Interprofessional education for community mental health : changing attitudes and developing skills

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Interprofessional Education For Community Mental Health: Changing Attitudes and Developing Skills

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Abstract

This study explores the role of interprofessional education for post-registration mental health professionals in community services. Community mental health services have undergone huge changes in recent years. The need for improved interprofessional team working, the increased use of psychosocial interventions and increased collaboration with users and carers are just some of the demands services had had to adapt to. A part time, university based programme was set up at the University of Birmingham in order to address the needs of community mental health services. This programme is the focus of the present study.

The study is underpinned by a social psychological theory of attitude change, the contact hypothesis, and theories of adult learning and professional education. A systematic literature review of post-qualification education in mental health reveals that there are many gaps in the evaluation literature. This study adds to that literature by examining outcomes for students in terms of their reactions to the programme, attitude change to their own and other professions, as well as attitudes towards service user involvement in mental health services. Finally, change in the behaviour of the students is examined in relation to interprofessional working, the implementation of psychosocial interventions and collaborative working with service users. Multiple methods were used to assess the three levels of outcomes. Standardized questionnaires were used before-and-after the education programme (N=81) in combination with semi-structured individual (N=22) and group interviews with students and observations of the teaching sessions.

Students held strong interprofessional stereotypes that did not change during the programme. Findings suggest that this may be due to the educational environment, which did not encourage interprofessional interactions, or it may a reflection of 'real' interprofessional differences that are reinforced in everyday interactions. Students did increase their use of the two psychosocial interventions taught on the programme despite a lack of time and resources

which was reported as a barrier to implementation. Students also reported increased positive attitudes toward the involvement of service user in mental health services at the end of the programme. The findings of the study suggest that programmes involving mental health professionals can be successful in increasing the use of psychosocial interventions amongst nurses, social workers and occupational therapists and in promoting collaboration with service users. However, they also show that learning together does not necessarily lead to improved working together. The study concludes that interprofessional education programmes should be carefully designed to maximise opportunities for interprofessional collaboration.

Statement of Originality

The data for this thesis were collected whilst I worked as a research assistant on the external evaluation of the University of Birmingham Programme in Community Mental Health. The Project Director (Professor John Carpenter) was also the supervisor for this thesis. The material presented in this thesis was part of the wider research evaluation design. I was specifically responsible for the data collection of the Interprofessional Education Questionnaires. I designed and carried out of the participant observations and semi-structured interviews. I designed questions for the group interviews at the end of year one of the programme and collected data in collaboration with team colleagues. I carried out the analyses of the qualitative and quantitative data as presented in this thesis.

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1. INTRODUCTION

In this study I evaluate the impact of an interprofessional, post-qualifying programme in community mental health on the attitudes, skills and behaviour of students. The programme at the University of Birmingham was set up to address issues of poor interprofessional working, a shortage of staff trained in psychosocial interventions and the need to work more inclusively with service users. This thesis attempts to assess the success of the programme in addressing the three areas.

1.1. Background to the research

At the end of the twentieth century policies, in Britain and many other countries, dictated that mental health services should move away from the hospital base toward the community. These policies, commonly referred to as 'community care', had enormous implications for those who delivered mental health services as well as those who received such services.

During the early 1990s the policies of community care came under the media spotlight. There were well documented examples of some serious, although rare, cases involving the neglect of those with severe and long-term mental health problems (Ritchie et al., 1994). Investigations into such cases typically criticised the inadequacy of communication and transfer of information between health services, social services, and other agencies. As a response to such cases the government emphasised the need to focus services on those with the greatest need and this was to be done by close and effective interagency working (Department of Health, 1995). It was at this time that the role of community mental health teams (CMHTs) was consolidated in British mental health services (Department of Health, 1996). CMHTS brought together mental health nurses, social workers, occupational therapists, psychologists and psychiatrists in order to meet the needs of people with mental health problems.

CMHTs required professionals to work in a team-based way, changing the traditional hierarchy in mental health services. Problems in interprofessional teamworking are commonly attributed to professional socialisation which is traditionally a uniprofessional affair and can be seen to lead to ignorance of the roles of others and negative attitudes about other professions. Interprofessional education has been put forward as a solution to the problem of poor interprofessional collaboration (Hammick, 1998).

The move away from large-scale institutions has not been the only change to affect mental health services. Changes to the way mental health has been understood have been influenced by the growth of the user movement in Britain and by the growth in the evidence base of psychosocial interventions. The influence of the user movement strengthened towards the end of the twentieth century and the principle of user involvement is now advocated by central government, encouraged by service commissioners and accepted as a feature of service development by managers (Pilgrim and Waldron, 1998). To incorporate the principle of user involvement requires changes in the attitudes and behaviour of professionals in their interactions with users.

Developments in research into social and psychological elements of severe mental health problems have led many to question simple theories about the aetiology of schizophrenia and other mental health problems (Fadden, 1998). Psychosocial interventions have increasingly been found to be effective for people with severe and long-term mental health problems (Brown et al., 1972; Falloon et al., 1985; Birchwood, 1996) leading many to believe that psychological and social factors have a role to play in the management of mental health. However, despite evidence to support their use their availability in clinical practice remains poor (Anderson and Adams, 1996). This has led to calls for the increase in training in such interventions (e.g. Onyett et al., 1995).

The need to train the mental health workforce in interprofessional working, the principle of user involvement and the use of psychosocial interventions has therefore come from many different areas. There are still a large number of

gaps in the evaluation literature for post-qualifying training in mental health and many of the claims that training is the solution to problems in mental health services are largely unsubstantiated.

1.2. Research problem

The problem addressed in this research is:

> *How can an interprofessional, post-qualifying, university-based programme help to improve the practice of those who work in community mental health services?*

For the purposes of this study the research problem has been broken down into three research questions and each question has related hypotheses.

The first research question addresses the need to improve interprofessional working amongst health and social care professionals. It aims to investigate how students learn to work in teams and how attitudes may change during an educational programme.

> ***Research Question 1: "How do students learn to work together and how do attitudes to one's own and to other professions change on an interprofessional education programme?"***

Five hypotheses are related to this research question. There are:

Hypothesis 1: All conditions of the contact hypothesis will be present.

Hypothesis 2: Ratings of heterostereotypes (stereotypes held about other groups) will become more positive from the start to the end of the programme as trainees' recognise the skills of others.

Hypothesis 3: Ratings of autostereotypes (stereotypes held about the ingroup) will become less negative from the start to the end of the programme as trainees no longer see their profession as their ingroup.

Hypothesis 4: Perceived autostereotypes (stereotypes about one's own group as seen by others) will become more positive from the start to the end of the programme as attitudes about other professions improve.

Hypothesis 5: Professional identity will decrease and team identity will increase from the start to the end of the programme.

The second research question examines skills, specifically how far learning about psychosocial interventions has translated in to change in behaviour at work or if change in behaviour did not occur what factors were inhibiting it.

Research Question 2: How do students learn about and implement psychosocial interventions in their work with people with severe and enduring mental health problems?"

This research question has three related hypotheses.

Hypothesis 6: Trainees' reported use of psychosocial interventions will increase from the start to the end of the programme.

Hypothesis 7: Perceived barriers to the implementation of psychosocial interventions will decrease from the start to the end of the programme.

Hypothesis 8: Role clarity will increase and role conflict will decrease from the start to the end of the programme as trainees learn new skills.

The third research question examines how a training programme can promote the principle of user involvement.

Research Question 3: "How do trainees' attitudes and behaviour change during and after attending a programme with a focus on service user involvement?"

This research question has one linked hypothesis.

Hypotheses 9: Attendance at a programme with a focus on service user involvement will lead to a positive change in attitude of students towards service user involvement with mental health services.

1.3. Methodology

The study uses quantitative and qualitative methods to answer the three research questions. Standardized questionnaires were used before-and-after the one-year education programme (N=81) in combination with semi-structured individual interviews (N=22) and group interviews with students. Observations of teaching sessions were made in order to increase my understanding of the educational context. The aim of using both qualitative and quantitative methods was to maximise the opportunity for data collection and give voice to the many participants of the programme. .

1.4. Thesis structure

The thesis is presented in a number of chapters and a brief overview of each chapter follows. Chapter 2 outlines the background to British mental health services and the five main mental health professions involved in community mental health teams. The chapter charts the move from institutional-based services to community and team-based services. Reasons for the emphasis on working with people with severe and long-term mental health problems and the change in values concerning users of mental health services are explored. The chapter also examines the evidence that psychosocial interventions have been found to offer benefits for people with severe and long-term mental health problems.

Concepts of 'professionalism' and 'interprofessionalism' are explored in Chapter 3. Sociological and educational theories are used to understand professionalisation and teaching and learning for adults. Models, such as competency-based models of interprofessional education, are considered alongside an analysis of the obstacles to interprofessional education. The chapter uses social psychological theory to understand theoretical assumptions that bringing different professional groups together will improve interprofessional attitudes.

The fourth chapter presents the current state of training for post-qualifying mental health staff through a systematic review of the literature. A total of 26 papers are included in the review and the chapter presents results of the review in six sections, each indicating a level of outcome of training. The chapter draws attention to gaps in the literature at all levels of outcome.

Chapter 5 introduces the programme in Community Mental Health at the University of Birmingham, which is the focus of this study. It also outlines the aim of the study, the research questions and the hypotheses. It presents both the methods used and the methodology. The penultimate section of the chapter discusses the analysis of data and the final section considers the ethical issues faced during the study and the writing up period.

The results of the study are presented in Chapter 6. The chapter presents results in four main sections. The first section is concerned with participation on the programme, including which professions attended the course and which did not. Results related to learning together and attitude change are then presented. The section following this relates to students' learning about and use of psychosocial interventions. The subsequent section concerns the extent that user involvement was covered on the programme, learners' reactions to the user involvement focus on the programme ad service users as trainers on the course. Changes in students' attitudes and behaviour related to user involvement are then outlined. Finally, the experiences of service users as students on the programme are then considered.

In the final chapter the implications of the study are discussed. The chapter pays particular attention to the interprofessional nature of the programme, the conditions that are deemed necessary for attitude change and the application of social psychological theory to interprofessional encounters. The findings from the study in relation to the training and use of psychosocial interventions are then explored in relation to the wider literature in this area. The innovative nature of the programme in relation to involving service users at all levels of the programme is then examined. Limitations of the study are considered within a discussion of methodological issues which relate to the research. Recommendations for future research are made at the end of the chapter with reference to the three areas of the thesis: interprofessional education, psychosocial interventions and user involvement.

1.5. Definitions

Definitions of initiatives that seek to bring together different professionals vary and terminology in this field is often not uniform. For example, multiprofessional, interprofessional and multidisciplinary are often used interchangeably. As a result, in this thesis I will use the CAIPE (1997) definitions of interprofessional education and multiprofessional education. Interprofessional education is used to refer to occasions when two or more professions learn with, from and about one another to facilitate collaboration in practice. Multiprofessional education is used to refer to occasions when two or more professions learn side by side are termed multiprofessional education (CAIPE, 1997).

1.6. Conclusion

This chapter has laid the foundations for the thesis. It has introduced the research problem, the three research questions that I attempt to answer and the hypotheses that are tested. The methodology has been briefly outlined and the structure of the thesis described. A more detailed description of the background, findings and implications of the research follow in the following chapters.

2. THE DEVELOPMENT OF MENTAL HEALTH SERVICES

2.1. Introduction

This chapter examines the historical development of mental health services in Britain. I will argue that it is necessary to comprehend how mental health has been conceptualised in order to make sense of the problems encountered in services today. After exploring mental health services in the 18th, 19th and 20th centuries I will examine the growth of the five main mental health professions. I will look at their professional development both pre- and post-community care policies. Finally, I will appraise the development of the increasingly prominent service user movement in Britain and explore the implications the movement has had on mental health policies, especially in relation to service user involvement.

2.2. Histories of Mental Health Services

To understand how mental health professions work today, it is important to understand the evolution of the professions and the services they have operated in. The history of mental health services is by no means straightforward or clear cut. There are multiple "histories" of mental health and its meanings. The story being told often depends on who is telling it. Traditionally, those who dispensed treatment have told the history of mental health services; little attention has been paid to those who have received those services or treatment. Caution is needed when attempting to outline a history of something as controversial as mental health services. Whilst those who have recorded such a history may not have deliberately misled their readers it is important to note that histories are often written and revised as much in a spirit of self-preservation as any need to find the truth (Newnes, 1999). There are also many theoretical differences in the accounts that have been written to date of the development of mental health services. Here I will outline the development of mental health services highlighting whose viewpoint is being told. History is always complex but this is exacerbated in

the history of 'mental illness' as there are differences of opinion on what it is and some (Szasz, 1961) even question whether it even exists.

Any study of the history of mental health services will immediately draw the reader's attention to the wide variety of terms used, both in the past and at present, to refer to the recipient of services and their supposed underlying "condition" or "illness". What is now referred to as mental distress/ disorder/ illness or health problem was once called 'madness', 'lunacy' and a variety of other terms now considered stigmatising. There is controversy about the use of all terms as not only does each refer to a diverse group of people with differing strengths and problems but also the phrases themselves carry implicit value judgements (Perkins and Repper, 1996). In this thesis I will use the term 'mental health problem' except where the historical context dictates otherwise. In this case I shall use the term as used at the time in order to reflect the beliefs underlying the concept of mental health problems. I will also refer to those who use, or have used, mental health services as service users as opposed to patients. The term patient implies a passive recipient of services (Pilgrim and Rogers, 1997).

2.2.1. The Eighteenth Century

This thesis is concerned with some of the problems that have emerged since the move of mental health services to the community. As such it is easy to think that those who have been considered to have mental health problems have always been removed from the rest of society. Yet it was not until to the nineteenth century that such segregation took place. Up to and including the eighteenth century there was no such formal segregation. Busfield (1996), a clinical psychologist and sociologist, refers to this period as the commercial and charitable healing phase. During this period the dominant view was that 'madness' (as it was then referred to) was organic and that those who suffered from it were not accessible to reason (Paterson, 1997). There appears to be a general consensus that during the first half of the eighteenth century the majority of people with mental health problems were to be found in the community, living either at home or boarded out under the Poor Law (Coppock

and Hopton, 2000). The treatment of mental disorders was, at this time, dominated by superstition, moral condemnation, ignorance and apathy. In 1800 only a few thousand people were confined in establishments, usually gaols, bridlewells or 'madhouses'. The 'madhouses' were private institutions and their organisation was usually prompted by motives of profit. However, abuses and potential abuses of the private 'madhouse' system and Poor Law establishments led some individuals to begin experimenting with more humane methods of care and treatment.

2.2.2. The Nineteenth Century

By the middle of the nineteenth century those who displayed signs of mental distress were clearly defined as a distinctive 'problem population' and there was a rapid growth in asylums to accommodate them. Busfield (1996) refers to as 'the segregation of the insane' phase. The growth in public asylums was influenced by many factors that were pertinent at the time, not least, the noted abuses of the private 'madhouses' and Poor Law establishments which were often brutal or degrading in the extreme (Smith, 1990). Unfortunately, the growth in public asylums was not due purely to attempts to improve the poor conditions of those institutions and their harsh regimes. Other influential factors Busfield (1996) identifies include the economic and political advantage to the state and the opportunities for professional advantage alongside humanitarian concerns. Coppock and Hopton consider the growth in public asylums to be a 'march of progress' from the days of indifference, neglect, and brutality towards a more enlightened 'moral' approach categorised by the application of science, humanitarianism, and benevolence (2000, p.17).

The philosophy of 'moral treatment' became popular during the nineteenth century. It claimed to provide a positive institutional ideology that justified and legitimatised the development of separate institutional provision for the 'mad'. This ideology asserted both the need to remove the individual from existing environmental pressures and the need to create a special, well-ordered institution with its own therapeutic properties. The 'mad' were no longer believed to be totally deprived of their reason and moral treatment aimed to

appeal to their residual reasoning (Coppock and Hopton, 2000, p.18). However, the institutionalisation of those with mental health problems also served other factors. For example, it has been seen as a form of social control (Foucault, 1967). While the move had begun to segregate those deemed to have mental health problems in asylums, similar forms of social containment were taking place with the poor in the workhouses and criminals in prison. Busfield (1996) argues that there was already an institutional bias in the Poor Law system that was heightened by the Poor Law Report 1834. The philosophy of the new Poor Law embodied a view of institutions as a convenient and appropriate way of deterring the economically dependent from applying for Poor Law relief. Simultaneously it was seen as instilling proper social attitudes and values in inmates. By 1845 all county authorities were compelled to establish asylums and to enforce their regulation under the Lunatics Act.

The asylums also offered a professional advantage to those who provided treatment. At this time it was doctors who had the power and control in hospital care and they extended this by expanding into the asylums. Previously laymen had run asylums but they offered material benefits for medical doctors. These included: access to new patients, a broader range of clinical expertise, more adequate training, contact with other doctors and opportunities for clinical research. The advantages that doctors claimed from the asylum system became clear during the twentieth century.

2.2.3. The Twentieth Century

British mental health policy underwent enormous changes in the twentieth century, discussed below. It is perhaps worth noting that whilst I use the term British, Scotland and Northern Ireland have often produced separate guidance or law. However, I have chosen to use the term British as opposed to the more accurate, although limiting, term English. This is because as Rogers and Pilgrim (2001) point out '...the professional norms in the British Isles have more that connects them than separates them.' (p.ix). Many of the themes of policy and its effects have been similar although details may have varied. For

example, major influences on mental health policy in the twentieth century included the formation of the National Health Service and the First and Second World Wars. These influences are much the same for England, Wales, Scotland and Northern Ireland. Of course, the twentieth century also saw the de-institutionalisation of people with mental health problems, as well as those with learning difficulties, physical disabilities and older people. The enormity of de-institutionalisation and its ramifications for services necessitates consideration in its own right.

2.3. The Mental Health Professions

I will now look at how the various mental health professions have developed up to the 1970s before considering the implications of de-institutionalisation. I will concentrate on the five mental health professions that are usually found in community mental health services (Department of Health, 1996). These are nursing, occupational therapy, psychiatry, psychology and social work. This is, of course, not to say that other professions such as the police, probation and general practitioners do not play a role in mental health. They are not however, generally found in community mental health teams in the UK at the present time. I will discuss the development of each profession separately, to show how each discipline has reacted to or pre-empted the events influencing mental health services of the time. I will begin with psychiatry because it is the longest standing of the mental health professions and the dominant discipline in mental health services up to the 1970s.

2.3.1. Psychiatry

The rise of psychiatry as a profession occurred in the nineteenth century with the rise of the asylums. The asylum doctors claimed to offer two advantages: a scientific, rather than moral or spiritual response to 'madness' and a legitimisation for the removal of 'the insane' to medical institutions. Porter (1987) argues that prior to the nineteenth century the resources and institutions had not been developed which would have permitted a single professional group to assume full legal control of those considered mentally ill.

The 1828 Madhouse Act gave official recognition of the role of the medical profession in the management of the 'mentally ill'. This was based on the premise that they were the most appropriately qualified persons to safeguard the physical well being of patients; 'mental illness' was essentially seen as a medical problem. By 1841 the Association of Medical Officers of Asylums and Hospitals for the Insane was founded and its journal The Asylum Journal (which was later to become The British Journal of Psychiatry) followed in 1853. These developments can be seen as arising from the wider contexts of scientism.

By 1900 there were 100,000 people confined in state asylums (Coppock and Hopton, 2000). Once the public asylums were built the rhetoric of moral treatment disappeared. The cost of the asylums meant that any therapeutic element they were supposed to embody had disappeared. Psychiatry changed very little from this period up until the first decades of the twentieth century. Turner (1988) dubs this the era of 'Chubb lock psychiatry' indicating the low level of scientific progress made by psychiatrists.

It was also during this time that Eugenics Theory became popular politically and especially within psychiatry. Worries about a 'declining national stock' increased calls for the segregation of those deemed 'mentally disordered'. However, degeneracy theory was challenged during the First World War when mental distress was seen in men of 'respectable and proven' character after time in the trenches. This encouraged some, especially army doctors, to look at the role of environmental factors in mental distress. The army doctors gained considerable experience in dealing with nervous disorders and after the war there was a boom in outpatient facilities such as those provided by the Maudsley Hospital and the Tavistock Clinic (Coppock and Hopton, 2000, p.3). Observing the success of the army doctors who were using psychological and psychoanalytic techniques encouraged some medical doctors to begin experimenting with these techniques also. Many of these doctors then began making a strong contribution to the discourse about mental disorder and in 1919 the British Psychological Society expanded to include a medical section.

Psychological theories opened up a new area of focus for psychiatry outside the asylum but inside little changed, here patients continued to receive mainly physical treatment.

The early part of the twentieth century was an important time for psychiatry as a profession. By the 1930s professional training in psychiatry was well established. Senior posts in hospitals were restricted to those doctors who possessed the Diploma in Psychological Medicine or Diploma in Mental Diseases. It was also during this time that the Poor Law principle of deterring people from seeking help was overthrown. The importance of voluntary treatment had been highlighted by the needs of those returning from the First World War. The 1930 Mental Treatment Act gave full legislative support to the introduction of voluntary treatment and to outpatient services. Coppock and Hopton argue that this was an important element in facilitating the transfer from a custodial to a therapeutic ethos in psychiatric theory and practice. The Act was based on the conclusions and recommendation of the 1924 Royal Commission on Lunacy and Mental Disorder (the Macmillan Commission). The Commission's ideas on the nature of mental distress, treatment, and aftercare, and its use of medical terminology have been seen by some to be highly significant (Coppock and Hopton, 2000). This inquiry changed the terminology of 'asylums' to 'hospitals', 'attendants' to 'nurses' and 'lunatics' to 'patients'. Pilgrim and Rogers (1997) assert that it was the Macmillan Commission and the following Act that signalled the consolidation of medical hegemony in the field of mental distress.

Psychiatry's stronghold on the field of mental distress was further tightened by the Report of the 1954-7 Royal Commission on the Law Relating to Mental Illness and Mental Deficiency (the Percy Report). The Commission recommended that all matters relating to admission and discharge, whether 'formal' (compulsory) or 'informal' (voluntary) were to be governed by the medical profession. Rogers and Pilgrim (1996, p.69) argue that the Commission had made the following assumptions. Firstly, that 'mental illness' was something that could be identified reliably by psychiatrists. Secondly, that once 'mental illness' was identified, this automatically implied a need for

treatment. Thirdly, that early treatment was so crucial it justified the loss of liberty and fourthly, that psychiatric treatment was effective. Finally, it assumed the integrity of doctors was beyond doubt. The latter end of the twentieth century saw all of these assumptions called into question.

The Commission also made significant steps towards de-institutionalisation. It asserted:

> 'The recommendations of our witnesses were generally in favour of a shift of emphasis from hospital care to community care. In relation to almost all forms of mental disorder, there is increasing medical emphasis on forms of treatment and training and social services which can be given without bringing patients into hospital as in-patients, or which make it possible to discharge them from hospital sooner than was usual in the past.' (Royal Commission on the Law Relating to Mental Illness and Mental Deficiency 1954-57, 1957, p.207)

The aspirations of the Commission were not given full legislative support until the Mental Health Act 1959. The move away from the asylums increased in emphasis from the 1959 Act and through to the 1960s. In 1962 Enoch Powell, as Minister for Health, launched the Hospital Plan. This was the official closure programme for large mental health and mental handicap hospitals and their replacement by a network of services to be provided in the community. Unfortunately, the 1960s were not a period of transition from the asylum to the community. Rather the decade was a period of re-institutionalisation as the 1959 Mental Health Act had a clause that permitted patients to be admitted to any hospital facility, including general hospital units (Rogers and Pilgrim, 1996). To psychiatry, which had always been considered the lowest status branch of medicine this offered an opportunity for them to join their higher status medical colleagues in district general hospitals. In short, the early and mid twentieth century saw psychiatry establish itself as a profession with statutory responsibilities in mental health services and strengthen its own training programme.

2.3.2. Clinical Psychology

Psychology is a relative newcomer to the field of mental health and can trace its roots back to the early 1900s. Pilgrim and Treacher, both of whom have qualified and practiced as clinical psychologists, document the development of the profession (Pilgrim and Treacher, 1992). The first practitioners of clinical psychology in Britain did not emerge until the 1950s and it was 1960 before the profession was formally established. It was the First World War that gave clinical psychology the first opportunity to develop as a new profession. As already noted the effect that the conditions of war had on the mental health of soldiers, regardless of class, cast doubt on the theory that 'mental illness' had a purely biological aetiology. This was especially significant since the breakdown rate amongst officers was even higher than in lower ranks (Pilgrim and Treacher, 1992, p.8).

The successes of the army doctors in treating those suffering shell shock led to a keen interest in psychoanalysis and the predominant view of 'mental illness' changed so that it included some psychological influences. However, it was still mainly seen as a biological matter. Pilgrim and Treacher (1992) contend that it was the retaining of a respect for somatic considerations that ensured non-medical practitioners were excluded from treatment. They have highlighted the Second World War and the approach of 'scientific' psychology as the main developments that paved the way for the profession to grow. They traced the main developments in British clinical psychology back to two institutional settings: the Maudsley Hospital and the Tavistock Clinic. Both these institutions saw psychology grow under important patriarchal medical advocates. The Maudsley Medical School, which became the Institute of Psychiatry in 1948, was organised to include separate autonomous departments of psychiatry, psychology, physiology, biochemistry and biometrics. At the Maudsley, psychology's main role was seen as being limited to the design and administration of mental tests-psychometrics, under the guidance of Professor Hans Eysenck. The medical profession was not threatened by psychometrics, as it was not concerned with treatment.

The challenge of psychologists to establish themselves as more than just psychometric technicians and have the chance to build therapeutic relationships with patients was led by the Tavistock Clinic. The Tavistock Clinic had proved the value of psychological approaches during both world wars. The end of war saw the return of Tavistock staff who were vibrant with the successes and status of their privileged military existence (Pilgrim and Treacher, 1992, p.19). It was felt that the time was ripe to expand and professionalise their clinic. This was despite attacks by Eysenck who was trying to secure psychologists' future as experts in scientific psychometric testing. In the end the Tavistock pioneers withstood the attacks of Eysenck and the defences of psychiatry to protect its stranglehold on therapeutic relationships. The Cassell Hospital opened in 1919 as a NHS in-patient facility to deploy psychoanalytically orientated approaches, establishing psychodynamic approaches within British mental health services.

Prior (1993) outlines the resistance that psychologists met when they tried to assume a role in the treatment of patients. For example, the Trethowan Committee (DHSS, 1977) argued that in the National Health Service there was 'a continuing medical responsibility which [could not] be handed over to any [other] profession' (p.25). It was made clear that the work of psychologists should continue to be overseen by psychiatrists. Pilgrim and Treacher claim that this created great difficulties for the new psychology graduates who were socialised post-war. They had been educated in scientific rationality and egalitarian ideologies and these were incompatible with the hierarchical and authoritarian relationships in the new National Health Service.

2.3.3. Mental Health Nursing

The profession that was until recently known as psychiatric nursing has its roots in the asylum system where nurses were originally attendants. Typically, the attendants were working class men who were selected for their strength as much of the work involved literally "manhandling" people (Rogers and Pilgrim, 1996). In this way they differed significantly from the general nurses of the time who tended to be middle- and upper-class women. This difference in class composition was due to, and perhaps sustained by, the stigma attached to asylums. General nursing was perceived to be a worthier occupation because their patients were from all sections of society whereas those with mental health problems were already a marginalised group (Rogers and Pilgrim, 1996, p.108).

The distinction between the two groups remained official until 1914 when psychiatric nursing became a recognised part of the nursing profession. Working conditions in the asylums were poor, hours were long and pay was at a rate similar to agricultural workers. In 1912, many establishments had 16-hour working days and workers only received one day off per month. The asylums were situated in rural and sparsely populated areas and this combined with the working conditions meant that workers were isolated. Martin (1985) identifies isolation as an important factor in explaining the origins and perpetuation of hospital scandals.

Up until the mid-twentieth century, the care of people with severe mental health problems was largely provided in public psychiatric institutions and most aspects of these institutions were custodial. Trained nurses performed roles such as bathing, feeding, toileting and dressing and preventing patients from harming themselves and others (Butterworth, 1995). In subsequent years other functions were added such as assisting with hydrotherapy, electroshock or insulin coma, while counselling patients has only recently emerged as a role.

2.3.4. Social Work

Psychiatric social work only began to emerge in the early twentieth century. This is not surprising considering that the predominant view of 'mental illness' until the late nineteenth/ early twentieth centuries was that it was an organic deficit. The first psychiatric social worker was employed (under that title), in London, in 1936 and the growth of this profession was slow. According to Titmuss (1963) there were only 24 full time psychiatric social workers in England by 1959. Social work originated outside of the psychiatric hospitals mainly because of the limited way that doctors perceived the social workers' role. Prior (1993) contends that it was generally considered that what went on in a hospital was a medical problem and should therefore be under the control of the medical profession. The main focus of work for psychiatric social workers tended to be with families and in preparing patients to leave the hospitals. In short they were seen in terms of aftercare.

Child guidance clinics have been credited (Timms, 1964) with expanding the role of social work. Child guidance clinics were developed during the 1920s and 1930s in Britain. Psychiatrists and psychologists benefited most from them but social workers were able to find a therapeutic role at these sites. There were, Prior (1993) asserts, three separate developments in the years 1930-50 which encouraged social workers to try and establish themselves as part of the psychiatric system. The first of these developments was that social factors were seen to be intimately involved in the causation of mental disorder. The second was that psychiatric disorders were now seen as widespread in the community and not restricted to a limited number of organically degenerative individuals consigned to the hospitals. Thirdly, there was an expansion in the kinds and number of symptoms regarded as psychiatric.

The therapeutic access given to social workers by child guidance clinics meant that the profession was exposed to and incorporated many of the theories and language of psychoanalysis. This was also evident in the training courses of the 1950s and 60s where trainees were routinely introduced to studies of the nature of human personality and the

psychopathology of family relations. By the end of the Second World War methods of professional intervention included practical techniques such as behavioural therapy, social skills training and various forms of personal counselling.

The 1960s saw a reorganisation of the profession of social work. The Seebohm Report of 1968 led to the generic training for all social workers, including those working in the psychiatric field. The move towards generic training was based on the belief that social work skills were the same regardless of their client group thus there was no need to train psychiatric social workers differently from those who worked with children or people with physical disabilities. This report situated psychiatric social workers in the community under the authority of elected members in the new local authority social services departments rather than under hospital boards and the medical profession. From the 1960s onwards social work has moved towards a greater community focus.

2.3.5. Occupational Therapy

Occupational therapy has its roots in medicine and was developed under the patronage of a few influential doctors (Paterson, 1998). One such influential medic was Dr Elizabeth Casson who worked on the wards of a mental hospital in the 1920's. She was struck by the bored idleness of the patients on the ward and noticed how there was a change in mood and well being when they became involved in purposeful and interesting activities (Grove, 1988). This inspired her to use occupation as a form of treatment. After a visit to the United States of America where she visited a School of Occupational Therapy she came back to England and set up the first English school, Dorset House, in Bristol in 1929.

Both the medical profession and the governments of the day have influenced the growth of the profession of occupational therapy (OT). The profession's first major recognition and publicity came from the British Medical Association when it held an exhibition of OT at its Centenary Meeting in 1932. The few

schools of occupational therapy continued to train people but a major boost for the profession came during the Second World War. After visits to Dorset House the Ministry of Health asked Dr Casson to train large numbers of occupational therapists for hospitals all over the country. Under the programme, 200 candidates were trained for work with psychiatric as well as general hospital patients.

At this time occupational therapy was still based very much in long stay hospitals. Occupational therapy's stated purpose was '...to help these patients readjust themselves to life and guide them back to a useful life either in the outside world or in the hospital community' (Haworth and Macdonald, 1946, p.10). However, occupational therapy has not remained unchanged in the last fifty years. Like all the mental health professions it has had to respond to a number of changes such as advances in medical science and technology, demographic and social factors and legislation (Paterson, 1998). The pharmacological revolution of the 1950s was greeted with great enthusiasm by a number of those involved in occupational therapy. Clauser and Wise (1958) illustrate this point:

> '... due to the administration of the tranquillisers [chlorpromazine and reserpine] ... many patients presented a picture of being more relaxed and better organised as individuals. Hallucinations were much less overt, creating a less distracting atmosphere. The manifestation of hostility appeared greatly decreased, granting the therapist a better opportunity to reach the patient' (p.18).

The Professions Supplementary to Medicine Act 1960 has been highlighted by Paterson (1998), herself an occupational therapist, as a landmark in occupational therapy's professional development. The Act created registration boards for each of the professions covered with powers to provide for the registration of members, for regulating their professional education and professional conduct and for cancelling registration in cases of misconduct. Following this Act the need for a national code for ethics was highlighted. This was drawn up by representatives of the profession and required that

'Members shall not undertake the treatment of any patient except under medical direction' (Joint Council of Associations of Occupational Therapists in Great Britain, 1962).

Some OTs moved from a hospital base to a community base during the 1970's. This coincided with the popularity of the anti-psychiatry movement. The move to the community and the employment of some OTs in social services departments created an ethical dilemma in relation to the requirement to work under medical direction. The concept of medical direction was modified to encompass the client's general practitioner.

2.4. Community Care

While the 1950s and 1960s had seen the beginning of a turn in policy against the large mental hospitals it was not really until the 1970s that asylums hit crisis point. As already seen with the Hospital Plan of 1962, up until this point services for people with mental health problems could be best described as 'reinstitutionalisation' as opposed to de-institutionalisation. Many Services had merely moved from the old large hospital to the District General Hospitals. Yet, policy kept with the notion of community care: the reasons for this are manifold.

Some commentators, such as Scull (1977), have put forward the reason of 'economic determinism'. The old asylums were expensive to maintain and it is this that Scull suggests is the primary reason for the closure of such institutions. However, Scull's argument has been found wanting since the process of de-institutionalisation has its roots in the 1950s. Rogers and Pilgrim (2001) contend that the financial explanations are actually better suited to the 1970s and the fiscal problems precipitated by the OPEC oil crisis. Busfield (1986) identifies the pharmacological revolution and a shift of concern to acute psychiatric problems as other reasons why services moved away from a hospital base. Some argue that the importance of the use of major tranquillisers has been overstated in the history of community care because de-institutionalisation was initiated for a number of groups who did not receive

the drugs, such as older people and people with learning difficulties (Rogers and Pilgrim, 2001). The argument that services shifted their focus away from those with severe mental health problems towards those with acute needs is one that has remained with community care up to and throughout the nineties. I shall consider this argument in detail later.

Rogers and Pilgrim (1996) argue for another perspective, which they label a 'change in psychiatric discourse'. The scientific literature and knowledge base of psychology grew in popularity in the middle of the twentieth century. Its focus on psychodynamic and behavioural theories of mental health challenged the separatist reasoning behind the asylums and mental hospitals. By the mid twentieth century 'mental illness' was commonly considered to have some environmental and social basis and the sharp distinction between those who were sane and insane became blurred. The evidence that anyone could experience mental distress challenged the assumption that the insane should be removed from the rest of society. This meant that impetus for an improvement in services came from a number of sources, not just governmental policies.

For whatever particular reason or collection of reasons, policies of community care continued and in 1975 the White Paper, *Better Services for the Mentally Ill* was published. This laid down, for the first time, the principles of effective community care. Hunter (1992, p.172) identifies these as:

- the expansion of local authority personal services, including social work support
- the relocation of specialist services in local settings
- the establishment of the right of organisational links
- a significant improvement in staffing.

Coppock and Hopton (2000) argue that by the late 1970s it was obvious that the state's interpretation of community care was changing. Whereas, previously the emphasis had been on care *in* the community the incoming Conservative Government of 1979 and the economic pressures of recession

saw a move towards care *by* the community. A major review of mental health services was undertaken in 1978 and culminated in the 1983 Mental Health Act. Unfortunately, little attention was paid to poor service provision and standards in mental health services. Instead, the Act focused on two main issues: - the long-standing issue of civil liberties of detained patients (Coppock and Hopton, 2000) and the highlighting of professional roles and practice in relation to the compulsory detention of patients (Rogers and Pilgrim, 2001).

By the mid-eighties relatively little progress had been made towards meeting the principles of effective community care identified by the 1975 White Paper. The Audit Commission (1986) highlighted the persistent problem of confusion between local authorities' and health authorities' responsibilities for community care. It also identified the underfunding of community services. Whereas some 80-90 per cent of people with mental health problems were now living in the community, more than 80 per cent of the available resources were spent in the hospital sector.

The need for action was apparent and in 1986 the government appointed Sir Roy Griffiths to produce recommendations on the future of community care. The report was published two years later (Griffiths, 1988) and was a personal report that did not take formal evidence but did have a small advisory committee (Payne, 1995). The main principles of the report were that:

- central government should appoint a Minister of Community Care
- local authorities should take the lead role for all community care groups. This included the identification of need, the creation of packages of care and the co-ordination of services
- housing authorities should be responsible for providing only the 'bricks and mortar' component of community care
- health authorities should continue to be responsible for medically required community health services
- public financial support for residential and nursing care should only be given following assessments of the financial means of the applicant and the need for care

- finally, individuals would be expected to plan well ahead for their own future community care needs.

The White Paper *Caring for People* was published in November 1989 and followed much of the Griffiths Report's proposals, although it did not support the recommendation of a Minister of Community Care. It emphasised that local authority social services departments were to become the lead agency for community care. It also outlined plans for social service departments to become 'enabling agencies' (Department of Health, 1989, p.17) with the task of developing a mixed economy of care. This increased the role the independent sector was to play in the provision of community care services. The White Paper spelt out that 'packages' of care were to be organised under the case management (later to be called care management) process.

It was not just local authorities that were expected to make changes; a new responsibility for district health authorities was introduced in 1990 (Department of Health, 1990). This required that all services for people with mental health problems must institute the "Care Programme Approach" (CPA). CPA had much in common with case management. It involved the assessment of continuing health and social needs, the provision of appropriate services and care co-ordination by one named individual, when a person was to be discharged from a psychiatric hospital.

Local authorities and health authorities were encouraged to work together in the provision of services but in reality this caused a number of problems. Not least amongst these were confusions over roles and responsibilities between local authorities and health authorities. In the past the division was clearer; health care equated to hospitals and social care equated to the community. However, most people with mental health needs require a wide range of services.

The National Health Service and Community Care Act was passed by Parliament in the summer of 1990, yet it was not implemented until 1993. Problems in the implementation of the reforms hindered its progress. Mental

health services have undergone enormous changes during the implementation of community care and this meant professionals needed to change their practice. The period from the late 1970s to the present has been a turbulent time for mental health service providers and users as services have adapted to the community base.

2.4.1. Services and Community Care

One of the most fundamental changes to services was the increase in community mental health centres and the creation of community mental health teams. Community mental health centres (CMHCs) arrived in the UK from the USA around the 1960s. They were the product of a federal scheme set up under the guidance of President John F. Kennedy who sought a 'bold new approach' in the delivery of services for those with mental health problems and learning disabilities (Bachrach, 1991). They had a number of aims but primarily they sought to provide services to a broad range of people in an attempt to move away from the 'medical model' (Onyett and Smith, 1998). CMHCs offered a holistic approach to mental health and included a strong emphasis on health promotion and community development. In the UK CMHCs became popular and increased in numbers from one in 1977 to 54 in 1987 (Sayce, 1989). However, whilst many applauded CMHCs for their inclusive approach others criticised them for being over-inclusive, over-ambitious and naïve. The main criticisms of CMHCs were that they overlooked the needs of people with the most complex mental health problems in favour of the 'worried well' and moved against a trend towards service provision in primary care settings (Peck, 1994, 1995; Sayce *et al*, 1991; Patmore and Weaver, 1992). The concentration on those with less severe mental health problems, it was suggested, meant that those who were harder to engage, but often had the greatest need, "fell through the net".

Focus on Severe and Enduring Mental Health Problems

The neglect of the needs of those with severe and enduring mental health problems came to the forefront of the British national conscience in the early 1990s. The media publicised a number of serious, although extreme and

relatively rare cases involving people with mental health problems. Particularly prominent was the case of Christopher Clunis who fatally stabbed Jonathon Zito at a London tube station. Clunis had a diagnosis of paranoid schizophrenia. The report of the inquiry into his care and treatment, referred to as 'The Ritchie Report' (Ritchie *et al.*, 1994), revealed an extremely poor and inconsistent pattern of care by mental health and associated services. The failure of agencies to work together was clear from the inquiry. There had been inadequate communication, liaison, and transfer of information between health services, social services, the police, and other agencies such as housing authorities. It was also clear from the inquiry's findings that policies such as Section 117 of the 1983 Mental Health Act and the care programme approach were not being implemented satisfactorily.

The Ritchie Report was just one that noted the failure of services and professionals to meet the needs of those with the most challenging problems. Professionals and agencies faced a number of difficulties in working together and in implementing the Care Programme Approach and care management. In response to the Ritchie Report the Department of Health produced a document on good practice for discharge and aftercare procedures: *Building Bridges* (Department of Health, 1995). As well as emphasising the need to focus services on those with the greatest need *Building Bridges* also promoted close and effective interagency working. It made it clear that this was necessary as:

> 'The key principle underlying good community care for mentally ill people is that caring for this client group is not the job of one agency alone, just as it is not the responsibility of one professional group alone' (p. 26).

Building Bridges identified community based mental health teams as the most effective way of delivering multidisciplinary, flexible and sensitive services (Department of Health, 1995, P.35). It recognised many of the problems teams encountered and attempted to alleviate the confusion in such services by defining severe mental illness in order that services could be targeted at

the people with the greatest need. It also attempted to clarify some of the confusion over health service led care programming and local authority led care management. It recognised the overlap between the functions of care management and CPA and suggested that CPA was a specialist variant of care management for people with mental health problems. *Building Bridges*, along with the ensuing *Spectrum of Care* guidance (Department of Health, 1996) consolidated the role of CMHTs in mental health services. The *Spectrum of Care* outlined the basic tenets of CMHTs thus:

> 'CMHTs cover defined population groups. This means each team is responsible for delivering and coordinating a specialised level of care. The teams include: social workers; mental health nurses; psychologists; occupational therapists; and psychiatrists' (Department of Health, 1996, p.5).

The above definition leaves much room for variation between teams and indeed teams have taken different forms. Some CMHTs have kept a base at community mental health centres; others have based some workers in primary care. Generally, they offer a range of social psychological and medical interventions to meet the needs of people with mental health problems. However, the increase in CMHTs has not been welcomed by all and problems in the operation of these teams are well documented (Onyett *et al.*, 1994, 1995, 1997). Findings by Onyett and colleagues from a national survey of CMHTs in England and an additional postal survey of team members in 60 of these CMHTs indicated that many staff were emotionally over-extended and exhausted. A major pressure for respondents was the lack of resources. They also found that on average, people with severe and long-term mental health problems make up less than half of a CPNs caseload. Onyett *et al.* (1995) recommend that CPNs' training should include providing psychosocial interventions for this user group specifically.

Psychosocial interventions

Onyett and colleagues claim that psychosocial interventions have been found to be effective with people with severe and enduring mental health problems.

They refer to a number of studies which began in the 1950s when the move to the community and the closure of long-stay institutions saw many people with mental health problems living with their relatives and researchers began to study the effects on their relapse rates. An early study from Brown *et al.* (1958) found that people who had schizophrenia who returned to live with their parents and close family did worse than those who lived alone or in hostel accommodation. This prompted research into the home environment and resulted in the development of the measure of Expressed Emotion (Tarrier, 1996). The exact nature of Expressed Emotion (EE) is still the subject of some debate but it is now considered to have three dimensions; the frequency of critical comments, the presence of hostility, and the magnitude of emotional overinvolvement. The continued work of Brown and others in the field (e.g. Brown *et al.*, 1972; Vaughn and Leff, 1976) developed the concept of EE and it was found to be associated with higher levels of relapse. This combined with the discovery of the inadequacies of neuroleptic medication led some to question simple theories of the aetiology of schizophrenia (Fadden, 1998).

In reply to such questions about the aetiology of schizophrenia a vulnerability-stress model suggesting triggers for episodes of schizophrenia was put forward by Zubin and Spring (1977). Nuechterlein and Dawson (1984) and Nuechterlein (1987) have since refined the model. They suggest that a range of biological, psychological and psychosocial factors interact, and influence the course and outcome of schizophrenia. The model views episodes as resulting from an interaction of stressful events in the environment and an individual's inherent vulnerability. The view that psychological and social factors have a role to play in the management of schizophrenia led to the development of a number of psychosocial strategies to bring about positive change in the course of the disorder (Tarrier, 1996).

Many studies have concentrated on the role of the family, especially families where there is high EE. Interventions were developed in order to change the Expressed Emotion by educating families about schizophrenia, adopting a practical problem-orientated approach and helping the family to cope better with the difficulties of living with a person with schizophrenia (Tarrier, Haddock

and Barrowclough, 1998). Falloon *et al.* (1985) demonstrate that after two years there was still a significant reduction in relapse rates for those families receiving family intervention compared to control treatments. Mari and Streiner (1996) present a systematic review of family interventions for people with schizophrenia. The review includes twelve randomised control trials and the interventions all offered family psycho-education and support and most included some form of skills based training for relatives. Findings from the review indicate that there is evidence that such interventions reduce relapse rates, rehospitalisation, and costs of treatment and also increase compliance with medication. However, Anderson and Adams (1996) report that despite evidence to support the use of family intervention in clinical practice its availability remains poor.

At the same time as the role of the family was being explored in relation to schizophrenia cognitive behaviour therapy (CBT) was also developing as a treatment for mental health problems. There has been documented evidence of interest in cognitive-behavioural therapy in severe mental health problems since the early 1950s, for example Beck published a case study in 1952 (Beck, 1952). However, it has more commonly been used for depression and anxiety and it was not until the late 1980s that interest in CBT for psychotic disorders increased. Cognitive behavioural therapy is based on the assumption that cognitive and environmental processes influence symptoms or problems and that they can be modified by the use of cognitive and behavioural skills (Haddock *et al.* 1998). Studies have tended to show that psychotic and affective symptoms can be reduced using cognitive behavioural treatments (Tarrier, Haddock and Barrowclough, 1998). The evidence for the individual cognitive-behavioural treatments is weaker than that for family interventions as studies have mainly used case studies or non-randomised controlled trails, with small numbers of participants.

The other recent development in the psychosocial treatment of psychosis has been in early interventions. Birchwood *et al.* (1989) proposed that people with schizophrenia have identifiable individual and characteristic relapse signatures that are displayed before the relapse of their psychotic illness. Therefore, if

service users and family members can be helped to identify what the early signs of relapse are, treatment can be sought quickly. Birchwood (1996) provides evidence that identifying relapse in its prodromal stage and providing pharmacological treatment can reduce the severity of a subsequent relapse and reduce rehospitalisation rates. Despite evidence of the effectiveness of these psychosocial interventions they are still not commonly available in practice.

2.5. The Response of the Professions to Community Care

The developments of mental health services since the 1970s have included the move to a community base, the formation of teams and the development of psychosocial interventions. The professions have responded to these developments in different ways. The move to the provision of services in the community has met with both resistance and enthusiasm by professional groups. According to the literature (e.g. Onyett et al., 1997; Mistral and Velleman, 1997; Peck and Norman, 1999) resistance has tended to come from the professions of psychology and psychiatry. On the other hand, nursing, social work, and occupational therapy have responded rather more positively to the changes and challenges this has demanded.

2.5.1. Community Psychiatry

Psychiatry as a profession has not greeted the move towards community based services with open arms. Instead, the development of services away from the hospital base has been perceived by some as a threat to the profession. The literature (Freeman, 1999; Onyett *et al.*, 1997) highlights a number of reasons for this, such as:

- a continuing strive for equal status with other branches of medicine,
- confusion over the role of psychiatry in the newly organised services,
- a burden of expectations,
- continued ambivalence towards CMHTs,
- the issues of vacancies at all levels of the profession and
- the unsuitability of training.

