

**A DESCRIPTIVE SURVEY TO IDENTIFY THE SKILL AND INFORMATION
NEEDS OF HCSPITAL BASED MULTIDISCIPLINARY MENTAL HEALTH
STAFF IN THE MOVE TO COMMUNITY CARE**

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**A thesis submitted to The University of Glasgow for the degree of Master of Science
(Medical Science) in the Faculty of Medicine (Nursing & Midwifery)**

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Abstract

Mental Health care was changing from a segregational hospital-based service to an integrational community-based service. The Government policy documents that were setting the community care objectives indicated that staff would require further education as a result of the changes (DoH, 1994; DoH, 1993; DoH, 1989a; SHHD, 1988). However the documents did not indicate what education was required. Furthermore a search of the mental health literature in the UK did not reveal any empirical studies of sufficient size and methodological rigor to identify what education was required. Literature from the USA in mental health and from learning disabilities and general nursing in the UK suggested that mental health staff moving into the community would need to learn more skills and gain more knowledge in order to be effective.

This study aimed to identify and describe the skill and information needs of a multidisciplinary population of mental health staff in the movement from a hospital-based working environment to a community-based working environment. In order to describe the skill and information needs four research questions were posed. The questions addressed issues of: identification of the current educational preparation of staff; identification of the current skills and skills required for community practice and identification of the knowledge possessed by some multidisciplinary mental health staff about community care changes.

Questionnaires were distributed to the population of mental health care workers in one Scottish Health Board (n=695) and a 36% response rate achieved. A volunteer subsample of 20 questionnaire respondents were interviewed to enrich and clarify data from questionnaires. Data analysis revealed a diversity of skills was possessed by mental health staff. However, it was concluded that hospital based mental health staff needed to learn more skills and gain more knowledge to transfer to community based posts.

This study makes a positive start in identifying the skill and information needs of a population of mental health care staff moving to a community-based working environment. However, as a consequence of the low response rate the findings are considered tentatively. Conclusions and recommendations have implications for service purchasers, providers, professionals and clients.

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Author's Declaration

The author declares that the information contained within this thesis was gathered, analysed and described by the author. The material contained herein was written solely by the named author.

Signature _____

Date 1st March 1996

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Researcher's Note

The terms "mental health staff" and "the mental health multidisciplinary team" in this study refer to: clinically-based nurses; health care assistants; occupational therapists; physiotherapists; dieticians; paramedical helpers; community psychiatric nurses and community residential staff (all grades). The terms exclude psychiatrists, psychologists and social workers. The rationale for the choice of staff groups included is provided in section 3.3.1 (p.47).

Abbreviations

Abbreviation	Full title
CDE grades	C, D and E grade hospital based nurses
CMHC	Community Mental Health Centre
CMHT	Community Mental Health Team
CPN	Community Psychiatric Nurse
CR	Community Residential Staff
df	Degrees of Freedom
DoH	Department of Health
FGH grades	F, G and H grade hospital based nurses
HCA	Health Care Assistant
MDT	Multidisciplinary Team
NHS	National Health Service
NS	Not significant
OT	Occupational Therapist
PAMs	Professionals Allied to Medicine (OT, Physiotherapy, Dieticians)
p	Probability
SHHD	Scottish Home and Health Department
UKCC	United Kingdom Central Council for Nursing, Midwifery and Health Visiting

Chapter One

The Introduction

1.0 Background

As a staff nurse in the National Health Service (NHS) for five years, I was conscious of major changes in almost every aspect of health care. While these changes were aimed at improving patient care, there was minimal recognition of the consequences for staff.

One of the major changes in the NHS was the movement to community care (DoH, 1989a). The White Paper outlining the community changes (DoH, 1989a) and the subsequent legislation (NHS and Community Care Act 1990) proposed that care be provided in the community whenever possible; recommended an increase in multidisciplinary collaboration; and altered funding arrangements to promote the transfer of care to the community and interdisciplinary working.

Community care changes in mental health were debated commonly in the national media and often in a negative context (MacDermid, 1994; Waterhouse, 1993). While it appeared that there was general agreement that community care was a "good thing", there were concerns about the implementation of the policy (Gousy, 1994; Rye, 1993a). Nonetheless with the legislating of community care clients were *going* to move to the community and as a consequence so were many staff.

1.1 Formulating the Research Questions

Project 2000 (P2000) aimed to educate nurses to work in both hospital and community. In Scotland practising nurses had been educated prior to P2000 with an education that focused on the hospital context. I felt, as a hospital based nurse, I was inadequately prepared to change my role without further education and I perceived my colleagues to be often frustrated, unhappy and confused with the magnitude of health service change.

Government policy and professional reports indicated that mental health staff would require further education as a result of community care (DoH, 1994; DoH, 1993; DoH, 1989; SHHD, 1988; Turner, 1987). However, a review of the literature showed that little research had been carried out to identify what education was required. Two areas of potential educational need struck me as

particularly important: the skills staff need to transfer from hospital to community and their understanding of the changes that were taking place.

This study aimed to identify the current skills, the additional skills required for hospital staff to transfer to the community and the information needs of hospital staff from different occupational groups. Consequently the following questions were addressed:

1. What is the current community educational preparation of some of the different groups of mental health staff that make up a multidisciplinary team?
2. What current skills do the nurses, the health care assistants and the professions allied to medicine groups of mental health staff perceive that they possess?
3. What skills are the current hospital staff going to need to learn to practice safely in a multidisciplinary community team?
4. What is the current knowledge level of some of the different groups of mental health staff about the community care reforms?

The thesis is split into six chapters, this introduction being the first. The literature review outlines what has changed as a result of community care for mental health practitioners and provides justification for the choice of research questions. The study method is explained and the conduct of the study is justified. The findings are then presented, followed by the discussion of the findings including study limitations. Finally conclusions are drawn.

Chapter Two

The Review of the Literature

2.0 Introduction

A major review of the literature was undertaken with no date limits imposed. However particular attention was paid to the years immediately preceding the White Paper "Caring for People" (DoH, 1989a) and thereafter.

The literature review aimed to formulate and refine the research questions and to identify the most appropriate methodology to answer the questions given the constraints of time and funding. In particular the review addressed the changes in community care, mental health staff's knowledge about community care and the skills mental health staff required to move to the community.

2.1 Background to the Community Care Ideology

The ideology behind caring for mentally ill people has changed over the past 50 years (Turner-Crowson, 1993; Goodwin, 1990). One strand of the ideological revolution has been the movement towards community care and away from institutional care. The reasons for the shift involve treatment, humanitarian and political factors (Turner-Crowson, 1993; Goodwin, 1990; King's Fund, 1987).

It is claimed that treatment changes in the 1950s moved mental health care towards community care (Goodwin, 1990; Jones, 1953). For example, the introduction of psycho tropic drugs enabled reduction of more florid behaviour patterns and therefore enabled patients to be managed in the community (Goodwin, 1990). At the same time, Maxwell Jones (1953) introduced the concept of the therapeutic community which freed professionals from the confines of treating in hospital. The therapeutic community is not site dependent.

On humanitarian grounds, Goffman's work on asylums (1961) was important in moving mental health care away from institutionalisation in that he argued that long term care in asylums might do "inmates" harm. Goffman's theories, increasing legal pressures to protect individual rights, increased patient and carer preference for non-institutional forms of care and public scandals about

abuse and neglect in institutions combined to provide strong humanitarian grounds for the movement away from hospital based care and towards to community (Turner-Crowson, 1993; Goodwin, 1990; King's Fund, 1987).

In 1989 the Department of Health White Paper "Caring for People" was published laying down the blueprint for the subsequent NHS and Community Care Act 1990. It is not certain whether the legislative changes were a response to public and professional pressures or a means of achieving the Government's political and financial aims. However whether a response or a directive, political issues had a role in altering the philosophy of mental health care (Goodwin, 1990).

In summary, community care for mentally ill people was a radical alteration in ideology. It was no longer socially or politically acceptable to segregate and confine the mentally ill from the rest of society. Therefore for perceived patient benefit and for political reasons mental health care was moving to the community.

2.1.1 Legislative Reforms for Mental Health Care

The publication of the White Paper, "Caring for People" (DoH, 1989a) was central to the change process in that it laid out a framework for altering care delivery.

Proposed changes were in line with the arguments of patients' choice and the right to live in a community environment and were, perhaps, considered to be a "cheaper" care alternative. Specifically "Caring for People" dictated that services should be promoted to enable mentally ill people to be cared for at home whenever feasible and agencies' responsibilities, such as health boards and social work departments, were to be clarified so that professionals could be held accountable for their performance (DoH, 1989a). Further emphasis was given to patients' choices and rights through the "Patient's Charter" (NHS in Scotland, 1991). As with the prevailing Government's policies, the independent sector services were to be promoted along with those in the NHS (DoH, 1989a; DoH, 1989b).

Griffiths(1988) had previously proposed that assessment of need should be the determinant of care provision. "Caring for People" adopted this strategy and demanded that assessment of need and good case management be the "cornerstones" of care. Multiagency and multidisciplinary teamwork were said to be vital in the provision of mental health care (DoH, 1989a).

To promote the transfer and maintenance of patients into the community, carers' needs for practical support were to be given priority (DoH, 1989a). However the dominant directives for community

care were financial. Social Work was decreed the lead agency for community care and moneys that were once in the health service were to be transferred to Social Services (DoH, 1989a; Griffiths, 1988). The two agencies (Health Boards and Social Work Departments) had to co-operate to provide a package of health and social care. An additional financial incentive was the specific grant for mental health which was provided to promote hospital to community transfer (DoH, 1989a). Thus, the legal changes not only required a shift to community care but also built in financial requirements to ensure the shift occurred (DoH, 1989a; Audit Commission, 1986).

The Griffiths report (1988) "Agenda for Action" and in Scotland, the Scottish Health Authorities Review of Priorities for the Eighties and Nineties (SHARPEN) (SHHD, 1988) had previously made similar recommendations for change as Caring for People (DoH, 1989a). While recognising these and incorporating them into the UK national agenda, Caring for People took community care one step further.

In 1990 The NHS and Community Care Act was enacted and the above proposals became policy. It was indicated that the proposals be implemented in a staged process, culminating with the transfer of funding from the health boards to the social work departments in April 1993 (Royal College of Nursing/ Community Care Support Force, 1993).

2.1.2 The Meaning of Community Care Changes for Staff

The philosophical and legal shift to community care necessitated changes for many staff in the mental health field. At its most basic community care meant two things for staff. First, that most staff would have to work in a different environment, community not hospital, and second, the need for staff to know about local and National plans for change (The NHS in Scotland, 1991).

Government reports indicated a need for increased multidisciplinary working (DoH, 1989a; SHHD, 1988) and this was consistent with the dominant view that mentally ill people required an input from an array of services (Turner-Crowson, 1993). To work in a different environment and increasingly within a multidisciplinary team indicated a need for professional and non-professional staff to have the necessary skills. While almost all reports proposing community care changes indicated that current mental health staff would require education (DoH, 1994; DoH, 1989a; SHHD, 1988), there was little indication as to what education was required. Skills were a common policy focus (DoH, 1994; DoH, 1993; Scottish Office, 1991) but none of the reports provided research based evidence for which skills were required.

Subsequent to Caring for People (DoH, 1989a) and The NHS and Community Care Act 1990, additional reports have addressed the community care ideology. Two of relevance to England and Wales are The Key Area Handbook for Mental Illness (DoH, 1993) and the Review of Mental Health Nursing (DoH, 1994). While both of these reports are generally more specific than previous documents concerning the implementation of community care for the mentally ill and the skill requirements of staff, neither indicates a research basis for the skill requirements identified and neither refers to the situation in Scotland.

Scotland as a whole has progressed more slowly than the rest of the UK towards community care. For example the reduction in residents in Scotland between 1990 and 1992 was 246 and it was only recently that the first mental health hospital closed (Scottish Health Statistics, 1993). While some of the features of the English and Welsh systems may have been imported into Scotland, there are features of Scotland that make it distinct; for example, the rural nature of some of Scotland's communities, the overall health and cultural differences that occur between populations and the differing stages that have been reached in the community care change process.

The Professions responded to the changing ideologies through changes in pre registration education. In Nursing, Project 2000 (P2000) aimed to create a practitioner capable of working in hospital and community environments. In Scotland, the first diplomates graduated in 1995. However, in the main most current practitioners will have been educated in the 1982 schemes of training or in earlier hospital-based programmes. Nursing's governing body, the United Kingdom Central Council (UKCC) responded to changing care philosophies and made requirements for all qualified nurses to continue their education (UKCC, 1990). For the first time in the history of nursing, a nurse must attend a prescribed minimum number of study days within a three year period in order to renew his or her registration (UKCC, 1990).

Nevertheless, consideration of the ideological changes in mental health care left some important questions requiring consideration:

- what qualifications do staff have for community practice either gained through formal education or through continued professional updating ?
- do staff know what is changing in respect of community care ?
- do staff have the skills to adapt to the new environment, that is working in the community within a multidisciplinary team ?

2.2 The Knowledge Staff Have Concerning Community Care

Interestingly, the literature review only identified one study that directly assessed the knowledge of staff about the community care reforms (Caldock, 1993). Caldock used a non-validated questionnaire on an opportunistic sample of nurses from various backgrounds attending a conference (n=64). The findings indicated that there was a wide variety of opinion on the differences between care and case management; that resourcing, working together, communication and understanding other professionals roles were perceived as the major challenges facing community care; and nurses' views seemed inconsistent with the prevailing ideologies in that they viewed case management and assessment as the least important challenges facing community care.

Caldock (1993) proposed that the findings indicated widespread confusion and misunderstanding about the implications of the community care White Paper (DoH, 1989a). In particular; the misunderstanding between professions about professional group roles and inconsistencies between reports of prevailing community care ideologies may have negative implications for interprofessional working.

By Caldock's admission, the findings are not generalisable due to the opportunistic sampling and small sample size and may not be directly applicable to the mental health speciality, but they do raise important issues that require further investigation. In particular what do nurses and other mental health staff know about community care and therefore what information, if any, do they require ?

2.2.1 Studies and Reports Suggestive of the Need for More Information

While Caldock's (1993) study was the only located research that directly focused on the actual knowledge of mental health staff, there were other studies that concluded staff needed more information in their move to community care.

A study in Learning Disabilities was useful in this aspect. Within a comparative framework, Allen, Pahl and Quine (1990) used unstructured observation, a standardised postal questionnaire and subsequent extended interviews with a subsample of hospital staff, all community staff and managers from both areas. They achieved a survey response rate of 58% (n=271) (87% for community staff and 56% for hospital staff). Their methods, large sample size and use of prevalidated instruments allowed the results to be considered both valid and reliable.

The relevant findings indicated that:

- unqualified staff were unclear about the new philosophy of care;
- community staff who had previously worked in the hospital experienced the highest levels of role ambiguity and role conflict;
- ex-hospital staff had knowledge that they could use in the community service;
- learning disability staff wanted more training in resident teaching techniques and behaviour modification and management;
- low morale was evident which was attributed to uncertainty.

To resolve the issues arising from the findings it was proposed that uncertainty be managed at a strategic level as early as possible; that staff should understand why the policies had been decided on and services should be presented to staff as being in transition rather than with a hospital closure focus. Role conflict in particular was thought to relate to a lack of previous experience of dealing with resource issues. Allen et al (1990) proposed that induction training provided community staff with some benefits in that those who had training experienced less ambiguity, had improved visualisation of how they fitted in to the service and were less likely to leave.

In their long term political and economic study, Korman & Glennerster (1990) proposed that "active reorientation" was required for learning disability staff in the move to community care. Interestingly they commented that staff did not in fact believe that closure was going to occur. Again this is suggestive of the need for more information.

The studies in the mental health disciplines are smaller or less methodologically robust than the two previously described learning disability studies. However a small body of literature converges on the conclusion that mental health staff require more information as a result of community care.

Massey (1991) interviewed 22 mental health nurses, 13 hospital-based and 9 ex hospital-based, now working in the community. Massey proposed that long serving staff (greater than five years) suffered "institutional loss" on losing their hospital and this had implications for the resettlement of patients in the community; for example, community staff continued to identify with the hospital, delivering care in the traditional hospital manner, thus creating hospitals in the community. In a later literature review, Massey (1993) developed these arguments about staff attitudes during hospital closure and proposed some recommendations for managers, including the need for effective communication in all directions and crossing professional boundaries. It was claimed that staff need clear information, guidance and support during hospital closure and that there should be a clear change strategy.

Kennedy (1990), Gousy (1994) and Reda (1995) proposed that while positive about the concept of community care, mental health staff were concerned about the reality. These samples were small (Reda, 1995, n=16) and two were either exclusively nursing (Kennedy, 1990, n=18) or primarily nursing (Gousy, 1994, n=28). The three researchers (Reda, 1995; Gousy, 1994; Kennedy, 1990) proposed that further training was required for mental health staff as a result of community care.

Carlisle and Laurent (1993) and Tomlinson (1991) suggested that nurses were negative about community care. Information from group interviews with nurses about staff development revealed concerns about their jobs and resources in general, concerns that untrained staff would be caring for patients and disbelief that reprovision would in fact happen (Tomlinson, 1991).

There were also anecdotal reports in the literature that proposed more information was required for staff to move to community care (SHAS, 1994; Laurent, 1993; Scottish Office, 1991). Predating the legislation (DoH, 1989a), Turner (1987) proposed an educational programme to aid staff in relocating into the community which included giving information on the community as a concept; the community as a working environment; meeting workers who are not from health care; "normalisation" principles and changing attitudes i.e. philosophy of care and practice. However, Turner (1987) provided no research based evidence for her assertions.

Low staff morale was suggested in some of the previously mentioned studies (Massey, 1993; Allen et al, 1990). However, Cochrane and Jowett (1994) found that morale in their sample of general staff nurses working in a hospital preparing for trust status (n=40) was relatively high. Morale was high for two of the three themes tested (cohesive pride and personal challenge), which suggested that staff were forward looking with a determination in moving towards and achieving goals. However for the third dimension, the "leadership synergy", morale was lower which it was claimed may obstruct the achievement of organisational goals. Discontent with management was apparent in 88% of respondents with little trust and confidence in leaders. It was suggested that:

"Trust in leadership is put into jeopardy when it is perceived that superiors are not concerned with supporting and meeting the needs of nurses. This can lead to a threat to the organisation's vision and a danger of nurses losing their sense of purpose."

More recently a CSAG report (1995) advised on the clinical care standards being achieved for people with schizophrenia. It was suggested that the most important feature distinguishing "good" profile districts from "poor" profile districts was staff morale. Therefore staff morale may have a direct impact on the quality of patient care and it has been suggested elsewhere that morale can be improved by the provision of information (Allen et al, 1990).

In summary, although none of the above studies set out to identify either understanding or information needs of mental health staff, all agree that more information is required for staff moving to the community. The conclusions were reached from studies in different disciplines and from studying transfer problems that could be improved by providing information. However all fail to identify what mental health staff, particularly non-nursing staff, know now and also what mental health staff need to know for the future. Caldock claims that:

"The consequences of nurses remaining unconvinced about the direction of the forthcoming reforms could be highly detrimental to their implementation." (Caldock, 1993, p.596).

Although Caldock referred specifically to nurses, this statement is likely to hold true for all mental health staff.

2.2.2 The Portrayal of Information to Staff

The findings described above suggest that mental health staff have limited knowledge of community care provision. However information regarding the implications and the positive benefits of community care had been made available to mental health staff including a Scottish Office circular (1991) outlining the content of "Caring for People" applicable to Scotland (Robinson, 1994; Royal College of Nursing and The Community Care Support Force, 1993; Teasdale, 1993; Scottish Office, 1991; NHS and Community Care Act 1990; DoH, 1989a; SHHD, 1988).

However, there has been incessant negative media regarding community care. There has been high profile coverage of "community care failures" such as the stabbing of Mr Zito in London by a schizophrenic client discharged to care in the community (MacDermid, 1994; McMillan, 1994; Waterhouse, 1993). A lack of resources and a failure to co-ordinate care has been blamed for service inadequacies such as Mr Zito's stabbing (Casey, 1994; MacDermid, 1994; McMillan, 1994; Rye, 1993a; Turner-Crowson, 1993) resulting in further changes in legislation towards greater control of people with mental illness (Sandford, 1994; Waterhouse, 1993). However, changing the legislation has not been enough to satisfy the critics; for example, Rye (1993b) argues that changing the legislation is only a marginal issue as strategic planning, increased collaboration, ensuring choice and a more sophisticated approach to discharge planning are also required. Also Sanford (1994) claims that the rapid changes in legislation indicate that the changes were intended primarily to meet Government needs with the needs of people with mental illness as a secondary consideration.

The negative media portrayal of community care has been prolific both in the national and professional media and is as likely to affect mental health staff as the rest of the population. A

potential consequence of the portrayal of community care in a negative manner is the distorting effect the information may have on the knowledge of staff about the philosophy underlying community care.

2.2.3 Conclusion of the Knowledge Staff have about Community Care

Turner-Crowson (1993) argues that one of the critical issues in managing change in the UK mental health services is a vision of what needs to happen. She claims (1993, p.39) that:

"The aims of the whole enterprise must be clear to, and fully supported by, those responsible for carrying it out, and there must be some measure of agreement over what matters most."

It has been argued that the mental health literature does not identify mental health staff knowledge of community care reforms. The small scale studies from mental health, studies from related disciplines and the ambiguous media portrayal of community care suggest more information is required. Combining the above findings and Turner-Crowson's views indicates that action is required to identify what staff know and what information they require in order to achieve organisational goals and as a consequence to get appropriate mental health care for patients.

2.3 The Skill Requirements of Mental Health Staff

The hallmark of any professional group is its knowledge and skill base which enables it to have a sense of autonomy, integrity and be accountable for their practice (Drummond, 1990).

Reviewing the literature pertaining to mental health staff skills revealed some interesting issues. No specific mental health study has adequately identified the differences in skills used by hospital-based and community-based mental health staff despite the recognition in policy that hospital staff need to learn more skills to move to the community (DoH, 1994; DoH, 1989a; SHHD, 1988). The skills of staff in general may be a contentious yet important issue. There appear to be concerns about which skills belong to which profession (Shaw, 1993; Teasdale, 1993), yet little has been done to identify which skills are unique and which skills are generic within a multidisciplinary context. These issues are addressed below.

2.3.1 Educational Considerations

The training and education of professionals aims to provide them with skills (NBS, 1993) and in respect of Nursing, the UKCC Code of Professional Conduct requires that each nurse is adequately prepared for their role. Skill acquisition is therefore important.

Considering the changes to community care, one of Nursing's responses was an altered pre registration education, Project 2000 (P2000). P2000 aimed to prepare nurses with the skills to work in hospital and community. However the P2000 schemes of training did not start in Scotland until 1992 and the first diplomates have just completed their training. The majority of nurses working in mental health were therefore educated in the structures prior to P2000. The 1982 modular schemes and the preceding structures had limited community content.

The presence of courses (CPN diploma, BA in Community Health Studies), designed specifically to prepare professionals of all disciplines to work in the community, suggests post-basic education to prepare for community practice is required. However, Brooker (1990) followed up 87 students who completed a CPN course in England and argued that CPN educational courses did not place enough emphasis on skill education.

The lack of evidence of actual skills possessed and the recency of the commencement of P2000 in Scotland might lead one to contend that additional information is required about the skill requirements of hospital based staff moving to the community.

2.3.2 Hospital to Community Skill Differences

The literature search did not discover any empirical studies conducted in mental health and in the UK to identify the skill needs of staff moving from hospital to community. Therefore literature from mental health in America and from related disciplines in the UK on this issue is described here.

Lawton's (1990) study in learning disabilities was particularly useful in identifying the skills required for community practice. Lawton sent F to I grade mental handicap nurses (RNMH) questionnaires (n= 214, response rate of 39%) and interviewed a small subsample of participants (n=14) and experts in the field. The study is limited by the low response rate and the use of a questionnaire that was not prevalidated. However the respondent set was large and responses came from all sites sampled.

The findings indicated that:

- the difference between hospital and community nursing was in "community skills" which include multidisciplinary working, time management and promoting client choice and independence;
- the difference between team members is in the individual professionals skills. It is however difficult to identify the origins of this latter conclusion as the study sample were all nurses;
- training needs to incorporate shared and peripheral skills;
- a survey approach enabled identification of skill differences between hospital and community staff.

To bridge the hospital community gap, Lawton suggested that training should be completed, to an individually certified level, in four common core components: management, teaching, counselling and community skills. Additional components should be applicable to staff's speciality. She proposed that shared training could be utilised more fully.

An American study (Glasscote and Gudeman, 1969), although dated, remains a useful work to examine the roles and educational needs of staff in a community mental health centre. Eight centres were surveyed and 119 supervisors and 129 non-supervisors were interviewed. All centre staff were sent questionnaires (response rate 68%) and "trip reports" were compiled after visits.

All staff groups prioritised patient care as their personal top priority and this was consistent with the activity analysis with 57% of time being spent on patient care. Interestingly 33% of questionnaire respondents did not acknowledge any training gaps in their jobs. This was a common response from the nursing aides (61%) but the authors argue that it may be a matter of being trained to a certain level before one can recognise what one does not know.

Allen et al (1990) agree, in that, the HCAs in their sample thought that they knew their role but the view of the study researchers did not entirely coincide. In Allen et al's study (1990) the most common training gap for those who stated deficiencies was in some aspect of clinical skills (61%) with 93% of nurses, 67% rehabilitation workers, 72% aides and 50% activities therapists giving this response. A further 32% of participants felt there was a gap in knowledge about community organisation and social structure and 22% on administration and supervision. The high percentages of staff, particularly nurses who felt deficient in clinical skills, is a matter of concern particularly when one considers the high percentages of staff time spent on direct patient contact.

Other learning disability UK studies and American mental health studies have also indicated that staff in hospital and community use some different skills (Allen et al, 1990; Raynes and Sumpton,

1987; Siegel, Haughland & Fischer, 1983; Davis and Underwood, 1976; Zahourek, 1971).

Combining the common threads from these studies indicates that:

- the skills of staff in community orientated posts differed from those in the hospital in that community staff tended to deliver more direct treatment therapy than hospital based staff; tended to be dealing with situations alone and were in contact with more additional agencies (Allen et al, 1990; Siegel, Haughland & Fischer, 1983; Zahourek, 1971);
- hospital based staff tended to have non-structured one to one relationships with clients,, maybe in group therapies and observing clients (Siegel, Haughland & Fischer, 1983; Zahourek, 1971. Allen et al (1990) found that hospital charge nurses had a managerial role but had the highest levels of resident interaction in comparison to their junior hospital staff and community staff;
- Interestingly in hospital and community, a great deal of time is spent on indirect patient care activities such as staff communication or paperwork (Siegel, Haughland & Fischer, 1983);
- the most useful aspects of past education for community practice were theoretical concepts from social sciences, psychiatry and public health; focusing on the patient as part of a wider network; clinical experience (Davis and Underwood, 1976);
- Davis and Underwood (1976) suggested that the hospital trained nurses in their sample did not feel that there was anything in their education that prepared them for working in the community;
- further skills and skill information that staff have said that they require were psychiatric schools of thought including work on verbal and non-verbal communication; theory on psychotic conditions; treatment modalities e.g. crisis intervention; assertiveness skills and learning how to provide consultations (Raynes and Sumpton, 1987; Davis & Underwood, 1976, Zahourek, 1971).

Evidence from all studies reported in this section has indicated that hospital and community staff have some different skills and that if staff are to move from one sector to another, they must be equipped with the skills suited to both areas. Further education is the proposed solution. Allen et al (1990) hold the belief that the priority education should be directed through charge nurses as they are the pivotal point in change.

None of the preceding evidence can be applied directly to the mental health field in the UK. However if one extrapolated from the evidence it leads to a conclusion that UK mental health staff need to learn more skills to move successfully from hospital to community. Which skills they need to learn is the issue that requires to be addressed.

2.3.3 Skill Requirements for the Community Mental Health Worker

The absence of empirical study on the skill needs of mental health staff necessitates examination of the anecdotal evidence for guidance on the skills community mental health staff will need.

Caring for People (DoH, 1989a) advocates that assessment of need and good case management are to be the cornerstones of care. Therefore the necessary skills to assess and case manage are required. Reports suggest that many other skills are needed in combination to assess and case manage (Connolly, 1992; Worley, 1991a and 1991b; Green, 1990).

The Key Area Handbook for Mental Illness (DoH, 1993, p.119-120) indicates that it would be useful if all mental health staff were educated in the following skills:

- "appropriate care and treatment of postnatal mental illness, eating disorders and pre-senile dementia's
- counselling techniques
- behavioural, cognitive and family therapies
- equal opportunities - particularly for women and ethnic minority users of services
- communication and presentation skills
- restraint techniques."

Interestingly, which skills the professionals already have and which they need to learn was not indicated.

For Nursing, the Mental Health Nursing Review (DoH, 1994) had a remit to identify the skills for the future of mental health nursing, Smith (1994) has argued that it failed to do so with the necessary precision. The terms of reference for the Review committee were:

"to identify the future requirements for skilled nursing care in the provision of services for people with mental illness."
(DoH, 1994, p.vi)

The Review team claim that if they had to sum up their recommendations into one it would be that nursing re-examine policy and practice in the light of the needs of service users. Smith (1994) argues that the recommendations can be classified into six areas: Patients' Charter, education, management, professional, policy and future skills. Only two of the 42 recommendations pertained to skills despite the terms of reference (Smith, 1994). In particular this Report suggested establishing protocols for multidisciplinary working as well as clearly defining roles within teams and identifying training requirements for nurses working in large mental hospitals. It was proposed that cost effective and shared learning packages should be explored. Annex F is dedicated to the skill requirements of Mental Health Nursing. The skills identified fall into the Nursing Process categorisation of assessment, planning, implementation and evaluation. As with the Key Area Handbook the origins of the prescription are not clear and the current skills that staff possess are not differentiated from the skills they require.

2.3.3.1 The Skill Issues in Multidisciplinary Working

The policy documents on community care strongly advocate multidisciplinary working (DoH, 1994; DoH, 1993; DoH, 1989a; SHHD, 1988). Therefore mental health staff need skills that enable them to work in a multidisciplinary team. The Community Mental Health Team (CMHT) or Centre (CMHC) structure is the most commonly adopted model in the UK (Sayce et al, 1991).

It is argued that the main problem in identifying what skills staff require to work with other members of a mental health team is the lack of clear conceptualisation of CMHTs and CMHCs. Huxley (1988, p.14) provides the following non-specific definition of a CMHC:

"an abstract concept used to describe a network of resources based on common principles, but expressed in a variety of forms."

He maintains that there is no single definition of a CMHC as the centres themselves are variable. The variability in terms of service provided, composition of staff, caseload size and content is described in high quality studies and reports elsewhere (Turner-Crowson, 1993; Patmore & Weaver, 1991; Sayce et al, 1991; Glasscote & Gudeman, 1969).

Within the United Kingdom NHS structure, the CMHC framework differs from the larger scale American structure (Echlin, 1988) in that the UK service generally does not include inpatient provision within the CMHC structure. Therefore literature often refers to CHMTs (Waddington, 1993; Buller, 1992; Patmore & Weaver, 1991). It has been said that the main structure for interdisciplinary working is the team (Bloom & Parad, 1976, p.676) which is defined as:

"a group of practitioners from varying professions who have shared responsibilities for carrying out the clinical and other tasks"

Bloom and Parad maintain that interdisciplinary working involves a greater interdisciplinary dependence than multidisciplinary working. While it is said that interdisciplinary working is the ideal (Bloom & Parad, 1976), in the UK, reference is more commonly made to multidisciplinary working (DoH, 1989a; SHHD, 1988) and the multidisciplinary team in the community for mental health is often referred to as a CMHT (Buller, 1992).

Bloom and Parad (1976) attempted to identify the realities of interdisciplinary working in American CMHCs. Their main conclusion was that interdisciplinary functioning was a rule rather than an exception. However there were professional differences for example, in that nurses and staff in the "other" mental health professionals group expressed the greatest preference for interdisciplinary working and psychiatrists and psychologists the least, despite the fact that psychiatrists spent the greatest amount of time in interdisciplinary interactions.

There are problems identified with multidisciplinary working. The main issue that is said to exist is professional conflict, coinciding with fears of role erosion and role blurring which, it is claimed, may undermine team function (Watson, 1994; Shaw, 1993; Busuttil, 1992; Weaver & Patmore, 1990; Joice and Coia, 1989; Bloom & Parad, 1976; Glasscote and Gudeman, 1969). The concern of health professionals centres around social work "take over" (Teasdale 1993), the movement towards a generic mental health professional (Shaw, 1993); lack of a shared professional philosophy (Purser et al, 1988) and the increasing emphasis put on non-professional carers (Shaw, 1993). Shaw (1993) claims that employers can employ anyone to do the job as long as they demonstrate competence and with the introduction of NVQ's (National Vocational Qualifications in England and Wales, Scottish Vocational Qualifications - SCOTVEC - in Scotland) there is no longer a reliance on professional qualifications. Vocational qualifications require that the individual is examined and found to be competent in a range of tasks. Shaw argues that this "proof" of ability may undermine the need for professionals and consequently professionals need to provide their unique and their common contributions.

Joint training is one solution proposed to remedy some of the multidisciplinary problems (DoH, 1994; Spensley & Langley, 1977). The underlying assumption in joint training is that the product will improve patient care but little evidence is available to support this claim (Bloom & Parad, 1976). However, some advantages to joint training have been documented:

- facilitated role flexibility (Sifneous, 1969);
- widened the scope of community education (Sifneous, 1969);

- decreases costs and professional time (DoH, 1994; Spensley and Langley, 1977);
- counterbalances the inefficiency secondary to professional conflict, through a greater appreciation of other professional's roles (Spensley and Langley, 1977);
- can improve staff recruitment to traditionally difficult areas e.g. chronic mentally ill (Addleton, Tratnack and Donat, 1991);
- can make staff more positive towards the client group (Addleton, Tratnack and Donat, 1991).

2.3.3.2 Summary of Skill Requirements for the Community

Government policy reports (DoH, 1994; DoH, 1993; DoH, 1989a) suggest some skills needed for community practice but fail to indicate which skills are additional for moving from hospital to community. The Mental Health Nursing Review (DoH, 1994) provides some guidance on the necessary skill requirements which could form the basis of educational initiatives and the literature for the paramedic and unqualified staff is lacking. The skill gap therefore needs to be identified for the multidisciplinary team.

Advantages and disadvantages of multidisciplinary working have been identified. It is likely that multidisciplinary working will prevail given the impetus put on this framework by the Government (DoH, 1989a; SHHD, 1988). Therefore solutions to the problems of multidisciplinary working are required. One solution has been discussed, that is joint training. The content of joint training, should aim to decrease conflict. It is possible that by identifying the common and unique skills of the different multidisciplinary groups, that each group can assert its uniqueness yet use their common foundation to cohabit within a multidisciplinary structure.

2.3.4 The Current Skills of Mental Health Staff

The inability to identify which skills are required for hospital staff to move to community practice leads to a need to identify current skills of mental health practitioners as a baseline. However the succeeding information highlights the difficulties in skill identification.

2.3.4.1 Paramedical Staffs' Skills (Occupational Therapists; Physiotherapists; Dieticians) - Hospital and Community

Reviewing the literature revealed little specific to mental health for occupational therapists (OTs), physiotherapists or dieticians. It is possible the lack of specific mental health literature may be a result of the generic nature of their training. There does not appear to be community courses specifically for these groups e.g. no community OT course. Given that all the aforementioned paramedical groups often work in both hospital and community concurrently, it may be that preparation for community practice occurs at an undergraduate level.

The World Federation of Occupational Therapists (College of Occupational Therapists, 1994, p.1) defines OT as:

"the treatment of physical and psychiatric conditions through specific activities in order to help people reach their maximum level of function and independence in all aspects of daily life."

Thus OT education aims to create a practitioner with skills to promote activities of daily living.

It has been suggested that OTs have specialist skills that are necessary and beneficial to a multidisciplinary mental health team (Joice and Coia, 1989). OTs aim to promote recovery, encourage patients to achieve their maximum potential, prevent hospitalisation, promote good work and leisure habits and rehabilitate while advancing self confidence (Busuttil, 1992). Joice and Coia (1989) claim that the core skills an OT takes to the multidisciplinary mental health team are the use of selected purposeful and meaningful activity as a treatment modality, activity analysis and assessment and treatment of functional capabilities. They also say that there are common skills that are shared with the team such as knowledge of mental illness, counselling and communication as well as the skills pertaining to individual's own specific interests.

