with their father. I knew each of the people there very well, yet I was not really a member of that little 'community'. It was not a comfortable feeling, or one that was easy to identify or talk about with the other people involved. Parents of handicapped people who live in a residence may feel the same way. Any parent who has had a child in hospital will recognise the feeling. For that period of time they are an outsider and their role as parent seems minimal; other people, mostly people they don't even know, are making decisions about their child. The feeling is one of frustration and powerlessness – and most people would feel silly to admit to it at the time.

Ralph Ruddock discusses the view that a person's behaviour is determined a great deal by the role he is in at any given time. and how the past influences the present behaviour of the individual. He also reminds us that individual behaviour varies widely with changes of role and of self-image.[3] Barrie Hopson is saying basically the same thing when he classifies 'transitional experiences' as those which include personal awareness of a discontinuity in one's life space, and new behavioural responses required because the situation is new or the required behaviour is novel, or both.[4] He points out that transition demands adjustment. In order to cope, the individual will be asking questions like:

> How can I accept this situation?
> What behaviour is expected of me?
> What do I want from this situation?

If we look at the way we view community-based residential services for people who are mentally handicapped, and especially at the tasks performed by people responsible for the residences at different levels, we can begin to get a feel for the confusion parents experience when they try to function as part of the team.

An Ordinary Life says, for instance:

> 'A residential service is a home-making service.'
>
> 'Home-makers have two kinds of tasks – 'doing' and 'teaching'. . . Some of these tasks are very personal and private, others less so, but they are all part of what our society takes for granted as home life.'[5]

Later, it discusses the three main levels at which residential work is done, as well as different ranges of responsibility for decision making and planning. What these definitions and discussions incorporate are all the tasks and responsibilities we usually associate with the term 'parenting'.

So we need to deal with the principle of normalisation not only at a philosophical level, but also at the practical level of everyday living – and for everyone involved. That means looking at all the tasks involved in the planning and implementing of programmes for people who are in residences and *including parents at every stage.* We need to move away from thinking of parental involvement only in terms of the toothpaste and buttons of everyday life.

How do we do it?

An Ordinary Life makes suggestions for the participation of both clients and parents at all levels of planning and implementation. Genuine partnership includes:

the involvement of clients and parents in assessment of needs;
prioritising short and long-term goals for individual clients;
developing job descriptions and criteria for staff;
assisting in training for both home-making and supervisory staff;
considering existing community resources;
proposing possibilities for dealing with the unmet needs of clients;
monitoring and evaluating services after a specified period of time.

The issue is how parents can be involved as FULL members of the team. Effective team work of any kind requires a balance of working towards clearly identified goals through a strategy of specific tasks, as well as recognising and responding to the emotional needs of individual team members.

> 'Expectations that people have of one another shape the goals they have and the energies they invest in joint enterprises. The problems of self-esteem and failure can. . . affect the expectations parents and professionals have of one another and. . . can limit the energy that people invest.'[2]

References

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SOME STARTING POINTS FOR STAFF WHO REALLY WANT TO INVOLVE PARENTS

Complete this sentence — and see where it takes you!
'The problem with parents being allowed to be part of the decision-making team in *our* situation is. . . .

Think of the worst thing that could happen if they were part of the team. . . .

Think of the best thing that could happen if they were part of the team. . . .

Ask yourself these questions:

At what point in the planning process are parents invited/allowed to participate?

Is training in the normalisation principle available to parents?

Are issues discussed in easily-understood, non-jargon language?

Are initials which parents — or other team members — may not understand used instead of the names of different groups and agencies?

Do other team members consider the views of parents and clients seriously?

Are meetings held at times and places which fit with parents' commitments?

Are meetings held in places accessible by public transport?

Are meetings held in places accessible to people with physical handicaps?

Are clients and parents involved in the assessment of clients' needs?

Are clients and parents involved in the discussions and decisions on criteria for staff?

Are parents involved in the training for residential staff, both as participants and as presenters?

Are parents involved as presenters in training for supervisory staff?

Are parents encouraged to meet with other parents who have a child in the residence?

Are parents part of an effective and continuing monitoring and evaluation team?

Have staff and parents together looked at the tasks involved in the daily life of residents to see how parents and relatives can contribute to their ordinary life?

Has the team thought about a 'sibling day' to help brothers and sisters cope with the transition in their own lives?

Has the team looked at how parents and relatives can feel part of the 'community' of the residence, rather than outsiders?

SOME THOUGHTS – AND MORE QUESTIONS

about what involvement means

Involvement means being there, being valued, being listened to. It means planning ahead as well as being concerned with what's happening now.

Involvement can create trust. It's lack of trust that leads to conflict. Professionals can welcome parents and make it easier for them to participate.

How individualised can services be? If services really are designed around individuals, then individual parents will be involved.

What are the limits of parents' involvement? Are there some who really don't want it? Who represents their son's or daughter's interest then? What is the role of the advocate, of relatives and friends?
How old are the people in the residence when their parents' involvement starts to lessen or even cease?
How representative can parents be? Should they be involved in wider decisions or only those that directly affect their son or daughter? Parents' contributions can be highly individual without being limited to concern for their own child. Parents can grow in this role. Will professionals welcome them as equals in planning?

and about how involvement can be achieved

At service level we could

ask the parents how they want to be involved and/or represented;

draw up a written statement about the contribution we expect from parent members of the team ;

use exchange diaries between home and residence;

make sure that parents have the same information as professional workers, that they have the same right of access to information – and the same duty to observe confidentiality;

make sure that parents are involved in their own child's individual plan meeting;

make opportunities to meet parents often – at their home – or why not in a pub?

Remember that relationships may be more important than formal structure in decision-making.

Remember that parents are more professional than the professionals!

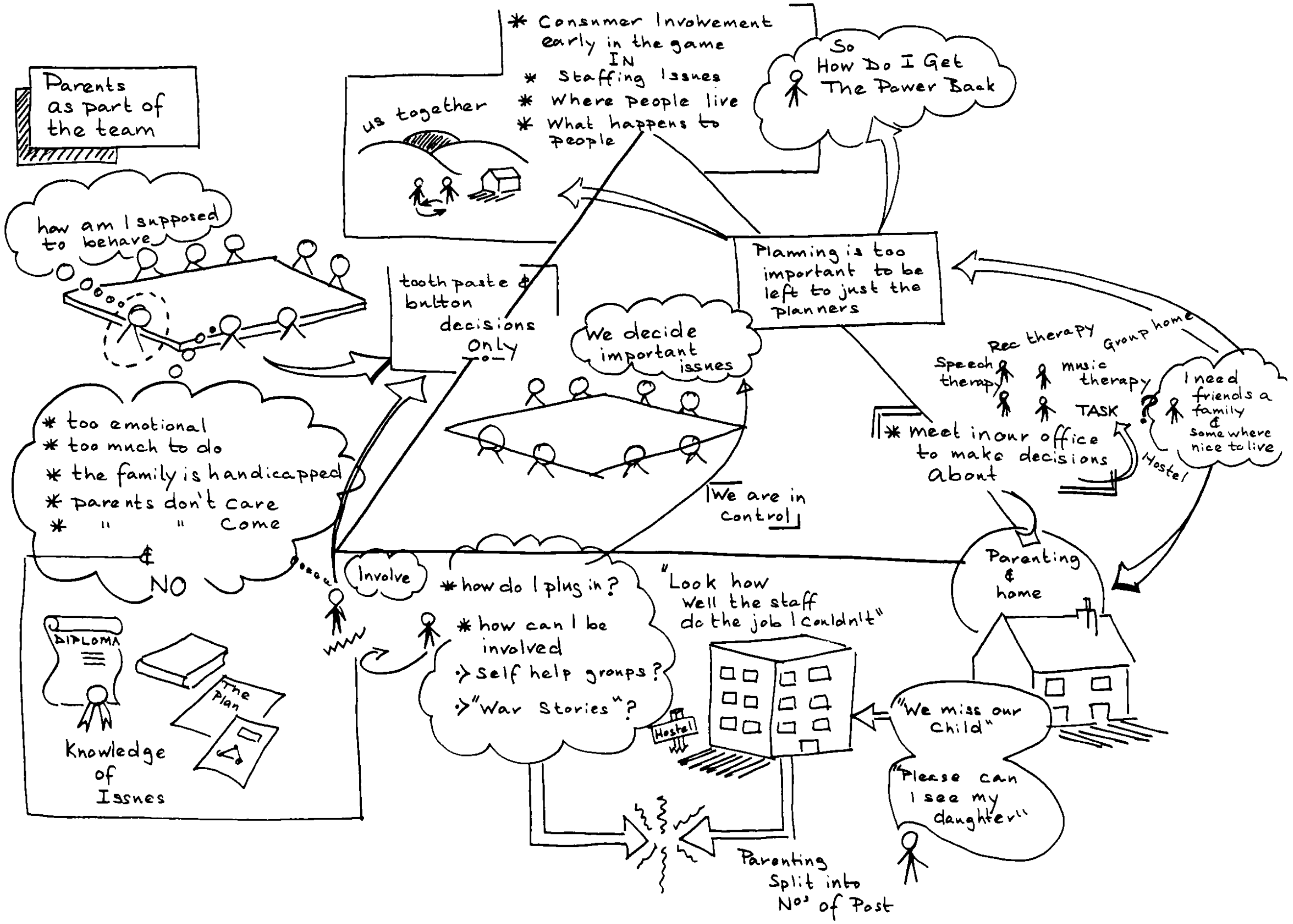
At planning level we could

ask parents how they want to be involved and/or represented;

hold a local conference and not only invite, say, MENCAP, but also invite parents in order to help them develop their participation;

separate the role of 'befriender' more clearly from that of advocate.