Psychiatry has long been considered the poor relation in the family of medicine and has fought hard to rid itself of this label. The 1960s saw a number of psychiatrists begin to mount pressure within medicine for the speciality to have its own college. However, they faced considerable resistance and it was not until 1971 that the Royal College of Psychiatrists was established (Freeman, 1999). This was a significant step for the profession and coupled with the move to District General Hospitals saw psychiatry improve its status as a medical speciality. Freeman (1999) voices concern over how long these advances would protect the profession within the pro-community environment. When discussing DGHs he states:

> 'If psychiatry continues to move out of it to 'community' settings, it will once again become isolated, poor and devalued. Psychiatry should then have gone full-circle, to become once more the pariah of medicine.' (P.10-11).

Freeman implies that psychiatry did manage to achieve equality of status within medicine. This claim seems somewhat disputable when pay is examined. Onyett *et al.* (1997) reports that salaries for senior consultants and those managing services were consistently lower in mental health than in other sectors of the NHS. Thus, psychiatry still has some way to go before it has established itself in the medical community. The move away from the hospital base has provided an opportunity for many of the professions that have traditionally been subservient to psychiatry to increase their own autonomy and claim to expert skills and knowledge. This has challenged the interprofessional boundaries and created, as yet, unresolved conflict and confusion.

The second problem with psychiatry and the move to a community base for mental health services has been the confusion over the role of psychiatrists, in the National Health Service generally, but also specifically in the community. The role of mental health managers in the allocation of resources has decreased the role of psychiatrists and created a tension between clinical and

managerial leadership. The role psychiatrists have to play is not clear. Of course, they retain the role of the responsible medical officer that means they are responsible for medical tasks. However, the issue of medical responsibility is complicated by the fact that it also encompasses responsibility for monitoring the health care of users and there is no clear definition of what 'health care' entails (Onyett, 1998, p. 173). Additionally, their contribution to teamwork is less well defined. Peck and Norman's (1999) report on facilitated group discussions of mental health professions are perhaps the best illustration of role confusion.

Peck and Norman report on workshops that were used to explore issues of professional identity and the nature of collaboration between professions in mental health. The facilitated group meetings were held with psychiatrists, nurses, social workers, OTs and clinical psychologists. The professionals met in their disciplinary groups and were asked to write a consensual account of their profession. Later the participants met to discuss the accounts the other professions had written and respond to them. Peck and Norman (1999) summarise the accounts of each of the mental health professions and the responses provided by the other groups. In the group discussions psychiatrists report that they have multiple roles that include: clinician, therapist, clinical leader, supervisor, 'team player', responsible medical officer, researcher, service developer and manager. The ultimate concern the psychiatrists express during these discussions were that they felt there was an expectation from the public and managers that mental health problems such as psychosis, suicide and relapse were solvable and manageable, whereas the reality is much more difficult.

The burden of such expectation is indeed a problem for psychiatrists in the community. Public and political anxiety over risk and people with mental health problems has created a very difficult climate in which psychiatrists operate. In Peck and Norman's group discussions, psychiatrists emerged as the most burdened and demoralised of mental health professions. This finding is consistent with Onyett *et al.*'s (1997) study of CMHTs, which found that of all health professionals psychiatrists had the highest level of emotional

exhaustion, and suffered a greater sense of 'de-personalisation'. The psychiatrists who took part in Peck and Norman's group discussions explained the burden and demoralisation in terms of the expectation on psychiatrists to 'underwrite' a mental health service. Yet, they felt they had only limited control over the service (i.e. responsibility without the power). The psychiatrists in the group also recognised that as a profession they had been slow to adapt to changes, especially those they have been ambivalent about such as the Care Programme Approach and the development of CMHTs.

Unfilled vacancies have apparently been a problem for psychiatry since the formation of the National Health Service (Kendell, 1998) and remain so today. The inadequacies of the data mean it is difficult to gain an accurate picture of the level of unfilled vacancies in any profession (Sainsbury Centre for Mental Health, 2000). However, the report on the recruitment and retention of mental health staff by the Sainsbury Centre for Mental Health (2000) states that in 1998 14% of psychiatry consultant posts were vacant or were filled by locums. This was a 32% increase between 1995 and 1998. It also reported that more than a third of NHS Trusts have difficulties recruiting psychiatrists.

The heavy use of locums in mental health services poses a problem since many are inadequately trained and cannot provide long-term continuity (Sainsbury Centre for Mental Health, 2000). This brings forth the issue of training in psychiatry, for it is not only locums who are inadequately trained. Consultants are said to lack management, consultancy and facilitation skills, which are often ignored in training in favour of the increasing emphasis on bio-medical aspects (Onyett *et al.*, 1997). This is in line with a number of criticisms of psychiatry that argue it concentrates too heavily on biomedical aspects of mental health to the detriment of other influences. Fernando (1992) argues that this is due to the number of attacks psychiatry has faced for not solving the problems of society and has led to institutional psychiatry turning in on itself and returning to the traditional basics of medicine. That is, an emphasis on biological and genetic aspects of health and illness. This return to bio-medical roots has been seen in America, which experienced de-institutionalisation earlier than Britain. American psychiatry has gone through

a significant reorientation, from a psychoanalytical to a biological basis (Shorter, 1997).

Thus, psychiatry as a profession experiences diametrically opposing tensions. On the one side psychiatry is anxious to retain the acceptance of the wider medical profession and so is eager to maximise the bio-medical knowledge and skills of psychiatry. On the other side, psychiatry has to adapt to services that are demanding social, psychological and environmental factors in mental health are acknowledged.

2.5.2. Clinical Psychology

Clinical psychology too has been reluctant and at times hostile towards the development of CMHTs. For example, Mistral and Velleman (1997) report on a survey of all professional members of all CMHTs (17) in one trust. Responses from psychologists in the survey were significantly different from more of their CMHT colleagues, and on more questions, than any professional group. Psychologists also indicated significantly greater agreement than their CMHT colleagues that CMHTs were professionally isolating and that CMHT bureaucracy and inter-professional politics involved too great an amount of work. Compared to other professional groups, psychologists also expressed a greater preference for an independent single professional group as opposed to multiprofessional groups. Mistral and Velleman suggest a number of reasons to account for psychologists' dissatisfaction with CMHTs. These include psychologists' perceptions of:

- CMHT organisation and leadership,
- Optimum use of professional training,
- Professional demarcation and
- Pay differentials.

Organisational and leadership issues are of key concern in CMHTs. Galvin and McCarthy (1994) argue that the question has rarely been asked whether multidisciplinary community teams were the appropriate way of meeting the identified mental health service need. They assert:

> 'In our experience the rationale for team establishments is rarely thought through and little serious thought is given to the skills and expertise needed to provide specific specialist services to meet the needs of potential clients. (Galvin and McCarthy, 1994, 161-162).

Leadership in CMHTs is also a contentious issue. One of the psychologists who responded to Mistral and Velleman's survey in 1997 commented that the main difficulty with their CMHT was that the consultant psychiatrist was the team leader and had very little leadership ability. This highlights the issue of who should lead CMHTs. Traditionally psychiatrists determined treatment in the hospital but no one profession has an automatic leadership role in CMHTs. Instead the position of CMHT managers has been created. However, Norman and Peck (1999) consider that the credibility of managers in CMHTs has been undermined by their failure directly to address power (supported by differences in status, education and remuneration) as a major force that pervades CMHTs. Others (e.g. Onyett *et al*, 1997; Norman and Peck, 1999) note that many psychiatrists in mental health services see themselves as responsible for the work of other professionals as well as their own, and for organisational issues. Norman and Peck (1999) address this by stating:

> 'Although based on the long tradition of relationships in psychiatric hospitals, the vicarious responsibility of the consultant psychiatrist for the clinical practice of colleague professionals from other disciplines within CMHTs is a myth' (p.226).

Norman and Peck (1999) cite Onyett (1995) to support their claim that there appears to be no basis in law or health policy for psychiatrists to shoulder the responsibilities that they do. The issues of role blurring within CMHTs have also been influential in the determination of clinical psychologists' attitudes towards CMHTs. Clinical psychology training requires a first degree in psychology and then a further three years study to gain a doctorate. The extensive training is second, in length of time, only to psychiatry amongst the

mental health professionals and contributes to psychology's claims of specialist skills and hence higher rates of remuneration.

Rogers and Pilgrim (2001) contend that the current orthodoxy of cognitive behaviour therapy (CBT) within the clinical psychology profession has made the encroachment by other professional groups on its role more likely. Since CBT is an eclectic and methodologically-driven form of problem-solving with clients it can be carried out by any professional trained in the approach. The number of training programmes that seek to train multidisciplinary groups in approaches such as CBT is therefore a particular threat to the profession. Rogers and Pilgrim went on to suggest that this problem is exacerbated by the fact that clinical psychology is without a legal mandate for practice in mental health, unlike psychiatry, nursing and social work.

The incorporation of psychological approaches into their practice by other professional groups is yet another example of role blurring which CMHTs are increasingly accused of due to the lack of clarity surrounding the organisation of these teams. Anciano and Kirkpatrick (1990) have been particularly scathing of CMHTs where a "generic mental health worker" stance was adopted. They asserted that it leads to a situation where referrals are made on an arbitrary basis. This, they argue, led to psychologists being expected to do work that is inappropriate considering their skills. They cite the example of psychologists who were asked to take part in running a social club for clients. If psychologists are facilitators of change, such work makes poor use of specialised skills. Without doubt, it is an expensive way to organise such a service although their main objection may have more to do with the perceived loss of status accorded to the performance of these less skilled tasks.

Pay differentials is the final reason Mistral and Velleman identify for their psychologists' dissatisfaction with CMHTs. They argue that throughout the 1990s the pay increases for clinical psychologists were lower than for either doctors or nurses. They suggest that this comparison could lead to a perception of professional inequality, a lowered self-evaluation and increasing dissatisfaction. However, this contrasts with Rogers and Pilgrim (2001) who

argue that by the end of the 1980s remuneration of senior psychologists was close to that of their medical counterparts. Significantly, clinical psychologists working in higher education are able to claim clinical pay scales. The same right has not been given to nurses, social workers, or occupational therapists. This, they suggested, indicated that by comparison psychologists should feel on the positive end of professional inequality and have higher self-evaluation.

Mistral and Velleman (1997), Galvin and McCarthy (1994) and Anciano and Kirkpatrick (1990) all argue that CMHTs are inappropriate environments in which to situate psychologists on a full time basis. They speculate that a consultancy role would be more appropriate. It is perhaps worth noting that none of the authors tackled the concern of Onyett (1999), another psychologist, who suggests that clinical psychologists are so reluctant to take on full team member roles in CMHTs because it involves them working with people who are socially devalued, and commonly demonised as dangerous and unworthy.

Whether psychology will embrace CMHTs is impossible to predict. At present there are a high number of vacancies within the profession. The exact figure for the extent of shortfall is harder to come by, as the British Psychological Society does not publish a breakdown of the numbers of clinical psychologists working in adult mental health services. However, estimates by the Sainsbury Centre for Mental Health (2000) suggest that there were approximately 3000-4000 clinical psychologists and the numbers were steadily increasing. It is, unfortunately, unclear whether numbers will rise sufficiently to meet demand although, this seems unlikely without a dramatic increase in the availability of places on training programmes.

The relative scarcity of clinical psychologists has meant that many work across a number of teams and so do not feel fully committed to any one team. This has led to a large degree of autonomy for clinical psychologists in defining their own highly individual roles within CMHTs (Peck and Norman, 1999). This autonomy is highly valued by its members but is yet another factor that seems likely to mitigate against clinical psychologists becoming

more fully involved in CMHTs. The power of numerically small professions has been discussed so far but perhaps it is now important to examine how the larger professional groups have responded to the challenges of community-based services.

2.5.3. Community Mental Health Nursing

Deinstitionalisation has meant a move for the largest professional group involved in mental health services: that is nursing. The move created an opportunity for psychiatric nursing to leave behind the limitations of the hospital environment. However, it also required a different approach and a different set of skills. Unfortunately, no extra money was set aside for this additional training and many nurses were moved from the large hospital into the community feeling that their training had not prepared them for this new role.

The dominant view of severe and enduring mental health problems, such as schizophrenia, at the time was that they were intractable conditions, which did not respond to psychological methods of treatment (Gournay, 1995). This coupled with the fact that people with schizophrenia often exhibit behaviour which makes engagement with them difficult meant that there was a move towards nurses concentrating their efforts on people with less serious conditions, such as anxiety (Gournay, 1995). This population of people were regarded as easier to work with and often showed signs of improvement relatively quickly. However, a randomised control trial of non-psychotic patients who received input from CPNs in a primary care setting found that there was no difference between the group of patients receiving GP care, and patients seen by a CPN. The same study failed to find evidence that referral to a CPN saved GP time. The authors, Gournay and Brooking (1994), conclude that CPNs should refocus their activity on people with serious mental health problems.

Gournay (1995) argues that public dismay at the sight of vulnerable mentally ill people on the streets, the development of effective interventions in

schizophrenia, the loss of credibility of the anti-psychiatric schools and the success of the various model services which had provided community treatment all influenced the gradual refocus on severe and enduring mental health problems. What Gournay omits in the above list is an influential survey by White (1991), which found that 80% of people with schizophrenia in England were not on a caseload of a mental health nurse working in the community. The same survey also showed that a quarter of CPNs did not have a single person with schizophrenia on their caseload.

This combination of factors led to the Department of Health commissioning Professor Tony Butterworth to head the Mental Health Nursing Review in 1992. The Report was published two years later and made over forty recommendations (Department of Health, 1994). One of the most fundamental was that "the essential focus for work of mental health nurses lies in working with people with serious and enduring mental illness in secondary and tertiary care, regardless of setting". The review also made the recommendation that the title 'mental health nurse' should be used for nurses who work either in the community or in hospital and day services. This recommendation was taken up in the UK and the Royal College of Nursing's Society of Psychiatric Nursing changed its name to the Society of Mental Health Nursing (Butterworth, 1995). The dropping of the term community psychiatric nurse has been seen as a dilution of the impact of medical authority (Rogers and Pilgrim, 2001). However, the name is still commonly used in practice, which begs questions about claims that medical authority has been diluted.

Rogers and Pilgrim (2001) argue that the refusal of community mental health nurses to support the Royal College of Psychiatrists' proposal for Compulsory Treatment Orders was an example of the dilution of medical authority. This proposal would have entailed nurses administering forced medication, by injection, in service users' own homes. Community mental health nurses argued that this would get in the way of the therapeutic relationship they had with service users and they refused to endorse the proposal. Rogers and

Pilgrim identify this as an important factor in the proposal failing to gain legal status.

The stand against Compulsory Treatment Orders taken by community mental health nurses is perhaps indicative of the greater autonomy CMHTs have given nurses (Mistral and Velleman, 1997). Mistral and Velleman suggest that CMHTs offer a freedom from the hierarchical constraints of the hospital system in which they were trained. They went on to speculate that this leads community mental health nurses to make downward social comparisons with hospital-based nurses. Evidence that nurses have responded to the freedom of community services can be found with Leary and Brown (1995). They compare ward-based mental health nurses with their community-based colleagues and report that the ward-based nurses had a far more negative experience. The ward-based nurses experienced less job satisfaction, a lesser sense of personal accomplishment and greater feelings of detachment from their patients.

However, the move to the community has not been a universally positive experience for community mental health nurses. Attempts to keep up with rapid change, confusion about their role within multidisciplinary teams, professional rivalries, low status and low pay have all been identified as factors in the low morale of mental health nurses working in community teams (Onyett *et al.*, 1997). What nurses frequently cite as their most important source of job satisfaction is their clinical contact with service users and "seeing them move on" (Sainsbury Centre for Mental Health, 2000). It is then ironic that the opportunities for promotion with the profession often mean an end to contact with clients and a move to management.

Nursing is also facing internal conflict over the essential skills and knowledge for the profession. Many in the profession aspire to high calibre training whilst others view nursing as an essentially practice-based occupation. This "common-sense" view considers that nursing skills are best learnt on the job. It also makes it very difficult for nursing to protect its role since its area of expertise it not articulated. The introduction of Project 2000, a generic

approach to training all nurses, brought these tensions to the surface and the issue of training is often cited as an area where change is needed. Onyett *et al.* (1997) report that there was a substantial lobby from within the profession for the development of an entirely new qualification in mental health nursing. Training currently involves a three-year degree course, where the first 18 months are spent on a general nursing programme and the final 18 months are spent on a mental health branch programme. This current programme of training has been criticised for failing to give nurses the skills they need to engage service users in therapeutic relationships (Butterworth, 1995). The importance of outlining core skills and knowledge is particularly relevant for nursing since there is much confusion over the roles it, social work and occupational therapy adopt in community mental health services.

2.5.4. Social Work

The fact that social work and community mental health nursing share the same client group, adults with severe and enduring mental health problems, in the same sector, the community, has led some to presume that the professions are interchangeable. However, this ignores a number of important differences between the professions.

Firstly, social work is the longest standing community-based mental health profession. By comparison community mental health nursing is relatively new. Secondly, despite apparently sharing a psychosocial approach with social work, nursing has retained a biological emphasis. Its approach is best described as bio-psycho-social. This, Sheppard (1990) argues, has implications for the services that users receive. He reports social workers acted as advocates, working with outside agencies and professionals as well as tackling more practical, emotional and relationship problems to a far greater extent than CPNs. CPNs rarely used community resources and agencies but where they were involved, CPNs appeared to have a strong reliance on contact with doctors.

Sheppard's work is over ten years old and it is perhaps not fair to compare nursing, pre the Mental Health Nursing Review (Department of Health, 1994), with social work that has a tradition of community-based work. It is a rather obvious expectation that those who were trained in the hospital context will continue to rely on doctors and have fewer community contacts, especially considering many nurses were moved to the community without any extensive retraining. However, more recent evidence suggests that mental health nurses have retained some of their reliance on, and deference to doctors. In Mistral and Velleman's (1997) study of community mental health professionals, nurses indicated significantly more agreement than social workers that professionals need to "form closer ties with GPs". They also indicated significantly greater agreement compared to social workers and occupational therapists that GPs should "have substantial influence over the choice of therapist for referred patients". Miller, Freeman and Ross (2001) present a study of six multiprofessional teams, one of which was a community mental health team. They observed each team and interviewed its members over a 3-month period. They found that CPNs rarely backed social workers in disagreements with consultants. This resulted in social workers finding any challenge to the consultant hard to maintain because they were numerically out numbered. This has implications for any challenges to the medical model. Miller, Freeman and Ross (2001) also note social workers' dissatisfaction with CMHTs when there was an assumption by health professionals that their own input was the more important to the team's work. Social workers were perceived by other members of the team as having a role limited to housing and finance.

The third difference between social work and mental health nursing is that of their legally ascribed roles. Mental health nurses can give depot injections and take a more active role in medical treatment. Social workers on the other hand may have the role of Approved Social Worker (ASW). The role of the ASW was introduced by the 1983 Mental Health Act and with it comes a number of responsibilities and duties in relation to the compulsory admission of patients to hospital. The role has acted to increase the significance of mental health work within social work practice. The role has also had

implications for those social workers with approved status that work in CMHTs. Miller, Freeman and Ross (2001) findings indicated that the regular 'on call' system that requires ASWs to prioritise their ASW work over CMHT meant they were often absent from team meetings. Both the consultant psychiatrist and social workers found that the ASW duties interfered with their work and this was frustrating.

Social workers who took part in the Peck and Norman's (1999) facilitated group discussions perceived the threat that health dominated CMHTs pose to the culture of social work was a major concern. They felt that differences in the culture of social workers and health professionals were often not acknowledged. They also thought it was professional supervision that helped social workers retain their culture, which had been nurtured in their professional training.

Social workers had a particular concern about feeling outnumbered and dominated by health professionals. It is not possible to compare the numbers of social workers with the numbers of mental health nurses working in community mental health services, since the data for social workers in the mental health field are poor. The data has in fact been called the most fragmented for any staff group (Sainsbury Centre for Mental Health, 2000). However, the data available show significant levels of vacancies and rapid turnover in the residential sector. Further, it is not known how many of those categorised as social workers are qualified social workers. Thus again the inadequacy of data prevents any real comparison of professions.

Thus, social work appears to face many of the same challenges as other professions in the move to community services. This is surprising considering its history of providing community services. Yet, it is also understandable considering many of the problems are related to working in health-dominated, multidisciplinary teams. The move away from social services departments has not been easy for social workers. As we have seen with the other professions considered thus far, CMHTs have created a blurring of roles for social workers and the profession must cope with this threat to professional

identification. Whether social work can retain its professional culture remains to be seen. Many of the issues facing social work at present can also be seen by another mental health profession that also often finds itself the single representative in CMHTs: occupational therapy.

2.5.5. Community Occupational Therapy

Occupational therapy has significantly developed its role in community services within the last twenty years and training has also progressed to higher education level to meet these changes. Paterson (1998) considers that the legislation of community care is generally supportive of the humanistic aim of occupational therapy which is to enable autonomous clients to reach their potential while living, learning, working, and playing as integrated members of society. Community care and early discharge from hospital has had implications for the profession, which it has attempted to meet with numerous developments.

The demands of multidisciplinary working have posed problems for occupational therapists. Literature from the USA also provides cause for concern about the position of OTs in mental health, where declining numbers of therapists have been noted (Bonder, 1987; Kleinman, 1992; Paul, 1996). The major problems in mental health in the USA were deficiencies in role definition, unifying theory and research validating practice (Barris and Kielhofner, 1986). Craik, Chacksfield and Richards (1998) claim that the major problems in mental health services identified by Barris and Kielhofner are also present in the UK.

Studies of community-based multidisciplinary teams in the UK have found that occupational therapists feel that they are looked down on by other professionals, especially nurses (Onyett *et al.*, 1997). The occupational therapists that took part in Peck and Norman's (1999) facilitated group discussions felt that there was a widely perceived equivalence between occupational therapists, community mental health nurses and social workers. This, they perceived, resulted in pressure for all professionals to work

generically. Support for this claim is provided by Craik *et al's* (1998) survey of 200 members of the Association of Occupational Therapists in Mental Health to determine the profile of occupational therapists practising in mental health in the UK. The OTs in their study demonstrated concern over the retention of a specialist role when working in multidisciplinary teams. This was opposed to becoming a generic worker or as the participants put it 'not becoming just another keyworker' or 'sliding into the blender'. The pressure for occupational therapists to succumb to the call to work generically is increased since they are often the only representative of their profession in the team. That occupational therapists perceived that their professional role is seen to be neither understood nor respected by other professionals further exacerbates this issue (Sainsbury Centre for Mental Health, 2000).

Data from the Sainsbury Centre for Mental Health's (2000) review on the mental health workforce reveals that occupational therapy has a particular problem with retaining staff. They quote a turnover rate of 51.1% for full-time staff. Although this relates to all occupational therapists, not specifically those working in mental health it does act as an indicator. Mental health is just one area of speciality for OTs who are trained to work with a number of client groups, such as older people, people with learning difficulties and physically disabled people. This relatively high turnover means that occupational therapy is particularly susceptible to the 'freezing' of posts and financial cuts. Since there is likely to be a vacancy that over stretched service managers can always delete or replace with a nurse who has the added use of being able to dispense medication. Occupational therapy posts are therefore vulnerable to the threat of erosion.

The increase in use of talking therapies may further contribute to the role confusion with nurses and social workers. Mental health professionals are increasingly using psychosocial interventions, such as CBT. However, occupational therapists have traditionally operated from a base that uses activity-based treatment rather than talking treatment (Craik *et al.*, 1998). Thus, role confusion and the pressure to work generically may increase unless occupational therapists can articulate to team managers and team

members their unique contribution to the team is and how this is strengthened by the use of specialist skills. This may prove to be difficult in a context where many occupational therapists working in mental health services are relatively inexperienced. Over one third of respondents in Craik *et al's* (1998) survey had worked in mental health for less than five years. Furthermore, 54% of respondents had only worked in mental health. Therefore, they had no experience of the wider role of occupational therapy. The same study also found that one-third of respondents were not managed by an occupational therapist. They argue that while this may be acceptable for more senior practitioners it is a matter of concern that basic grades were managed by non-occupational therapist.

The American literature suggests that one of the key factors of the decline of the occupational therapist in mental health was the deficiency of research that validated the practice of occupational therapy. The picture seems to be much the same in the UK considering the findings of Craik *et al.* (1998) that fewer than half the respondents had participated in research and only 15% had been actively involved in research that was not connected to obtaining a qualification. The respondents were aware of the need for research, audit and evidence-based practice and recognised that together these constituted one of the issues facing the profession

Thus, the evolution of mental health services has been revealing in terms of highlighting many of the problems that currently face the different professional groups. However, what remains missing from this analysis is the voice of those at the core of mental health services: service users.

2.5.6. Service Users

Service users' experience of mental health services has often been excluded from written histories. Although there are a few notable exceptions, e.g. Porter (1987) the history of mental health has often been written from the viewpoint of professionals. Some commentators (e.g. Newnes, 1999) claim that this history is biased, although often unintentionally, towards

professionals with an aim of maintaining their own professional advantage. So far, I have considered how the mental health professions have developed alongside society's changing perceptions of mental health problems. I have also considered the different perceptions of 'mental illness', whether it is seen as organic or as a product of social and environmental problems, or a combination of both. The views presented all take for granted that 'experts' have a privileged view of mental health. However, Rogers, Pilgrim and Lacey (1993) take a viewpoint that is different; they see the user as the expert. Rogers and colleagues argue "both physical and mental illnesses are socially negotiated, and those deemed to be suffering from them on a short-term ('acute') or long-term ('chronic') basis have something of value to say directly from their experience" (p. 17-18).

Pilgrim and Waldron (1998) identify the segregation of those perceived to have mental health problems as one reason why the views of service users have been excluded from discourses on 'mental illness' and mental health services. They assert that mass segregation in asylums obscured the question of citizenship. They identify de-institutionalisation as one reason for the increase in interest in the notion of citizenship and the rise of the user movement. However, even when there has been an increasing research interest in the views of service users of general health and hospital services the interest in the views of those with mental health problems has not been as great. Rogers, Pilgrim and Lacey (1993) trace this disregard of mental health service users' opinions back to the organic bio-medical view of mental health problems. Under such an analysis 'psychiatric patients' (as labelled by this model) have been, and are still, considered by some to be incapable of offering a rational or valid opinion about the services they are using. However, an understanding of the social and psychological factors involved in mental health emphasises the importance of treating all with dignity and respect. Rogers, Pilgrim and Lacey (1993) argue that it is important to listen to the views of those who receive services and it is especially important to listen to those who have been involved in the psychiatric sector. In contrast with most people who use general medical services, whose contact with specialists are generally brief, people with severe mental health problems are

usually involved in long-term and extensive contact with specialist services and professionals.

Secondly, receiving a label of 'ill' is often far more stigmatising and has far greater negative consequences when it is a psychiatric diagnosis as opposed to a physical diagnosis. The negative effects of being labelled "mentally ill" include social exclusion, rejection, poverty and isolation (Sayce, 1998). For example, a survey in the mid 1990s found that only 13% of people with severe mental health problems were actually employed; this was the lowest figure for any other group of people with long-term impairments or health problems (Office of National Statistics, 1997). The results of a survey of service users published a year later revealed that of 778 respondents, 69% had been put off applying for a job because of fear of unfair treatment; 62% said they had been treated unfairly by family or friends and 14% had been physically attacked (Read and Baker, 1996). Despite media portrayals of a link between mental health problems and violence most people with mental health problems are not violent (Sayce, 2000). Indeed, service users are more likely to be victims of crime than offenders (Murphy, 1991). Unfortunately, the police and the Crown Prosecution Service often do not see people with mental health problems as 'credible witnesses' and so these crimes are not recorded (Sayce, 1998).

The first decades of the twentieth century saw a change in attempts to include service users and value their insight. The reasons for this included the civil rights movements of the 1960s and 1970s coupled with the increasing popularity of anti-psychiatry, which challenged the acceptable and legitimate view of psychiatry (Cooper, 1968). Anti-psychiatry questioned the knowledge base of psychiatry and was particularly hostile to the use of physical treatments for mental health problems, particularly the use of electro-convulsive therapy and major tranquillisers.

This attack on psychiatry did not have such a dramatic influence on mental health services in the UK as it did in the USA. Psychiatric services in the UK changed relatively little but the rise of civil rights groups in the USA

emphasised the role of identity and the struggle of marginalised and oppressed groups in modern society. Thus whilst the women's and black movements sought to improve the interests of women and black people so a developing mental health users' movement has sought to improve the rights of people with mental health problems. This movement was again slow to develop in the UK and it was during the 1980s that the movement began to make progress (Rogers and Pilgrim, 1991). The development of community care provided a substantial number of opportunities for this movement, leading, by the early 1990s to both Conservative and Labour government edicts about the centrality of users in planning care and the delivery of services (e.g. Department of Health, 1995).

The 1980s saw the beginnings of a more powerful users' movement. Previously, the mental health users' movement in Britain consisted of two small, but well-established groups. These groups included the British Network for Alternatives to Psychiatry, an alliance of patients and professionals sympathetic to an anti-psychiatry perspective, and the Campaign Against Psychiatric Oppression, consisting mainly of users of mental health services (Peck and Barker, 1997).

In 1985 Survivors Speak Out was formed; this group took a more campaigning stance within the user movement. The strength of the user movement was evident by 1987 when direct action was taken in a campaign against the Royal College of Psychiatrists proposal for Community Treatment Orders. It was around this time that the UK user movement lobbied the Advertising Standards Authority to remove a number of posters published by SANE (Schizophrenia a National Emergency) which these users perceived as stigmatising (Rogers and Pilgrim, 2001).

The philosophy of consumerism, which underpinned policy during the successive Conservative governments in the eighties, also helped to advance the mental health users' movement. The Conservative intentions of rights of individual consumers and the introduction of general management principles challenged the dominance of professionals in the design and delivery of health

and welfare (Coppock and Hopton, 2000). The importance of services being accountable to 'the patient' is a major facet of consumerism. Consumer choice has been introduced through the development of quality assurance mechanisms and the Patient's Charter (Department of Health, 1991). Thus, as central government continued to privatise public services and introduce free market principles and economic libertarianism, a space was created for users.

Nevertheless, the strengthening of the mental health users' movement was not necessarily so simple. The mental health users' movement arose from a quest for self-determination and opposition to medical psychiatry. Hopton (1994/1995) argues that central to this is the right to own and define one's own distress and to have a decisive influence in finding solutions to that distress. The user movement has taken many forms to achieve its aims. Some sectors of the movement want to reform mental health services. Others want them abolished. Some welcome people who support their aims but who have never themselves used mental health services as members. These people have been termed "allies". Other groups see allies as a threat to the integrity of self-advocacy (Rogers and Pilgrim, 2001). The type of action taken also varies with some groups preferring to act as consultants and trying to change systems from 'within'. Others argue for wider, oppositional campaigns.

The influence of the user movement undoubtedly strengthened towards the end of the twentieth century. The principle of user involvement in mental health is now advocated by central government, encouraged by service commissioners and accepted as a feature of service development by managers (Pilgrim and Waldron, 1998). However, the involvement of service users has not been without its problems. Coppock and Hopton (2000) assert that such involvement often smacked of tokenism and that there is rarely any recognition that service users are not a homogeneous group. Collaborative working between professionals and service users is still challenging; it requires professionals to change the way they work, often with no additional training to support and guide their practice. Changing attitudes about user

involvement had been slow prior to the 1980s but support has increased in recent years and this should be reflected in the practice of all those involved in mental health services.

2.6. Conclusion

Mental health services have undoubtedly undergone huge changes since the time of the asylums, particularly in the latter half of the twentieth century. The professions who work in mental health services have had to respond to these changes. The move to the community was not simply a geographical one. It also changed the hierarchy established in the long-stay institutions and demanded more flexible professional boundaries. The well-publicised "failures" of community care and the perceived neglect of those with severe and enduring mental health problems resulted in an increased visibility of this group of people and a subsequent concern for appropriate care and treatment. Psychosocial interventions have been found in a number of studies to offer benefits for people with severe and enduring mental health problems who live in the community. The developments made in psychosocial interventions for severe and enduring mental health problems and a concern for 'user involvement' suggest a need for training for the mental health workforce. The need for changes in attitudes towards collaborative working with other professionals and service users, and for training in the use of psychosocial interventions is common to all professional groups in mental health. It would therefore seem appropriate to train these professionals together on a programme that is designed to meet the training needs of all professional groups in mental health.

3. INTERPROFESSIONAL EDUCATION AND THE CONTACT HYPOTHESIS

3.1. Introduction

This chapter will explore issues of professional education with special reference being paid to the premise that educating the mental health professions together can improve working relations and result in positive change for service users. It will also examine the processes that underlie professional identity and interprofessional encounters. This will be done through the use of sociological, educational and social psychological theories that have been applied to professionalisation, teaching and learning and to intergroup relations.

Occasions when two or more professions learn side by side are termed multiprofessional education (CAIPE, 1997). Multiprofessional education often seeks to increase knowledge and develop practice skills of the students who take part but generally it does not attempt to change the attitudes of participating professionals to working together. However, in order to resolve rivalry between professions, overcome prejudices and negative stereotyping it would seem that attitude change is necessary. Interprofessional education has been put forward as a way of meeting these objectives. Interprofessional education has been defined by CAIPE (1997) as occurring when two or more professions learn with, from and about one another to facilitate collaboration in practice. The terms multiprofessional and interprofessional are often used interchangeably, along with a range of other terms, such as shared learning and joint training. This is often very confusing and in order to aid clarity the terms multiprofessional education and interprofessional education are used here according to CAIPE (1997) definitions.

Various bodies have called for closer collaboration between health and social care professionals. For example, *Modernising Health and Social Services* (Department of Health, 1998a) called for education and training to be based

upon a common agenda and *A Health Service for all the Talents* (Department of Health, 2000a) criticised current education and training for failing to take account of the need to support holistic and multidisciplinary care. The premise underlying its exhortation is that it improves collaboration between professions.

Barr (2002) has traced the movement towards interprofessional education in the UK back to the 1960s. Developments in community care, as well as in primary care where some GPs had formed group practices, saw the establishment of teams made up of a number of different professionals. In relation to community care the relocation from long-stay hospitals of individuals who had complex needs as a result of their mental health needs and institutionalisation required that the teams worked closely together. This required flexible boundaries as well as clarity of objectives. However, flexible boundaries also increase the risk of disputes. Professions have invested time and energy in protecting the interests of their members and this has often been at the expense of their relations with other professions, who may be seen as competing for status and its rewards.

3.2. Professionalism

The ultimate aim of interprofessional education, as outlined by CAIPE (1997), is to facilitate collaborative practice to improve the quality of care for patients or users. This is a very ambitious aim and put so simply it hides the complexity involved in attempts to operationalise it. In fact, interprofessional education is an extremely complex area. Barr (1998) expanded on some of the objectives of interprofessional education covered by its aim to improve collaboration. These include modifying attitudes and perceptions, enhancing motivation, securing common knowledge bases, reinforcing collaborative competencies, effecting change or improvement in practice and benefiting patients. Not all programmes of interprofessional education (IPE) attempt to cover all these objectives but their aims will usually cover one if not more of

the objectives. Whilst many agree that IPE is a good idea, there is little consensus on how to put it into practice.

Attempts to understand interprofessional collaboration are require examination of the concept of 'professionalism' and exploration of the reasons for poor collaboration between the professions. There are many competing definitions of professionalism but no one generally accepted view. Carrier and Kendall (1995) define professional life as being based upon the possession of certain attributes in as much as, the work of professionals is dignified, skilled and proficient and is undertaken for financial rewards as opposed for charitable purposes. Becher (1999) adds other attributes to this list, such as professionals are intellectually and practically trained in a skill that enables them to offer a specialised service. The service usually calls for a high degree of detachment and professionals collectively have a particular sense of responsibility for maintaining the competence and integrity of the occupation as a whole. Finally, Becher notes that professions are organised in bodies that, with or without state intervention, are concerned to test and regulate standards of competence and conduct. Becher recognises that a number of features are omitted from the list such as autonomy and the recognised entitlement to material rewards and a high level of status. However, as Eraut (1994) acknowledges the lack of one clear generally accepted definition of a profession results in a list of traits of the most powerful professions which others seek to emulate. Eraut uses Johnson's (1972) definition of 'professionalization' as being the process by which occupations seek to gain status and privilege.

Professional groups have been characterised in numerous ways. For example, Etzioni (1969) distinguished between 'semi-professions' and 'full-professions'. Social work, nursing and occupational therapy are considered to belong to the category of semi-profession because of the perceived limitations of their knowledge-base, training and autonomy whilst medicine is considered a full profession. There is no doubt that differences between the professions have led to differences in rewards and status.

Professional status is secured by four factors according to Becher (1994), one of which is professional knowledge. In order to establish high professional status a profession's knowledge base should be seen as specialised and technical as opposed to commonsensical and straightforward. On this scale the knowledge base of medicine is seen as specialised and technical, as is psychology that has a knowledge base rooted in empiricism and positivism (Pilgrim and Treacher, 1992, p.172). The knowledge base of social work is based upon the social sciences. However, much of this knowledge base is seen as commonsensical and straightforward. Eraut (1994) argues that social work has had some difficulty in articulating a distinctive knowledge base. Nursing and occupational therapy have also suffered from not having a knowledge base that is seen as specialised and technical. In some ways this has been due to a body of opinion within these professions that practice is more important than theory. MacDonald (1995) makes this point:

> 'While practice is an essential part of any profession and its training, in the caring professions there is a considerable body of opinion that holds practice is actually the most important aspect. This is particularly true of nursing, but there and elsewhere this notion has important consequences: first it devalues the knowledge aspect of the occupation, thus casting doubt on its standing as a profession: and secondly, it emphasises the caring part of the occupational task, and as caring is something everyone undertakes in the context of the family, this again devalues the occupation'. (p.135).

Additionally in considering professional status Becher identifies the process of 'closure', whereby professions clearly demarcate themselves from their competitors whilst clearly identifying their members and imposing significant demands on membership. Becher's final two factors that he asserts affect professional status are size and a collective image. Thus, Becher argues, professions that wish to achieve high status should remain small and present a collective front, at least publicly, in political matters.

When this analysis is applied to the mental health professions it can be seen why psychiatry and psychology are perceived as high status professions and nursing, social work and occupational therapy are considered as relatively lower status professions. Psychiatry has been able clearly to demarcate itself from its competitors and impose significant demands on those who wish to become members. In other words, it has successfully achieved closure. As a profession, it has secured legislative powers to prescribe drugs, to admit and discharge from hospital against their patients' wishes if necessary and offer treatment within the NHS (Busfield, 1996, p.132). To close off successfully, a profession must justify that its knowledge base has a technical or scientific rationality and requires specially trained practitioners to use it. Psychiatry appears to meet these criteria. Psychology, although it does not have any formal powers under mental health legislation, has managed to close off from its competitors by guarding entry to the profession and imposing significant demands on those who wish to become members. Entry to professional training for psychology is extremely difficult. Training for clinical psychology is an all-graduate enterprise and members of the profession acquire the title of "doctor" (Clin. Psy. D), drawing parallels with medicine. It is also important to note differences in length of professional training. Social work training is currently a minimum of two years in duration compared to the usual three years for occupational therapy and nursing. It is, however, about to become a three-year training from 2003 under reforms outlined by the Department of Health (2002). Clinical psychology training is six years (three years of which are at a postgraduate level) and psychiatry training involves a minimum of three years following a five-year medical degree and one year's experience as a house officer in a hospital.

As mentioned above professional knowledge has important implications for professional groups. It also plays an important role in professional education that may influence interprofessional education. Eraut (1992) proposes that there are three kinds of knowledge: prepositional, process and personal. He defines prepositional knowledge as discipline-based concepts, generalisations and practice principles that can be applied in professional action (p.103). Propositional knowledge has been the traditional focus of professional

education however the literature on adult learning and professional education suggests that this type of knowledge may not be the best to encourage professionals to work collaboratively, especially in the health and social care professions. Personal knowledge is about the interpretation of experience and the bringing to the surface assumptions, which are then examined for their impact on professional practice. Taylor (1997) contends that it is this kind of knowledge that distinguishes professional education in the interpersonal sphere from other kinds of professional education where personal knowledge may have less direct bearing on practice. Process knowledge is the third type of knowledge identified for professional education. Eraut defines this as 'knowing how to conduct the various processes that contribute to professional action' (1992, p.105).

3.3. Interprofessionalism

Thus there are various forms of professional knowledge that may be used in professional education and these may vary in their suitability when applied to interprofessional education. Professional status and power has traditionally been formed by a profession's ability to insulate itself from others. Professional knowledge, shared during professional education has been one way of doing this. Hammick (1998) argues that the emergence of collaborative practice and interprofessional education means a shift in the traditionally insular fields of knowledge of the individual professions. Hammick uses the work of Bernstein (1996) on the sociology of education to formulate a framework for translating interprofessional education into practice. Bernstein uses the term 'singular discourses' to describe the early organisation of knowledge, for example into areas such as biology and psychology. A change to this classification has been the 'regionalisation' of knowledge into areas of professional knowledge such as medicine.

Hammick proposes that interprofessional education aims to re-contextualise traditional and discrete bodies of professional knowledge into the knowledge of collaborative practice. Hammick goes on to say that IPE achieves its aims

of sensitising students to the role of other professions and teaching the delivery of interprofessional care by undermining the constructs of traditional education.

Hammick does not suggest that this reclassification will be easy. She acknowledges that it will result in 'new power relations' that will compete for new resources and influence. She goes on to suggest that any attempt to put IPE into practice should address this potential for conflict. She draws on the advice of Wilmot (1995) for an understanding of how conflict should be handled. Wilmot (1995, p.259) contends that IPE must create the conditions where there is 'authentic interprofessional dialogue' in which students are clear about their own and others' professional values and communicate, empathetically, their respect for each other. Hammick suggests that in practice this means designing learning situations that value and use the experience of all students. This requires changes to the traditional educational environment and the creation of the opportunity for students to interact with each other.

Freire (1981) has criticised the traditional pedagogic approach to adult education and learning. He stresses the importance of empowering learners, which does not happen in the pedagogic system. Knowles (1980) proposed that adults learn best when they have responsibility for their own learning and Boud (1988) states that self-directed learning should be the aim of adult education. The role of the teacher, Boud claims, is to assist the learner in aspirations to become self-directed, independent and interdependent. This is important because it is claimed that students who learn independently and interdependently transfer skills into practice more effectively than those who experience a traditional pedagogic system (Boud, 1988). However, whilst the claim that those who learn to be independent learners are likely to carry those skills into practice does not sound reasonable, Taylor (1997, p.8) observes that there are few examples of it being tested empirically.

Evaluations of medical education at McMaster University in Canada have given some indications of the transferability of independent learning skills. For

example, Ferrier and Woodward (1987) compared the career paths of McMaster graduates from 1972-79 with those of other graduates from Canadian English-language schools and found indications that McMaster graduates had a higher than average interest in academic medicine. However, there is a problem attributing this to the McMaster's approach as no baseline measures of educational interest before training were taken.

In an earlier study (Woodward and Ferrier, 1982) surveyed graduates of the McMaster's programme for their views on how well, or not, they were prepared for postgraduate work by the medical curriculum. Positive reports were received up to five years after graduation. They felt especially well prepared in terms of independent learning, self-evaluation and problem-solving skills as compared to fellow postgraduates. Taylor (1997) notes that although the McMaster's researchers have carried out a large number of studies they have not examined outcomes for graduates in terms of how their training has helped them in practice. She then builds on the work at McMaster University by interviewing students on a professional training programme at Bristol University. The two-year programme in social work uses an approach called the Enquiry and Action Learning (EAL) approach to teaching and learning. The structure of the course is designed to integrate principles of self-directedness and students assume responsibility both individually and in groups for what they learn. Taylor interviewed students in placement and their practice teachers, and at the point of qualifying and 9-12 months in to practice. Taylor's interviews revealed that the students and practice teachers' views of problem-based learning were consistently very positive. However, she herself acknowledges that her findings are based on small pieces of data and cannot be definitively causally linked with Enquiry and Action Learning.

Despite substantial amounts of empirical research to support a more towards increasing independence of learners Taylor goes on to argue 'How can students prepare for practice in a rapidly changing postmodern world where little is certain or predictable and where the knowledge of today is likely to be defunct tomorrow' (1997, P.4). Whilst knowledge may not be totally worthless

so quickly, Taylor makes the point that students need to be able to develop skills that enable them to keep up to date with and evaluate the nature of knowledge. This realisation, by some professional educators, that teaching in a didactic style dependent upon propositional knowledge does not equip students for lifelong learning has led to the development of a new model of professional education, termed the 'post-technocratic model' (Bines, 1992)

Bines (1992) proposed a tri-partite classification of professional education. The first part of which is the pre-technocratic model, which concentrated on practical routines, prescribed in a 'cookbook' manner. It is also known as the apprenticeship model. The technocratic model consists of a systematic knowledge base, which legitimates claims to autonomy, status and closure in complex divisions of labour. Students are exposed to professional values and behaviours through practical placements. This model is based on what Schön (1983, 1987) has described as 'technical rationality'. Schön claims that this model fails to reflect the nature of professional knowledge and action as well as ignoring the ways in which professionals actually develop their practice. Contrary to what the technocratic model suggests most professional activity is not based on the two-step application of knowledge to practice but in an integrated, more spontaneous and tacit way. However, it is important to note that Schön's theory of 'reflection in action' has been disputed. Eraut (1994) argues that Schön does not have a simple coherent view of reflection but he has a set of overlapping attributes. He criticises Schön's use of case studies claiming '...he selects whichever subset of attributes best suits the situation under discussion' (1994, p.145).

The 'post-technocratic' model has been suggested as a replacement to the problematic technocratic model. Here more emphasis is placed on individual student learning and progress, as well as issues of professional practice. Despite the fact that this model is becoming increasingly popular, it still brings with it a number of new challenges. These include the need to develop knowledge of competencies, an understanding of how students acquire competence and questions about the best settings for this learning to take place (Bines, 1992, p.16).

Although still not fully developed the post-technocratic model does recognise that continuing professional development is necessary. The model concentrates on not just updating various elements of technical and professional knowledge but also emphasises policy analysis and implementation, problem-solving and general management skills. To put it more succinctly, the post-technocratic model is concerned with three main aspects of professional development: the professional knowledge base, competence in professional action and the development of reflection. Although, this model is presented with no evidence other than opinion, it still remains theoretically the closest to Hammick's framework of IPE. The emphasis on problem-solving, policy analysis and implementation and the elimination of the subject specialist may lend itself more easily to a reworking of traditional, insular classifications of knowledge.

Hammick's (1998) framework suggests that to change towards a positive view of interprofessional working students need to be clear about their own professional values and those of others. The need for participants of interprofessional education to be clear and confident about their roles is one that often emerges in the literature on IPE. It is often used as an argument to introduce interprofessional education with qualified practitioners rather than students enrolled on programmes leading to a professional qualification. Post-qualification programmes, it may be suggested, enable participants to draw upon their own experience as well as implement their learning directly into the workplace. However, a case has been made for IPE at a pre-qualification stage.