Dietetic education aims to ensure dieticians have the following qualities on completion of education: knowledge of human nutrition; collecting and assessing information; planning nutritional programme; research and evaluation skills; producing practical advice and support; communication skills and delivering high quality service (Dieticians Board of CPSM, 1994). American literature suggests that dieticians are of specific value to a community mental health team (Johnson, Haney, Flowers & Andrew, 1977; Lamb and Oller, 1976). The two papers located (Johnson et al, 1977; Lamb and Oller, 1976) claim there is value in formal and practical nutritional education for mental health clients and therefore value in having a dietician on the mental health team.

Canadian research proposes that the generic skills physiotherapists rate as important are patient assessment and treatment planning (Sandford, Stratford and Solomon, 1993; Aston-McCrimmon, 1986). The two studies disagree on the importance of communication with Aston-McCrimmon finding it to have the third most important weighting and Sandford et al the least important weighting. In mental health, Crews' personal account (1990) claims that physiotherapists can make a valid contribution to the mental health team including taking on key worker and team leader roles. She states that the physiotherapist in psychiatry has to know about psychiatric conditions and medical treatment and understand the care delivered by the other team members. Thus it is argued that physiotherapists have a role in the community mental health team (Crews, 1990).

Therefore each PAM discipline would claim to make a contribution to community mental health care. However the specific skills that they have in mental health care and the skills they may have to learn as a result of community care are ill defined.

2.3.4.2 Health Care Assistant (HCA) Skills - Hospital and Community

The introduction of skill mix into the clinical areas has altered the role and function of health care assistants (Dewar, 1992; Hancock, 1992a; Dickson & Cole, 1987). Two papers have recently been published which address the role (not skills) of HCAs (Chang, 1995; Dewar & MacLeod-Clark, 1992). However neither provides evidence of HCAs skills or roles specific to mental health.

In 1991, White's Delphi study of experts identified a probable and highly desirable statement that a clearly defined role for mental health HCAs would emerge. However to date it has not.

The relevant points that emerged from the aforementioned HCA papers (Chang, 1995; Dewar & MacLeod-Clark, 1992) are discussed. First, HCAs' roles are inconsistent, for example depending on local negotiation or presence of primary nursing and many types of support worker are in existence in addition to HCAs. Support workers in general were said to have enabling and assisting (particularly in patient care) roles and many duties were clerical or cleaning and tidying. Another point of interest was that trained staff did not think it appropriate for HCAs to make notes on patient records (Chang, 1995). However, it is possible that some of these roles may be appropriate for mental health HCAs.

One American study examined the use of ten untrained staff working with people with schizophrenia in a community home (Mosher, Reifman, Menn, 1973). It was claimed that the untrained staff were tolerant but tough, hard-working, energetic, integrated, considered feelings and relied on their

intuition. They relied on the intuition to perceive options, make judgements and adapt to the environment. Overall it was claimed that these characteristics rendered the staff well suited to the role. This work suggests that there are characteristics about some untrained staff that might make them suitable for their mental health post.

A small scale study suggested that training HCAs may be beneficial to their effectiveness (Narayanasamy, 1985). A sample of 24 HCAs (response rate 69%) and eight charge nurses (100% response rate) in two hospital sites were surveyed. Most HCAs and charge nurses thought that their effectiveness was increased following training in terms of orientation, job satisfaction and confidence.

In summary there is inadequate evidence regarding the skills of HCAs with the mentally ill. However minimal evidence suggests training may infer some benefits and personal characteristics may be important to their role performance. The latter may have implications for the selection of mental health workers.

2.3.4.3 Hospital Based Nurses Skills

Several studies can be identified that address hospital based nurses skills (Rolfe, 1990; Shanley, 1984; Cormack, 1983). However, no study identified has addressed a global picture of hospital based skills of mental health nurses (alone or in conjunction with the multidisciplinary team). Most research examines nurses roles (Cormack, 1983) rather than skills or the research is confined to one skills area, for example communication (Altschul, 1972). A further consideration is the age of the majority of the skill research in that it predates the current wave of NHS reform (Shanley, 1984; Cormack, 1983; Altschul, 1972).

Cormack's study (1983) addressed the hospital based nurses' role (not skills). His work sampled mental health nurses in all specialities and all shifts of employment. In reviewing the literature up to 1983 he claimed that it rarely reflected the systematic study of what a psychiatric nurses role *is* but is what it *should be* and that these do not equate. It is thought that this statement holds true thirteen years later.

Cormack aimed to describe the role of psychiatric nurses in eleven Scottish Hospitals. He collected 4477 critical incidents from 1164 patients and staff. He classified nurses roles into four main areas: staff initiated therapeutic intervention, administrative activity, providing, planning for and monitoring physical care and personnel activity. He claimed that there were minimal speciality and

grade differences. This is somewhat disturbing given the grades reviewed were from HCA to charge nurse (including students). It was evident that while Cormack provided evidence of the boundaries of the mental health nurses role he did not identify specific skills.

The literature that examines hospital-based mental health nursing skills is generally specific either to a group of skills or a speciality. For example Shanley (1984) considered the nurse patient relationship and consequently the skills of empathy, unconditional positive regard and genuineness. Goold (1992) reviewed empathy only. One of the early studies (Altschul, 1972) reviewed communication skills. Green (1990) examined assessment skills and claimed that these skills were insufficient in elderly care. Rawlinson (1990) considered self awareness. While each of these studies was important and contributed to the body of knowledge surrounding mental health nursing, evidence is still lacking on the broader picture of the skills of mental health nurses in the 1990's.

There is a body of prescriptive literature indicating what skills authors believe mental health nurses should possess. The JCMHNO of England (Butterworth, 1986) and psychiatric nursing association for Scotland (Shanley and Murray, 1991) issued statements regarding the role of the mental health nurse. As with Cormack (1983), roles rather than skills were emphasised but some skills were proposed. These include: empathy, unconditional positive regard, genuineness, techniques such as counselling and group work and ability to assess. It is possible to identify further prescriptive accounts in the literature but as these may not be indicative of actual practice (Cormack, 1983) they are not discussed.

Thus it is not possible to identify an overall view about the current skills of the hospital-based mental health nurse. Consequently one must first identify what skills are possessed to identify what skill education is required to make up for deficiencies.

2.3.4.4 Community Based Nurses Skills

As with the skills of hospital-based nurses, there are problems in identifying the CPN skills. First with the changes in health care it may be that the CPN role has altered and at present CPNs work in a variety of settings e.g. from hospital bases, in primary care teams, in CMHTs (Martin & James, 1992; Brooker & Jayne, 1984). Second, much of the available evidence is anecdotal or skill specific. However, in health care CPNs are one of the important community providers of mental health care (Simmons & Brooker, 1987) and as such there is value in identifying their skills both from a professional identity stance and to identify the skills that are required for community practice.

As with hospital-based nurses the identified studies tended to focus on roles rather than skills. Pollock (1989) examined 12 CPNs and 7 patients to look at the CPN role from their perception. It was found that CPNs juggled resources, sought to legitimise their work and justify care, greatly believed in the importance of forming relationships with clients and had individual ways of working yet still provided a uniform service. However, there were two problems with this study: the small sample size limited to two CPN bases in one Scottish city and the complexity of the study design make it difficult to identify the validity of the findings.

Tryer et al (1990) concluded, as a result of their study of 6 CPNs in Nottinghamshire, that CPNs had a "superhuman" role involving counselling, psychotherapy, behaviour therapy and assessment. Although the CPN numbers were small, these researchers analysed all referrals (n=1767) over a six month period as a way of considering CPN role. Delivery and administration of medications was the most common purpose of visiting those with major psychoses but there were also a large number of visits involving long term support (66.8%) and psychotherapy (14%). It was claimed that the emphasis in CPN training is on neurotic disorders but the majority of visits are to those with psychotic disorders. There was concern about the "superhuman" role of CPNs as it was not thought to be feasible and concern over a trend towards nurses down-grading work with long term clients in favour of specialist therapies and intensive case work.

A 1994 literature review of the respective roles of mental health social workers and CPNs concluded that the main differences were individual rather than professional (Gillam, 1994). For CPNs one of the main functions was said to be clinical focusing on symptoms and medication treatments which supports Tryer et al's (1990) findings. Other roles included psychosocial, environmental and liaison. It was claimed that the evidence points towards CPNs being inadequately trained for their role.

Additional research tends to focus on specific skills. For example Brooker and Butterworth (1991) evaluated training CPNs in psychosocial intervention to work with families caring for a relative with schizophrenia and recently Morrall (1995) has examined autonomy and the CPN. As with hospital-based nurses there is no doubt that these add to the body of knowledge pertaining to Community Psychiatric Nursing but evidence is still lacking on the broader picture of the overall skills possessed by CPNs.

One particularly useful, although anecdotal, report of the evolution and skill acquisition of CPNs is provided by Pope (1985). He considered the evolution of the CPN service in three stages. The first was the medical model where the main skills are supportive, monitoring stability and administering

medications. The second was the hospital to community transition with skills based on the above but increasing mainly due to personal interests. The third was the development of the CMHTs where each member is responsible for the clients he or she accepts. It was considered that each team member was required to have the following basic skills which were seen as the minimum for effective CMHT membership (Pope, 1985, p.12):

"assessment skills;
counselling skills;
family therapy skills;
group work skills;
problem solving skills;
evaluative skills."

In addition community knowledge was also required. It was maintained that the CPN services can only move from stage two to stage three if existing hospital based staff are incorporated into the service but hospital staff need further training.

An American author commented on the CPN service in the UK (Grau, 1986). He described their comprehensive role as involving home assessment and devising a treatment plan, providing specific therapy and co-ordinating services. Similar skills are advocated for CPN skill training (Bowers & Crossling, 1994).

There appears to be some, although minimal, convergence on the range of CPN skills and this is useful in considering skills required for community practice. However there is little empirical study pertaining to these skills and consequently a benchmark is required.

2.3.5 Summary of the Skill Requirements of Mental Health Staff

American mental health, UK Learning Disability, UK mental health anecdotal and UK mental health prescriptive literature provides evidence that hospital based mental health staff need to learn additional skills to move successfully into the community. The difficulty in identifying which additional skills are required is complicated by a dearth of recent and relevant literature from all strands of the multidisciplinary team identifying which current skills hospital based staff have for caring for mentally ill people.

In the current climate of health care rationalisation and the commissioning process, justification and evidence of staff skills by providers of health care is crucial to the commissioning of their services.

In addition identification of the common and unique skills of each professional and supportive staff group is important for improving multiprofessional harmony and to prevent role erosion.

Therefore there is a need to identify what skills hospital based mental health staff require to move to the community because:

1. information on current mental health staff skills is lacking;
2. policy and professional accountability requires that mental health staff are sufficiently skilled;
3. there is a need to identify what people need to know to create appropriate educational packages for transition;
4. identification of common skills will promote multidisciplinary team working;
5. identification of unique skills will enhance professional identity and decrease the risk of role blurring.

2.4 Literature Pertaining to the Method

A review of the literature pertaining to research methodology suggested that a descriptive survey using a questionnaire and a semi-structured interview schedule was the most appropriate research design to address the research questions (justification in chapter three).

2.4.1 Descriptive Survey Design

Oppenheim (1992) identifies two types of survey: descriptive and analytical. He claims that the aim of a descriptive survey is to count, for example, characteristics and the presence of these characteristics in different groups within a population. An analytical survey explains why the characteristics occur (Oppenheim, 1992).

Polit and Hungler (1991) maintain that the greatest advantage of survey designs, in general, is their flexibility and broadness of scope. The disadvantages listed by Polit and Hungler are that the information obtained tends to be superficial and there is no opportunity to link cause and effect. However in terms of Oppenheim's definitions, it would seem that Polit and Hungler referring only to descriptive survey designs. Therefore if one's research questions do not aim to identify cause and effect, then this can not be considered a disadvantage of the descriptive survey design.

Oppenheim (1992) indicates that obtaining a representative sample is a key issue in a descriptive survey design. If it is possible a complete population should be sought such as all employees of a

single firm. Therefore if one's research question aims to describe a population and if it is possible to use a total population in one locality and one's topic is broad, then a descriptive survey is the design of choice.

Within a descriptive survey design, several different methods can be used to ascertain information (Oppenheim, 1992; Polit and Hungler, 1991). Two commonly used methods are questionnaires and interviews (Oppenheim, 1992). A questionnaire is the term generally used when the respondent is sent the form to complete themselves (self-report questionnaire) and an interview when the questions are asked and recorded by an interviewer.

2.4.2 Questionnaires

The use, design and data collection using self-report questionnaires and interviews, has been the subject of much literature (Burns and Grove, 1993; Oppenheim, 1992; Barker, 1991; Polit and Hungler, 1991; Rees, 1990; Gordon and Stokes, 1989). Reviewing the literature reveals some consensus of opinion regarding the suitability, advantages and disadvantages of questionnaires to specific research problems.

The frequently documented advantages of a questionnaire are:

- relatively inexpensive to administer to a large sample (Polit and Hungler, 1991);
- time efficient, i.e. large numbers of participants can complete a self report questionnaire within a short time span (Polit and Hungler, 1991);
- returns are not subject to interviewer bias (Barker, 1991; Polit and Hungler, 1991);
- a large variety of information may be obtained with a single form (Polit and Hungler, 1991; Lawton, 1990);
- open questions are considered useful when some areas of a problem are known but all responses cannot be anticipated (Field and Morse, 1985);
- participants can be anonymous (Oppenheim, 1992; Polit and Hungler, 1991);
- may be the most appropriate data collection tool when the subject under review is embarrassing or taboo (Barker, 1991; Field and Morse, 1985);
- questionnaires are familiar to most people (Rees, 1990).

Conversely the self-report questionnaire has disadvantages. Probably the most serious disadvantage is the potential for a low response rate (Burns and Grove, 1993; Oppenheim, 1992; Polit and Hungler, 1991). Response rates of 50-60% are said to be required to claim validity of the findings yet it is not uncommon to receive response rates of 30% (Burns and Grove, 1993; Polit and

Hungler, 1991; Rees, 1990). The main issue is however the issue of non-respondents in that the higher the proportion of non-respondents the higher the likelihood of a respondent set that is not generalisable to the population at large (Oppenheim, 1992).

Additional disadvantages of self-report questionnaires include:

- the information obtained is generally superficial (Oppenheim, 1992; Polit and Hungler, 1991);
- there is no option to probe ambiguous responses (Polit and Hungler, 1991);
- there is no option to clear up misunderstandings of question interpretation (Barker, 1991; Polit and Hungler, 1991);
- it is not possible to be completely certain who has completed the questionnaire (Barker, 1991).

When using a self-report questionnaire to collect data one is aiming to have maximum validity and reliability in the results (Oppenheim, 1992). When searching for a valid and reliable tool, Burns and Grove (1992) suggest that a "blueprint" questionnaire should be sought, that is a questionnaire that has been prevalidated on a similar study population. However in the absence of an ideal questionnaire the researcher is required to design a tool appropriate to the research questions.

Design considerations in making a valid and reliable tool are: to ensure that the content of the questionnaire accurately reflects the research questions (content validity) and that the questionnaire appears to be appropriate to the research questions (face validity) (Polit and Hungler, 1991). Both content and face validity are commonly achieved through a comprehensive literature review.

The structure of the questionnaire is also important to reliability and validity and has an effect on the response rate (Oppenheim, 1992). Questionnaires should be less than twelve pages long, take twenty minutes or less to complete and each question should have less than twenty words (Oppenheim, 1992). In addition the appearance of the questionnaire is important. Research is not conclusive on exactly which appearances promote the highest response rates yet there are some generally adhered to principles (Oppenheim, 1992). It is thought that questionnaire should be easy to follow, seem appropriate to the respondent, question wording should be simple and should not look off-putting (Oppenheim, 1992; Polit and Hungler, 1991). Additional actions during data collection which may assist to increase response rates are: "advertising" the study, using simple language, making the questionnaire short, addressing envelopes to individual participants, assurances of confidentiality and providing incentives for participation (Oppenheim, 1992; Gordon and Stokes, 1989).

The way in which validity and reliability is tested and response rates estimated is generally through pilot work. Oppenheim (1992) maintains that expert advice or reliance on past experience is no substitute for well organised pilot work. It is through pilot work that a researcher can identify specific problems in the data collection tools and processes for the specific study.

From the preceding information it would seem that self-report questionnaires would be the data collection tools of choice in a study with a large, geographically disperse sample, with a broad and sensitive topic and when anonymity of response is required. However self report questionnaires also had some disadvantages which the researcher would be wise to minimise. Some solutions to minimise disadvantages are given above. However an additional solution is to combine data collection tools in a single study (triangulation).

2.4.3 Semi-Structured Interviews

Interviews vary in structure along a continuum from totally unstructured to completely structured. The degree of structure employed will be dependent on the research questions.

Semi-structured interviews are particularly useful when specific topics require to be included yet some flexibility for exploration is required (Polit and Hungler, 1991). The commonly considered advantages of the semi-structured interview include the following:

- high response rate, commonly 80-90%, (Barker, 1991; Polit and Hungler, 1991);
- clarification of ambiguities in questions asked and responses (Barker, 1991; Polit and Hungler, 1991);
- the interviewer can ensure that all questions are answered therefore promoting comparability of responses (Barriball and While, 1994; Polit and Hungler, 1991);
- the interviewer knows who has responded to the questions (Barker, 1991; Polit and Hungler, 1991);
- expansion on responses is straightforward to obtain (Barker, 1991);
- additional information can be collected, for example non verbal behaviour (Barker, 1991).

However, as with questionnaires, there are disadvantages associated to interviews. The main disadvantage is the bias apparent in interpersonal interactions and the associated judgement in analysing the responses. This is often termed interviewer bias (Polit and Hungler, 1991) and affects reliability and validity of the findings (May, 1991). To counterbalance bias, it is suggested that interviewers may standardise the interview to a more "questionnaire like" format thus reducing the flexibility (Oppenheim, 1992). In addition the interviewer may adopt a "neutral" standpoint, for example not agreeing or disagreeing with interviewees and wearing in conservative dress

(Oppenheim, 1992). May (1991) considers that the non-standardised nature of interviews may not be a threat to reliability and validity but reflects a difference in aims between interviews and questionnaires. For example interviews may be to construct theory and questionnaires to test theory.

Further disadvantages of interviews include:

- time consuming (Oppenheim, 1992; Polit and Hungler, 1991);
- expensive, particularly in interviewer time (Barker, 1991; Polit and Hungler, 1991);
- large volumes of data are generated which if unstructured are difficult to analyse (Polit and Hungler, 1991);
- anonymity is not possible (Barker, 1991);
- sample is limited due to time consuming nature of interviews (Polit and Hungler, 1991).

The considerations in design and data collection using interviews are essentially equivalent to those in designing questionnaires. The principle difference is in data collection with the addition of an interviewer.

In summary, it may be evident that the disadvantages of questionnaires mirror the advantages of interviews and vice versa. Consequently, it would seem that there may be benefits of combining the methods in a single study.

2.4.4 Triangulation

Combining methods in single study is referred to as triangulation (Denzin, 1970). There is ambiguity in the literature regarding definitions and types of triangulation as well how this design is accomplished (Corner, 1991; Kimicki, Polivka and Stevenson, 1991; Jick, 1979; Denzin, 1970; Campbell and Fiske, 1959). However, the advantages of triangulation are generally considered to be in a more holistic portrayal of the topic and improved validity (Jick, 1979).

The assumption is that by triangulating methods (or data sources or investigators) one will neutralise the weaknesses apparent in any one approach and exploit the assets (Jick, 1979). Therefore by following a questionnaire with a semi-structured interview one would be able to enrich, clarify, validate and enhance the holistic interpretation of the problem.

2.4.5 Content Analysis

Content analysis is the traditional approach for quantifying and categorising qualitative data (Berelson, 1952). The advantages of content analysis are in the structured and objective nature of the approach (Berelson, 1952) which it is claimed enhances reliability and validity (Lenninger, 1985; Mostyn, 1985). Several authors have proposed structures within which data can be content analysed (Burnard 1994; Burnard, 1991; Lederman, 1991; Lenninger, 1985; Mostyn, 1985; Weber, 1985). Most of the structures proposed are for unstructured interview data but provide a framework for content analysing qualitative data collected from other sources. However whether using a content analysis structure as it stands or adapting it, utilisation of a predefined method across all data infers consistency on the resultant categories. The overall stages are: immersion in the data, initial coding, broader coding, examination of codes for mutual exclusiveness and consistency of content, making necessary changes and validity checking with study participants or colleagues (Burnard 1994; Burnard, 1991; Lederman, 1991; Lenninger, 1985; Mostyn, 1985; Weber, 1985).

It is possible to identify two types of content analysis which may exist separately or in combination in a single study (Field and Morse, 1985; Mostyn, 1985; Weber, 1985). The first type of content analysis, referred to as manifest (Field and Morse, 1985) or quantitative (Mostyn, 1985) is in keeping with the original definition of Berelson (1952), that is identifies *what* is said. The second type is latent (Field and Morse, 1985) or qualitative (Mostyn, 1985) content analysis where inferences of meaning are drawn from what is said or written i.e. *why* it is said.

Thus manifest content analysis is a valid and reliable method to analyse qualitative data generated from open questions and interviews yielding categories that will describe what has been said.

2.5 Conclusion to the Literature Review

The ideology and legislation underpinning mental health care has changed. In particular there has been an ideological and physical shift to caring for the mentally ill in the community rather than the institution (Goodwin, 1990; DoH, 1989a).

It has been argued that while there is recognition in policy that staff will require education as a result of the community care movement, the required education is not defined (DoH, 1994; DoH, 1993; DoH, 1989a; SHHD, 1988). Furthermore the review of professional literature did not identify any studies within mental health care and within the UK that had adequately identified what additional

skills and information, if any, staff required to move successfully from a hospital working environment to a community work environment.

It was not possible to identify from the literature what staff know about community care in mental health. The available evidence suggests that staff may lack some information about community care (Caldock, 1993; Allen et al, 1990). Furthermore the findings of previous research and professional reports suggested that the lack of knowledge and the effects of change may effect the service delivered to the clients (Massey, 1991; Allen et al, 1990; Korman & Glennerster, 1990). The effects may range from a high staff turnover in the community (Allen et al, 1990) to clients in the community continuing to be treated as they were in hospital (Massey, 1991).

There was no UK mental health evidence to indicate what, if any, skills mental health staff would require to move successfully to the community. However, evidence from mental health American literature (Siegel, Haughland & Fischer, 1983; Zahourek, 1971; Glasscote and Gudeman, 1969) and UK Learning Disabilities Literature (Allen et al, 1990; Lawton, 1990) suggested that staff may have to learn new skills as a result of changing to community care. The problem of identifying the community care skill requirements is compounded by the fact that it was difficult to identify the current skills of the various groups in the multidisciplinary team. Therefore more information is required to identify what skills mental health staff have now and what skills they require for the future.

To date the studies that have addressed skills or information needs have achieved their aims using a survey approach that combined questionnaires and interviews as methods of data collection (Allen et al, 1990; Lawton, 1990). The literature pertaining to these methods suggests that this would be an appropriate way to approach the problem of skill and information needs of mental health staff.

Chapter Three

Materials and Methods

3.0 Research Questions

Overall the study aimed to identify and describe the skill and information needs of mental health staff in the move to community care. The following questions required were posed:

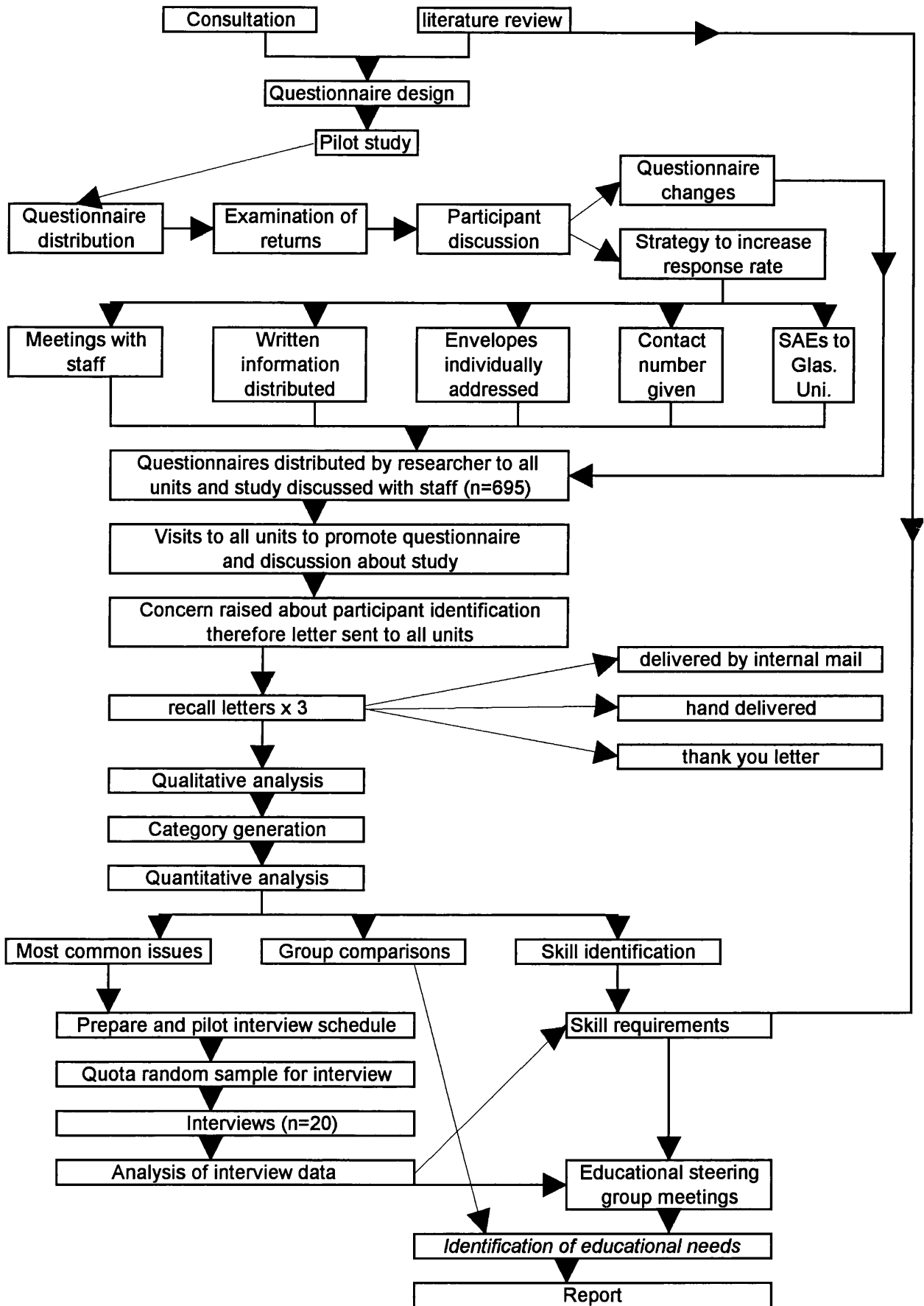
1. What is the current community educational preparation of some of the different groups of mental health staff that make up a multidisciplinary team?
2. What current skills do the nurses, the health care assistants and the professions allied to medicine groups of mental health staff perceive that they possess?
3. What skills are the current hospital staff going to need to learn to practice safely in a multidisciplinary community team?
4. What is the current knowledge level of the some of the different groups of mental health staff about the community care reforms?

3.1 Overview of Study Design

This study was a descriptive survey implemented in two stages (figure 3.1). Each stage was preceded by a pilot study to test the data collection tools and processes. Stage one data were collected using a self-report questionnaire distributed to a total sample in one Scottish Health Board. Stage two data were collected using a semi-structured interview prompt schedule with a volunteer sample of respondents who had agreed to interview by stating their willingness on the questionnaire.

Qualitative data were analysed using Ethnograph and quantitative data by Minitab. Stage one data were analysed and key variables and group differences identified. The key variables formed the basis of the interview prompt schedule. The resultant interview data were used to enrich, clarify and expand upon the questionnaire data.

Figure 3.1 Overview of study method



3.2 Justification of Method

The methodological review of the literature (section 2.4) indicated that a descriptive survey was the method of choice on the basis of the nature of the research questions, in that, the perceptions of the staff were being sought and the aim was to describe, not to identify cause and effect (Oppenheim, 1992). There was a breadth of research questions: that is the identification of skill and information issues in one study and the sample were multidisciplinary and geographically diverse. Questionnaires have been said to be the method of choice to access large amounts of data from a variety of professionals in a variety of sites (Oppenheim, 1992; Polit and Hungler, 1991). Similar studies, such as those referred to in the literature by Lawton (1990) and Allen et al (1990) used descriptive survey methodologies to identify skill and information issues. Finally the degree of sensitivity surrounding community care and noted particularly in the consultation period (section 3.4) and the preference of the funding body for a total locality sample also made a descriptive survey the method of choice (Oppenheim, 1992).

Within a descriptive framework and given the time and funding constraints of the study, there were two possible research designs identified. The first design was to distribute self-report questionnaires to a total multidisciplinary sample in one health board and the second to utilise in-depth interviews with a stratified random sample within a health board. Considering the above rationale for the choice of a descriptive survey and the advantages of utilising a questionnaire as described in the literature review (section 2.4.2) the former design incorporating a questionnaire with a total sample was the data collection tool selected. There were additional benefits of using a questionnaire with a total sample in that: the breadth of information required could be obtained within a relatively short time (Lawton, 1990); respondents could be offered anonymity and confidential handling of data thus responding to the sensitivity identified at the consultation phase (Barker, 1991); anyone who wished to, could participate in the study; and participants would be able to identify complete the questionnaires in their own time thus allowing for considered responses - particularly useful when considering skills. Thus a questionnaire was selected as the principal data collection tool.

The literature revealed (section 2.4) that the advantages and disadvantages of questionnaires and interviews were mirror images and that previous similar studies (Lawton, 1990; Allen et al, 1990) had found advantages of combining methods of data collection in the one study. Therefore it was decided to incorporate a semi-structured interview with a small sub-sample of respondents into the study design to capitalise on the advantages of interviews, in particular to enrich, clarify and expand questionnaire data. A semi-structured interview format using a prompt schedule was identified from the literature as the most appropriate interview design as it allowed inclusion of the

key areas of interest, flexibility in exploring these areas and ensured all relevant areas were considered (Polit and Hungler, 1991).

In summary, a descriptive survey method was found to be the most appropriate using a triangulation of data collection tools, namely self-report questionnaires and semi-structured interviews.

3.3 Description of the Population and Sample

3.3.1 The Choice of Study Groups

The initial study proposal was restricted to nursing staff. However in keeping with Department of Health (1989a) guidelines encouraging multidisciplinary team working and following consultation with study supervisors, Trust and Health Board management, it was decided to widen the study to include other disciplines. The decision upon which groups were to be included was based on considerations of: which groups were most likely to be affected by the hospital to community transfer; which staff groups had the greatest patient contact; and constraints of time and funding. It was thought the groups identified in the population below would be most affected by the shift to community care, had the greatest direct patient contact and was achievable within constraints of time and funding. However, it is recognised that the multidisciplinary team can include health professionals other than those mentioned in this study.

3.3.2 The Population

The population were all hospital based mental health staff in the following groups:

- C to H grade clinical nurses;
- health care assistants (HCAs);
- occupational therapists (OTs);
- physiotherapists;
- dieticians;
- paramedical helpers;
- community psychiatric nurses;
- community residential workers.

It is evident that the numbers of staff in each group were dissimilar. However following local consultation (section 3.4) and discussions with a statistician and study supervisors it was decided to use a census sample of NHS staff within this one health board.

3.3.4 Semi-Structured Interview Sub-Sample

A stratified random quota volunteer sample of questionnaire respondents was interviewed on statistical advice (n=20). A total of 81 questionnaire respondents volunteered to be interviewed. Randomisation of the volunteer respondents to select the interview sample was achieved using random number tables and the strata were study groups as depicted in table 3.3.3. It was considered that 20 interviews were achievable within time and funding restraints and enabled a representative of all study groups to be interviewed.

3.3.5 Sites of Data Collection

All sites of delivery of mental health care in one Health Board were included in the study. These were:

- one large institution providing acute and continuing care (approximately 400 beds);
- one small hospital catering for the long term care of the elderly mentally ill - this hospital had been identified for closure for some 20 years and originally comprised some 400 beds and was now reduced to 90 which were already contracted out to an independent agency;
- two wards in each of two district general hospitals;
- four community nursing sites
- one ward in one residential nursing home;
- two supported accommodation areas.

3.3.6 Background to the Health Board District

The Health Board area within which the study was conducted has a population of approximately 375, 000 spread out over a large land area and incorporating several small islands.

Mental Health Care provision is spread unevenly in the district with the majority of services being based in the South and the majority of the population in the North. The area has high unemployment following the decline of the mining industry. Several villages within the district are rural, and for many of the rural villages, hospitals are the main local employers.

The large "institution" where the majority of the sample was based is surrounded by small mining communities and it would seem the hospital has provided employment for many generations of families. Its impending closure or restructuring was therefore a matter of concern for the Community as well as to individual employees.

Against the backdrop of pervading high unemployment and the staff suspicion of their employers, the study aimed to identify the skill and information needs of the staff employed in mental health care.

3.4 Consultation

Prior to final decisions regarding study design and content, a period of consultation was undertaken with key managers and practitioners in NHS and non-NHS facilities within the health board district. The purpose of the consultation was to: assist in the choice of study design; to refine study content through identification of pertinent community care issues; to orientate the researcher to the mental health provision in the locality; to increase the study profile; and to enhance the ownership of the study by the participants through their involvement at the outset of the study.

One main route of consultation was with the steering committee appointed to oversee the project. The steering group consisted of members of staff from the University Research Team, the Health Board and the Trust. Due to the mix of people involved, the steering group provided very useful discussions pertaining to study design.

The local consultation process involved making appointments to visit the identified individuals. Each consultation had a non-structured interview format, during which the researcher took field notes and validated responses with individuals. The meeting commenced on each occasion with the researcher explaining the purpose of the study and the visit. On completion, a contact number was given for the researcher to maintain open lines of communication.

Field notes were transcribed as soon as possible after the meeting and examined for common themes. This "analysis" was intended to challenge thinking and generate new ideas for inclusion in the study.

Consultation enabled identification of issues in study design and content. Of particular relevance to study design was the very strong impression gained that there were issues of concern to the staff regarding community care; employment; mistrust of "management" and consequently, study

participation. Of particular concern was the mistrust of "management" which seemed to be manifested in a number of ways:

- a belief that the study was a way for the "management" to identify troublesome staff;
- a belief that staff were selected unfairly for the existing 6 week community course;
- a belief that the staff selected for the 6 week course had an increased opportunity to be "chosen" for future employment;
- that some staff were going to be made redundant and "management" was trying to identify staff for redundancy.

The reasons behind the above issues of concern were not clear but it did appear that these views were prevalent throughout the study areas (although it was not possible to prove this). Consequently design considerations incorporated the idea that staff needed to be certain of the study's intentions and to feel secure in participating in the study.

Additional issues were identified for inclusion in the questionnaire, namely staff knowledge about past and anticipated changes, sources and satisfaction with information and preparation for a community role as the Trust were identified to be running a six week community training programme.

In conclusion the consultation process was very informative for the researcher's orientation to the study area and for refining study design and content. The consultation also served to raise the study profile with potential respondents. An abstract was submitted and published as a means of maintaining this profile (Bugge & Smith, 1994).

3.5 Construction of Data Collection Tools

Burns and Grove (1993) maintain that the ideal data collection tool is one that has been used and validated on a similar study population. However, it was not possible to identify a suitable questionnaire or semi-structured interview prompt schedule from the existing literature. Therefore the questionnaire and interview schedule had to be designed specifically for the study.

3.5.1 Stage One: Questionnaire Construction

The information in this section outlines the justification for questionnaire content and structure. Data collection is discussed in section 3.8.

3.5.2 Justification of Questionnaire Content

Consistent with the research questions, the questionnaire was set out in three sections: demographic and educational questions; skill questions and information questions.

Decisions regarding questionnaire section content were made following consideration of the research questions; close scrutiny of the available literature (Caldock, 1993; White, 1991; Allen et al, 1990; Lawton, 1990), Government policy documents (NHS in Scotland, 1991; Scottish Office, 1991; DoH, 1989a; SHHD, 1988) and local policy documents (AAHB, 1993a; AAHB, 1993b; AAHB, 1992); local consultation and discussion with the steering group and research supervisors.