Remember that participation is easier if services are planned locally.


Parents as part of the team
how am I supposed to behave
tooth paste & button decisions only
us together
* Consumer Involvement early in the game IN
* Staffing issues
* Where people live
* What happens to people
So How Do I Get The Power Back
Planning is too important to be left to just the planners
We decide important issues
We are in control
* too emotional
* too much to do
* the family is handicapped
* parents don't care
* " " come
& NO
Involve
Rec therapy
Group home
Speech therapy
music therapy
TASK
I need friends a family & somewhere nice to live
* meet in our office to make decisions about
Hostel
Parenting & home
* how do I plug in?
* how can I be involved
-› self help groups?
-› "War Stories"?
"Look how well the staff do the job I couldn't"
Hostel
DIPLOMA
The Plan
Knowledge of Issues
"We miss our child"
"Please can I see my daughter"
Parenting Split into No's of Post

Defining tasks: from policies to job descriptions

Shirley Mathieson
Claire Wilson
Peter Jordan
Carol Rowlands

How are tasks to be defined once the shape of a service is agreed?

Here is an outline of NIMROD's experience in drawing up guides to operational procedures and job descriptions for the staffed houses that form part of its comprehensive community-based residential service for all the mentally handicapped people within a 60 000 catchment population in west Cardiff.

The framework of what NIMROD offers was set up before the service started, by the working party of the authorities which set it up and are responsible for it. So there are some clear parameters within which its staffed houses must operate.

NIMROD's general goals are:

to promote the health, safety and human rights of each client;

to ensure that each client is enabled to live in as normal a way as possible.

It pursues these through:

a comprehensive service – which means that there can be no selection of clients, most of whom will come from mental handicap hospitals (or other forms of long-term residential care in an institutional setting);

accommodation in ordinary houses, the size and shape of which (four bedroomed, terraced) are more or less predetermined by availability;

staffing laid down before the service started. For the staffed houses, this means 1 senior care assistant, 5½ fte care assistants, and 2 fte care assistants to cover nights on waking duty. All staff are paid on residential care officer grades: senior care assistants on grades 3/4, care assistants on grades 1/2. There are no domestic staff, so care assistants are responsible for caring for and teaching residents, as well as cooking, cleaning, shopping, decorating, gardening, keeping records, and so on.

Procedural guides

These were developed with the help of the Mental Handicap in Wales Applied Research Unit (which is also monitoring NIMROD's progress) and grew from some basic questions.
What do you need to do:

to run a house as a home;

for six people;

with skill training;

with staff on shifts;

with external and internal monitoring?

There are now no fewer than 27 procedural guides for the staffed NIMROD houses. They fall into four categories of activity:

running the house (domestic);

running the house (administrative);

teaching/behaviour;

reviewing practice.

An important aspect of the way NIMROD works is that its management can get a cross-section of views of how things are changing as it develops. So the guides have changed too – sometimes at the suggestion of a care assistant.

The guides have changed as practice has shown that they could reflect more accurately what actually happens. For example, the Research Unit thought it useful for the household jobs guide to include a card which laid out specific, step-by-step procedures for different jobs, so that teaching of these jobs could be standardised. The care assistants disagreed – and so the 'job cards' have been taken out of the guide. To take another example, it became apparent as time went on that not all residents will be willing to participate in household chores. So the part of the guide that used to read 'You [care assistants] should not do jobs which are the responsibility of a resident who is capable of doing them' has now been changed. It now reads: 'You should not do jobs which are the responsibility of a resident who is capable of doing them, unless a resident refuses to be involved in household chores, in which case it may be necessary to re-rota the tasks with a Senior Care Assistant/Care Assistant responsible for them.'

The guides have changed as it has been recognised that they are unclear or illogical. For example, the Guide on Planning Menus has been changed to take account of special diets and the need to record these in the medical record. It has also been expanded to take account of the fact that some residents may be overweight and need help with this – either through simple explanations of how they can cut down on some foods and avoid others or, if the problem is more serious, through a medically-supervised and clearly-planned reducing diet.

The guides have changed as it becomes obvious that procedures have been overlooked or need clarifying. For example, the presentation of the guide on *house meetings* has been made much clearer and more simple to follow. The provision that only the senior care assistant can chair these meetings has been dropped. And the guide now includes provision for *staff meetings* as well as meetings for everyone who lives and works in the house.

How worthwhile are the procedural guides?

NIMROD has found some pros and some cons.

Pros

They are useful for training staff.

They allow standards to be defined and monitored.

They, in theory at least, make it easier to set up further houses.

They indicate shortfalls in policy and practice: in an area which the guides do not cover, these are likely to be ill-defined.

They allow change to be decided and acknowledged rather than simply creeping in.

They are flexible and can meet continuing experience and indicate to NIMROD where its practice appears satisfactory and where it is going wrong.

Cons

They are time-consuming to prepare and revise.

They are not necessarily used – certainly not day to day though they may serve as an aide mémoire or a reference point.

They could lead to rigidity of practice.

Not all topics lend themselves to prescriptive statements; some by their nature are more concerned with principles.

Job descriptions

As the NIMROD procedural guides have developed, so have the job descriptions which flow from them become more complex. In general, the stress has altered to emphasise the involvement of clients and how tasks are to be done.

Care assistants

In the Working Party Report the outline of the principal duties and responsibilities of care assistants was relatively simple. The original list looked like this:

1 The personal care of clients – washing, dressing, toileting, etc.

2 Their recreation and diversion, including maximising opportunities for self-help.

3 Operating the training programme and recording clients' progress.

4 The care of any clients confined to bed.

5 Preparing or coordinating the preparation of meals.

6 Maintaining the household, including minor running repairs, redecoration, etc.

7 Encouraging the active participation of volunteers and clients' parents and relatives in the running of the unit.

8 Making the senior care assistant aware of operational problems and difficulties as they arise, whether or not these have been resolved on the spot.

9 Developing a close and friendly liaison with next-door neighbours and the relatives and friends of clients and volunteers.

The first care assistants were appointed to an elaborated version of the Working Party Report outline. The list of the principle duties and responsibilities looked like this:

1 ***Following the NIMROD procedural guides***

  1.1 Following the procedures for various duties as laid down in the NIMROD procedural guides.

  1.2 Informing the senior care assistant of any inadequacies in the procedural guides and in conjunction with other staff deciding upon and testing alternative procedures.

2 *Sustaining, developing and contributing to the care of clients in the staffed house*

2.1 Carrying out self-help tasks for those clients who are unable to do these tasks themselves; aiding more capable clients who are in difficulty.

2.2 Providing basic health care for clients; giving first aid when necessary.

2.3 Treating clients in accordance with principles of normalisation.

2.4 Offering general practical advice and help to clients as the need arises.

2.5 Ensuring that clients have opportunities to participate in leisure activities.

2.6 Supervising or helping clients who are carrying out domestic duties.

2.7 Ensuring the general engagement of clients in leisure pursuits or domestic activities.

2.8 Encouraging the active participation of volunteers and clients' friends and relatives in the activities of the house.

3 *Sustaining and contributing to the training of clients in the staffed house*

3.1 Teaching skills to individual clients in line with individual plans.

3.2 Keeping records of each client's progress.

3.3 Attending six-monthly Individual Plan meetings.

3.4 Ensuring that clients have opportunities to practise their newly acquired skills and maintain their established ones.

4 *Research*

4.1 Collaborating with the Mental Handicap in Wales Applied Research Unit in evaluating the NIMROD service.

5 *Any other duties which are required as the service develops*

5.1 After discussion, taking on other duties identified as necessary in the residential setting.

5.2 Undertaking duties, in an emergency situation, in any other NIMROD house.

Once the care assistants actually started doing these jobs, however, it soon became clear that there were gaps so, working closely with the care assistants, NIMROD is currently revising the principle duties and responsibilities again. The new draft under discussion includes:

A new entry under Section 2: providing assistance in self-help tasks to give opportunities for clients to learn these skills.