Areskog (1994) presented support for introducing interprofessional education at an early stage through his evaluation of undergraduate courses of IPE at Linköping University, Sweden. In the programme at Linköping, first year undergraduates from six professional backgrounds: nursing, occupational therapy, medicine, laboratory technology and community care, share a ten week introduction to their studies. After this introductory period IPE is continued throughout the curriculum. Areskog (1995) identified the

assumption behind pre-qualification IPE as the premise that it will influence attitudes in a positive direction in relation to teamworking and reduce the risk that students become trapped in a conventional professional role. Areskog proposes some goals for such initiatives at the pre-qualifying level. The first, he claims is an overall goal and is to prepare the minds of students for future life-long cooperation between different professions. The second goal is to give all students a basic level of knowledge and skills that are essential for continuing education and the professional roles they will soon adopt. The use of interprofessional education from the onset also develops a frame of common reference for performance within the healthcare delivery sector. Thus IPE at the pre-qualification level aims to ensure a common level of skills across professions as well as aiming to prevent the formation of negative attitudes. Whilst this seems relatively uncontroversial, Barr (1996) draws attention to the fact that IPE at this stage involves inexperienced participants who need to meet profession specific requirements in what may already be a crammed curriculum.

The need to develop skills as well as share knowledge and change attitudes has lead to a debate about the most appropriate model of interprofessional education. Barr (1998) suggests that a new model of interprofessional education may be called for since the knowledge-based and attitude-based models have yet to demonstrate their effectiveness. The knowledge-based model is grounded upon the premise that a curriculum is applicable to a number of professional groups. It was the perceived gap in this model that was considered to emphasise similarities between professional groups rather than their differences that led to the development of the attitude-based model. This model uses interactive teaching methods to enable students to explore similarities and differences in their respective roles and responsibilities (Barr, 1998). However, evaluations of attitude change reveal both positive and negative changes, highlighting that such programmes could make relations between professions worse. Additionally even if attitude change was positive it does not necessarily follow that it will lead to a change in behaviour. The lack of research that supports the knowledge-based and attitude-based models and the increasing complexity of the relations between health and

social care professionals are two factors Barr (1998) identifies as reasons for a new model.

Competency-based education has been put forward as the successor to the previous models of interprofessional education. Rawson (1994) defines competencies as the basic stock or 'toolkit' of knowledge and skills necessary for vocational development. Competency education has increased in recent years and individual professions have started to devise competencies for those on their qualifying awards. Competency-based models of interprofessional education have also begun to emerge. Engel (1994) examines competences that play a significant role in successful collaboration by a number of professional groups. Amongst these he identifies adapting to change and participating in change as two of the most fundamentally important attributes for any professional group in a world where change is often massive and rapid. Amongst the competences that he identifies as making adapting to change possible is the individual's own professional competence. Engel asserts that the more self-confidence an individual feels in his or her own professional abilities then the inverse proportion of stress is incurred by changing situations.

Other competences Engel identifies to improve interprofessional collaboration are the abilities to be comfortable with ambiguity and to reason critically. Engel draws on the work of Schön (1983) to support his argument that professionals need to develop competences to improve teamwork. Schön emphasizes the importance of learning by reflecting on past experiences. Engel builds on this individual focus by suggesting that teams should also develop reflective practice. He contends that adaptation to practices by the team can occur through appraisal and the consequent learning. Engel goes on to describe a number of other competences that contribute to improved collaboration. He is not alone in suggesting a competency-based model for interprofessional education. For example, Spratley and Pietroni (1994) make the case for competencies of flexibility and creativity along with skills in communication and groupwork. Mathias and Thompson (1992) present a

case study of interprofessional education in which nurses and social workers used core competencies for working with people with learning difficulties.

There are indeed several core competencies, which the five mental health professional groups, and indeed health and social care professional groups more widely, all need to develop. Examples of such core, or common, skills are communication skills, the ability to understand group dynamics and the ability to establish and maintain effective relationships with users and carers. Competencies do not simply stop at the distinction between core or uniprofessional skills. Barr (1998) distinguishes between common competencies (which are those held in common between all professions); complementary competencies (which distinguish one profession from another) and collaborative competencies (which are necessary to work effectively with others).

In mental health a framework of capabilities that covers the skills, attitudes and knowledge required by practitioners in mental health has been drawn by an 'expert' group of professionals, users and carers (Sainsbury Centre for Mental Health, 2001). Whilst this framework of capabilities outlines broad tasks required of practitioners to work in mental health services, it does not claim to be a competency framework, although it could provide a foundation for a national set of competencies. The framework highlights five areas of capability for "modern" mental health practice. These include working in partnership with users, carers, families and other agencies and delivering evidence-based, bio-psycho-social interventions.

Barr (1998, p.182) proposes that the case for competency-based interprofessional education is based upon eight factors. Firstly, there is a need for IPE to reposition itself in the mainstream of contemporary professional education. The second factor is that it should enable students to relate professional and interprofessional studies coherently and thirdly students should be able to claim credit from IPE towards their professional education. Competency-based education needs to gain the approval of validating bodies and attract the support of employers. It should also

compensate for deficits in knowledge-based and attitude-based models of IPE and equip participants for collaboration in the workplace. Finally, competency-based IPE should respond to government calls for such collaboration. Thus the competency-based model has quite a feat to achieve if it is to meet all of these requirements and prove its effectiveness.

Evidence on the effectiveness of interprofessional education is still rather unclear. One of the primary reasons for this is that the legislation and policies that has made collaborative practice so important is only relatively recent. Therefore educational practitioners and course organisers are still in the process of reviewing how they can best meet the needs of health and social care workers. Those who are responsible for introducing interprofessional education have to manoeuvre any new educational programme around a number of obstacles, which are logistical, attitudinal, educational and political and structural.

3.3.1. Obstacles to Interprofessional Education

Whilst interprofessional education is indeed a complex endeavour even the most basic elements of it can prove problematic and hence many initiatives to improve collaboration flounder at the stage of bringing the students together. Timetabling clashes and accommodation problems are amongst those noted which can prove an obstacle for those trying to organise programmes of IPE (Pirrie *et al.*, 1998). These problems can be exacerbated when students belong to different institutions. For example, Goble (1994) notes that it is extremely rare for student doctors and student nurses to mix. For example, medicine has a long history in higher education and it is traditionally the long-established universities that provide medical education (Miller, Freeman and Ross, 2001). On the other hand, nursing and the professions allied to medicine are more recent entrants into higher education and are largely based in institutions that have only recently been awarded university status. Initiatives to bring these professions together will often have to work across institutions. It is possible that initiatives can work across organisational

boundaries but Miller, Freeman and Ross (2001) report a number of further difficulties they may encounter. These include a lack of leadership, since university faculties retain a high degree of autonomy and hence there may be no one person in a position to encourage cooperation. Lack of knowledge can also lead initiatives to flounder if staff in one faculty are not familiar with the staff, programme organisation or student profile in another faculty.

A barrier, concerned with pre-qualifying programmes is when to introduce IPE into the curricula. Medicine involves a five-year pre-qualifying programme, nursing and occupational therapy involve a three-year programme and social work may be three years or may end after two years leading towards the Diploma in Social Work. Thus should interprofessional initiatives begin at the start of training or towards the end? If initiatives are incorporated all the way through pre-qualifying training with whom do the fourth and fifth year medical students join? Interprofessional education programmes also face a challenge when it comes to the student mix in the cohort. Pirrie *et al.* (1998) identify an imbalance in student numbers from different professional groups. An imbalance in numbers can result in a course being dominated by one professional group or one sector (e.g. health or social services). There are also differences in when students begin their work-based placements. For example, psychology students are likely not to be involved in work-based placements until their post-qualifying programmes. This poses the question of when they should be involved in initiatives designed to increase understanding of the roles of other professions.

As well as the logistical difficulties of bringing together different groups, from different faculties, different institutions and different sectors there are also difficulties to be faced concerning the attitudes of those involved in IPE. This includes teachers and trainers as well as students and trainees. Those who teach, or facilitate IPE programmes come from different educational and professional backgrounds, just like the students. They are also exposed to the same prejudices and may hold the same negative stereotypes of other professions. Thus, it is important to ensure that all those who are involved in an interprofessional course share the same values in relation to IPE. Areskog

(1994) considers that on the whole the students on his courses of IPE were more positive than the teachers. One of the reasons for this, he suggests, may be that teachers have had little earlier practical experience of IPE. Areskog believes that different social and educational backgrounds of those involved in IPE do not have to be an obstacle. Instead these may be very fruitful in the educational setting. Indeed, it is the attitudes of those who are involved with IPE which are of particular importance and as such teachers should be involved in both the planning and implementation of IPE to help foster positive attitudes.

Other barriers identified by the literature include the attitudes of professional bodies (Shaw, 1993; Pirrie *et al.*, 1998), the nature of funding (Horder, 1996) and political commitment (Bassoff, 1983; Areskog, 1994). Shaw (1993) perceived that professional bodies (e.g. CCETSW for social work and the ENB for nursing) construct barriers to interprofessional education. Shaw suggested that interprofessionalism may simply be a veiled attempt to introduce anti-professionalism. He drew parallels between the deregulation of the trade unions under the Thatcher administration in the 1980's and recent policies concerning the professions. For example, linking the pay of general practitioners to certain performance criteria. Shaw claimed this has induced reluctance in many professional bodies to recognise their inter-dependence with other professions, especially those less powerful or of lesser status.

However, this seems rather outdated, as professional bodies have made moves towards supporting interprofessional education. For example, the General Social Care Council (GSCC), which has the responsibility for the approval of social care courses, has states that the new social work degree must support partnership working. Additionally, all students are expected to demonstrate that they can work within multidisciplinary and multi-organisational teams, networks and systems (Department of Health, 2002). The professional body for nursing in England, the ENB, also clearly states its support for interprofessional collaboration and education. The ENB (2000) states:

> "Interprofessional, interdisciplinary teaching and learning which aims to encourage integration and collaboration in learning should be an integral part of pre-registration nursing and midwifery programmes." (English National Board for Nursing, Midwifery and Health Visiting, 2000, p. 13).

Whilst some professional bodies have made supportive moves toward interprofessional education in order to improve interprofessional working, others have been more reluctant. The Standing Committee on Postgraduate Medical and Dental Education (SCOPME) states that special training in teamworking is not necessary:

> "If individuals are provided with autonomy and a climate of equity and mutual respect between different professions is created, then a multiprofessional group will develop its own ways of working and learning effectively together." (SCOPME, 1999, p. 11).

Thus, some professional bodies do not recognise the need for training to improve interprofessional working. Pirrie *et al.* (1998) puts the reticence of some professional bodies down to their concerns to safeguard professional standards and ensuring that education and training are appropriate. However, professional autonomy, as mentioned by SCOPME, is an obvious concern of the professional bodies and it may be perceived that interprofessional teamworking is a threat to such professional autonomy. There is no doubt that the professional bodies do have a difficult task in trying to maintain professional autonomy which is sometimes considered incompatible with interprofessional teamworking. They are also concerned with safeguarding professional standards, and ensuring that education and training are appropriate to that purpose (Pirrie *et al.*, 1998). This can produce problems for organisers of IPE if professional bodies prescribe very rigid guidelines for course contents.

Horder (1996) identified one of the main problems with programmes of IPE as the short-term nature of funding, making any continuity difficult and long-term

planning hazardous. Pirrie *et al.* (1998) argues that the unreliability of many programmes of IPE results in them being overlooked in favour of more established courses. This may become less of a problem with political commitment to interprofessional education increasing. In the past policy makers have been criticised for their lack of commitment to IPE. However, government funding of IPE programmes has increased. For example, the National Health Service Executive (NHSE) South West funded a series of interprofessional education programmes in the south west of England. Amongst these is to project to provide trainee health professionals with experience of interprofessional relationships during placements (Annandale et al., 2000). Nationally, examples of support for interprofessional programmes can be seen by the Department of Health's decision to fund four sites in England designated as 'leading edge' sites for "common learning" development. The New Generation Project is one of the four leading edge sites. It involves all health and social work professional students studying at the University of Southampton and University of Portsmouth (University of Southampton, 2001). The National Service Framework (Department of Health, 1999) and the review of workforce planning (Department of Health, 2000a) have also helped to provide a strategic framework for the implementation of interprofessional education in the training of health and social care professionals.

Obstacles to interprofessional education seem to be manifold but are perhaps slowly decreasing. Interprofessional education can be put into practice. As yet there are a number of different forms it may take with seemly the same principle underlying them: that closer contact will make different professional groups work better together. In this way, interprofessional education appears to make intuitive sense. It seems sensible that if people are brought together they have the opportunity to learn about each other and hopefully dispel negative stereotypes that have been built up from an earlier separation. This has been the subject of study in the field of social psychology.

3.4. Theories of Intergroup Contact

Social psychologists have studied and debated theoretical issues in the field of intergroup relations for many years, this work can help shed light on some of the processes underlying IPE. One of the earliest pieces of work in this field was the seminal account of intergroup attitudes by Allport (1954). Allport looked at the origins of intergroup prejudice and produced a series of influential policy recommendations. These recommendations have since been refined and are collectively known as the 'contact hypothesis'. The central tenet of Allport's work was that the best way to reduce tension and hostility between groups was to bring them together. However, he went on to argue that this alone was not enough. Thus, he would not expect that throwing together a collection of individuals from different professions would lead to a successful team. He qualified his hypothesis with a number of conditions that he believed were important to the reduction of negative intergroup attitudes. These included that the groups should have equal status within the contact situation, they should work on common goals, have the support of authorities (institutional support) and finally they should cooperate with each other.

Since Allport put forward his hypothesis, it has been tested in a number of laboratory and field studies. For example, it has been applied to intergroup situations with Arabs and Jews in Palestine, Catholics and Protestants in Northern Ireland as well as being used during the desegregation of schools in the United States. The contact hypothesis still receives attention today and research has seen many other optimal conditions added to it. However, Pettigrew (1998) warns that there is a danger that this may become an open-ended laundry list of conditions, which is ever expandable and thus eludes falsification. Pettigrew asserts that many writers mistake facilitating conditions as essential conditions. However, the list of conditions has grown and some essential conditions have been added. A review of the literature by Hewstone and Brown (1986) identifies four additional factors. These are firstly that participants in the contact have positive expectations, secondly, that the joint work is successful. Thirdly, that there is a concern for similarities and

differences between members of the groups and finally that the members of the conflicting groups who are brought together perceive each other as typical members of the other group.

Pettigrew (1998) identifies three other problems that still trouble the hypothesis despite the large amount of research conducted on it. As well as the ever-expandable list of conditions, he highlights the 'causal sequence problem'. This questions the basic tenet of the contact hypothesis, which is that contact reduces prejudice. The problem with this is that the most prejudiced people are likely to avoid the contact situation. Thus, those who take part in intergroup encounters will usually be those who are least prejudiced. It is therefore difficult to establish that intergroup contact reduces prejudice.

3.4.1. Cognitive Processes and Attitude Change

Another problem with the contact hypothesis is that it does not specify how change will occur. Whilst intergroup attitudes are influenced by many factors, including historical, social and political factors, cognitive processes also play a role. Whilst changes in cognitive processes alone will not improve intergroup relations, an understanding of these processes can increase our comprehension of the factors involved in interprofessional education.

One of the most important cognitive processes involved in intergroup encounters is social categorisation. Categorisation involves the reduction and organisation of the social world into social categories and is a central cognitive process (Tajfel, 1981). It is vital to our functioning in the social world as it enables us to reduce the complexity of information. We then use the information to predict and guide our behaviour. Whilst categorization enables us to deal with large amounts of complex information quickly it has the drawback of sometimes leading us to make incorrect inferences. The mental shortcuts that are essential to our daily lives sometimes cause us to ignore individuality. An example of this is stereotyping. Stereotypes are generally

seen as negative and considered by many to be something to be overcome. However, in the field of social psychology there is recognition that stereotypes play an important cognitive role and stereotypes can be positive as well as negative.

Hewstone and Brown (1986) identified essential aspects of stereotyping. These are firstly, that other individuals are categorised, usually based on some observable characteristic such as gender or race. A set of attributes is then ascribed to most, if not all, of the members of that category. Everyone who belongs to that category is then assumed to be similar to each other and different from other groups. Thus outgroups (those groups of which we are not members) are generally seen as homogeneous whilst the ingroup (groups to which we perceive we belong) is seen as more diverse. A further problem with stereotypes, rather than just leading us to make incorrect inferences, is that they generate expectancies (Snyder, 1981). Cooper and Fazio (1979) found that people tend to see behaviour that confirms their expectations, even when it is absent. Rothbart, Evans and Fulero (1979) found evidence to support this. They showed that when stereotypes set up expectations of behaviour, disconfirming evidence tends to be ignored, but confirming evidence is remembered. As Hewstone and Brown (1986) put it, contact situations can easily become self-fulfilling prophecies. This may explain why contact alone is not enough to change intergroup attitudes.

Our need to categorise and the resulting stereotypes and self-fulfilling prophecies show some of the cognitive processes that may prevent attitude change during intergroup encounters, but what factors actually assist attitude change? Pettigrew (1998) identifies this as the third limitation of the contact hypothesis; that it did not address the process of how and why change occurs. In a review of the literature on intergroup contact theory he proposed four interrelated processes that mediate attitude change. The first of these processes is that intergroup contact improves attitudes between groups by providing an opportunity to learn about outgroups. This is in line with the view that ignorance promotes prejudice (Stephan and Stephan, 1984). However, Rothbart and John (1985) studied the cognitive effects of intergroup

encounters and found that positive change only occurred when the outgroup's behaviour was not in-line with the traditional stereotype and also that the outgroup members were seen as being typical.

The second cognitive process that is relevant here is cognitive dissonance (Festinger, 1957). Cognitive dissonance is based upon the central idea that individuals seek consistency in their cognitions (the things a person knows about themselves, about their behaviour and their surroundings). According to the theory if an individual holds two cognitions that are inconsistent they experience a state of psychological discomfort or tension (dissonance). Strategies to reduce dissonance include changing one's attitude, opinion or behaviour. They also include searching for consonant information or avoiding dissonant information.

Thus, students on an interprofessional programme may be made to interact with other professionals, producing cooperative behaviour. If this behaviour is inconsistent with existing negative attitudes held towards that profession, then the individual may change their attitude. New situations, such as an interprofessional learning environment, require adapting to new expectations. If this includes accepting members of the outgroup (other professionals), then this behaviour has the potential to produce attitude change.

The third important cognitive process is the role emotions play in intergroup encounters. Anxiety is common in such situations and can spark negative reactions. However, positive emotions can be facilitated by intergroup friendships. The final process is ingroup reappraisal were the intergroup contact provides insight about the ingroup as well as outgroups. When ingroup perceptions are reshaped this can lead to a less narrow-minded view of outgroups in general.

The final problem affecting the contact hypothesis is that of generalisation. Generalisation beyond the immediate contact situation is vital if the intergroup contact is to have broad and lasting consequences. Of course, when applied to interprofessional education it is hoped that positive attitude change about

other professionals met on the programme will extend to other professionals with whom they work. Thus, if a social worker attends an educational programme with nurses and then changes her attitude about nurses on the programme it is hoped that this attitude change will extend to other nurses whom the social worker deals with on a daily basis.

However, there is no one accepted view of how best to achieve generalisation. Brown (2000) explores this problem and he identifies three models, all forms of the Contact Hypothesis and all based upon Social Identity Theory (Tajfel and Turner, 1986). Social Identity Theory was developed in the 1970s and is based upon the idea that individuals derive their identity from their group memberships. There is an assumption that people prefer to have a positive identity as opposed to a negative one and as such they will perceive the group, of which they are members (ingroup) more positively than those they are not members (outgroups). Support for this theory came from studies that showed that mere categorisation was enough to elicit intergroup behaviour (Tajfel *et al.*, 1971). Tajfel *et al.* (1971) assigned schoolboys to one of two groups on an arbitrary basis and then asked them to allocate money, using a specially designed booklet. The participants consistently awarded more money to ingroup recipients than to the outgroup. This even occurred when the ingroup could gain more in absolute terms. It was not the amount of money the ingroup accumulated that was important but rather the fact that they got more than the outgroup. This was despite the fact that the groups were essentially meaningless, having no social or political history or even any future. It appeared that simply being assigned to a group had predictable effects on intergroup behaviour. Once historical, economic, political and legal aspects of intergroup relations are taken into consideration it is not surprising that intergroup bias is such a difficult area to address.

The three modifications to the contact hypothesis that aim to improve intergroup attitudes are decategorisation model, the common ingroup identity model and the salient category model. The decategorisation model (Brewer and Miller, 1984) proposes that the distinction between groups should be played down during intergroup encounters. In this way categorisations of

ingroup and outgroup become psychologically less important. Brewer and Miller suggest various ways of doing this such as personalising the intergroup situation so participants get to know each other as individuals rather than as members of a group. For example, participants on the programme should get to know each other as "Sarah" or "Bill" rather than as an occupational therapist or a social worker.

The Common Ingroup Identity model (Gaertner *et al.*, 1993) proposes that instead of stressing the individuality of group members, a superordinate group should be established so that members of previously competing groups would share membership of a new larger category. For example, instead of nurses and social workers perceiving themselves by their professional group the common categorisation of 'mental health workers' should be emphasised during intergroup contact situations. However, both the decategorisation and common ingroup identity models have been criticised for advocating the dissolution of category boundaries and therefore group identities (Brown, 2000). Brown notes that whilst such a strategy may be successful in a laboratory setting with ad hoc groups of a transitory nature it is psychologically and physically much more difficult to implement with real life groups. It certainly seems that with political, historical and economic factors that are related to the mental health professions that attempts to dissolve the group identities may be strongly resisted.

Hewstone and Brown (1986) therefore suggested an alternative model where some salience is maintained for the original groups and contact conditions are optimised. This model attempts to maximise the group nature of the contact as opposed to the personal nature. In this way Hewstone and Brown argue that contact should promote generalisation across members of the target outgroup. Evidence for this comes from Van Oudenhoven *et al.* (1996) who found that positive effects of contact are more likely to generalise to the outgroup as a whole when the group membership of a person is made salient. Brown *et al.* (1999) showed that the likelihood of this increases when the person in the contact situation is viewed as typical of the outgroup as a whole, as opposed to atypical. This approach argued that it is important to protect

the distinctiveness of groups involved in contact for two reasons. Firstly, the salience of group boundaries can promote generalisation across members of the outgroup and secondly, each group should be seen as distinct in terms of the expertise and experience it brings to the contact situation. This should result in mutual intergroup differentiation in which groups recognise and value the strengths and weaknesses of others. This is in line with what Turner (1981) terms comparative interdependence and suggests that in order to achieve superordinate goals groups must cooperate with each other. Thus, there is a need for the differentiation and coordination of intergroup activities into separate but complementary work-roles. Hewstone and Brown go on to assert that a mutual recognition of superiorities and inferiorities would be reflected ingroup stereotypes. They hypothesised that after intergroup contact that emphasised mutual intergroup differentiation, each group would view itself positively and hold positive stereotypes of outgroups. The positive stereotypes of the outgroup would be consistent with those groups' autostereotypes. In summary, this model argues that after intergroup contact each group is seen as it wishes to be seen and desired differences between groups are highlighted.

There are, though, problems with this model as well. Hewstone, Rubin and Willis (2002) identify two main problems, the first of which is that there is an increased risk of bias if the contact reinforces perceptions of intergroup differences and increases intergroup anxiety. Second, Brown and Gardman (2001) show that salient intergroup boundaries are associated with mutual distrust, which undermines the potential for co-operative independence and mutual liking. Hewstone, Rubin and Willis therefore suggest integrating the intergroup model of contact with the personalisation model. In other words, they propose that contact should be highly intergroup and highly interpersonal. Participants in an interprofessional environment should therefore be aware of the professional group of all members and have the opportunity to engage with outgroup members on a personal level.

Hewstone, Rubin and Willis see the three main intergroup approaches as complementary and reciprocal, not competing and exclusive (2002, p.593).

There is still, however, much confusion and debate about which model is effective under particular contact conditions and have the greatest impact on which outcome measures. Whilst there is still much that is unclear in this field, it seems likely that any intergroup encounter that seeks to improve intergroup attitudes should fulfil certain conditions.

3.4.2. Changing Attitudes: Necessary Conditions of Contact

The literature reviewed thus far suggests that the conditions for changing attitudes involve a number of essential factors. Firstly, there should institutional support for participation in the contact situation, this should be from the person or organisation that the participants feel is influential. For example, for those who work in community mental health services this may be their fellow professionals, their team or their managers. Secondly, participants should have positive expectations. Whilst it is important that similarities between the groups are emphasised differences should also be explored. The contact situation should emphasise the equality of participants on the programme even if they have different status outside (e.g. doctors and nurses). The learning atmosphere should be cooperative rather than competitive. Additionally, joint work should be successful if intergroup attitudes are to improve.

For positive attitude change to then be generalised from the outgroup members involved in the contact to all outgroup members the members involved in the contact situation must be perceived as typical. Thus for example, the nurses on the programme should be seen as representative of nurses whom social workers and occupational therapists encounter in their day to day working if they are to change their attitudes of nurses in general. The contact situation must also allow for intergroup and interpersonal contact so that participants can relate to outgroup members as individuals and representatives of their professions.

3.4.3. Social Psychological Theory Applied to Interprofessional Relations

Social psychological theories of intergroup relations have been applied to health and social care professionals by a number of researchers (e.g. Skevington, 1981; van Knippenberg and van Oers, 1984, Carpenter, 1995a and 1995b, Hewstone *et al*, 1994 and Carpenter and Hewstone, 1996). Skevington (1981) examined relationships between high and low status nurses. Based on social identity theory she hypothesised that the groups would show intergroup differentiation. However, very little intergroup differentiation was shown. She suggested that this might have been due to the contact between the groups during their working lives on the hospital wards. Unlike studies in the laboratory where participants were assigned to artificial groups the participants in Skevington's study worked closely with outgroup members in teams and thus the outgroup ratings may reflect real and considered differences rather than stereotypical impressions. An interesting finding of the Skevington study was that the high status group showed strong differentiation from the low status group when social change threatened their social identity. The findings of the study support the prediction of social identity theory that groups threatened by the new positive social identity of the low status group will show considerable discrimination.

Two researchers from the Netherlands (van Knippenberg and van Oers, 1984), report on a similar study involving two groups of nurses. One group of the nurses had high status and one low status. They found that both groups accentuated differences between themselves on characteristics they perceived themselves to be superior on. Thus the nurses with the more academic training saw themselves as superior on theoretical insight whilst the nurses who were trained in-service perceived themselves to have superior practical skills. The finding supports social identity theory, which claims that ingroups accentuate characteristics on which they are perceived to be superior and attribute greater importance to those characteristics.

Carpenter and colleagues at the University of Bristol have applied the contact hypothesis to programmes of IPE, which included the aim of changing attitudes as well as promoting increased knowledge. The four papers relate to IPE for medical and nursing students (Carpenter, 1995 a and 1995b) and medical and social work students (Hewstone *et al.*, 1994 and Carpenter and Hewstone, 1996). Conditions derived from the contact hypothesis that promote positive attitude change were integrated into the programmes. Thus the programmes provided an opportunity for students to work together in a co-operative atmosphere and group membership was emphasised throughout. For example, medical students were asked to adopt the role of doctor and social worker students the role of social worker in role-play situations. Group facilitators were asked to feed back positively on ideas by the students and highlight similarities and differences between the two groups.

The programmes, which ranged in length from one day to two and a half days, were evaluated in terms of changes in the participants' knowledge and attitudes. Attitude change was measured in relation to the participants ratings of attributes in terms of their own profession, the other profession (outgroup) and their perception of their own profession as seen by others. There were overall increases in the participants' self-reports of knowledge of the outgroup. The studies also revealed an improvement in outgroup attitudes, in general, although Carpenter and Hewstone point out that in 19 per cent of cases attitudes actually worsened. This highlights the point made by Johnson *et al.* (1984) that physical proximity among ingroup and outgroup members carries a risk of making things worse as well as the possibility of improving intergroup relations.

Mutual intergroup differentiation was evident in all of these studies suggesting that the ingroups were prepared to acknowledge superiority to the outgroup on some dimensions. Thus Carpenter (1995b) reports that both medical and nursing students demonstrated strong positive and negative stereotypes: nurses were seen, by medics and themselves, as caring, dedicated and good communicators whereas the medics were seen as confident by themselves and the nurses. It is worth noting that these stereotypes were already strong

despite neither group having at the time commenced their professional careers. This suggests that stereotypes are formed at a very early stage. This is supported by research by Pietroni (1991) who investigated stereotypes with medical, nursing and social work undergraduates. He also found that clear and distinct occupational identities were present at a relatively early stage of professional development.

The attitude change that did occur during the programmes shows that interprofessional educational encounters can improve relations between professions in terms of attitudes and knowledge of each other. However, these programmes were very short-term, with the longest lasting only two days and a half days spread over a week. Additionally positive attitude change was not universal and there was no follow-up of participants in order to investigate how long the positive change lasted, neither were there control groups in the study design. Hence, whilst there is some evidence that social psychological theory can be applied to the field of interprofessional education and health care professionals the evidence that it produces positive outcomes is limited.

3.5. Conclusion

Whilst the exact conditions of successful intergroup contact have yet to be defined and agreed there is a general consensus in this field that some effort is required to improve attitudes in such a context. Hewstone and Brown summarise this by stating "It is in short unlikely that two groups can be brought together and harmony will ensue unless contact is augmented or boosted by additional factors." (1986, p.22). There are still many gaps in the area of knowledge of interprofessional education and attitude change. For example, it is not known how exactly attitude change occurs in intergroup encounters. It may be due to increased knowledge, a change in behaviour that leads to a change in attitude, the influence of making friends with the outgroup or the reframing of one's original thoughts of the ingroup.

Whilst the state of knowledge is still in a certain state of confusion there is common agreement on a number of contact conditions that programmes of IPE should incorporate if they wish to change attitudes. The conditions include: institutional support, participants with positive expectations, equality of participants in the contact situation, an atmosphere that is co-operative not competitive, and successful joint work. One of the key issues for interprofessional education is that positive attitude change is generalised from the outgroup members that take part in the contact to the wide outgroup. This is also a key issue, yet to be adequately addressed by the contact hypothesis. At the moment the literature suggests that the best way of achieving generalisation of positive attitude change is by creating an environment that stresses group identification whilst also creating the opportunity for interactions on a personal level. Thus, those in intergroup situations should be aware of the group identity of other participants but at the same time see them on a personal level. It is then hoped that the participants will make friends whilst still seeing their new acquaintance as a typical member of the group they represent.

4. POST-QUALIFYING TRAINING IN MENTAL HEALTH

4.1. Introduction

The first chapter documented the growth of the five main mental health professions from the eighteenth century to the present day. It highlighted many of the problems facing mental health services since the move to the community. These included poor collaboration between professionals, the lack of availability of evidence-based psychosocial interventions, the drift away from those with the greatest need for services (those with severe and enduring mental health problems) and the limited involvement of service users. Chapter three showed that training has been put forward to address these problems, especially poor collaboration, and discussed the theoretical underpinnings of attempts to train professionals together in order to improve such collaboration. Whilst theory may support the premise that training can have positive outcomes for those who work in mental health services there is a need to examine the evidence to support this premise. The evidence base for post-qualifying training for mental heath staff will be assessed in this chapter. The review of the literature will focus on the outcomes of such training and evaluate the state of knowledge that supports claims of effective outcomes.

4.2. Training in Mental Health

The need for the training of the mental health workforce has been put forward by various government policies, to improve collaboration but also to address other problems. In 1998 the government published *Modernising Mental Health Services: Safe, sound and supportive* and outlined that whilst care in the community had benefited many, there had also been too many failures. It attributed the failures to the poor management of resources and underfunding, families being over-burdened, service users losing contact with services and problems in recruiting and retaining staff. The Government states its new vision for mental health services as such:

> "A modern mental health service will provide care which is integrated, and which is focused on the individual, recognising that different people have different needs and preferences. It will be evidence-based and outcome driven." (Department of Health, 1998b, p. 21)

The government cemented its vision for mental health services when it produced the National Service Framework (NSF) for mental health (Department of Health, 1999). The NSF outlines seven standards of services, in five areas: mental health promotion, primary care and access to services, effective services for people with severe mental illness, caring about carers and preventing suicide. The delivery of the standards outlined in the NSF has led many to comment on the need for the training of the mental health workforce, if they are to deliver the necessary services. For example, a report by the Sainsbury Centre for Mental Health contends:

> "The NSF has significant workforce implications. Its aspirations cannot be delivered without a combination of increased numbers of staff and the rapid enhancement of skills and competencies. The latter includes teamworking, partnership working, and working in more generic and flexible ways." (Sainsbury Centre for Mental Health, 2000, p.15).

The NSF proclaims that all education and training should be evidence-based and should stress the value of team working as well as of involving users and carers in the evaluation of education and training. A review of workforce planning in the NHS (Department of Health, 2000) sets out the need for change. It outlines a number of propositions amongst which is the need to modernise education and training to ensure that staff are equipped with the skills they need to work in a complex and changing NHS. It criticises current arrangements in workforce planning for not being supportive of "multi-disciplinary" training, education and working and proposes that "genuinely multi-professional" arrangements for education and training be made

Thus various government documents call for evidence-based training that will help deliver changes in mental health services. The focus on evidence-based practice stems from the belief that practice should be grounded in research to secure the greatest gain from the available resources (Sackett *et al.*, 1997). This has led to an increase in training programmes that must teach students how to integrate their own individual expertise with the best available clinical evidence from systematic research (Milne *et al.*, 1999). As part of evidence-based practice, training programmes themselves should be evaluated. However, there are many outcomes that can be measured. For example, Tarrier, Haddock and Barrowclough (1998) asked whether the outcome of training is related to the knowledge gained, skills acquired, number of staff trained, the implementation of learning, clinical outcome or some characteristic of the service or organisation. Because training programmes for mental health professionals tend to cover a number of aims, evaluations of such programmes must attempt to measure a variety of outcomes.

4.3. Other Reviews of Training Programmes

Reviews of training programmes are useful to shed light on some of the issues that surround the evaluation of training programmes for the health and social care professions. A review of the literature on the training and dissemination of innovative psychosocial treatments for schizophrenia by Tarrier *et al.* (1998) highlights a number of problems in teaching psychosocial skills to "front-line staff". Amongst these are the high dropout from training and the poor implementation of the skills acquired.

Reviews of research on the training of staff in health and social care have highlighted a number of common shortfalls in the literature. For example, Barr *et al.* (1999) found that evaluations were, for the most part, conducted by the teachers and trainers themselves and therefore risked the loss of objectivity. The Barr *et al.* review was concerned with evaluations of interprofessional education in health and social care and was not purely concerned with the field of mental health, however many of the issues covered in the review are

similar to those in mental health. What is of particular note about the Barr *et al.* review is that it used an expanded methodological inclusion criteria as opposed to the more limited 'gold standard' of randomised controlled trials prescribed by the Cochrane Collaboration Review (Zwarenstein *et al.*, 1999). A review conducted by Zwarenstein *et al.* for the Cochrane review on interprofessional education found that no studies at all met its inclusion criteria. However, Barr *et al.* justified their use of an expanded range of methodologies by arguing that uncontrolled for and qualitative studies can shed light on the processes and forms of training and that it is important to compare and contrast the different types of training currently in use. For the same reasons the wider methodological inclusion criteria is adopted here.

Reeves (2001) reports on a systematic review of interprofessional education for staff involved in the care of adults with mental health problems. He also used a less constrained inclusion criteria in terms of outcome and methodology, than that demanded by the Cochrane review. Reeves reviews 19 evaluations of interprofessional education in mental health and concludes that the evidence relating to the effects of IPE involving staff working with people with mental health problems is patchy. The main problems he identifies with the papers are their general lack of information relating to the methods employed and their associated limitations. Other problems he highlights are; the lack of consideration of how IPE impacted on user care, uncertainty of the longer-term impact of the effects of IPE, poor descriptions of the evaluated IPE programmes, and limited applicability due to cultural influences. Reeves makes two recommendations for the building of a sound evidence base. The first is that research designs include a multi-method and longitudinal dimension in order to understand both the processes and impact of IPE over the longer term, and secondly, that there is rigorous data collection of outcomes for service users.

4.4. The Literature Review

To assess the evidence on post-qualifying training programmes in mental health I reviewed the literature in this area.

4.4.1. Method

The first step in this review was to conduct a search of various electronic databases (Assia, CINAHL, ENB Healthcare, Medline, PsychFIRST and the Cochrane library) from 1990 to the present (2002). Each database was searched using the search strategy (Table 4-1).

Table 4-1: Search Strategy

#1	EDUCATION* or TRAIN* or LEARN* OR COURSE* or TEACH*
#2	POSTGRADUATE or POSTQUALIFYING
#3	COURSE EVALUATION
#4	PROGRAM* EVALUATION
#5	EVALUATION RESEARCH
#6	EVALUATION METHODS
#7	EDUCATION and CONTINUING
#8	EDUCATION and GRADUATE
#9	EDUCATION* OUTCOMES
#10	GRADUATE TRAINING
#11	PATIENT OUTCOME
#12	#1 or #2 or #3 or #4 or #5 or #6 or #7 or #8 or #9 or #10 or #11
#13	MENTAL ILLNESS or MENTAL HEALTH or MENTAL DISORDER or MENTAL DISTRESS
#14	SEVERE MENTAL ILLNESS or SEVERE MENTAL DISTRESS or SEVERE MENTAL HEALTH
#15	SCHIZOPHREN* or DEPRESSION or PSYCHOSIS
#16	#13 or #14 or #15
#17	OLDER PEOPLE or ELDERLY
#18	BEHAVIOURAL COGNITIVE THERAPY
#19	PSYCHOLOGICAL THERAPIES
#20	PSYCHOSOCIAL INTERVENTIONS
#21	COGNITIVE BEHAVIOURAL THERAPY
#22	BEVAVIOUR or BEHAVIOR THERAPY
#23	#12 AND #16

The abstracts generated from the search were then reviewed to ascertain that they related to:

- An education or training programme (all training programmes lasting longer than one day were included)
- The programme was at the post-qualifying level ("post-qualifying" training was defined as being any training for staff who attained a basic qualification in one of the professions working in mental health services, i.e. mental health nursing, psychiatry, clinical psychology, social work, occupational therapy and any related fields, e.g. drug and alcohol workers).
- The programme had been evaluated and methods of the evaluation were reported
- Outcomes of the evaluation were reported
- Training was focused on secondary care services, as opposed to primary care

All papers that met the inclusion criteria were then assessed to establish the quality of evidence presented. This stage of the review assessed the methodology used in the evaluation and the outcome assessed. Finally, the strength of evidence for each level of outcome was assessed in accordance with the typology used in the National Service Framework.

Methodology was classified according to the framework used by Barr *et al.* (1999) in their review of IPE. This is helpful in assessing the limitation and strengths of a particular study. They identify seven research designs:

- Action research studies
- Before and after studies (with and without control groups)
- Case studies
- Interrupted time series studies
- Longitudinal studies
- Post-intervention studies
- Randomised control trials

Outcomes were assessed using the Kirkpatrick (1967) framework of training outcomes that has been used widely. This four level framework was used, for example, by Milne *et al.* (2000) to evaluate a brief staff training programme in psychosocial interventions for severe mental illness. It has also been used by Reeves (2001) to review the literature on the effects of interprofessional education in mental health. Barr and colleagues expanded Kirkpatrick's original framework to six levels to review the literature on interprofessional education in health and social care (Barr *et al.*, 1999).

Each of the levels in Kirkpatrick's model measures different but complementary aspects of training. The first of the four levels Kirkpatrick identified was labelled "reaction". In this level students' feelings about the training they have received are considered. This level is perhaps the easiest of all levels to measure and is often done through a "happy sheet" which students complete after sessions or at the end of the entire programme. Many evaluations of training stop at this level. However, as Thrackway (1997) points out this tells us nothing about whether learning has taken place, if the students' working practice has improved or if this improvement can be attributed to the training programme.

Kirkpatrick's second level measures learning which may or may not have taken place on the training programme. Kirkpatrick advises that a before-and-after method should be adopted here, if possible, and a control group, who do not receive the training, should be used to compare with those who have been trained.

Kirkpatrick's third level is termed behaviour, and is concerned with the transfer of learning to the workplace. Kirkpatrick's final level, results, is often the most difficult area to evaluate. It aims to measure whether the training programme has made a difference to the lives of service users.

Barr *et al.* (1999) expanded the second and fourth levels of Kirkpatrick's model. They split the second level of learning to consider, separately, the modification of attitudes and perceptions and the acquisition of skills and knowledge. They split the fourth level to consider changes in organisational practice and benefits to service users (I have also examined benefits to carers in this review). This expanded framework (Table 4-2) has been used to assess the evaluations in this review because it enables us to consider in more detail the type of learning that has occurred and who benefits from this.

Table 4-2: A classification of outcomes of education (From Barr *et al.*, 1999)

Level	Description
Level 1: Learners' reactions	These outcomes relate to participants' views of their learning experience and satisfaction with the programme.
Level 2a: Modification of attitudes/ perceptions	Outcomes here relate to changes in reciprocal attitudes or perceptions between participants, towards patients/ users and their condition, circumstances, care and treatment.
Level 2b: Acquisition of knowledge/ skills	This relates to concepts, procedures and principles and skills.
Level 3: Change in behaviour	This level covers behavioural change transferred from the learning environment to the workplace prompted by modifications in attitudes or perceptions, or the application of newly acquired knowledge or skills in practice.
Level 4a: Change in organisational practice	This relates to wider changes in the organisation and/ or delivery of care, attributable to n education programme.
Level 4b: Benefits to service users/ carers	This covers any improvements in the health and well being of service users or carers as a direct result of an education programme.

The quality of evidence in each level of outcome was assessed with the typology used in the National Service Framework (Table 4-3). Type I is considered the best and Type V is considered the worst in terms of strength of evidence.

Table 4-3: Assessment criteria of type and strength of evidence

Level of Evidence	Description
Type I	Strong evidence from at least one published systematic review of multiple well-designed randomised controlled trials
Type II	Strong evidence from at least one published properly designed randomised controlled trial of appropriate size and in an appropriate clinical setting
Type III	Evidence from published well-designed trials without randomisation, single group pre-post, cohort, time series or matched case controlled studies.
Type IV	Evidence from well-designed non-experimental studies from more than one centre or research group.
Type V	Opinions of respected authorities, based on clinical evidence, descriptive studies or reports of expert consensus committees.

4.4.2. Results

A total of 26 papers met the inclusion criteria for the review. All of the 26 papers were then read and contextual, methodological and outcome information was extracted from them.

Context

In order to give an impression of the range of training initiatives that have been evaluated in mental health this section presents information on aspects, such as, the location of the training programmes, the number of students involved, the professional background of students, the teaching methods employed and the length of programmes.

Location

Most of the studies reported have been published in the UK (N=19). That the next greatest source of papers should be the United States (N=6) is perhaps not surprising when it is noted that the electronic databases used are biased in favour of North American publication (Reeves, 2001). The bias in favour of North American studies means that one must be careful to avoid assumptions that programmes will be transferable to the UK. The USA and UK vary in terms of educational context and mental health settings. One paper was published in Australia (Kavanagh *et al.*, 1993).

Number of students

The 26 studies varied enormously in the number of students that their evaluations of training reported. For example, Repper (2000) report an intervention involving only seven students whilst O'Boyle *et al.* (1995) report on an initiative involving 423 health professionals. This wide variation in numbers of students is usually due to some papers reporting one longer term training programme involving fewer students whilst other report on shorter programmes that have been repeated.

Uniprofessional versus Interprofessional

A number of training initiatives involved more than one professional group, i.e. they were interprofessional training programmes. Twelve papers were categorised as interprofessional, in that they involved two or more professions learning together. That almost half of the papers should involve interprofessional training is perhaps an indication of the increasing focus on teamworking within mental health services. Indeed, six of these papers were published within the last five years. Where evaluations report on uniprofessional programmes these were usually for nurses working in the mental health field. Only one uniprofessional programme involved a profession other than nursing. This was the study of clinical psychology graduates in the United States as reported by Freiheit and Overholser (1997). Two papers are not clear about the professional background of staff involved in the training programmes they report on (Cook *et al.*, 1995; Corrigan *et al.*, 1997). Students in these two papers are referred to as either clinical staff or

mental health professionals, which are terms that are too vague to shed light on any interprofessional activity that may be involved.

One of the difficulties of interprofessional training is highlighted by Parsons and Barker (2000) who describe the evaluation of a programme designed to be interprofessional but due to difficulties in recruiting other professionals was in reality a uniprofessional course for nurses. They identify several barriers that prevented other disciplines joining the programme. These include the issues of local funding and the heavy time commitment; this was a particular problem for occupational therapists in relation to the provision of study leave. Psychologists on the other hand stated that it was the level of the course that they did not find appealing, as it was sub-degree level.

Methods Used During the Training

The training initiatives, which were evaluated, utilised a number of different teaching methods. Four papers were not clear about the teaching methods used in the programmes they evaluated (Gournay *et al.*, 2000; Newell and Gournay, 1994; Smith *et al.*, 1994; Williams *et al.*, 1991). However, most papers did give details of the range of methods used. Almost two thirds (N=17) of the papers report the use of "received learning" (lectures and other didactic teaching). However, this was rarely the sole method used. "Exchange based learning" was commonly reported and examples include the schizophrenia family work training for nurses reported by Brennan and Gamble (1997) where students take on families from their own caseloads and this work is clinically supervised through the use of discussions with peers and the course facilitator amongst other methods. Simulation-based and practice-based learning were other popular methods. Simulation-based learning involves the use of role-play and games amongst other strategies to make learning more interactive. Thus, Milne *et al.* (2000) evaluated the use of role-plays and simulation exercises, which were used in combination with other methods, to train mental health staff from a multiprofessional background in psychosocial interventions for severe mental illness.

Since the papers all involve staff currently working in mental health services it is not surprising that practice-based learning was a popularly used method. This method includes placements and work-based assignments and was used, amongst others, in the psychosocial interventions training programme evaluated by Brooker *et al.* (1992). Action-based learning was also reported. This includes approaches such as problem-based learning and collaborative enquiry and was used in the joint training of approved social workers and drugs workers (Bailey, 2002).

Corrigan and colleagues (Corrigan *et al.*, 1995; Corrigan *et al.*, 1997) have proposed a different approach to training that they term interactive staff training (IST). They developed this approach in response to criticisms made about didactic training, which does not always lead to more frequent use of the trained intervention. The approach of IST uses principles of organisational psychology to address organisational barriers that prevent many newly trained staff from implementing their new skills. Corrigan and associates believed that training should be conducted with the whole team and should focus on goals, which the staff perceive to be relevant to their clinical goals. More detailed discussion of the range of training programmes is given below in a review of outcomes of training. Many of the evaluations reported outcomes at more than one level, in this case an overview of the training programme is given in the first level and the following levels report the methods used to evaluate that specific outcome.

4.5. Levels of Outcome

4.5.1. Level 1: Learners' reactions

Five studies reported outcomes at the first level identified by Kirkpatrick: learners' reactions. All of these studies used a post intervention design and four out of the five studies used ad hoc instrument in order to elicit participants' reactions to the training. Milne *et al.* (2000) were the only authors in this review to report psychometric properties of the instrument used to

measure learners' reactions to the training. They used the Training Acceptability Rating Scale (TARS) (Davis *et al.*, 1989) to assess learners' reactions to an eight-day workshop on psychosocial intervention training. The TARS covers a number of aspects of training including its general acceptability, effectiveness, negative side effects, appropriateness, consistency and social validity as well as the perceived outcomes of training, the competence of the trainers and general satisfaction. Respondents were also asked three open-ended questions related to their views on the most helpful part of the workshop, recommendations for change and any other comments. Milne *et al.* (2000) stated that the TARS has good test-retest reliability and internal consistency as well as acceptable construct and concurrent validity. Participants in Milne *et al.*'s study gave high ratings for satisfaction with both the acceptability and the effectiveness of training.