Consequently the demographic and education section contained questions regarding the demographic variables that were identified as important from the literature (Allen et al, 1990) and educational questions on current qualifications, community qualifications and updating practice (Lawton, 1990; White, 1990; UKCC, 1990; Brooker & Jayne, 1984). The skill section asked about current skills, multidisciplinary working and roles in relation to others (Lawton, 1990; DoH, 1989a). The understanding section had questions about knowledge of reforms already in place, expectations about the future and information sources (Scottish Office, 1991; Caldock, 1993).

The questionnaire used in the main study contained 40 questions. The questionnaire contained open, closed and filter questions. Within the 40 questions there were 73 items (appendix 2, item 5).

3.5.3 Justification of Questionnaire structure

The structure of a questionnaire is critical to the reliability and validity of the results (Oppenheim, 1992). Therefore all actions were aimed at increasing the reliability and validity of the tool, including promoting the response rate.

Similar questions were organised together in each of the three sections. While it has been said that demographic data should not be the first questions asked (Oppenheim, 1992), they were put first in the questionnaire. The rationale for going against this view was that the demographic data were less threatening than the skill and information data. This choice was tested during local consultation and pilot work and was felt to be the correct order. The skill section was second and the information section third. The information section was last as it was thought to be the most sensitive.

The order of questions within each section was considered to prevent bias (Oppenheim, 1992). Consequently questions which would have influenced responses to subsequent questions were

separated; for example, the questions regarding professional updating. Alternatively questions were arranged into different questionnaire sections, such as the question on concerns about working in the community was put in the skills section to keep it separate from the remaining information questions.

It was hoped that by linking similar questions and making the questionnaire as interesting, relevant and easy to follow as possible it would encourage participant responses.

Open and closed questions were designed. Where it was possible to identify exclusive response options, the questions were closed and when it was not the questions were open. Of the 73 question items 19 were open and 54 were closed (or treated as closed).

Advice on readability was sought from the University's English Department but discussion revealed that readability tests were not in fact thought to be more useful than pilot work in staff based studies such as this. Attempts were made to ensure questions had less than twenty words to improve readability as suggested by Oppenheim (1992).

The presentation of questionnaires has been the subject of conflicting research findings (Oppenheim, 1992). However Oppenheim (1992) indicates some issues that are reported consistently to be the preferred presentation. Consistent with these preferred approaches (Oppenheim, 1992), an attempt was made to make the presentation simple, the typeface easy to read and the questions well spaced on the paper. In addition, the questionnaire was ten pages which is less than the maximum twelve suggested.

A column "for office use only" was written on the questionnaire for coding purposes. Pilot study participants indicated that this presentation was not off-putting.

Summary of Questionnaire Construction

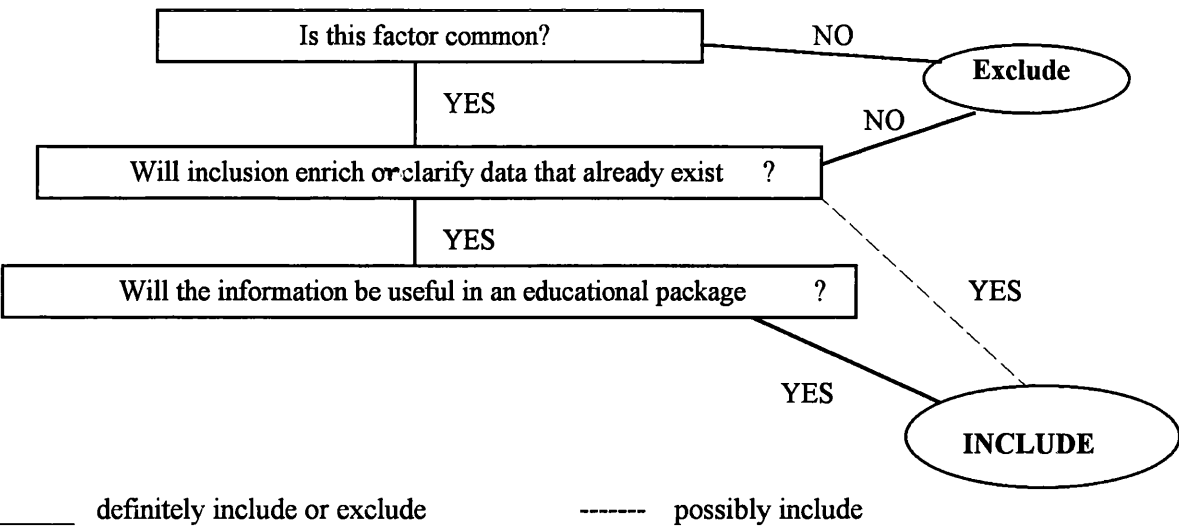
In line with recommendations in the literature (Oppenheim, 1992; Barker, 1991; Polit and Hungler, 1991), questionnaire content was decided upon and organised in order to promote reliability and validity of the findings.

3.5.4 Stage Two: Semi-Structured Interview Construction

The semi-structured interviews were included in the research design in order to enhance the richness of the questionnaire data. Therefore the interview content was defined by the key points originating

from the questionnaire through identification of group differences, prevalent skills and issues. Inclusion in the interview was based on the discriminatory process depicted in figure 3.5.4.

Figure 3.5.4 Discriminatory process to decide upon information for interview inclusion



Additional areas that defined prompt schedule content were from the literature, local consultation, consultation with the steering group and research supervisors.

There were eleven issues identified for inclusion: communication, counselling, liaison, MDT, assessment, patient centred care, education (including autonomy), information, continuing in mental health care, management skills and response rates.

Within a semi-structured format there are varying degree of schedule flexibility. A prompt schedule (Polit and Hungler, 1991) was the chosen structure as this would allow inclusion of all key variables as identified from the questionnaires while giving the interviewer flexibility to explore the issues in any order and to follow alternative paths if these were raised by the interviewee.

The same principles of structure as applied to the questionnaire were used to organising the prompt schedule such as question order. Each of the eleven issues identified above was a single schedule sequence. For example, the communication sequence was split into four sections: importance, definition, group differences and improvement. Considerations of question wording were the same as for the questionnaire. However when interviewing it was possible to use alternative expressions for the same questions in order to attain "stimulus equivalence" (Oppenheim, 1992) that is all interviewees having the same understanding of the question.

Summary of Interview Construction

Thus interviews were constructed to be sensitive to the content of the key areas and enhance reliability and validity of information.

3.6 Ethical Considerations

As access to patients was not required, it was not a requirement of this study that it be passed by an ethics committee. However that is not to say that ethical considerations were absent. It remains the responsibility of all researchers that the highest ethical and moral codes are adhered to (Reid, 1991).

Polit and Hungler (1991) propose that there is information that should be disclosed to all participants prior to their participation in a study. Those of relevance to the study are considered here. First, participants should be aware that they have the choice to participate and withdraw. In the study letter, interviewees were "invited" to participate in the study and were free to withdraw at any time. As the questionnaire was a self-report format, participants were free to fill in or omit any questions if they chose to.

Again, participants should be informed of what is requested of them and any subsequent follow up. They should know how they are selected, that they are research participants, potential costs (in this instance time), potential benefits (in this instance educational development), study purpose and funding. All this information was provided verbally and in the letter of consent that accompanied the questionnaires and was given to interview participants to read.

Participants should be aware that the data they provide will be treated confidentially and that their name will not be disclosed to others. Also a contact point for the researcher should be made available. This information was reiterated on several occasions, both verbally and in writing, including at an initial meeting, at questionnaire distribution and on consent letters.

The ethical principles of beneficence, the respect for human dignity , the principle of justice and the principle of informed consent were adhered to (Polit and Hungler, 1991). The study therefore fulfilled the obligation of adhering to moral and ethical principles.

3.7 Pilot Study

The piloting of the questionnaire and interview schedule are considered below. The purpose of the pilot study was to test the methods and process of data collection (Oppenheim, 1992).

3.7.1 Pilot of the Questionnaires

The aims of the pilot study were as follows:

- to test the wording and content of the letter of consent;
- to identify ambiguities in question wording;
- to assess the length of time involved in completion of the questionnaire;
- to ensure the questionnaire would yield the type of responses required (validity);
- to ensure the questionnaire would consistently yield the type of responses required (reliability);
- to identify any other comments regarding the questionnaire e.g. style and content;
- to obtain an approximate indication of the response rate;
- to test data analysis system.

3.7.2 Sample for Questionnaire Piloting

The pilot was conducted within a different health board to the main study and in accordance with the guidelines of Oppenheim (1992). The use of a total sample for the main study precluded piloting in the same area. The pilot sample was a convenience sample. The Health Board chosen was the one in closest proximity to the University. Access was gained through the formal channels of Senior Nursing Management. Attempts were made to ensure that the pilot sample resembled closely that for the main study. This was achieved by sampling in a community site and a hospital site and requesting participation from equivalent grades and working areas of staff to the main study. A total of 73 staff (22 community and 51 hospital) were asked to participate in the pilot study representing 10.5% of the main study sample. All grades of hospital and community nurses from acute and continuing care adult and elderly areas were sampled and community paramedics.

A problem in the hospital sample was identified on arrival on the wards in that there were more staff on each of the wards than the researcher had been informed about. A total of 43 names were given to pilot in the hospital but there were 51 staff. Additional questionnaires were therefore left but it was not possible to identify the grades of the additional staff who received questionnaires.

3.7.3 Process of Questionnaire Piloting

The pilot study of the questionnaire was conducted in two consecutive phases in order to enable changes made following the first phase to be piloted in the second phase. The first stage of pilot work was conducted at a community mental health centre (CMHC) and the second at a large mental hospital.

The initial contact to request access to CMHC staff was by telephone in conversation with the Centre Manager. Verbal permission was obtained following discussion regarding the study. A formal written letter was subsequently sent to the centre manager (see appendix 1) and permission granted to pilot. Access was requested in writing from the Nursing Services Manager for the hospital. When there was no response to an initial letter (appendix 1), a second letter was sent. Following this the researcher was invited and duly attended a senior nurses' meeting. The study was explained to the nursing managers and verbal consent to access the staff was given. Written permission followed.

The names and grades or position of the participants were requested and supplied from hospital and community sites.

To distribute the questionnaires and explain the study to the staff, an appointment was made to attend the CMHC charge nurses' meeting. In the hospital setting there was no appropriate meeting in which to meet all the charge nurses and distribute the questionnaires. Therefore each ward was visited separately. An initial letter was sent to each of the wards prior to distribution of questionnaires. The purpose of this letter was to confirm the date and time of the researchers visit to the wards as arranged with the senior managers giving the individual units the option to make a more suitable appointment if required.

The following information was given at the hospital and community meetings and it was requested that this information be shared with all other participating staff:

- the researcher's position and base;
- study funding;
- the purpose of the main study i.e. to identify clinical strengths and issues in community care;
- the long term aim of team building and constructing education for staff moving from hospital to community;
- that the questionnaire was constructed specifically for the study and this is where the researcher wanted their help;

- what was required of them i.e. fill in the questionnaire noting down any questions that were ambiguous, difficult, they were unsure of and to complete the comments page that was also provided (including time to complete questionnaire);
- to return the questionnaire in the stamped addressed envelope (SAE) provided by the specified date;
- that the researcher would return to discuss any comments and issues from examination of the data two weeks later;
- that the researcher was grateful for their time;
- that the researcher looked forward to reading their replies and comments.

Much of the preceding information was contained within the letter of consent but nonetheless it was felt important to reiterate it verbally in an attempt to encourage responses and promote discussion. The consent letter contained additional information about contacting the researcher and guarantees of protected anonymity and confidentiality (appendix 1).

At the CMHC the questionnaires, letters of consent, SAEs and comment forms were then left in named envelopes for distribution by the centre manager and charge nurses. However, due to concern regarding anonymity voiced in the CMHC pilot study and the concern over identification noted in the initial consultations, questionnaires to hospital staff were not put in named envelopes. The questionnaires were left with the nurse in charge to be distributed or collected by the individual staff member.

In both hospital and community meetings were arranged on a day after the questionnaire return deadline date to return and discuss the questionnaire with staff.

3.7.4 Questionnaire Pilot Data Analysis

The questionnaire was taken to a statistician prior to the pilot study to obtain his opinion on the coding system envisaged. Following discussion it was agreed that the coding system was satisfactory and acceptable to take forward to the pilot study.

On return of the questionnaires and comment forms, they were examined for example to identify particular questions that were omitted. Data were analysed using the same process as in the main study (section 3.9) to identify any problems with the analysis process. The researcher made note of any comments or particular problems identified and took the notes with her to the discussions with participants.

3.7.5 Questionnaire Pilot: Findings Pertaining to the Study Design

A 72% response rate was achieved from the community staff (n=16) and 35% from the hospital staff (n=18). There were responses from all grades of staff in all areas. The nurse in charge was asked if any questionnaires remained uncollected/ not distributed. Across the four hospital wards 11 questionnaires were not collected despite all being left where they could be seen by all staff. Thus 21.6% of the hospital sample did not receive questionnaires. It appeared that all community staff received questionnaires. Consequently, a strategy was formulated to attempt to boost participation in the main study including distributing questionnaires in named envelopes.

Most staff thought that the consent letter was easy to follow. However some comments were made and the letter altered accordingly. For example, the community staff thought that some of the wording in the letter could be altered to make it clearer from the letter the type of questions contained within the questionnaire. On their suggestions, changes were made and repiloted with the hospital sample.

Overall most staff in both sites thought that the questionnaire was relevant and easy to follow. The pilot responses were thought to be related consistently to the questions the researcher intended to ask the questionnaire was therefore felt to be valid and reliable for its intended purpose. The exceptions and remedial actions taken are discussed below.

Some in the CMHC found certain questions to be ambiguous, for example the statements pertaining to staff knowledge of reforms. Following discussion changes were made to the statements and other ambiguous questions and the questionnaire repiloted with the hospital sample. The hospital staff did not find the statements ambiguous but thought that some questions were repetitive, these repetitive questions were removed.

Some hospital staff thought that the question on skills was narrow in that some people may see skills as synonymous with tasks. Discussions suggested that changing the wording to incorporate the notion of personal or clinical strengths would yield more relevant information.

Additional comments included suggestions for additional questions, such as asking about access to education. Following discussion with research supervisors, the additional questions suggested were not included as they were not thought to be appropriate to the research questions.

The mean time of questionnaire completion was 30 minutes. When asked, CMHC staff did not think 30 minutes was too long but some hospital staff thought that it was. It was hoped that with

the removal of repetitive questions and further rationalisation of the questionnaire the main study participants would not find the questionnaire too long. The estimated time of questionnaire completion was added to the consent letter for the main study.

Following the data analysis, some minor alterations were made to the code book for the closed questions. Analysis of data from a sample question, (question 21) revealed the volume of data that was likely to be generated from the open questions. It was felt that traditional cutting and pasting techniques were going to be too cumbersome and alternative ways of analysing the open questions ought to be sought. Therefore Ethnograph (Seidel, Friese & Leonard, 1994), a qualitative data analysis package was purchased. Further data were analysed using the package and it was thought that the package would be beneficial in the analysis process. In addition categorisation lists were identified for two of the "open" questions where the response sets were very narrow and these questions were treated as "closed" in the main study.

3.7.6 Pre-Pilot and Pilot of the Interview Schedule

The aim of the interview pilot study was to test the prompt schedule. The aims were as with the questionnaire piloting (section 3.7.1), with the alterations that the consent information was given by telephone and on the interviewee's arrival and response rates were not being tested.

3.7.7 Sample and Process of Interview Schedule Pilot

The first stage of the pre-pilot involved giving the prompt schedule to three colleagues to read and comment on. Subsequently the interview schedule was rationalised and the wording of some of the questions was altered. The researcher then tested the schedule by interviewing colleagues (n=4) to enable identification of issues such as timing and ambiguous questions. Again some questions were changed and prompts altered. Third, the CMHC where the first stage of the pilot was approached and access requested to 3 members of staff (appendix 1). Access was granted by the Resource Centre Manager and an appointment made to visit the centre.

All three interviews were conducted on the same day with two G grade and one E grade nurse.

3.7.8 Findings and Actions Taken Following Interview Pilot

Two out of the three CMHC interviewees thought that the interview was easy to follow and the questions clear and easy to answer. The third however felt that some questions were unclear and often required clarification. Examination of the data revealed that there were three questions that could be omitted and that alternative expressions for asking the same question should be considered to attain stimulus equivalence (Oppenheim, 1992) for individuals who have difficulty in answering the questions. Two handouts were used at pilot to clarify questions, following the pilot one was omitted and the other altered to make it clearer.

3.7.9 Summary of Pilot Study

Overall it was thought that the aims of the pilot studies were achieved. Ambiguities in the consent letter, questionnaire and interview and unexpected issues in data collection were identified. The data analysis procedures were found to be too time-consuming and difficult to manage. Therefore the Ethnograph (Seidel, Friese & Leonard, 1994) was identified as being a useful computing aid to categorising the qualitative data. As far as it is possible to comment on a questionnaire that has not been used on multiple populations, the questionnaire was thought to be valid and reliable for the main study population and the interview schedule for the sub-sample of the population. Response rates are a common problem with self report questionnaires and through the pilot study a comprehensive strategy to encourage the maximum possible response rate was formulated.

In both instances (questionnaire and interview), discussions with steering group members and study supervisors helped shape the final format of the data collection tools.

3.8 Implementation of Main Study Data Collection

Figure 3.1 gives an indication of data collection and indicates where the data collection is placed in the overall scheme of the study. Prior to data collection access to the field was required.

3.8.1 Access

Access to NHS staff was requested by letter (appendix 2) from the Chief Executives of the three trusts involved in the study. Access was permitted to all staff requested except two rotational occupational therapists on the grounds that they were not permanently working in mental health.

Access to the nursing home and residential areas was gained from the matron and area managers respectively (appendix 2). Both had previously been consulted in the initial phases of the study. Two letters were sent to the matron of the Nursing Home with the support of the research supervisors as there was no reply to the first letter and had in the past been difficulty in gaining access to this person for an appointment. However access was eventually granted to all areas requested.

Once formal access to the field was granted, information about the study was disseminated through the hierarchical line management. Nursing Officers, paramedical managers and residential managers were all informed about the study and the permission to access from executive management. Meetings were then held with first line managers to disseminate to their staff.

As in the pilot study, lists of names were requested from personnel departments. All names and working areas requested were supplied.

3.8.2 Stage One: Questionnaire Distribution

The process of questionnaire distribution and return is related to reliability and validity particularly through the response rates. The following is the strategy formulated after the pilot study to enhance the response rate.

Oppenheim (1992) claims that informing potential study participants about the study prior to them receiving the questionnaire is one way of boosting the response rate. Therefore, prior to questionnaire distribution, meetings were arranged with unit heads of department or charge nurses to explain and "advertise" the study, to promote discussion and to increase awareness of the study in the area (figure 3.1). The staff present were encouraged to share the information with others and were given printed information (appendix 2) to consolidate the verbal information presented.

To ensure all participants received a questionnaire, each was delivered in an individually addressed envelope. The names were hand-written on the envelopes to achieve a more personal effect. The researcher delivered the questionnaires to each unit/ ward by hand, explaining the study to the available staff and promoting discussion. It was hoped that these actions would prevent the situation in the pilot where many staff did not receive a questionnaire while the more personal approach promoted responses (Oppenheim, 1992). Further to the initial visit, all units were either contacted by telephone (community units) or visited again over the two or three days following

questionnaire distribution. The purpose again was to promote returns but, in addition, these latter visits ensured all relevant staff had received questionnaires.

All questionnaires were given an individual number for the questionnaire to have a unique identity. Groups of questionnaire numbers were sent to specific units, for example 1 to 30 were sent to a specific ward. This was to enable the researcher to identify if responses were from all areas. A list numbered from 1 to 45 (there were 45 distinct units) was kept with the numbers of the questionnaires sent to each unit written alongside. As each questionnaire was returned a tick was put against the appropriate ward or unit.

A consent letter was distributed with each questionnaire (appendix 2). All information required for ethical acceptability was included in the letter and the letter was as tested at pilot. Letters were addressed "Dear Colleague" rather than individually to promote a feeling of anonymity in envelope content. SAEs were also provided and addressed to the researcher at the University. The letter and the SAE tried to distance the study from local politics by stressing the University base. Information on the funding source (Health Board) was necessary for informed consent (Polit and Hungler, 1991). Staff were informed that the questionnaire would take approximately 30 minutes to complete and asked to return the questionnaire within two weeks.

Stage one questionnaire data were collected over the period from March 1994 to May 1994.

3.8.3 Response Rates to Questionnaires

Despite the care taken and described above, staff remained concerned about study participation. This became apparent during the initial visits to all units. The primary concern seemed to centre around participant identification. Although explanations were given at the time to appease fears further action was thought to be necessary. Therefore, all units were sent several copies of a letter (appendix 2) explaining that the numbers on the questionnaires were administrative aids, not personal identification numbers, and to score out the numbers if preferred. It was thought that a questionnaire returned without its unit source identified was better than not returned at all. Furthermore, the letter reconfirmed information given at meetings that "Management" did not have access to the study questionnaires and that the questionnaires were confidential to the researcher. Although a contact number was given prior to the study and in all letters, in fact the researcher did not receive any telephone calls asking for further information regarding this matter.

The return rate for the questionnaires was low (18%). Consequently a recall letter was sent through the internal mail giving staff a further two weeks to return the questionnaires to the researcher. Potential respondents were informed again that individuals were not being linked to responses and that Management had no access to questionnaires. If another copy of the questionnaire was required staff were asked to telephone or contact the researcher to request a new copy. The importance of everyone's contribution was stressed. Staff were also informed that they would receive a summary of the final results when the study was complete. As the respondents were unknown all recall letters were distributed to all participants with a statement asking them to ignore the letter if they had already completed the questionnaire.

At this later return date the response rate remained low (27%). One can expect that half of the current respondent size to respond to a second set of questionnaires with fewer responses to a recall letter (Waugh, 1992) but due to the fact that questionnaires would have to be sent to the whole sample, it was not considered to be financially viable. In addition, it was not possible to ascertain who had completed the questionnaires already returned and therefore any one individual could complete the second and first questionnaire thus biasing the findings. It was thought that many actions had been taken to increase the response rate and it was not thought that sending more questionnaires would necessarily be any more successful. Therefore, following consultation with research supervisors, and consulting the literature (Waugh, 1992; Oppenheim, 1992; Polit and Hungler, 1991) the researcher decided that it was not advisable to send out a second set of questionnaires. A second recall letter was sent increasing the return date by a further three weeks.

The content of the second letter was shaped by the response pattern. It was evident that some groups were responding more than others: for example the response rates were high from CPNs and poor from HCAs. Therefore, the contribution of the low response rate groups was emphasised in the second recall letter (appendix 2). This second letter was distributed to all units by the researcher again in an attempt to enhance discussion and promote responses. Hospital management also included the study in their team brief providing management backing of the study.

At the final date on the second recall, the response rate remained low (35%). Consequently, a third letter was sent (appendix 2). This letter was intended as a thank you letter but also a final recall to obtain questionnaires from anyone else who would still fill them in. It was thought that the questionnaire had taken up staff time and effort and everyone (responders and non responders) should be thanked for their consideration of the study and the researcher. It was accepted that this third letter was unlikely to yield many further responses (Oppenheim, 1992).

Summary of Questionnaire Data Collection

In summary questionnaire data were collected over two months. A strategy to encourage participation was enacted using guidance from the literature, pilot work and consultation with supervisors and steering group. Despite the care taken in setting up the study the response rate remained low and three further recall letter were sent.

3.8.4 Stage Two: Semi-Structured Interviews

Volunteers for interview were recruited through the addition of a final section in the questionnaire. A statement in the letter and on the questionnaire was given stating the interview purpose, requesting volunteer interviewees and stating that data would be treated confidentiality.

Letters were sent to willing interviewees (n=81) while the questionnaire data were being analysed explaining that analysis was ongoing and that the researcher would contact them in the near future regarding interviews (appendix 3). Following the random quota sampling of participants, potential interviewees were contacted by telephone if a number was provided or by letter if only an address was given. They were given information reconfirming the purpose of the study, an assurance of confidentiality and asked for an appropriate date and venue for interview. SAEs were provided for return letters. If staff had moved on and the remaining staff did not know where they could be contacted or if staff did not reply to two letters then the next randomly selected participant was contacted to maintain the quota of 20.

Staff were given a choice of venue for the interview and asked for a suitable date and time. The majority of respondents wanted to be visited in their workplace during a shift when they were on duty. The researcher was able to comply with all requests. One person did not attend on the arranged appointment but did attend following a second appointment. All others attended as arranged.

3.8.5 The Interviews

Data were collected over one month. Each interview took between 30 and 50 minutes. Time was taken at the beginning to put interviewees at ease through general conversation. Care was taken to ensure participants understood the questions they were asked. The interviewer took a non-judgmental stance to whatever was said neither agreeing nor disagreeing with participants.

Field notes were taken during the interview and recited back to interviewees to confirm their agreement with what the researcher had written. As soon as possible after completion of the interview, the researcher transcribed the notes onto the interview schedule by hand to expand on the short hand notes written during interview. The researcher's additional thoughts, ideas and impressions were also written down after the interviews. Although tape recording is one way qualitative researchers claim to decrease bias (May, 1991) tape recording was rejected for the following reasons: the sensitivity noted during the consultation phase; the volume of data already collected; restraints of time in the subsequent transcribing of tape recorded material and the value in validating transcribed responses with the interviewees at the time of interview.

Summary of Semi Structured Interview Data Collection

Interviewees were recruited through the questionnaires, contact was maintained by letter and following randomisation participation was requested from the interview sample. Interviews were conducted in the interviewees workplace over one month with all interviewees who agreed to interview participating.

3.9 Data Analysis Process

Figure 3.9 gives an overview of the data analysis methods and process.

3.9.1 Stage One: Analysis of Questionnaire Data

The data generated from the questionnaire were both quantitative and qualitative. As suggested by Oppenheim (1992), a code book was established prior to and tested during the pilot study. The code book contained all predefined numerical codes for the closed questions, the numerical codes for the open questions once finalised (section 3.9.2), space to write any "other" responses given and comments on the analysis process.

As the code book was already established for the closed questions the analysis process was straightforward. An example of the coding for one of the closed questions as it appeared in the code book was question 7 and is shown over the page.

BOX 13: AREA OF EMPLOYMENT

- 1 Hospital: acute adult mental health
- 2 Hospital: adult continuing care
- 3 Hospital: elderly acute or admissions
- 4 Hospital: elderly continuing care
- 5 Community psychiatric nursing services
- 6 Community residential services
- 7 Other

List other options below.

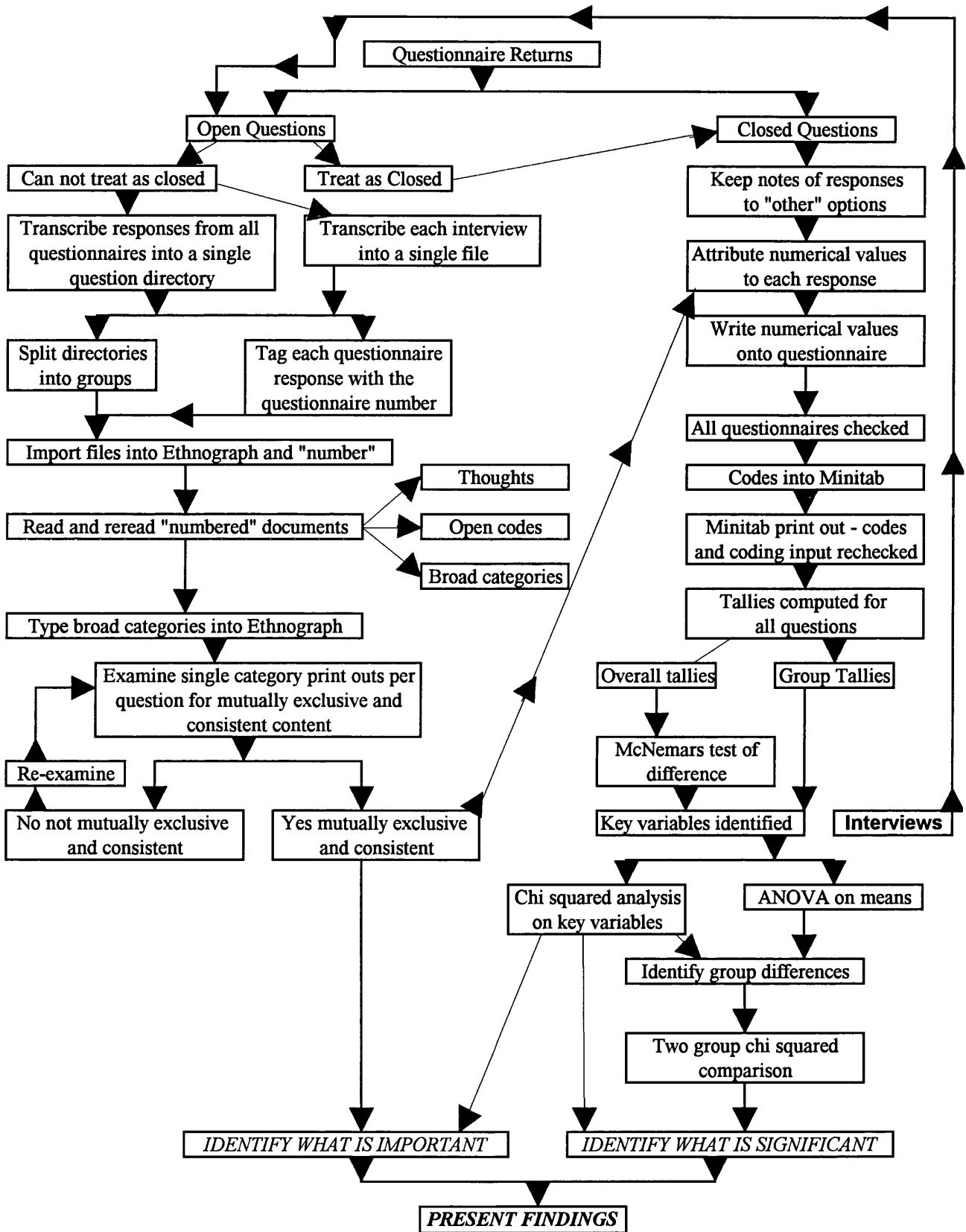
Therefore if the respondent ticked "Hospital: acute adult mental health" a number one was the relevant code. The appropriate numerical codes were entered directly into the boxes which were on the questionnaires in the "for office use only" column. If, the "other" option was ticked, respondents were always asked to specify, for example in this instance to specify what other area of employment. Each of these other options was written into the coding book and they were examined for commonality on completion of entering the codes. When writing in the code book all information was tagged to its questionnaire number to ensure that the original source could always be traced to check up on discrepancies and justify actions.

Of the 73 questionnaire items, 42 were closed questions where all options were specified and exclusive and the respondent had to tick the appropriate boxes. A further 12 items could be coded prior to the distribution of the questionnaires although they were strictly "open" in the sense that the responses were not pre-specified. An example of one of these questions was question 2 asking staff to give their job title. Although staff had to write out their title it was possible to compile a list of responses to be piloted, for example ward sister or staff nurse.

At pilot, two of the twelve "open" questions (11 and 12b) treated as closed were piloted as open questions. However, examination of the relevant literature and pilot responses revealed that a coding scheme could be formulated for them prior to the main study questionnaire distribution. To ensure that the codes for these two questions were appropriate for the main study data, a random sample (10%) of main study questionnaires were selected covering all study groups. All responses in all selected questionnaires could be attributed to one of the codes. Therefore, these questions were analysed in the same way as the other closed questions.

Having gone through all closed question items (or questions treated as closed), (n=54) and entered their numbers onto the questionnaires, these data were ready to enter into Minitab.

Figure 3.9 Data Analysis Process



3.9.2 Open Questions - Qualitative Data Analysis

It was not possible to identify coding frames for the remaining nineteen question items prior to questionnaire distribution. Consequently a method to post-code the responses was sought (Miles and Weitzman, 1994; Fielding and Lee, 1991). The Ethnograph (Seidel, Friese & Leonard, 1994) was located and utilised for the analysis of the qualitative data.

Miles and Weitzman (1994) maintain that when deciding which computer package to employ in one's analysis, consideration should be given to the researcher's computing skills, the anticipated analysis and the type of project. This study was a survey which required quantification of qualitative data for statistical analysis by a researcher who was a relative computer novice.

The manufacturers of the Ethnograph (Siedel, Friese & Leonard, 1994; Siedel, Kjolseth & Seymour, 1988) state that it facilitates the process of: noticing areas of interest in your data; marking those areas with code words and retrieving those areas for further analysis. The Ethnograph was chosen as the data analysis package for the following reasons; the manual was easy to follow for a novice; it facilitated the categorisation of questionnaire responses (quantification) and the organisation of the data; and promoted time efficiency and enhanced reliability and validity in coding.

3.9.3 Content Analysis

Content analysis was the qualitative analysis framework. Manifest (traditional, quantitative) content analysis was identified in the literature as the analysis method of choice for the questionnaire data (Field and Morse; 1985; Mostyn, 1985; Berelson, 1952). Manifest content analysis is consistent with the traditional content analysis emphasis of quantifying the qualitative data, that is identifies what is said rather than the why.

Despite the seemingly large number of studies that use open questionnaire items, there was limited literature identified for guidance on an appropriate content analysis structure and process.

The majority of the literature identifying content analysis structure and process referred to the analysis of unstructured interview data (Burnard 1994; Burnard, 1991; Lederman, 1991; Leninger, 1985; Mostyn, 1985; Weber, 1985). Consequently, the structure and process of content analysis described for interviews had to be adapted and the resultant process combined the work of several authors (Burnard 1994; Burnard, 1991; Lederman, 1991; Leninger, 1985; Mostyn, 1985; Weber, 1985). An overview of the process is shown in figure 3.9.

It was decided to use all questionnaires in content analysing the data despite the accepted practice of using a sample of questionnaires to create the categories (Polit and Hungler, 1991; Weber, 1985). This was because the use all questionnaires would promote the researcher's familiarity with the data. The group variability (multidisciplinary and multiple specialities) and small numbers in some groups made it difficult to obtain a representative sample of the respondent set. It was thought the time and effort saved by reducing the questionnaires would not compensate for the possible loss in comprehensive category generation.

Weber (1985) indicated that the first essential decision in the process of content analysis is to identify the unit of analysis (Weber, 1985). According to Weber's description of analysis units, the thematic unit of analysis was chosen for this study. That is each theme (single concept) is considered in isolation but the theme may be a single word, a phrase, a sentence or several sentences. The theme was the unit of analysis that most closely resembled the notion of identification of all ideas generated by staff.

The next stage of the process is immersion in the data and for this study involved the transcription of the raw data into data files using a word processor (Burnard, 1991). This task was completed by the researcher to promote familiarity with the data. Immersion was further facilitated by rereading the transcripts through twice while taking down notes on common issues, thoughts and ideas.

With such a large data set, data organisation was of extreme importance. A directory was created for each individual question and each directory comprised several files. A file contained all the data for one question from one group; for example all the data from question 22 for CPNs.

Each directory could be stored as a catalogue in Ethnograph, thus facilitating the ease of analysis. Importantly Ethnograph enabled the researcher to organise the data such that every response was tagged with its corresponding questionnaire number. Linking questionnaire numbers in this fashion allowed all responses to be traced back to their original source at all stages in the analysis process.

Once the data were organised, open coding followed with categories being generated to cover all the data. Broader categories were drawn from the open codes. These broader codes were entered in Ethnograph. Category print outs were obtained for all codes and examined for mutual exclusiveness and consistency of content. The entries in the "other" categories were also examined for statements that may be merged into existing categories or to generate further categories. Changes were made, for example merging similar categories or transferring statements to

appropriate codes. The process of reading the category print outs continued until the researcher was satisfied that the categories were consistent and mutually exclusive. Once the researcher was satisfied and the reliability and validity checks were complete (section 3.10), each variable was allocated a numerical code and the data were ready to enter into Minitab.

3.9.4 Quantitative Analysis

In accordance with the rationale for computing package choice previously identified by Miles and Weitzman (1994) (section 3.9.2) Minitab was chosen because it was designed for students learning statistics and as such was thought to be more "user friendly" than the other packages available. The researcher found Minitab useful and found it straightforward to understand the processes under which the data were being manipulated.

For the purposes of this study, respondents were grouped according to: grade, occupational group, hospital or community base and responsibilities of each post. The six groups were as shown in table 3.9.4.