An addition to 2.5 to include introducing new leisure activities.

Another new entry under Section 2: bringing to the attention of other staff any matter of concern regarding a client's health, behaviour or happiness.

A practical addition about responsibility for the administration of drugs when the care assistant is in charge of the house.

An amplification under Section 3 to emphasise the contribution of care assistants to individual plan meetings by suggesting teaching needs of clients and ways these can be met.

Other amplifications under this section which include the care assistants' responsibility to devise and implement goal plans, and devise new methods of recording if necessary.

A new responsibility for helping to train new staff.

A new responsibility for monitoring the level of hotel services within the unit and maintaining this.

A new responsibility for calling and holding weekly house meetings when the care assistant is in sole charge.

A new responsibility for administrative duties as care assistant in charge.

Senior care assistants

NIMROD has also been through a similar exercise of revising and amplifying the principal duties and responsibilities of the officers in charge of its staffed houses as laid down in their job descriptions. Again, in the Working Party Report, these looked fairly simple.

1 Sustaining and developing a training programme within each residential unit.

2 Ensuring that an adequate level of care assistant support is available within each residential unit.
   - 2.1 Participating in the appointment of residential care assistants.
   - 2.2 Appraising the performance of residential care assistants.

3 Monitoring the quality of life, the residential environment and the hotel service provided in his/her unit.

4 Participating in an on-call rota for the district as a whole with other senior care assistants, community care managers and the project coordinator.

5 Managing the budget of his/her residential unit.

6 Providing such information and systems for managing the income and expenditure of the residential unit as may be required from time to time by the community care manager.

7 Developing a close and friendly liaison with next-door neighbours and the relatives and friends of clients and volunteers.

But again, before the first senior care assistants were recruited, NIMROD decided there was a need to spell things out in more detail. The principal duties and responsibilities for senior care assistants looked like this when the service started:

1 ***Acting in accordance with the NIMROD procedural guidelines***
   - 1.1 Following the procedures for various duties as laid down in the NIMROD procedural guides.
   - 1.2 Responding to care assistants' suggestions as to the adequacy and practicality of these procedures.
   - 1.3 Informally assessing the adequacy, practicality and appropriateness of the NIMROD procedures for his or her particular residential unit.
   - 1.4 With care assistants, suggesting, deciding upon and testing alternative procedures to those which are inadequate.
   - 1.5 Informing the community care manager of any changes in procedure and gaining his/her approval of any permanent change.

2 ***Sustaining, developing and contributing to the care of clients in the residential unit***
   - 2.1 Providing the levels of help needed in self-help tasks to give opportunities for clients to learn these skills.
   - 2.2 Providing basic health care for clients; giving first aid where necessary.
   - 2.3 Treating clients in accordance with the principles of normalisation.
   - 2.4 Offering general help and advice to clients.
   - 2.5 Ensuring that clients have the opportunity to participate in leisure activities; introducing new leisure activities.

2.6 Supervising or helping clients who are carrying out domestic duties.

2.7 Ensuring the general engagement of clients in leisure pursuits or domestic activities.

2.8 Informally assessing the level of clients' engagement; taking steps to remedy this if it seems too low; encouraging care assistants to do the same.

3 *Sustaining and contributing to the training of clients within the residential unit*

3.1 Contributing to six-monthly Individual Plan meetings by suggesting teaching needs of the client and ways of meeting them; encouraging care assistants to do the same.

3.2 Teaching skills to individual clients in line with Individual Plans.

3.3 Keeping records of each client's progress.

3.4 Attending six-monthly Individual Plan meetings.

3.5 Ensuring that clients have opportunities to practise their newly acquired skills and maintain their existing ones.

4 *Administrative duties – staff deployment*

4.1 Arranging staff rotas.

4.2 Authorising overtime working or changes in hours of work to suit prevailing conditions.

4.3 Informing the community care manager of any inadequacies in the level of staffing.

5 *Participating in the appointment, training and appraisal of care assistants*

5.1 Participating in the interviewing and selection of care assistants.

5.2 Contributing to the training of care assistants, where appropriate.

5.3 Monitoring performance of care assistants (see section 6).

6 *Monitoring the level of care and the hotel services within the residential unit*

6.1 Monitoring performance of care assistants, in accordance with checklists provided, and giving positive and constructive feedback.

6.2 Monitoring the standard of the hotel services in accordance with checklists provided, and taking appropriate action.

7 *Calling and holding weekly house meetings of staff, clients and other interested parties*

7.1 Ensuring that all interested parties are informed.

7.2 Encouraging staff and clients to attend.

7.3 Ensuring that all attending are able to express their opinions.

8 *Administrative duties – budgeting*

8.1 Managing the day-to-day income and expenditure of the staff house.

8.2 Providing such information as may be required from time to time by the community care manager.

9 *Research*

9.1 Collaborating with the Mental Handicap in Wales Applied Research Unit in evaluating the NIMROD service.

10 *Any other duties which are required as the service develops*

10.1 After discussion, taking on other duties identified as necessary in the residential setting.

10.2 Undertaking duties, in an emergency situation, in any part of the NIMROD project.

The above is currently under review and even when this review is put into practice it is unlikely to be the final version of the job description of the duties and responsibilities of

NIMROD's senior care assistants. Staff are finding, for instance, that basic house administration and staff reviews are taking far more time than was anticipated, and this will have to be acknowledged. The senior care assistant's new role as key worker to each of the clients in their house will also have to be acknowledged. This was originally intended as part of the job of the psychologist and social worker who work for NIMROD centrally, but as the service grows, they cannot be key workers for all clients. The senior care assistant's responsibility for developing liaison with neighbours and relatives and friends of clients and volunteers inadvertently got dropped from the second version of the job description. But it is no less important now. Other liaison work – with the Department of Health and Social Security, the Adult Training Centres, for instance – is important too.

How do job descriptions change?

Job descriptions change by clarification of the context within which staff work. For example, the emphasis on treating clients in accordance with the principles of normalisation; the pinning of the job description to the procedural guides.

Job descriptions change by clarifying the practical implications of philosophy. For example, getting a balance between what staff do for and with clients and what they can help clients do independently for themselves.

Job descriptions change by recognising the contribution of each staff member. For example, the much closer correspondence between the duties and responsibilities of senior care assistants and those of care assistants; the encouragement of staff initiatives – in suggesting possible amendments to the procedural guides, in suggesting new ways to teach skills to clients and record their progress, in introducing new leisure activities, in participating in the training of new staff.

Job descriptions change by testing plans and theories against reality. NIMROD's original plan was that there should be three members of staff on duty when residents were at home; in practice, there are only two. At the same time, due to lack of appropriate day care, clients are more often at home during the day than anticipated and they often need more time-consuming practical help than was at first envisaged. The combination of these circumstances means that there is less time for helping clients to learn on an individual basis than was hoped for.

Job descriptions change to recognise more accurately what people actually do. For example, the proposed addition to the care assistants' job description of the responsibility for administering drugs and for administrative duties when they are acting as care-assistant in-charge.

Job descriptions change to reflect more accurately what clients and staff need. For example, NIMROD is now finding that the behaviour of some clients is posing more difficulties for other clients in the house than was originally anticipated, and it plans to do further work on the management of these problems.

JOB DESCRIPTIONS – SOME QUESTIONS AND REFLECTIONS

How do tasks get into job descriptions? Are they hot air or do they reflect a policy and a philosophy? How can they be matched to a changing reality?

The need to work out what's needed, what happens, and to put it all together.

The need for someone to know about the development of skills and how to break tasks down into their components.

The need to ensure that the existence of detailed job descriptions doesn't lead to a depersonalised performance of tasks ('We do it because the book says we should...').

The importance of feeding back information on tasks done in accordance with the job description so that the description can be modified if necessary.