This finding is indicative of the findings reported by the other studies. Overall, students reported a high level of satisfaction with training. Ashworth *et al.* (1999) report the evaluation of a one-year training programme in cognitive therapy. The programme at the Newcastle Cognitive Therapy Centre in the United Kingdom was interprofessional in nature and students came from clinical psychology, psychiatry, general practice, community psychiatric nursing, social work and occupational therapy. They followed-up 65 students, from four different intakes of the course with a questionnaire. They achieved a response rate of 80%. The aim of the questionnaire was to examine how useful the students had found the course and find out how the course had affected their clinical practice. Participants were asked to rate the quality of teaching and supervision on the course. Average ratings of both teaching and supervision were quite high. On a seven point scale (1=very poor, 7=excellent) teaching was rated 5 and supervision 6. Half of the respondents rated the quality of teaching at 6 or above (very high) and 75% rated the quality of supervision at 6 or above. There were no significant differences in the ratings of the quality of teaching or supervision by professional groups.

Bailey (2000b) examined participants' views of a shared learning programme for mental health workers and drugs workers. She found that the mental

health workers particularly valued the specific inputs spread over two days on drugs and alcohol, whilst the drug workers had learned significantly from the two-day mental health module. This suggests that different groups may value different aspects of the training process. This is particularly important when applied to interprofessional education where different professional groups may have very different areas of expertise, knowledge and even values and attitudes.

Smith *et al.* (1994) reported the evaluation of one phase of a three phase project to train nursing personnel in long term care facilities providing care for older people with mental health problems. This training project in the United States was three years long and used a "train-the-trainers" model. Under this model instructors trained nurses in a two-day intensive training session (ITS). These nurse trainers then used the training materials to train staff in their own facilities. Forty-three nurses were trained to act as trainers in phase two of the project, and in turn they trained 177 staff across six training programmes (a total of 520 staff attended one or more training programmes during phase 2). The evaluation measured outcomes of participants' satisfaction, the acquisition of knowledge and changes in attitudes. Trainers and trainees completed evaluation forms designed to measure their level of satisfaction with the training that had taken place. Results indicated that trainers evaluations of the ITS were consistently high and trainees regarded the overall quality of the programme and its usefulness quite high.

Verbal discussions were also reported as a way of eliciting trainees' opinions on the course they had been involved with. May (1996) followed up a small sample of participants who had taken part in two-day training initiative for key workers in mental health. This small sample, exactly how small is not reported, were asked to express their opinions of the programme through a brief, informal telephone survey. This occurred some time after the training, exactly how long after is not reported. Participants in this survey remarked that their initial expectations of the training had been low, or even negative. They had not expected that their views and concerns would be taken into account during the training process rather; they expected to be presented with

information, which "only may be useful". This is perhaps reflective of trainees' past experiences of didactic training and suggests the importance of a more learner-centred approach both in the delivery and evaluation of training

Summary of Level 1

All the papers reported using measures which were self-report and most used a post-intervention design. That self-report measures were used makes sense when it is considered that it is the trainees' own opinions that are being measured. However, the evidence must be considered methodologically weak. There is consistent Type V evidence from descriptive studies that training is well received by learners. However, there are a number of problems with the quality of this evidence. Firstly, it is not always clear that learners' responses were anonymous and in the case of the telephone interviews reported by May (1996) this was clearly not the case. Thus, respondents may have felt unable to express their true feelings about the training, especially if they were negative. Secondly, the validity and reliability of the instruments used is only reported by one study (Milne *et al.*, 2000). Thirdly, the reliance on post-intervention designs provides only weak evidence, as it does not relate trainees' expectations before the training. It is therefore possible that trainees enjoyed the experience of training but did not learn what they originally went on the programme to learn. Finally, there is very likely to be a publication bias in favour of positive findings of training.

Unfortunately, it is not possible to conclude from the studies included in this review what sort of training is preferred by which groups of mental health professionals. In order to make comparisons between courses in terms of learners' reactions there needs to be consistency in the measurement of this outcome. As it stands the instruments used are usually designed by course tutors to evaluate their own specific programme. Comparisons between courses using such different outcome measures are impossible. It is also important to note that trainees' positive evaluations of training programmes do not necessarily mean that they learnt anything from the training. Outcomes at the other levels are more informative about learning that may have occurred following the training.

4.5.2. Level 2a: Modifications of Attitudes and Perceptions

Six studies sought to assess the modification of attitudes and perceptions as a consequence of training. The most commonly used research design was a before and after approach, using self-report measures. None of the six studies reported data at all three levels of baseline, post-intervention and follow-up. The attitudes measured varied from attitudes towards older people, opinions on depression, attitudes towards mental health service users as trainers and opinions about the aetiology of schizophrenia. Studies tended to give greater details about the measures used to assess changes in attitudes than they did in relation to learners' reactions and a number of studies used measures that were standardised and proved to be valid and reliable.

O'Boyle *et al.* (1995) report on a two-day, interprofessional training programme in the US on the diagnosis and treatment of depression. The programme was designed for health professionals and participants included social workers, nurses, psychologists, and doctors. The training consisted of presentations by experts on depression and small group discussions. Over four hundred participants took part in the programmes held in six cities across one state. Opinions of depression were measured at the start of the programme using a ten-item questionnaire. Items covered included the participants' views of their own training and ability to recognise and treat depression. As well as their perceptions about how accurately lay people and clinicians could recognise depression. Since participants only completed the scale once, it was not possible to report any changes that may have occurred after training. Nevertheless, responses were analysed for differences between professionals, age and length of experience. No significant differences were found between opinions of participants grouped by age or length of experience. There were, however, differences between professions. They were found to differ significantly in their opinion of their ability to recognise mood disorders with psychologists reporting a greater perceived ability than nurses or social workers. The professions also differed in their

opinion of the amount of training about mood disorders they had received with psychologists reporting more training than social workers and counsellors. This study is obviously limited in that it did not measure change over time in the attitudes of participants. Nevertheless, the finding that professions differed significantly in some of their attitudes before training is interesting. Caution must be applied to the generalisation of these findings since they are from an American study and one cannot therefore assume that the same differences would be found with professionals in the UK.

Three of the studies that measured attitudes were concerned with programmes that sought to teach skill-based interventions to practitioners. In their evaluations, two measured the trainees' attitudes towards the intervention taught (Freiheit and Overholser, 1997; Leff and Gamble, 1995), two measured the trainees' attitudes towards schizophrenia (Brooker and Butterworth, 1993; Leff and Gamble, 1995) and one measured attitudes about interventions (Brooker and Butterworth, 1993). Brooker and Butterworth (1993) assessed the attitudes of eight trainees on a uniprofessional training programme at the University of Manchester. The 17-day, part-time, programme was spread over six months and aimed to train community psychiatric nurses (CPNs) to deliver psychosocial interventions to families caring for a relative with schizophrenia at home. The authors found very few significant changes in attitudes were found from the start to the end of training and no significant changes were found on the Opinion about Schizophrenia Questionnaire (OSQ: Soskis, 1972). The CPNs' beliefs at the start of the course about the cause of schizophrenia, as measured by the OSQ, revealed that psychosocial theories were the most popular. This belief increased after training and the belief that schizophrenia was due to family development theories decreased, as would be expected in relation to the focus of the programme. There were no significant changes in the CPNs' opinions about the usefulness of certain interventions commonly used in schizophrenia. At baseline the trainees felt that major tranquillisers, family-stress management programmes and information about the illness were the most useful interventions. Twelve months after training the same three interventions were

still considered the most useful but major tranquillisers were ranked below family-stress management programmes and information about the illness.

Similarly, Brooker and Butterworth (1993) found no significant changes on the Attitude to Treatment Questionnaire (ATQ: Caine *et al.*, 1982) which measures the attitudes of staff working in psychiatric settings to psychological and psychiatric interventions. Although scores did decrease this was not as dramatic as that found by Gournay (1986) in a study of nurse therapists. Both studies had the same number of students and the authors of the paper suggest differences between the two sets of findings may be due to the length of the two training courses. Where nurses in Gournay's study demonstrated a move away from an 'organic' model of schizophrenia towards a more 'psychological' one this was after an eighteen-month training course as opposed to six months in Brooker and Butterworth's (1993) study. The study's lack of significant changes in attitudes may be due to the small number of students involved in the training programme. It is also likely that findings were affected by the trainees' already positive approach to psychosocial interventions. All trainees demonstrated in interviews that they had a sympathy for behavioural methods, a commitment to travel regularly to Manchester from all over England and an enthusiasm to work with families using psychosocial interventions. Thus, these trainees may not be representative of the wider mental health workforce.

Freiheit and Overholser (1997) used a before and after design with a self-report measure to assess attitudes of trainees on a cognitive-behavioural psychotherapy training course. The programme, in the United States, involved 40 clinical psychology graduates. Data was collected from the students on the cognitive behavioural course for six consecutive cohorts. The programme consisted of didactic training and supervised application of cognitive behavioural techniques with individual users. The Behavior Therapy Survey (BTS) was given to students before starting the programme and again at the end of the programme, nine months later. This self-report scale consisted of three sections: assessing knowledge, attitudes and behaviours related to behaviour therapy, these correspond to levels 2a, 2b and 3 of

outcome in Kirkpatrick's framework. The attitude section included 25 statements related to theoretical premises of behavioural, cognitive, psychodynamic and client-centred principles as well as general negative and positive attitudes towards cognitive-behavioural therapy. In order to determine if the trainees attitudes towards cognitive behavioural techniques affected the trainees' attitudes (and, as we will see later, their knowledge and implementation of learning) trainees were divided into three groups. These groups were based on their primary theoretical orientation at the start of the course and were made up of those who had a cognitive-behavioural orientation, those that did not and those with an undecided orientation.

The groups in Freiheit and Overholser's (1997) study differed significantly on some of the attitude subscales. Students with a cognitive-behavioural orientation had significantly fewer negative and more positive evaluations about CBT at the start of the course than those from a non-cognitive-behavioural orientation. Additionally the cognitive-behavioural orientated students had significantly higher scores on the behavioural ideology attitudes subscale and significantly lower scores on the psychodynamic ideology attitudes subscale than students with a non-cognitive-behavioural orientation. These differences disappeared by the end of the programme. The authors conclude that participating in a course about cognitive-behavioural psychotherapy significantly decreases initial negative biases towards CBT. This study claims to show that a training programme can produce significant attitude change for trainees. However, this attitude change could be related to some wider reason, such as a change in national policy. A control group of participants who did not receive training would have strengthened this study. The study is also limited by concentrating only on clinical psychology graduates. The authors acknowledge that seasoned clinicians may have been more strongly biased at the start of the programme.

Leff and Gamble (1995) devised a training programme for community psychiatric nurses in family work for schizophrenia. The study reports on four of these courses. Data from these courses is also reported separately. Lam *et al.* (1993) report on data from the first two courses, data from the third

course is presented by Gamble *et al.* (1994) and data from the fourth course is reported by Midence *et al* (1995). Twelve students took part in the first and third course, nine took part in the second and ten took part in the fourth. The first three months of training involved didactic teaching, utilised in order to enhance the trainees' theoretical knowledge and expertise in schizophrenia family work. The following six months were designed to enhance the trainees' clinical skills using supervised casework, reflecting upon experience and discussions with the peer group and course facilitator.

Leff and his colleagues used a 13-item attitude and assumptions questionnaire to measure change in the trainees' attitudes to schizophrenia and family work. Data were collected at three time points in a longitudinal design, at the beginning of the course, two months later and then at the end of the course, nine months later. There was some variation between courses in the findings. Trainees on courses one and three showed significant gains over the first two months. However, trainees in course two did not show a significant change until the end of the programme. On the fourth course, trainees showed a significant improvement on the attitude questionnaire after two and after nine months. No psychometric properties for either questionnaire were reported limiting the strength of the study.

Only one study reported on the effect of using service users as trainers. This was Cook *et al.* (1995) who evaluated a two-day programme to deliver the basic concepts and techniques involved in delivering community development services to mental health professionals in the US. They used a before and after design to assess the trainees' attitudes towards people with mental illness in the roles of service recipient, service deliverer and trainer. Trainees received the same training on the first day and this was delivered by someone who was not a user of mental health services. On the second day the 57 trainees were randomly assigned to receive training from either a service user or a non-service user trainer.

In Cook *et al.*'s study, trainees completed an attitude measure before the first day of training and again at the end of the intervention. The study tested the

hypothesis that there would be significantly more positive attitudes after training for those who were trained by the service user trainer as opposed to the non-user trainer. The authors report that those who were trained by the user trainer had more positive attitudes, than those trained by the non-user trainer, towards people with mental illness overall, as service providers and trainers following the training. Those trained by the user trainer also expressed more non-stigmatising attitudes than those trained solely by the non-user trainer. The only outcome that was not significantly affected by the user trainer concerned attitudes about the recovery potential of people with mental illness. The positive change in attitude achieved could be due to the trainees having a new trainer on the second day of training. Alternatively, it could be due to some other personal characteristic of the trainer, as opposed to their status simply as a user of mental health services. Thus, the generalisations that can be drawn from the study are limited. Nevertheless, for an evaluation of a two-day training programme the randomisation of trainees adds robustness.

The final study in this section measured trainees' attitudes towards older people. Smith *et al.* (1994) evaluated and report on one phase of a three-phase project to train nursing personnel in long term care facilities providing care for older people with mental health problems. The training project in the United States was three years long and used a "train-the-trainers" model. Under this model instructors trained nurses in a two-day intensive training session (ITS). These nurse trainers then used the training materials to train staff in their own facilities. Forty-three nurses were trained to act as trainers in phase two of the project, and in turn they trained 177 staff across six training programmes (a total of 520 staff attended one or more training programmes during phase 2). A before and after design was used to assess attitudes with a 16-item Likert-type scale. Both trainers and trainees showed relatively positive attitudes towards older people before the training. Trainees, who completed both before and after measures, showed positive attitude changes in 13 out of 15 items. However, trainers showed a less dramatic pattern. They increased their scores on only five items and showed slight decrements on the remaining items. The authors suggest that the discrepancy between

trainers and trainees may have been due to trainers having substantially more positive attitudes to begin with.

Summary of Level 2a

These studies demonstrate that there is some Type III evidence that training programmes in psychosocial approaches can change beliefs about mental illness and the attitudes trainees have about its treatment. However, the evidence comes mostly from programmes of psychosocial interventions with participants who have *chosen* to attend, indicating their interest in the ideology of psychosocial interventions. It cannot be assumed that such attitude change would inevitably occur in participants who were resistant to such approaches before training. Nor can it be assumed that changes in expressed attitudes will lead to changes in behaviour. It is disappointing that only one study reported the involvement of service users in the training process, especially as the principles of the NSF promote the involvement of people who use services in workforce development.

4.5.3. Level 2b: Acquisition of knowledge and skills

The acquisition of knowledge and skills is assessed by eleven of the studies reviewed. Most of the studies used self-report questionnaires which were administered before and after the training to assess changes in levels of knowledge and skills. Eight of the eleven studies report on programmes that focused on psychosocial interventions, such as cognitive-behavioural therapy, family intervention and behavioural methods. These studies tended to evaluate knowledge in relation to the skills being taught. For example, Brooker and Butterworth (1993) evaluated the training of community psychiatric nurses (CPNs) in psychosocial interventions and measured skills from audiotapes of clinical work by the trainees. Members of the course team rated the audiotapes, without knowledge of the time the tapes related to, using the Behavioural Family Therapy Skills Measure (BFTSM: Laporta and Falloon, 1989). Each student submitted five tapes, two, four and six months after training, of their work with families. No significant changes were found in the

level of skills at any of these intervals, however, all the trainees were competent in psychosocial interventions as measured by the BFTSM. This study is limited by its lack of baseline scores on many measures and although the audiotapes were blind rated the raters were not independent of the training programme.

Freiheit and Overholser (1997) explored the effect of pre-existing biases towards cognitive-behavioural therapy on the acquisition of knowledge over a nine-month course for clinical psychology graduates. The Behavior Therapy Survey (BTS) was given to students before starting the programme and again at the end of the programme, nine months later. Using this self-report scale, students claimed to have gained a significant amount of knowledge from the start to the end of the programme, regardless of the students' initial therapeutic orientation. There were no independent tests of knowledge and no follow-up measures to establish over what period the reported increase in knowledge of cognitive-behavioural techniques remained.

Not all studies reported that trainees increased their knowledge and skills, Kavanagh *et al.* (1993) evaluated the training of therapists in cognitive behavioural family intervention for schizophrenia in Australia. The training took 30-35 hours and usually took place in 5 full days or 10 half days over 5-10 weeks. The course used a variety of teaching methods including brief lectures, discussion sessions, demonstrations, and role-play. The training was evaluated in terms of the number of families seen, the difficulties trainees had encountered in using the structured family intervention in their workplace, their knowledge of the intervention and the application of the material in routine work. A response rate of 94% (N=45) was achieved in response to the postal survey. Respondents were from a variety of professions, the majority were trained in psychiatric nursing but psychologists, social workers, occupational therapists and a psychiatrist were also trained and returned the questionnaire. The main findings of the survey were that the training had achieved only a very limited impact on the knowledge levels of the trainees. Seventy percent of those trained could not recall enough of the cognitive therapy material to allow them to use it competently. This result may also

overestimate the true extent of the level of knowledge amongst trainees since 37% of the sample did not complete the knowledge section of the questionnaire.

Leff and Gamble (1995) assessed knowledge using a multiple-choice 40-item questionnaire directed at factual knowledge about schizophrenia and family work. Data were collected at three time points, at the beginning of the course, two months later and then at the end of the course, nine months later. Trainees on all four courses showed significant increases in knowledge from starting the course to the assessment two months later, this was sustained at the end of the course. No psychometric properties for the questionnaire were reported limiting the strength of the study.

Milne *et al.* (1999) evaluated the effectiveness of a nine-month cognitive therapy training programme. The course, at the Newcastle Cognitive Therapy Centre in the UK, was multiprofessional and the intake studied consisted of 6 clinical psychologists, 6 psychiatrists, and 8 mental health nurses. A range of teaching methods were used including didactic instruction, clinical work and supervision in pairs, which utilised strategies such as role-play and modelling. The evaluation examined changes in the trainees' level of competence and its generalisation to their service users' coping strategies. The competence of the trainees was assessed using the CTS-R (Blackburn, Milne and James, 1997) which is reported to have adequate inter-rater reliability and high internal consistency. The scale was used by expert raters who independently double rated video tapes of the trainees at three time points during a 12-week period of therapy. The average of the two scores awarded to each of the recordings made up the final competency rating. Trainees showed significant improvement in their levels of competence in cognitive therapy, moving from ratings of 'advanced beginner' to 'competent'. Since experts who were blind to the timing of the videotapes made ratings and they rated trainees more competent at the end of the training, strength can be added to the claim that trainees can develop skills in cognitive therapy through this sort of training.

In a later study, Milne *et al.* (2000) used multiple measures to evaluate a training programme in psychosocial interventions for severe mental illness. The acquisition of knowledge and skills by CPNs (n=45) was measured using a case study and the Functional Analysis Test (FAT: Milne, 1984) before and after the training. The FAT involves rating a video clip of an incident and is reported to have good test-retest reliability and criterion validity. Results of the case study showed significant improvements in the participants' skills and knowledge of PSI methods and principles after the training.

Donat *et al.* (1991) designed a programme to train inpatient staff in the use of behavioural methods. The two-day workshops were based in Virginia, USA, and involved 234 participants, most of who were psychiatric aides but also included nurses and mental health workers. The programme involved role-play and participants were encouraged to use their past experience and make suggestions regarding the examples and methods used in the training to make it more relevant for other trainees. The authors measured the outcome of the training using a test of knowledge (the Knowledge of Behavioural Methods inventory, McKeegan and Donat, 1988). This was given to the trainees before and after the two-day workshops. Very few results of the questionnaire are published but the few that are state that knowledge of behavioural methods increased from the start to the end of the programme for members of all disciplines. Nurses were reported to have shown the greatest increase in knowledge. Differences in knowledge which existed prior to the programme disappeared as a result of the training programme. However, this paper gives only a brief outline of the measure used and no details of its reliability or validity or reported.

Two other studies reported professional differences in the level of knowledge and skills acquired during training. Ashworth, Williams and Blackburn (1999) asked trainees after they had completed a one-year training programme in cognitive therapy if they thought it had improved their knowledge and skills. Ashworth and colleagues found that as a group the trainees were already knowledgeable about cognitive therapy before the course. Trainees reported that they felt all course elements to be important in the development of

knowledge and skill and supervision was particularly highly valued. Respondents reported that their skills had improved as a result of the course. However, there was no evidence of this above self-report level by the students. The postal survey also asked participants to rate the impact the course had had on their clinical skills. All respondents rated that their cognitive therapy skills were enhanced, as well as their general therapy skills. Significant differences between professionals were found. Doctors rated their general therapy skills and cognitive therapy skills as more enhanced by the course than did clinical psychologists or nurses. However, the study design is weak in terms of relying solely on self-report data, using an ad hoc questionnaire that was not tested for reliability and having no baseline scores for students before they started the programme. Thus, it is not possible to conclude that respondents' reports regarding changes in skills level as a result of the course are a true level of actual improvement. However, it appears that participants vary in the extent that they feel the programme contributed to any change in their levels of knowledge and skills.

O'Boyle *et al.* (1995) used questionnaires to measure knowledge before the start and at the end of the two-day course on the treatment and diagnosis of depression. The knowledge test was completed by 274 at both time points. Scores increased significantly from the start of the course (mean score 53%) to the end of the course (mean score 67%). Psychologists and doctors had higher scores before the start of the course than participants from other professions (which included teachers and administrators). At the end of the programme psychologists scored higher than social workers and both psychologists and doctors scored higher than participants in the "other" category. There were also professional differences in the opinions about depression scale. Psychologists reported a greater perceived ability to recognise mood disorders than did nurses or social workers and doctors reported a greater perceived ability than nurses. These differences may be influenced by previous training in this area. Psychologists and doctors reported more training about mood disorders than did social workers and others.

Parsons and Barker (2000) described a programme in core skills for mental health and its evaluation. Semi-structured questionnaires and focus groups were used to evaluate the programme in terms of their reaction to the training and knowledge acquired. The data presented is qualitative in nature and was analysed using thematic analyses. The main findings of the study were that students and supervisors felt that the programme had increased the trainees' knowledge and both felt that practice had been improved. The study used only self-report measures from the students and supervisors and no independent assessment of the programme is reported. The study's claim that trainees improved in terms of their knowledge during the programme would have been strengthened if standardised measures had of been utilised.

Smith *et al.*'s (1994) evaluation of a project to train nurses in long term care facilities providing care for older people with mental health problems was described earlier. They found nurses scored higher than nursing aides on the knowledge test both before the start and at the end of training. Significant differences were noted for trainers and trainees between the start and the end of the programme. This study used self-report measures, which were tested for content validity and reliability, to report outcomes at three levels.

Summary of Level 2b

Only one of the eleven studies that assessed the acquisition of knowledge and skills did so before the training commenced, after it and at follow-up (Leff and Gamble, 1995). Three of the studies report only post-intervention data (Brooker and Butterworth, 1993; Ashworth *et al.*, 1999; Kavanagh *et al.*, 1993). The most popular research design was a before-and-after method. This is an obvious gap in the training evaluation literature and requires more longitudinal studies in order to explore how long knowledge and skills are retained after training. Higher quality evidence is provided by some of the studies which employed knowledge tests and used videotapes of skills, especially when the expert rates were blind to the timing of the tapes. This produces some Type III evidence that training in psychosocial interventions can increase knowledge and skills.

4.5.4. Level 3: Changes in behaviour

Change in behaviour is the most commonly measured outcome for training as reported by the studies included in this review. This level covers the implementation of learning, such as trainees putting their newly acquired skills, knowledge or changed attitudes into practice. That this is the most commonly reported outcome is not a surprise. Milne (1985) reviewed a sample of 17 brief staff training programmes that had undertaken evaluations. He found that a change in behavioural proficiency was the main outcome measured in 11 of the studies, closely followed by the evaluation of the acquisition of knowledge. Milne's results are very similar to this review, 13 out of 26 studies reported change in behaviour as an outcome, and as can be seen above 11 studies reported the acquisition of knowledge and skills as an outcome.

Many of the studies that reported change in behaviour as an outcome have used post-intervention surveys to report on the trainees' jobs and use of skills since completion of training. These studies are obviously limited by a lack of independent assessment and baseline data. Six studies in this section have adopted this approach (Ashworth *et al.*, 1999; Brennan and Gamble, 1997; Fadden, 1997; Gournay *et al.*, 2000; Kavanagh *et al.*, 1993; Newell and Gournay, 1994). Response rates to each survey varied enormously. Gournay *et al.* (2000) report the lowest response rate of 45.6 % and Kavanagh reports the highest response rate of 94%. However, Kavanagh's figures exclude those trainees who had left the participating health service before the time of the survey and those who were on leave. I shall now consider each study separately.

Ashworth *et al.* (1999) sent a postal survey to trainees from a one-year cognitive therapy programme after they had completed the training. A response rate of 80% was achieved with 52 of the possible 65 trainees completing and returning the survey. A positive finding was that 96% of respondents (n=50) reported continuing to use cognitive or cognitive-

behavioural treatments with users in some or most of their caseload. Ninety percent stated that their predominant therapeutic approach was now either cognitive or cognitive-behavioural. However, this result is impossible to interpret without knowledge of the respondents' favoured therapeutic approach before training. One would expect that those who choose to go on such a training programme would favour cognitive approaches. The number of users seen in the month prior to completing the survey showed wide variations, from 0 to 80. The majority (71%) of respondents reported carrying out a cognitive formulation with at least half of their users. However, whilst 56% of respondents had seen five or more users where cognitive therapy was used as the main focus of treatment, 31% had seen two or less users. Six respondents had not been able to see any users because either the individual therapy was not applicable to their current job or they worked as psychiatrists or GPs with no therapy patients. Ashworth and colleagues also found differences between professionals in their reports of the implementation of skills taught on the programme. Nurses and clinical psychologists reported seeing larger numbers of users for therapy using cognitive therapy as the main focus of treatment compared to doctors and others.

Brennan and Gamble (1997) reported the post-intervention evaluation of a uniprofessional programme to train mental health nurses in the principles and procedures of schizophrenia family work. The nine-month training course was devised in 1991 at the Institute of Psychiatry and Brennan and Gamble followed-up trainees who had completed the course during its first five years. The course involved three months of didactic teaching followed by six months of students working with families on their caseloads under clinical supervision. The six months supervision involved experiential role-play, encompassing reflective experience, critical analysis and discussion with peers and the course facilitator. All 38 participants of the programme between 1991 and 1995 were sent a postal questionnaire. The questionnaire was adapted from the Buckinghamshire behavioural family work trainers (Fadden, 1997) and addressed three main areas. These were family intervention in practice, difficulties encountered in using the approach, and the overall training. The response rate was fairly low with eighteen students returning questionnaires

(47.4%). No statistical analyses were performed on the results. Rather, results are presented in terms of respondents' difficulty with implementing their learning and correspond to reported outcome Level 3-change in behaviour. The main problems respondents identified were using assessment methods, collaborating with co-workers, integrating the family work with their caseloads and /or other responsibilities at work, obtaining consultation or supervision and allowance of time from the service to do the intervention. Respondents also identified personal issues that presented difficulties, the greatest of these were a lack of progress by users and families and integration of outside commitments and responsibilities, for example, their own family.

Newell and Gournay (1994) followed-up nurse behaviour therapists (NBTs) who had trained on the ENB 650 course in adult behavioural psychotherapy. A previous follow-up of NBTs by Brooker and Brown (1986) was used as a guide for the survey. At the time of Newell and Gournay's study 187 nurses held the ENB certificate in adult behavioural psychotherapy, having been trained at one of four sites in the UK. The programme, which began at the Maudsley Hospital, London in 1972 expanded to sites at Chichester, Plymouth and Sheffield. The questionnaire that was used by Brooker and Brown (1986) was expanded and was sent to all trained NBTs resident in the UK who were still practising as nurses. The questionnaire was returned by 113 of the 142 eligible participants, representing a response rate of 79.5%. The questionnaire was concerned with the organisation of clinical practice, training, and supervision, as well as career patterns. The main findings of the survey were that respondents, on average, still spent most of their time (56%) on clinical activities. Twelve percent of their time was spent on management activities and nine percent spent on both teaching and the supervision of others. Job satisfaction was measured and found to be consistent across the four training sites (average scores ranged from 71% to 67%). The majority of trainees were very satisfied with their working lives. One worrying finding was that 22% of respondent never received clinical supervision. Most respondents received weekly supervision (27%), 17% received it monthly and 15% fortnightly. The respondents were found to be a highly educated group within nursing who continued to seek further education after training. This survey

was followed by a 25-year follow-up of graduates of the programme and is reported by Gournay *et al.* (2000).

Gournay *et al.* (2000) reported on the third follow-up of practising nurse behaviour therapists (NBTs). As in the previous two follow-ups (Brooker and Brown, 1986; Newell and Gournay, 1994) a postal survey was used to examine the clinical practice, organisational context and career and professional issues of graduates of the programme. Again all trained nurse therapists resident in the UK who were still practising as nurses were followed-up. This number now totalled 274 but 37 of these potential respondents could not be traced due to inaccuracies in the database. Thus of 237 graduates, 105 returned analysable questionnaires, representing a response rate of 45.6%. Additional data on a further 27 nurse therapists is also included in the results.

Respondents to Gournay *et al.*'s survey did not differ from non-respondents according to the site of their training, nor on whether they were currently in clinical practice. However, respondents were significantly younger than non-respondents. The majority of respondents were found to retain some level of clinical involvement (81%) and on average respondents spent 50% of their time in clinical practice. The other main areas of involvement for respondents were on managerial work (16%), teaching (8%) and research (7%). The two most common problem categories treated by nurse therapists who responded to the survey were obsessive compulsive disorder and depression. These both showed an increase from the previous survey by Newell and Gournay (1994). Obsessive-compulsive disorders accounted for 18 % of the caseload of nurse therapist in the 2000 study where as in 1994 they made up less than 12%. By 2000, depression accounted for almost 16% of the nurse therapist' caseloads rising from 10.1% in 1994. Another area of change from the 1994 study was found in supervision. Only three respondents (4%) reported never receiving clinical supervision. However, the frequency of supervision was variable with 42% receiving it monthly, 26% fortnightly, and 16% receiving it weekly. The poor response rate to this survey weakens the study and it again relies solely on self-report data from the trainees. This combined with a lack

of baseline information means very little can be generalised about outcomes of the programme on the behaviour of students. However, the repeat of the survey over the years does enable comparisons of outcomes between graduates at different times. Thus whereas lack of supervision was a reported problem for NBTs in the first two surveys this appears to have been addressed by the time of the third survey.

Kavanagh *et al.* (1993) evaluated the training of therapists in cognitive behavioural family intervention for schizophrenia in Australia, which was described in the above section. A response rate of 94% (N=45) was achieved in response to the postal survey. The main findings of the survey were that the training had achieved only a very limited impact from the family training on clinical work. Seventy percent of those trained used the intervention with only one family. Findings also suggested that trainees overestimated their actual use of the cognitive and behavioural intervention strategies. The greatest areas of reported difficulties by the respondents were integration of the cognitive-behavioural intervention with their caseload or other responsibilities at work and gaining an allowance of time from work to do the intervention. Fifty-six and fifty-one percent of respondents, respectively, reported moderate or greater difficulty with those two items. They also found differences between professions in the use of interventions with psychologists reporting lower ratings of difficulty in using the interventions as opposed to psychiatric nurses.

Similarly poor results were found in the UK by Fadden (1997) who surveyed 86 participants who had been trained over a 6-year period on eight different training courses in the skills and techniques of Behavioural Family Therapy (BFT). They were a multiprofessional group who were trained and included nurses (community and in-patient), clinical psychologists, psychiatrists, occupational therapists, social workers and rehabilitation officers. The training involved four phases and commenced with an introductory meeting where trainees were given preparatory reading material. The second stage focused on skills acquisition during a three-day training course which utilised role-play, videotaped examples and other active learning techniques. Ten weekly sessions of group supervision, each lasting for one and a half-hours made up

the third stage. In the final stage monthly on-going supervision groups were arranged.

Trainees were surveyed between 9 months to 3.5 years after they had completed the training courses. The questionnaire used was closely modelled on that used by Kavanagh *et al.* (1993). The questionnaire asked participants how many families they had worked with using a BFT approach and had seen at least three times. The questionnaire then asked about the difficulties they had faced in implementing their learning in their work and how these had been overcome. The questionnaire also included 33 items on service issues, clinical issues and personal issues which respondents rated for levels of difficulty. A response rate of 70% (N=59) was achieved. Seventy percent of respondents reported that they had been able to use the BFT approach in their work, however, the number of families seen was small. The average number of families seen by respondents was 1.7, and a large number of families (40%) were seen by a small number of respondents (8%). The most common difficulties experienced by trainees in implementing BFT were locating appropriate families and then engaging them in the therapy and integrating the work with their caseloads or other responsibilities at work. Other difficulties included lack of time to do the sort of work they had been trained to do and problems in taking time in lieu or getting paid overtime.

Milne *et al.* (2000) used multiple measures to independently evaluate a training programme in psychosocial interventions (PSI) for severe mental illness. Change in behaviour was measured using a generalisation questionnaire. This was an ad hoc self-report instrument, however, its test-retest reliability was tested on a sample of 16 mental health professionals and significant correlations were found for all but one section. The measure asked participants to note which psychosocial intervention instruments and methods, from a list of 13, they had utilised in the three months before and after the training programme. They were also asked to note the number of users they had used the approaches with in the previous three months and the clinical impact of the work. Participants were then asked to rate the generalisations across behaviours, persons and responses and note the support for the PSI

approach provided from thirteen different sources. The results showed a statistically significant increase following training in seven of the thirteen methods listed. A small training generalisation effect was also reported including generalisations to other behaviours, to other people and other responses. The section of the measure that asked for ratings of support was found not to be reliable so the results need to be treated with caution. However, trainees rated contact with other course members, contact with PSI supporters and their supervision group as the three greatest sources of support.

Bailey (2002a & b) used a before-and-after design to monitor changes in assessment practice, and risk assessment and management practice. At the start of the programme (T1) trainees were asked to provide information about four users with whom they were working on an ongoing basis. Trainees were then asked to complete the same information for the same users a month after the training. The response rate was low with only 25 participants completing the information at T1 and 14 at T2. In total information was available for 44 users at both T1 and T2. The study identified a barrier to implementing change in practice in the relatively short opportunity workers may have to engage and intervene with users. Of the 44 users identified at T1, eleven were no longer in receipt of services at T2. These users had been either discharged, admitted to hospital, moved out of the area or lost contact with the service.

Brooker and Butterworth (1993) evaluated the training of community psychiatric nurses (CPNs) in psychosocial interventions using the Aspects of CPN Organisation and Practice Questionnaire (AOQ). The ACQ was devised by one of the authors to measure changes in the way trainees organised their work, such as caseload numbers, the percentage of users with a diagnosis of schizophrenia, the degree of support offered locally and relationships with referring agencies. Results for this measure are reported after training, six months after training and one year after training. There was a significant increase in the proportion of the working week spent working with families before and after training (15% and 45 % respectively). The number of

intervention hours per family given by CPNs each month also changed significantly. Trainees rated that most of their support, locally, came from psychiatrists and psychologists rather than their own managers. This study is limited by its lack of baseline scores.

Corrigan *et al.* (1997) evaluated an approach to training called Interactive Staff Training (IST) in the US. The approach was used in three residential establishments and included 35 staff who made up 56% of the day shift in the establishments concerned. The training consisted of monthly 90 minute meetings where staff identified the needs of their programme, selected behavioural rehabilitation strategies to meet those needs, decided how to implement the strategies and finally considered the risks and benefits of specific plans. An interactive staff training consultant met with the programme committee monthly, over a period of eight months, to facilitate the process. The authors reported that direct care staff and clinical staff were involved, however no break down of professional membership is given.

The evaluation used a before and after design to measure the barriers to the implementation of behavioural therapy, burnout and collegial support. Three self-report measures were used. The Barriers to the Implementation of Behaviour Therapy Scale has been found to have three meaningful and reliable factors (Corrigan, Kwartarini and Pramana, 1992). The Maslach's Burnout Inventory (MBI: Maslach and Jackson, 1986) was used to assess burnout. The Social Support Questionnaire (SSQ: Sarason, Levine, Basham *et al.*, 1983) was used to measure perceptions about the current size of a person's support network and his or her satisfaction with it. It was modified in this study so that staff only listed colleagues with whom they worked. The authors report that following eight months of IST staff perceived fewer institutional constraints to setting up behavioural innovations, more collegial support and less philosophical opposition to behavioural therapy. The authors also report that there was no significant change in the size of the collegial support network after interactive staff training but satisfaction with the support network increased significantly. Satisfaction did not differ significantly by job category. Direct care staff reported significant improvement in emotional

exhaustion but there was no significant change for clinical staff. However, the evaluation of IST is dependent upon self-report measures.

Freiheit and Overholser (1997) examined how pre-existing biases towards cognitive-behavioural therapy may affect the use of cognitive behavioural techniques over a nine-month course. The scale showed that students perceived themselves to be using more cognitive behavioural techniques at the end of the course than at the beginning. There were no significant differences between the three groups (those who were cognitive-behavioural orientated, those non-cognitive-behavioural orientated and the undecided) on the use of cognitive techniques.

Repper (2000) evaluated a multidisciplinary training programme in psychosocial interventions for those who work with people who have serious mental health problems. The evaluation of the one-year postgraduate certificate course at Sheffield University, in the UK looked at the implementation of skills taught on the course and outcomes for service users. Semi-structured interviews with the seven trainees were used to understand the nature of their work with users. Repper argues that the trainees' accounts had the advantage of not only explaining what they did, but also why they did it. Observations from tutors and recollections' of users supported the data from the trainees' interviews. Trainees on the course reported using a greater range of skills, extending beyond those taught on the programme. However, they did not use advanced or highly specialised skills. Reasons identified for this include inadequate teaching or supervision, a lack of confidence on behalf of the trainees and a perceived lack of relevance to the users. Other barriers to the implementation of skills which were identified in the study were related to issues in the workplace. These included: isolation of the trainees, a lack of support and understanding in their workplace, high caseloads, lack of time and the failure of services to enable trainees to work out of hours. Repper also discusses the problem of previous studies of training in psychosocial interventions that has been conducted with highly motivated students who had attended courses at personal cost. In this study the training was set up as a result of a Trust's ambition to train a given number of employees from a range

of disciplines. However, there were problems with the interprofessional nature of the course and there were no volunteers to attend the course from occupational therapy.

Williams, Moorey and Cobb (1991) assessed trainees on a Cognitive Behaviour Therapy training course for competency in using the approach. They asked trainees from the first three intakes of the course to produce an audiotape of a cognitive therapy session twice. Once, was after the initial two-day workshop and the second was at the end of the course. Only one third of the students (N=11) produced the audiotapes and this reflected a bias towards psychologist (eight out of the eleven who submitted the tapes were psychologists and many of them had over five years therapeutic experience). The tapes were rated by two of the authors of the paper, who were blind to the order of the tapes, using the Cognitive Therapy Scale (Young and Beck, 1980). Eight of the eleven participants showed improvements in CTS scores after training. However, one participant showed a considerable decrease in scores from the start to the end of training. This study was affected by a number of methodological flaws. Firstly, the raters were also trainers so they were not independent of the training process. Secondly, just one third of the total sample produced the tapes and many of those trainees already had extensive therapeutic experience. This small, biased sample makes conclusions difficult to draw.

Summary of Level 3

The evidence, so far, to support the hypothesis that training can affect the behaviour of staff is patchy. The reliance on self-report, post-intervention designs leads to a poor quality of evidence that can be categorised as Type V. The poor quality of evidence shows equally disappointing results. Freiheit and Overholser showed that participants in their study used more cognitive behavioural techniques at the end of the course than at the beginning, regardless of their original theoretical orientation. However, since there was no follow-up we do not know how long this increased use of the techniques lasts. Other studies have highlighted the difficulties trainees have in implementing their learning. Since most of the studies are concerned with

training in the use of psychosocial interventions it follows that many of the problems identified are related to skills. Commonly reported problems appear to be related to roles at work. Thus, Ashworth *et al.* (1999) found that some trainees had not implemented any of the skills they had been trained in because therapy was not applicable to their job (this related specifically to psychiatrists and doctors). Kavanagh *et al.* (1993) and Fadden (1997) both found trainees had problems integrating the new skills with their caseloads and gaining time in lieu or overtime from the service in which they worked. Additionally, many respondents reported difficulties incorporating the new interventions with their personal commitments, especially since work with families often involves working out of office hours.

Appropriate supervision also appears to be a problem, although it is reassuring to see this reduce as a problem for nurse therapists in the follow-ups reported by Newell and Gournay (1994) and Gournay (2000). It is also not clear where trainees find the most support. Nurses in the Brooker and Butterworth (1993) study found psychiatrists and psychologists more supportive than their own managers. Participants in Milne *et al.*'s (2000) study reported course members and other PSI supporters as more supportive (however, this section of the questionnaire was not reliable). Corrigan *et al.* (1997) were the only authors to report measuring barriers before and after training and they found perceived barriers reduced after their Interactive Staff Training. Further work is required to examine if other forms of training would achieve such results.

4.5.5. Level 4a: Change in organisational practice

This level relates to wider changes in the organisation in which trainees work as well as to their delivery of care. Only two studies reported outcomes at this level. Corrigan *et al.* (1995) assessed the effects of interactive staff training (IST) on staff programming and patient aggression in a US psychiatric inpatient ward. Twenty-two line-level staff working on the day shift on the ward took part in the study. These included nurses, social workers,

psychiatrists and psychologists. The study used a multiple baseline design where data was collected over a 9-month period. After the baseline data was collected staff were invited to participate in weekly one-hour IST meetings conducted by two of the authors. The first two meetings were used to develop and conduct a staff needs assessment regarding strengths and limitations of the programme. The next two meetings were used for the staff to identify individuals to participate in the programme development committee. During the next two months the programme committee and other interested staff met with the two authors to make decisions about improving their existing incentive programme. This revised programme was implemented at the end of month 12 of the study. The skills training programme was targeted during months 18 to 20 of the study and a new programme was devised and implemented during month 21 of the study. Data was collected on staff and users participation in a token economy programme and participation in the skills training programme. Data was also collected on staff attitudes using the Barriers to Implementation of Behavior Therapy Test (BIBT: Corrigan *et al.*, 1992). This was completed before the beginning of training and after 15-months of participation, to determine the effects of IST on attitudes about behavioural programming. However, this was only completed by a small sample of staff members (N=6)

Results of this study show that in the baseline period, no staff members participated in the irregular token economy and this did not change during the three-month programme development phase. However, 75.5% of staff members participated in the programme per day during programme implementation. This change in participation was also reflected by users where 87.3% of users participated daily during programme implementation. Changes in staff participation in skills were noted after the 20th month when the IST developed skills training programme was implemented. An average of 29.7% of user participated in groups each day during baseline and this number increased to 70.3% after staff members began the skills training programme. Staff reports of aggressive incidents and physical restraint also decreased after the token economy and skills training programmes were implemented. The staff that completed the BIBT showed that their attitudes

about barriers to behaviour therapy had improved. There was less reported philosophical opposition to behavioural interventions and staff believed that institutional constraints were less of an impediment. The authors recognised that some of their data is reliant on staff self-report and perceptions as well as that some of the outcomes could be seen as processes. However, they argue that the staff training paradigm led to a significant increase in the use of an intervention that has already been shown to be effective. Thus increasing the participation of staff and users is an important goal in its own right. The study design could be strengthened by the use of a randomised control group and independent ratings of outcomes for staff and service users.

Milne *et al.* (2000) assessed change in organisational behaviour by examining absenteeism-sickness data before, during and three months post-training. This data was collected from central records for NHS personnel only, this related to 32 of the 45 trainees. There were no significant changes in absenteeism over the three periods assessed (before training, during training and at follow-up). Change in organisational practice obviously relates to more than just not being absent. However, it is one of the few attempts made to measure changes to organisational practice. The lack of studies that measure this outcome is perhaps reflective of the difficulty of achieving change in organisations rather than changing an individual's practice.

Summary of Level 4a

There is little evidence of wider changes in the organisation in which trainees work. This is often difficult to assess and only two studies in the review reported this level of outcome. This is an obvious gap in the literature, particularly in relation to demands to improve teamworking and interprofessional collaboration. Thus the quality of evidence is weak and is best categorised as Type V.

4.5.6. Level 4b: Benefits to users/ carers

Six studies attempted to measure changes in service users and their carers as a result of a training programme. This outcome is often referred to as the ultimate aim of any training programme. The studies that measure this level tend to use more robust designs than those found in the other levels. One of the first studies to attempt to measure the outcome of training nursing for service users is Brooker *et al.* (1992). They report on a pilot study to train community psychiatric nurses in psychosocial interventions. The programme was designed to teach the CPNs a variety of interventions. These included assessment and health education for all family members. A family stress management programme and goal setting aimed at increasing the social and personal functioning of both the client and the relative. Nine students took part on the one-day per week programme, which lasted for six months (30 full days).

The evaluation of the programme examined outcomes for service users of those trained. A 'quasi-experimental' design was adopted and the CPNs on the programme were matched with a colleague who was from the same health authority. Both groups of CPNs were trained to administer outcome measures but only one group received the training in psychosocial interventions (the experimental group). The aim was for each CPN to obtain three families, therefore the target was a total of 54 families in the study. Thirty families actually took part in the study after 17 dropped out during the one-year follow-up. A before-and-after design with a follow-up six months after the end of the formal teaching was used. Results for users showed no significant differences on four of the eight subscales of the KGV (Krawiecka *et al.*, 1977), in neither the experimental nor the control group. However, there was a significant improvement for the experimental group at follow-up on three of the subsection: depression, anxiety and retardation. Both groups showed a significant improvement on delusions at post-intervention. The experimental group showed a significant improvement on the social adjustment scale at both post-intervention and follow-up. There were no significant changes for

the control group on this measure. Relatives' assessments of the users did not change in the control group. However, relatives in the experimental group expressed significantly higher levels of satisfaction with the users' personal functioning at post-intervention and follow-up. Relatives' estimates of positive change in personal functioning and their ratings of level of personal functioning of the users also increased significantly at both the post and follow-up assessments.

In a second study by Brooker *et al.* (1994) the eight CPNs who took part in the training acted as their own controls. Trainees were trained in the use of a variety of outcome measures and they were administered at baseline, six months after baseline and finally, one year after baseline. Six outcome measures were used. The KGV was completed by the CPN based on an interview with the service user, the Social Functioning Schedule (SFS: Birchwood, 1983) was completed by the relative in discussion with the CPN. The carer or relative completed the General Health Questionnaire (GHQ: Goldberg and Hillier, 1978) and the CPQ themselves. The Knowledge about Schizophrenia Inventory (KASI: Barrowclough *et al.*, 1987) was rated independently from audiotaped interviews between the relative and the CPN. Finally, a score was calculated by a researcher from raw data provided by the CPN for the standardised dosage of haloperidol. The outcome measures were used to assess outcomes for users and carers of the CPNs. Resources were not available to randomly allocate families to a control or experimental group so trainees acted as their own controls and were asked to identify 6 families. An initial sample of 60 families (3 control and 3 experimental for each trainee) became a target sample of 48 after two trainees dropped out of the programme. A total of 41 families were recruited to the study and 34 remained in the study for 12 months. The experimental group received psychosocial interventions after 6 months whilst the control group had to wait a further 6 months before they were offered the opportunity to receive PI. From 24 control families one dropped out before the end of the 12-month study period, 15 took up the offer of psychosocial interventions and 8 remained a control subgroup who never received PI.