Table 3.9.4 Study Groups for Data Analysis

Group	Description and rationale
HCA's	A and B grade staff as they are both untrained staff groups.
CDE grades	C, D & E grade hospital based nurses (staff and enrolled nurses) as all are qualified nurses with direct patient care responsibilities but less management responsibility than charge nurses.
FGH grades	F, G & H grade hospital based nurses (senior staff nurses and charge nurses). This group presented the greatest problem in defining groups. Some F grades had given their job title as staff nurse and others as charge nurse. However the decision was reached to group these together as they all had greater management responsibility than the CDE grades on job descriptions, and in the main study hospital F & G grades rarely worked together. Therefore F grades held the unit responsibility in the G grade's absence.
Professions Allied to Medicine	Occupational Therapists, Physiotherapists, Dieticians and their helpers. It was decided to group these professionals for the purpose of statistical analysis but where any one group differed from the norm presented, reference to this would be noted.
Community Residential staff	All grades of community residential staff. Trained and untrained staff together due to the small numbers in the overall group sample and their dissimilarity to the other groups.
Community Psychiatric Nurses	All nurses grades of nurses working from community bases (E, G & H grades). Grades were mixed due to the small numbers and similarity of the group population.

3.9.5 Statistical Tests and Data Analyses

The statistical analysis was a process of discrimination; that is the large data volume was rationalised by identification of the important and significant points.

In the first instance overall and group tallies were computed for all variables. Thus the issues identified most commonly by the staff and other important issues could be identified.

Subsequent discrimination used statistical tests. To identify the variables that were documented significantly most often, McNemar's test of difference was used on statistical advice and following discussion with study supervisors. Further analyses were computed for the significantly most important variables as identified by McNemars' test, those variables identified as being important (for example to skill identification) whether common or not, and those variables that were one of the three most common entries for any one group.

Group differences were tested using Chi-Squared test following consideration of the discriminatory process identified by Coolican (1990) in that the aim was to identify difference, the data were nominal, unrelated and numerical counts. A statistician was consulted and agreed with the chosen test and in addition suggested the use of ANOVA (One Way Analysis of Variance) to test difference across the mean number of aware statements (questions 23-33).

On statistical advice, all chi-squared test were across all six groups unless there were less than forty subjects in a category. In which case numbers of subjects were compressed into two groups, either hospital or community. This was to promote validity of statistical testing.

The chi squared test across six groups did not allow identification of the exact point or direction of significance. Consequently further chi squared tests were computed, for variables with group differences when tested across six groups, comparing two groups at a time allowing the direction of significance to be identified.

Level of significance was set at $p=0.01$ where the 1% margin of error was felt to be acceptable.

Thus following quantitative analysis, important issues and group differences could be identified. These issues were further explored at interview.

3.9.6 Stage Two: Analysis of Interview Data

Interview data were qualitative and smaller in volume than the questionnaire data. Analysis procedures followed the same format as those formulated for the qualitative questionnaire data but the ability to probe at interview enables some latent aspects to the analysis. Thus the researcher was aiming to enhance the questionnaire data that already existed; for example, by providing definitions of skill categories.

There were minor differences in the analysis from the analysis of the questionnaire data. Data were organised with each interview as a single file and each file was broken down by identification of the question asked.

Each question was considered as with the questionnaires, codes entered into Ethnograph, print outs examined and a short category list identified for descriptive purposes. The categories were examined for consistency and mutual exclusiveness and a short write up compiled of each category and stored as an Ethnograph file. These explanations were used to enhance the questionnaire data in the presentation of the findings.

3.9.7 Summary of Data Analyses

Data were analysed in a sequential, discriminatory process (overview figure 3.9). The most important and significant variables were identified and group differences computed using chi-squared test and ANOVA.

3.10 Reliability and Validity

In essence all of the above considerations were to promote reliability and validity of the study. However the main reliability and validity testing was completed during piloting where the questionnaire and interview prompt schedule could be tried out and discussed with participants similar to those in the main study.

3.10.1 Reliability and Validity In Study Design

The study design aimed to achieve maximum reliability and validity. The review of the literature revealed that the use of triangulation (Denzin, 1970; Campbell and Fiske, 1959) was one vehicle to improve validity in particular.

Jick (1979) maintains that triangulation is a continuum from the more complex multiple design studies to the more simple studies aiming to use triangulation to create a more complete picture of the problem. In this study context, triangulation improved validity through the creation of a more complete picture (Jick, 1979) and by validating previous information with respondents.

3.10.2 Validity in Study Data Collection Tools

Validity of responses is essential to enable meaningful interpretation of results (Oppenheim, 1995; Poitl and Hungler, 1991). Validity requires that the researcher get at the truth. All steps in questionnaire and interview design were aimed at improving validity (section 3.5); for example avoidance of leading questions.

Content validity (Polit and Hungler, 1991) aims for the content of the data collection tool to accurately reflect the nature of the research questions. In this study it was addressed by the completion of a thorough literature review of the skill and information needs of mental health staff. In addition, content validity was enhanced during the initial consultations (section 3.4) by identification of the issues for staff at a local level. The appropriateness of the content was also discussed with the steering committee and study supervisors and most importantly tested during pilot studies. Some alterations were made to questionnaires following pilot (section 3.7).

Content validity of the semi-structured interview schedule was achieved through the use of the most important variables identified from the questionnaires, through discussion with study supervisors and during the pre pilot and pilot studies. Thus interview content reflected study findings and the reality of the problems as expressed by participants.

Face validity aims to identify that a tool appears to measure what it is intended to measure. In this study face validity was achieved by questioning of pilot study respondents. Following discussions with pilot study participants some alterations were made to the letter of consent making the content of the questionnaire more explicit to the respondent and the face validity was then considered adequate. Following pre pilot and pilot of the interview schedule discussion indicated that face

validity was acceptable. It is considered that content validity is a better indication of validity than face validity (Oppenheim, 1992).

For the interviews, the researcher had to ensure validity of the recorded data. In this study, validity of responses was ensured through the use of field notes recorded by the researcher by hand during interviews and validated with respondents during the interviews. It was felt that this was beneficial by limiting the data volume produced and by the researcher ensuring that she had accurately interpreted and recorded what was said with each respondent.

3.10.3 Reliability of Data Collection Tools

Reliability is an issue of consistency (Polit and Hungler, 1991). Consistency in questionnaires and interviews is achieved by all respondents have the same understanding of the same question, described by Oppenheim (1992) as "stimulus equivalence". For both questionnaires and interviews, the way in which a question is posed could be a source of bias, for example if a question is leading. For interviews, the interviewer could be the source of bias; for example if an interviewer noticeably agrees with a respondents answers.

Reliability in the questionnaires and interviews was promoted by all the actions given in section 3.5 pertaining to design of the tools. For example avoidance of ambiguous questions.

In addition all interviews were conducted by a single individual (the researcher) using a semi structured prompt schedule. The researcher attempted to be consistent on all occasions, adopting a neutral stance and not "leading" the respondents. The prompt schedule was adhered to for all interviewees. It is accepted that complete consistency in approach and total impartiality are impossible to achieve within a semi-structured format, nonetheless, consistency was inferred through the use of a single investigator and adherence to the prompt schedule.

The main reliability testing of the questionnaire and interview schedule was tested during the pilot phase (section 3.7) through examination of responses and participant discussion. For example, where participants recognised different meanings, discussions were undertaken about more appropriate wording to improve a more global comprehensibility.

3.10.4 Validity In Data Analysis

Validity of the qualitative analysis was facilitated by the use of Ethnograph. The Ethnograph enabled the researcher to print out individual categories for examination and subsequent manipulation of these categories was straight forward in Ethnograph functions. This promoted validity because data were easily examined a a single set and therefore inconsistencies could be easily identified and altered thus promoting accuracy.

Validity of coding was checked by giving two transcripts to a study supervisor. One of the transcripts the researcher had coded at the start of the process and one at the end. These were chosen to assess consistency over time. In both instances the researcher's and the supervisor's coding incorporated the same ideas and the categories were grouped in the same way.

Having finalised the coding frame for the open questions, two colleagues were given completed questionnaires. The questionnaires were completed using a random stratified sample (every tenth questionnaire) of all study groups. They were given also given the completed coding lists and asked to code the responses. Discrepancies were identified between the researcher's coding of the responses and the coding of her colleagues. On discussion, these discrepancies were identified to be in the code descriptions in that the descriptions required to be more comprehensive and more clearly identify their boundaries. Improvements to the code descriptions were discussed with the colleagues and changes made to improve the coding frame. The questionnaire coding was again discussed with the colleagues following changes and thought to be improved. Thus the categories were considered to reflect the true nature of the responses.

To ensure validity of coding entry into the database, each questionnaire response was checked against the original Ethnograph coding prior to codes being put onto spread sheets by a data preparation service. The service guaranteed that all records were checked by the person putting in the data and validated by another operator. The spread sheets were then converted to Minitab worksheets. A print out was taken of the Minitab worksheet and every tenth record checked to identify errors in coding input. An error was found in half the questionnaires and every record for every questionnaire was therefore rechecked by the researcher. Final checks were made when tallying all numbers to assess for abherent codes and thus further cleanse the data. Thus the codes for quantitative analysis were considered to accurately reflect the codes on the questionnaires and in the coding book.

3.10.5 Reliability in Data Analysis

Reliability of data analysis was facilitated by the researcher completing most stages of the analysis herself using predefined analysis structures which were acceptable to study supervisors and the statistician. The exceptions are indicated below.

Reliability in data coding was checked by obtaining lists of codes from all files from Ethnograph and examining these lists for discrepancies such as spelling errors. Reliability of numerical coding was checked by the researcher going through all questionnaires with the finalised coding lists and recoding all the data, first and second codings only showed minimal differences. Therefore the coding was considered reliable.

3.10.6 Summary of Reliability and Validity

Attempts were made to achieve reliability and validity of the data through the use of triangulation in study design, methods employed in tool construction and piloting and in methods of data analysis.

Chapter Four:

Presentation of the Findings

4.0 Introduction

The findings are presented in five sections: the response rates, the demographic data, the educational data, the skills data and the knowledge of reforms data.

The following points should be noted:

- interview data are used to expand on questionnaire data where appropriate;
- as not all respondents answered all questions, the percentages refer to the percentage of respondents answering each question;
- although all tables and figures are displayed with percentages, chi squared calculations used numbers of respondents;
- due to the small number in some study groups, for example 12 community residential staff, it was unlikely that statistical group comparisons for these small groups were going to identify differences;
- chi-squared values were calculated across six groups and if significant group by group comparisons were made. While it was possible to present all group by group calculations it was thought that to do so overwhelmed the findings with statistics. Therefore statistics for six group comparisons are presented and reference is made in the text to the direction of significance identified by group to group comparison. An example of the group by group statistical calculations and the appropriate six group statistical comparison is presented in Appendix 4.

4.1 Response Rates

Table 4.1 shows the response rates for each study group, the numbers in each group who volunteered for interview and the number interviewed. The overall response rate was 36%.

As can be seen (table 4.1) the response rates to the questionnaires varied between groups (26-86%). A total of 20 staff were interviewed.

Given the low response rate overall at questionnaire and the variations in response rates between groups, participants were asked at interview why they thought there was such a low return rate for the questionnaires. The main reasons given were:

- an overall negative attitude among the employees, for example, apathy, low morale;
- concern regarding confidentiality and anonymity of questionnaire data;
- negativity to questionnaires in general;
- there were too many questionnaires being circulated in the Trust at the time.

Table 4.1 Response rates and interviewees by group

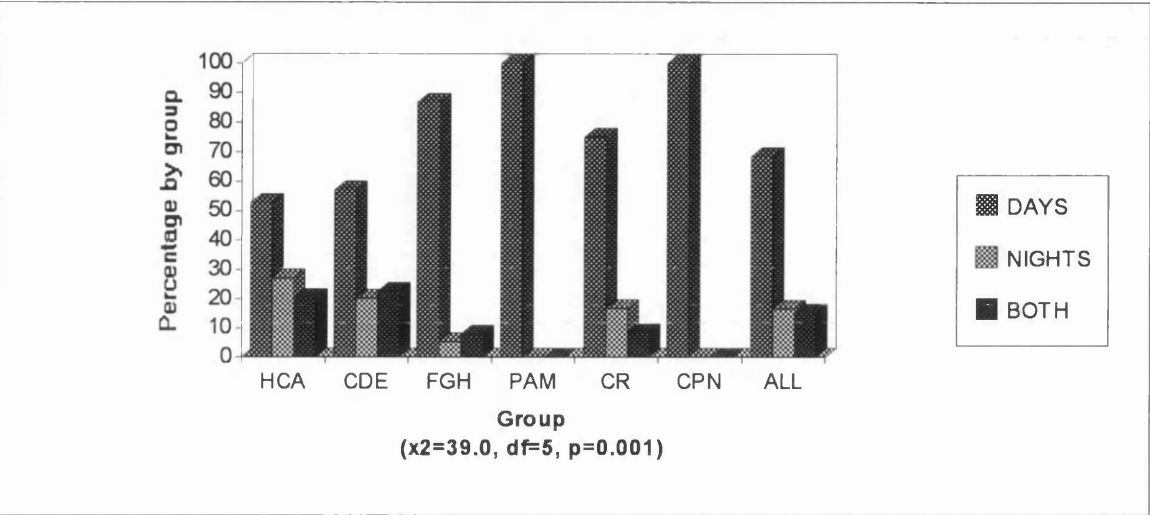
GROUP	RESPONSE RATE % (number of respondents)	No. CONSENTED TO INTERVIEW	No. INTERVIEWED
Community			
CPN	86 % (n=19)	13	2
Community Residential	37.5 % (n=12)	7	1
<i>Total Community</i>	<i>57 % (n=31)</i>	<i>20</i>	<i>3</i>
PAM			
OT	77 % (n=10)	6	1
Physiotherapist	71 % (n=5)	1	1
Dieticians	100 % (n=3)	2	1
Paramedical Helpers	45 % (n=5)	1	1
<i>Total PAM</i>	<i>68 % (n=23)</i>	<i>10</i>	<i>4</i>
Hospital Nurses			
F/G/H grades	57 % (n=38)	17	3
C/D/E grades	33 % (n=84)	27	7
HCA's	26 % (n=75)	7	3
<i>Total Hospital Nurses</i>	<i>32 % (n=197)</i>	<i>51</i>	<i>13</i>
<u>OVERALL TOTALS</u>	<u>36 % (n=251)</u>	<u>81</u>	<u>20</u>

4.2 The Demographic Data

4.2.1 Shift and Hours Worked

As can be seen in Figure 4.2.1 the majority of respondents worked day shift (68.4%) with all CPNs and PAMs and 87% of FGH grades working day shift only.

Figure 4.2.1 Shift by Group (%)

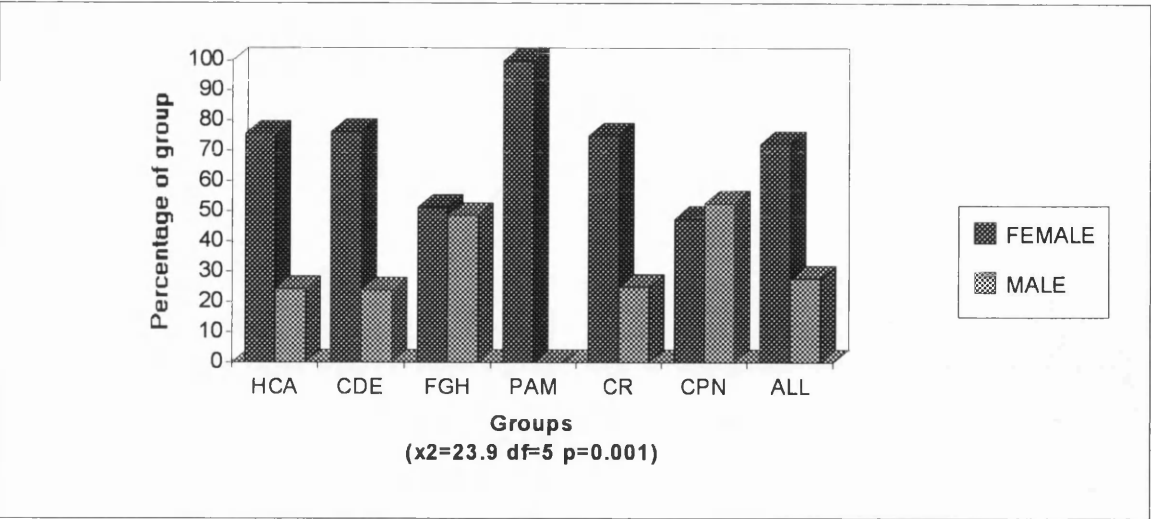


The majority of respondents (85.3%) worked full-time but there were group differences ($\chi^2=20.2$, $df=5$, $p=0.01$) in that PAMs were significantly more likely to be part-time than trained nurses (CDE and FGH grades) and CDE grades significantly more likely to work part-time than FGH grades.

4.2.2 Gender

It can be seen (figure 4.2.2) that the majority (72.3%) of the respondents were female but there were group differences ($\chi^2=23.9$ $df=5$ $p=0.001$). In particular, more FGH grades (48.6%) and CPNs (52.6%) were male and all PAMs were female.

Figure 4.2.2 Distribution of Respondents by gender (Group %)



4.2.3 Age and Speciality

Respondents came from all age groups and work areas. As expected CDE grades were younger than other groups in that they were more likely to be 20-29 years ($x^2=21.8$, $df=5$, $p=0.001$). There were significantly more HCAs than FGH grade respondents ($x^2=12.0$, $df=1$, $p=0.001$) in the elderly continuing care area.

4.2.4 Length of Employment in Current Post and Working with the Mentally ill

Respondents had been in their present post and worked with the mentally ill for varying lengths of time with 45.8% of respondents having worked with the mentally ill for greater than ten years. However there were group differences in that:

- as expected CDE grade nurses and community residential staff had spent fewer years in their current post (1-3 years in present post, $x^2=23.5$ $df=5$ $p=0.001$);
- HCAs were significantly more likely to have spent greater than 10 years in their post than CDE grades and community residential staff ($x^2=16.3$ $df=5$ $p=0.001$);
- FGH grades were significantly more likely to have worked with the mentally ill for greater than 10 years than all other groups except CPNs ($x^2 = 22.0$ $df=5$ $p=0.001$).

4.2.5 Summary of Demographic Findings

The demographic data indicated that respondents came from all study groups, specialities, age groups, shifts, hours worked, and had spent a wide range of time in their present post and with the mentally ill.

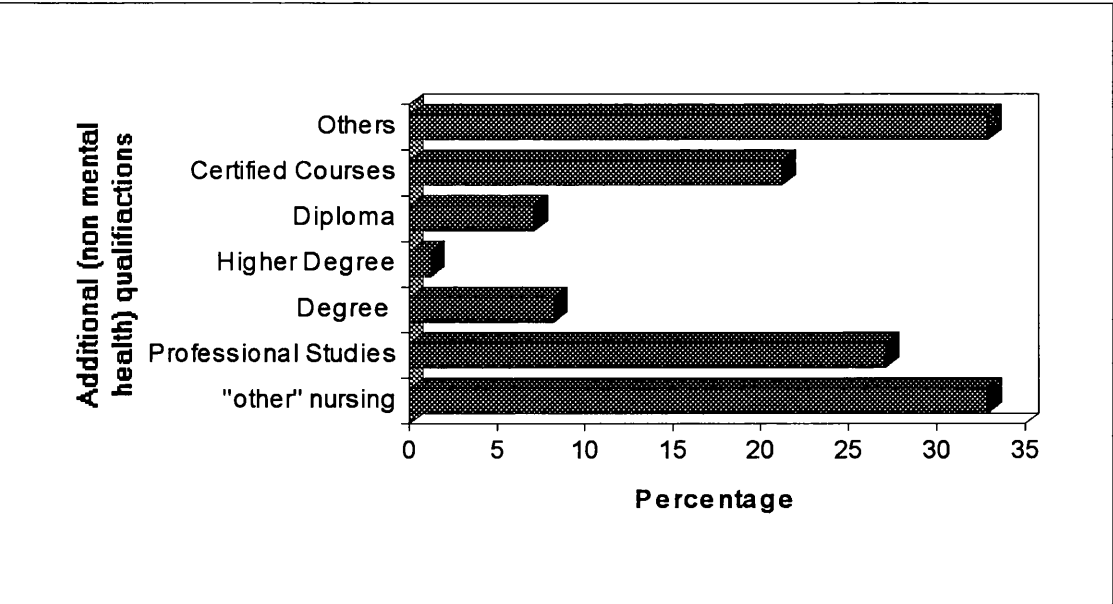
4.3 The Educational Data

4.3.1 Qualifications

Respondents were asked to indicate from a fixed set of responses the qualifications they had in relation to mental health care. As expected: most HCAs (n=54) were unqualified but some (n=13) had SCOTVEC (Scottish Vocational and Educational Certificates) training and three had other relevant training. Nurses were either RMN or EN certified with 52.6% of CPNs having a CPN Diploma while some nurses had other mental health-related qualifications. The PAMs all held a degree or diploma relevant to their profession with 2 helpers having SCOTVEC training. Of the 12 community residential staff, six were RMN or had SCOTVEC, 2 were unqualified and 4 had other mental health-related qualifications.

As can be seen in **Figure 4.3.1**, 85 (33.9%) respondents had qualifications additional to those in mental health. The most common additional qualifications held were: other nursing registrations, such as RGN; the miscellaneous group "others" which included certificates for supervising learners; and at least one module of professional studies.

Figure 4.3.1, Additional (non mental health) qualifications



4.3.2 Attendance and Usefulness of Community Courses

When asked if they had attended any courses/ seminars that would help to move to a community post, 50 respondents said "yes". Fifteen had been on the 6 week Trust community training, 10 on SCOTVEC and 9 on specialist training. The majority had attended courses locally either at the Trust training centre or the College of Nursing and Midwifery (n=26). Most courses were up to and including 6 months and completed in 1993 or 1994.

When the 50 participants who attended useful community preparation courses were asked concerning the usefulness of the courses attended (n=34), they noted gaining knowledge, issues related to client care such as increased understanding of clients rights and working with the MDT as beneficial. However some respondents (n=19) also noted that: some courses were too short; that certain information (not specified) was omitted; and that not all co-workers were helpful during their learning experience, for example not supportive of a student on a learning placement.

4.3.3 Keeping Up-to-Date with Changes in Patient Care

Respondents were asked if and how they kept up to date with new developments in patient care (n=248). Fifteen respondents (6%) said that they did not keep up to date and, of these, ten were HCAs. The respondents who said that they did keep up to date (n=233) and gave an indication as to how, each gave an average of 2.0 updating methods. The four most common responses were: using the literature (66.7%), formal education (39.6%), informal discussion (26.6%) and through management literature (21.6%). However, there were however group differences.

Figures 4.3.3a and 4.3.3b indicate that HCAs were significantly less likely to say that they kept up to date by reading the literature and formal education than all groups of trained nurses and PAMs. However HCAs documented literature from management significantly more (figure 4.3.3c) than FGH grades and CPNs. FGH grades also documented literature significantly more than CDE grades (figure 4.3.3a).

Figure 4.3.3a Group percentages of respondents using literature to update about changes in patient care

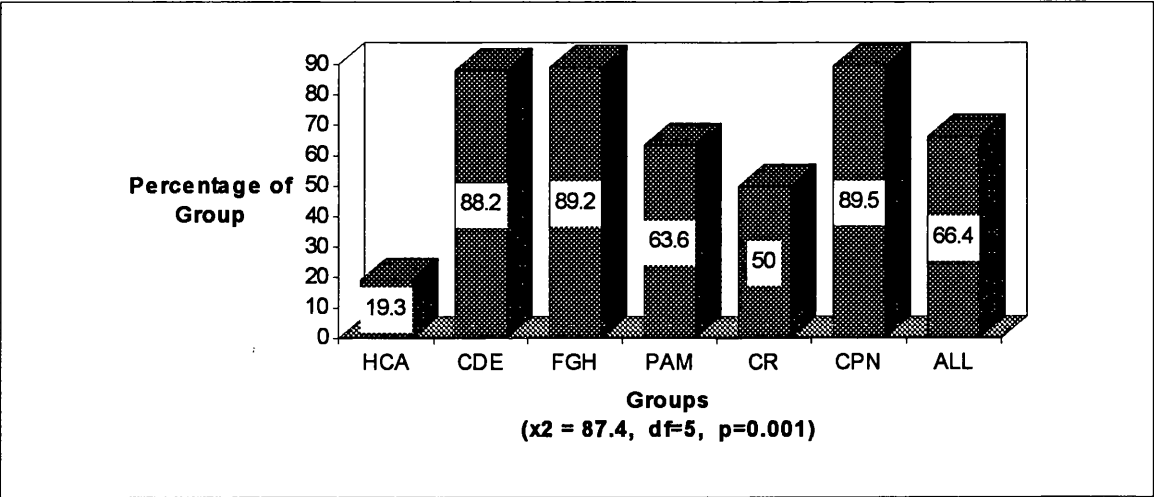


Figure 4.3.3b Formal education as a means of updating about patient care by group percentage

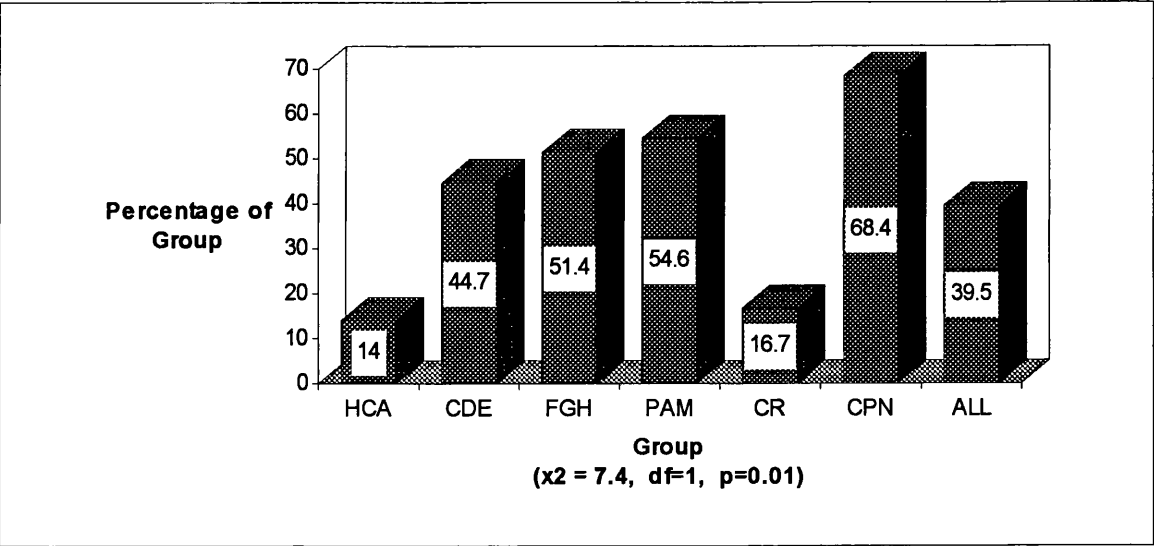
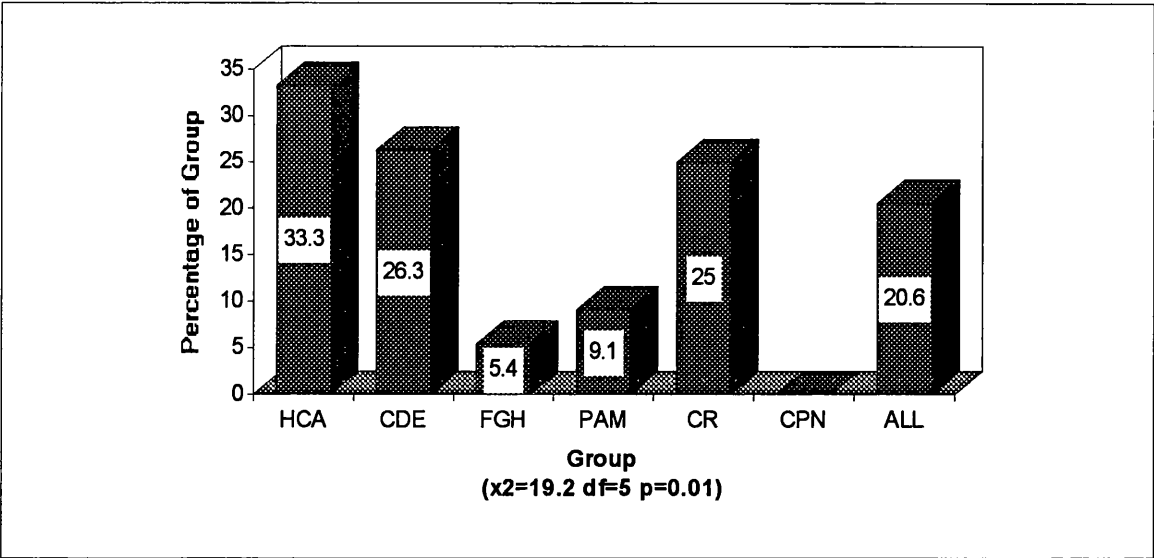


Figure 4.3.3c Using management literature to update about patient care by groups (%)



When asked which, if any, professional journals they had read in the past two weeks, 102 respondents answered. A total of 35 respondents said that they had not read any journals in the last two weeks. Of the 67 who had, Nursing Times (n=41) and Nursing Standard (n=23) were the most common responses from nursing staff and Therapy Weekly from PAMs (n=7).

4.3.4 Summary of the Educational Data

The majority of the hospital based respondents and under half of the community respondents did not have a community qualification either as a formal qualification or an additional qualification. Some participants had attended courses that were useful for the community.

Respondents said that they employed a variety of methods to keep up to date with changes in patient care but the methods used differed between the study groups.

4.4 The Clinical Strengths of Mental Health Staff

4.4.1 Skills of Mental Health Staff

A total of 72.3% of respondents from all study groups indicated that hospital and community staff used different skills.

Respondents were asked to prioritise their top five skills that they considered essential for their current working environment. The majority of respondents answered this question (92.8%) each person giving an average of 4.5 skills. Forty one skill categories were generated from the responses (appendix 5). These 41 categories could be grouped to form six broad categories (appendix 5).

The six broad categories were: interpersonal skills, providing care skills, possessing knowledge, management skills, personal qualities and "others". The data presented in section 4.4.1 is data analysed from question 17 (appendix 2). The most important and significant variables are discussed below under the heading of the broad skill category. The skill differences between the groups are then presented.

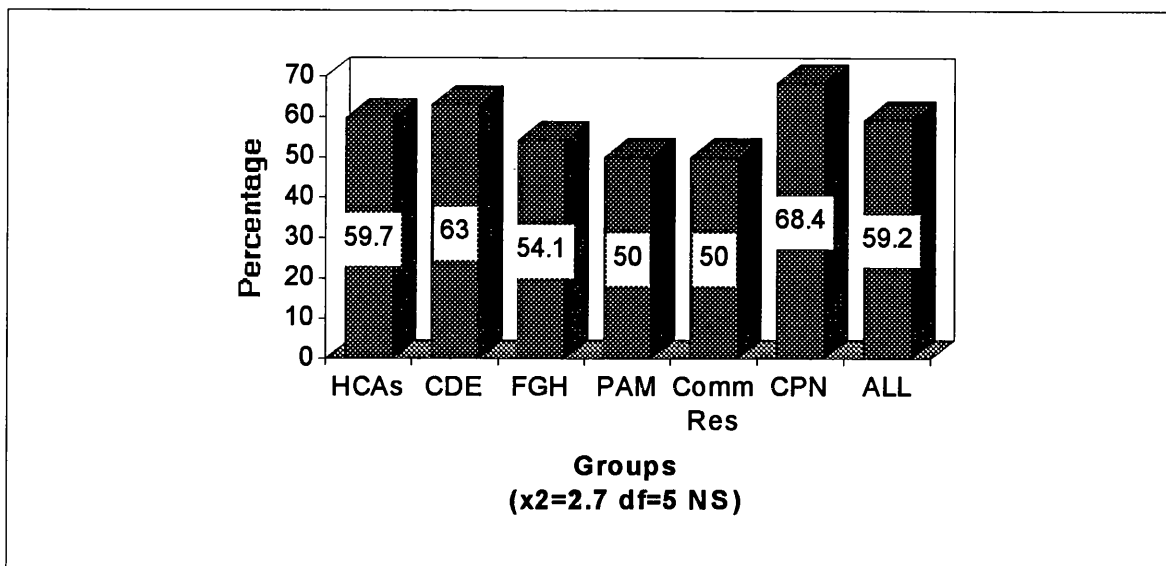
4.4.2 Interpersonal Skills

The broad group, interpersonal skills includes the sub-categories of communication, counselling, listening and liaison (appendix 5). Examination of Table 4.4.7 and Figure 4.4.8 reveals the perceived importance of interpersonal skills.

4.4.2.1 Communication and Listening Skills

Figures 4.4.9.1 to 4.4.9.6 indicate that all groups prioritised communication as number one when asked about the skills essential for their current post. Figure 4.4.2.1 shows the percentages of respondents in each group that had documented communication within their top five. It is evident that all groups perceived communication skills to be important.

Figure 4.4.2.1 Percentages of respondents prioritising communication in their top five skills



Listening was the sixth top scoring skill (figure 4.4.8), it was fifth for FGH grade nurses and second for community residential staff. More information was sought about communication and listening at interview.

The 20 questionnaire respondents who were interviewed defined communication as an interpersonal interaction that takes on many forms such as verbal and non verbal forms. Although listening may be considered a distinct skill, the ability to listen was considered to be so central to the ability to communicate that listening was generally considered to be a component part. The perceived importance of communication was linked to the need to transfer information, "for the patients", centrality to the job and because communication has a purpose.

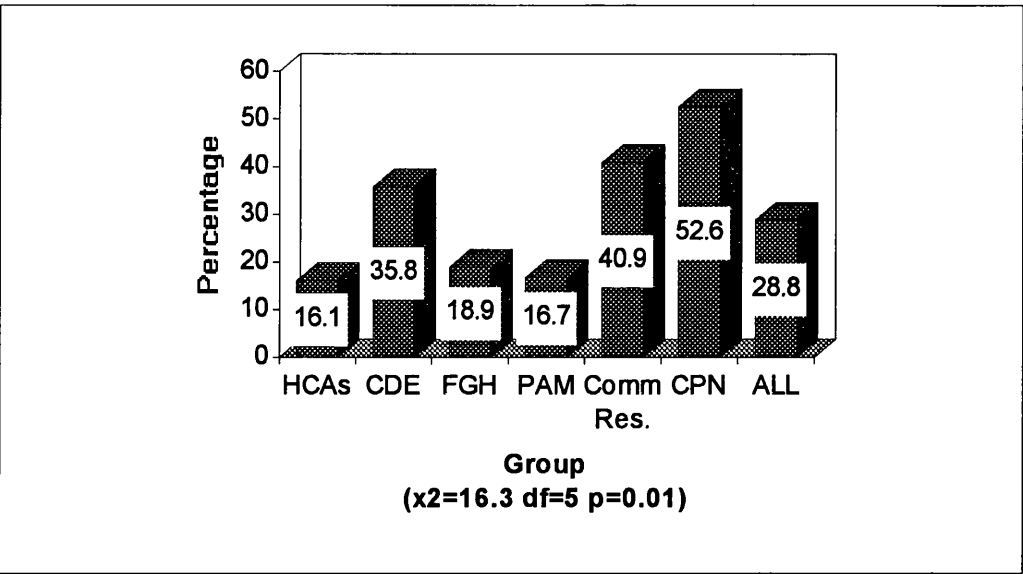
4.4.2.2 Liaison

Liaison was the second highest scoring skill overall (figure 4.4.8). It scored within the top five for the CPNs, PAMs and the CDE grades (figures 4.4.9.6, 4.4.9.4 & 4.4.9.2). There were group differences in the perception of liaison as important (Figure 4.4.2.2) in that CPNs were significantly more likely to perceive liaison as important than HCA's and FGH grades and CDE grades perceived its importance more than HCA's.

Data from questionnaires and interviews suggests that liaison involves working in a team such as sharing information about clients, involves networking and moving towards common goals. Hospital and community liaison were thought to be the same (interview data). The purpose of

liaison was to ensure all staff know their role, "using" other professionals skills to compliment ones own, working for the clients and to enable staff to share information and therefore improve service efficiency.