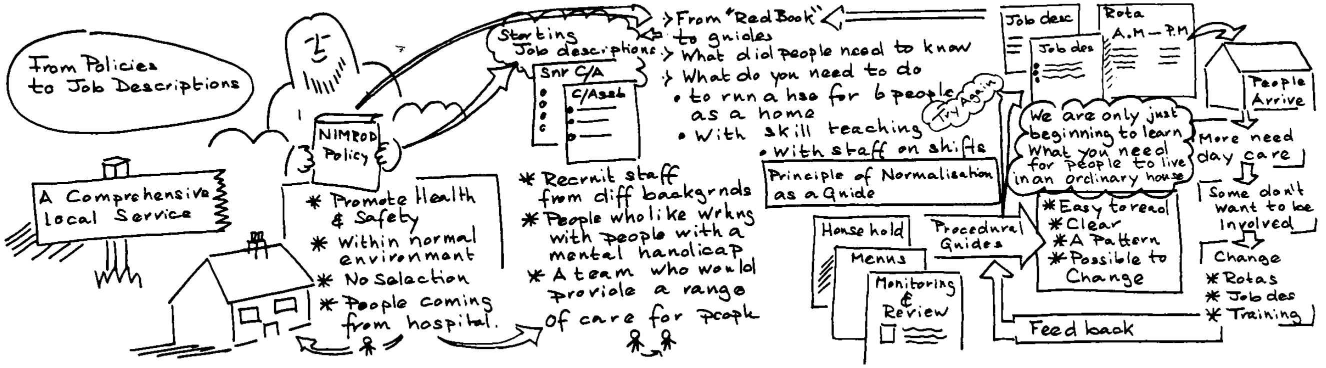
In theory, there's a potential to write individual job descriptions for each member of staff who works with an individual client, and to modify this as the client's needs change.

The number of staff and clients in a house will influence the way tasks are performed and so perhaps lead to modification of job descriptions. It may simply not be possible to make necessary changes because there just aren't enough staff.

Where does training fit in?

NIMROD feels that it hasn't yet really faced the issues of in-service training. The house staff start as a group and have a six week induction, but as new staff join, they have to learn without this formal period of induction. The realities of life have their effects, too: there simply has not been enough time for staff to put their initial training in goal planning into action for the first six months of the houses' life, and by the time this has been possible, the training will have been too long ago for staff to be confident of their skills.

Yet the process of drawing up and amending job descriptions is itself a training process.


From Policies to Job Descriptions
A Comprehensive local Service
NIMROD Policy
* Promote Health & Safety
* Within normal environment
* No Selection
* People coming from hospital.
Starting Job descriptions
Snr C/A
C/Asst
From "Red Book"
to guides
What did people need to know
What do you need to do
• to run a hse for 6 people as a home
• With skill teaching
• with staff on shifts
Try Again
Principle of Normalisation as a Guide
* Recruit staff from diff backgrnds
* People who like wrkng with people with a mental handicap
* A team who would provide a range of care for people
House hold
Menus
Monitoring & Review
Procedural Guides
Job desc
Job des
Rota
A.M – P.M
People Arrive
We are only just beginning to learn What you need for people to live in an ordinary house
* Easy to read
* Clear
* A Pattern
* Possible to Change
More need day care
Some don't want to be involved
Change
* Rotas
* Job des
* Training
Feed back

Selection, recruitment and promotion

David Felce

What sort of senior staff will we need for the service outlined in *An Ordinary Life*? Where do we look for them? How do we select them? What training can we offer them once selected? And how do we attract them to continue working in their living unit?

There are problems.

What skills do we seek in senior staff?

We want people with both a sense of direction and the skills to get there. We want people whose direction stems from normalisation and is based on respect for the dignity and potential for growth of each individual client, and who use behavioural principles to translate this into action. We don't necessarily want people with academic qualifications, though we do want them to have reading, writing and academic skills. We want people with the interpersonal skills to work with a team of staff, with mentally handicapped people and their parents, and to put across their own values. We want people who are skilled in behaviour analysis, who know how to write successful programmes for individuals and how to arrange the environment so that it doesn't handicap them. We need people with the practical skills of cooking, cleaning, laundry, house maintenance, accounting and nursing – not because we expect them to do all this themselves, but because a prerequisite of encouraging staff to do as much of it as possible themselves is that senior staff should be *able* to do it.

Where do we look for senior staff?

Ideally, we want senior staff who have already worked in a community setting with mentally handicapped people, who have a belief in a comprehensive, no-buck-passing philosophy, who can give evidence that they can operate intense and relevant programming – and who are still looking for a direct care job! A few of these people may exist.

But we are far more likely to be looking for senior staff among those whose experience is limited to an institutional setting, who work within a buck-passing system, who have worked with people with different degrees of handicap but without any differentiation of practice, and who know programming terminology but do not operate by it.

What skills are we prepared to train?

We have to ask ourselves three questions. Who are the trainers? What time do they have to put in? What are they competent to teach? The answers will probably not be encouraging. We have to assume that we will train very little, that we have to look for senior staff who already have around 80 per cent of the skills they will need.

So our problem comes down to this: How do we staff a high quality service from a traditionally poor quality service, and how do we select skilled staff from a large pool of indifferent staff?

In the short term

We should be very clear about what skills we are looking for and select people with these. We should remember that skills are not related to qualifications, with where people have already worked, or with whether they have been on a management course. We should also remember that the information people usually give when applying for job is, in short, of very little relevance to us.

We should try instead to elicit other information – about how people would respond to running an autonomous unit, about their programming skills, about their own philosophical stance. When people apply for a job, we could offer them guidelines to let them know what we will be asking of them. These might look something like this:

Guidelines for candidates

In our discussions about selecting the best person for this post we have become aware that the standard application form does not encourage applicants to provide the information we need to prepare a shortlist. We have therefore prepared this brief summary outlining the major components of the job in order to give candidates insight into the range of skills and experience we are looking for. Candidates should read it carefully and keep it clearly in mind when completing their application forms.

This unit is a house in a residential area and is not part of any hospital complex. The person-in-charge will be expected to develop considerable autonomy and be prepared to accept responsibility for making many of their own decisions. They will have to coordinate and manage the work of a small team of staff (who will be responsible for all caring, occupation, training and housekeeping). Applicants should therefore describe ***how*** they have done or would envisage doing these tasks (rather than simply listing the positions they have held).

The emphasis of the unit will be very much on helping mentally handicapped residents achieve greater independence. The person-in-charge will need to have skills in the development of individual teaching programmes and be aware of the implications of implementing such programmes on a day to day basis. Applicants should therefore describe actual practical experience in these areas. An anonymous description of the method followed in one successful treatment would be relevant.

The successful candidate will be someone who has taken an interest in and attempted to keep up to date with changing models of care for mentally handicapped people during recent years. They will obviously be expected to identify with current local philosophies and will have to argue the case in favour to many people who doubt the appropriateness of the type of care model. Applicants should therefore express something of their knowledge of developments in residential care for the mentally handicapped and indicate their opinion about them.

From ***Guidelines for Candidates*** for a Wessex locally-based hospital unit

Once our staff have been selected, we should then offer them very specific training – in goal planning, for instance, or first aid or the details of normalisation.

In the long term

We should be aiming to make our district self-sufficient in staffing.

Our plan would be to recruit literate junior staff who have no experience when they join us, to develop our own training package and resource personnel, and promote these staff once we have trained them, so that they become first deputies and then people in charge of units. To ensure their career prospects, we will have to work either to shift the emphasis currently placed on formal qualifications, or to get our own training recognised.