There were no significant differences between the control and experimental patients or relative at pre-treatment. The 19 families in the experimental group showed a significant reduction of positive and negative symptoms over the time that they received the intervention. The control group showed no change in positive and negative symptoms during the first 12 months of the study but families who later accepted the intervention showed a significant decrease in positive and negative symptoms at 12-month follow-up. Scores for social adjustment showed a similar pattern, they increased in the experimental group by one-year follow-up but did not change for the control group. For the control group who later accepted PI there was a significant improvement. The monthly median dose of haloperidol decreased for users in the experimental over the 12 months after PI had commenced and this pattern was shown later for the users in the control group who later accepted PI. The mean number of days spent in hospital fell for the experimental group after 12 months and this was later repeated for the control groups who took part in the psychosocial interventions. Outcomes for carers also improved. Median scores on the General Health Questionnaire, a measure of stress, decreased significantly for relatives in the experimental group. Scores for the control group remained similar until some accepted PI and then their scores reduced. Ratings of satisfaction (achieved by combining ratings of 'overall satisfaction with services', 'satisfaction with frequency of CPN contact', 'understanding of relative's illness' and 'overall satisfaction with drug services') improved significantly for the experimental group. However, ratings did not improve in the control group, or the subgroup of controls who accepted intervention. Relatives in the experimental group showed a significant increase in knowledge, this was replicated by the subgroup of controls who accepted the intervention later however no change was found in control families who did not accept PI.

The study showed positive effects for users and carers as a result of training CPNs to deliver psychosocial interventions. However, the study suffered from a number of methodological problems. Firstly, the authors recognise that the small number of users per nurse requires that further work is done with larger samples. Secondly, the random assignment of families to treatment could not

be achieved and assessment of the families was neither blind nor independent. The study design also assumed that trainees on the programme would not implement any of their learning with the control families, but it is possible that there was some transfer of the benefits to control families

Lancashire *et al.* (1997) evaluated a nine-month pilot training course held at the University of Manchester, in England. The programme trained twelve community psychiatric nurses in psychosocial interventions for serious mental health problems. The nurses attended the university for one day each week for formal teaching and supervision of their clinical work. Another day each week was spent undertaking psychosocial interventions with four clients from their caseloads. The programme participants received training in the use of the Krawiecka, Goldberg and Vaughan psychiatric assessment scale (KGV) and their reliability of ratings was assessed by the ratings of six videotaped interviews. The trainees' ratings were found comparable to ratings by a panel of five faculty members. The Social Functioning Scale (SFS; Birchwood *et al.*, 1990) measures users' self-reports of social performance skills that are likely to be affected after the onset of serious and enduring mental illness was also used. A before and after design was used with the measures being administered before the psychosocial interventions were implemented, and a follow-up assessment took place 12 months later. From 33 users that took part in the study 82% (N=27) completed measures at both time points. There were significant reductions in the KGV total symptom score, in positive symptoms and in affective symptoms. Users also showed an increase in the overall social functioning score. Despite the significant improvement in social functioning users did not show a significant reduction in negative symptoms of schizophrenia. The use of the standardised measures helps to support the authors claims that the data offers tentative support for the proposition that community psychiatric nurses can be instructed in psychosocial methods of intervention that have a demonstrated effect on users' outcomes after 12 months. This claim would be strengthened if the study had used a control group and users were followed-up to see how long this effect lasted.

Leff *et al.* (2001) reported on the most robust study measuring benefits for service users. They evaluated a course in family work skills for community psychiatric nurses in terms for outcomes for service users. The evaluation builds on that reported earlier by Leff and Gamble (1995) which assessed the same training programme in terms of changes in knowledge and attitudes of the trainees. A randomised control trial was used and users in the control group received two sessions of education about schizophrenia, while the experimental group received the full family intervention. The intervention for the experimental group comprised techniques for improving communication within the family, reducing relatives' criticism and over-involvement, lowering contact between patient and high Expressed Emotion (EE) relatives, increasing the social networks of family members and setting realistic objectives. The approach included cognitive and behavioural elements as well as techniques from family therapy. CPNs who had participated in the training course delivered the interventions for the experimental group. The control group received the two educational sessions from a CPN who had not been trained but worked in the same services as those that had. Thirty service users, 16 in the experimental groups and 14 in the control group took part in the trial. Seventeen trainees took part in the training, 15 were CPNs and 2 were support workers. Finally, data were available for 19 experimental relatives and 15 control relatives.

A number of measures were used to assess outcomes for service users, some were rated by a clinician blind to the users' treatment group and other were completed during an interview with trained research workers. Assessments were administered at baseline and one-year after the user had been discharged from hospital or had recovered from an episode in the community.

There were no differences between the service users in the experimental group or in the control group at baseline on age, number of previous admissions or length of illness in months. There were also no significant differences between relatives in the two groups on any of the components of Expressed Emotions, knowledge scores, burden scores or assessment of the

users' social functioning. At the one-year follow-up relatives in the experimental group showed a significant reduction in Critical Comments and Over-involvement scores as well as a significant increase in Warmth. The control group did not show any significant change son those scales. Relatives' ratings of burden decreased in both the experimental group and the control group, the reason for which is not clear. There were however, no changes in knowledge scores for either group over time. The strong design used by Leff and colleagues is weakened by small sample sizes, which the authors suggested, may have disguised statistically significant effects.

Milne *et al.* (1999) used a before-and-after design to assess the benefits for users of a nine-month cognitive therapy training programme Newcastle. The Coping Responses Inventory (CRI; Moos, 1990) was administered to 20 service users with depression or anxiety disorder at the beginning and end of treatment, which took place at the training centre. The CRI is a measure of an individual's coping strategies and is seen as a mediator of therapeutic change. It is not however a measure of change in symptoms or behaviour. There were significant improvements overall in eight of the eleven items on the scale. This study lacked a control or comparison group, which, as the authors suggested, might be obtained through a double baseline assessment.

Repper's (2000) evaluation of the one-year training course in psychosocial interventions considered many measures of outcomes for service users. These included standardised measures such as the Brief Psychiatric Rating Scale (BPRS: Overall and Gorham, 1962), the Social Functioning Scale (SFS: Birchwood *et al.*, 1988), and quality of Life (Lehman, 1983). Other measures used included monitoring changes in service use and prescribed medication as well as users' personal goals. Trainees also took part in eight interviews throughout the course about the users' day-to-day progress. These interviews concentrated on the trainees' activity with users and the users' lives in general. Three of the students also did formal work with families and this was assessed using the Burden on Family Interview (BFI: Pai and Kapur, 1981). This is reported to have high inter-rater reliability. This data was collected at 3 baseline periods (6 weeks apart), during the training, at the end of the course

and after the intervention (to assess durability over 24 months). Results showed that by the end of the course the 19 users had started to achieve their personal goals and almost half (9) had fewer symptoms. The study did not find significant changes in the social functioning or quality of life of service users. Only two service users improved reliably on the SFS and only one on the measure of quality of life. Six of the service users who met most of their personal goals also achieved improvement on the BPRS

Summary of Level 4b

It is positive to see that six studies have attempted to measure outcomes for service users and carers, especially when one considers how difficult this is to do. All of the studies report using standardised measures over a period of time, which is in contrast to the other levels of measurements where ad hoc instruments have played a predominant role in evaluations. It is also positive to see that studies attempted to measure social outcomes and users' and relatives' satisfaction as well as symptoms. There is Type III evidence to suggest that psychosocial interventions taught to mental health professionals can have a positive impact on the lives of services users and their carers. However, there are several gaps in the state of knowledge in this area. All of the studies report on quite small numbers of trainees and hence small numbers of users. As can be seen by *Leff et al.* (2001) this can cause problems when applying statistical tests. Only one study reported the random allocation of users to treatment and included controls although this is difficult to achieve for ethical reasons. There remains a need to demonstrate that training mental health professionals can have an impact on the people who receive their services, in a way that service users and carers perceive is meaningful.

4.6. Conclusion

This review shows that evidence for each outcome is rather weak. Methodological problems abound. Disappointingly, there is a lack of independent evaluations. This echoes the finding of Barr *et al.* (1999), in their

review of interprofessional education in health and social care, that most evaluations were carried out by teachers and trainers themselves. Whilst it is positive to see teachers and trainers evaluating their programmes independent evaluations increase credibility. Common problems associated with the research designs of many studies include a lack of longitudinal designs that include follow-up assessments. Thus any change in attitude, knowledge or skills is often not investigated for its durability. The reliability and validity of instruments used to investigate changes in attitudes, skills and knowledge is also problematic. Many studies do not give enough details of the instruments they use and the use of ad hoc instruments make comparisons between studies impossible. Milne *et al.* (2000) acknowledged this problem, noting that the measurement weaknesses "for research on staff training in the field of severe mental illness appear to be common" (p. 90).

The classification of outcomes showed that most evaluations measure the acquisition of knowledge and skills and changes in behaviour. These results repeat those found seventeen years ago by Milne (1985). Additionally, many of the evaluations included in this review were studies of training programmes in psychosocial interventions with a focus on skilling trainees. Therefore, it seems sensible that the acquisition of such skills and their implementation should be a commonly measured outcome. That much of the training is concerned with psychosocial interventions such as cognitive behavioural therapy and family intervention reflects the growth in programmes in this area. Indeed, a survey by Brooker *et al.* (2002) to map university-accredited, post-qualifying training for mental health professionals found that across England, as a whole, psychosocial interventions formed the largest component of relevant training programmes (34%).

The evaluation of these programmes suggests that they offer positive benefits to service users and carers. This has been in terms of satisfaction (Brooker *et al*, 1992; 1994) and an improvement of psychiatric symptoms (Leff *et al.*, 2001). However, it is worrying to note the difficulties associated with the implementation of psychosocial interventions into the workplace. Findings from the UK and Australia show that workers report difficulties: locating and

engaging families; obtaining supervision; achieving flexibility of working hours; and collaborating with co-workers. This strongly suggests that interventions taught on programmes may not be implemented into routine practice without significant support to overcome such barriers.

Whilst nearly half of the evaluations reported initiatives involving two or more professional groups none gave detailed information about the context for interaction between the groups. Thus whilst I have referred to these initiatives as "interprofessional" the use of the term "multiprofessional" may have been more appropriate. It is not clear from the studies whether the professions learnt from and about one another as opposed to learning alongside each other. This is reflected in the lack of information about the teaching methods used, with many studies simply stating what methods were used without elaboration. There is, as the literature stands at the moment, no good evidence to demonstrate that any one method of training is more effective from another in relation to the training of the mental health workforce. Nor is there any evidence on differences between professional groups receiving various teaching methods. However, the literature did reveal some differences between professions. For example, O'Boyle *et al.* (1995) found professions differed significantly in some of their attitudes before training. This suggests that interprofessional programmes may have to overcome the difficulty of targeting information at a level which is suitable to the needs of all. Ashworth *et al.* (1999) found that different professionals reported a greater enhancement in skills following training and differences in their implementation of skills.

Of the evaluations that report on uniprofessional initiatives all but one involved nurses. That nurses were the profession with the highest representation in the training programmes is not surprising considering they are the largest profession in the field of mental health. Brooker *et al.* (2002) found that the recruitment of professions other than nursing to training programmes, especially at Master's level, is extremely poor. In the same survey Brooker and colleagues also found that the majority of courses do not seem to involve service users in the management, student assessment or evaluation of

programmes. As previously mentioned the National Service Framework for mental health advises that service users and carers should be involved in the planning, provision and evaluation of training. However, only the initiative reported by Cook *et al.* (1995) reported the involvement of service users. In summary, the evidence-base for the training of the mental health workforce has a number of gaps in relation to the involvement of service users, as well as interprofessional education and the training and ultimately the implementation of psychosocial interventions.

This thesis will attempt to address a number of gaps in the literature. Firstly, it will investigate attitude change in relation to one's own and other professions. It will do so by examining the teaching environment for the conditions as set out by the contact hypothesis. Secondly, it will assess the teaching of psychosocial interventions in an interprofessional environment and the students' reported ability to implement the taught skills. Finally, attitudes towards user involvement in a post-qualifying programme will be examined as well as students' reports of resulting changes in practice. This thesis does not attempt to measure benefits to users and carers nor changes in organisational practice, which may result from the training.

5. RESEARCH METHODS

5.1. Introduction

This chapter will outline the methods used to evaluate the processes and outcomes of an interprofessional post-qualifying programme for staff who work in mental health services. In terms of Kirkpatrick's (1967) framework the methods used will measure outcomes at Level 1 (Learners' reactions), Level 2a (Modifications to attitudes and perceptions) and Level 3 (Changes in behaviour). The aims and design of the study will be explained, alongside a discussion of the training programme, its participants and the methods used to measure outcomes.

5.2. Context: The Birmingham University Programme

The training programme considered in this study is the Programme in Community Mental Health, at the University of Birmingham. Those joining the programme sign up for one year. This leads to a Postgraduate Certificate. Those who wish to, and achieve the necessary standard can continue the programme for an extra year's teaching that leads to a Postgraduate Diploma. Again, there is an opportunity for those who meet the necessary standard to continue. The successful completion of a dissertation after a period of supervised research in the third year leads to a Master's degree. The programme is part-time and students attend for one-day per week. The programme aims to improve the quality of community-based care for people with severe and enduring mental health problems by promoting the development of workers' practice based skills (University of Birmingham, 1997).

The programme commenced in 1997 and trains those who work in community mental health services in psychosocial interventions, interagency and multidisciplinary working as well as the philosophy and legislative framework of community care. According to the course handbook the programme aims

to give practitioners from all professions a common skill, knowledge and value-base. Modules include a 14-week general foundation designed to give students an overview of the recent developments in mental health care and an understanding of current approaches to care and treatment. It also aims to help students become aware of their own values and beliefs about mental health care. The first year of the programme includes modules on psychological interventions, user participation and self-help and working in community teams and pharmacology. The focus of the first year is concentrated on shaping attitudes to aid interprofessional working, improve collaboration with service users and introduce the students to psychosocial interventions.

5.2.1. The External Evaluation

At the same time as the programme was commissioned it was decided that it should be externally evaluated over five-years. Durham University successfully tendered for the contract and it began the evaluation in the late summer of 1998, almost a year after the programme had started. I, along with Professor John Carpenter and Diana Barnes made up the Durham University evaluation team. Whilst the external evaluation and data for this thesis are fundamentally linked there are differences. The methodology for this thesis included methods of data collection that were not part of the tender that was awarded the external evaluation contract. The methods, which relate only to this thesis, are the semi-structured interviews and the participant observations. The external evaluation examined changes over the second and first years of the programme and explored outcomes for service users.

5.3. Aim of the Study

Training in mental health can have many outcomes, as seen in Chapter 4. Important outcomes of a training programme are often considered to be changes in attitudes and the increase in skills. In relation to mental health there has been identified a need to: improve the attitudes of mental health professionals to promote interprofessional team working, increase the use of

psychosocial interventions and promote positive attitudes regarding service user involvement. This thesis addresses these three needs in relation to one training programme and the outcomes of the training for the students who took part.

The literature reviewed in the previous chapters forms the basis of the questions that this thesis aims to tackle. These questions can be divided into three different areas and are presented in terms of three research questions with a number of related hypotheses.

The first question addresses the need to improve interprofessional working amongst health and social care professionals. Poor teamworking has been put down to negative stereotypes of other professions and hence there is a perceived need to improve interprofessional attitudes as the basis for improving interprofessional team working. How this is best done is, as yet, far from clear. Thus the first research question investigates how students learn to work in teams and how attitudes may change during an educational programme.

> ***Research Question 1: "How do students learn to work together and how do attitudes to one's own and to other professions change on an interprofessional education programme?"***

Social psychologists have investigated the area of attitude change and developed theories based on empirical evidence. One of these theories, the contact hypothesis, states that intergroup contact by itself will not improve attitudes between different groups. The first hypothesis is based upon the contact hypothesis and the conditions it outlines for attitude change to take place.

Hypothesis 1: All conditions of the contact hypothesis will be present.

In terms that are more explicit this means that respondents will demonstrate on the "Conditions of the Contact Hypothesis" scale (Appendix E) before starting the programme (Time 1) that:

- There is support for their participation on the programme from their employer, members of their own profession and members of their mental health team, and
- They have positive expectations about participating on the programme.

At the end of the programme (Time 2) they will demonstrate that:

- Both similarities and differences between the mental health professions were emphasised on the programme.
- Participants worked together as equals
- The atmosphere on the programme between members of different was co-operative not competitive
- There was successful joint work between members of the different professions on the programme.

Additionally, the final contact hypothesis variable, which is that participants are considered typical of the group they represent (in this case their profession), will be assessed using qualitative interviews with the students.

The second part of the research question relates to mutual intergroup differentiation (Hewstone and Brown, 1986), where the different professions recognise each others' strengths and weaknesses. The assessment of whether mutual intergroup differentiation has taken place during the programme involves the testing of three hypotheses:

Hypothesis 2: Ratings of heterostereotypes (stereotypes held about other groups) will become more positive from the start to the end of the programme as students' recognise the skills of others.

Hypothesis 3: Ratings of autostereotypes (stereotypes held about ingroup) will become less negative from the start to the end of the programme as students' no longer see their profession as their ingroup.

Hypothesis 4: Perceived autostereotypes (stereotypes about one's own group as seen by others) will become more positive from the start to the end of the programme as attitudes about other professions improve.

The third, and final part of research question 1 relates to identity. The students who take part on the programme are part of two groups, their profession and their team. It is predicted that the interprofessional nature of the programme will reduce the level of identification that the students feel with profession and increase their level of identification with their team. This leads to the fifth hypothesis:

Hypothesis 5: Professional identity will decrease and team identity will increase from the start to the end of the programme.

Whilst the first research question concentrates upon attitudes the second examines skills. Specifically, the research question examines how far learning about psychosocial interventions was translated in to change in behaviour at work or if change in behaviour did not occur what factors were inhibiting it.

Research Question 2: How do students learn about and implement psychosocial interventions in their work with people with severe and enduring mental health problems?"

The programme aims to teach the students to use PSIs but as the literature review in chapter 4 showed the implementation of such skills is often hindered by a number of factors. This study examines students reported use of psychosocial interventions and the barriers they perceive to the implementation of PSIs.

Hypothesis 6: Students' reported use of psychosocial interventions will increase from the start to the end of the programme.

Hypothesis 7: Perceived barriers to the implementation of psychosocial interventions will decrease from the start to the end of the programme.

The learning and implementation of new skills would be expected to have an impact on the students' understanding of their role. It is expected that the teaching of psychosocial interventions will improve the students' perceptions of their purpose of work and therefore:

Hypothesis 8: Role clarity will increase and role conflict will decrease from the start to the end of the programme as students learn new skills.

The importance of involving service users in mental health services, and the training and evaluation of the workforce was outlined as an important aim of government policy in Chapters 2 and 4. How an educational programme seeks to do this is still largely unexplored in the mental health literature. Therefore the third research question is:

> ***Research Question 3: "How do students' attitudes and behaviour change during and after attending a programme with a focus on service user involvement?"***

The hypothesis that relates to this research question will be tested using data from the qualitative elements of the study, i.e. the observations of students, individual interviews with the students and group interviews with the students.

Hypotheses 9: Attendance at a programme with a focus on service user involvement will lead to a positive change in attitude of students towards service user involvement with mental health services.

5.4. Methods

The study used quantitative and qualitative methods to answer the three research questions. These methods are described below, along with details of how they were administered and operationalised. First, I outline the sample of the study.

5.4.1. Sample

The study sample included all students who started the programme in cohorts 2, 3 and 4 (that is they were the second, third and fourth intake of students to start the programme).

Profession

As the programme is interprofessional, a number of professional groups were brought together in the same learning environment. The programme was aimed at those who work in community mental health services. The professionals who usually make up these services include social workers, community psychiatric nurses, occupational therapists, psychologists and psychiatrists. The majority of students who started the programme were from a nursing background (over 60 %,) (Table 5-1). Social work and occupational therapy were the next largest providers of students with 15% and 11% respectively.

Table 5-1: Number and percentage of students who started the Programme in each cohort by professional group.

	Cohort 2	Cohort 3	Cohort 4	Total	Percentage (%)
Nursing	28	27	32	87	61
OT	9	6	1	16	11
Psychiatry	-	1	-	1	0.7
Psychology	1	1	-	2	1.4
Social work	9	6	6	21	15
Other	4	4	8	16	11
Total	51	45	47	143	100

The general term 'nurses' will be used when relating to those from a nursing background in this study, as whilst many nurses were qualified as community psychiatric nurses others were qualified as Registered Mental Nurses (RMN). It is hypothesised that the attitudes that will influence professional identity will be formed during basic professional training and hence it is *any* nursing qualification that results in this categorisation. The group referred to as 'Others' includes students who may not have been professionally affiliated, such as support workers, as well as those who work in the voluntary sector.

Also included in the 'Others' category are service users. Five service users started the programme in the cohorts included in the study; the first student joined the programme with Cohort 3 and another four joined with Cohort 4. These students are classified as 'other' since they also had other roles. For example, two service users joined the programme in their role as advocates. Students self-defined their roles but where their status as a service user is relevant this will be made clear throughout the thesis. All the professionals' roles reflect the self-definition of students on the programme.

A number of students had 'blurred roles'; not just students who were also service users. For example, some students were professionally qualified as social workers but did not work in a statutory service. Instead they worked in

the voluntary sector in a role that did not demand they were social work qualified. For the purpose of this study students were asked to choose the professional category that they felt was most important to them.

Organisation

The students came to the programme from across 16 trusts in the West Midlands region. Most trusts sent eight or more students over the three years, however some sent as few as one or as many as eighteen. Students represented a wide variety of teams and whilst the course was designed for those who work with people with severe and enduring mental health problems in the community, students also came from hospital-based services.

Age

The majority of students, across all cohorts were aged between 31 to 40 years (Table 5-2). Very few students, (only five individuals, less than 4%) were aged over 50 years of age. The mean age of students on the programme was 36 years. Cohort 4 was a slightly younger group than the previous two intakes. There were no students aged over fifty years in cohort 4. The mean age for cohort 4 was 34 years as opposed to 38 years and 37 years for cohorts 2 and 3 respectively.

Table 5-2: Age group of students starting the programme

	Cohort 2	Cohort 3	Cohort 4	Total
20-30 years	6	7	11	24
31-40 years	28	19	24	71
41-50 years	11	8	10	29
51 and above	4	1	0	5
Missing	2	10	2	14
Total	**51**	**45**	**47**	**143**

Ethnicity of students

Most of the students on the programme defined their ethnic background as 'White British'. However, there was a not inconsiderable representation from minority ethnic groups, especially in cohort 2. A total of 16 students from cohorts 3 and 4 did not complete the ethnicity section of the questionnaires, or did not complete the questionnaires at all. The questionnaires on which students self-defined their ethnicity were our only record of such data and as such there is no data on the ethnic origin of those 16 individuals.

Table 5-3: Ethnic background of students starting the programme

	Cohort 2	Cohort 3	Cohort 4	Total
African	1			1
Afro-Caribbean	3	1	3	7
Black British			1	1
East African Asian			1	1
Eastern European	2			2
Indian	1	1		2
Other Black		1	1	2
Other White	5		2	7
Mixed	2			2
White British	37	34	31	102
Missing		8	8	16
Total	**51**	**45**	**47**	**143**

Gender

Most of the students who started the programme were women (Table 5-4). This was the same for all three cohorts with women making up approximately two thirds of the year group.

Table 5-4: Students starting the programme by gender

	Cohort 2 (%)	Cohort 3 (%)	Cohort 4 * (%)	Total (%)
Female	36 (71)	28 (62)	31 (67)	95 (67)
Male	15 (29)	17 (38)	15 (33)	47 (33)

*Data for 1 individual is missing

5.4.2. Quantitative questionnaires

Sample

The quantitative questionnaires were given to the three cohorts of students, at two time points, between August 1998 and June 2001. The aim was for the sample to include all students at the start of the programme and at the end of the first year, thus it was to be a total sample. Unfortunately, this was not to be. The sample was affected by the absence of a number of students on the days when the questionnaires were distributed at the university. Follow-up questionnaires were sent to students who did not attend the sessions but the return rate was poor.

Instrumentation

The quantitative questionnaires were made up of a number of self-completed Likert-type scales designed to measure changes in interprofessional attitudes and the use of psychosocial interventions. The scales were organised into a booklet and bound into a plastic cover. In addition to the scales outlined below, the questionnaires also asked for demographic information. The questionnaire asked for date or birth, gender, ethnic origin, professional role, length of time working in present position and length of time working in present team. Reliability of the scales was calculated using Cronbach's alpha, a generally accepted measure of internal consistency of Likert-type scales. Kline (1993) notes that alpha should never be below 0.7.

Professional and Team Identification

In order to establish the extent to which the students identified with their profession and team they were asked to complete two ten-item 'identity scales' (Professional Identification Scale - Appendix B, Team Identification Scale – Appendix C). These were based on a scale developed by Brown *et al.* (1986) and have been used to study a variety of groups engaged in intergroup encounters (Carpenter, 1995b; Onyett *et al.*, 1997). Participants were asked to indicate their position on a five-point scale (1=never, 2=seldom, 3=sometimes, 4=often, 5=very often) on five positive and five negative statements on the professional and the team identity scales. Negative items were then reversed scored so that a higher score indicates a more positive sense of identity.

Role Clarity and Role Conflict Scales

Role clarity and role conflict were measured using the scales devised by Rizzo *et al* (1970). These scales (Appendix D) are well established and have been used by Onyett *et al.* (1997) and Carpenter *et al.* (2000) in studies of mental health workers. Both scales are reported as having excellent psychometric properties by their authors. Role clarity is a six-item measure concerned with the extent to which staff are aware of what is required of them by the organisations, including goals, and tasks and whether they feel they have the authority to carry out their responsibilities. Role conflict is an eight-item measure of competing demands on the individual worker, inadequate resources, incompatible requests, and disagreement at the level of management.

Conditions of the Contact Hypothesis

In order to assess the extent to which the conditions required by the Contact Hypothesis were present in the educational environment, students were asked to rate how each of the five professional groups were considered in relation to 'status in society' (Appendix E). A

seven-point scale was used, as previously used by Carpenter and Hewstone (1996), where 1 indicated very low status and 7 indicated very high status. Each of these ratings was made at two time points, at the start and end of the programme. At Time 2 an additional question was added and students were asked to rate the status of the five professional groups on the course.

Students were also asked to rate four contact hypothesis factors at Time 1. These related to the extent they felt there had been institutional support, support from members of their own profession and support from members of their community mental health team for their participation on the programme. They were also asked about their own expectations about working on the course alongside members of other professions. At Time 2 additional variables were added. They were asked to rate the extent that similarities and differences between professional groups had been emphasised on the programme, whether they had worked together as equals and if joint work had been successful.

Interprofessional Attributes

In order to assess changes in the way respondents viewed their own and other professions the Interprofessional Attributes scale (Appendix F) was adapted from a scale used in previous studies of interprofessional attitudes of healthcare professionals. Carpenter (1995a, 1995b) used the scale with medical and nursing students and a similar scale was used by Carpenter and Hewstone (1996) with social work and medical students. The scale was developed from a list of stereotypical traits generated by medical and nursing students. They identified positive and negative traits of their own and other professions. Students (not the students who had generated the list) were then asked to indicate the extent to which those traits were applicable to:

- their own professional group (autostereotypes)
- the other professional groups (heterostereotypes)

- their own group as seen by the other groups (perceived autostereotypes)

The characteristics of mental health professionals rated in this study were:

- Academic rigour
- Interpersonal skills
- Leadership
- Practical skills
- Breadth of life experience
- Professional competence

Students were then asked to rate on a seven-point scale (where 1=very low and 7=very high) how each characteristic related to:

- Social workers
- CPNs
- OTs
- Psychiatrists
- Psychologists
- Their own profession as seen by others professionals

It was possible to identify the students' own professional group from the demographic information in the questionnaire. From this it was possible to establish how the students thought their own professional group rated on each attribute (autostereotype). Students were also asked to rate how they thought other professionals saw their own profession (perceived heterostereotypes).

Barriers to implementation

In order to measure changes in the way students perceived obstacles to the use of psychosocial interventions in their practice I used the Barriers to Implementation scale (Appendix H) derived from Corrigan, Kwartarini and Pramana (1992) and adapted by Carpenter. The original scale by Corrigan *et al.* (1992) provides reliable and valid scores that represent staff perceptions about several organisational barriers to the implementation of behaviour therapy in a residential treatment unit in the USA. Carpenter adapted the scale to assess the implementation of psychosocial interventions in the UK. The 32-item scale measures five areas that may prove problematic for implementation. These are time and resources; support and interest; beliefs about psychosocial interventions; knowledge, skills and supervision; and user and carer beliefs. The adapted scale demonstrated excellent internal consistencies (Carpenter *et al.*, 1999). The scale is a six-point scale (0=not a barrier at all, 1=slight barrier, 2=small barrier, 3=modest barrier, 4=large barrier and 5=insurmountable barrier).

The Implementation Scale

The Implementation scale (Appendix G) is concerned with the use of psychosocial interventions. It is a five-point scale on which students are asked to rate how often in the previous 3 months they had used the following interventions (1 indicates that the student has never used the intervention in the previous three months and 5 indicates that they have used it extensively in the previous three months):

- Assessment and care programming
- Care co-ordination
- Advice giving (to users)
- Optimising medication
- Psychotherapy and counselling
- Cognitive behavioural therapy

- Family/ carer intervention
- Group therapy
- Providing occupation, education or training
- Meeting social, recreational or spiritual needs

Procedure

The role that the questionnaires played in the evaluation of the programme was explained to the students on their introductory visit to the course. They were then invited to complete the scales for the first time. This was before the students had received any teaching on the programme. The questionnaires were distributed whilst the students were in a classroom type situation. As explained verbally, and on the cover of the questionnaire itself, completion of the questionnaires was voluntary. Students completed the questionnaires of their own free will and they were told that their decision whether or not to complete the questionnaires would not affect their progress on the course. Where students had queries about completing the questionnaires these were dealt with by members of the evaluation team. They were given the questionnaire again at the end of their first year of teaching on the programme. No student refused to complete the questionnaires.

5.4.3. Semi-structured interviews

Semi-structured interviews were used to explore in greater depth the participants' attitudes to working with other professionals, learning new skills and reactions to the programme's user focus. These interviews were conducted at the students' workplace, and were part of the wider evaluation of the Birmingham University programme. This wider evaluation involved visiting one mental health team in each trust that had sent students to the programme. The aim of those visits was to find out the effect on the team of sending individuals to the programme and involved interviews with the team manager and a group discussion with team members. During those visits I interviewed all students who had attended or were attending the programme and who were willing and able to talk to me. The decision was made to visit

teams belonging to health trusts because it was the trusts that funded the programme. Therefore, most students came from trusts.

Sampling

The initial sampling procedure of choosing to visit one team in each trust that had sent students on the programme is what is known as "stratified" sampling. Robson (1993) states that this involves dividing the population into a number of groups, where members of a group share a particular characteristic. In this case the shared characteristic was that their place on the programme had been sponsored by a particular trust. In most cases, they were employed by the trust, but the trust also sponsored staff employed by social services and the voluntary sector who collaborated in the provision of mental health services in their areas. It was decided to sample in this way because it was hypothesised that levels of support and the working environment in the students' workplace would influence their attitudes and ability to implement skills and affect change. Trust policies vary and it was felt that this would be reflected in the students' attitudes towards the programme and their ability to implement their learning. It was decided to visit teams from the trusts, together with their colleagues from social services and the voluntary sector where they were working together. However due to financial limitations it was not possible to visit social services or voluntary sector projects in which a solo student was based.

Once the strata have been decided it is usual to then randomly sample within the strata (Robson, 1993, p. 138). In this case it was not possible to sample randomly within trust groups. The next stage in the sampling process is probably best described as purposive sampling. The programme administrative staff provided the external evaluation team with a list of trust contacts for the programme and permission to visit the area was sought from these contacts. The first step in obtaining permission was via a written letter to the named trust contact for the programme, explaining the evaluation and what would be required of the team. The letter asked for advice on the suitability of visiting teams in the area. The response to this letter varied. Some trust contacts were keen to organise a visit for the evaluation team and

suggested teams that had sent students to the programme. In this situation we accepted the advice of the trust contact. This may easily have led to a biased sample since many trust contact may have been keen to take us to their "best teams".

Interview Schedule

The interview schedule (Appendix A) was drawn up from my reading around the subject matter and my own observations of the programme. I was interested in understanding the students' motivation for going on the programme, their experience of learning alongside other professionals, their experience of learning about and trying to implement psychosocial interventions and their experience of user involvement. In some cases students had learnt alongside service users, not just other professionals, this was a new experience for most of the students and their reaction to this was explored.

The interview schedule included six main sections. The first was concerned with factual information such as their professional background, and length of time they had been qualified. It also related to information about their working environment and whether they worked in a multidisciplinary team. The second section of the schedule was concerned with professional roles and identity. This section was intended to expand my understanding of the experience of being on an interprofessional programme and how this may influence issues of identity. The prompts used were based upon the contact hypothesis and were there to encourage students to think about the conditions under which attitude change may or may not have occurred. The next section related to the teaching environment of the programme. This was intended to validate findings from my earlier observations as well as to explore group dynamics.

A section on 'Teams and Trusts' was concerned with organisational support that the students may or may not have received from their team members, line managers and at an organisational level, from the trust as their employer. 'Supervision' and 'Practice' were the two final sections. Supervision was

considered to be important in terms of helping students implement their learning. Issues of professional relationships were also explored in terms of receiving supervision from someone from another professional background, if this was appropriate. Practice was concerned primarily with the students' perceptions of outcomes of the programme. I was interested if they felt that the programme had changed the way they worked with other professionals and service users as well as if they were able to implement their learning. I was particularly interested in the ability of students to implement the psychosocial skills they had been taught since this was one of the aims of the programme. The schedule ended with general questions to ascertain positives and negatives of the programme by asking students what they had enjoyed most and least. Finally, students were encouraged to discuss any other aspect of the programme they considered relevant.

The questions were structured in an order that asked factual biographical questions first, these were followed by open-ended questions. The aim of the interview was to elicit information about the students' personal experience of the programme and as such I attempted to keep the atmosphere informal. The flexibility of using a semi-structured method allowed conversation to flow without too much intervention from myself. It allowed those who participated to discuss what was relevant to them although I was able to influence the discussion by following up interesting (to me) responses and exploring underlying motives. Padgett (1998) advises that an interview guide should contain an initial set of questions that focus on areas of interest but should not become a straitjacket.

Procedure

Before the interview began I explained to the student that the information was to be used as partial fulfilment for my Ph.D. and that the interview concerned their experience of the course, especially their experience of working alongside other professionals. I reinforced to the student that they did not have to take part in the interview and this would not have any effect on their progression or outcome of the programme. I went on to assure the participant that they could choose not to answer any question they did not wish to. I also

explained to the students that I was part of an external evaluation team and that no data that could identify them as individuals would be seen by anyone other than me. All students who I explained this to agreed to take part in the interview.

I decided that audio taping the interviews would be the best method of recording the data. This way I would be able to pay full attention to the participants as they talked. I always asked the participants if they had any objections to my tape-recording the sessions. No student stated any objections. Unfortunately this did not mean that I was always able to tape record the interviews. As already mentioned the rooms where interviews took place were out of my control and, as perhaps reflects one of the difficulties of mental health services - buildings are often not designed for the purposes they are used. Thus I was not always able to place the recorder close enough to the interviewee or myself; alternatively the acoustics of the room were sometimes poor. I soon learnt to take notes in all interviews, in case of failure of the tape recorder, I then wrote up my notes more fully as soon as possible after the interview. Needless to say my transcripts of interviews that were successfully tape-recorded are more detailed than those where I had to rely on memory to flesh out.

Interviews generally lasted between 45 minutes to just over one hour. The discussion was generally quite informal as most of the students recognised me from my visits to the programme and many had spoken to me on the telephone whilst arranging the visit to their team.

5.4.4. Participant Observation

Participant observation was used to enhance my understanding of the teaching environment, teaching content, and student interactions. In short, it was to aid my understanding of the experience of being a student on the programme. This helped me formulate interview questions for the individual and group interviews as well as being a very useful data collection method in itself.

Setting

I observed teaching sessions with cohort 2 and cohort 4 whilst both were in their first year of the programme. I observed nine full-day teaching sessions with cohort 2 from January to June 1999 and four full-day teaching sessions with cohort 4 from March to April 2001. The sessions with cohort 2 were spread across four different modules: Contemporary Approaches to Psychiatric Treatment (CAPT), User Participation and Self-help, Psychological Interventions (PI) and Working in Community Teams. The first year of teaching also included a Foundation module focusing, which lasted for twelve weeks, with six weeks each spent on both values and skills. Unfortunately, I was unable to attend those early sessions. The four modules that I was able to attend were each made up of four full-day teaching sessions. The sessions that I did observe with cohort 2 covered 50% of the teaching sessions held in the period between January and June 1999.

Following my observations with Cohort 2, the teaching staff made changes to the programme, particularly the Working in Community Teams module. Their aim was to make the module much more dynamic, increasing interactions between the students and fulfil the conditions necessary for change as outlined by the contact hypothesis. I therefore thought it was important to observe this module and see if the programme had changed in any significant way, if so how and what effect this had on students.

Procedure

During the teaching sessions I took the role of a 'participant as observer' (Robson, 1993). I sat in on teaching, took part in group exercises and spent coffee and lunch breaks with the students. This meant my role was overt not covert. I explained to the students that I was an observer during discussions with them and I had been introduced to them at the beginning of the course as a member of the external evaluation team. Robson (1993, p.197) points out that this approach can be beneficial in evaluations of innovatory programmes because it can lead members to become more analytically reflective about processes and functions of the group. I tried to build relationships with

members of the group by sitting with students during teaching and coffee and lunch breaks. They would often ask how my research was going and then tell me how they were finding the course.

Recording of information was made in the form of brief notes recorded 'on the spot' during the teaching sessions. These brief notes included verbatim comments that people made, notes about where people were sitting and their body language during teaching sessions. Shortly afterwards I would write the notes up in more detail, including events I had forgotten, impressions and feelings I may have had on a situation and interpretations of observations I may have made. I also recorded information from my informal contact with the students during the coffee and lunch breaks. Observational data were analysed using the grounded theory approach (Glaser and Strauss, 1967). Silverman (1993, p.46) gives a simplified model of grounded theory. This begins with an initial attempt to develop categories, which illuminate the data. An attempt is then made to 'saturate' these categories with many appropriate cases in order to demonstrate their relevance. Finally, these categories are developed into frameworks that are more analytic with relevance outside the setting.

Using the grounded theory approach, I started the observations with a research question in mind. Strauss and Corbin (1990) argued that 'We need a research question or questions that will give us the flexibility and freedom to explore the phenomenon in depth' (p.36). My research question was 'How do mental health professionals learn to work collaboratively, and acquire psychosocial intervention skills in an interprofessional educational environment?'

Grounded theory has been criticised for its failure to acknowledge implicit theories that guide work at an early stage (Silverman, 1993, p.47). Yet, Strauss & Corbin (1990) stressed the importance of previous reading and experience of the researcher to the area being investigated. Theoretical sensitivity refers to the attribute of having insight, the ability to give meaning to the data, the capacity to understand, and the capability to separate the

pertinent from that which isn't (Strauss and Corbin, 1990, p.42). Strauss and Corbin argued that theoretical sensitivity comes from the literature, professional experience, and personal experience. In accordance with grounded theory, my experience as a student of professional education and background reading provided me with some understanding of concepts and relationships of interprofessional education (such as personal identity and stereotypes) that appeared to be significant. I was then able to look out for these in the situation I was studying. However, I was also aware of the importance of not allowing pre-defined variables to get in the way of the discovery of new ones. It is this point that grounded theory stresses.

Themes did begin to emerge during my observations and I was able to go back and check these emerging concepts with previous observations to see if they fitted, as well as comparing them with new observations. This is an important process of grounded theory, which is also called the "constant comparative method of analysis" (Glaser and Strauss, 1967, p.101-116). Finally, once these concepts seemed to fit the evidence from the observations I placed them into an analytic framework.

5.4.5. Group Interviews

Group interviews were used to try to capture the main points of the programme from the students at the end of their first year. The intention was that they would give all those who had experienced the first year of teaching the opportunity to discuss what they felt were the important areas of learning of being on an interprofessional programme. As well as to discuss how they were able to implement their learning about user involvement, interprofessional working and psychosocial interventions into the workplace.

Sampling

Group interviews were held with all the students at the end of their first year on the programme. The student group was split into three smaller groups, on the basis of trust of origin. Each group was made up of between 8 and 12 students; this is similar to the optimal size of focus groups outlined by Krueger

(1994). Krueger suggests that 7-10 is the optimal number of participants for focus groups because it is small enough to allow everyone to share in the discussion but large enough to generate diversity of opinion. These sessions were held during 'evaluation days' when the programme staff structured the day around a review of the events of the previous academic year. I and the two other members of the external evaluation team facilitated these groups. Selection for the groups was made on the basis of trust membership to enable discussions about implementation on a local level.

Topics

The groups focused on the following five questions:

- What effect has the interprofessional make-up of the student group had on your learning?
- Has the interprofessional nature of the course had an impact on the way you work?
- What skills have you learnt on the course?
- Have you been able to implement the skills at work?
- Has the emphasis the course places on working from the perspective of service users changed your attitudes or practice?

The aim of using open-ended questions was to focus the students on the areas which were of concern to the evaluation but remain flexible enough to allow for a variety of opinions. I was aware of the need to facilitate the groups in such a way that one person did not dominate the discussion and everyone had the opportunity to participate. The facilitation of the groups was very much helped by the fact that small group discussions were a familiar format for the students, and as such they knew what was expected of them. In this way one of the limitations of focus groups, which is that they are dependent upon the cooperation of participants, was avoided. The students were all cooperative. However, the groups may have suffered from participants being familiar with each other. Padgett (1998) warns that familiarity among group members can lead to more habitual ways of interacting and inhibit "fresh" opinions from emerging.

Procedure

Information from the groups was made at the time in the form of brief notes. These notes were expanded upon as soon as possible after the initial groups were held. This usually occurred on the long train journey from Birmingham to Durham. This method of recording meant the facilitator could try to direct the group and take notes at the same time. Unfortunately, it also meant that I am unable to attribute the source of much of the data to the professional concerned since when facilitating the groups the evaluation team were not always aware of each participants professional identity.

5.4.6. Timetable of Data Collection

Data were collected over a period of almost three years (Table 5-5). The quantitative questionnaires were distributed to the students at the same time in the academic year for all three cohorts. The group interviews also took place at the same time each year. The semi-structured interviews took place over a period of one year. Thus, where data from the semi-structured individual interviews are reported some cohorts may be in different years. For example, when the interviews first began cohort 3 were in their first year of the programme, however towards the end cohort 3 students moved into the second year. I conducted my participant observation sessions with two cohorts, spanning a period of two and a half years.

Table 5-5: Timetable of data collection methods used to evaluate the programme

	Questionnaires	Group interviews	Participant Observation	Semi-structured interviews
Sept 1998	Co2 T1			
Oct				
Nov				
Dec				
Jan 1999			Co2	
Feb				
Mar				
Apr				
May	Co2 T2			
June				
July		Co2		
Aug				
Sept	Co3 T1			
Oct				
Nov				
Dec				
Jan 2000				
Feb				
Mar			Co1, 2, 3, & 4	
Apr				
May	Co3 T2			
June				
July		Co3		
Aug				
Sept	Co4 T1			
Oct				
Nov				
Dec				
Jan 2001				
Feb				
Mar				
Apr				
May	Co4 T2			
June			Co4	
July		Co4		

5.5. Methodology

Both qualitative and quantitative methods were used to answer the research questions. The use of multiple methods, or triangulation of methods, can offer a number of advantages. One of which is that it allows different but

complementary questions within a study to be answered (Robson, 1993). The aim of using both qualitative and quantitative methods was to maximise the opportunity for data collection and give voice to the many participants of the training programme. The use of structured questionnaires enabled all students commencing the programme to participate. The completion of the questionnaire at two time points, once at the start of the programme and at the end of the first year of teaching enabled change to be measured from the first year of the programme. The use of a "participant as observer" method enabled me to increase my own understanding of the programme and witness the teaching process. This provided me with an excellent opportunity to meet the students informally and understand issues that were important to them, as well as to observe group interactions. The use of semi-structured questionnaires enabled me to have in-depth discussions with a limited number of students. These interviews were based in the students' workplaces providing me with an opportunity to increase my understanding about the students' individual circumstances and their individual problems. The use of group interviews at the end of academic teaching years provided the opportunity to discuss with students, in small groups, what issues had been important to them. They were especially useful for finding out the students' views on how successful the programme had been in fulfilling its aims.

However, whilst the triangulation of methods is widely practised as a means of enhancing rigor in studies (Padgett, 1998, p. 96) it is criticised by some (e.g. Silverman, 2000; Denzin and Lincoln, 1994). They argue that just because data comes from different sources and points to the same conclusion it is not necessarily 'true'. Hammersley and Atkinson (1995) agree, they argue that different methods can easily all point to the same incorrect conclusion. Multiple methods have been employed in this study not in the belief that they will reveal the 'whole picture'. Rather, the use of different methods has been employed to reveal different perspectives and counteract various disadvantages of the methods used in isolation.

5.6. Data analysis

This section describes how quantitative data from the scales and the qualitative data from the group interview and semi-structured individual were analysed.

5.6.1. Quantitative data

All quantitative data were analysed using the Statistical Package for the Social Sciences (SPSS) version 10. Data were only analysed for matched pairs (where respondents had completed questionnaires at Time 1 and Time 2) in order to increase the statistical power of the study. I conducted the analysis in a number of stages. Stage 1 involved investigating the data for differences between Time 1 and Time 2 for each cohort of students and the overall group of students. The data were not necessarily normally distributed, consequently I used both parametric and non-parametric statistical tests and applied the convention that the findings could be considered robust if both tests produced statistically significant results and pointed in the same direction. Statistical analysis of simple changes in the measures therefore involved four paired t-tests (parametric) and four Wilcoxon Signed-Rank tests (non-parametric) for each scale, one for each of the cohorts and one for the total student group. The second stage of data analysis involved testing for differences between professional groups. The students fell into four professional categories; nurses, social workers, occupational therapists and others. The 'others' group was made up of people who were not professionally qualified in any of the main disciplines in mental health. This second stage of analysis involved three separate steps. Differences between professions were explored at Time 1 and then at Time 2. Changes in scores were calculated by deducting Time 1 scores from Time 2 scores. Differences between professions at Time 1, Time 2 and in scores between T1 and Time 2 were tested using standard Analysis of Variance (ANOVA) and its non-parametric equivalent the Kruskal-Wallis test. Again, I chose to use parametric and non-parametric tests because of concerns about the normality of distribution of the data. When both tests give the same result then one can have confidence that there is a

genuinely statistically significant effect. The conventional 0.05 level of significance was adopted (Clark-Carter, 1997)

Differences between cohorts are not reported for the Interprofessional Attributes after initial inspection of the data indicated no substantial differences between students on different cohorts. Additionally sample sizes were low for the number of comparisons to be made so I decided to combine the data between different cohorts for the analyses.

5.6.2. Qualitative data

The first step in data analysis of the semi-structured interviews with students was to transcribe the tapes and field notes. I transcribed the audiotapes myself which I believe helped to develop a greater intimacy with the data. I noted pauses longer than a few seconds and laughter because these may have affected the meaning of what was said. Data from the group interviews were written up as fully as possible. Data analysis for the group and semi-structured interviews was the same. Once my field notes and interviews were transcribed I transferred the data into N-VIVO, a qualitative data analysis software package (Richards, 1999). I used N-VIVO to code the data thematically. I began to develop a list of themes from the data. Coding initially involved reading through the transcripts line by line to familiarise myself with the data. Since the interviews followed a similar structure there were obviously central themes common to all respondents. It was though, the differences to the general questions that went on to provide a number of codes. The use of pre-existing concepts has been criticised for obscuring more than it enlightens (Padgett, 1998). To some extent my coding was based on pre-existing concepts, as I could not detach myself from my knowledge of the course or the wider literature. Yet, I feel that the use of open coding alongside the use of themes I was already aware of did enlighten the data. Once I had read all the interviews through and coded them for the first time I began to read back through them. From this rereading new codes emerged. I repeated this process until the coding became repetitious; Glaser and Strauss (1967) refer to this stage as 'saturation'.