Figure 4.4.2.2 Percentages of respondents listing liaison in their top five skills

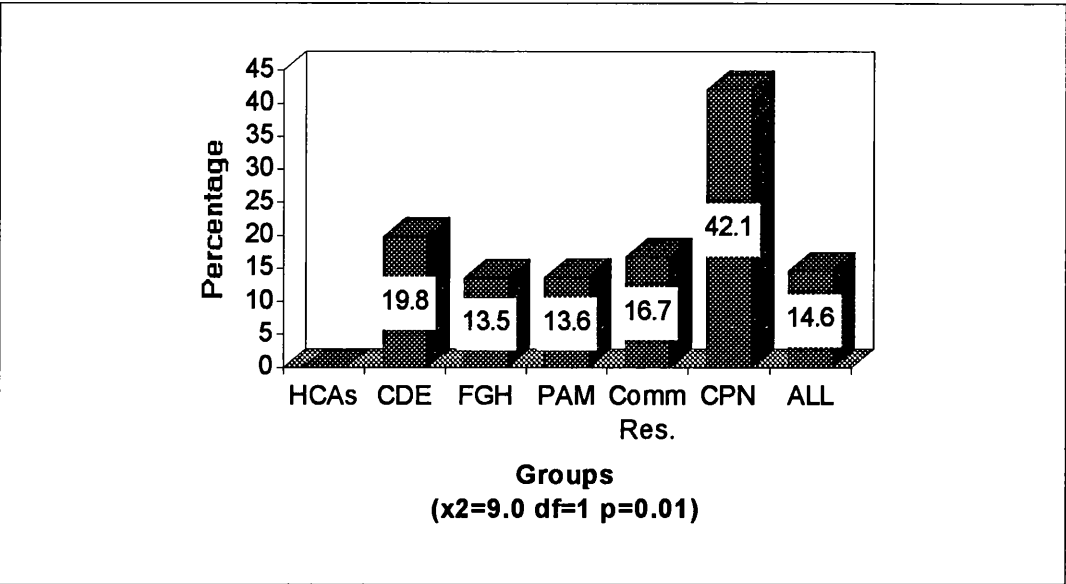


4.4.2.3 Counselling

Counselling was the eighth scoring skill overall (figure 4.4.8) and was second for CPNs (figure 4.4.9.6) and fourth for CDE grades (figure 4.4.9.2). Interestingly, no HCAs perceived counselling as one of the top five skills that was important for them (figure 4.4.9.1). Due to the small numbers (n=34) who indicated the importance of this skill comparison across all groups was not possible, hospital to community comparison was therefore carried out and community respondents were found to be significantly more likely to perceive counselling as important than hospital respondents (Figure 4.4.2.3).

At interview participants were asked to give a definition of counselling. Interviewees gave mixed definitions. On the one hand interviewees defined counselling as a means of advising others in a formal or informal context and on the other hand counselling was defined as was working with individuals to allow them to come to their own decisions.

Figure 4.4.2.3 Group percentages of respondents who perceived counselling as one of their top five skills



4.4.3 Providing Care Skills

A second broad skill category generated when participants were asked to identify and prioritise their top five skills was providing care skills (appendix 5). As a group the skills for providing care were: implementation, observation, assessment, crisis, group work, rehabilitation, environment monitoring, therapeutic use of self, treating clients as individuals and advocacy (appendix 5).

Implementing care was the third highest scoring skill (figure 4.4.8) and rated in the HCA, CDE grade, PAM and community residential staffs' top five (figures 4.4.9.1, 4.4.9.2, 4.4.9.4, 4.4.9.5). As expected, there were no significant group differences for the choice of implementing care as a top five essential skill ($\chi^2=6.5$ $df=5$ NS). This finding was expected because the study sample were chosen to select the multidisciplinary team staff who had the greatest patient contact.

Assessment was not one of the overall top ten skills but was in the CPN and PAM top five (figure 4.4.9.6 and 4.4.9.4). There was no significant group difference for this variable ($\chi^2=4.2$ $df=1$ NS).

When asked to define assessment at interview, participants defined assessment as identification of issues for a person. That was issues that involved finding out about the "whole person", or identification of their problems and needs. It was also planning and evaluating their care. Other related issues were liaising with others to gain information and that assessment might be a continual process.

For most interviewees the assessment had two strands: obtaining a set of information and using various methods to obtain this information such as communication or observation. The information related to any aspect of the person e.g. physical or mental state or could be specific to an individual mental health workers role such as OT kitchen assessment.

4.4.4 Possession of Knowledge

Interestingly when asked about clinical strengths, many respondents documented possession of knowledge as one of their five essential skills. The broad category possession of knowledge grouped together seven subcategories relating to possessing knowledge in various aspects of mental health, such as knowledge of medication and its effects (appendix 5). The statistical comparison for the broad knowledge group indicated group differences ($\chi^2=15.8$ df=5 $p=0.01$) in that HCAs were less likely to rate knowledge as a top five essential skill. Examination of the sub category possession of knowledge in general revealed group differences which are presented below.

The sub category of knowledge (general) included all non specific references to possession of knowledge (appendix 5). It was the fourth highest scoring skill (figure 4.4.8) and was in the FGH grade and PAM top five figures 4.4.9.3 and 4.4.9.4).

FGH grades and PAMs were significantly more likely to rate knowledge as a top five essential skill than HCAs ($\chi^2=16.0$ df=5 $p=0.01$).

4.4.5 Management Skills

Management skills formed another broad skill category. The five management skills grouped together to form the broad category were management skills (general), organisational skills, empowering or enabling or motivating or facilitating skills, support skills, leadership skills and autonomy. Statistical analysis when taking the five subcategories together as the broad category indicated a highly significant group difference ($\chi^2=45.1$ df=5 $p=0.001$) in that FGH grades were more likely to rate these skills that the other groups.

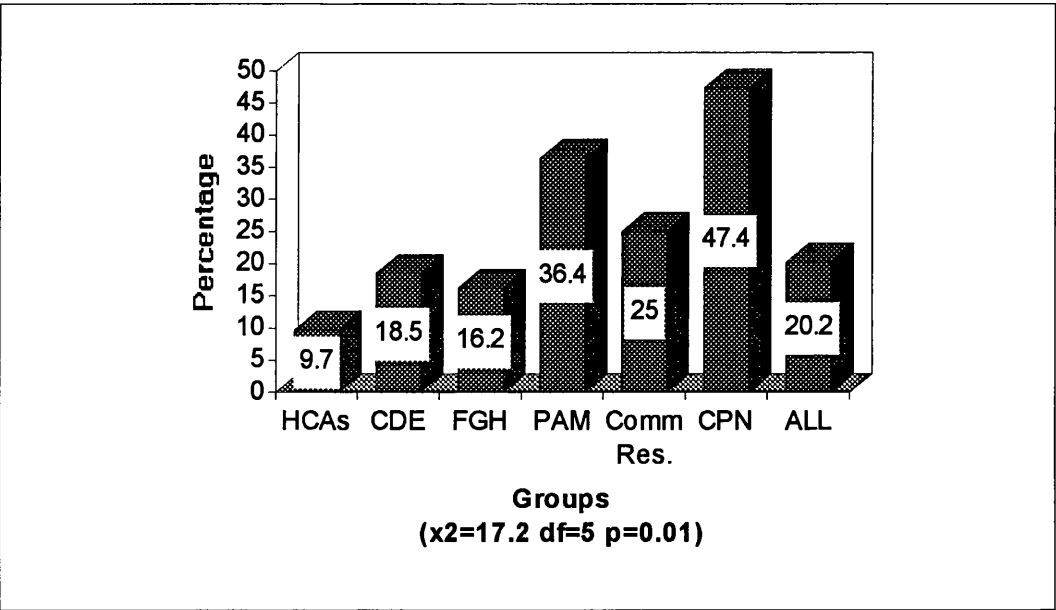
Interview and questionnaire data defined management skills as skills related with organising and supporting others, resource allocation and service efficiency. These skills affect the patients

through their effect on the staff or direct effect on patients e.g. through resources and through enhancing broader service efficiency.

Management as a sub category was the ninth scoring skill (figure 4.4.8). Both management and leadership skills were only in the FGH grades top five skills (figure 4.4.9.3). There were no significant group differences for either variable (management, $\chi^2=0.8$ df=1 NS: leadership, $\chi^2=0.1$ df=1 NS).

Autonomy was the seventh highest scoring skill (figure 4.4.8) and was in the CPN and PAM top five (figures 4.4.1.8.6 and 4.4.1.8.4). There were significant group differences (figure 4.4.5) in that CPNs and PAMs were significantly more likely to perceive autonomy as important than HCAs and CPNs more important than CDE grades.

Figure 4.4.5 The group percentages of respondents indicating autonomy as one of their top five skills



Definitions from questionnaire responses and from asking participants at interview indicated that autonomy was a skill related to working alone without the immediate help of others, including the ability to manage oneself, be accountable, and make one's own decisions. Most interviewees thought that they had some autonomy in their role but that "total autonomy" is often constrained by other factors such as managers influence. Seven interviewees from all groups thought that they were autonomous and two did not, both hospital workers.

When asked about preparing staff for an increase in autonomy four issues emerged at interview. The first was that it was not possible to prepare for an increase in autonomy, the second was through discussion, the third was non specific references to education and the fourth to find out about resources and this will indirectly improve autonomy.

4.4.6 Personal Qualities

The fifth broad category generated by grouping the subcategories was personal qualities and contained 13 sub categories (appendix 5). Analysing the 13 categories together identified a significant group difference for the broad personal quality category ($\chi^2=22.1$ $df=5$ $p=0.01$). This group of skills was particularly dominant in the HCA group with three of the HCA top five being personal qualities (figure 4.4.9.1).

Understanding was in the top five for HCAs and community residential respondents. Empathy was in the top five for CDE grades and was the tenth highest scoring skill.

One of the subcategories of personal qualities was patience. Patience was the fifth overall scoring skill (figure 4.4.8) and was the second HCA skill (figure 4.4.9.1). Interestingly no CPNs indicated patience in their top five skills. This difference was significant ($\chi^2=22.1$ $df=5$ $p=0.001$) in that HCAs were significantly more likely to rate patience in their top five than all trained nurses (hospital and community).

4.4.7 The Skills Prioritised as Most Important

The skills that respondents prioritised as their number one essential skill from the 41 subcategories were analysed separately. All groups were most likely to rate communication as their most important skill but the consensus of opinion within groups was low (Table 4.4.7); for example 21% of HCAs rated communication as their most important skill, while a further 11% said that implementation of care was their most important skill and a further 10% that patience was their most important skill. Although the skills ranked two and three differed between the study groups, no significant differences were identified between the variables presented in table 4.4.7.

Table 4.4.7 The first essential skills as perceived by percentage by group

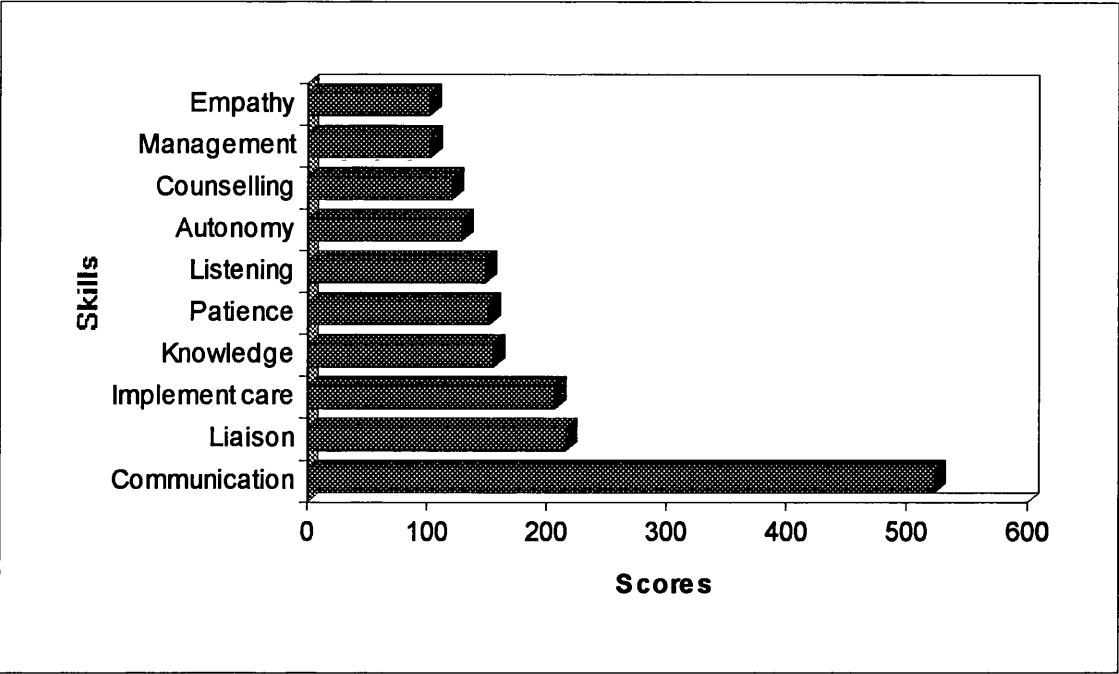
Groups N=	HCA's 62	C/D/E 81	F/G/H 37	PAMs 22	CR 12	CPN 19	ALL 233
RANK 1 <i>group %</i>	communi- cation <i>21</i>	communi- cation <i>32</i>	communi- cation <i>22</i>	communi- cation <i>18</i>	communi- cation <i>25</i>	communi- cation <i>37</i>	communi- cation <i>26</i>
RANK 2 <i>group %</i>	implement care <i>11</i>	liaison <i>10</i>	manage- ment <i>19</i>	knowledge <i>14</i> autonomy <i>14</i>	listening <i>17</i>	counsel <i>16</i>	possess knowledge <i>6</i> implement <i>6</i>
RANK 3 <i>group %</i>	patience <i>10</i>	patience <i>7</i>	possess knowledge <i>13</i>		numbers too small	numbers too small	

4.4.8 Prioritization of Five Essential Skills

Respondents were asked to identify their top five essential skills and to prioritise the skills they identified. The skills the respondents prioritised as most important were given a score of five, those that were second were allocated a score of four and so on. **Figure 4.4.8** indicates the overall top ten scoring skills taking into account the scores from all groups from all variables.

Figure 4.4.8 indicates that communication, liaison, listening and counselling, the four skills grouped together to form the broad category interpersonal skills, all featured in the overall top ten scoring skills. Patience and empathy, both subcategories of personal qualities featured, in the top ten. Autonomy and management (subcategory) skills were seventh and ninth respectively as subcategories of the broad category of management. Implementing care as a subcategory of providing care skills was the third highest scoring skill and knowledge (general) as a sub category of the broad knowledge category was fourth.

Figure 4.4.8 Top ten scoring skills



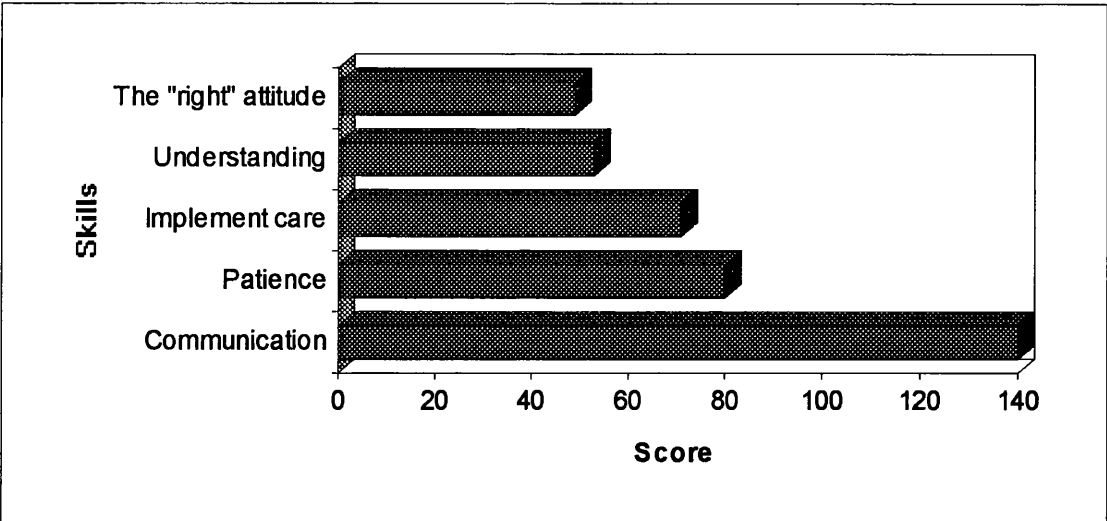
4.4.9 Group Differences in Essential Skills Prioritised

There were group differences in the skills each group prioritised. **Figures 4.4.9.1 to 4.4.9.6** indicate the top scoring skills for each study group.

4.4.9.1 Health Care Assistant's (HCAs) Skills

Figure 4.4.9.1 indicates that HCAs (n=75) top five skills placed emphasis on communication, care giving and personal qualities. Like the other study groups HCAs prioritised communication and implementing care within their top five essential skills. However they differed from the other study groups in their perception of the importance of skills grouped as personal qualities. In particular they ranked patience, understanding and having the "right" attitude with their top five scoring skills. They were significantly different from the other study groups in their ranking of patience ($\chi^2=22.1$ df=5 p=0.001).

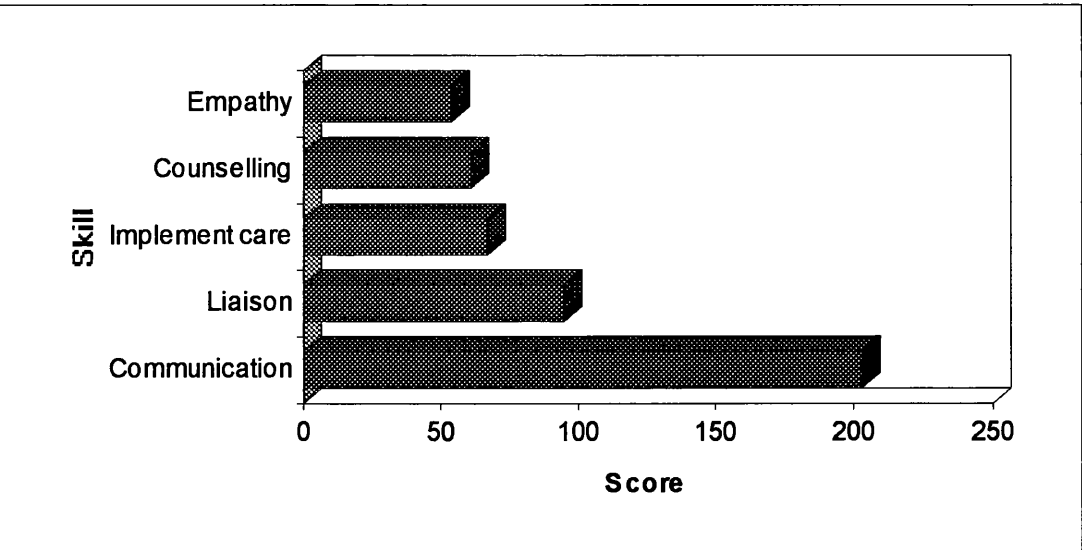
Figure 4.4.9.1 Top five Health Care Assistants' (HCA) skills



4.4.9.2 CDE Grade Hospital Based Nurses Skills

Figure 4.4.9.2 indicates that CDE grade's prioritised interpersonal and care giving skills. Similarly to other study groups they prioritised communication and implementing care within their top five scoring skills. As well as communication , they also rated two other interpersonal skills within their top five: counselling and liaison. In this they were similar to the CPNs but were significantly different from the HCAs for liaison ($\chi^2=16.3$ df=5 p=0.01). CDE grades were the only study group to rate empathy within their top five scoring skills ($\chi^2=0.1$ df=1 NS).

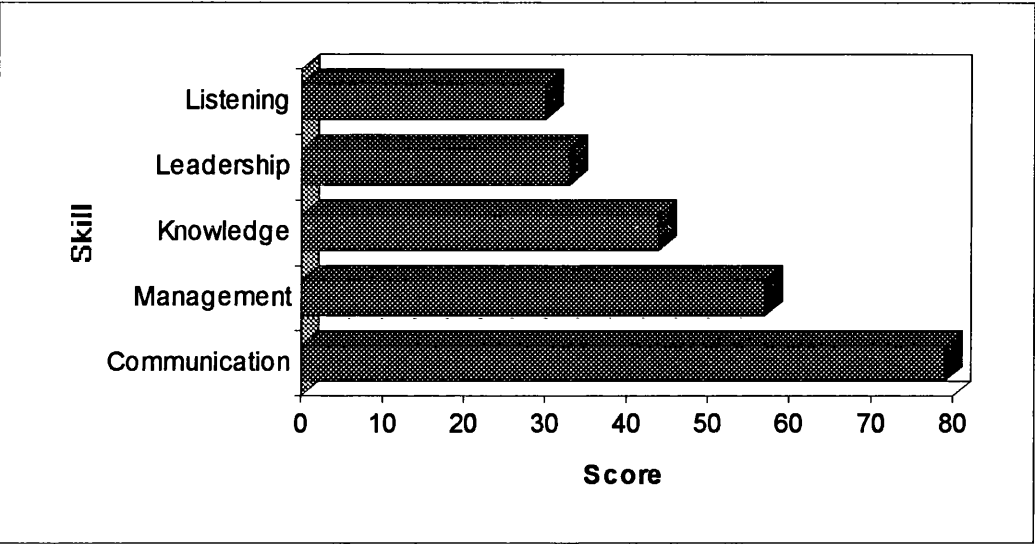
Figure 4.4.9.2 Top five CDE grade hospital nurses skills



4.4.9.3 FGH Grade Hospital Based Nurses Skills

Figure 4.4.9.3 FGH grades placed important on interpersonal skills, management skills and possessing knowledge. In keeping with the other study groups their top scoring skill was communication. However FGH grades did not to rate implementing care within their top five ($\chi^2=6.5$ df=5 NS). Instead FGH grades rated management, leadership and knowledge skills within their top five, in this they differed from the other study groups and differed significantly for knowledge ($\chi^2=16.0$ df=5 $p=0.01$).

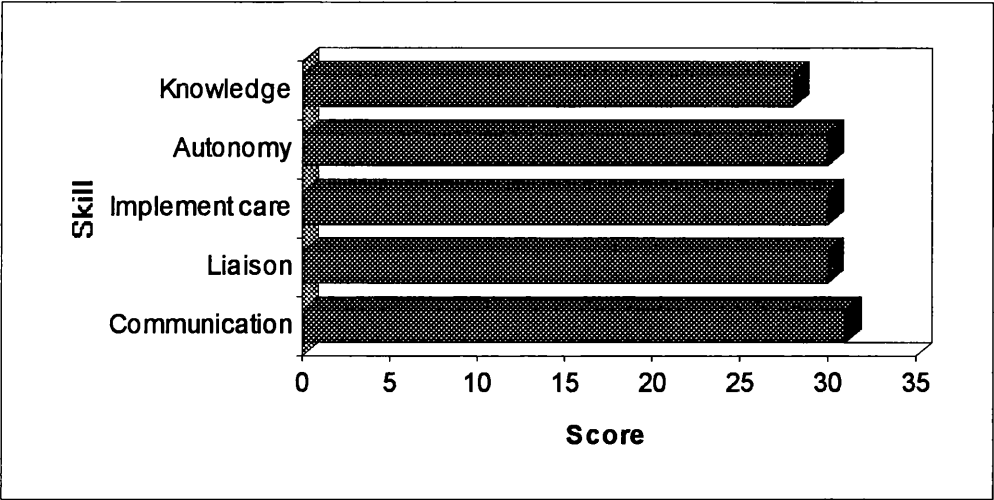
Figure 4.4.9.3 Top five FGH grade hospital based nurses skills



4.4.9.4 Professions Allied to Medicine (PAMs) Skills

Figure 4.4.9.4 indicates that PAMs perceive a mixed group of skills to be essential for their current working environment. This may be as a result of the diversity of professionals in the PAM group (occupational therapists, physiotherapists, dieticians and their helpers). They rate communication and implementing care similarly to the other study groups. They are like CPNs but different from other study groups in that they rate autonomy ($\chi^2=17.2$ df=5 $p=0.01$) and liaison ($\chi^2=16.3$ df=5 $p=0.01$) within their top five. PAMs are similar to FGH grades in that they perceive knowledge within their top five scoring skills ($\chi^2=16.0$ df=5 $p=0.01$).

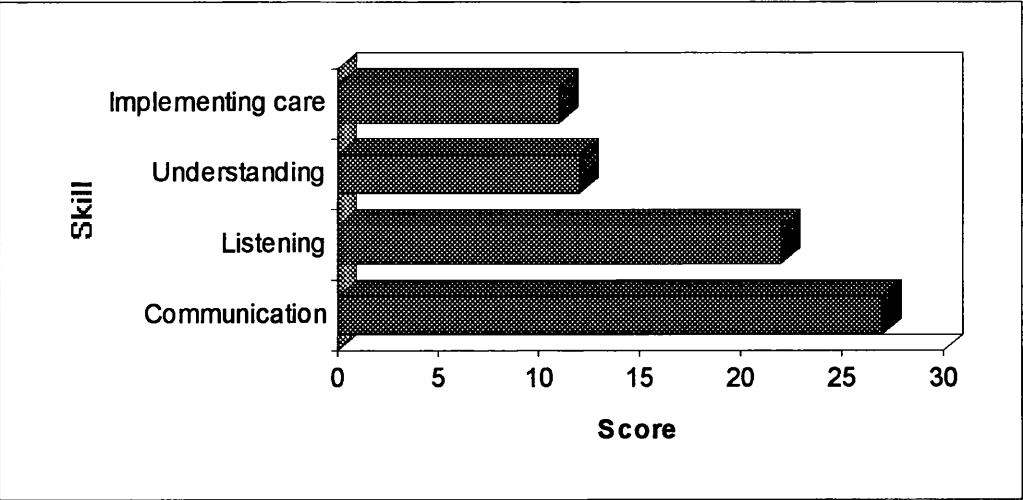
Figure 4.4.9.4 Top five Scoring Professions Allied to Medicine (PAM) skills



4.4.9.5 Community Residential Staff's Skills

As a result of the small number in the community residential group it was only possible to distinguish the top four scoring skills. **Figure 4.4.9.5** indicates that interpersonal skills, care giving skill and personal qualities were important.

Figure 4.4.9.5 Top four Scoring Community Residential staffs' skills

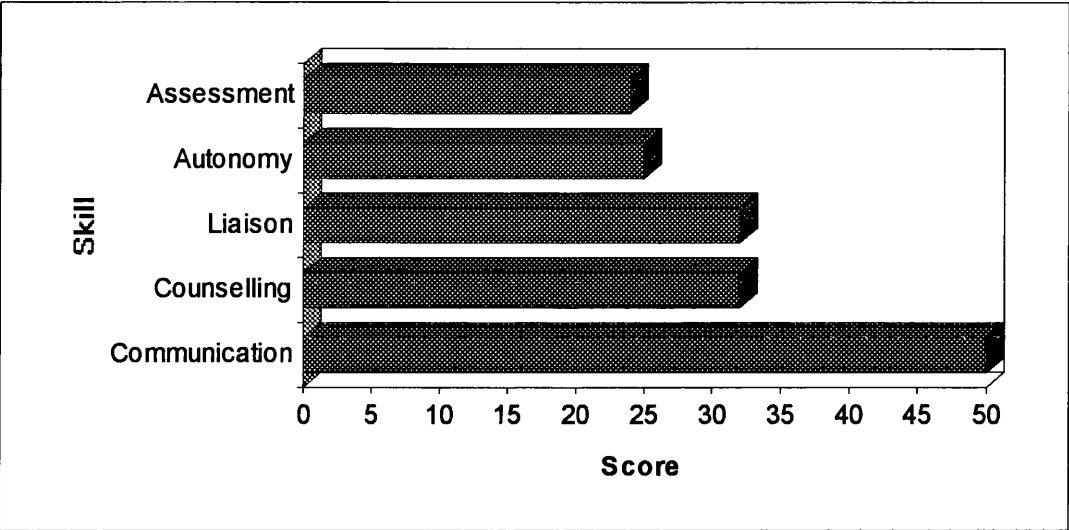


4.4.9.6 Community Psychiatric Nurses Skills

Figure 4.4.9.6 demonstrates that CPNs rate interpersonal, providing care skills and management skills. In similar fashion to the PAMs group, the CPNs prioritised a mixed group of skills. Like the other groups, CPNs rated communication at the top of the list. They did not score

implementing care within their top five ($\chi^2=6.5$ df=5 NS). CPNs were the only group to rate assessment in their top five ($\chi^2=0.1$ df=1 NS). They perceived autonomy to be an essential skill ($\chi^2=17.2$ df=5 $p=0.01$) and liaison ($\chi^2=16.3$ df=5 $p=0.01$). Similarly to the CDE grade hospital nurses they CPNs perceived counselling to be important but the community respondents as a whole perceived counselling to be more important than the hospital respondents ($\chi^2=9.0$ df=2 $p=0.01$).

Figure 4.4.9.6 Top five Community Psychiatric Nurses (CPN) skills



4.4.10 Roles within the Multidisciplinary Team

Respondents were asked to respond to an open question asking them their role in the multidisciplinary team. Each respondent (n=230) gave an average of 2.0 categorisable responses. Sixteen categories were generated from the responses. **Table 4.4.10** displays the top three responses (Percentage) for each study group.

Examination of **Table 4.4.10** indicates that there were perceived differences in group roles, however the only significant variable was "professional" that is the ability to bring one's professional opinion to bear on an issue, and it was significantly more important ($\chi^2 = 9.5$ df=1 $p=0.01$) for the community-based participants than the hospital-based participants.

Table 4.4.10 Roles in relation to the multidisciplinary team by group (percentage)

GROUP N=	HCA's 57	C/D/E 82	F/G/H 38	PAMs 33	CR 12	CPN 19	ALL 230
First group %	Provide care 40	Liaison 49	Liaison 42	Provide care 41	Important 42	profess- ional* 42	liaison 37
Second group %	Liaison 25	Member of the team 27	Manage- ment 29	Assess 27 Liaison 27	Liaison 33	Provide care 26 Others 26	Provide care 28
Third group %	Assistant 18	Provide care 26			Provide care 25 Manage- ment 25		Member of the team 18

* significant at p=0.01

4.4.11 Role in Relation to Voluntary Organisations

Respondents were asked to state their role in relation to voluntary organisations. Responses were grouped into six categories. Each respondent (n=172) gave an average of 1.3 responses. Community residential staff were not asked about their role in relation to voluntary organisations as they were in the voluntary sector. Again it is evident that the study groups perceived their roles differently from each other (table 4.4.11).

In particular, 76% of HCAs did not think that they were involved with voluntary organisations. All other groups indicated varying degrees of involvement. All groups identified acting as a resource (e.g.: educator, advisor, supporter) as important but CPNs were significantly more likely than HCAs and trained hospital nurses to see resource-related activity as essential ($\chi^2=25.4$ df=4 p=0.001).

Table 4.4.11 Role in relation to voluntary organisations by group

GROUPS	HCA n=31	C/D/E n=69	F/G/H n=35	PAMs n=18	CPN n=19	ALL n=172
First <i>group %</i>	Not involved 76	utilise services 29 liaison 29	liaison 46	liaison 39 act as a resource** 39	act as a resource** 74	liaison 31
Second <i>group %</i>	act as a resource** 16 together 16		utilise services 23		liaison 37	act as a resource** 28
Third <i>group %</i>		act as a resource** 22	act as a resource** 20	others 28	work together 26	utilise services 20

** significant at p=0.001

4.4.12 Roles in the Local Community

Respondents were asked to state their role in relation to the local community. Participants (n=184) gave an average of 1.2 responses and eight categories were generated. The most common response was acting as a resource to the community (51%); for example, providers of a service, educators and advisors. This was the most common response for all groups except HCAs ($\chi^2=12.1$ df=5 NS). A total of 17% of respondents indicated that they were not involved with the local community. In particular, HCAs and CDE nurses were the least likely to indicate involvement ($\chi^2=5.2$ df=1 NS). A liaising role to the local community was perceived by 9.8% of respondents. There were no significant group differences.

4.4.13 Summary of Findings for Clinical Strengths

Study respondents perceived themselves to have a wide variety of skills. There was consistency in the skills respondents perceived they had and the roles they perceived they had in relation to others, such as the multidisciplinary team. Although there was a diversity of skills identified, the groups differed in the skills they indicated to be their five essential skills for their current working environment; for example HCAs were more likely to perceive personal qualities to be important than other study groups. Interpersonal skills were rated highly by all study groups, in particular communication was important for all.

Respondents indicated a variety of roles in relation to the multidisciplinary team, the local community and the voluntary organisations. Again these roles differed between the study groups; for example, CPNs were more likely to perceive themselves as a resource to the local community than other study groups.

4.5 The Understanding of Mental Health Staff about Community Care Reforms

4.5.1 Awareness of Policy Changes

Respondents were asked to indicate their understanding of the central health service issues by completing a true/ false/ don't know question in relation to twelve statements. **Table 4.5.1a** indicates that there was no consensus of opinion. The percentage of respondents aware of statements ranged from 50.2% to 91.1% and no single group was aware of all issues. Participants were most aware that clients should be cared for in their own home whenever feasible and sensible (91.1%), that joint health board-social work planning is required (87.0%) and that the number of people with dementia will rise (83.1%). Interestingly, 8.9%, 13% and 16.9% were not aware of each of these key issues. Of the twelve given statements respondents were least aware that Government policy recognises that staff have training needs in the light of the reforms (50.2%) and that the mentally ill are a priority in Scotland (50.8%). On average participants were aware of 7.8 statements with one person not aware of any of the statements and fifteen aware of all twelve statements.

There were group differences in statement awareness (table 4.5.1a). The CPNs were the most aware group and the HCAs least aware. For all significant statements (table 4.5.1a) the HCAs were significantly less aware than at least one other group.

A one-way analysis of variance (ANOVA) tested the null hypothesis that there were no differences between the study groups in the mean number of statements of which they were aware. The null hypothesis was rejected ($F=11.78$ $df=5$ $p=0.001$) in that a significant association was found between mean statement awareness and study group. **Table 4.5.1b** presents the confidence intervals for the subsequent Tukey's analysis. It is evident from the table (4.5.1b) that the differences can be attributed to the HCAs having a different mean awareness to all other study groups in that none of the confidence intervals testing HCAs against the other groups cross zero.