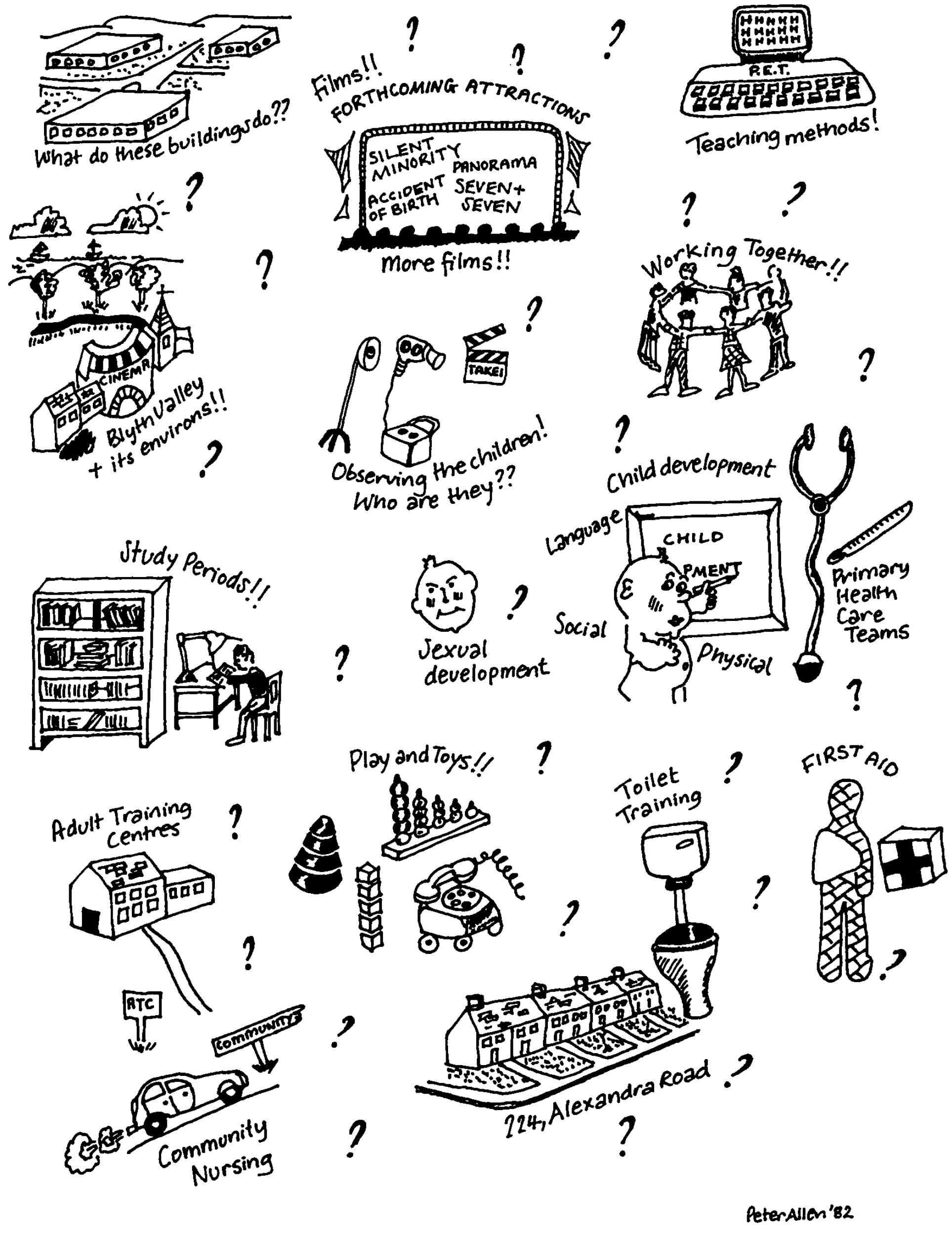
SELECTION, RECRUITMENT AND PROMOTION – SOME QUESTIONS AND REFLECTIONS

When does self-sufficiency in staffing become complacency? What is the balance between continuity of staffing and the turnover needed to ensure rejuvenation for the service?

How do we assure professional status if we drop the current emphasis on qualifications?

There's a danger of underestimating the need for training in specific skills; resources have to be found for this.

There's the difficulty of finding the trainers. So many need a course in the principles of normalisation themselves before we let them loose on new staff. . . .


What do these buildings do??
Films!!
FORTHCOMING ATTRACTIONS
SILENT MINORITY
PANORAMA
ACCIDENT OF BIRTH
SEVEN + SEVEN
More films!!
R.E.T.
Teaching methods!
CINEMA
Blyth Valley + its environs!!
TAKE!
Observing the children! Who are they??
Working Together!!
Child development
Language
CHILD
PMENT
Social
Physical
Primary Health Care Teams
Study Periods!!
Sexual development
Play and Toys!!
Toilet Training
FIRST AID
Adult Training Centres
ATC
COMMUNITY
Community Nursing
224, Alexandra Road
Peter Allen '82

Training direct care staff

Peter Allen

In November-December 1980 and May 1982, three-week orientation trainings were held for care staff who then went to work with young people who had newly moved from Northgate hospital in Northumberland into ordinary houses in their own communities. The staff were selected from around 150 applicants for each of the two houses; most of them were single and some were living on their own. The training programme assumed that they would have a varying level of previous expertise. Many of the teachers were chosen because they were the professionals who would be making a specialist contribution to the life of the houses in future. The course was to some extent based on previous experience in preparing substitute families for Northumberland's respite care scheme. Major responsibility for the programme design and development was taken by the psychologist member of the small working group which had specified some of its initial aims.

Aims and objectives of the orientation

To provide a background on child development in both the normal and the handicapped person.

To make staff aware of the specific difficulties encountered by the handicapped person, in developmental terms.

To help staff understand the factors which contribute to pressures within the families of handicapped people.

To make staff aware of the specialist facilities that exist for handicapped people.

To make staff aware of the educational provision for handicapped children.

To help staff understand the methods involved in the teaching of skills.

To make staff aware of the historical aspects of mental handicap.

To make staff familiar with the ways in which a group communicates.

The shape of the programme

The three week programme looked like the illustration opposite.

Put another way, it looked (for the May 1983 training) like the chart on page 36.

Key contents

Before care staff move into the house, they will need information on three key topics: the young people, the house and its surroundings, each other and 'support' staff.

The young people

Some answers to the questions can be arrived at by getting staff to take part in structured passive observation and interviewing. Instant or Polaroid photographs can be taken of the children in their present settings and coupled with written descriptions. These will include hourly routines, an indication of the child's friends in the group in which he or she spends

WEEK 1

Introduction Administration	224 Alexandra Road The first NHS house Presentation by house staff
Historical perspective Film 'Accident of Birth'	Observation of children in school
Observation of children in school	Collating observations
Working together – 2 day workshop	
Working together – 2 day workshop	

WEEK 2

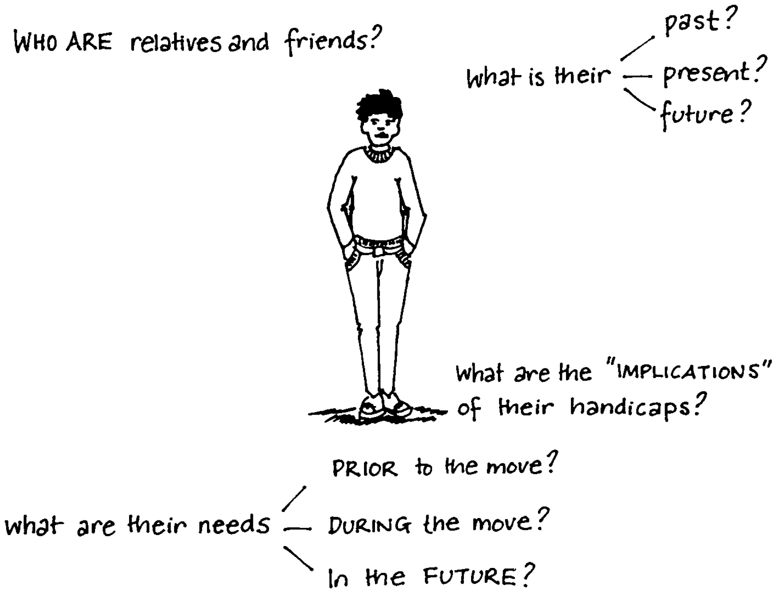
Child/adolescent development – 2 day course	
Child/adolescent development – 2 day course	
Short term family care	Films 'Silent Minority' 'Panorama'
Meeting parents	Community nursing service
Education of children with special needs	Introduction to teaching methods

WEEK 3

Teaching methods and programme planning – 2 day workshop	
Teaching methods and programme planning – 2 day workshop	
Primary health care team First aid	Incontinence Provisions for mentally handicapped adults
Blyth Valley – environs and amenities	Normalisation: exercises
One day 'fun' workshop	

MOVING INTO THE HOUSE, YOU NEED TO KNOW

ABOUT THE YOUNG PEOPLE



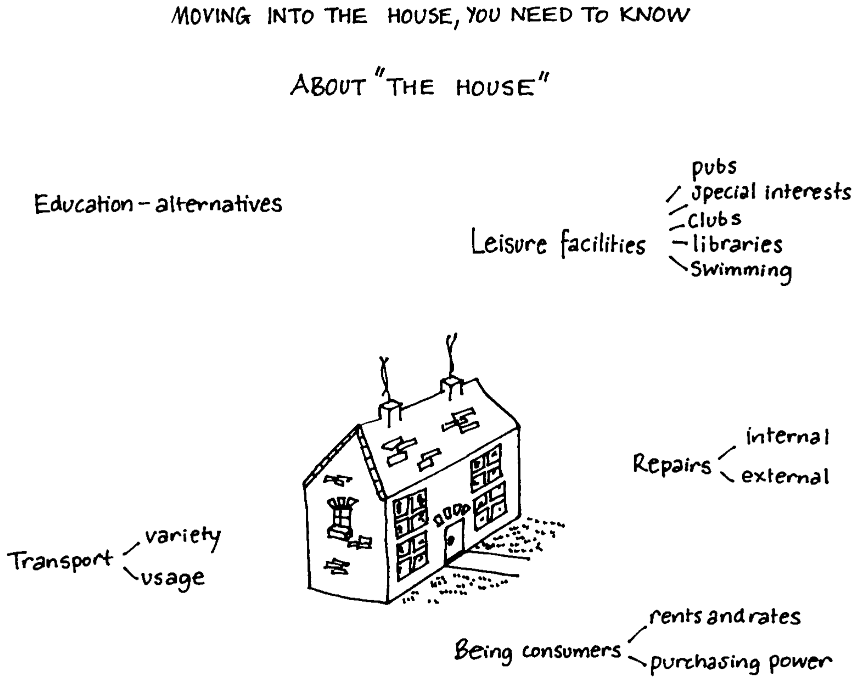
his or her day, and the nickname that he or she is known by. If videotapes are also made, then a fairly full description of the child can be built up when put together with the charts that parents and/or relatives make when they attend a training session. These charts can include the child's likes, dislikes, routines, relatives, history and aspirations for the future.