5.7. Ethical Considerations

Ethical issues during the research process have been tackled a number of ways. Firstly, an effort has been made to inform the participants about the research. Thus, students on the programme were informed of the programme's evaluation and the methods that were employed to achieve this. Participants were informed of their right to refuse to take part in the research, or withdraw at any time. In this respect, participants did not have to complete the quantitative questionnaires, or agree to be interviewed. Efforts were made to ensure participants' right to anonymity and confidentiality in a number of ways. For example, students were asked to give their dates of birth, this information was required to establish the age of participants as well as the matching of questionnaires at the two time points. This raised issues of confidentiality. Students were assured that all data would be treated confidentially and no information that could lead to the identification of any individual would be revealed. In order to inform the development of the programme anonymized results of the questionnaires were taken back to the students and course organisers. However, these results were grouped together.

Secondly, interview notes were coded so respondents could not be identified. Where information has been fed back to the programme staff this information has been anonymised so no one individual can be identified. At times, this has meant some valuable information could not be used. For example, where an individual was a sole representative of a profession, as occurred with psychology and psychiatry. These individuals often had very interesting insights about their particular experience but to use the information would have been to reveal the identity of the individual. This also means that where I quote from respondents I only give full details, of their profession, cohort and year of the programme, where this means they are not easily identifiable. Permission to audiotape the individual interviews was always sought from the participants. Notes were taken during interviews where participants did not wish to be taped.

Obviously the decision to omit data from individuals who would be easily identifiable has meant a bias against psychologists and psychiatrists. This is limiting and whilst their views would undoubtedly have been valuable in terms of representing a wider view of the programme a compromise had to be reached. In the end I felt that the decision to omit the views of these individuals was the only way to protect the confidentiality that I had assured the participants. Additionally the decision to visit teams that belonged to health trusts has meant that those few social workers that were employed by social services departments have also been omitted. This decision was made based on the financial limitations of the project.

6. RESULTS

6.1. Introduction

This section outlines the results of the quantitative and qualitative methods used in the study to answer the research questions. These include the extent that the pre-conditions for attitude change outlined by the contact hypothesis were covered in the teaching environments, and changes in attitudes towards one's own profession, other professions and service users. It also examines changes in working practices associated with participants on the course. Firstly, the characteristics of those who took part in the study by returning questionnaires at both time points and taking part in the semi-structured interviews are described.

6.2. Participants

Of the 143 students originally recruited to the programme in the three cohorts, 110 (77%) successfully completed the first year of the programme and chose to either stop on for further study or to leave the programme with the certificate. Nurses made up 63% of those who completed this level; social workers made up 11%, OTs 12% and "Others" 15% (Table 6-1).

Table 6-1: Number of Students who passed the certificate level of the programme without deferring

	Cohort 2	Cohort 3	Cohort 4	Total
Nursing	22	19	28	69
SW	6	2	4	12
OT	6	6	1	13
"Others"	4	4	8	16
Total	38	31	41	110

No psychiatrist successfully completed the first year of the programme in cohorts 2, 3, or 4. The one psychiatrist who did join with Cohort 3 had to withdraw in the first year after moving to another part of the country. One

psychologist did complete the first year of the programme but her data is included in the group "Others" so as to protect confidentiality.

The lack of psychiatrists and psychologists from the programme was regretted by many of the students.

> *"There was no psychiatrist in my year, it would have been very helpful if there was. It must have been harder for the psychologist." (Nurse Co2 Yr2)*

> *"I think that it would have been good to have more of a mix professionally." (Social worker Co2 Yr2)*

The lack of psychiatrists and psychologists from training and other interprofessional activities was not considered to be uncommon:

> *"There are not enough psychologists and psychiatrists [on the course], it mirrors what happens in real life." (OT)*

Two nurses, from the same team, referred to one of the difficulties in psychiatrists taking part in training:

> *"The psychiatrist in this team was interested in going on the course but was unable to in the end. (Nurse, Co2 Yr2)*

Her colleague expanded:

> *"Our psychiatrist wanted to start with us but he took over as Medical Director." (Nurse, Co2 Yr2)*

Another student thought the absence of psychiatrists had another reason.

> *"The reason they don't attend is that they think they are superior." (Nurse Co2 Yr3)*

Students considered that the programme had elements that the professions of psychiatry and psychology would benefit from:

> *"I do think psychiatrists could learn from the value-base of the course. (Nurse Co2 Yr3)*

> *"It is important to get the medical profession there as they are the ones whose attitudes need to change." (Nurse Co2 Yr2)*

Another student referred to the professions of psychiatry and psychology as "higher" professions. This perhaps reflects their perceived higher status. She stated:

> *"I think the higher professions should be there. I see psychologists as more pressured." (Nurse Co3 Yr1)*

Thus, although one psychiatrist and two psychologists started the programme only one of these professionals, a psychologist, completed the first year of training. The drop out rates from the programme varied from 13% for cohort 4 to 31% for cohort 3 (Table 6-2). Questionnaires were sent to those who dropped out of the programme, unfortunately, response rates to this questionnaire were so low they are not examined here.

Table 6-2: Drop out rate of students (number and percentage of students who did not achieve the Certificate).

	Cohort 2	Cohort 3	Cohort 4	Total
Nursing	6	8	4	18
SW	3	4	2	9
OT	3	-	-	3
"Others"	1	2	-	3
Total	13 (25%)	14 (31%)	6 (13%)	33 (23%)

The response rate of the quantitative questionnaires from those who successfully completed the first year and returned questionnaires at both time points was 74% (Table 6-3). The highest response rate was achieved for cohort 2 (89%) and the lowest response rate was from cohort 3 (65%).

Table 6-3: Number (and %) of respondents who completed year 1 of the programme and returned questionnaire at Time 1 and Time 2

	Cohort 2	Cohort 3	Cohort 4	Total
Nursing	20 (91%)	12 (63%)	20 (71%)	52 (75%)
SW	4 (67%)	1 (50%)	2 (50%)	7 (58%)
OT	6 (100%)	5 (83%)	1 (100%)	12 (92%)
"Others"	4 (100%)	2 (50%)	4 (50%)	10 (63%)
Total	34 (89%)	20 (65%)	27 (66%)	81 (74%)

Most respondents were aged between 31-40, 59% overall (Table 6-4). Very few respondents were aged over 51, with no respondents from cohorts 3 or 4 aged over 51.

Table 6-4: Number and Percentage of Respondents in Age Group

Age	Cohort 2	Cohort 3	Cohort 4	Total
20-30	3	6	9	18
	(9%)	(30%)	(33%)	(22%)
31-40	24	11	13	48
	(71%)	(5%)	(48%)	(59%)
41-50	5	3	5	13
	(15%)	(15%)	(19%)	(16%)
51+	2	–	–	2
	(6%)			(3%)
Total	34	20	27	81
	(100%)	(100%)	(100%)	(100%)

Women made up over two thirds of respondents. Only 28% of respondents overall were men (Table 6-5).

Table 6-5: Gender of Respondents

	Cohort 2	Cohort 3	Cohort 4	Total
Male	10	5	8	23
	(29%)	(25%)	(30%)	(28%)
Female	24	15	19	58
	(71%)	(75%)	(70%)	(72%)
Total	34	20	27	81
	(100%)	(100%)	(100%)	(100%)

The students who took part in the semi-structured interviews represented all cohorts of the programme (Table 6-6). Whilst I am not considering other forms of data from Cohort 1 students, I did interview three of the students from the first cohort and have chosen to include this data. This is because their experience as "guinea pigs" may have shaped the experience of students in later cohorts.

Table 6-6: Number of students interviewed by cohort

Cohort	Number of students
Cohort 1	3
Cohort 2	9
Cohort 3	6
Cohort 4	4

The students who took part in the semi-structured interviews represented a number of professions (Table 6-7). Nurses made up the largest professional group but they were also the largest professional group on the programme. Only one psychologist was interviewed. The data from this respondent is not reported, as it would lead to the easy identification of the individual respondent.

Table 6-7: Number of students interviewed, by professional

Professional background of student	Number of students interviewed
Nursing	15
Occupational therapy	4
Social work	2
Psychology	1
Total	22

Overall, 92 students took part in the group interviews at the end of year one. The largest number (38) was from Cohort 2 and the smallest number was from Cohort 3 (24). Thirty students from Cohort 4 took part in the group interviews.

In total five teaching modules were observed in my role as participant observer. Four of these with Cohort 2 and one was with Cohort 4. The main aspects of each of the modules observed with Cohort 2, including the number of sessions I observed with each module, are summarised in Table 6-8. I found that the teaching modules varied in the type of professional knowledge, according Eraut's (1992) classification, they used (this is expanded upon in section 6.5.1). The profession of the presenters also varied.

Table 6-8: Details of Participant Observation Sessions

Module	Number of sessions observed (cohort)	Profession of Presenters of the module	Type of Knowledge used in the Teaching
Contemporary Approaches to Psychiatric Treatment (CAPT)	2 (Co 2)	Psychiatry	Propositional Process
Psychological Interventions in Psychosis	2 (Co 2)	Psychology	Propositional Process
Working in Community Teams	3 (Co 2) & 4 (Co 4)	Nursing and Social Work	Personal Propositional
User Participation and Self-help	2 (Co 2)	Service users and Social work	Personal Process

6.3. Learning to Work Together and Attitude Change

In order to answer the question: "How do students learn to work together and how do attitudes change on an interprofessional education programme?" I draw on data about the conditions of the contact hypothesis and their presence or absence in the educational environment. I will then go on to report the data on professional and team identity, and role clarity and role conflict. Finally, I will report on the data from the Interprofessional Attributes and interviews, which addressed the issue of attitude change towards one's own and other professions.

6.3.1. Conditions of the Contact Hypothesis

In order to explore the extent that conditions of the contact hypothesis were present on the programme, students were asked to rate the extent that there was:

- institutional support (i.e. from their employer),
- support from members of their own profession and
- members of their community mental health team

for their participation on the course. They were also asked to rate their expectations about working on a course alongside members of other professions.

6.3.2. Support

The students' ratings of support for their participation on the programme at Time 1 were generally high (Table 6-9). On a seven-point scale (1= no support at all, 4= some support and 7= a great deal of support) all scores were greater than 4 indicating students from all cohorts had received at least some support. This was from their employers, members of their profession and members of their community mental health teams for their participation on the programme. At the start of the programme, cohorts 3 and 4 and the participants overall considered their professions to offer a greater degree of support than their employers, or members of their community mental health team. All cohorts rated members of their community mental health teams as offering the lowest levels of support at the start of the programme.

At the end of the programme, participants in all cohorts, and overall, continued to rate their profession as providing the greatest level of support. Institutional support was rated lower that professional and team support by all cohorts and overall. Ratings of institutional support decreased significantly for cohort 2 and for participants overall.

Table 6-9: Ratings of Support and Expectations Mean scores and (SD) by cohort and overall.

	Institutional support Mean (SD)		Professional support Mean (SD)		CMHT support Mean (SD)	
	T1	T2	T1	T2	T1	T2
Cohort 2 (N=34)	5.29 (1.24)	4.53[1] (1.67)	5.24 (1.54)	5 (1.61)	4.73 (1.46)	4.88 (1.47)
Cohort 3 (N=20)	5.5 (1.5)	4.9 (1.07)	5.79 (1.08)	5.58 (1.07)	5.31 (1.66)	4.94 (1.95)
Cohort 4 (N=27)	5.36 (1.11)	4.68 (1.6)	5.59 (1.08)	5.22 (1.37)	5.08 (1.41)	4.72 (1.72)
All (N=81)	5.37 (1.26)	4.67[2] (1.51)	5.49 (1.3)	5.21 (1.42)	4.97 (1.49)	4.84 (1.65)

[1] Institutional support cohort 2 (Paired t-test, p=0.03, Wilcoxon, p=0.04)

[2] Institutional support overall (Paired t-test, p=0.001, Wilcoxon, p=0.001).

Differences between professions

At the start of the programme nurses, social workers and occupational therapists all rated members of their profession as providing more support than their employer or members of their teams (Table 6-10). The '"Others"', however, rated professional support as lowest. They rated institutional support as the greatest source of support for their participation on the course. The differences between the professions on their ratings of professional support were statistically significant. Professional variations on ratings of institutional support and support from members of their community mental health teams were not statistically significant.

Table 6-10: Ratings of Support and Expectations Mean scores and (SD) by profession at Time 1

	Institutional support Mean (SD)	Professional support Mean (SD)	CMHT support Mean (SD)
Nurse	5.31	5.4	4.94
(N=52)	(1.2)	(1.16)	(1.55)
Social Worker	4.83	5.71	5.14
(N=6)	(1.83)	(1.25)	(1.57)
OT	5.83	6.33	4.8
(N=12)	(1.03)	(0.98)	(1.03)
"Others"	5.44	4.67	5.13
(N=9)	(1.51)	(1.94)	(1.46)

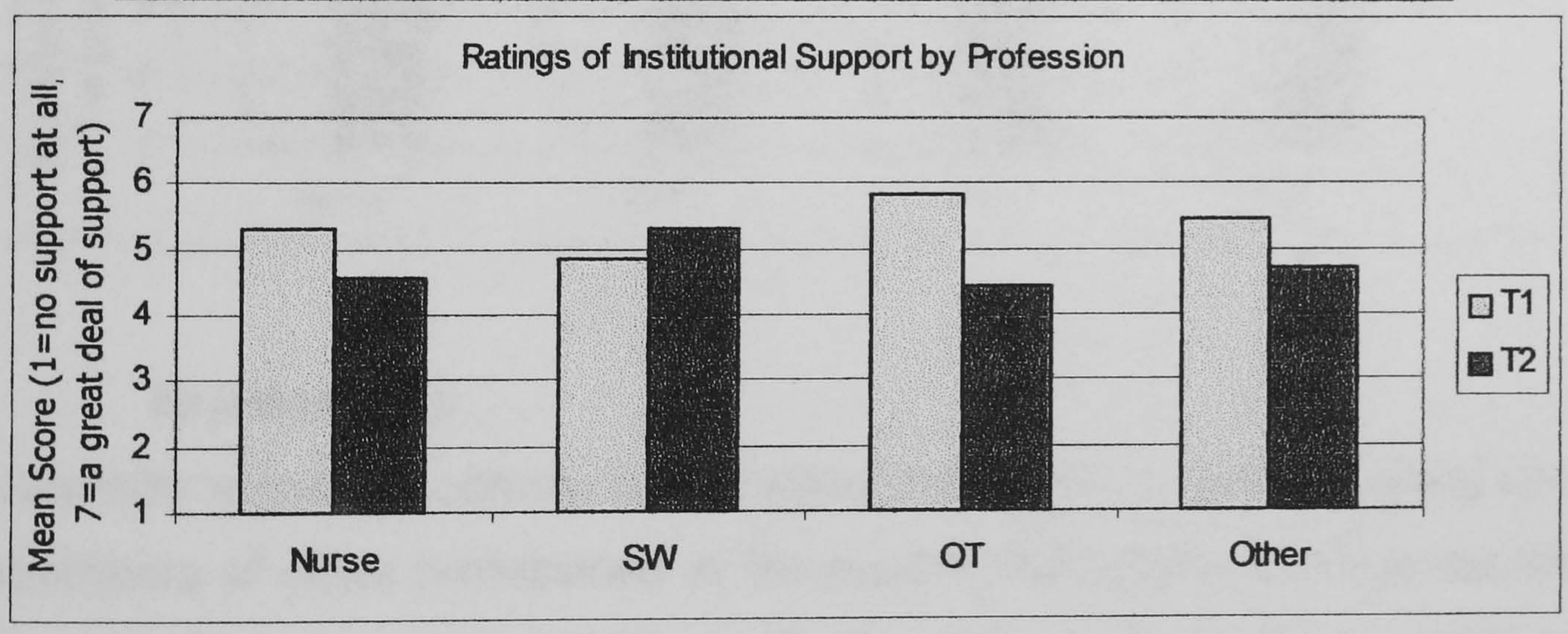
At the end of the programme, nurses, OTs and "Others" rated the members of their professional group as providing the most support for their participation on the programme (Table 6-11). Social workers rated institutional support as higher than either professional support or support from member of their community mental health teams. Nurses and OTs both rated institutional support as the lowest form of support while "Others" considered members of their community mental health teams as least supportive. None of the differences between the professions were statistically significant on any of the three scales.

Table 6-11: Ratings of Support Mean scores and (SD) by profession at Time 2

	Institutional support Mean (SD)	Professional support Mean (SD)	CMHT support Mean (SD)
Nurse (N=52)	4.56 (1.58)	5.12 (1.45)	4.88 (1.69)
Social Worker (N=7)	5.29 (1.11)	4.86 (1.21)	4.57 (0.98)
OT (N=12)	4.42 (1.56)	6 (0.95)	4.89 (1.05)
"Others" (N=9)	4.7 (1.7)	4.8 (1.75)	4.12 (2.64)

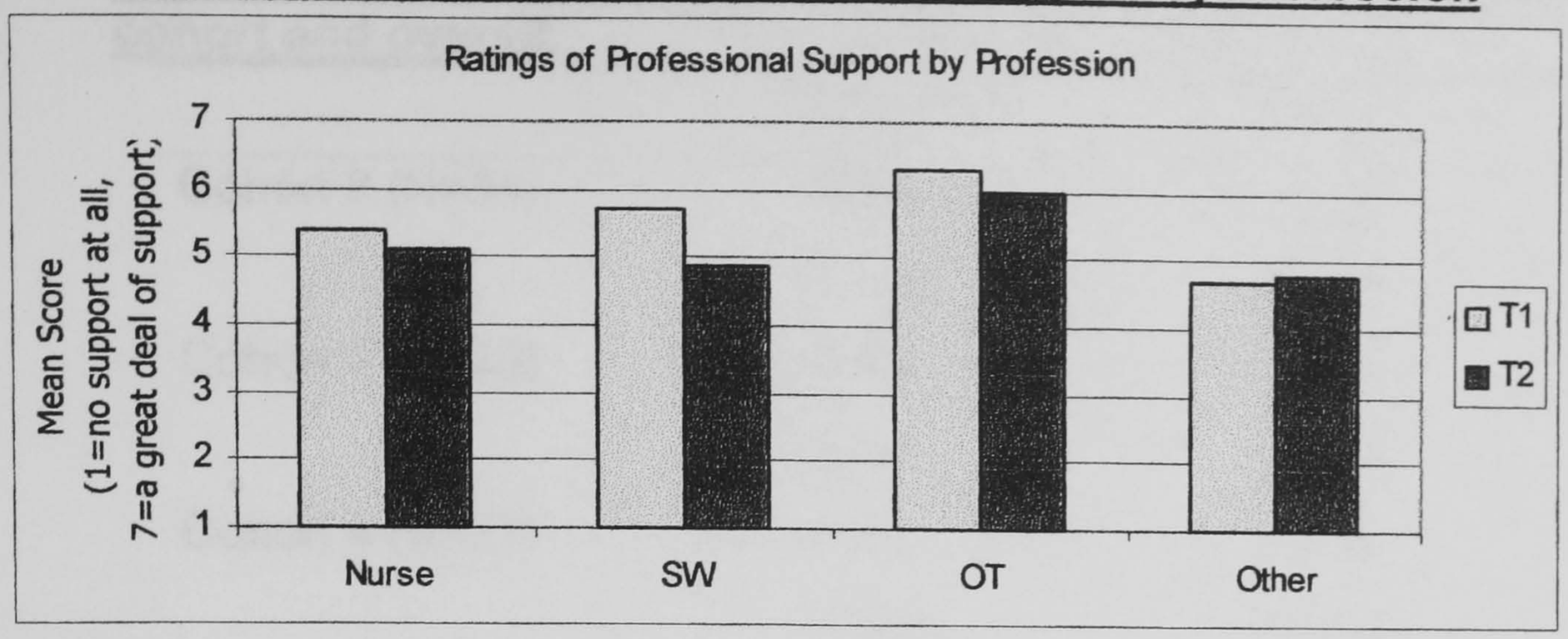
Ratings of institutional support decreased for all professions except social workers where it increased (Figure 6-1). These changes over time were not significant.

Figure 6-1: Ratings of Institutional Support by Profession



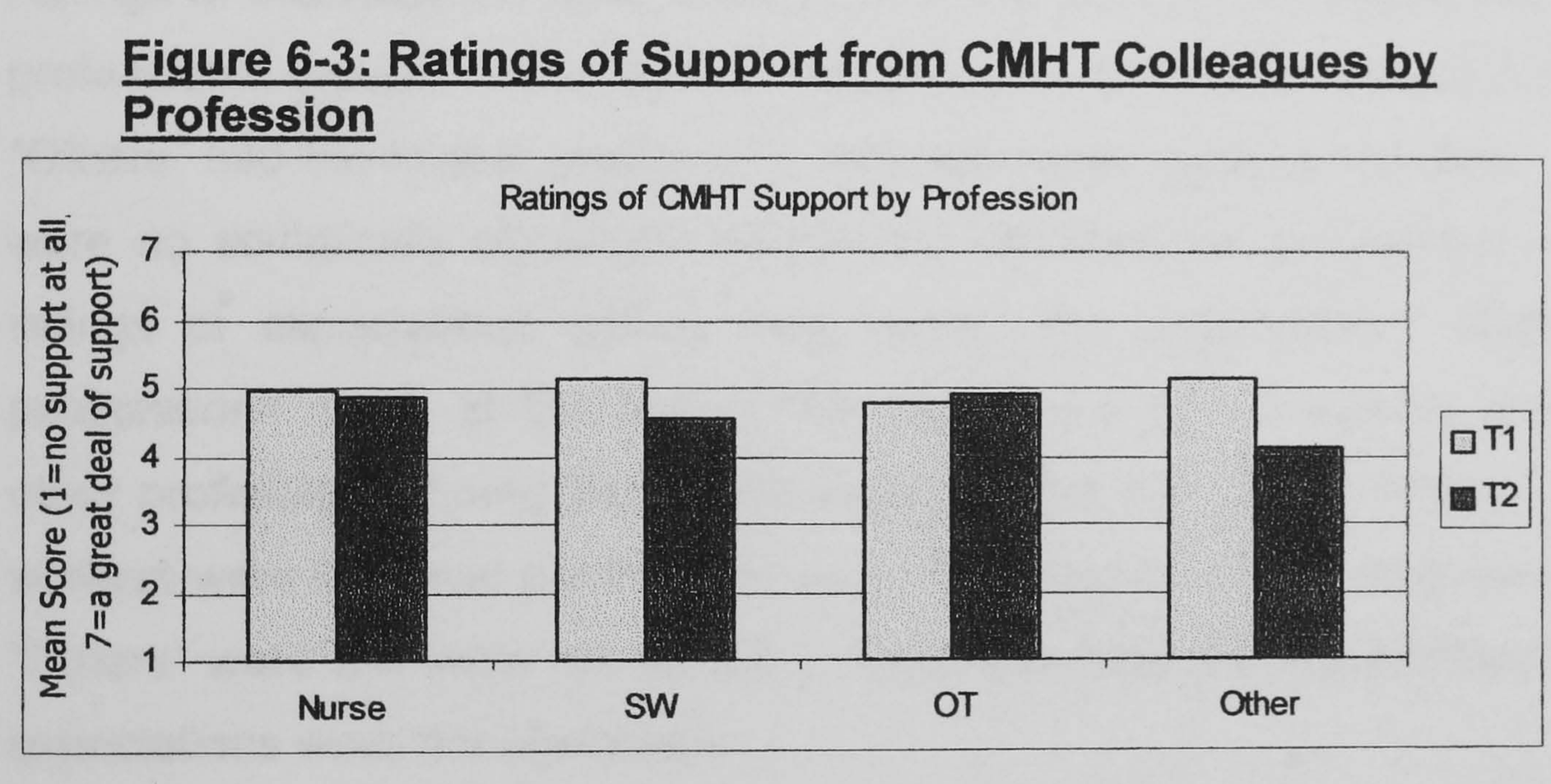
There were no statistically significant changes in the ratings of professional support by any of the professional groups from the start to the end of the programme (Figure 6-2).

Figure 6-2: Ratings of Professional Support by Profession



There were also no statistically significant changes in the students' ratings of support from members of their community mental health teams (Figure 6-3).

Figure 6-3: Ratings of Support from CMHT Colleagues by Profession



Expectations

Students across all cohorts had positive expectations about working alongside members of other professions at the start of the course and this continued at the end of the programme (Table 6-12). Mean scores for all students were 6.14 at Time 1 and 6 at Time 2 out of a possible 7 (1 indicated very negative expectations, 4 indicated neutral expectations and 7 indicated very positive expectations).

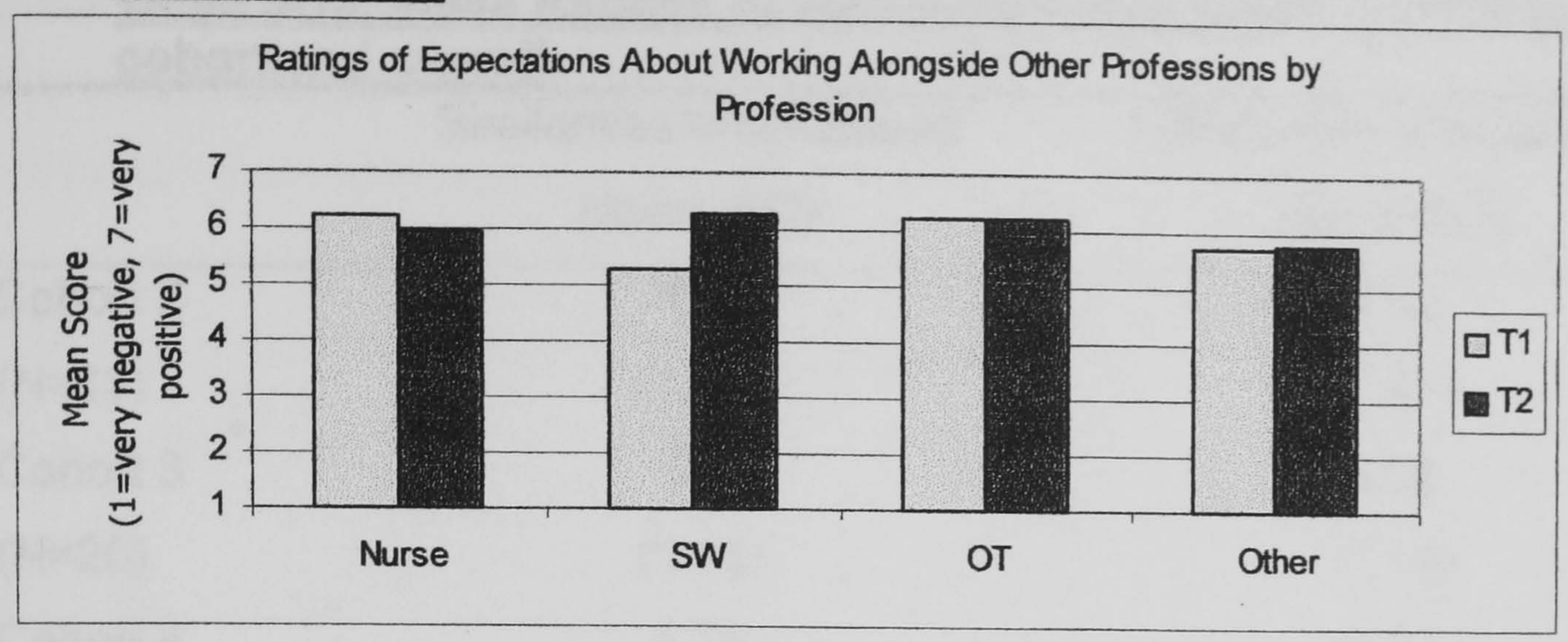
Table 6-12: Ratings of Expectations Mean scores and (SD) by cohort and overall.

	Time 1	Time 2
Cohort 2 (N=34)	6.26	6.24
	(1.08)	(0.92)
Cohort 3 (N=20)	5.95	5.95
	(1.05)	(1.15)
Cohort 4 (N=27)	6.11	5.74
	(1.05)	(1.32)
All (N=81)	6.14	6
	(1.06)	(1.13)

Ratings of expectations were all positive at the start of the programme for all professional groups. OTs had the most positive expectations (mean 6.25) and "Others" had the lowest (mean 5.7), although these were still positive. There were no statistically significant differences between the professions in their ratings of expectations before they started the programme. Ratings of expectations made at the end of the programme about working alongside other professions during the course were positive for all professions. Social workers were the most positive (mean 6.29) at the end of the programme and "Others" were the least (mean 5.8). Variations between the professions on expectations were not significant.

Social workers expressed more positive attitudes about working alongside other professionals on the course at the end of the programme than at the beginning (Figure 6-4). There was no change for OTs, and nurses' expectations showed a non-significant fall from 6.23 to 5.94 at the end of the programme.

Figure 6-4: Ratings of Expectations about working alongside other Professionals



Contact Hypothesis Conditions: Part 2

At the end of the first year of the programme students rated 8 questions related to the contact hypothesis. Students were asked to rate, in relation to the course, the extent to which:

Similarities between mental health professionals had been emphasised

Differences between mental health professionals had been emphasised

Participants worked together as equals

The atmosphere between members of different professions was co-operative

The atmosphere between members of different professions was competitive

Members of different professions tended to stick together

Members from the same mental health team tended to stick together

There was successful joint work between members of the different professions

Differences by cohort and overall

Students across all cohorts felt that similarities between professions were emphasised to some extent on the course. The mean score overall was 5.16, (on a seven point scale where 1 indicates not at all and 7 indicates a great deal). Students also thought differences had been emphasised, although to a slightly lesser degree than similarities (Table 6-13).

Table 6-13: Mean Ratings of the Contact Hypothesis Conditions by cohort and overall

	Similarities emphasised Mean (SD)	Differences emphasised Mean (SD)
Cohort 2 (N=33)	5.48 (1.25)	4.58 (1.41)
Cohort 3 (N=20)	5.2 (1.15)	4.58 (1.18)
Cohort 4 (N=27)	4.74 (1.29)	4.52 (1.37)
All (N=80)	5.16 (1.27)	4.63 (1.33)

There was quite high agreement that students worked together as equals on the programme. The mean score for all participants was 5.56 out of a possible 7. Respondents showed agreement with the statement that 'there has been successful joint work between members of the different professions. Mean scores for the three cohorts ranged from 5.19 to 5.52 (on a seven-point scale, where 1=strongly disagree, 4=not sure and 7=strongly agree).

Table 6-14: Mean Ratings of Equality of Working Together and the Success of Joint Work by Cohort

	Work together as equals Mean (SD)	Successful joint work Mean (SD)
Cohort 2 (N=33)	5.67 (0.96)	5.52 (0.91)
Cohort 3 (N=20)	5.35 (1.79)	5.2 (0.95)
Cohort 4 (N=27)	5.58 (1.36)	5.19 (1.36)
All (N=80)	5.56 (1.33)	5.33 (1.09)

Respondents viewed the atmosphere between members of different professions on the programme as much more co-operative than competitive. Students from all cohorts agreed with the statement that the atmosphere between the members of different professions had been co-operative; the mean score was 5.85. Students, in general, were not so sure that the atmosphere had been competitive between members of different professions (mean score 3.2).

Results indicate that respondents perceived that students tended to 'stick together' with their team colleagues as opposed to their fellow professionals. This pattern was consistent across all cohorts. Agreement that members of different professions had tended to stick together was 3.91 (on a seven-point scale with 7 indicating strongly agree) for all cohorts. This was opposed to 4.7 for agreement that members from the same mental health team had tended to stick together.

Table 6-15: Mean Ratings of the Atmosphere on the Programme and Group Interactions by Cohort

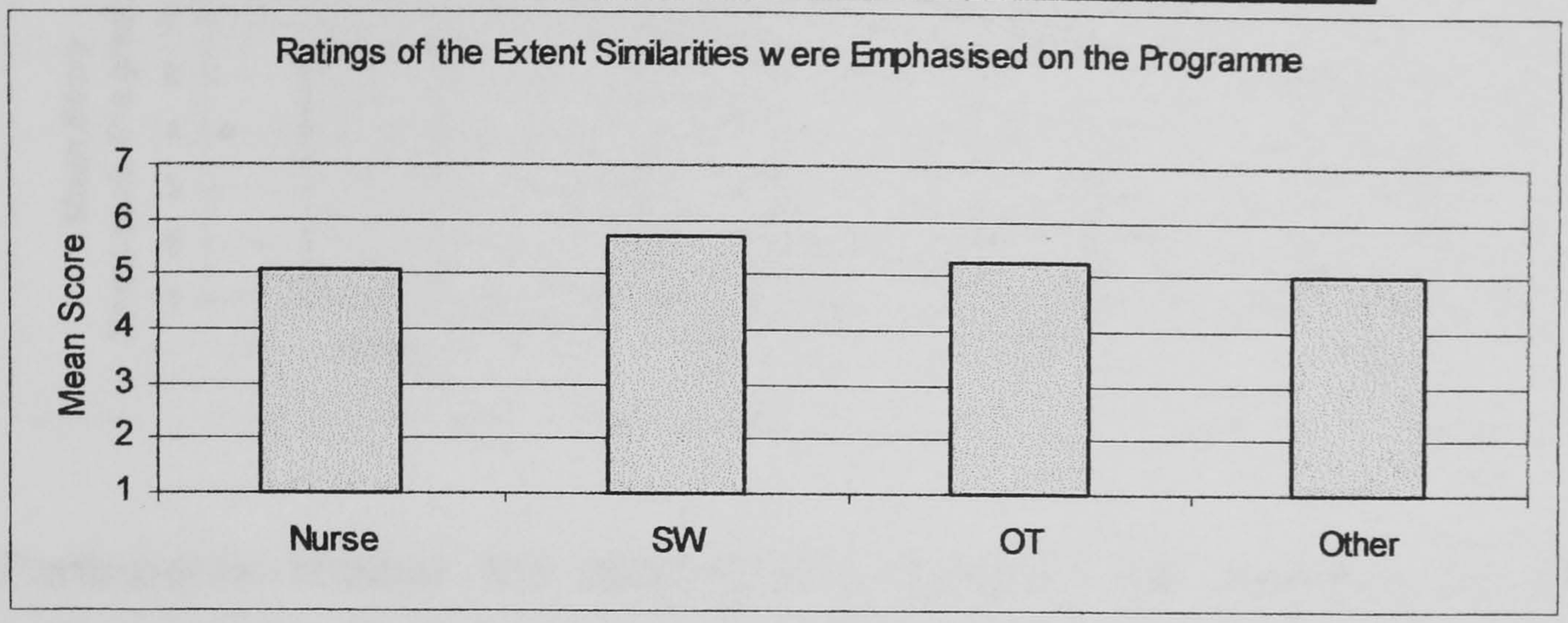
	Atmosphere co-operative Mean (SD)	Atmosphere competitive Mean (SD)	Professions stick together Mean (SD)	Teams stick together Mean (SD)
Cohort 2	5.97	2.94	3.52	4.73
(N=33)	(0.98)	(1.62)	(1.44)	(1.42)
Cohort 3	5.8	3.4	4.35	4.85
(N=20)	(1.51)	(1.35)	(1.39)	(1.46)
Cohort 4	5.74	3.37	4.07	4.56
(N=27)	(1.13)	(1.36)	(1.36)	(1.4)
All	5.85	3.2	3.91	4.7
(N=80)	(1.17)	(1.47)	(1.42)	(1.41)

Differences by Profession

All professions gave high ratings for the extent that similarities between mental health professionals had been emphasised on the course. All ratings were above five on a seven-point scale (1 indicated similarities were not

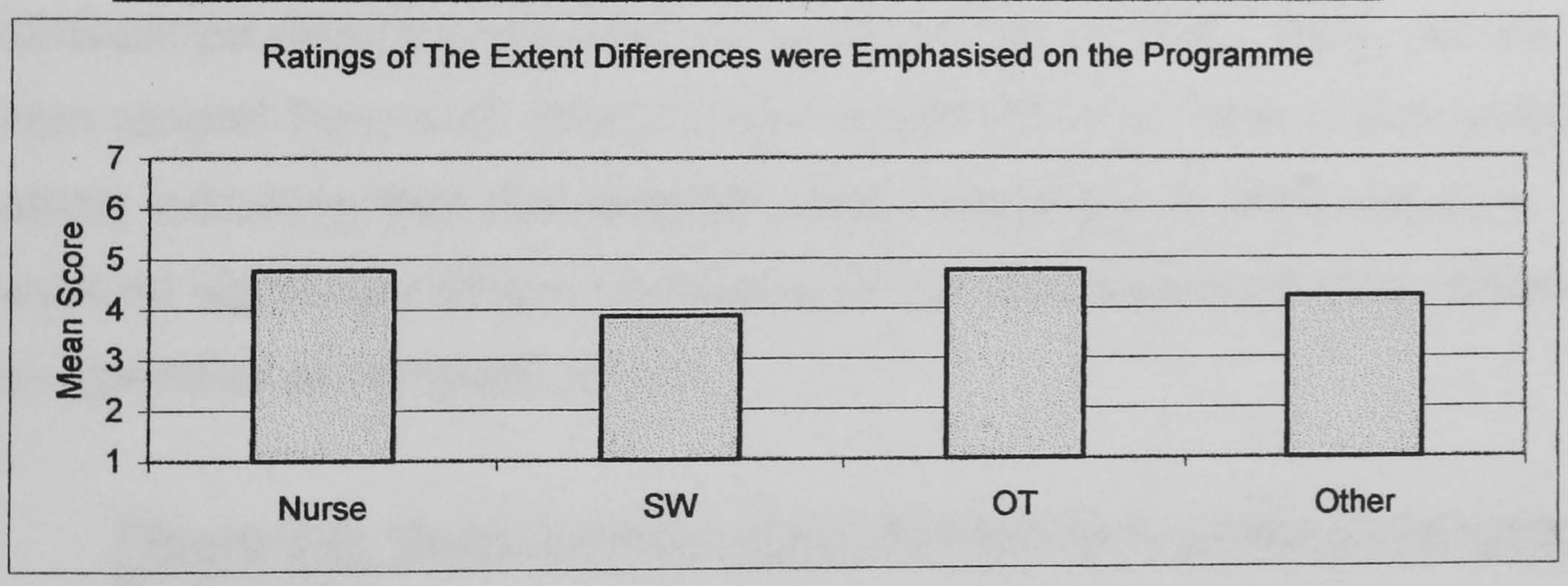
emphasised at all and 7 indicated that they were emphasised a great deal). Social workers felt similarities were emphasised the most (mean 5.71) and "Others" gave the lowest rating of 5.

Figure 6-5: Mean Ratings of Similarities by Profession



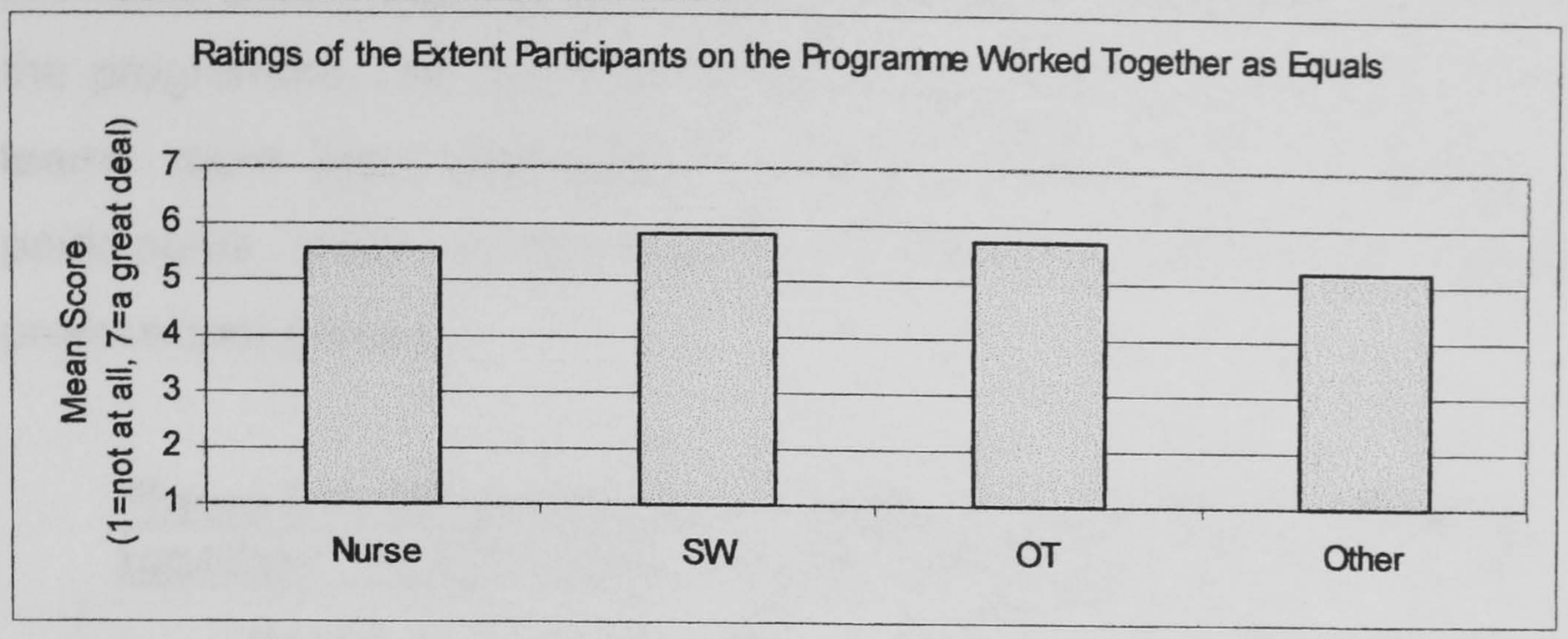
All professions agreed that differences between mental health professionals were emphasised to a lesser degree than similarities (Figure 6-5). Social workers felt that differences were emphasised the least (mean 3.86) and nurses thought differences were emphasised the most (mean 4.77).

Figure 6-6: Mean Ratings of Differences by Profession



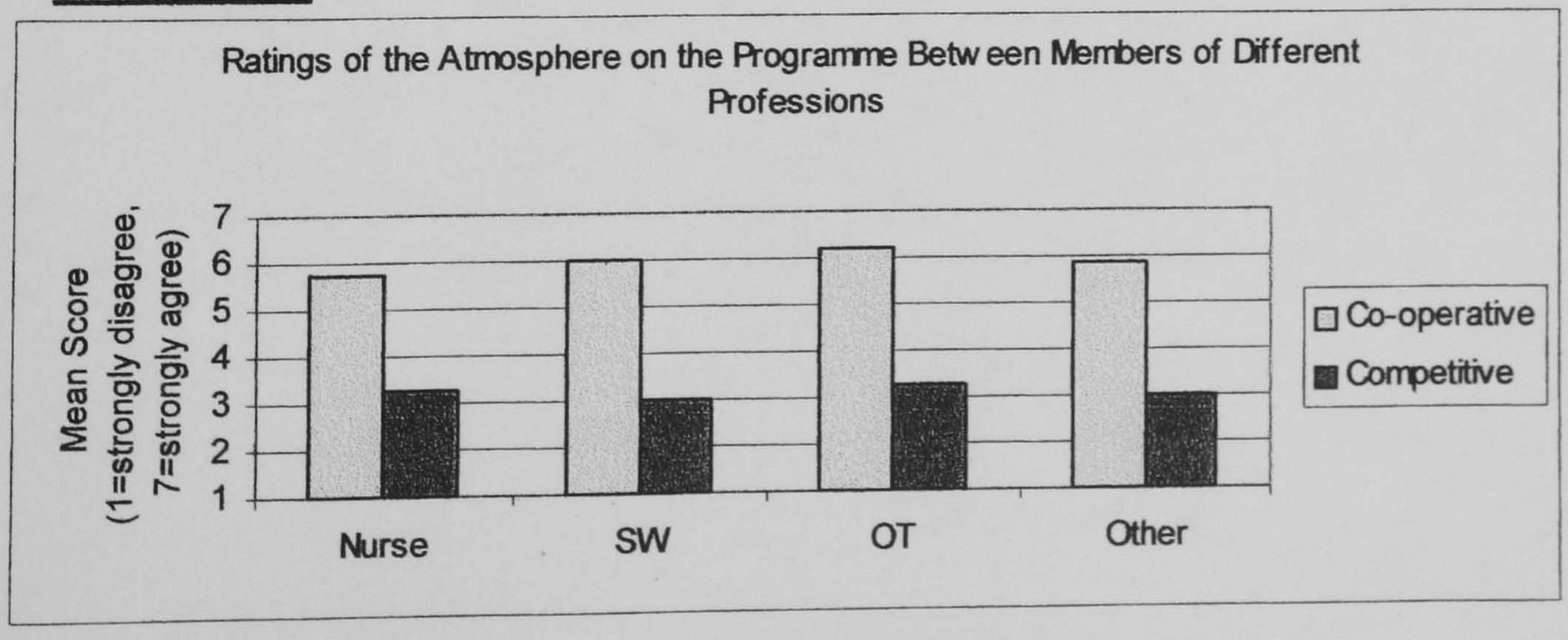
There were no significant differences between the professions on their ratings of "the extent that participants work together as equals" on the programme. On the seven-point scale, where one indicates not at all and seven indicates a great deal all professional groups had mean scores above 5 (Figure 6-7). Social workers considered that participants worked together as equals the most (mean 5.86) and "Others" had the lowest mean score of 5.22.

Figure 6-7: Mean Ratings of Working Together as Equals on the Programme by Profession



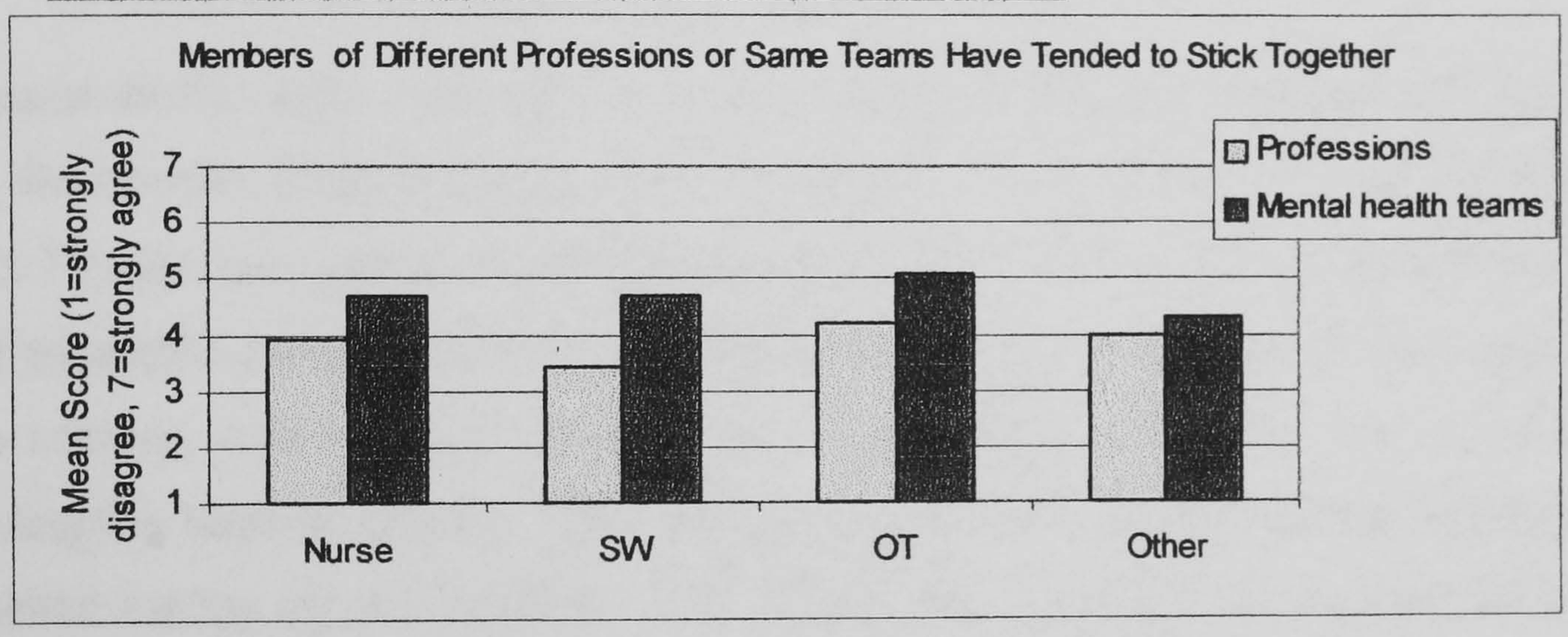
Participants viewed the atmosphere between the members of different professions on the course as co-operative. Participants rated their agreement that the atmosphere had been co-operative on a seven-point scale (where 1 indicated strong disagreement and 7 indicated strong agreement). Mean scores ranged form 6.17 (for occupational therapists) to 5.75 (for nurses). These scores indicate that they agreed with the statement that the atmosphere had been co-operative. Participants showed less agreement with the statement that the atmosphere on the course between members of different professions had been competitive (Figure 6-8). Mean scores on this item ranged from 3.25 (from nurses and OTs) to 3 (from social workers and other) indicating that respondents mildly disagreed or were not sure. There were no significant differences between the professions on their ratings of the co-operative or competitive item.