Table 4.5.1a Percentage of staff aware of 12 questionnaire statements by group

Statements	Groups	All groups	HCA's	C/D/E	F/G/H	PAMs	Community Residential	CPNs	x ²	df	p
High Priority to Mental Illness		50.8	33.3	47.6	61.1	65.2	66.7	84.2	22.3	5	0.001
Home care Preference		91.1	87.8	92.9	94.4	90.9	75.0	100.0	7.5	5	NS
Patients' Charter		58.9	39.7	66.7	75	54.5	66.7	68.4	18.2	5	0.01
Additional Funding Available		54.9	31.9	68.7	57.1	60.9	50.0	73.7	24.9	5	0.001
Government Recognise Need for Extra Training		50.2	42.6	55.4	69.4	30.4	41.7	47.4	11.8	5	NS
Assessment is a cornerstone of care		63.8	42.3	66.7	77.8	72.7	72.7	89.5	24.2	5	0.001
Need to seek medical opinion prior to deciding on nursing home care		51.4	51.4	57.1	51.4	39.1	50.0	42.1	3.2	5	NS
Social Work is the lead community care agency		75.1	65.3	74.7	75.0	91.3	66.7	100.0	13.7	5	NS
Joint service planning required		87.0	81.9	86.9	94.4	82.6	83.3	100.0	6.8	5	NS
Promotion of independent sector		68.2	52.8	62.7	86.1	69.6	100.0	94.7	26.2	5	0.001
High Priority for Carers		58.4	47.2	61.5	69.4	43.5	66.7	79.0	11.6	5	NS
Rising numbers of elderly with dementia		83.1	66.7	88.9	86.1	91.3	100.0	94.7	21.4	5	0.001
Mean number of aware statements per group		7.8	6.3	8.2	8.9	7.8	8.3	9.7			

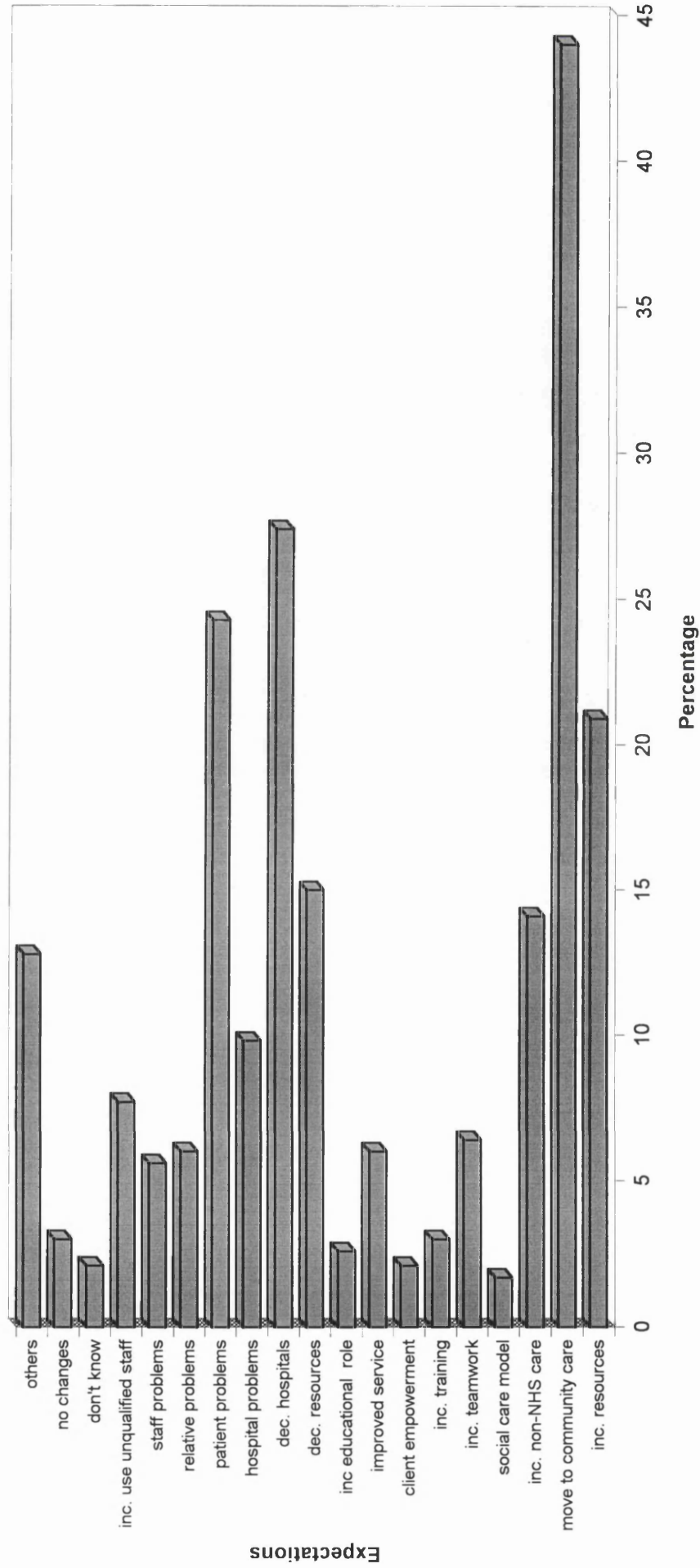
Table 4.5.1b Confidence intervals testing means statement awareness

GROUPS	HCA's	CDE Grades	FGH Grades	PAMs	Community Residential
CDE Grades	-3.017 -0.922				
FGH Grades	-4.023 -1.353	-2.027 0.591			
PAMs	-3.138 -0.001	-1.146 1.946	-0.635 2.872		
Community Residential	-4.121 -0.032	-2.135 1.920	-1.579 2.801	-1.832 2.847	
CPNs	-5.170 -1.790	-3.180 0.158	-2.655 1.071	-3.826 1.019	-3.948 0.126

4.5.2 Future Expectations

Respondents were asked to comment on their future expectations for working with mentally ill people. A total of 93.2% of participants gave an opinion with each respondent giving an average of 2.1 responses. A diversity of expectations were expressed which were classified into 19 categories (figure 4.5.2). Positive and negative opinions were expressed with no consensus of opinion. There were no statistical group differences for the most common categories. The most common response was that there would be a movement to community care (44.0%). Interestingly no CPNs gave this response perhaps because they are already embedded in the community. Secondly a scaling down of hospitals was anticipated (27.4%). Problems for clients (24.3%) and an increase in resources (20.9%) were also expected.

Figure 4.5.2 Respondent Expectations for Working with Mentally Ill People in the Future



4.5.3 Multidisciplinary Team Working

A total of 92.4% of study respondents gave an opinion on the composition of a multidisciplinary team, with an average of 2.4 responses per person. Three responses dominated the 13 generated categories: that is 80.6% of respondents thought that the multidisciplinary team comprised of various disciplines, 63.8% thought that the purpose of the team was for the client and 37.9% thought that the team was to do with working together. However the HCAs had a less focused perception of an MDT than the other study groups in that HCAs were significantly less likely than all groups except community residential workers to think that the multidisciplinary team comprised various disciplines ($\chi^2=28.5$ $df=5$ $p=0.001$) and incorporated the idea of working together ($\chi^2=22.6$ $df=5$ $p=0.001$) and 25.4% of HCAs defined the multidisciplinary team in a non specific manner such as:

"all staff who have a contact with patients"

When asked if they thought their multidisciplinary role would change, over half the respondents thought that it would not (56%). The 44% ($n=100$) of respondents who thought that their role would change were asked to say how they thought it would change. Each respondent gave an average of 1.4 changes. The four most common responses were moving to a community base (23%), their role improving and broadening (22%), working more within a team (21%) and that there would be more influence from other disciplines (18%). There was no consensus of opinion.

Reference to MDT difficulties was made in response to several questions. At interview this issue was explored further. Combining the questionnaire and interview data suggested that the difficulties were thought to relate to:

- interdisciplinary role conflict;
- overlapping skills between professional groups;
- increased use of unqualified staff;
- other disciplines "taking over", for example social workers taking over roles that have traditionally been considered health workers roles;
- the health board - social work divide;
- general personality clashes;
- nursing gradings;
- the uncertainty that exists about changes.

However, five of the interviewees thought that the MDTs were working well together at present and half did not anticipate future problems as staff would learn to work together. Eight interviewees thought that there might continue to be team difficulties perhaps secondary to social work domination or lack of promotion.

Again the data indicated a lack of consensus of opinion. There were implications for the success of teamwork.

4.5.4 Information Sources

Respondents were asked to identify their sources of information about change from a predefined list (table 4.5.4). An average of 4.3 sources were indicated per respondent. The most common sources were peers, team brief, ward managers and newspapers. The eight predefined sources were more commonly utilised than any "other".

Table 4.5.4 shows that there were group differences in the information sources in that:

- HCAs were significantly more likely to rely on team brief than CPNs and CDE grades more than community residential staff;
- there was a tendency for HCAs and CR staff to use peers less than other groups but it was not possible to locate the exact point of significance;
- HCAs used journals significantly less than all groups except community residential staff;
- CDE and FGH grades used newspapers significantly more than HCAs and CR staff and FGH grades significantly more than CPNs;
- FGH grades used trust managers more than HCAs ($\chi^2=15.8$ df=1 p=0.001).

It can be seen that study groups differed in their sources of information, in addition a poor consensus of opinion on change was identified. In particular, HCAs relied on more passive sources of information than other groups.

Table 4.5.4 (n=245) Information sources used by groups (percentage) and significance values

SOURCE	GROUP	All groups	HCA's	CDE	FGH	PAM's	Community Residential	CPN's	x²	df	p
Peers		84.1	75.0	88.0	88.9	95.7	58.3	94.7	15.8	5	0.01
Journals		42.5	12.5	55.4	61.1	47.8	25.0	68.4	44.3	5	0.001
Self		26.1	16.7	27.7	36.1	17.4	50.0	31.6	10.1	5	NS
Newspapers		60.0	40.3	72.3	86.1	60.9	25.0	52.6	33.7	5	0.001
Trust managers		27.4	12.5	28.9	47.2	30.4	25.0	36.8	16.2	5	0.01
Ward Managers		61.2	65.3	62.7	44.4	78.3	50.0	57.9	8.4	5	NS
Noticeboard		33.1	40.3	34.9	38.9	8.7	41.7	10.5	13.3	5	NS
Team Brief		78.4	88.9	80.7	75.0	78.3	41.7	57.9	19.4	5	0.01
Others		15.9	5.6	15.7	28.8	17.4	25.0	26.3	11.8	5	NS
Mean Number of Information sources		4.3	3.6	4.7	5.1	4.3	3.4	4.4			

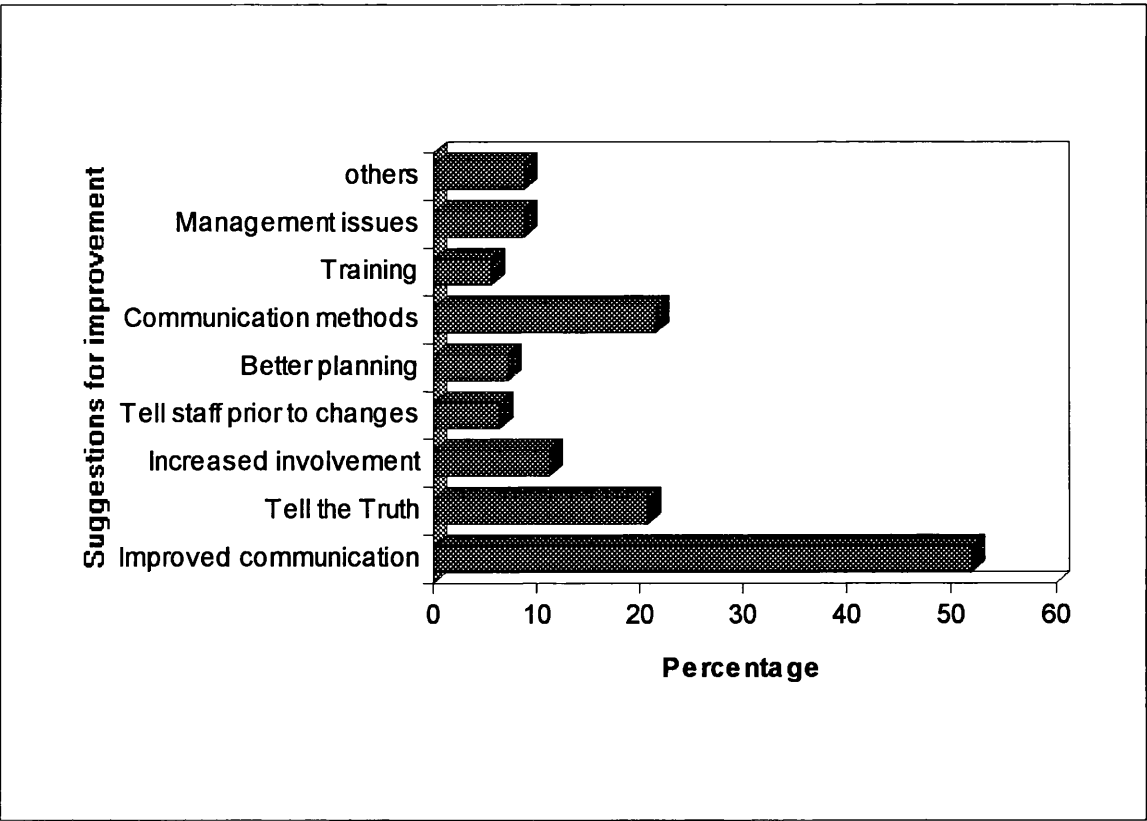
4.5.5 Satisfaction with Information Given and Suggestions for Improvement

Less than half of the respondents (46%), in all groups thought that they had been adequately informed about changes that had already occurred ($\chi^2=5.7$ df=5 NS). Despite being the most aware group of the legislation, over half the CPNs did not feel informed about the changes.

The 54% of respondents who were dissatisfied were asked to make suggestions for improvement. An average of 1.4 responses were given per dissatisfied respondent with nine categories generated (figure 4.5.5).

Figure 4.5.5 indicates that the most common suggestions for improving satisfaction with information are to make communication better, to use alternative communication methods and to "tell the truth". When asked about mistrust at interview, participants claimed staff mistrust originated with management problems, for example management held back information; some information had been found to be untrue; or had come from incorrect sources first such as the media. Some interviewees did not believe that they had been deliberately lied to or misled but felt 'these things happened in big organisations'.

Figure 4.5.5 Suggestions for improvements in satisfaction with communication.



In combination, interview and questionnaire data suggested that communication could 'be better', mistrust lessened and satisfaction with information improved by:

- increasing use of formal channels of information;
- more meetings some of which should be on night duty;
- giving information in writing e.g. memos or newsletter;
- giving more or different information;
- improving management communication e.g. they should give all the information they have even if it is uncertain;
- consult with staff about proposals;
- tell staff the plans;
- some staff do not feel that anything can be done about it.

Some examples of responses from questionnaires are given below:

- more management meetings with staff to keep us up to date;
- better communications between managers and ward staff not only charge nurses;
- staff meetings, straight honest answers, information leaflets, billboard, posters, telephone helpline;
- we could be informed prior to the changes;
- more consultation with deliverers of care (people at the coal face) prior to change;
- a monthly/ weekly/ fortnightly paper from heads office with a breakdown of prospective plans;
- probably nothing as I feel management are in the dark mostly as well.

Therefore many respondents were not satisfied with the information they had received and respondents visualised ways to improve their satisfaction.

4.5.6 Information Staff Require to Move to the Community

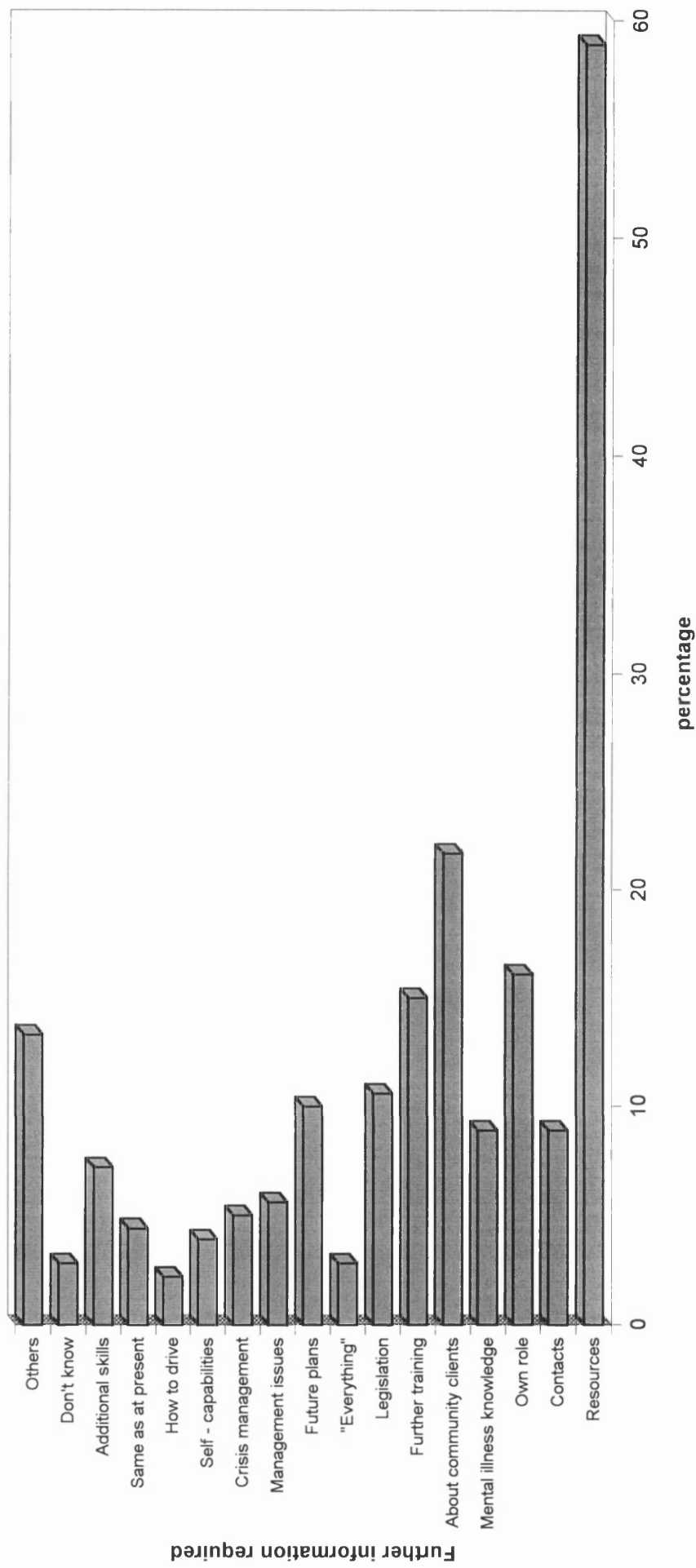
Hospital participants were asked to indicate what they wanted to know to move to the community. The responses of the 81.8% who gave an opinion were classified into 17 categories (figure 4.5.6). A diversity of further information was indicated with each respondent giving an average of 2.0 categorised items. Although all respondent groups most commonly wanted further information on resources, HCAs were significantly less likely to indicate this response ($\chi^2=12.1$ df=3 $p=0.01$).

The following provide some examples of the resource information required:

- knowledge of community resources, type of social supports generally available, information re employment etc;
- all services which are available to clients and ways to access them;

The community respondents (n=30) were asked to reflect on their educational needs or those things that they had to learn when first entering the community. Their most common responses centred on a recognition that clients were individuals in their "own territory" (n=14) and the need to be more autonomous (n=14). The third most common response was resource (n=12) and this included similar resources to those listed by the hospital respondents.

Figure 4.5.6 Information Hospital Staff Want to Know to Move to the Community



4.5.7 Respondents Concerns about Working in the Community

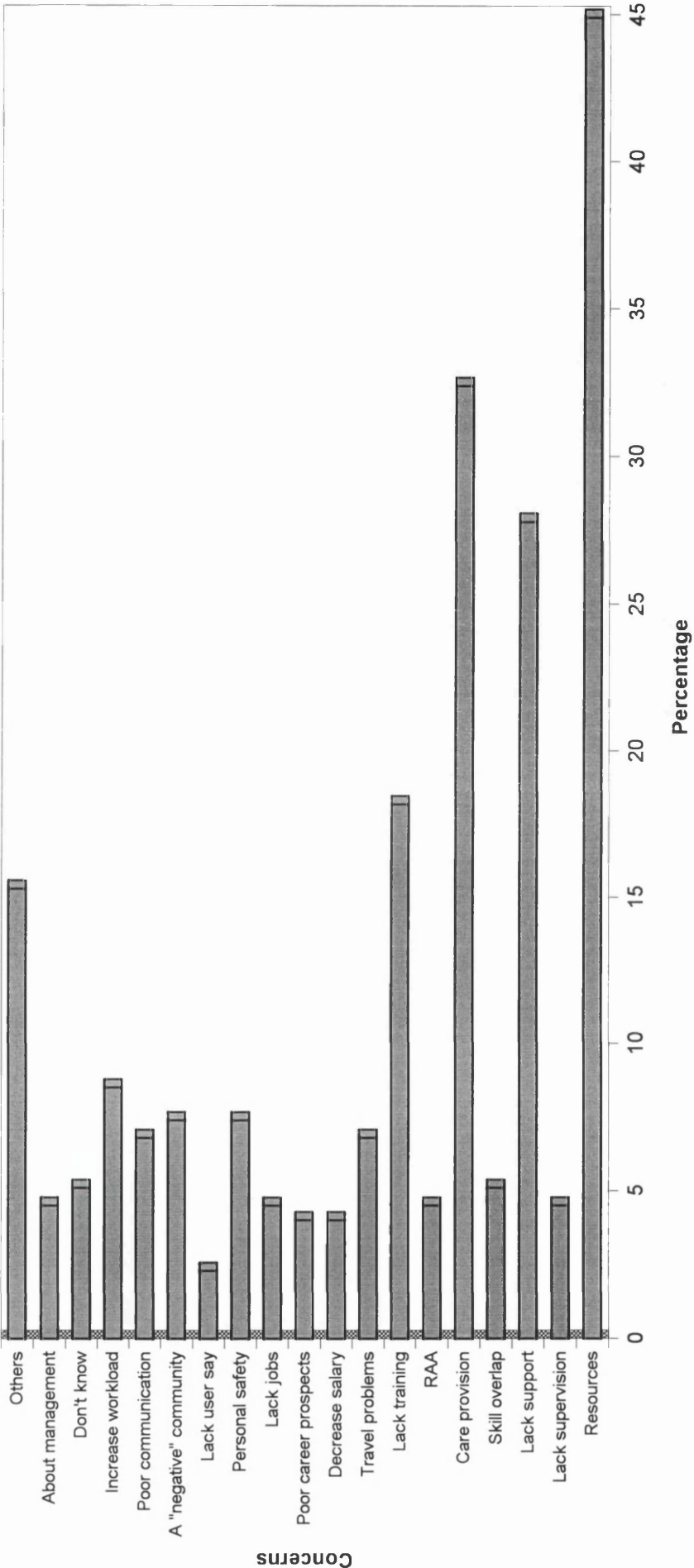
A total of 21.2% of respondents said that they did not have concerns about working in the community ($\chi^2=7.8$ $df=5$ NS). The 78.9% who had concerns gave an average of 2.3 concerns. There were no significant group differences.

Respondents indicated a wide variety of concerns (Figure 4.5.7). The three most common concerns were: concern about resources (including a lack of funding, budgets controlling care, lack of staff, lack of facilities e.g. day care and lack of beds); concern about care provision for clients in the community service and lack of or less support for staff, carers and patients.

Interviewees had mixed views about staff support in the community with half thinking that support was inadequate, five that support was good and five were uncommitted. Education, support groups, team and peer support were suggestions for supporting community staff.

Interestingly, 18.2% of respondents were concerned about their lack of training for the community, 9.1% of participants made positive comments about community care despite being asked for concerns and 5.1% of respondents were concerned about overlapping professional roles.

Figure 4.5.7 Respondent's Concerns about Working in the Community

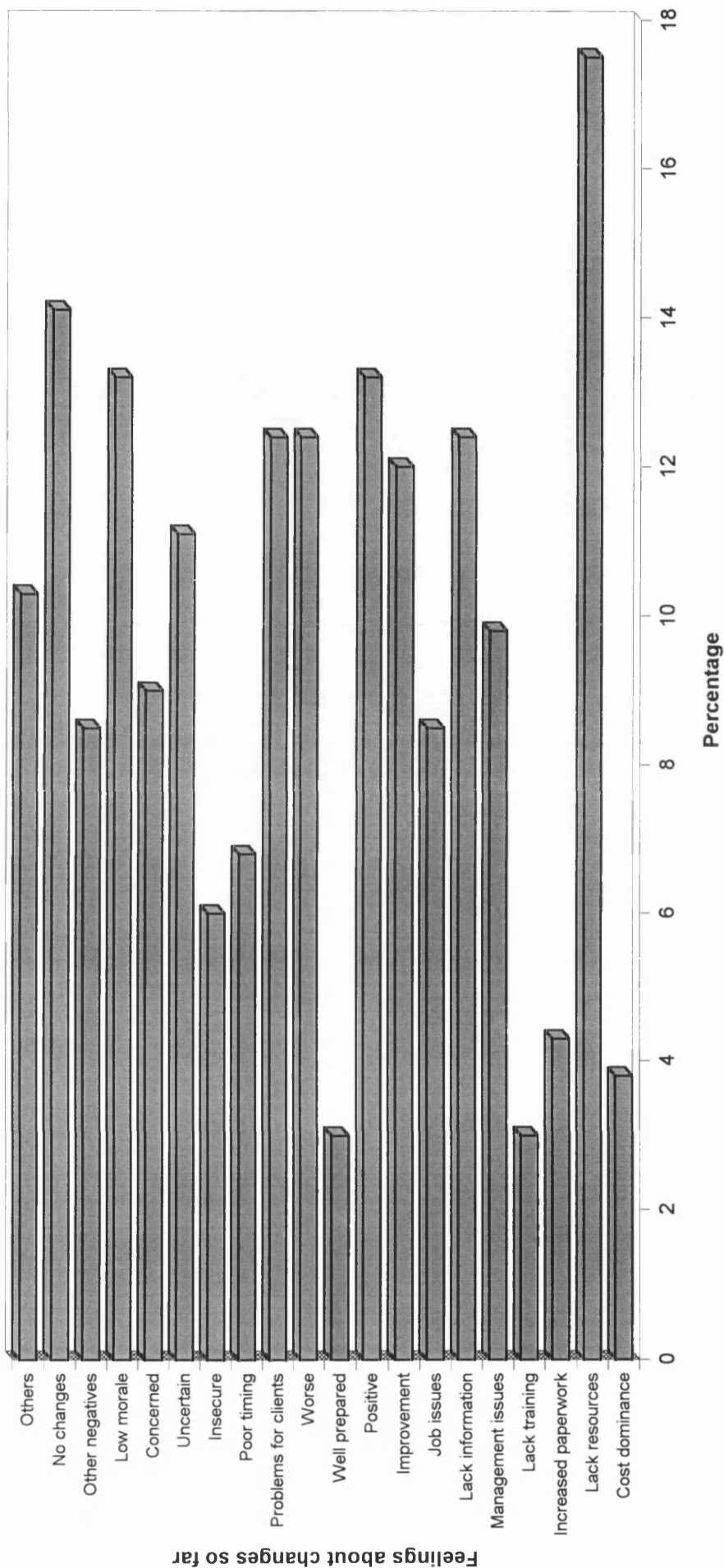


4.5.8 Staffs' Thoughts about Past Changes

Respondents were asked to give their thoughts about changes that had already occurred. A wide variety of responses indicated a diversity of opinions (figure 4.5.8). Each respondent gave an average of 1.9 responses with no consensus of opinion. There were no significant group differences.

The most common responses were a lack of resources such as facilities and interestingly no changes having occurred. The joint third responses indicated contradictory views with 13.2% indicating low morale while a further 13.2% indicated that they felt positive about the changes. Considering the responses overall, they appear to be more negative than positive.

Figure 4.5.8 Respondents' thoughts about changes in the workplace so far



4.5.9 Continuing in Mental Health Care

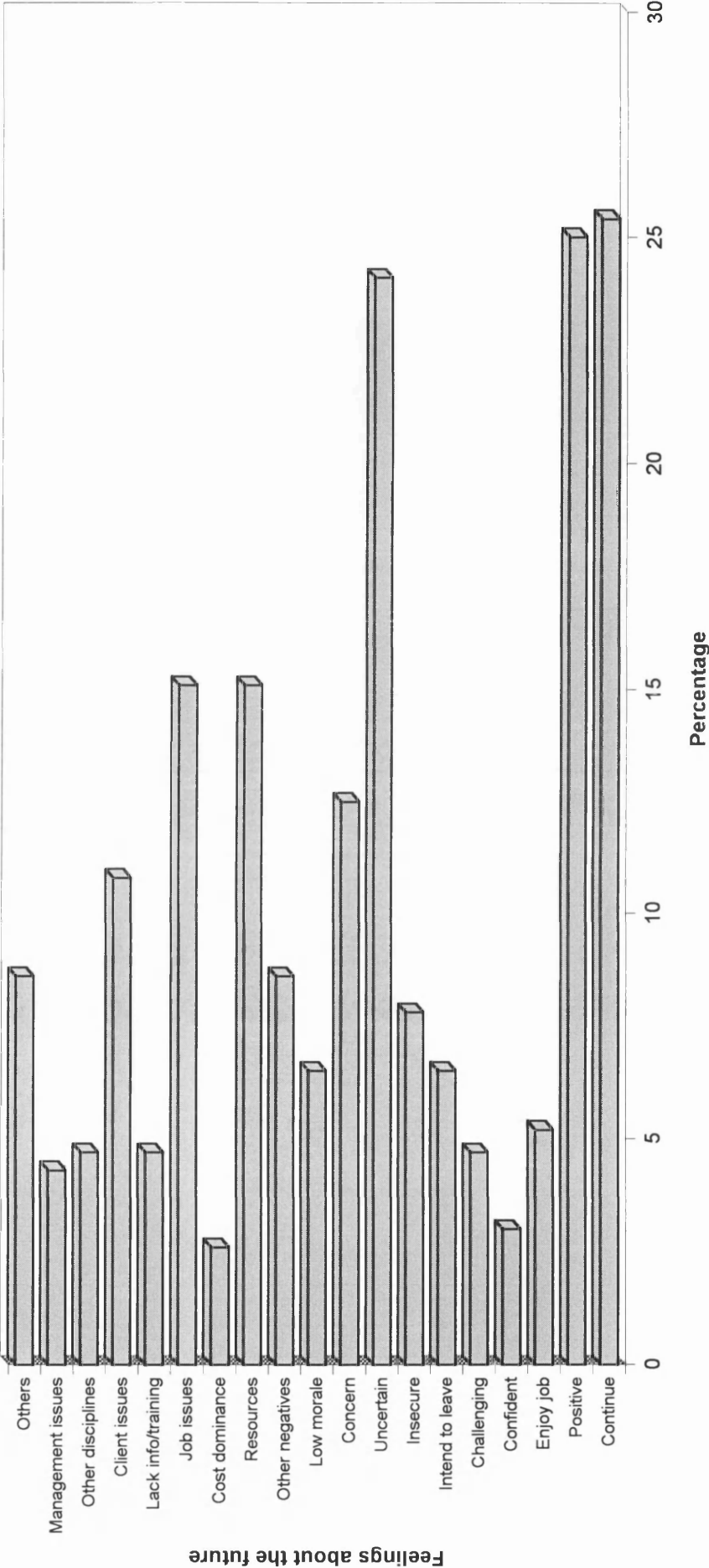
Participants were asked to say what they thought about continuing to work in mental health care in the future. As with the preceding questions, there was a diversity of responses (figure 4.5.9). On average, respondents gave 2.0 responses and there were no significant differences between the common variables.

The three dominant themes (figure 4.5.9) were a wish to continue working in the mental health services in the future, having a positive attitude to the changes and uncertainty about the future. Ambiguity was apparent in many of the preceding questions, regarding thoughts about the future, responses also indicated some degree of ambiguity. However "positive" responses dominated more than in the other questions in that all groups, except CDE grades, had "feeling positive" in their top three responses.

Interviewees were asked about continuing in the mental health services. Sixteen of those interviewed wanted to continue, two did not and two did not know. Of those who wanted to continue, five wished to remain in the hospital, three wanted to move to the community and eight wanted to specialise in mental health, e.g. addictions services. The main reasons for wishing to continue were to do with personal or attitudinal factors such as enjoying the job or interest in the field.

Uncertainty was the most common response among trained hospital respondents. Interviewees related uncertainty to job insecurity and hospital closure; inaccurate or lack of consistent information; and the lack of control that staff and management have over Government changes. To make staff feel more certain about the future, interviewees proposed more information from management and reassurance about jobs. However, some interviewees did not think that there was any information that could lessen uncertainty. Most interviewees thought that patient care would be affected through the negative feelings among staff.

Figure 4.5.9 Respondent's thoughts about Continuing in Mental Health Care in the Future



4.5.10 Summary of Staffs' Understanding of Health Service Changes

The data yielded interesting findings regarding respondents' knowledge about community care. In particular the following points emerge from the findings:

- respondents wanted more information to move to the community;
- the responses indicated participants had some understanding of the health service reforms;
- there was no consensus of opinion pertaining to health service changes;
- there was no consensus of opinion regarding past or anticipated changes;
- mental health staff were particularly concerned about resources for community care;
- HCAs were less informed than other study groups;
- HCAs used passive means to collect information;
- respondents suggested various methods for improving satisfaction with information about change;
- HCAs had a less focused perception of a MDT.

The findings are discussed in the subsequent chapter.

Chapter Five

Discussion of the Findings

5.0 Introduction

This study aimed to identify the skill and information needs of mental health staff in transition to community care. The research was considered the first stage of a process to enable hospital-based mental health staff to function safely, effectively and efficiently in community settings.

From the findings it was evident that mental health staff did have skill and information needs. This was compatible with previous literature in mental health and related disciplines (Caldock, 1993; Kennedy, 1990; Allen et al, 1990; Lawton, 1990). Three recurrent themes emerged from the findings that have relevance to the skill and information needs of mental health staff:

- the current skills of mental health staff and the skills required for the future in the community;
- the current knowledge of mental health staff and the need for more information;
- the need for management action.

This is not to say that the above three issues were the only issues examined. Indeed the study has raised many other issues that warrant further consideration. However the three themes above are the recurrent, dominant themes and are therefore the basis of the discussion. Additional issues are raised as considerations for further research.

5.1 The Research Questions

The first research question aimed to identify the community educational preparation of the different groups of mental health staff that make up a multidisciplinary team. The findings indicated that only a small proportion of staff had attended courses that they thought were useful for community preparation (n=50). However respondents used a variety of methods to keep up to date with changes in patient care and the updating methods employed differed between study groups.

The second question addressed the current skills mental health staff perceived to be essential. A total of 41 skill categories were generated indicating a diversity of skills. Again there were differences between the study groups. Some consensus of opinion was contained within each study group to enable predication to be made about the current skills possessed.

The third question aimed to identify and describe the skills that hospital-based staff would need to learn to work in the community. This question was addressed using a combination of findings and the literature. The future skill prescription will be identified later in the discussion.

The fourth question aimed to identify and describe the knowledge level of the mental health staff regarding the community care reforms. There was no consensus of opinion among study respondents about the changes that had already occurred or about anticipated changes in the future. Furthermore there were differences between the study groups in the knowledge they possessed.

It is thought that the findings addressed the research questions. Further consideration is given to the central issues, that is skill and information needs, in this discussion.

5.2 Limitations of the Study

The response rate was 36% and this may affect the representativeness and generalisability of the findings. However, there were responses from all occupational groups in all working areas across a variety of demographic variables. Lawton (1990) obtained a response rate of 39% (58% community field, 42% community residential and 38% hospital) and Allen et al (1990) achieved a response rate of 58% (87% community and 56% hospital) with a range of 40-92%. Furthermore the reasons proposed by interviewees in this study for non-response were similar to those proposed by Lawton (1990) and the reasons were similar to the issues raised by staff and management during initial consultations; for example, low morale and mistrust of management. While it is claimed that a response rate of 50-60% is required for validity of the findings, response rates of 30-40% are not uncommon (Burns & Grove 1993). Nonetheless, the findings and discussion must be considered tentative in view of the response rate and the possibility that the non-respondents differ from the respondents.

A second limiting factor was the small numbers in the paramedic and community residential study groups. It was not possible to draw definite conclusions for these groups due to their small composition. However the sample represented a total paramedical population in one Scottish Health Board.

The skills identified were those perceived by the mental health staff. These skills may not have been used in practice and if they were, it was not possible to ascertain their therapeutic benefit.

Nevertheless, the respondents' perception of what is important should be used as directions for future study.

Despite the limitations, the study is valuable. Within the questionnaire, data are validated in that the skills staff have perceived as important are similar to the roles they indicate that they have. In addition, the findings are similar to those in studies in fields related to mental health (Lawton, 1990; Allen et al, 1990). The fact that the respondents were from all demographic variables and all working areas also strengthens the case for generalisability.

5.3 Profile of Study Groups

The literature raised difficulties in identifying which skills (section 2.3) and information (section 2.2) mental health staff possessed. The difficulties arose from a lack of empirical study in mental health disciplines within the UK. A profile of each study group follows to identify, from this study's data, the demographic characteristics of each group; which skills and qualifications each group possessed; and the level of knowledge each group possessed about community care changes.

5.3.1 CPNs (Community Psychiatric Nurses)

The typical CPN works full time day shift and has worked with the mentally ill for a minimum of four years. The individual is equally likely to be male as female and could be in any age group. He or she is RMN qualified with half of the group possessing a CPN diploma. Some CPNs work in specialist roles. They perceive their most important skills to be: communication, liaison, autonomy, counselling and assessment. They consider themselves to be independent professionals and a community resource. CPNs differ from hospital staff in that they place more emphasis on autonomy, assessment, counselling and acting as a resource to other agencies. The views of this sample of CPNs are in line with those found elsewhere (Morrall, 1995; Tryer, 1990; Pollock, 1989). CPNs were the group most aware of the changes being aware of 9.7 of the twelve true or false statements on average.

5.3.2 Community Residential Staff

Due to the small number in the community residential group (n=12) and the mix of grades, little can be concluded from the findings. Overall it would appear that the typical community residential worker is female and either professionally or vocationally qualified. They come from all age groups and have spent varying lengths of time working with mentally ill people. Their main emphases are on communication, liaison, integrating clients into the community and acting as a resource to the community. These findings are similar to those of Lawton (1990). On average community residential staff were aware of 8.3 of the twelve true or false statements. As with the CPNs there were central change issues of which the community residential staff were not aware.