All this information will act as an *aide mémoire*, an indicator of needs, and an aid towards thinking about the child's present and possible future during the training programme. It will remind staff that the young people are central to the whole business.

Most of the presentations under this heading looked at specific areas of development – at language, acquisition of skills, physical and adolescent development. Presentations on topics such as teaching methods and incontinence began to provide an understanding of the implications of handicap for particular young people.

The house

The training assumed that the care staff would not have to learn home-making skills. It concentrated instead on wider aspects of the house and its context. The staff considered details of the house's operational policy. They also learned more about the local environment and its resources from a representative of the district council.



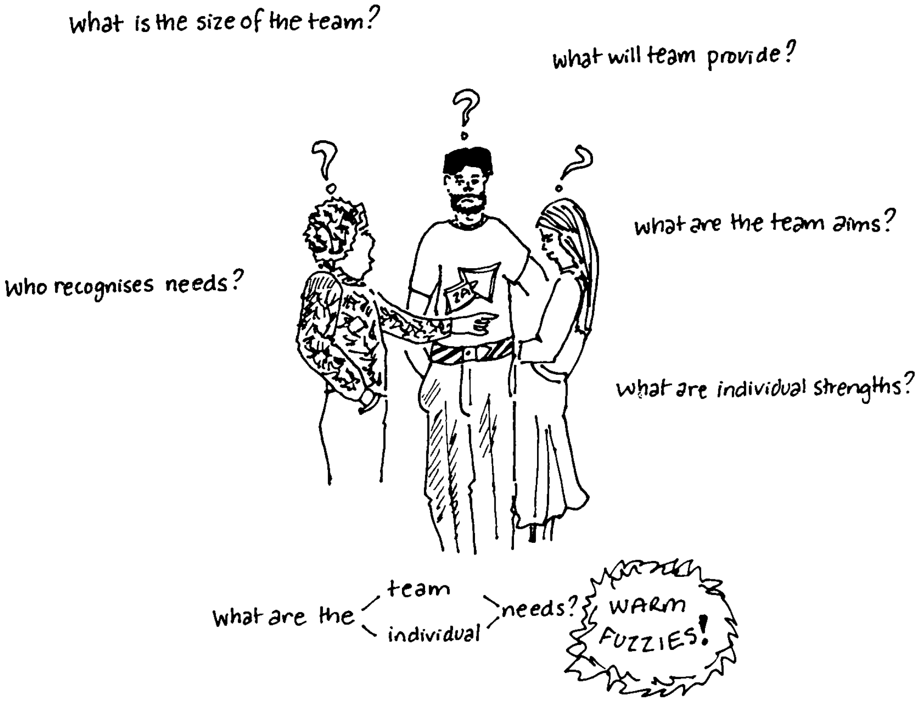
Each other

This aspect of the training tackled *team-building objectives*. In part this was people-oriented – concentrating on developing a climate of trust and openness in which members of the group could respond to each other's professional and personal needs, in which enthusiasm was encouraged and in which conflict – within limits – was seen as creative. In part it was task-oriented – making use of individual strengths, teaching necessary skills and helping staff use the time well. They learned to balance the two approaches and why both are important to the life of the team.

This section also dealt with *leadership*. Given the coordinator of the project and charge nurse as leaders, the team builder's task was to support the development of their style of leadership and to encourage the group members to seek out the kind of leadership they needed and wanted. This is delicate and especially difficult if the leader is blocking the team's effectiveness. There is also the delicate issue of the team builder's own leadership competitiveness. The hope is that we can create a climate where these issues can come up without being forced.

MOVING INTO THE HOUSE, YOU NEED TO KNOW

ABOUT EACH OTHER



We found out about the *recognisable phases of team development*. First, people get to know each other and welcome each other into the team ('inclusion'), but there is as yet no sense of 'we'. Some people will put on a very sociable face; others will withdraw, and all may feel slightly uneasy. Then there is the development of group norms and competition for air space and power and the gradual development of roles. This phase can be tense or openly hostile, and people often feel irritated, defensive or paranoid. Finally, the team settle down, is relaxed, affectionate and quite cohesive, with a sense of 'we', of flow and working together. Some teams will develop a creative challenging and risk-taking climate. Others will be oriented to stability and safety, with responsibility placed with the leader, 'them' or 'the government'. Reaction varies between these poles and depends partly on the task, the leadership and the members themselves. It's worth noting that while new members of the team have to go through these stages with the group, leaving members go through them in reverse order. ('Team' here can include parents and children as well as staff – and did so, especially in the second workshop.)

This aspect of the training also tried to empower staff to look to their professional development when leaving the team, and dealt with crisis management.

Key points about training

It is not a test, but a period of orientation. Some people were anxious that they were going to be examined at the end of it.

One person needs to be the focal point. The group needs a coordinator who knows what is going on.

The training should be free from interruptions or sabotage. (We don't need interruptions from the social services department asking 'But can't you take him tonight?' three days before the end of the course. Or people bursting into a very intensive discussion to work out off-duty sheets. Or someone picking the same sort of moment to deliver the fridge...)

The training should be held away from established care patterns. (These programmes were not held in the goldfish bowl of Northgate hospital, from which the young people would move, and which presented so many of its own images of mentally handicapped people, but on neutral ground.)

The size of the team should be established before the training starts.

Training usually leaves people on a 'high'. People should be aware of this as it is usually not possible to rush into action the moment the training is finished.

Training needs to have a local flavour. Try to employ people in the training who come from the area of the house.

Points for the future

The need to provide induction for new staff.

The need for continued training and attention to career prospects.

Could parents attend the whole of the training programme? Care staff get more induction training than parents get training during their whole life....

And what about training for foster or substitute parents?

EXERCISES IN TEAM WORK

1 You may feel it unlikely that your loved ones, children, friends or indeed you yourselves will ever need any form of long-stay care. But it could happen.

If you were given the luxury and prior knowledge, you might decide that there were a lot of important things you would like your prospective carers to know about you.

Imagine that either you yourself or someone close to you had to go into long-stay care. And as a group decide:

what type of information should be collected about you;

how it should be collected;

by whom;

to whom it should be given.

2 Returning mentally handicapped people to communities of which they become full members has many implications. They become consumers, for instance, and if they live in a staffed house, staff may find themselves purchasing food, decorations and furnishings locally. New services may need to operate in an autonomous way, and this may present problems in the preparation of staff and in subsequent management.

If this essential autonomy and independence is to be maintained, it is important to know how it can be both fostered and sabotaged. As a group, explore ways in which autonomy can be attained or sabotaged both during preparatory training and in the service itself.

3 In order to work together effectively in teams, we need to know each other's strengths and needs; we also need to know how to put the team's ideas into practice. But it may not be straightforward to decide the composition of a team.

As a group, consider the case of a group of people moving from a long-stay hospital to a staffed house in the community.

What should be the composition of the team – and why?

How can this team membership be reflected in training?

Who has the ultimate decision on its membership?

What implications does this have for the service?

4 Although we hope that the people who provide a service will work together as a team, it may be difficult to decide what tasks the team should actually undertake. Imagine a house with three young mentally handicapped people and eight staff, with a variety of 'support' staff like a residential manager, a social worker, a physiotherapist, speech therapist and community nurse, who all visit regularly, as well as the parents of two of the children. All these people see themselves as members of a team which is working for the benefit of the young people.

As a group decide:

what tasks will the team be undertaking;

where will these take place;

who will they involve;

how this can be taught to staff during their training?

And some responses

1 Information needs to be collected which identifies the needs of the individual. For instance, his/her history, family relationships, things that have happened to him, his own skills, likes and dislikes, fears and attitudes, ambitions, hopes and spiritual needs, physical problems, needs for routine, and dietary needs. None of this should be static or taken as prescriptive; it should be continually updated.

How should the information be collected? From the person or his/her immediate support groups: through a life-history book and interviews; through talking to people who have been close to the person. Ideally, one person should collect the information initially, then others contribute from time to time.

Who should the information be given to? The person the information is about, and others only after specific agreement. They include the residential care team and some other professional people.

Compare this response to a request for information about an individual, to the usual one which leads to an organisational and stereotyped response — 'he needs a residential place', or 'she needs a psychiatrist'.

2 What maintains autonomy in a house:

a chequebook as well as a moneybox for the person in charge;

permission to buy furniture where they will, not just out of a DHSS catalogue;

a willingness to challenge the 'rules' which turn out not to be rules at all?