Figure 6-8: Mean Ratings of the Atmosphere on the Programme by Profession



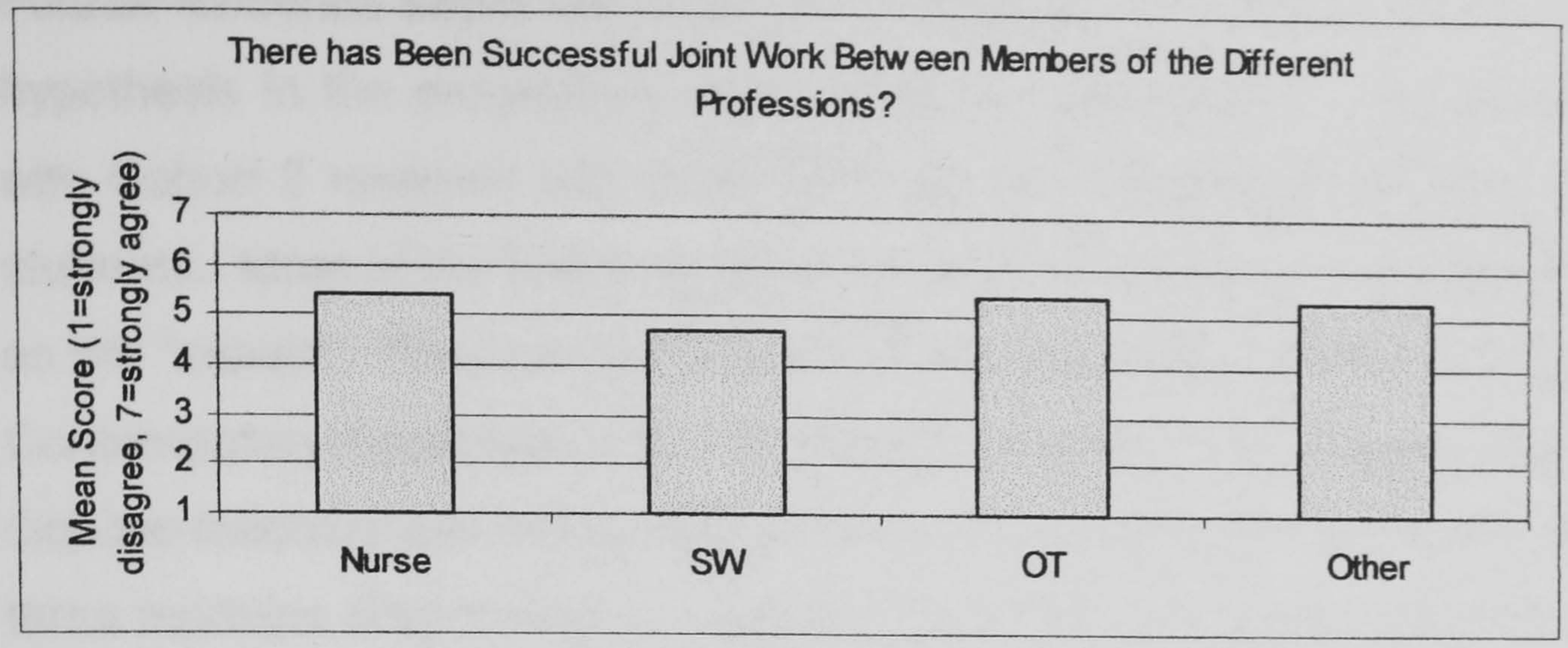
Participants rated the extent to which they felt members of the different professions or members of the same teams had tended to stick together on the programme. All professions considered that students tended to stick in teams more than professional groups (Figure 6-9). In general, course participants were undecided on whether students stuck together in professional groups.

Figure 6-9: Mean Ratings of Professions or Teams "Sticking together" on the Programme by Profession



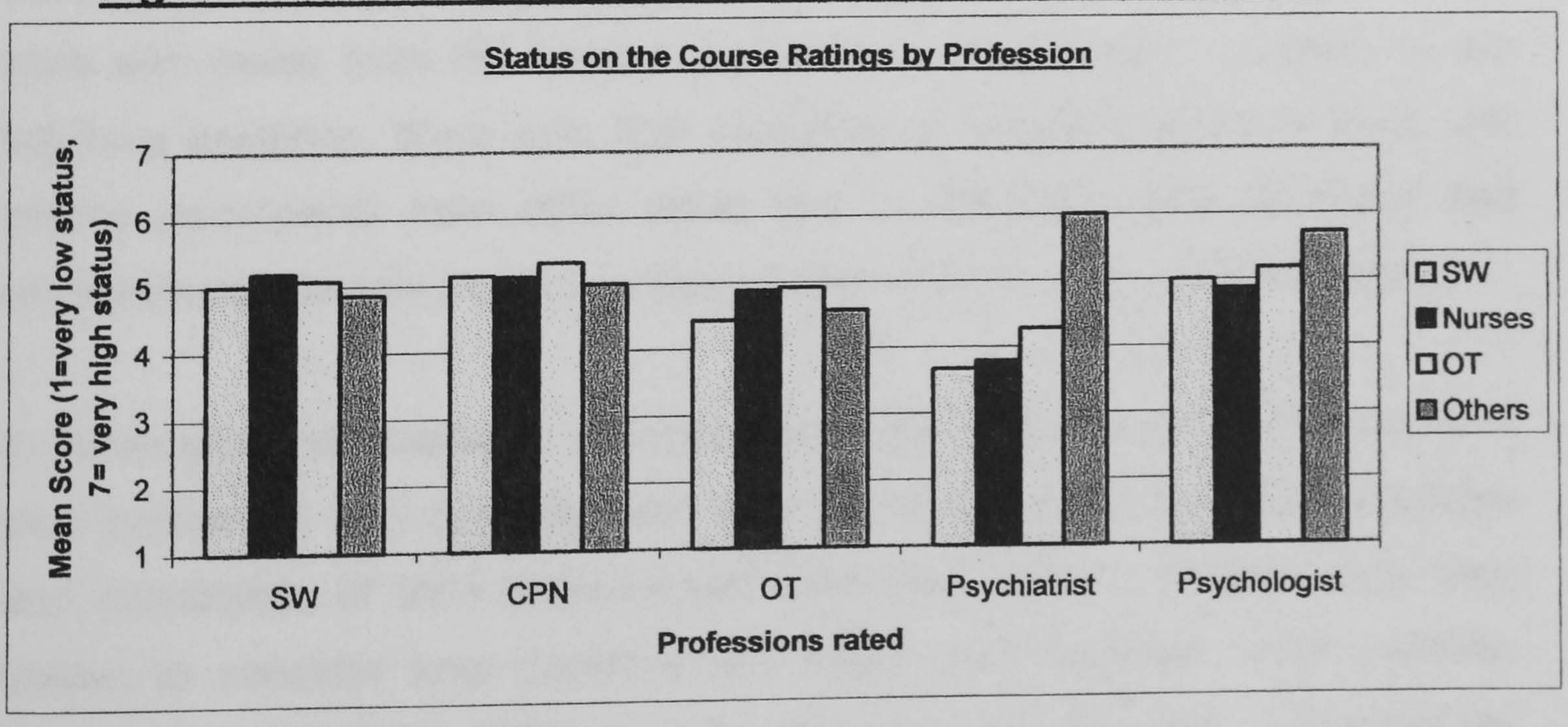
Occupational therapists showed the highest level of agreement that there had been successful joint work between members of the different professions on the programme (Figure 6-10). OTs had a mean score of 5.08 on the seven-point scale. "Others" showed the lowest level of agreement (mean 4.33). However, this variation between professional groups was not statistically significant.

Figure 6-10: Mean Ratings of Successful Joint Work Between the Professions



Respondents rated their views on the status of different professional groups on the course (Figure 6-11). On a scale of 1 to 7, where 1=very low status and 7=very high status, there was some variation in the ratings by profession. For example, nurses saw social workers as having the highest status levels on the course, whilst social workers and occupational therapists saw nurses as having the highest status. The "Others" group saw psychiatrists as having the highest status on the course. The other three professional groups all gave psychiatrists the lowest ratings. This difference between the professional groups in their ratings of the status of psychiatrist on the course was significant (ANOVA, p=0.039, K-W, p=0.032).

Figure 6-11: Ratings of Status on the Course by Profession



Observations

Further evidence about the presence or absence of conditions of the contact hypothesis in the programme came from my observations. My observations with Cohort 2 revealed that there were only very limited interactions between students. Most of the teaching relied on didactic instruction with the presenter as the "expert". There were slight variations between modules. For example, Contemporary Approaches to Psychiatric Treatment was heavily based upon didactic teaching and made very little use of small groups. However, the other three modules (Psychological Intervention, Working in Community Teams and User Participation and Self-Help) all developed a common pattern. This consisted of the presenter taking a lecturing role, imparting information to the students who took notes. The latter part of the sessions then allowed participants an opportunity to discuss some of the new ideas and information in groups of approximately, three to six.

The students themselves, not the presenters, usually decided membership of the small groups. The students typically chose those sitting around them. These were usually colleagues from the same team or trust group, and quite often they travelled to the programme venue together. Thus, students typically worked with other students who they already knew quite well. If the presenter determined group membership, it was usually done on the basis of existing teams or service membership. For example, people would be told to work with those from the same trust group as themselves. Outside of the teaching sessions, there was little evidence of interprofessional mixing with course participants from other areas due to difficulties with structural and environmental factors, such as a lack of time and the layout of the building.

In these group discussions, students were not invited to act as members of their profession and consider how they would act within the responsibilities and constraints of their professional roles and duties. Neither were they invited to consider how professionals might work together collaboratively. Similarities rather than differences in roles were emphasised. For example, shared (or so it was assumed) values concerning community care, user involvement and anti-discriminatory practice were continually emphasised.

Consequently, the difficulties in interprofessional working were infrequently exposed and explored.

Since students were not invited to view interactions in terms of an interprofessional encounter and professional identity did not appear to be salient. Students did comment on their team background and said which trust area they were from but they rarely said to which professional group they belonged.

After feedback from the external evaluation team about the teaching environment several changes were made to the module Working in Community Teams and I observed this module with Cohort 4, who were the first group of students to experience the changes. The aim of the observations was to compare the teaching with that observed earlier with Cohort 2. During the observations a range of teaching styles were used with quite a substantial emphasis on small group work. This involved students being asked to work with those whom they had never worked before and students making greater use of the physical environment of the teaching room. This appeared to energise the students, particularly after lunch, and students appeared to enjoy this element of the programme. Didactic teaching took place but never formed the whole basis of a day's teaching. It was always interspersed with group work.

In the second set of observations there was an obvious effort to encourage students to think about their professional role and one group exercise seemed to be particularly effective. This exercise was in two parts and the first section took place in the Foundation module. When students started the programme they were asked to get into professional groups and think about what they considered the core elements of their own and other professions. These "core elements" were recorded on to flip charts. The flip charts were reproduced in one of the sessions in the module Working in Community Teams. The students were asked to return to their original groups and reconsider what they had recorded months earlier. The exercise showed that the students had changed considerably in their attitudes to their own professional role. The

nurses reported that they were shocked by how "medical" their original contribution had been and felt that they now delivered a more holistic service. They were also keen to point out that they could not point to any one perspective or set of skills that belonged solely to their profession but they did not consider this a negative factor.

The first set of observations revealed that many of the pre-conditions of attitude change outlined by the contact hypothesis were not met. Differences were not discussed, rather similarities were emphasised. The students had little opportunity to interact with each other, thus limiting the potential for friendships to develop between professionals. As students were not required to interact it was impossible to judge whether the atmosphere was co-operative or competitive. However, the second set of observations revealed that the changes to the programme had created an environment where differences were explored and students interacted much more with those who they did not already know. The atmosphere, as observed, was co-operative, and not overtly competitive.

6.3.3. Typical

In accordance with the contact hypothesis students in the semi-structured interviews at their workplace were asked to rate how typical they thought the students on the course were of their profession (i.e. were the nurses on the programme 'typical' of nurses in general?). There was a spread of opinions with some students indicating that the students on the course were typical of their profession.

> *"Yes, I think they are typical." (Social worker Co2 Yr2)*

Others felt that if not all the students were typical of their profession then in general a lot of students were.

> *"Quite a few of the people on the course are typical of their roles." (Nurse Co2 Yr3)*

However, not everyone agreed that the students were typical of the professional groups they belonged to.

> *"The people on the course are certainly not typical of their profession." (Nurse Co4 Yr1)*

Respondents reported that there were differences between mental health professionals who worked in the community and those who worked in hospital settings. On the whole the students were seen to be typical of those who work in community settings.

> *"Students on the course are generally representative of CMHTs." (Nurse Co3 Yr1)*

One respondent further divided mental health staff into those who were "radical" and those who were not. In this way students on the programme were seen to be typical only of a subgroup that work in mental health services.

> *"I'd say that they are typical of radical community staff who are around, or more forward thinking. I think we have got a good bunch of people who are interested in this and who want to progress things." (OT)*

One of the most common reasons why students on the programme were seen to be more typical of community professionals rather than those who worked in hospitals was due to the perceived differences in attitudes. There was a strong feeling that the people on the course were much more enlightened and forward thinking than professionals whom they encounter in their day-to-day practice.

> *"They tend to be people who are more motivated perhaps, people who want to be involved in change, although it is not necessarily about change. They are people who like to be informed." (Nurse Co4 Yr1)*

The students had a perception that those who attended the programme wanted to change services more than those who generally work in the five main mental health professions. The nurses on the programme were seen to be less typical of their profession by the non-nurses on the programme. For example, one OT talking about the nurses on the programme explained:

> *"I think they are typical of community staff, but not the inpatient staff. They are a group that I find more stuck. So from that point of view they are not typical of nurses per se." (OT)*

An occupational therapist colleague expanded upon this point, making it clear she thought the nurses who were students on the programme were definitely not typical of the nursing profession.

> *"The nurses are atypical. On the course the nurses are more open minded, willing to move forward. They are not as defensive of their profession. They are at the edge of crawling out of their hole that many nurses are still at the bottom of. " (OT)*

A social worker on the programme discussed how the nurses on the programme were unlike those they had prior experience of.

> *"You come across the feeling 'are these real nurses' because I ain't met many like them before." (Social worker Co4 Yr1)*

That the nurses were willing to 'move forward' was unexpected by other students.

> *"I was quite surprised by the nursing staff on the course they were more 'with it', more forward thinking." (Social worker Co2 Yr2)*

At least one nurse was inclined to agree that students on the programme had been more progressive than those typically found in practice.

> *"Those on the course are more enlightened, motivated, enthusiastic than typical mental health staff." (Nurse.Co2 Yr2)*

An element of self-selection bias was identified as the reason why so many of the students were more enlightened (or perceived as more enlightened) than those whom the students felt they encountered in mental health services. For example, one nurse felt that nurses who remain close to the traditional hospital-based services for mental health would not put themselves forward for such a programme.

> *"A lot of the people who are old asylum nurses would not go on the course. The staff on the course are more community based." (Nurse Co3 Yr1)*

The perception that it was only those who were more "enlightened" who would attend the programme was not restricted solely to nurses.

> *"I don't know if this was due to the type of people who do courses but I found that they were pretty socially aware." (Social worker Co4 Yr1)*

The students perceived that the programme attracted the more ambitious, forward thinking professionals working in mental health.

> *"I think that the students on the course are the ambitious ones and they are taking advantage of free training. Things skew up so a Masters degree is essential to go anywhere, so that adds kudos." (OT)*

Further evidence that the students on the programme were the more ambitious, forward thinking representatives of their professions came from the students' accounts of their own motivation for attending the programme. The programme was seen by many students to be beneficial to their career prospects. For example, one nurse explained how the qualification attained from the programme could be used to progress within the profession of nursing.

> *"Getting a Master's degree fits in with the nurse consultant posts that are being created." (Nurse Co1 Yr3)*

Another student had taken a long-term view about what the programme could offer and saw it as a way of widening career options beyond nursing in practice.

> *"The long-term aim was to develop and promote new skills and move on. I thought when I retire I could use the new skills to lecture." (Nurse Co1 Completed Yrs 1 & 2)*

However, career progression was not the main reason reported by the majority of students for attending the programme. Students typically gave much more in-depth reasons behind their motivation for joining the programme rather than one simple reason. One commonly reported motivating factor was the opportunity the programme provided them to improve their existing skills.

> *"I felt I needed more education and was ready to take it on. I needed to be aware of new movements and thinking." (OT)*

The opportunity to study after pre-registration training was also considered important, for example:

> *"I think sadly in a lot of ways community psychiatric nursing, as it is now, is not very intellectually demanding. You do a lot of routine work and once you have got your skills to a certain level you don't train that much more. I really did welcome the opportunity to do a bit more studying and to read." (Nurse Co1 Yr3)*

The academic qualification that the programme offered (eventually a Master's degree) was considered important.

"I love the idea of doing a Master's." (Nurse Co3 Yr1)

The academic qualification was considered important not just for the advantages it offered for career progression but also because many students did not have an undergraduate degree.

"I do not have a degree and I wanted one." (Nurse Co1 Yr3)

"I hadn't really done much in formal education after I qualified and I didn't have a degree." (Nurse Co2 Yr3)

The fact that the programme did not have any financial costs, to be met by the students, was considered a benefit by many of the interviewees:

"That the place was paid to do a Master's was an additional bonus." (OT)

However, it was not just personal outcomes that attracted the participants to the programme. The opportunity to improve services for the people they work with was also highly valued.

"I wanted to do the same job better. There is always room for improvement and I wanted to go with the new thinking." (Nurse Co3 Yr1)

Many of the students made a link between improving their skills eventually leading to an improved service for their clients.

"I wanted to go on the course to give my clients a better service." (Nurse Co4 Yr1)

The way most students talked about improving the services they could offer to service users was by increasing their skills. The psychosocial interventions taught on the programme were a major incentive for many of the students who

took part on the programme. They voiced the desire to learn about psychosocial interventions and put them into practice.

> *"My primary motivation was the skills and theory bases of the course." (OT)*

Some students saw psychosocial interventions as a way of offering more to the people they worked with than they currently were skilled to offer.

> *"I wanted to know about CBT, counselling and psychosocial interventions. I thought there was something better than dishing out tender loving care." (Nurse Co3 Yr1)*

Thus, there is some evidence from the students themselves that they are concerned with learning about new ways of working and improving services and outcomes, for themselves and for service users. This suggests support for the interviewees' claims that many of the students on the programme were not representative of their profession, but were more representative of the professionals who want to improve mental health services.

Summary: There was a high level of agreement between different cohorts of students and the different professions that they had received institutional support for their participation on the programme. They also showed high levels of support from their professional colleagues and their team members. Students also felt that similarities were emphasised as well as differences. When the students did work together they reported that they did so as equals, that the joint work was successful and the atmosphere on the programme was much more co-operative than competitive. This is evidence that the conditions of the contact hypothesis were met in this situation. The final condition of the contact hypothesis is that participants see the other participants as representative of the outgroup (other professions). This however, proved less conclusive. Students tended to view the other participants as representatives of the more motivated and forward thinking section of their professions. There was evidence that nurses, in particular,

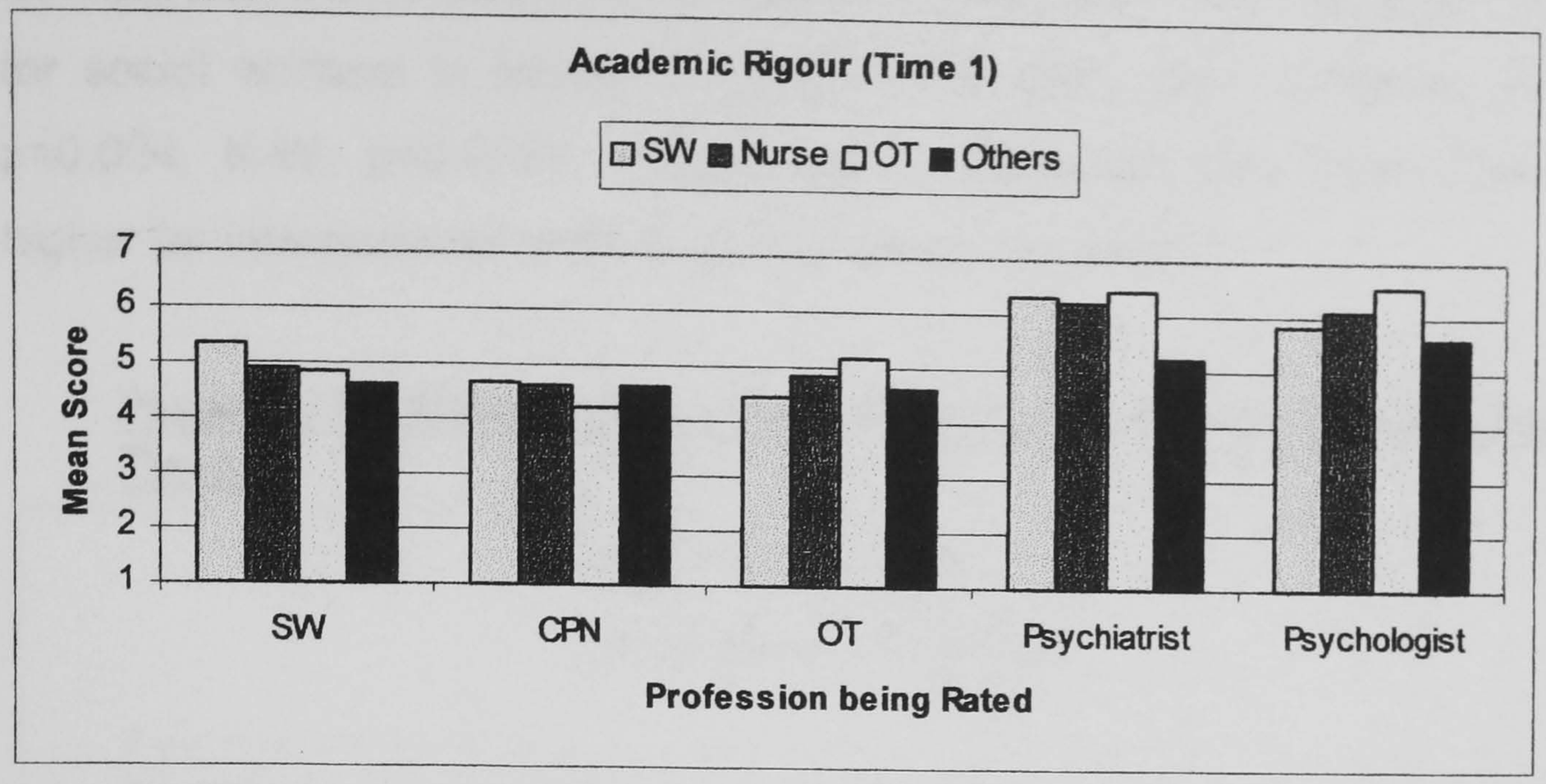
were viewed as significantly different from those encountered in everyday-working situations.

In the following section, a series of hypotheses about changes in heterostereotypes and autostereotypes are tested. The figures below show how nurses, social workers, OTs and the remaining group of course participants (the "Others") rated the core community mental health professionals on the set of "attributes" (stereotypes). The core professional groups included psychiatrists and psychologists whose numbers were too few for separate analysis. Participants' ratings of their own profession (autostereotypes) are also shown e.g. the ratings given by OTs on the course of OTs in general.

6.3.4. Interprofessional Stereotypes

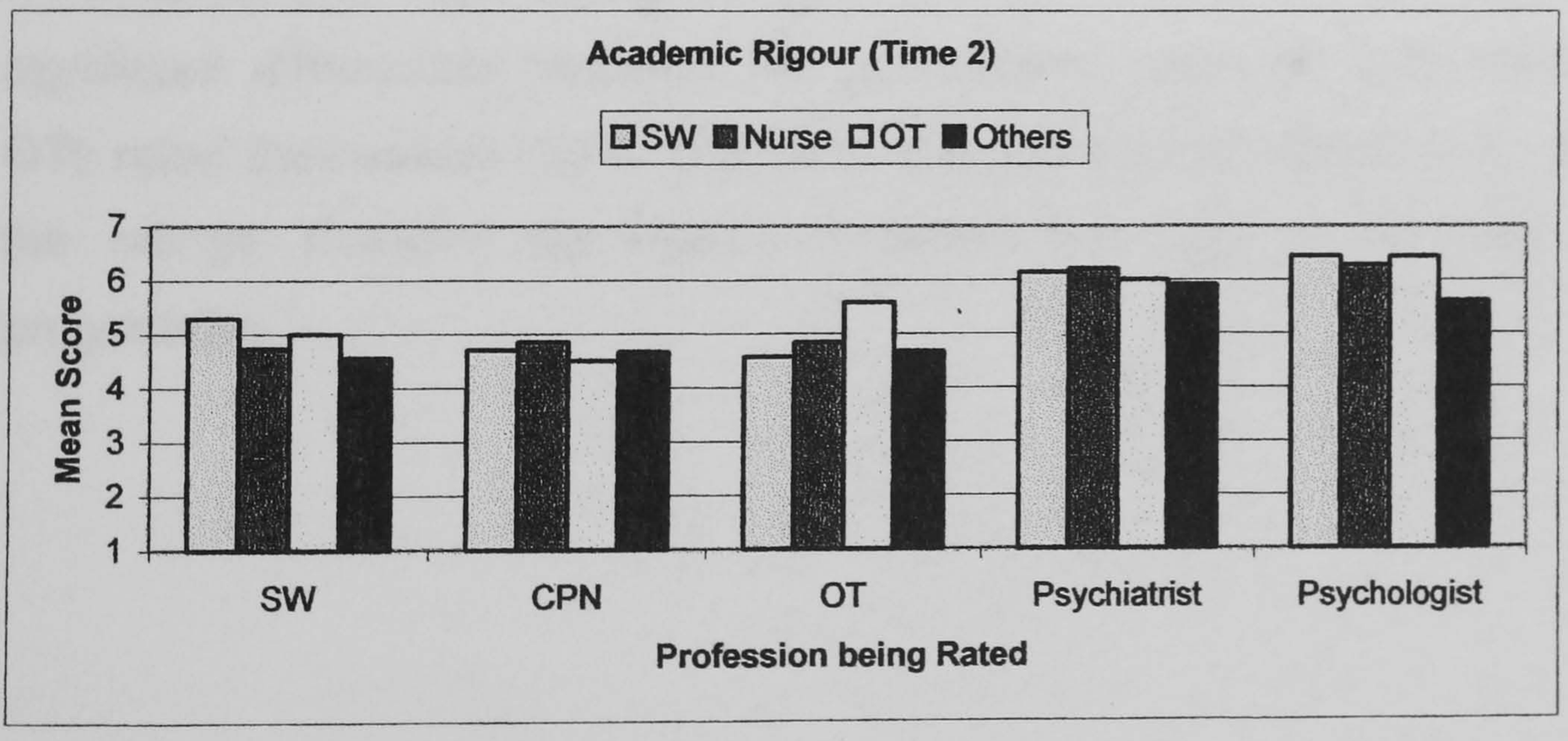
Psychologists and psychiatrists received the highest ratings for ***academic rigour*** from all professions, at the start of the programme (Figure 6-12). Ratings for social workers, nurses and OTs were quite similar with both social workers and occupational therapists rating their own profession higher than the other professions on academic rigour.

Figure 6-12: Mean Ratings of Academic Rigour by Profession at Time 1



At the end of the programme, psychiatrists and psychologists were still seen as having the highest levels of academic rigour (Figure 6-13). The professions differed significantly (ANOVA, p=0.04, K-W, p=0.033) on their ratings of academic rigour for occupational therapists. Occupational therapists rated themselves the highest (mean 5.6) and social workers rated them the lowest (mean 4.6). There were no significant changes over time.

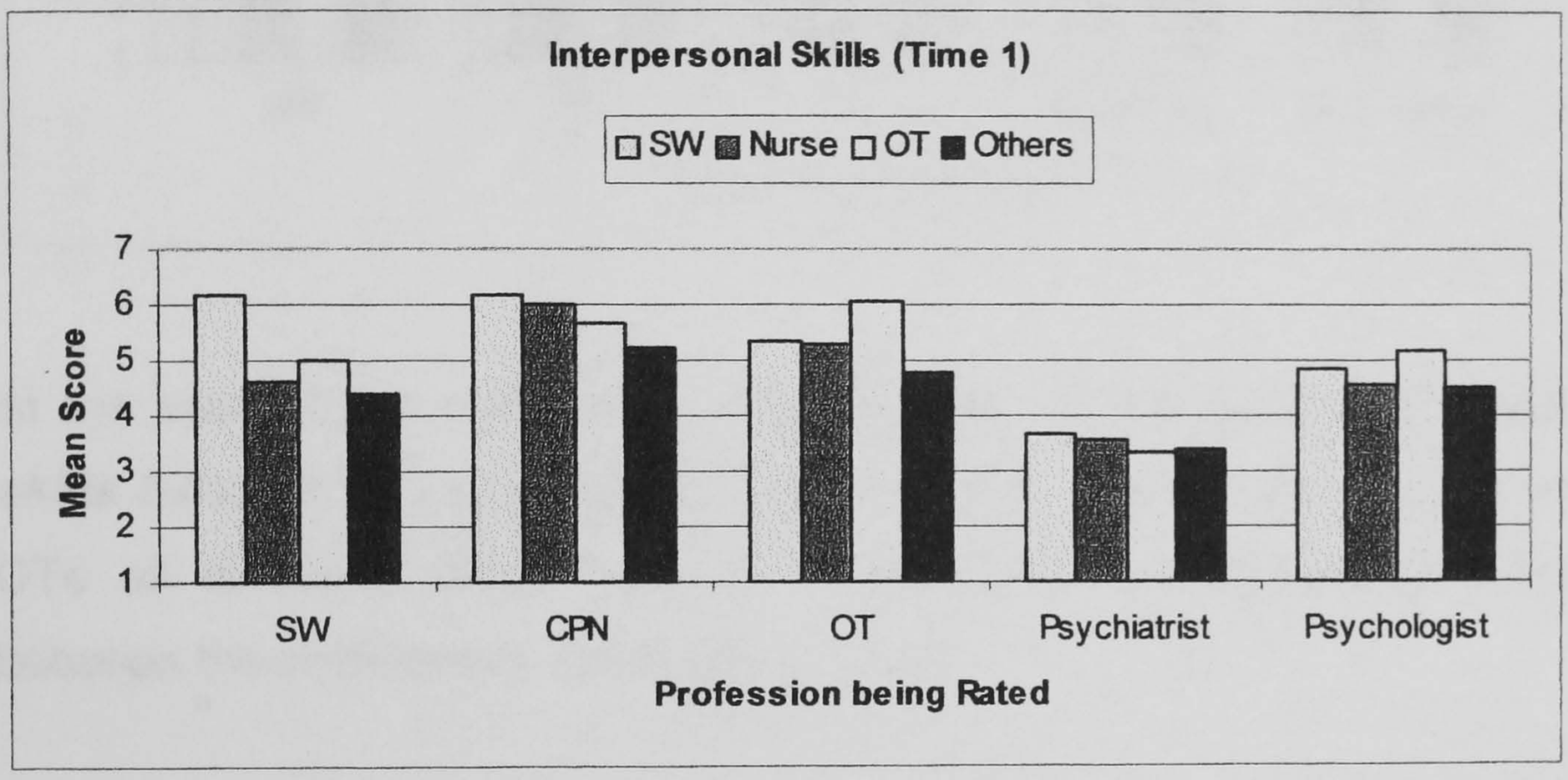
Figure 6-13: Mean Ratings of Academic Rigour by Profession at Time 2



Psychiatrists were rated by all professions, as having the lowest levels of ***interpersonal skills*** at the start of the programme (Figure 6-14). There were high ratings for nurses and OTs on this scale. Social workers rated

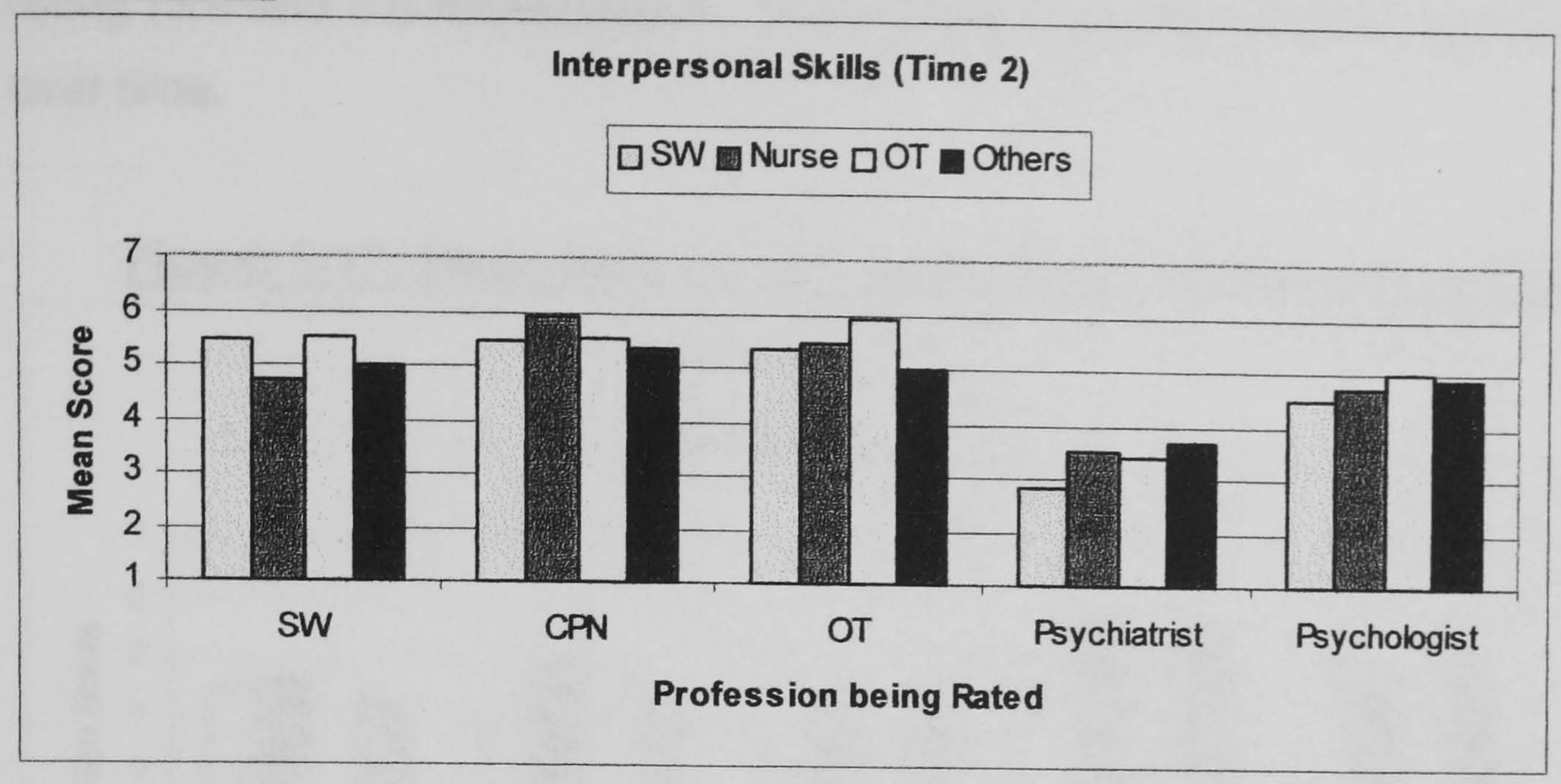
themselves high in this area (mean 6.2) whilst the "Others" rated social workers between 4 and 5 on the seven-point scale. This variation in ratings for social workers in terms of interpersonal skills was significant (ANOVA, p=0.024, K-W, p=0.027). Occupational therapists also rated themselves higher for interpersonal skills than any group rated them.

Figure 6-14: Mean Ratings of Interpersonal Skills by Profession at Time 1



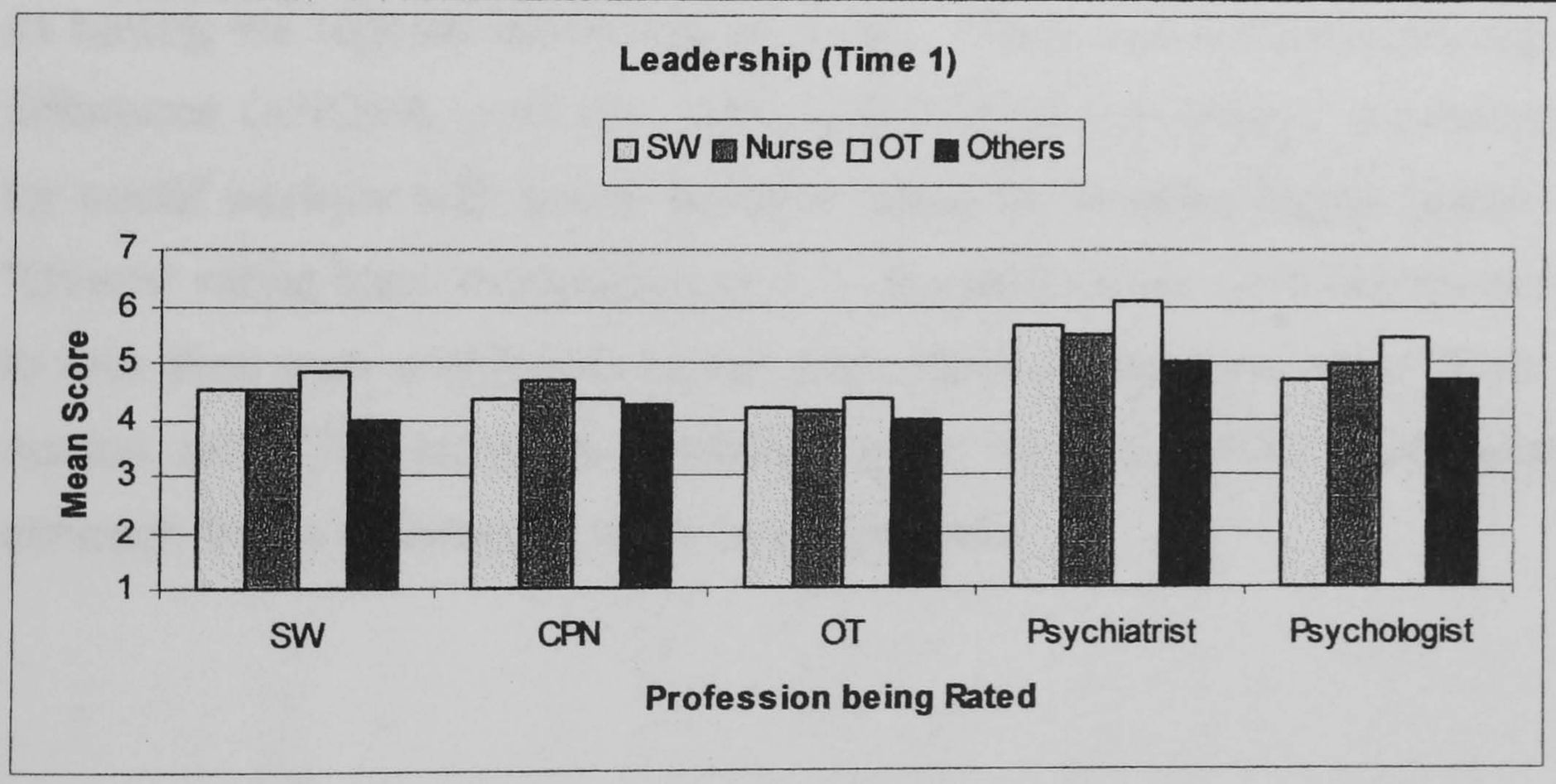
At the end of the programme, psychiatrists were still seen as having the lowest level of interpersonal skills, whilst social workers, nurses and OTs received similar high ratings (Figure 6-15). There were no statistically significant differences between the professions, although both nurses and OTs rated themselves higher than the other professions rated them. None of the ratings changed significantly between the start to the end of the programme.

Figure 6-15: Mean Ratings of Interpersonal Skills by Profession at Time 2



At the start of the programme, psychiatrists scored highest on ***leadership skills*** followed by psychologists, (Figure 6-16). Social workers, nurses and OTs all received similar ratings. There were no significant differences between the professions making the ratings.

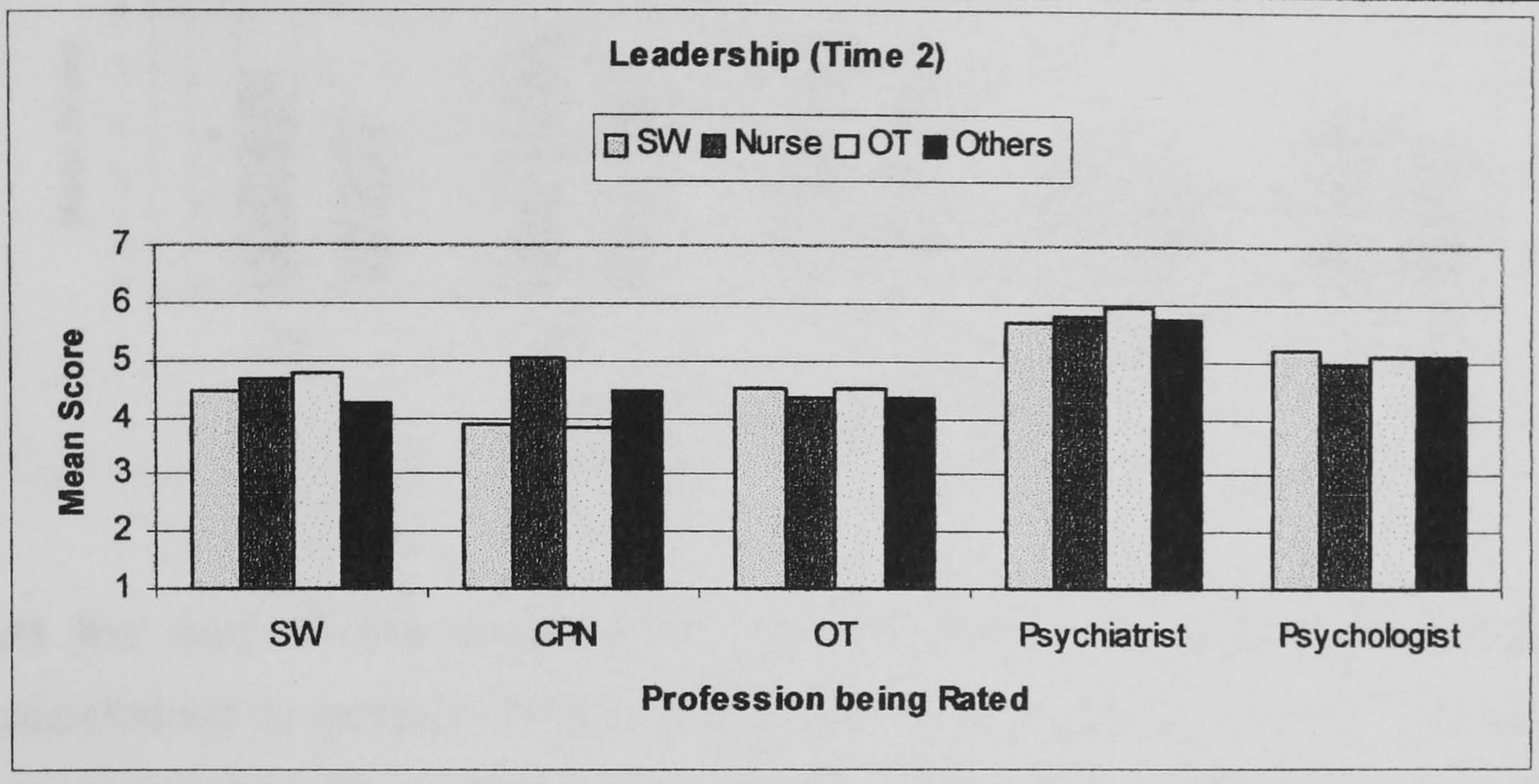
Figure 6-16: Mean Ratings of Leadership by Profession at Time 1



At the end of the programme, psychiatrists were still seen to have the most leadership qualities, followed by psychologists (Figure 6-17). Whilst there was agreement between the professions on their ratings of leadership qualities, of social workers and OTs, there was a significant difference in the ratings of nurses (ANOVA, p=0.001,K-W, p=0.001). Nurses awarded themselves the

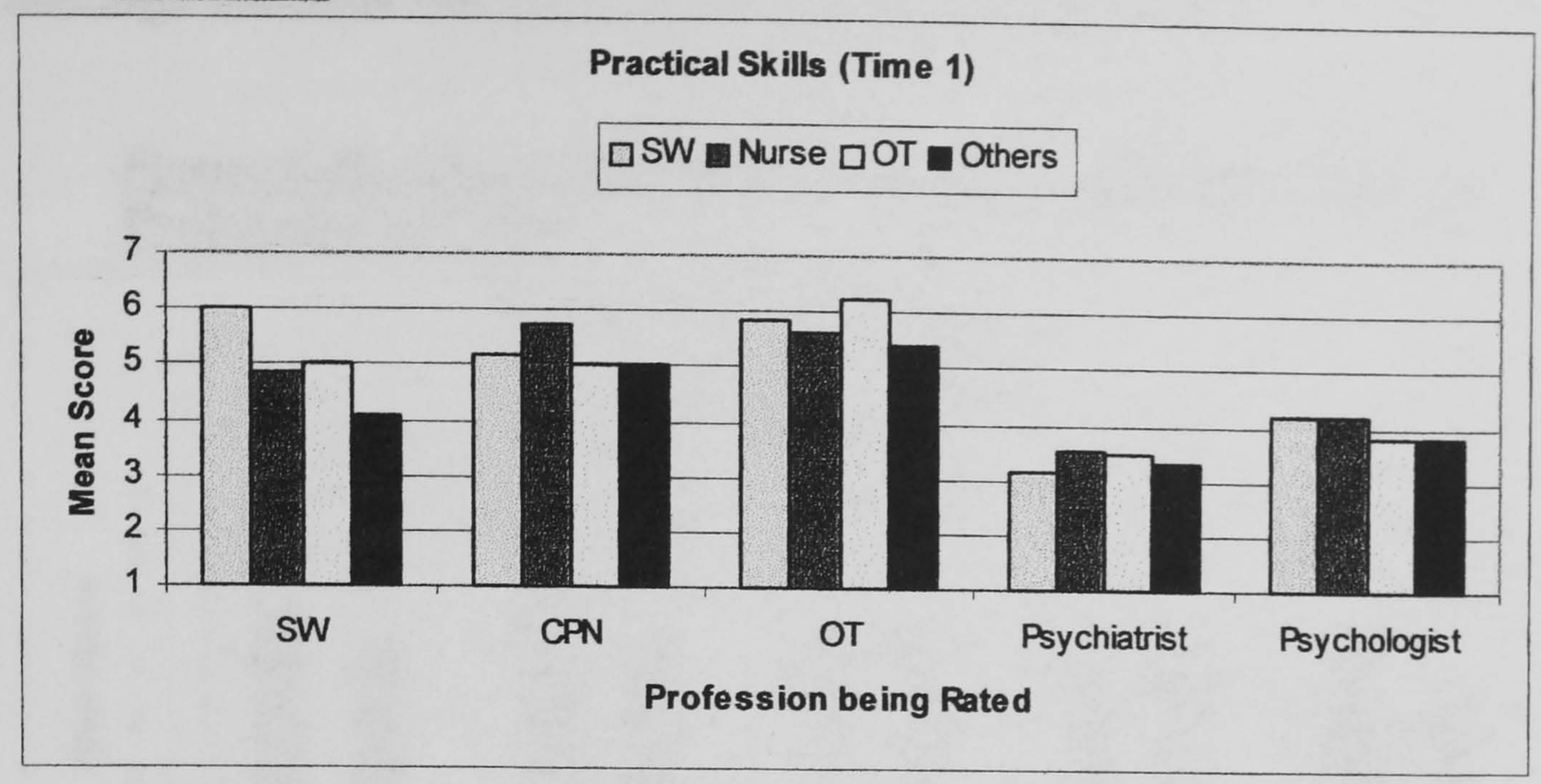
highest score (mean 5) and social workers and OTs awarded them the lowest rating (3.9 and 3.8 respectively). There were no significant changes in scores over time.