5.3.3 FGH grades (F,G and H grade hospital based nurses)

The typical FGH grade hospital nurse works full-time day shift, has spent over ten years working with the mentally ill, is RMN qualified and probably has an additional qualification, commonly a second nursing registration. The FGH grade is equally likely to be male as female and as one would expect, FGH grades tend to be older than CDE grade nurses. The five skills most commonly listed by FGH grades are communication skills, listening, management, knowledge, implementation and leadership skills. Liaison is considered to be part of their outreach community role as opposed to being one of their top five priority skills. In addition, they perceive that they are a resource to the community, for example they provide a service to the community. Considering the FGH grade profile overall, it would seem that they perceive themselves to be managers; for instance management skills are one of their most common identified competencies. Interviewees also held the belief that FGH grades were managers. FGH grades differ from the other groups in this management role and from the CPNs specifically in that they do not delineate liaison, counselling and autonomy in their top five skills. Literature and job descriptions support this FGH grade management profile (Allen et al, 1990; Lawton, 1990). It is claimed that FGH grades, as managers, are pivotal in a changing hospital environment (Allen et al, 1990) as all information goes through this level. Findings from this study support the idea that FGH grades are a pivotal point in change (Allen et al, 1990) as most other study groups used FGH grades as a source of information about change. FGH grades were aware of 8.9 of the twelve statements and used the greatest number of information sources (average 5.1). The 3.1 statements of which FGH grade respondents were generally not aware is of particular concern if all other staff groups are using them as a source of information.

5.3.4 CDE grades (C,D and E grade hospital based nurses)

CDE grades are typically young (commonly 20-29 years old), female, full-time, work a variety of shifts and have spent a relatively short period of time working with the mentally ill. They are either RMN or EN trained. The five most common skills prioritised by CDEs are: communication, implementing care, liaison, empathy and counselling. They perceive themselves to be a resource to the community and refer clients to voluntary organisation services. Literature and job descriptions confirm this perception of their role (Cormack, 1983 and Altschul, 1972). CDE grades were aware of 8.2 of the central community care true or false statements on average. Again the concern centres around the number of which staff are not aware.

5.3.5 PAMs (Professionals Allied to Medicine - occupational therapists, physiotherapists and dieticians)

The treatment of three distinct professions as one group due to small numbers, means that little can be concluded from the findings about the individual professions. The typical paramedic is female, 39% are part-time, has spent varying lengths of time in her present post and in mental health care and has the degree or diploma relevant to her profession. She is not in any particular age span. Many work concurrently in several mental health areas. They list skills and roles as communication, autonomy, knowledge, providing care, assessment, liaison and acting as a resource. The literature from each of the disciplines confirms these skills and roles (College of Occupational Therapists, 1994; Dieticians Board of CPSM, 1994; Crews, 1990; Aston-McCrimmon, 1986) but the focus is different for each of the disciplines. Local consultation revealed a belief that the changes in skills for PAM groups were mainly functional as role performance does rely on being in a hospital environment. Study findings confirm the belief that PAMs require minimal skill changes to work in the community; for example comparing CPN and PAM top five skills revealed no significant differences. PAMs were aware of 7.8 statements on average indicating that just over one third of change information is not perceived by PAMs.

5.3.6 HCA's (Health Care Assistants)

HCA's are typically older, unqualified, female, full-time and have spent a prolonged period of time in their present post and with the mentally ill. Their top five listed skills are personal qualities (patience and understanding), communication, listening and implementing care. However when asked about their role outwith the hospital, the dominant response indicates that many HCA's perceive that they are not involved in the local community. In this they differ from the other study groups. In the MDT they provided care to clients, liaised and assisted others as required. The

HCA's own perception of their role is supported by the literature (Chang, 1995; Dewar and MacLeod Clark, 1992). In contrast to previous findings (Cormack, 1983), there were differences in HCA roles in comparison to the other staff in that HCAs were more likely to rely on personal qualities than other groups. However HCA skills showed some overlap with their professional counterparts for example through the perceived importance of communication and through implementing care which is probably necessary to enable them to act as support workers (Chang, 1995). HCAs were the least aware groups of the changes which has implications for their effective care delivery to the clients.

5.4 The Current Skills of Mental Health Staff and the Skills for the Community

The diversity of responses to the skills question and subsequent generation of 41 skill categories indicated that staff perceived that they had many skills. The variety of skills identified was a positive indication of the contribution of the mental health professions and their assistants to mental health care. Variety may also highlight the importance of treating people as individuals and therefore using different skills for different people.

The findings of this study are supported by previous research of hospital staff's need for skill acquisition or skill adaptation for community practice (Kennedy, 1990; Lawton, 1990; Allen et al, 1990). A skill prescription is presented in section 5.4.2.

5.4.1 Provision of Skill Education

The difficulties in identifying the skill difference from the current hospital context to the future in a community context are complex.

Previous policy was criticised for failing to provide an adequate prescription for the skills education and therefore skill differences between hospital and community (section 2.3). In particular it was stated that the Mental Health Nursing Review (DoH, 1994) did not adequately identify the skill requirement for the future of mental health nursing despite its remit (Smith, 1994) and Government policy in general had failed to identify the origins of the skill prescription for all disciplines (DoH, 1994; DoH, 1989a).

The difficulties of identifying the skills required and the delivery of the education are complex. In this study a diversity of skills were identified, some of which were discipline-specific. Therefore

there is an initial difficulty in identifying which skills are required by which professions and the subsets within professions; for example charge nurses and staff nurses. Secondly the difficulties stem from individual differences, in that, on an individual level professional development will differ and as a consequence, skill acquisition will differ. For Nursing, the different professional development pathways of each individual professional is identified by the UKCC (1990) in making PREP something that is unique to an individual. A third complicating factor is, that any given skill may be used differently in a different environment, that is community liaison and hospital liaison may not be the same thing. Whether the skills are different has not been established. All these complications lead to a conclusion that the starting point for change may be to move all staff onto a common denominator level, that is a common skill starting point regardless of site of practice. This conclusion is in keeping with the belief of the Mental Health Nursing Review Team (DoH, 1994, p.20):

"All mental health nurses should be using the same core skills, irrespective of setting within which they practice"

It could be argued that all multidisciplinary team professionals working in mental health should possess the same core skills to ensure mentally ill people in both hospital and community receive the same high quality service across all professional groups. The Review (DoH, 1994) states that specialist skills should be developed to meet the specific needs of clients and that these specialist skills should be in addition to the core skills. It could be said that the specialist skills are those that will distinguish between professional groups and different grades of staff within professional groups.

The literature (Lawton, 1990; Addleton, Tratnack & Donat 1991; Bloom and Parad, 1976) and Government policy (DoH, 1989a; SHHD, 1988) proposes advantages of providing training in a multidisciplinary context on the basis that it:

- promotes team working;
- helps staff learn from one another;
- delineates professional role boundaries;
- creates a shared body of knowledge;
- promotes more coherent movement to organisational goals.

Therefore educating staff in core skills within a multidisciplinary environment may be beneficial in achieving these goals.

However there may also be problems in educating in a multiprofessional context. Sifneous (1969) argued that the education would fail to recruit participants if the uniqueness of individual groups was not recognised. This study's findings indicated that staff were concerned about "other disciplines

taking over". These findings are supported by previous research (Watson, 1994; Shaw, 1993; Busuttil, 1992; Weaver & Patmore, 1990; Joice and Coia, 1989; Bloom & Parad, 1976; Glasscote and Gudeman, 1969).

It would seem that getting a balance between enhancing team working and promoting professional uniqueness is a challenge to face educators into the next century. The benefits to the clients of joint training or individual professional training or indeed a mix of the two are not clear. The advantages and disadvantages of multiprofessional education will be a subject for researchers in the future.

Nonetheless this study identified that hospital staff need to learn more skills to move successfully into the community. Government policy indicates a desire to see more joint training initiatives (DoH, 1989a) yet, there may be problems with joint training in that it may undermine professional uniqueness. It is thought that the solution is to consider the education of the multidisciplinary team on core skills, in a joint training environment, in keeping with the ethos of the Mental Health Nursing Review (DoH, 1994). But, in addition, to encourage profession specific and individual specific skill specialisation, for example as PREP is aiming for in Nursing (UKCC, 1990), to maintain professional uniqueness. In this way some education would be multidisciplinary and some unidisciplinary.

5.4.2 The Common Core Skills that are Required

It has been said that this study and previous studies have indicated that staff need to learn more skills as a result of community care (Allen et al, 1990; Lawton, 1990). If staff are not provided with the necessary skills some individual staff may not have the skills that they require to deliver high quality mental health care. As a consequence standards of patient care may not be maintained. For Nurses, the individuals who are insufficiently prepared for their role will be in breach of the UKCC Professional Code of Conduct.

At present there is insufficient evidence to identify the unique skill requirements of each study group. However it is possible to prescribe a common core skill requirement for the future in mental health.

The study established that CPNs perceive communication, liaison, autonomy, counselling and assessment to be their five most important skills. Further they perceive themselves to be a community resource and an independent professional in the MDT. These are therefore the skills used by current community staff to fulfil their role requirements. As the mental health service philosophy is moving to have a community base, including people who are in hospital within the

community, it is thought that the community skills should be possessed by all mental health staff. The skills possessed by the CPNs are in line with those proposed in policy documents for mental health care delivery (DoH, 1994, DoH, 1993, DoH, 1989a). It is concluded that there are advantages of educating mental health staff to a common core level in a multidisciplinary context with five identified community skills. The rationale for this belief follows.

Communication

Over the past three decades there has been debate about the importance of communication in mental health care (Lacey, 1993; Cook and Fontaine, 1991; Aston- McCrimmon, 1986; Shanley, 1984; Cormack, 1983; Altschul, 1972). In this study interview participants linked the importance of communication to transferring information, working with patients and to the purpose of communication; for example, getting information from management. Therefore the ability to communicate is seen as necessary to facilitate multidisciplinary working and to provide effective client care.

Communication was the most important and most commonly used skill identified by all study groups. Therefore training in communication skills could form the basis of multidisciplinary training, aligning everyone to using the same routes and methods of communication. Particular groups may require specific educational input on communication; for example HCAs may have to learn to use written communication more than at present (Chang, 1995).

Liaison

The findings suggest that liaison is important for multidisciplinary working and consequently for the effective functioning of the community mental health team. For example, interviewees claimed that the purpose of liaison within the multidisciplinary team was to improve the clients care, to ensure that all staff knew their own and others' roles, to use other team members skills to compliment one's own and to enhance service efficiency through information sharing and working together. It is evident that achieving these purposes is in line with current thinking concerning dissemination of information, joint agency working and patient empowerment (DoH, 1994; NHS in Scotland, 1991; Crews, 1990 and DoH, 1989a).

The CDE grades, PAMs and CPNs prioritised liaison in their current posts. Neither FGH grades or HCAs prioritised liaison as a skill but did mention it as an outreach role to the community. Therefore FGHs and HCAs may want to adapt a skill that they already possess to make liaison a more dominant part of their day to day work.

Autonomy

Evidence of autonomous practice in the community is confirmed by the literature (Morrall, 1995; Allen et al, 1990; and Pollock, 1989). CPNs perceive themselves to have autonomy in their role and an independent practitioner status in the MDT. Community staff also said that they had had to learn to become more autonomous when they first moved into the community. Autonomy is therefore an essential component of community practice.

Only the CPNs and PAMs ranked autonomy as important in their role. However, FGH grades considered themselves to be managers and it has been argued that the management role of the FGH grades is akin to that of the autonomous community practitioner (Allen et al , 1990). It would therefore seem reasonable to argue that a straightforward transition could be achieved between manager and autonomous practitioner. Neither the CDE grade nurses or the HCAs identified management or autonomy in their role. Training aimed to facilitate more autonomous practice in CDE grade nurses and HCAs may prepare them to practice effectively in the community. However, interviewees had difficulty in identifying how staff could be educationally prepared to become more autonomous. Education specifically designed to promote autonomy was not identified in the literature.

Counselling

So far the skills that have been considered (communication, liaison and autonomy) enable practitioners to assess and manage cases while working in an MDT context. However, the ability to counsel has been identified as a way of enabling staff to implement care for mental health problems (Lawton, 1990; Tryer, 1990). The importance of counselling for community practice centres round its role in assessment and treatment of mentally ill clients. It was recognised by interviewees that there would be professional differences in counselling e.g. occupational therapists counselling within their specific domain.

CPNs and CDE grades commonly listed counselling as a top five skill. The FGH grades, PAMs and HCAs (no HCAs listed counselling as one of their top five skills) did not list counselling as often. It is not being advocated that all levels of staff counsel clients for therapeutic gain but that the ability to use communication therapeutically to elicit a client's perception of any day to day issue is central to client centred care (Rodgers, 1961). In addition, it may be beneficial for HCAs to understand the purposes and benefit of therapeutic counselling by trained professionals in order to support the professionals in their role.

Assessment

Assessment is proposed as the cornerstone of care in *Caring for People* (DoH, 1989a). Only the CPN group put assessment as a top five skill. However the PAMs commonly considered assessment to be one of their MDT roles. The lack of emphasis put on assessment by some staff has been reported elsewhere (Caldock, 1993). Assessment is nonetheless an essential community competency as it is central to the changes incorporated in Government policy (DoH, 1989a).

Although formal assessment of need is likely to be a lead agency (social work) responsibility, the assessment of health needs remains a health professional responsibility. It may be that the need to assess health needs globally will be the responsibility of a manager who is able to allocate resources. Nonetheless following the allocation of resources, all staff must be able to assess clients in day to day situations and at the least be able to report differences from the norm. Interviewees commented that assessment is not a one-off situation but a continual process throughout a clients service contact history. Evaluation of actions form part of later assessments. It is likely that assessment is done informally and as such is often unrecognised, therefore the need is to make it more formal and systematic.

It would seem that all hospital-based groups have to enhance their assessment skills for community practice. It may be that PAMs need to adopt a more holistic role, as key workers, which necessitates a more global perspective and this may be achieved by education on assessment skills.

5.4.3 Summary of the Need to Learn More Skills

The study respondents perceived that they had many skills but this study's data and previous study findings (Lawton, 1990) indicate that more or different skills were required to make the transition from hospital to community practice. It is proposed that educating staff on five common core skills in a multidisciplinary context could facilitate the multidisciplinary working and effective community practice. Subsequent specialisation should be appropriate to organisational and professional role (DoH, 1994).

While it is argued that providing staff with the ability to communicate, liaise, work autonomously, counsel and assess to a common core basic level will promote multidisciplinary working and effective mental health care delivery, it is not claimed that these are the only competencies required or that all staff be equipped with these skills to the same level. Continued utilisation of the wide

of care. Training staff in both hospital and community in these skills may promote the ideal proposed in the Mental Health Nursing Review of the same service regardless of hospital or community location (DoH, 1994). Further training would be beneficial for the unique requirements of each professional group.

While these five skills are considered important to move mental health care into a community centred context, the skills required by mental health practitioners in a mental health multidisciplinary team will continue to evolve as the Health Service and Mental Health Service change. Further skill changes will be required as new Service developments unfold. Therefore the identification of skill needs should continue perhaps through an audit framework and through further research to clarify these findings as a result of the limitations noted above.

This study aimed to address the skill requirements of staff moving from a hospital base to a community mental health team. It is unlikely that all mental health staff will move to a community team, for example some staff may move to work in community residential facilities. Therefore, further research is required to address the skill and other educational requirements of these groups.

5.5 The Current Knowledge of Mental Health Staff and the Need for More Information

It is apparent from the findings and preceding profiles that some mental health staff lack knowledge about community care issues. When asked all study groups indicated further information and knowledge concerning community practice that they required. Therefore the findings are consistent with findings from previous mental health and related research and professional reports that suggest staff need to seek out or be given more information (Reda, 1995; Gousy, 1994; SHAS, 1994; Caldock, 1993; Massey, 1993; Allen et al, 1990; Kennedy, 1990; Korman & Glennerster, 1990).

There were group differences in the information staff possessed and in the methods staff employed to gather their change information. In particular HCAs used passive means to gather information and were the group who were least aware of the community care changes. The differing levels of information awareness between different staff groups may influence the coherent movement towards organisation goals. HCAs also had a less focused perception of the multidisciplinary team than the other study groups and this may adversely influence the effectiveness of the multidisciplinary team. If some staff are not provided or do not seek the necessary information, some individuals may be inadequately prepared to assess and meet the needs and preferences of clients in the community.

5.5.1 The Information Staff Require

There was no consensus of opinion on the twelve statements of central community care issues. Therefore some staff may need to learn more policy information. It is not that mental health respondents had no knowledge of community care changes. Indeed the changes staff expected were consistent with the Government proposals (DoH, 1989a); for example, movement to community care, hospital rundown and multidisciplinary working. The problems were that there were some key issues, such as home care being a priority that 9.1% respondents were not aware and the level of awareness was not consistent within groups or between groups. The consequence of lacking information and differing group awarenesses are that many staff are not able to efficiently work towards or achieve service goals (Caldock, 1993; Scottish Office, 1991).

From the findings it would seem that staff need more information about the adequacy of the provision of client care in the community and about how to care for clients in the community. Staff indicated concern about caring for clients in the community and clients well-being. In addition, when asked about information that they require to move to the community, hospital based staff indicated that they wanted more information about caring for clients in the community. Interestingly, one of the top three responses from all groups except HCAs was that they expected problems for patients in the future mental health services. It may be that the negativity portrayed in the media (MacDermid, 1994; McMillan, 1994; Rye, 1993b) has enhanced the belief that community care will lead to poor client care. HCAs were less likely to use literature as a means of updating practice and getting information about changes and less likely to expect problems for clients. However from this study it was not possible to be certain of the connection between negative media attention and concern for clients. Provision of information about adequacy and delivery of client care would aim to quell fears about patient care and enhance a positive staff belief in the service.

It would seem that staff require information that is pertinent to them as an individual in terms of their own professional role. For example, staff need to know about the aims and objectives of the unit they are employed in and the likely impact of the community care changes on them as an individual member of staff. Previous literature has suggested that community staff have high role ambiguity and the provision of strategic information early on is important to decrease staff turnover (Allen et al, 1990). At a local level individual information could take the form of specific Trust objectives, the likely impact of changes on individual members of staff and the aims and objectives of their particular unit.

In keeping with previous reports (Caldock, 1993; Gilbert, 1993) the findings indicate that staff need more information about community resources for clients. The dominant concern in all groups except community residential staff was about resources such as the whereabouts of and access to facilities for clients. When hospital staff were asked about the information they required, 'resources' was the dominant response. Therefore, it would be wise to provide staff with information about the availability, whereabouts and access to resources for clients.

The above needs for information suggest that the issues that concern staff (adequacy of client care and role erosion) may also be the areas where the staff perceive that they require more information (client care in the community, individuals role). Consequently it is reasonable to conclude that staff want information to alleviate their concerns.

5.5.2 How to give Staff Information

All groups of staff used multiple sources of information about change. However the sources of information utilised differed between the groups studied, particularly for the HCAs who tended to receive information from others, e.g. ward managers, rather than seeking it. Combining the HCAs differing paths of information and the fact that they were the least aware groups of the changes leads one to conclude that alternative methods of informing HCAs need to be sought. It could be argued that this is a professional responsibility as it is the professionals who are accountable for patient care. If so nurses in each clinical area should have a responsibility for educating HCAs in respect of community care, and any other, change.

There are different levels of awareness in the groups making up the multidisciplinary team with the HCAs the least aware group of the changes, and CPNs the most aware group. Unfortunately, co-operation and teamwork may be weakened if staff have different perceptions and priorities (Caldock, 1993). As staff use different means to get information, it would seem sensible to use multiple means to deliver information. The findings suggest, increased use of formal channels of information; more meetings some of which should be on night duty; giving information in writing e.g. memos or newsletter and giving more or different information.

5.5.3 Summary of the Need for More Information

The findings have indicated that staff across all groups need more information about national policy issues and about changes at a local level. Differences between groups in the knowledge they possess have been identified. It has been argued that the differences could effect the efficiency and

effectiveness of the service delivered to the clients. The respondents in this study suggested a variety of ways to improve their satisfaction with information, mainly through increased communication with management.

5.6 The Need for Management Action

Issues requiring proactive management action have arisen from the findings. The needs highlighted above to provide more information and skills are issues for management as well as the Professions.

The potential consequences of management inaction are severe. In that inadequate standards of patient care; poor service efficiency; uncoordinated movement towards organisational goals; unequal employment opportunities and an inability to achieve Trust goals may result from the skill requirements and information requirements of some mental health staff (Cochrane and Jowett, 1994; Caldock, 1993; Lawton, 1990). Therefore, positive management action is required.

5.6.1 The Issues for Management

Respondents were ambivalent about community care reforms. The negativity included low morale, uncertainty, concern for clients, the need for support and insecurity. Some interviewees believed that negativity had an adverse effect on client care. However despite the negativity, many staff remained positive and expressed a wish to continue in mental health care. This confirms previous findings where staff have been found to feel negatively towards some aspects of community care or change and yet positively about the service (Gousy, 1994; Cochrane and Jowett, 1994). Managers would want to consider ways of promoting the positive belief in the service while taking action to overcome the negativity.

In this study there was a great deal of experience available to the mentally ill in that nearly half the respondents had spent greater than 10 years working with the mentally ill. These long-serving staff are considered an asset to a hospital service that is winding down (Allen et al, 1990). However, Massey (1991) suggests that long-term staff in particular have difficulty transferring to work in the community. It has been suggested that:

“Trust in leadership is put into jeopardy when it is perceived that superiors are not concerned with supporting and meeting the needs of nurses. This can lead to a threat to the organisation's vision and a danger of nurses losing their sense of purpose.” (Cochrane and Jowett, 1994 P.227).

The need for additional support and counselling for staff transferring to the community has been considered elsewhere (Lowe, 1994 and Massey, 1991). Thus action is required when managing staff in transition to improve morale, decrease uncertainty, support staff and make them feel more secure while promoting the positive belief in the service.

Participants' mistrust of management may be a threat to patient care and the attainment of organisations goals (Cochrane and Jowett, 1994). Staff proposed that a feeling of trust may be facilitated by increasing the formal communication channels, by management providing all the information that they have (even if management do not 'know all the answers'), by ensuring staff know the plans for the future and by increasing flexibility of information transfer e.g. more meetings on night duty. To promote a positive belief in the service staff would have to trust their managers.

Respondents were dissatisfied with the information they received about changes that had happened so far and wanted improved communication. Even CPNs who appeared relatively aware of the changes were as dissatisfied as other groups of staff. It has been proposed elsewhere that early, effectively disseminated policy statements (Allen et al, 1990) early re-deployment policies (Korman and Glennerster, 1990) and communication in all directions (Massey, 1993) can help transition by decreasing uncertainty, low morale and increasing knowledge of individuals' roles.

In addition to the preceding issues pertaining to staffs' views, there was also a management issue pertaining to equal employment opportunities. Specifically, there was a predominance of males in FGH and CPN positions in the study respondents. Although male dominance in management is indicative of the NHS in general (Ball, Disken & Dixon, 1995; Disken, Wyatt & Dixon, 1995) it may be a symptom of inequality. The response rate in this study was 36%, therefore it is possible that this apparent inequality is a result of the response pattern of respondents and the findings fails to consider other relevant information. However, inequality remains a matter of concern as it has been claimed that the gender inequalities in the NHS have implications for service delivery (Hancock, 1992b).

This study's findings support by Korman and Glennerster's (1990) findings that top class management skills are required to achieve hospital closure without worsening of clients lives.

5.6.2 Action Required by Mental Health Managers

This study's findings and previous literature (Lowe, 1994; Massey, 1993; Hancock, 1992b; Massey, 1991; Allen et al, 1990; Korman and Glennester, 1990) suggest that managers need to be

proactive in order to ensure high quality patient care is delivered and organisational goals are achieved. More transparent communication with information flow in all directions has been proposed (Massey, 1993) as has support and counselling for staff in transition (Lowe, 1994; Massey, 1991).

It is likely that the scale of management action required in this particular health board will be costly in time and money. However high quality health mental health care provided by sufficiently skilled and informed staff is a necessary basis to care delivery. The media, and possibly as a consequence the professional and public, image of community care is negative. Managers require to consider ways of improving the profile of community mental health care - perhaps staff education and enhancing positive service views is one means of achieving this aim. It may be that the action required needs to be centralised and as such come under Government initiatives (Turner-Crowson, 1993).

5.6.3 Summary of Management Issues

The findings indicated that management action was required to decrease uncertainty, improve morale and as a consequence move towards achieving organisational aims. Improved communication, support and counselling for staff and managers being more open with staff have been proposed as solutions.

5.7 Future Research

Within the above discussion some proposals have been suggested for future research; for example the effectiveness of multidisciplinary and individual professional education. Additional issues are considered below.

Other research supports the findings of this study in that many mental health staff were not prepared for community practice; for example just over half the CPNs (White, 1990) and very few of the hospital staff (Lawton, 1990) held community qualifications. Alteration in pre-registration professional education, P2000 for nurses and the increasing role of SCOTVEC certificates have aimed to improve the community preparation of staff. In Scotland formal study is underway to identify the success of the "new" educational initiatives to prepare staff to work in the community. Research into community preparation of staff educated with a qualification for community practice is required.

The minority of mental health staff holding community qualifications begs the question of alternative means utilised to keep up-to-date with changes in patient care. For Nursing, PREP (UKCC, 1990) has forced updating issues to the top of nurses' agendas. Study respondents utilised a myriad of updating methods with literature, formal education and peer discussion topping the list. The literature read was generalist, such as Nursing Times. Despite the efforts made in the general Nursing press to provide updating "tests" and credits for staff one is left to ponder the value of the generalist literature for updating mental health professionals. Further research is required.

The response rate is a matter for further study. When the research relates to sensitive topics issues need to be addressed to identify means of increasing response rates. Perhaps educating the professionals about research and the strict conditions under which researchers must operate (confidentiality of data handling etc.) would increase willingness to participate. Definitive solutions are required.

The study has raised many other issues that researchers require to address.

5.8 Summary of Discussion

It has been discussed that some staff require to learn more or different skills to move from hospital to community; that some staff need more information about community care and that management need to take action to enable mental health service aims to come to fruition. Some actions have been proposed.

The study was limited by the response rate in particular and as such the findings must be considered tentatively. However, findings from similar studies (Allen et al, 1990; Lawton, 1990) and written reports in the professional literature indicate similar beliefs: that is staff need more skills, information and management action is required.

Overall the study has added to the body of knowledge pertaining to mental health care. More work is required to assess the efficacy of the altered training curriculum's for professionals (P2000) and their support workers and to audit the effect of the education designed to help the hospital to community transfer.

Chapter Six

Conclusions and Recommendations

6.0 Introduction

The overall aim of the study was to identify and describe that skill and information needs of a multidisciplinary group of mental health staff on the move to community care. To achieve the overall aim, four research questions were proposed. The conclusions are presented for each research question followed by the overall recommendations in the final section.

6.1 Community Educational Preparation

1. What is current community educational preparation of the different groups of mental health staff that make up a multidisciplinary team?

This study's findings indicated that few hospital based staff and half of the CPNs held a community qualification. However staff used a variety of means, for example literature and formal education, to keep up-to-date with changes. This study did not provide evidence to link the updating methods or qualifications with changes in practice.

6.2 Current Skills of Mental Health Staff

2. What current skills do the different groups of mental health staff perceived that they possess?

Individual professional groups indicated a wealth of skills. Some skills were shared by study groups but others were unique to individual groups. Charge nurses (FGH grades) perceived management skills as most important to their role; staff and enrolled nurses (CDE grades) relied on interpersonal skills and HCAs on personal skills. Thus hospital based nursing staff differ in their perception of skills. Continued identification of the unique skills of each group may promote multidisciplinary working through decreasing concerns about role erosion.

6.3 Skills Required for Community Practice

3. What skills are the current hospital staff going to need to learn to practice safely in a multidisciplinary community team?

This study's findings confirm previous findings (Lawton, 1990) that many hospital based mental health staff need to learn new skills, or adapt current skills, to move to a community based post. It is proposed that five common core skills be used as a basis of multidisciplinary community practice: communication, liaison, autonomy, assessment and counselling. These are the skills that will enable practitioners to work together in the community, with an understanding of each others roles and a means for decreasing inter-professional conflict. The teaching of these skills in a multidisciplinary context will promote, for example interagency working and has been said to decrease costs and professional time (DoH, 1994; Spensley and Langley, 1977). These skills are considered to be the core competencies not a reflection of the total skill requirement.

6.4 Knowledge of Mental Health Staff about Community Care

4. What is the current knowledge level of the different groups of mental health staff about the community care reforms?

Respondents had limited knowledge of community care reforms and the understanding varied between study groups. In order to decrease staff anxieties, promote movement towards organisational goals and to improve efficiency and effectiveness of patient care, mental health staff required more and consistent information about community care reforms. Information about community care policy, such as the facts within the policy as well as the implications; information that is pertinent to them as an individual about changes in their workplace and information about resources would be appropriate information (Allen et al, 1990).

Respondents used a variety of means of accessing information about change and the methods employed differed between the study groups. Dissemination of information using a variety of means and within a multidisciplinary context would move information through the channels already employed by staff. For HCAs in particular, a specific individual to inform them in respect of changes would improve their status as the least informed group.

6.5 Recommendations

The following were recommendations arising from each of the research questions.

- Further research should aim to identify the effect of the updating methods on professional practice and standards of patient care.
- Further research should aim to identify the effectiveness of the skills perceived to be important in this study on standards of patient care.
- All mental health staff should receive education in the five common core skills taught in a multidisciplinary context: communication, liaison, autonomy, counselling and assessment. Subsequent skill specialisation should be in line with professional and individual roles and responsibilities.
- All staff should receive more information about local and national policy changes and how they effect each staff member on an individual level.
- Guidance on whereabouts and access to local resources should be made readily available.
- More proactive means of information dissemination should be sought by management.

6.6 Summary

The study findings are limited by the low response rate. However, it was thought that the study achieved its aims in that further and important information was gained on each of the research questions.

Appendix One

Letters for Pilot Studies

- Item one: Letter requesting access from CMHT manager
- Item two: Letter to CMHT manager requesting names of staff
- Item three: Letter of consent to CMHT pilot participants
- Item four: Letter requesting access from hospital nursing manager
- Item five: Letter requesting names of hospital staff
- Item six: Letter of consent to hospital
- Item seven: Letter to hospital wards confirming appointments
- Item eight: Letter requesting access for interview
- Item nine: Thank you letter to CMHT

Item one: Letter requesting access from CMHT manager

10th November 1993

Dear

Following our telephone conversation of 9.11.93, I would like to request permission to pilot a questionnaire with some of your staff. The questionnaire aims to ascertain information about the skill base of the staff, their thoughts regarding the future of mental health care and some information about their educational level. Confidentiality and anonymity of the participants will be ensured.

If at all possible, I would like to do this in mid-December or early January at the latest.

If you require any further information about this please do not hesitate to contact myself or Professor Lorraine Smith. My extension number is 8368..

Thank you for your assistance with the project to date.

Yours sincerely

Carol Bugge
RESEARCH ASSISTANT

Item two: Letter to CMHT manager requesting names of staff

8th Dec 1993

Dear

Thank you for permission to pilot my questionnaire with your staff.

I would like to distribute the questionnaires on the 10th of January 1994, if this date suits you. Following this I would like to arrange to come back at a later date to ask the staff their opinions on certain aspects of the questionnaire. I was wondering if it would be possible for me to have some time to discuss this with the staff at one of your team meetings.

To allow me to distribute the letters, I would be grateful if you could send me a list of names of your staff. If possible, I would like to involve nurses, occupational therapists, physiotherapists and dieticians if you have members of these disciplines in employment. The list of names would allow me to distribute the questionnaires to specific individuals. There will not be any indication in the returned items that would allow for identification of the participants.

Again if you have any queries please do not hesitate to contact me.

Yours sincerely

Carol Bugge
Research Assistant

Item three: Letter of consent to CMHT pilot participants

7th JANUARY 1994

Dear Colleague,

Pilot study : Multidisciplinary transfer to the community

I would like to request your participation in a pilot study to assess a questionnaire. This questionnaire is to be used in a main study to look at the educational needs of psychiatric staff who are moving from hospital to community.

The pilot study aims to test the ability of the questionnaire to gain the required information. It asks about your education, your clinical strengths and your feelings about the changes in the provision of mental health care.

When you are filling in the questionnaire I would be grateful if you could time how long it takes you to complete and write this down on the space provided on the final sheet. Also on this final sheet is space for your comments on various aspects of the questionnaire such as overall design, order of the questions and relevance of the questions. Please be as critical as you can when filling this in.

All the information given will be anonymous and confidential. A stamped addressed envelope has been provided for the return of the papers. Please return this to me *by Thursday 20th January*.

Following the return of the questionnaires I have arranged to return to discuss the issues raised with you on January 24th.

Your participation in this pilot study would be greatly appreciated. If you have any questions please do not hesitate to contact me on extension 8368.

THANK YOU FOR YOUR TIME.

Yours sincerely

Carol Bugge
Research Assistant

Item four: Letter requesting access from hospital nursing manager

12th November 1993

Dear

I am a Research Assistant at the University of Glasgow working on a project under the supervision of Professor Lorraine Smith. The project I am working on aims to assess the clinical strengths of the care staff in the mental health field and to see how these skills could be utilised in the community environment. The study also aims to gather information about the concerns of the staff with regard to reforms in the provision of mental health care and their movement into the community. The study is sponsored by Ayrshire and Arran Health Board and the main study will be conducted within that locality.

My intention is to collect the information by using a questionnaire which I am currently constructing. I would like to request permission from yourself to pilot this questionnaire with some of the staff in Gartnavel Royal Hospital. This would enable me to identify any problems in the design of the questionnaire prior to implementing it in the main study. I would hope to involve 15 qualified nurses and 15 nursing assistants in the pilot study. The time involved would be approximately one hour per nurse. Confidentiality and anonymity would be ensured.

If it is possible I would like to commence the pilot study in the middle of December or early January at the latest. If you agree I would be pleased to come to Gartnavel Royal Hospital to further explain the pilot and liaise with the appropriate manager in access to your staff.

I would be most grateful for your participation in the study. If you require further information regarding this to help you reach a decision, either myself or Professor Lorraine Smith would be delighted to provide you with the information that you require.

I look forward to hearing from you in the near future.

Yours sincerely

CAROL BUGGE
RESEARCH ASSISTANT

Item five: Letter requesting names of hospital staff

22.12.93

Dear

Thank you for your letter dated 15th December.

I am grateful for your permission to pilot the questionnaire with some of your nursing staff at the hospital.

I look forward to receiving the list of staff from the wards involved. Following this I will contact you again to arrange a date, that is convenient for yourselves, for me to come to the hospital to give out the questionnaires.

Thank you for your assistance with the project to date.

Yours sincerely

Carol Bugge
Research Assistant

Item six: Letter of consent to hospital

31st JANUARY 1994

Dear Colleague,

Pilot study : Multidisciplinary care of the mentally ill

I would like to request your participation in a pilot study to assess a questionnaire. This questionnaire is to be used in a main study to look at some factors that may arise for psychiatric staff in a changing health service. More specifically those factors surrounding the movement towards community care.

The pilot study aims to test the ability of the questionnaire to gain the required information. It asks about your education, your clinical strengths and your feelings about the changes in the provision of mental health care.

When you are filling in the questionnaire I would be grateful if you could time how long it takes you to complete and write this down on the space provided on the final sheet. Also on this final sheet is space for your comments on various aspects of the questionnaire such as overall design, order of the questions and relevance of the questions. Please be as critical as you can when filling this in.

All the information given will be confidential and the anonymity of the participants protected. A stamped addressed envelope has been provided for the return of the papers. Please return this to me *by Monday 14th February*.

Following the return of the questionnaires I would like to come back at a suitable time to discuss some of the issues raised with you.

Your participation in this pilot study would be greatly appreciated. If you have any questions please do not hesitate to contact me on extension 8368.

THANK YOU FOR YOUR TIME.

Yours sincerely

Carol Bugge
Research Assistant

Item seven: Letter to hospital wards confirming appointments

10.1.94

Dear

Following a meeting with the Senior Nurses of the Community and Mental Health Unit, it was agreed that I could come to your unit to distribute questionnaires to yourself and your staff as part of a pilot study.