What sabotages autonomy:

the overconcern for safety (weekly firedrills and so on);

the use of the house for advertising, such as 'come and see for yourself how they lead such an ordinary life — and please make a contribution...';

the visits from councillors who want to make a political point or feel 'we have to check up on the people we provide services for';

the officers who mean 'and furthermore, we don't trust your reports of how well things are going...'?

3 What is a team anyway? And do we need them? The starting point has to be that the handicapped person needs just what anyone else needs — it's only getting there that's difficult. And what is a team from the perspective of the handicapped person? A new set of oppressors? Twenty-seven people telling you what to do instead of just one?

4 What are the tasks of a team?

Individual planning,. 'home-making', teaching (children), developing 'significant relationships' between each child and a member of staff, the personal and emotional care of children, management of fits, drugs, behavioural disturbance and so on;

administration of budgets, rotas and liaison with other parts of the service, good communication across staff shifts, identifying the prevailing leadership style;

developing sensitivity to each other, maintaining the balance between a 'home' and intensive training, and between risk-taking and security, maintaining the principle that the home belongs to the residents, not to staff, developing a local image and relationships, preparing — with parents — to let adolescents go.

Training support staff

Hugh Firth

In our concern about training for direct care staff, it is easy to forget that heads of homes, their managers, senior managers and administrators, as well as specialist professionals such as psychologists, social workers and psychiatrists, need training too. They need training in the basic philosophies behind the service and the values it tries to express. They need education on how to involve parents, relatives and clients themselves in planning services. They need to learn the right criteria for selecting staff – that genuineness, warmth and empathy are more important than formal qualifications as long as staff can learn whatever other skills they may need.

But apart from providing care staff with the skills they need, the most important job that support staff have to do is to prevent 'burnout'[1,2,3,4], loss of morale and 'professional depression'.[5] As Cherniss[3,4] has pointed out, burnout and loss of morale are highly contagious conditions; once they take hold in an organisation, reversing them may demand a sustained effort. Like learned helplessness[6], extinguishing their effects takes a lot of retraining. Yet a good service can only be provided by staff who have both skills and motivation. It cannot be offered by people who are in a state of emotional withdrawal from the people they work with, as a result of stress at work. So how are support staff to ensure that motivation is built and maintained?

Organisational support

A guiding philosophy and the dissemination of its values throughout the service is vital to start with. The sense of purpose this creates is one of the reasons why the morale of care staff in Nebraska remains good more than ten years after the community based service ENCOR was set up.[7]

Next, managers and planners will need to consider two major sources of job stress when they are designing new jobs and writing job descriptions: external demands, and the lack of opportunity for personal development, including lack of discretion or 'autonomy'.[8,9]

Probably the biggest constraint on managers' ability to support staff is the sheer overload of things to do. A direct care staff's viewpoint is this:

> 'I haven't had as much support as I would like, and I think there is a reason: because the agency is so short-staffed above me, people are worked so ragged and cut so short of hours that they really haven't had the *time* to come and offer me support.'

And a manager's viewpoint is this:

> 'I'm extremely isolated from my peers. I never see them. Either I am supervising the 16 people I'm responsible for, or I'm being supervised myself.'

Limitations on the number of clients for whom staff are responsible is a vital, if obvious, ingredient in the prevention of burnout. Less obvious, but as important, is the need to limit the number of staff for whom managers are responsible at any one time.

The lack of opportunity for senior staff to be involved in the kinds of work (such as planning) which are interesting and rewarding is often under-appreciated. Also dissatisfaction is not surprising amongst staff who see their own good ideas shot down or ignored by visiting 'specialists' or their own superiors.

Orientation and discussion of expectations are also vital elements in the prevention of burnout. Such orientation and subsequent counselling, 'burnout checkups' or other periodic reviews are essential for care staff. But they are perhaps even *more* essential for their supervisors and the staff who are trying to support them. Burnout caused by unrealistically high expectations is probably far more frequent among first-line and middle managers than it is among direct care staff themselves. Senior managers at the top of the agency need educating if they are to have the awareness and ability to deal with problems at this level.

Interpersonal support

Very little attention has been given in this country to the personal interaction between care staff, their managers and other professionals. Yet after lack of organisational support, poor personal support is probably the biggest cause of burnout or loss of morale among staff. So what are the skills and behaviours people need to provide good personal support?

My own research with 45 direct care staff and first-line managers in a local agency in the USA and a hospital in England strongly suggested that there are two equally important factors in providing good personal support for staff: what the helpful colleague, subordinate or supervisor *does*; and *how* they *communicate*.

People are seen as helpful or supportive if they work hard, set standards, take action, give ideas, share problems, get results, and if they are efficient and inventive. People are also seen as supportive if they communicate in particular ways. Staff saw people as supportive if they listened, were not in a hurry, took time, were available, were calm, gave their whole attention, showed interest, were open-minded, objective, insightful, concerned, and asked staff for their opinions.

As well as these *receptive* skills, supportive people demonstrated *expressive* skills. They were very positive, not cynical, actively offered help, said that staff's work was noticed, and said thank you. They left their personal problems at home. They did not take disagreement personally. They were tactful and humorous and not authoritarian. They were frank and gave feedback. They were constructive and trusted experience.

What are the implications of these findings for the skills support staff will need to support others in their turn?

Conflicts of interest are inevitable in any organisation. Most of us have learned readily to cast blame on people who do not behave as we would wish. We are not trained to understand, or to help people see our point of view. Our socialisation teaches us to criticise, not emphathise. So support staff need training in the, as yet, much neglected areas of conflict resolution and organisational problem solving.

Communication is important to support. Meetings are one way to offer it. *An Ordinary Life* stresses the need for daily unit meetings, weekly cluster meetings and monthly conferences with senior managers and support staff.

But more communication is not necessarily good communication: the usefulness of meetings depends on the interpersonal skills of staff who run them. My own research with staff from the residential division of ENCOR suggested that meetings were seen as having a specific but limited usefulness. They were useful for information exchange, for getting action and for establishing consistency among staff. But some staff found them useless because the managers were too dominant, doing more advice-giving than opinion seeking. Some staff expressed an inability to ask questions or express doubts or disagreements because their manager was not skilled at listening for the views of others. One residential staff member described meetings as actually detrimental to staff morale!

Staff do not depend chiefly on meetings for support: they depend on daily personal contacts with other care staff, family and friends. Care staff get most of their support not from their managers but from each other. For home managers, it is support from their boss and from outside professionals which is important. This suggests that managers are much more liable than direct care staff to suffer from isolation if they are not supported by their boss. This potential for isolation is important. It may set up a vicious circle of poor support leading to burnout or depression at every level.

So what makes for good personal support?

The communication skills needed are the same as those which make up the essence of good support in other settings: *attentiveness*, active listening and accurate empathy; *responsiveness*, non-possessive warmth and genuineness.[10,11]

The behaviour support staff must show if they are to provide effective personal support includes:

visiting frequently;

spending time with staff, both by seeing and participating in their work and by finding settings where they can talk;

spending time with clients;

actively seeking out staff concerns (taking time, asking staff their opinions, listening, showing interest);

giving advice or help when requested;

keeping confidentiality;

giving feedback *positively* (criticism should always be accompanied by some positive feedback);

monitoring managers' communication skills (clearly vital, but certainly exceedingly difficult to do well – it should itself be positive, and probably avoid any written appraisal);

talking directly to care staff (on occasion they will not be able to express their problems to their own immediate managers).

The most important skills are actively listening and seeking out concerns, and expressing warmth and positive feedback even when this includes criticism.

In conclusion

What may happen when personal and organisational support is not sufficient? Quite simply, staff may suffer professional depression or burnout. And my own research suggests that staff who suffer from professional depression are poor at supporting others. So a vicious circle may be set up. Starting perhaps with lack of organisational or personal support from the top, managers' morale may suffer and their ability to support their own staff suffer in turn. And that is bound to affect the quality of life of the mentally handicapped people for whom we are concerned.

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TRAINING FOR SUPPORT STAFF – SOME QUESTIONS

Does motivation or staff morale really affect the quality of care provided by staff?

Are organisational and personal support equally important to good morale?

Do 'burnout' and 'professional depression' really describe the same process?

If personal support is important to maintaining morale, are the personal skills required really the 'therapeutic' skills of attentive listening, empathy, warmth and feedback?

Given all this, can training for managers and support staff on these issues be made effective?

What is 'autonomy' in a statutory service? Are we really talking about 'areas of discretion' and 'delegated responsibility'?

How many people can one manager effectively be responsible for?

How can isolation among managers be avoided without continually pulling them out of their workplace to meet their peers and support staff? How can we take support to where people are working?