If it is convenient with yourselves, I will give out these questionnaires on Monday 31st January. I would like to come to the ward and leave the questionnaires with the staff on duty and give them a short explanation of what is involved (this will only take a few minutes). It was suggested to me that mid morning would be a suitable time, therefore I will come to the ward at 1030am on the aforementioned date.

In addition to this I would be grateful if I could return at a later date to discuss the questionnaire with the staff. If possible, I will arrange a suitable time to return when I come to the ward to distribute the questionnaires.

If this time or date is inconvenient, I would be grateful if you could contact me to arrange a suitable appointment. In addition if you have any other queries please do not hesitate to contact me on extension 8368.

Thank you for your willingness to be involved in this pilot study.

Yours sincerely

Carol Bugge
Research Assistant

Item eight: Letter requesting access for interview

7 November 1994

Dear

Multidisciplinary Care in The Community : The transfer of staff from hospital to community

Thank you for giving me permission and asking your staffs permission to be involved in the pilot of the interview schedule for this study. I am most grateful for your assistance and as in the past I appreciate the support that you have given me with this project.

I would be grateful if you would extend my thanks to the staff involved.

Yours sincerely

**Carol Bugge
Research Assistant**

Item nine: Thank you letter to CMHT

3 Feb 1994

Dear

Thank you all very much for your assistance with this study. Your willingness to complete the questionnaires and to give me comments on them was most useful. I feel that the main study will benefit from this pilot run.

The questionnaire is now being piloted again, this time in a hospital setting with some of the changes that you suggested being made.

I have asked my supervisors if you could have a copy of the final report. It was suggested that you write to Professor Lorraine Smith with this request. She may be contacted at the address below.

Once again I would like to thank everyone for their participation.

Yours sincerely

Carol Bugge

Appendix Two

Access to Main Study Sample and Questionnaire Data Collection

- Item one: Letter to chief executives for access
- Item two: Letters requesting names for sample
- Item three: Written information distributed to charge nurses prior to main study
- Item four: Letter of consent to main study sample
- Item five: Questionnaire
- Item six: Letter to staff regarding concerns
- Item seven: First recall letter
- Item eight: Second recall letter
- Item nine: Thank you letter

Item one: Letter to chief executives for access

18th Jan 1994

Dear

We would like to formally request your permission to access the staff employed in the mental health field in Ayrshire and Arran. More specifically, the nursing staff, occupational therapists, physiotherapists and dieticians that are employed by the Community Health Care Trust in Ravenspark Hospital, Ailsa Hospital, Ayrshire Central Hospital and Crosshouse Hospital. Along with the Community Psychiatric Nurses.

The questionnaire is being piloted in Glasgow in January, following this, we will have a better idea of the time taken to fill in the questionnaire. I would like to stress that the data collected will be confidential and that the anonymity of the participants will be protected.

It is hoped that the main data collection will commence in February or March 1994 with the distribution of questionnaires. At a later date, we would like to return to talk to a small subsample of this population who have stated a willingness to be interviewed. This would be to discuss some issues that have been raised in the questionnaire.

If you have any concerns or questions with regard to this request, either myself or Carol would be pleased to discuss them with you .

I look forward to hearing from you.

Yours sincerely

Professor Lorraine Smith
Head of Department

Carol Bugge
Research Assistant

Item two: letter requesting names for sample

10th November 1993

Dear

Following a telephone conversation with Jill Johnson in Manpower Services yesterday, I would like to request a list of the names of the staff working for the Trust in the Mental Health field. More specifically the names and working locations of the nursing staff (qualified and assistants) in Ailsa Hospital, Ravenspark Hospital, Ayrshire Central Hospital (Pavilions one and two) and Crosshouse Hospital (Wards 1D and 1E). In addition the names and working bases of the CPN's occupational therapists, physiotherapists and dieticians that are under Community Trust management. (I am aware that some of these professions are still under the management of the South Trust at present.)

This information would allow me to distribute the questionnaires to named individuals on specific wards or in specific sites. Their names would not be on the questionnaires and the list would be kept confidential. I hope to be ready to distribute the questionnaires in January of next year.

If you have any problems with this request please do not hesitate to contact either myself or Professor Lorraine Smith. I can either be contacted at the College of Nursing and Midwifery at Crosshouse Hospital on extension 2527 or at the University on extension 8368.

I am grateful for your assistance with the project to date and look forward to hearing from you in the near future.

Yours sincerely

Carol Bugge.
Research Assistant

Item three: Written information distributed to charge nurses prior to main study

UNIVERSITY OF GLASGOW, DEPARTMENT OF NURSING STUDIES

**MULTIDISCIPLINARY CARE OF THE MENTALLY ILL
The Transfer of Staff from Hospital to Community**

The National Health Service and Community Care Act 1990 brings care in the community to the forefront of mental health care. This study is concerned with the needs, concerns and thoughts of the staff working in this time of change in mental health care.

The study is to be conducted within the Ayrshire and Arran boundaries and the population involved will be staff, from both hospital and community settings, working in various disciplines who are caring for the mentally ill (nurses, health care assistants, occupational therapists, physiotherapists, dieticians and community residential and field workers.)

The first aim of the study is to identify the clinical strengths and educational level of these staff so that a picture can be established of what is currently offered to the clients. In addition it is hoped to determine what the staff think about the changes that are occurring and their concerns. As well as allowing the staff the opportunity to voice their thoughts in confidence and anonymously, this may help to identify issues that may be addressed by the provision of relevant information.

A further aim is to identify from job descriptions and the literature what skills would be required by staff to work in a community mental health team.

Finally, it is proposed that an educational package be devised in conjunction with Ayrshire and Arran College of Nursing and Midwifery that is sensitive to the skill and information requirements of staff in transition between hospital and community.

This package is aimed to assist staff in transition in a time of change.

This project is based in the DEPARTMENT OF NURSING STUDIES,
UNIVERSITY OF GLASGOW
68 OAKFIELD AVENUE
GLASGOW G12 8LS
041 339 8855

It is funded by AYRSHIRE AND ARRAN HEALTH BOARD
Grant holders PROFESSOR L. SMITH
DR E. SHANLEY
MISS E. GILLESPIE
Research Assistant MISS C. BUGGE (ext. 8368)

Item four: Letter of consent to main study sample

7 March 1994

Dear Colleague

Multidisciplinary care of the mentally ill : The transfer of staff from hospital to community

I would like to invite you to participate in a study concerning community care. This is a multidisciplinary study involving ALL hospital based nurses, health care assistants, occupational therapists, physiotherapists and dieticians involved in mental health care. Also ALL community psychiatric nurses and some community residential workers. The project is based in the Department of Nursing Studies, University of Glasgow and is funded by Ayrshire and Arran Health Board.

I have sent this questionnaire to you at home because I feel that it is important that everyone who wishes to make their contribution should have the opportunity to do so.

I am interested in finding out what you see as your clinical strengths, about your previous education and what you think about mental health care. Your views will be used to develop education programs for helping staff move from hospital to community. Your opinions are therefore important.

The questionnaire is to be completed anonymously. All information will be treated confidentially and it will not be possible to identify any individual in the study. Information will be held securely under the Data Protection Act 1984.

I also hope to interview some people individually about general issues raised by the questionnaires and their personal views. I believe it is important to have some in-depth discussion. Again anyone who agrees to an interview will have their anonymity protected and individuals will not be identifiable in the study.

The questionnaire should take about **30 minutes** to complete. I would be grateful if you could return it to me by **21 March 1994** in the SAE provided. If you have any questions regarding this project please do not hesitate to contact me on extension 8368.

Your help is most appreciated and the responses gained will contribute to the future of the delivery of mental health care in Ayrshire and Arran.

Yours faithfully

Carol Bugge
Research Assistant

Item five: Questionnaire

UNIVERSITY of GLASGOW
DEPARTMENT OF NURSING & MIDWIFERY STUDIES

1	2	3	4
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
FOR OFFICE USE ONLY			

YOUR ANSWERS TO THESE QUESTIONS ARE CONFIDENTIAL AND ANONYMOUS

SECTION ONE PERSONAL DETAILS

Please tick the appropriate box and give details as necessary

1. What is your clinical grade ?
(If you are working at an acting grade please state this acting grade)

A	<input type="checkbox"/>	B	<input type="checkbox"/>	C	<input type="checkbox"/>	D	<input type="checkbox"/>
E	<input type="checkbox"/>	F	<input type="checkbox"/>	G	<input type="checkbox"/>	H	<input type="checkbox"/>

5 ☐ ☐ 6

2. What is your job title e.g. staff nurse ?

7 ☐ ☐ 8

3. Do you work (excluding overtime) : DAY ☐
NIGHT ☐
BOTH ☐

☐ 9

4. Do you work : FULL-TIME ☐
PART-TIME ☐

☐ 10

5. Sex :

MALE ☐
FEMALE ☐

☐ 11

6. What age are you?

UP TO 20	<input type="checkbox"/>	41-50	<input type="checkbox"/>
21-30	<input type="checkbox"/>	51-59	<input type="checkbox"/>
31-40	<input type="checkbox"/>	60 OR OVER	<input type="checkbox"/>

☐ 12

7. Which area do you work in:

Tick one box only

HOSPITAL : ACUTE ADULT MENTAL HEALTH ☐HOSPITAL : ADULT CONTINUING CARE ☐HOSPITAL : ELDERLY ACUTE OR ADMISSIONS ☐HOSPITAL : ELDERLY CONTINUING CARE ☐COMMUNITY PSYCHIATRIC NURSING SERVICES ☐COMMUNITY RESIDENTIAL SERVICES ☐OTHER : PLEASE SPECIFY _____ ☐FOR OFFICE
USE ONLY☐ 13

8. How long have you been employed in your present job ?

LESS THAN ONE YEAR ☐1-3 YEARS ☐4-6 YEARS ☐7-9 YEARS ☐10 YEARS OR MORE ☐☐ 14

9. How long have you worked with mentally ill people (excluding training) ?

LESS THAN ONE YEAR ☐1-3 YEARS ☐4-6 YEARS ☐7-9 YEARS ☐10 YEARS OR MORE ☐☐ 1510. Please tick the professional qualifications that you have which are
related to working with the mentally ill

Tick as many as necessary

RMN ☐CPN ☐EN(PSY) ☐EN ☐SCOTVEC LEVEL 2 DIRECT CARE ☐SCOTVEC LEVEL 2 DOMICILIARY CARE ☐NONE ☐OTHER , PLEASE SPECIFY _____ ☐☐ 16☐ 17☐ 18☐ 19☐ 20☐ 21☐ 22☐ 23

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USE ONLY

24	25	26
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
27	28	29
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

11. Please identify any other professional and/or academic qualifications that you have obtained (including degrees and other professional certificates) ,that have not already been mentioned.

☐ 30

☐ 31

☐ 32

12. Do you keep up to date with changes in client care?

YES ☐ NO ☐

IF YES, please state how you keep up to date.

☐ 33

☐ 34

☐ 35

☐ 36

☐ 37

13. Have you attended any courses and/or seminars that would help you move to a community post ?

YES ☐ NO ☐

IF NO, PLEASE GO TO QUESTION 15

IF YES, PLEASE SPECIFY , the name of the course, where the course was held, the approximate date and the length of the course.

1. NAME _____

LOCATION _____

LENGTH _____

DATE _____

☐ 38

☐ 39

☐ 40

☐ 41

☐ 42

2. NAME _____

LOCATION _____

LENGTH _____

DATE _____

☐ 43

☐ 44

☐ 45

☐ 46

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14. If you have attended any courses that would help you move to a community post please say what you found most useful and least useful about them.

MOST USEFUL _____

LEAST USEFUL _____

☐ 47

☐ 48

☐ 49

☐ 50

☐ 51

☐ 52

15. Please list which professional journals you have read in the past two weeks.

53 ☐ ☐ 54

55 ☐ ☐ 56

57 ☐ ☐ 58

OR NONE ☐

59 ☐

SECTION TWO CLINICAL STRENGTHS

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16. Do you think hospital and community staff use different skills ?

YES ☐ NO ☐

☐ 60

17. Please specify which five clinical and/or personal skills, in order of priority, that you consider to be essential for you in your current working environment.

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____

61 ☐ 62 ☐ 71 ☐
63 ☐ 64 ☐ 72 ☐
65 ☐ 66 ☐ 73 ☐
67 ☐ 68 ☐ 74 ☐
69 ☐ 70 ☐ 75 ☐

[1]
80

18. In your opinion, what is a multidisciplinary team?

- _____
- _____
- _____
- _____

1 ☐ ☐ 2 ☐
3 ☐ ☐ 4 ☐
5 ☐ ☐ 6 ☐
7 ☐ ☐ 8 ☐

19. How do you see your role within the multidisciplinary team?

- _____
- _____
- _____
- _____

9 ☐ ☐ 10 ☐
11 ☐ ☐ 12 ☐
13 ☐ ☐ 14 ☐
15 ☐ ☐ 16 ☐

20. Do you see this role with the multidisciplinary team changing ?

YES ☐ NO ☐

☐ 17

IF YES, how do you see it changing?

- _____
- _____
- _____

18 ☐ ☐ 19 ☐
20 ☐ ☐ 21 ☐
22 ☐ ☐ 23 ☐

21. Please identify how you see your role in relation to :

a) VOLUNTARY ORGANISATIONS _____

b) THE LOCAL COMMUNITY _____

22. What are your concerns, if any, regarding working in the community ?

NONE ☐

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☐ 24

☐ 25

☐ 26

☐ 27

28 ☐ ☐ 29

30 ☐ ☐ 31

32 ☐ ☐ 33

34 ☐ ☐ 35

36 ☐ ☐ 37

38 ☐ ☐ 39

40 ☐ ☐ 41

☐ 42

SECTION THREE INFORMATION ABOUT CHANGES

FOR OFFICE
USE ONLY

Please indicate by ticking the appropriate box if you think the following statements are true or false or you don't know

23. In Scotland, people who have a mental illness are a priority group for community care.

TRUE ☐ FALSE ☐ DON'T KNOW ☐

☐ 43

24. Government policy emphasises that mentally ill people should be cared for in their own home whenever possible.

TRUE ☐ FALSE ☐ DON'T KNOW ☐

☐ 44

25. The Government states that a lot of consideration has been given to what the patients say they want out of services.

TRUE ☐ FALSE ☐ DON'T KNOW ☐

☐ 45

26. There has not been any additional Government funding to assist in the movement towards community care.

TRUE ☐ FALSE ☐ DON'T KNOW ☐

☐ 46

27. There has been no recognition in national policy that staff will have training needs as a result of the movement towards community care .

TRUE ☐ FALSE ☐ DON'T KNOW ☐

☐ 47

28. A Government report emphasises that assessment of a person's need for community services is seen as the cornerstone of care.

TRUE ☐ FALSE ☐ DON'T KNOW ☐

☐ 48

29. Social service departments do not have to obtain a medical opinion before deciding about a person's need for nursing care.

TRUE ☐ FALSE ☐ DON'T KNOW ☐

☐ 49

30. The lead agency for community care is the Social Services Department.

TRUE ☐ FALSE ☐ DON'T KNOW ☐

☐ 50

31. Health Boards and Social Services Departments must plan services jointly for their local communities.

TRUE ☐ FALSE ☐ DON'T KNOW ☐

☐ 51

32. Local and Government guidelines state that the independent sector should be promoted alongside public services.

TRUE ☐ FALSE ☐ DON'T KNOW ☐

☐ 52

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33. Government policy states that practical support for carers should receive high priority.

TRUE ☐ FALSE ☐ DON'T KNOW ☐

☐ 53

34. The number of elderly people suffering from dementia will remain unchanged.

TRUE ☐ FALSE ☐ DON'T KNOW ☐

☐ 54

The following questions ask you to say what you *think* the future holds for mental health care and how you *feel* about the future

35. What do you *feel* about the changes that have happened at your work place so far ?

55 ☐ ☐ 56

57 ☐ ☐ 58

59 ☐ ☐ 60

61 ☐ ☐ 62

63 ☐ ☐ 64

[2]
80

36.a) What changes do you expect in caring for the mentally ill in the future?

1 ☐ ☐ 2

3 ☐ ☐ 4

5 ☐ ☐ 6

7 ☐ ☐ 8

9 ☐ ☐ 10

b) How do you *feel* about working in the mental health services in the future ?

11 ☐ ☐ 12

13 ☐ ☐ 14

15 ☐ ☐ 16

17 ☐ ☐ 18

19 ☐ ☐ 20

FOR OFFICE
USE ONLY

37. Have you felt informed about changes that have happened so far ?

YES ☐ NO ☐

☐ 21

IF NO, what do you feel could be done to improve this?

22 ☐ ☐ 23

24 ☐ ☐ 25

26 ☐ ☐ 27

38. Where do you get information about the changes that are happening at your work?
Tick as many as necessary

- OTHER PEOPLE AT WORK ☐
- PROFESSIONAL JOURNALS ☐
- SELF ☐
- NEWSPAPERS ☐
- TRUST MANAGERS ☐
- WARD MANAGERS ☐
- HOSPITAL NOTICEBOARD ☐
- TEAM BRIEF ☐
- OTHER, PLEASE SPECIFY _____

☐ 28

☐ 29

☐ 30

☐ 31

☐ 32

☐ 33

☐ 34

☐ 35

☐ 36

39. Please identify what you think you need to know to work in the community.

37 ☐ ☐ 38

39 ☐ ☐ 40

41 ☐ ☐ 42

43 ☐ ☐ 44

45 ☐ ☐ 46

☐ ☐ ☐ ☐
47 48 49 50

☐ ☐ ☐ ☐
51 52 53 54

55 ☐ ☐ 56

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USE ONLY

40. Are there any other comments you would like to make about the changes ?

57 ☐ ☐ 58

59 ☐ ☐ 60

61 ☐ ☐ 62

63 ☐ ☐ 64

65 ☐ ☐ 66

[3]
80

THANK YOU VERY MUCH FOR YOUR HELP

.....

Thank you for completing this questionnaire. As I have said in the letter, I would like to interview a small number of the staff to discuss some of the issues that may be raised. If you would be willing to discuss your responses with me in confidence, at a later date, would you please state your name and where I can contact you. I would like to emphasize that your anonymity will be protected and no individual will be identifiable.

NAME _____

CONTACT NUMBER OR ADDRESS _____

If you require any further information to come to a decision about this please do not hesitate to contact me at the number or address below.

**CAROL BUGGE
RESEARCH ASSISTANT
DEPARTMENT OF NURSING & MIDWIFERY STUDIES
UNIVERSITY OF GLASGOW
68 OAKFIELD AVENUE
GLASGOW G12 8LS
041 330 4051**

Item six: Letter to staff regarding concerns

11 March 1994

Dear Colleague

Multidisciplinary care of the mentally ill : The transfer of staff from hospital to community

Over the last week I have distributed questionnaires to many of the staff involved in caring for the mentally ill. I am aware of concern of staff regarding the study.

The concerns seem to centre on the issue of anonymity, particularly the inclusion of the number in the top right hand corner of the questionnaire. This number is **NOT** a personal identification number. It was included for ease of administration on return of the questionnaires. **IF YOU WOULD PREFER PLEASE SCORE OUT THIS NUMBER.** If you are happy to leave the number in place then that would be helpful in administration of the questionnaire.

There is no intention to link any individual to the responses received. The Trust and the Health Board do not have access to the information given in questionnaires. It would be ethically unacceptable to allow the identification of specific individuals. Also by law, all information is held under the Data Protection Act.

I hope that this letter helps to straighten out this issue. I need your help. This is your opportunity to take part in shaping any educational courses which may be developed in the future.

Yours sincerely

Carol Bugge
Research Assistant

Item seven: First recall letter

Dear Colleague

Multidisciplinary care of the mentally ill : The transfer of staff from hospital to community

On the 7 March, I distributed questionnaires to nurses, health care assistants, physiotherapists, occupational therapists, dieticians and community workers. I had asked for these questionnaires to be returned to me by 21 March, I would like to extend this date to **4 April 1994**.

As stated previously, no attempt is being made to link responses to individuals . Management have no access to the questionnaires. If you have not responded because you are unhappy with the number on the form please score/white it out.

If you have already completed the questionnaire then please disregard this letter. If you have not completed it and require another copy please contact me at the number (ext. 8368) or address below. On the other hand if you have yet to complete the questionnaire could you please do so and return it to me by **4 April 1994**. Your responses are important. This is your opportunity to take part in shaping educational courses which may be developed in the future.

At the end of the study, I will send each unit a summary of the final results. You can expect this in June 1995.

I AM GRATEFUL FOR YOUR ASSISTANCE WITH THIS STUDY.

Yours faithfully

Carol Bugge
Research Assistant

Item eight: Second recall letter

6 April 1994

Dear Colleague

Multidisciplinary care of the mentally ill: The transfer of staff from hospital to community

This is the second recall letter to ask you to please return the questionnaire distributed several weeks ago. If you have already completed the questionnaire, thank you and please disregard this letter. If you have yet to complete it I would be grateful if you would return it to me by **30 April 1994**. Please contact me on extension 8368 if you have thrown out or misplaced your questionnaire but are prepared to complete it and I will send you another copy.

This study is about community care and how **ALL** staff feel about this. **EVERYONE'S** opinion is important whether you are a D grade nurse, an A grade health care assistant, an occupational therapy helper or a G grade nurse. This is not only to shape future education but also to find out how people feel about their futures. All information given will be protected in accordance with the Data Protection Act.

I am grateful to those people who have already filled in the questionnaire and would be delighted to receive more responses.

Yours faithfully

Carol Bugge
Research Assistant

Item nine: Thank you letter

3 May 1994

Dear Colleague

Multidisciplinary care of the mentally ill : The transfer of staff from hospital to community

I would like to thank all the staff in Ayrshire and Arran who received questionnaires as part of this study. I would also like to apologise for any inconvenience this may have caused and hope that you have found participating in the study to be worthwhile.

The response rate to date is 35%. If you still have a questionnaire that you would be willing to return then I would be pleased to receive it. It is now my intention to look at what everyone has said and compile a report as accurately as possible of the staffs' views on mental health care. A summary of this report will be sent to each unit in June 1995.

Thank you again for your time and your participation.

Yours faithfully

Carol Bugge
Research Assistant

Appendix Three

Interview data collection

Item one: Interim letter to interviewees while data analysis on-going

Item two: Requests for interviewees to participate

Item three: Recall letter to non respondents

Item four: Information given to interview participants

Item five: Interview schedule

Item six: Professional groups handout

Item seven: Letter to those not interviewed

Item one: Interim letter to interviewees while data analysis on-going

June 1994

Dear

Multidisciplinary care in the community : The transfer of staff from hospital to community

Thank you for saying that you are willing to talk to me about the information you have given in your questionnaire and other, more general issues. Because so many people have said that they are willing to participate in an interview, not everyone who has agreed to be interviewed will be interviewed.

At the moment I am analysing the data from the questionnaires. This is a time consuming process and I therefore hope to be ready to talk about the issues in September.

I will contact you again in the near future to make arrangements with you. If, in the meantime, you require any further information, please do not hesitate to contact me at the address or phone number below (extension 8368).

Your assistance with the project to date is much appreciated.

Yours sincerely

Carol Bugge
Research Assistant

Item two: Requests for interviewees to participate

17 November 1994

Dear

Multidisciplinary Care in the Community : The Transfer of Staff from Hospital to Community

You will remember that you completed a questionnaire earlier this year and gave your name as willing to be interviewed. I would now like to talk to you about some of the issues raised in the questionnaires.

Your name has been randomly selected from all those who agreed to be interviewed. The discussions will be informal and **strictly confidential**. Your name will not be disclosed. The discussions will take 30 to 40 minutes.

I would be grateful if you could return the enclosed slip in the SAE provided giving me details of suitable dates, time and location of interview. If you require any further information or would prefer to make the arrangements by phone please contact me on 041 339 8855 ext. 8368 or on 0563 73833 ext. 2527. If possible could you please return the form within the week.

I am grateful for your assistance with the project to date.

Yours sincerely

Carol Bugge
Research Assistant

Item three: Recall letter to non respondents

Dear

Multidisciplinary Care in the Community : The transfer of staff from hospital to community

Two weeks ago I wrote to you asking if you were still willing to be interviewed as part of this study. If you have already replied then please ignore this letter.

Your name was randomly selected from all those who said that they would be willing to be interviewed. I would like to talk about some of the issues that have been selected from what was said in the questionnaires. I have enclosed a form asking for suitable dates, times and location of interview.

If, on the other hand, you no longer wish to be interviewed, please tick the relevant box on the form. Please return the form in the SAE provided preferably within the next week.

If you require any additional information please do not hesitate to contact me on extension 8368 or on 0563 73833 extension 2527.

Thank you for filling in the questionnaire and I look forward to hearing from you in the near future.

Yours sincerely

Carol Bugge
Research Assistant

MULTIDISCIPLINARY CARE IN THE COMMUNITY

The Transfer of Staff from Hospital to Community

Thank you for agreeing to be interviewed. These are a few points that you may wish to know about the study / interview before we begin.

The study is funded by Ayrshire and Arran Health Board and is managed by The Department of Nursing Studies at The University of Glasgow. The Research Assistant working on the project is Carol Bugge. The overall aim of the study is to identify educational needs of staff who are moving from a hospital to community base and to ask staff their opinions on the changes.

The interview will take 30 to 40 minutes. Notes will be taken during this time and at the end of the discussion I will reflect back on what we have discussed to ensure that I have an accurate understanding. The discussion will centre around points that you raised in your questionnaire and other more general issues that have arisen from the questionnaires overall. The interview is **strictly confidential and your name will not be disclosed.**

Thanks again

Carol Bugge

Item five: Interview schedule

So, what I would like to do is ask you some questions that will help me to clarify meaning of some terms and expressions and also to expand on some key issues. These terms are things that are used commonly.

I'll be taking a few notes as I go along and will reflect back on what we have discussed as various points through the discussion.

I would like to stress that there are no right or wrong answers to the questions it is your thoughts and opinions that I seek.

1. Can we first consider communication.

- COMMUNICATION WAS USUALLY THE SKILL STAFF PUT FIRST/ WHY SO IMPORTANT
- WHAT IS COMMUNICATION? (GENERAL AND COMPONENT PARTS)
- ?LISTENING PART OF IT
- ?GROUP DIFFERENCES (IN WAY AND PURPOSE OF COMMUNICATING)- WHY
- HOW COULD COMMUNICATION BE BETTER ABOUT CHANGES

2. COUNSELLING

Counselling was another skill that a lot of people mentioned.

- From your point of view what do you think counselling is?
- WHO
- DOES THIS SKILL LINK TO COMMUNICATION

3. LIAISON

A lot of people mentioned this

- IN YOUR OPINION WHAT IS LIAISON
- IS LIAISON DIFFERENT IN DIFFERENT SETTINGS (HOSPITAL, COMMUNITY,) HOW IS IT USED AND PURPOSE
- WHO LIAISE WITH IN MDT
- PURPOSE LIAISON IN MDT GENERAL

4.MDT

You said that your role was _____

- Is this the role most _____ have
- ?ATTEND MEETING
- ?DIFFICULTIES BETWEEN GROUPS (NOW/ FUTURE)

5. PATIENT ASSESSMENT

- WHAT IS IT
- WHAT'S INVOLVED FOR YOU

6. PATIENT CENTRED CARE

OK we've talked about counselling, communication and assessment. From your point of view where does the patient fit in with these skills.

- **EXAMPLE OF COMMUNICATING**
- **HOW WOULD AN OUTSIDER KNOW IF A WARD/ TEAM WAS GIVING CARE THAT WAS PATIENT CENTRED - DO YOU THINK THAT THIS HAPPENS HERE ON THE WHOLE**
- **WHAT ABOUT IN COMMUNITY/HOSPITAL (IS THIS PATIENT CENTRED CARE)**
- **IS PATIENT CARE AFFECTED BY CHANGES**
- **WHO GIVES THE CARE**

7. EDUCATION

Community staff thought that had to learn to be autonomous

- **WHAT IS AUTONOMY**
- **YOU HAVE IT IN YOUR PRESENT PLACE OF WORK?**
- **PREPARATION**
- **?ADDITIONAL SKILLS**
- **IF AN EDUCATION PACKAGE HAS A BIT ABOUT SKILLS IN IT, IS THERE ANYTHING ELSE THAT YOU WOULD LIKE TO PUT IN?**

To hospital staff

- **WHAT DO YOU THINK WORKING IN THE COMMUNITY WOULD BE LIKE?**
- **SUPPORT IN COMMUNITY (SAME AS HOSPITAL, ANY PROBS)**

8. INFORMATION

- **There seems to be a good deal of uncertainty within the staff about the future. Can you tell me why you think that might be?**
- **ANY INFO TO IMPROVE**
- **It also seems that some staff think that the information they have been given in the past has not been the truth. Why do you think that is?**
- **ANY INFO TO IMPROVE**
- **THESE FEELING AFFECT PATIENT CARE**

9. CONTINUE

- **DO YOU WANT TO**
- **WHERE IDEALLY**
- **WHY**

10. SKILLS MANAGEMENT

- **WHAT**
- **WHO**
- **LINK TO PATIENT**

RESPONSES

- **The response rate for the study was 36%, do you have any idea about why some staff did not return the questionnaire.**

Item six: *Professional groups handout*

PROFESSIONAL GROUPS

HOSPITAL

HEALTH CARE ASSISTANTS (A/B GRADES)

ENROLLED/ STAFF NURSES (C/D/E GRADES)

SENIOR STAFF NURSE / CHARGE NURSE (F/G/H GRADES)

PARAMEDICAL GROUPS

OCCUPATIONAL THERAPISTS

PHYSIOTHERAPISTS

DIETICIANS

PARAMEDICAL HELPERS (OT OR PHYSIO ASSISTANTS)

COMMUNITY

COMMUNITY RESIDENTIAL STAFF

COMMUNITY PSYCHIATRIC NURSES (E/G/H GRADES)

Item seven: Letter to those not interviewed

30.11.94

Dear

Multidisciplinary care in the community : The transfer of staff from hospital to community

You will remember that you completed a questionnaire for this study earlier in the year and said that you would be willing to be interviewed. There were many people who stated a willingness to be interviewed. As a result of this it was not possible to interview everyone and I therefore randomly selected a small number of people to talk to. Your name was not one of those that was selected.

Never the less, I am grateful for your willingness to be interviewed and you will be informed of the results of the study late in 1995.

Yours sincerely

**Carol Bugge
Research Assistant**

Appendix Five

Example: Categories for Question 17: Skills

The following are the categories generated in response to the question 17 in the questionnaire. A total of 41 categories were generated which collapsed into six broader groups. Analysis was mainly on all 41 categories. However statistics for the six broader groups are also presented here. In addition the accumulated scores (if greater than ten entries in the category) for each of the 41 categories are presented and the number of people who said each category.

GROUP ONE = KNOWLEDGE (n=116; $\chi^2=15.8$ df=5 p=0.01*)

All categories are related to knowledge.

11 KNOW GEN (n=46)

General references to possessing a 'body of knowledge'. Non-specific or specific to broad professional (nursing or paramedical) role. Also the willingness to continue to learn.

N.B. Use of the word knowledge alone is in this category, although it is accepted that respondents may include e.g. a knowledge of mental health or medications in this response this can not be assumed.

Score =156

12 KNOW RESOU (n=13)

Possessing knowledge of resources such as: local facilities, local services, other professions' roles and their whereabouts and resources required.

Score =24

13 KNOW MEDS (n=7)

Knowledge of medications and medication actions and effects.

14 KNOW MH (n=27)

Knowledge of mental health issues and psychiatry. Also psychiatric symptoms and institutionalisation.

Score =102

15 KNOW PT (n=14)

Refers to knowing /understanding the patient and knowing the patients needs rather than action on these needs.

Score =37

16 KNOW EXPER (n=15)

Either single statements of experience or references to experience through time working in the field.

Score =49

17 EDUCATE (n=21)

The ability or practice of training/teaching/educating/advising others. Includes references to preceptorship, teaching relatives, teaching patients and teaching staff.

Score =41

GROUP TWO INTERPERSONAL (n=191, $\chi^2=11.3$ df=5 NS)

Skills to do with conversing/ working with others.

21 *COMMUNICAT* (n=138)

References to communication directly or to talking to people. Also written communication and reporting to others e.g. "reporting anything that I think is relevant to the Staff Nurse". Communication is the recorded category even if explained such as communication = talking and listening to others (Listening is not).

Score =523

22 *LISTENING* (n=46)

References to listening to others. If listening and understanding written, category recorded as listening.

Score =149

23 *COUNSEL* (n=34)

Only direct references to counselling included in this section.

Score =121

24 *LIAISON* (n=68)

Liaison, discussion, relationships with others. Ability to work with others perhaps in a team. All references to team work. Others includes professionals (own professional group and others), clients, relatives. Also the use of interpersonal skills if referenced globally like this. Global idea to cover the notion of working with other people and the ability to do this.

Score =216

GROUP THREE = PROVIDING CARE (n=139, $\chi^2=0.5$ df=5 NS)

Related to giving care.

30 *IMPLEMENT* (n=71)

Any references to direct care giving. Contents commonly non-specific e.g. clinician. Also use of therapeutic approaches (non-specific and specific references). Carrying out clinical procedures. Also clinical expertise included here (tends to suggest practical use rather than knowledge.)

Score =207

31 *OBSERVE* (n=29)

Direct references to observation and observational skills.

Score =95

32 *ASSESS* (n=27)

Assessment of others/ situations. (Others may be any others).

Score =90

33 *CRISIS* (n=7)

References to crisis management and crisis management techniques. Includes the management of aggression.

34 *GROUP* (n=10)

Ability to work with /facilitate groups.

Score =34

35 *REHAB* (n=4)

Ability to provide /plan rehabilitation or programmes.

36 *ENVIRON* (n=13)

Keeping environment clean, tidy safe or monitoring it. Provision of a safe environment.

Score =42

37 *THERSELF* (n=7)

Therapeutic use of self. References to role modelling, self awareness self consciousness in interactions. This is thinking of oneself as a therapeutic tool to help others.

38 *INDIVIDUAL* (n=9)

Treating the client as an individual and maintaining his individuality and dignity in his care.

39 *ADVOCATE* (n=7)

Advocacy for others staff/clients.

GROUP FOUR = MANAGEMENT (n=112, $\chi^2=45.1$ df=5 p=0.001)**

Skills used in directing, facilitating and managing others.

40 *MENT* (n=35)

Direct references to the use of management skills. To do with managing others /units.

Score =103

41 *ORGANISE* (n=22)

Organising others includes delegation.

Score =55

42 *EMF* (n=13)

Enabling/empowering, motivating, facilitating. To do with encouraging others to do better or just to do well. The notion of not doing the job yourself but making it easier for others to do it. Encouragement of others.

Score =38

43 *SUPPORT* (n=18)

Techniques used to support others. Includes supportive, approachable (others may be any others).

Score =33

44 *LEAD* (n=12)

Leadership of others.

Score =43

45 *AUTONOMY* (n=47)

Ability to work alone, also to motivate oneself and to assert oneself with others. Also to organise oneself. Notion of having the ability to encourage yourself and organise yourself.

Score =129

GROUP FIVE = PERSONAL QUALITIES (n=141, $\chi^2=17.8$ df=5 p=0.01*)

Personal entities that individuals possess and they think are valuable to their role.

50 *EMPATHY* (n=34)

Empathy

Score =102

51 *NON/JUDGE* (n=7)

Non-judgmental

52 *GENUINE* (n=2)

Genuineness- genuine approach to care.

53 *CONF* (n=19)

Confidentiality and privacy for clients.

Score =57

54 *COMPASSION* (n=10)

Compassion

Score =28

55 *U/STAND* (n=31)

Understanding (non -specific).

Score =89

56 *PROF* (n=28)

About being a professional : people can trust you; rely on you and you can cope with responsibility.

Score =73

57 *FLEXIBLE* (n=28)

Flexible and adaptable to change.

Score =61

58 *HUMOUR* (n=17)

Having a sense of humour or use of humour.

Score =37

59 *PATIENCE* (n=44)

Patience.

Score =152

60 *ATTITUDE* (n=27)

The use of the word "attitude" to describe various attitudes or having the "right" attitude.

Score =88

61 *C/S* (n=6)

Common sense

62 *OTHPERS* (N=19)

Other personality traits that were written. Includes kindness, pleasant manner, tact and tolerant.

Score =53

GROUP SIX = MISC.

65 *MISC.* (n=28)

Miscellaneous - singular entries.

A total of 1060 responses were recorded to question 17. That is an average of 4.5 skills per respondent.

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