WHAT MAKES US FEEL UNSUPPORTED?

People who delegate action – and then don't monitor results.

People who ask us to do something – and then aren't interested when we've done it.

People who don't honour agreed commitments.

People who make decisions about our job without consulting us.

People who forget conversations and decisions made.

People who say 'Hey guys, important work to shift!' – and then get bogged down in trivia.

People who say 'this doesn't seem to be what the Royal College recommends'.

Management planners who promise to do something and leave us still waiting two weeks later.

People with power who don't share our values.

Lack of feedback.

Lack of openness and sharing – which leads to a failure to work together towards an agreed valued-based goal.

Isolation from people who could share and be enthusiastic about our ideas.

Seeing other people get recognition for our work.

Uncertainty about the future – and our function.

Having lots of responsibility – and no authority.

Having too much to do, feeling overwhelmed, with no one available to help us out.

Not being able to find the sign that says 'the buck stops here'.

Taking over existing services: with poor practices when the previous manager is still around to influence those practices, however informally.

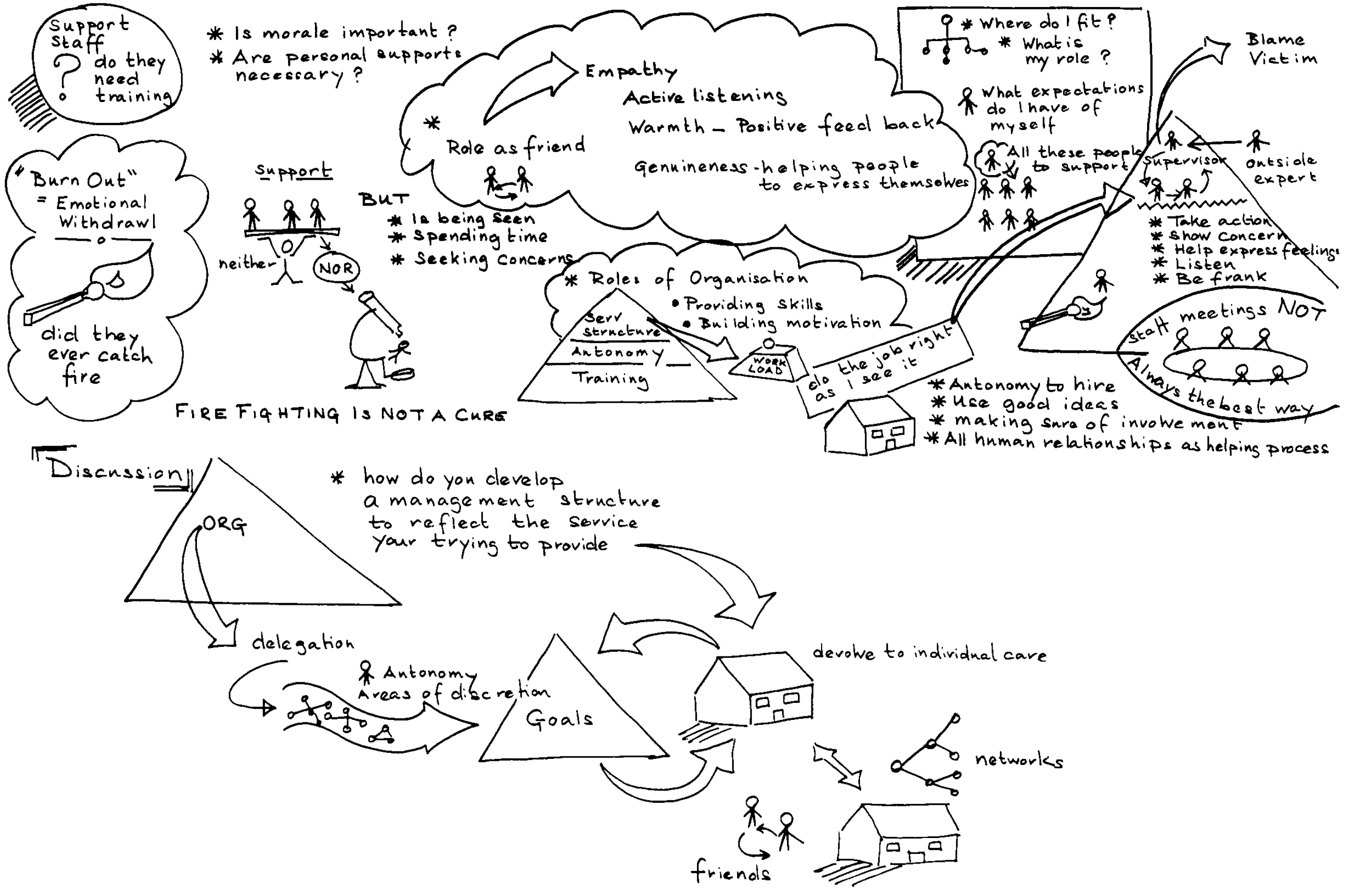
Sowing but not being able to reap because the pressure of work prevents follow-through.

Managers who don't have time for us because they are too thinly spread.

WHAT MAKES US FEEL SUPPORTED?

Someone with time to listen:
  who says 'I know what it's like';
  who holds similar values and comes from outside the situation;
  who helps clarify issues;
  who shares the situation and personal perceptions of it;
  who encourages us to bounce ideas off them.

Someone who notices that there's something wrong without us approaching them.
Someone who's been up against the same problem.
Someone who hates the same things.
Someone who supports us when we're not there.
Someone who offers further support.
Someone who makes us feel we're doing a good job, who recognises our successes.
Someone we can understand.
Someone who seems confident — and gives confidence.
Someone who shares ***their*** fears.
Someone who helps us keep things in perspective.
Someone who cares about what's happening to ME.
The opportunity to share experiences with others from outside our situation.
The opportunity to experience personal effectiveness.
The opportunity to offer and receive constructive criticism.
A clarity of vision.


Support staff ? do they need training
* Is morale important ?
* Are personal supports necessary ?
"Burn Out" = Emotional Withdrawl
did they ever catch fire
Support
neither-
NOR
BUT
* Is being seen
* Spending time
* Seeking concerns
*
Role as friend
Empathy
Active listening
Warmth – Positive feed back
Genuineness - helping people to express themselves
* Where do I fit ?
* What is my role ?
What expectations do I have of myself
All these people to support
Blame Victim
Supervisor
outside expert
* Take action
* Show concern
* Help express feelings
* Listen
* Be frank
Staff meetings NOT
Always the best way
* Roles of Organisation
• Providing skills
• Building motivation
Serv structure
Autonomy
Training
WORK LOAD
do the job right as I see it
* Autonomy to hire
* Use good ideas
* making sure of involvement
* All human relationships as helping process
FIRE FIGHTING IS NOT A CURE
Discussion
ORG
* how do you develop a management structure to reflect the service your trying to provide
delegation
Autonomy
Areas of discretion
Goals
devolve to individual care
networks
friends

Appendix A - Community Mental Handicap Services: Issues and Strategies for Staff Training

Two-day workshop held at the King's Fund Centre on 4 and 5 November 1982

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Appendix B

COMMUNITY MENTAL HANDICAP SERVICES:
ISSUES AND STRATEGIES FOR STAFF TRAINING

Two-day King's Fund Centre Workshop on Thursday 4 November
and Friday 5 November 1982

PROGRAMME

Thursday 4 November 1982

10.15am	Introduction: the purpose of the workshop Joan Rush and Hugh Firth
10.30	Putting Across Values: issues in the education of staff about value systems Alan Tyne and Mark Burton
12.30pm	LUNCH
1.30	Parents as Part of the Team: the implications for staff of involving families in a residential service Sherry Noley
2.00	Group Work
3.00	Tea
3.15	Defining Tasks: from policies to job descriptions Shirley Mathieson, Peter Jordan, Carol Rowlands, Claire Wilson
4.30 - 5.30	Group Work
6.00	DINNER
6.45	The Context and Climate for Training: when is training useful? Discussion of paper by John Hattersley
7.15	Selection, Recruitment and Promotion: some problems raised David Felce
7.45 - 8.45	Plenary Session: the context of training

COMMUNITY MENTAL HANDICAP SERVICES:
ISSUES AND STRATEGIES FOR STAFF TRAINING

Two-day King's Fund Centre Workshop on Thursday 4 November
and Friday 5 November 1982

PROGRAMME

Friday 5 November 1982

9.30am	Training Direct Care Staff: experience gained, issues raised (with comments on training substitute parents) Peter Allen
10.15	Coffee and Group Work
11.00	Support Staff: do they need training? Hugh Firth
12.00pm	Group Work
1.00	LUNCH
2.00	Plenary Session, the content and context of training Don Braisby, plus workshop contributors
4.00	TEA

£2.50