Figure 6-17: Mean Ratings of Leadership by Profession at Time 2



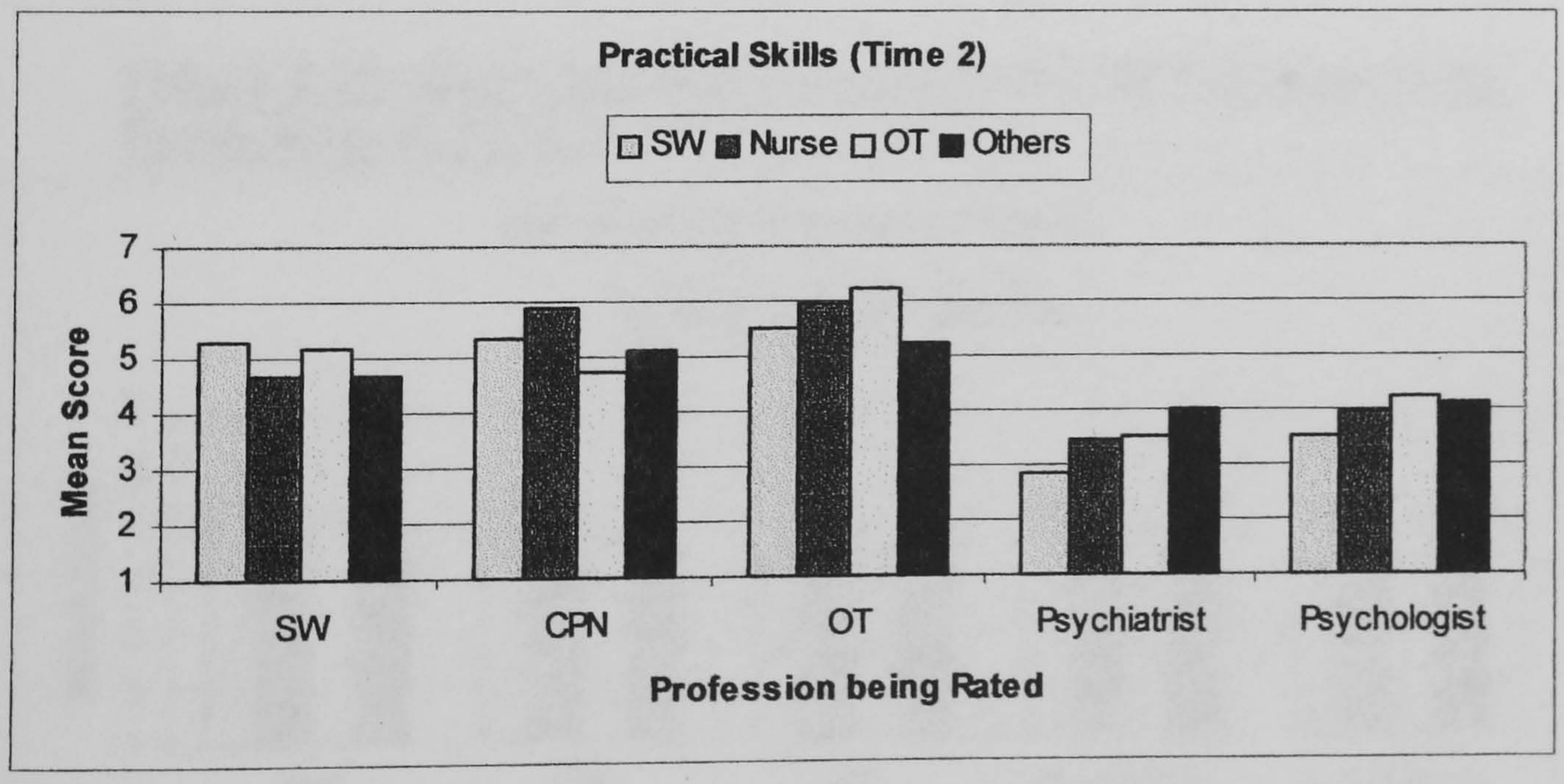
Psychiatrists and psychologists were perceived as having the least amount of ***practical skills*** of the mental health professions and OTs were generally seen as having the highest levels (Figure 6-18). There was a statistically significant difference (ANOVA, p=0.034, K-W, p=0.046) in the ratings of practical skills for social workers with social workers rating themselves highly (mean 6) and "Others" rating them moderately at 4.1. Social workers were not the only ones to rate their own profession higher than other professions rated them. Both nurses and OTs rated themselves higher than the other professions did, although these differences were not significant.

Figure 6-18: Mean Ratings of Practical Skills by Profession at Time 1



At the end of the programme, psychiatrists and psychologists were still considered to possess the lowest levels of practical skills and OTs generally considered to have the highest levels. However, nurses rated themselves higher (mean 5.9) than the other professions on practical skills. This variation in ratings by professions was statistically significant (ANOVA, p=0.001, K-W, p=0.001).

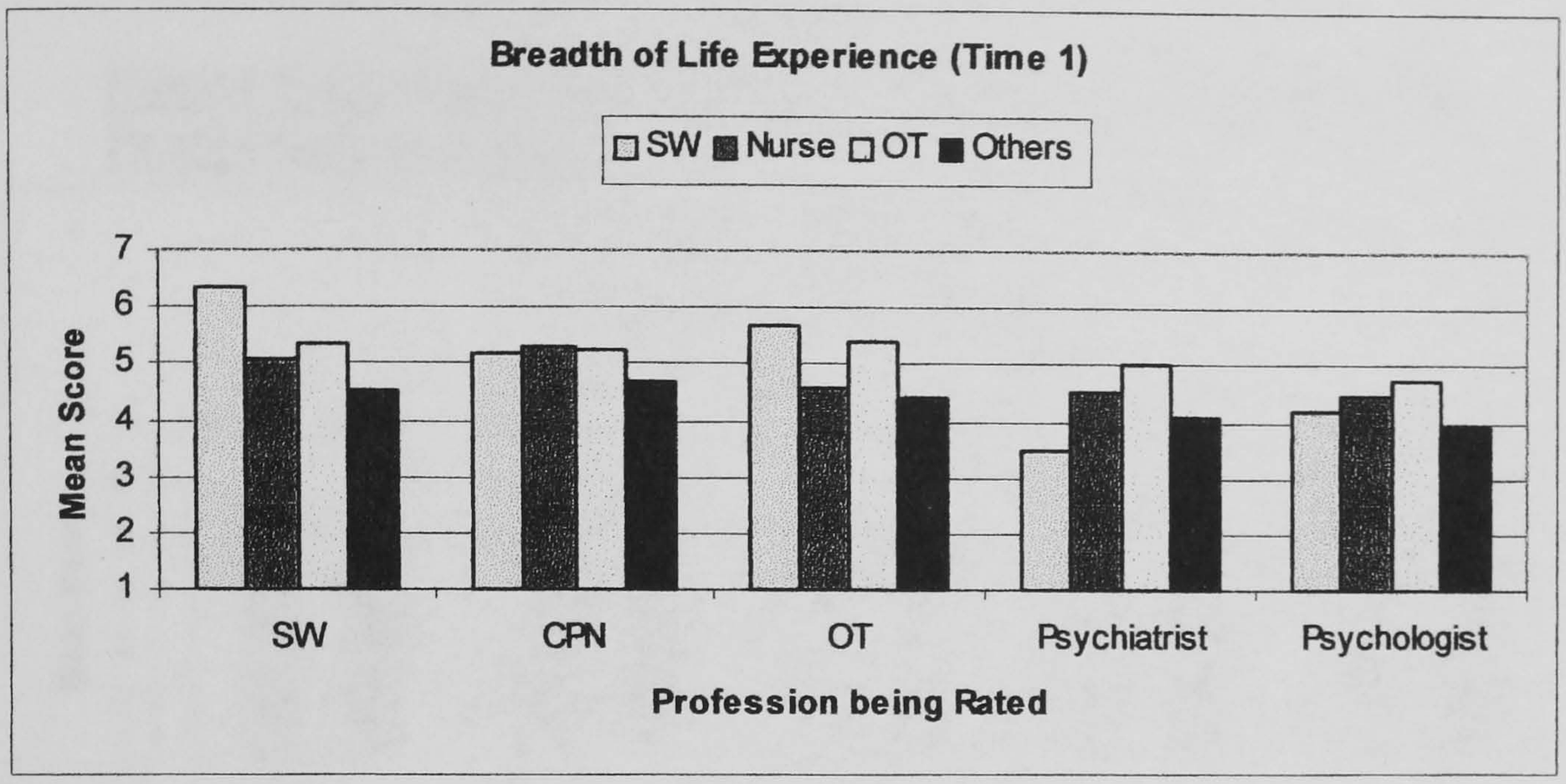
Figure 6-19: Mean Ratings of Practical Skills by Profession at Time 2



Psychiatrists and psychologists received the lowest ratings for ***breadth of life experience*** by all professional groups making ratings at the start of the programme (Figure 6-20). Social workers considered themselves to score

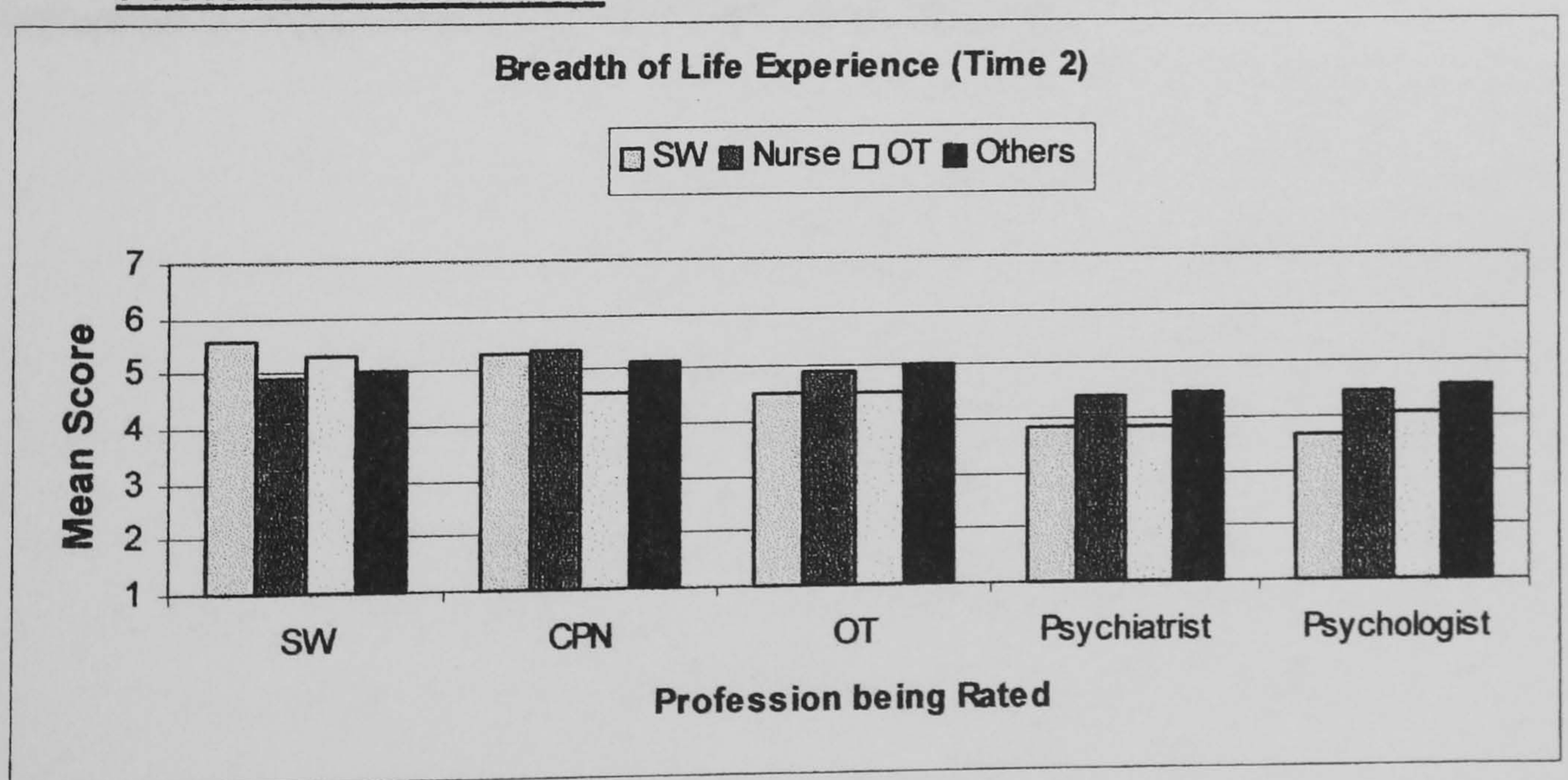
particularly highly on this attribute (mean 6.3) and the OTs tended to agree, although the other two groups did not rate them as highly.

Figure 6-20: Mean Ratings of Breadth of Life Experience by Profession at Time 1



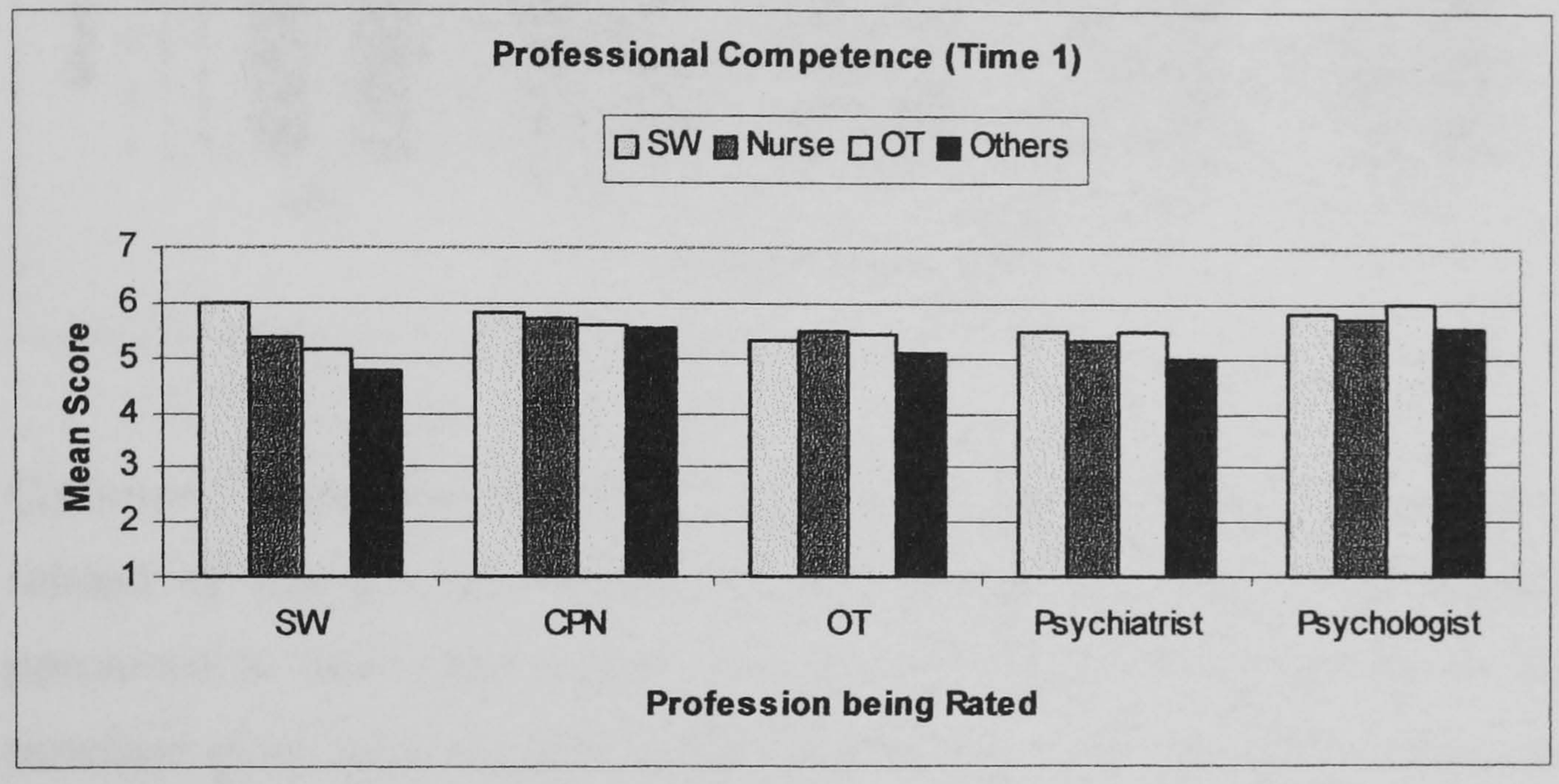
At the end of the programme, social workers had reduced their rating of themselves to 5.6 and scores were generally similar to all professions with social workers and nurses scoring slightly higher than psychiatrists and psychologists (Figure 6-21). There were no significant differences between the professions in their ratings or their change in scores over time.

Figure 6-21: Mean Ratings of Breadth of Life Experience by Profession at Time 2



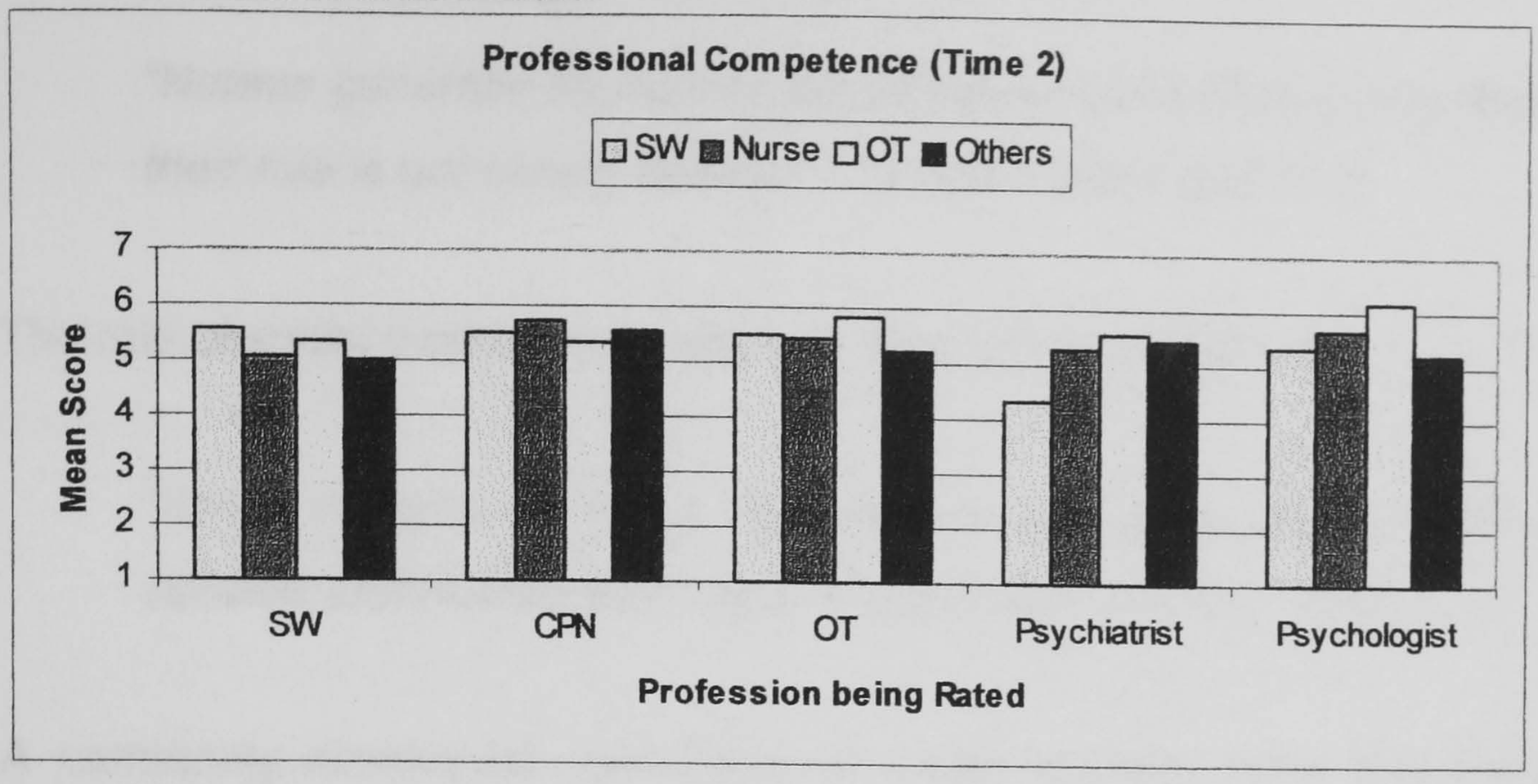
At the start of the programme there was no one profession that was considered to be more ***professionally competent*** than the others (Figure 6-22). All scores fell between the range of five and six, with the exception of the rating of social workers by "Others" (mean 4.8).

Figure 6-22: Mean Ratings of Professional Competence by Profession at Time 1



At the end of the programme most scores remained in the range of five and six with only two exceptions (Figure 6-23). Social workers reduced their rating of psychiatrists to 4.3 from 5.5 at the start of the programme. On the other hand, they increased their ratings of psychologists from 6 at the start of the programme, to 6.2 at the end. None of the changes over time or differences between professions were statistically significant.

Figure 6-23: Mean Ratings of Professional Competence by Profession at Time 1



Comment: There was evidence of agreement between the professions in their ratings of the six attributes. Thus, psychiatrists and psychologists were perceived to have high academic rigour and leadership skills but low levels of practical skills and breadth of life experience. Social workers were seen as having fairly high breadth of life experience and interpersonal skills but low leadership qualities. Nurses were seen as possessing good interpersonal skills and practical skills but only moderate academic rigour. Finally, OTs were seen as having high levels of practical skills but very low levels of leadership skills. Stereotypes of the professions did not change over time.

Interviews

Evidence from the semi-structured revealed that stereotypes of the mental health professions were firmly held. Additionally, whilst strong stereotypes were held there was also uncertainty about what the professions roles actually involved. Nurses were seen by the other students to still be dominated by a medical perspective on mental illness:

> *"Nurses are primarily dominated by the medical model. No matter how they try to dress it up it comes out in their language and the value judgements they use to describe service users and families. It is almost always negative." (OT)*

Others were still not clear about the role of nurses.

> *"Nurses generally try hard to be perceived as not just giving depo's but their role is not clearly defined." (Social worker Co2 Yr2)*

The role of social workers was also not clear to some students:

> *"Social workers are okay, they have a good grasp that is more person centred and holistic but I could not list what they do." (OT)*

A commonly mentioned stereotype of social workers were that they were "politically correct", or at least they spoke as if they were:

> *"I thought social workers were up there-they speak the right language." (Nurse Co4 Yr1)*

One OT commented on the limited perception that other professions had of occupational therapists. It was felt that social workers might do this less so.

> *"There is a tendency for other professions, especially nurses to be minimalist in their view of OTs. Social workers do this less so as they are trained more holistically and less in terms of the medical model." (OT)*

One of the commonly mentioned stereotypes of OTs was that they were "basket weavers". One OT explained this:

> *"At the course someone always says something about baskets and it always gets a laugh. It becomes increasingly irritating. The traditional stereotypes are still there for OT." (OT)*

Psychiatrists were seen to take a limited view of mental health problems and show a disregard for therapy.

"Psychiatrists are almost the same as nurses in the medical model. They are trained to think that medicine is the solution to everyone's problems. There is no learning about therapy, they see it as an add on." (OT)

Psychologists were seen as being aloof, which could have reflected their absence from the student group in two of the three cohorts studied.

"I have a block with psychology, they keep within their professional boundaries and come across as elite. Psychology see themselves as too important." (Nurse Co1 Yr3)

Psychologists were also seen to have choice over the cases they accepted, unlike nurses:

"I see psychology as getting the nice bits and nurses pick up everything else." (Nurse Co2 Yr2)

Reports of attitude in relation to other professions varied on the programme. Some students reported that yes, their view of other professions had altered since attending the programme:

"I have changed my attitudes towards most professionals, especially OTs. I used to look at them as a bonus not realising their skills." (Nurse Co4 Yr1)

"From the course I became a lot clearer about what other professions' strengths and weaknesses were. I was also more aware of things they could do really well that I knew I could not. But I am not sure it happened the other way round." (Social worker Co2 Y2)

However, others felt that their views had not changed.

> *"My views have not changed, but then I don't think I was particularly closed minded before." (OT)*

> *"The course has not really changed my views. I feel that I worked well with other professionals anyway." (Nurse Co3 Yr2)*

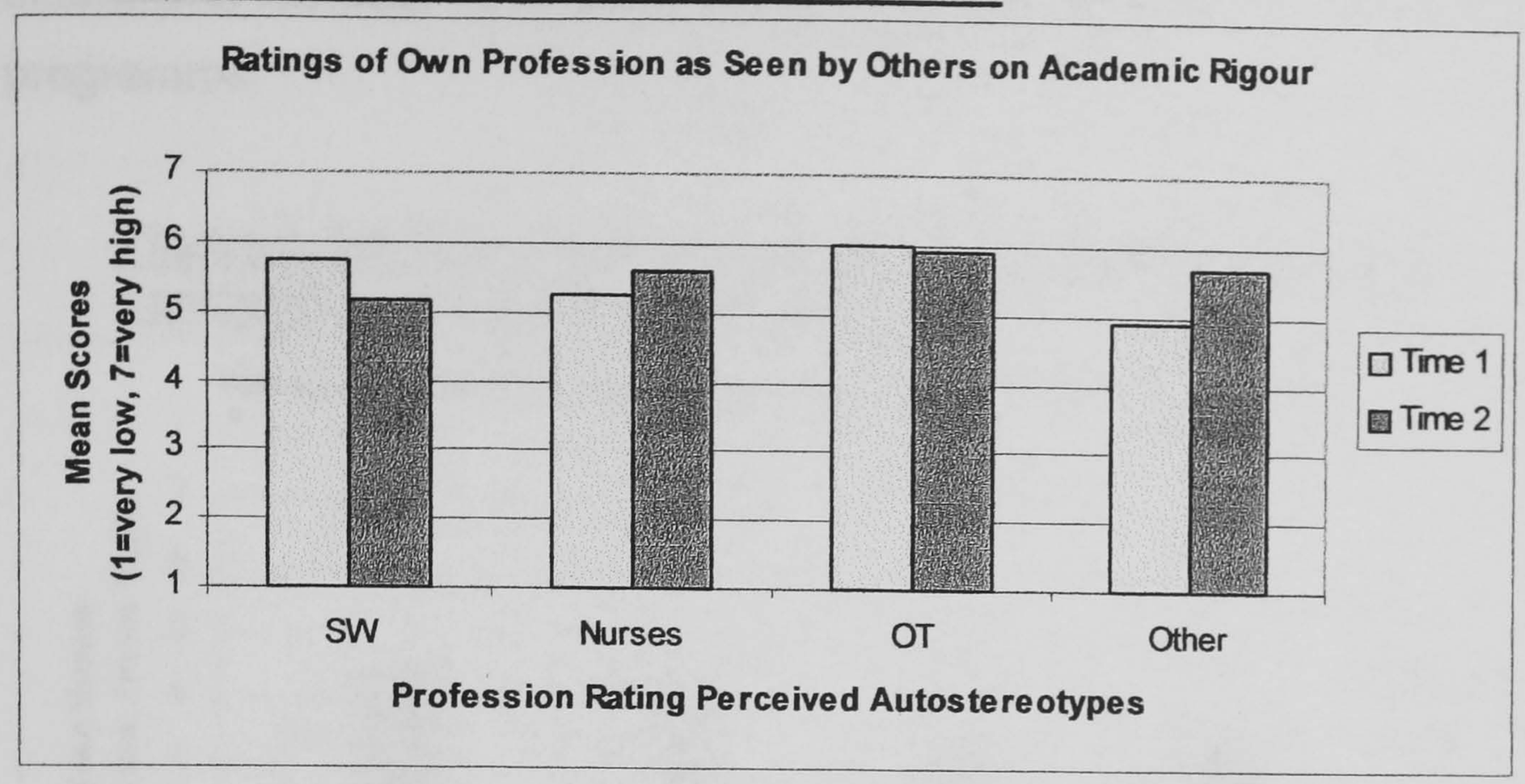
One student reported that the programme had changed his view of other professions but he would have liked to learn more about the role and culture of other professions.

> *I think that the course has changed my views of other professionals but not enough. I would like to have greater understanding of the theoretical base of other professionals. A lot of the course theories are social inclusion rather than health based. I see that as a core value of social work but I don't know where it has come from." (Nurse Co4 Yr1)*

Perceived Autostereotypes

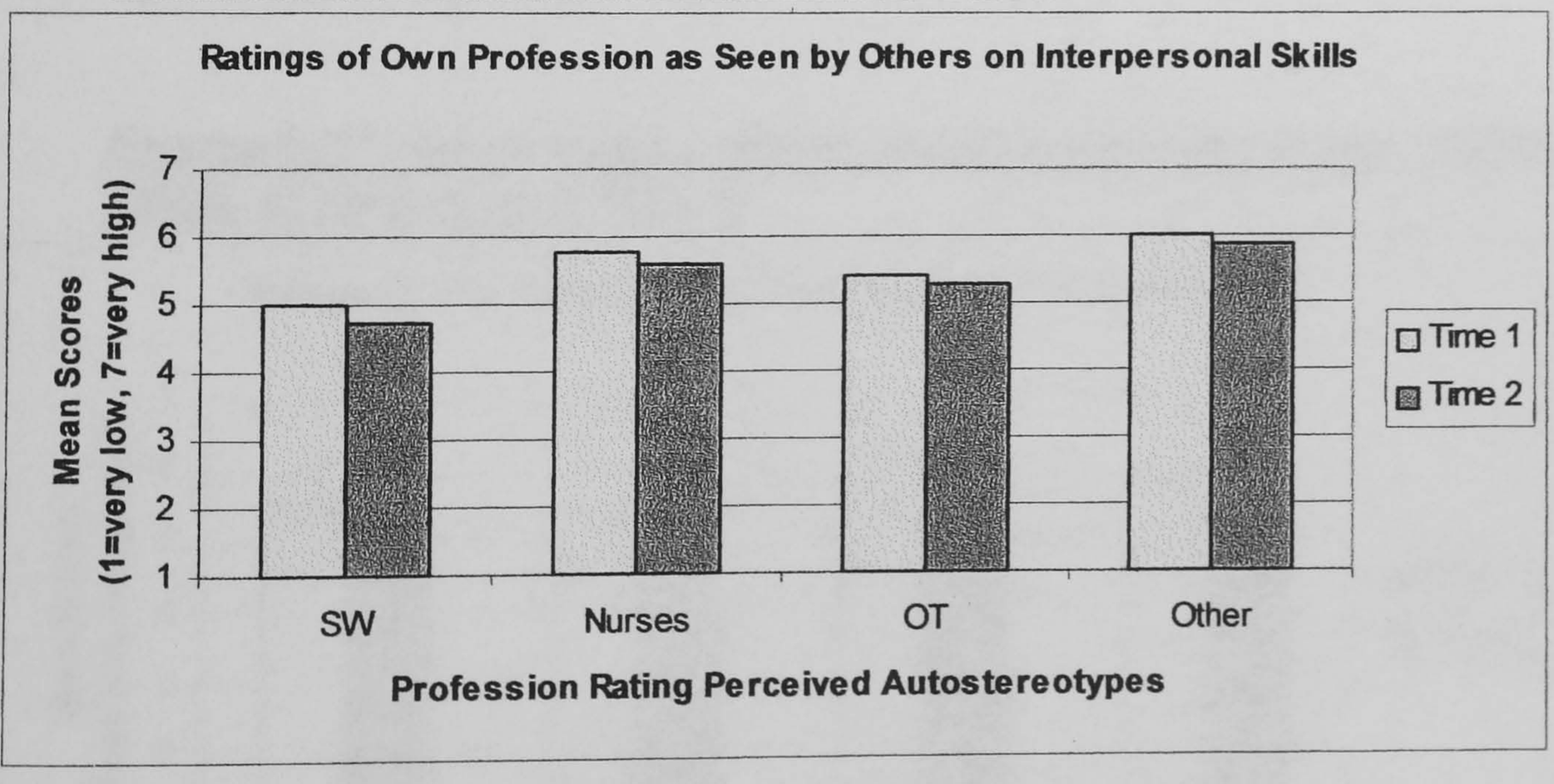
Perceived autostereotypes refer to the students rating of their own profession as they believe it is seen by others. Social workers, nurses and OTs perceived that their respective professions were considered quite highly by other mental health professions for ***academic rigour***, at the start of the programme (Figure 6-24). The professional groups varied in their change in scores at the end of the programme. Social workers apparently believed that other professionals rated them less highly at the end of the course. However, nurses and "Others" believed that other professionals' perceptions of their academic abilities had improved.

Figure 6-24: Mean Rating of Perceived Autostereotypes of Academic Rigour at Time 1 and Time 2



At the start of the programme, all the professional groups considered that their own profession was considered to rate between 5 and 6, on the 7-point scale for ***interpersonal skills*** (Figure 6-25). Thus, all professions considered that their fellow students thought they had a high level of interpersonal skills. They were marginally less confident at he end of the programme, with perceived ratings showing a marginal but non-significant decrease.

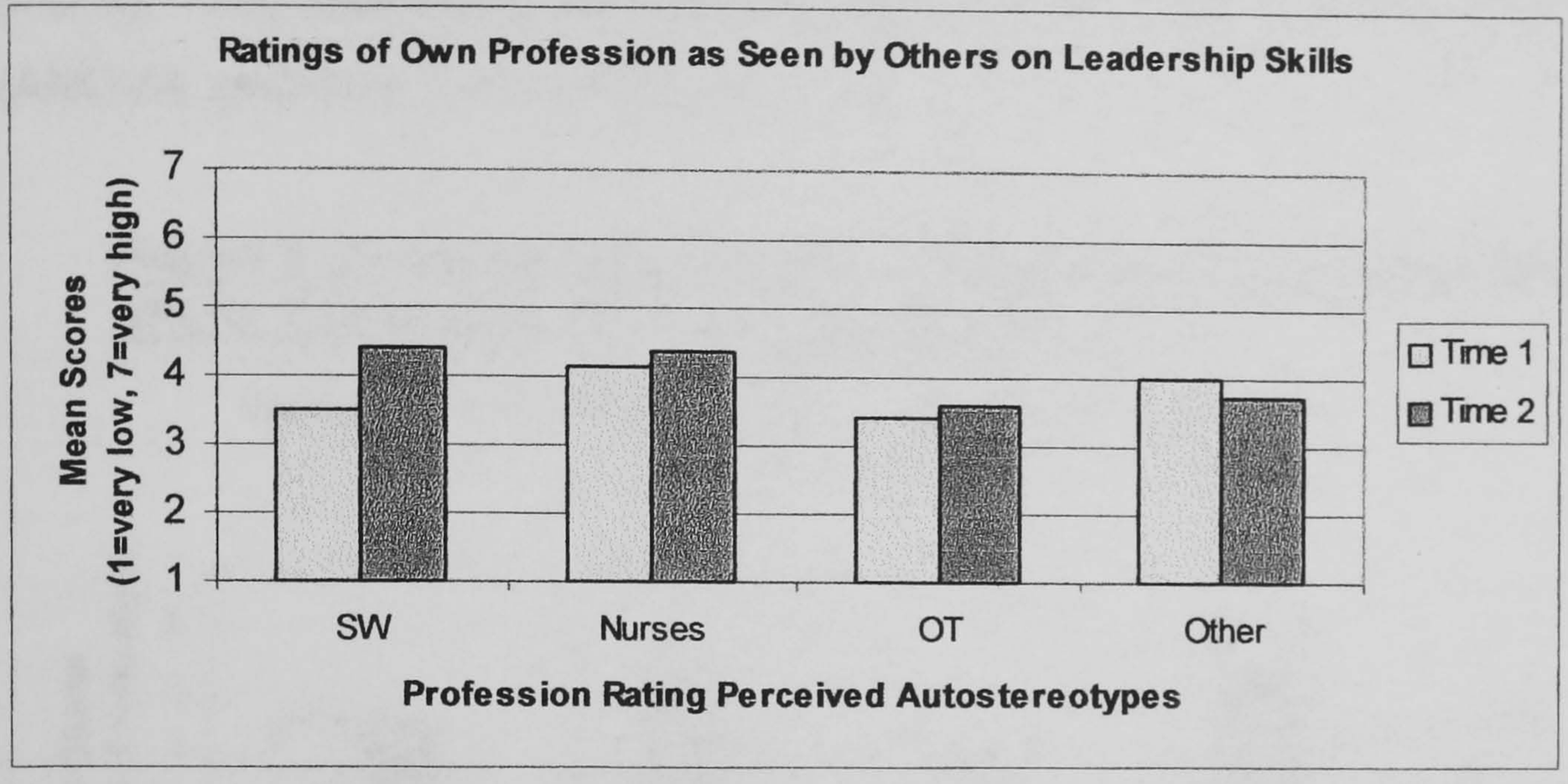
Figure 6-25: Mean Rating of Perceived Autostereotypes of Interpersonal Skills at Time 1 and Time 2



There was agreement between the four groups rating that their profession were seen as having poor ***leadership skills*** (Figure 6-26). However, social workers, nurses and OTs all believed that they were seen in a marginally

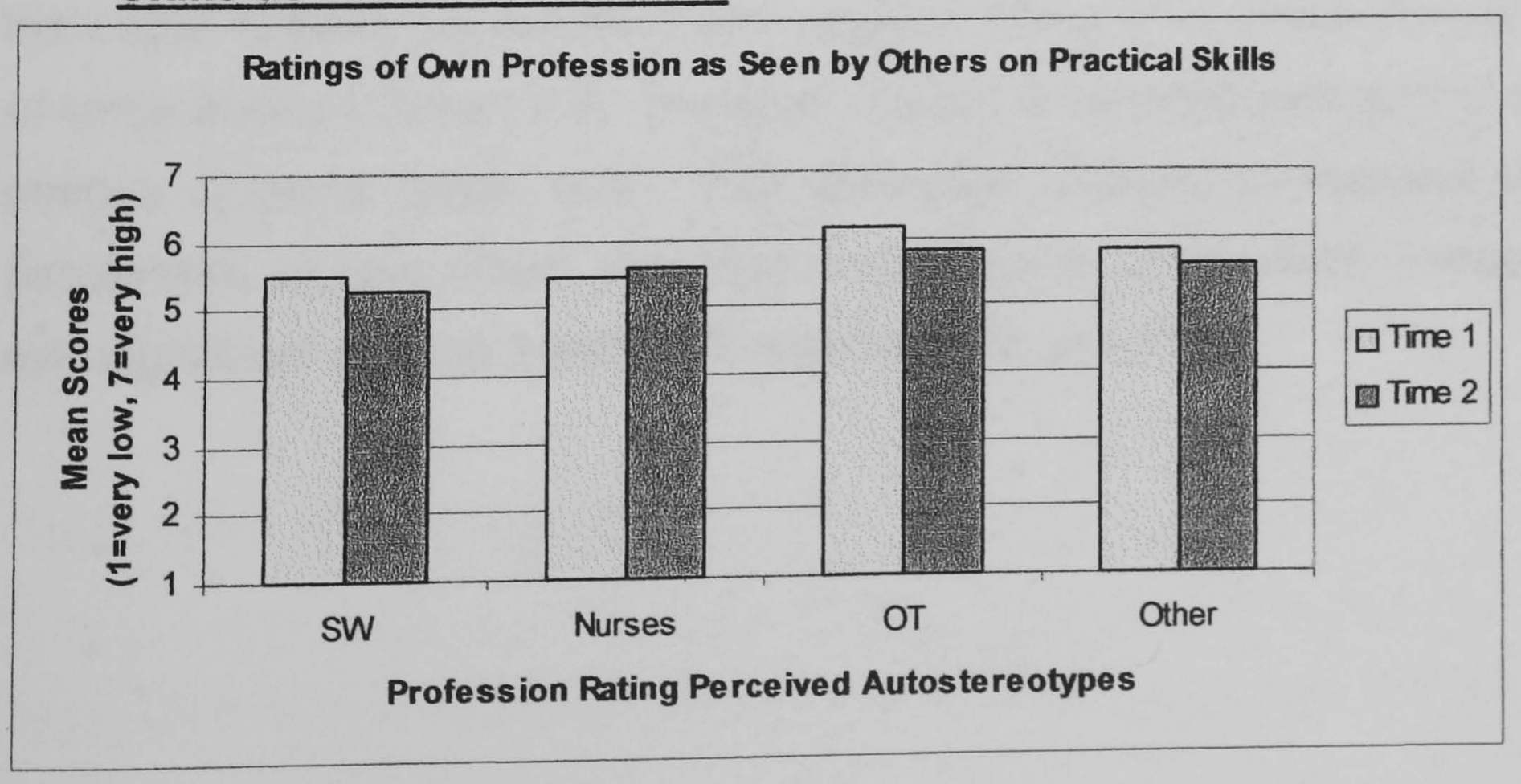
more positive light at the end of the programme. There were no significant differences between the professions at either the start or the end of the programme.

Figure 6-26: Mean Rating of Perceived Autostereotypes of Leadership at Time 1 and Time 2



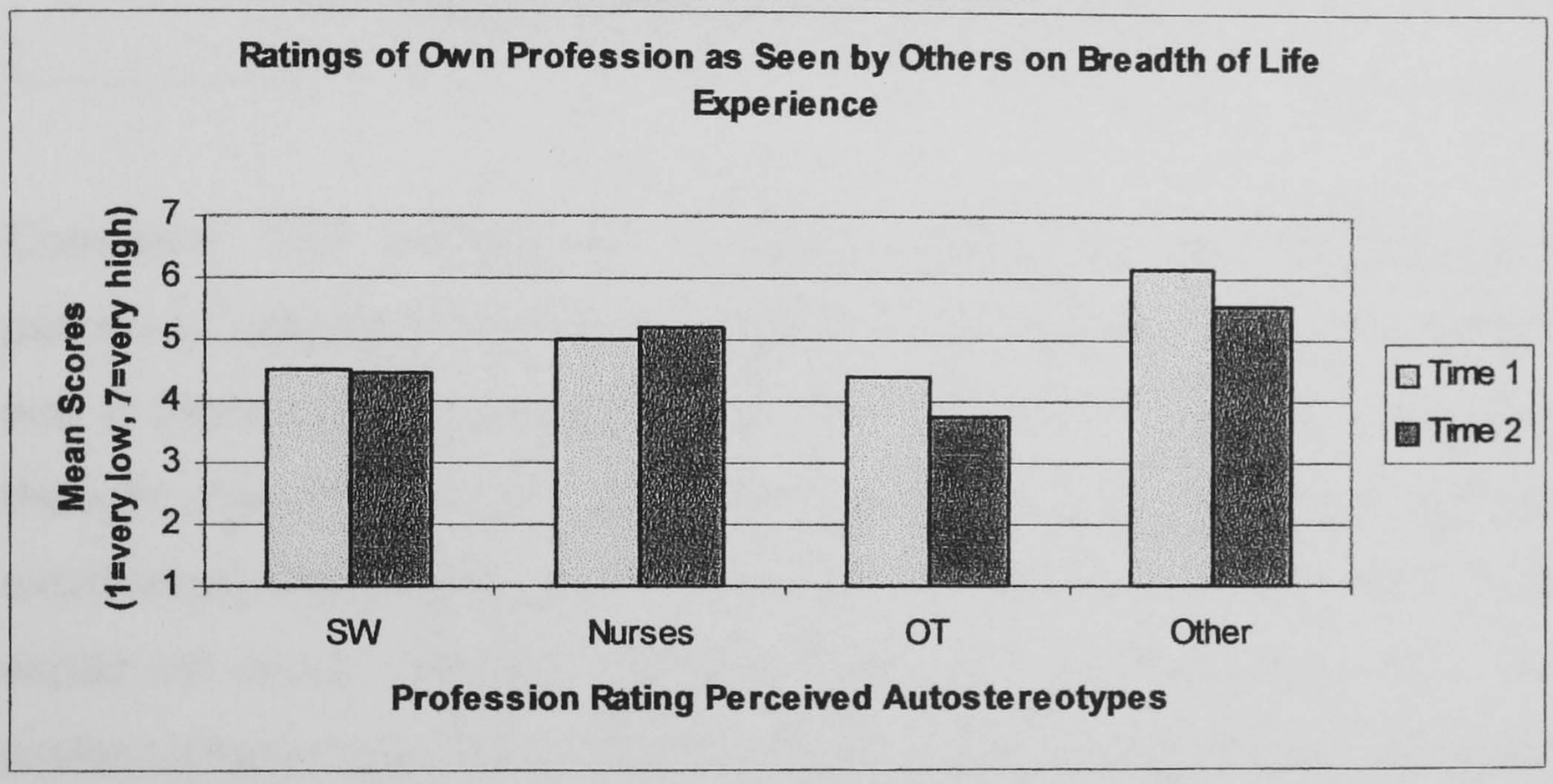
Occupational therapists considered that they would be seen as very high on ***practical skills*** by other mental health professionals (Figure 6-27). Social workers, nurses and "Others" also perceived that their profession was viewed highly in relation to practical skills. There were no significant changes over time.

Figure 6-27: Mean Rating of Perceived Autostereotypes of Practical Skills at Time 1 and Time 2



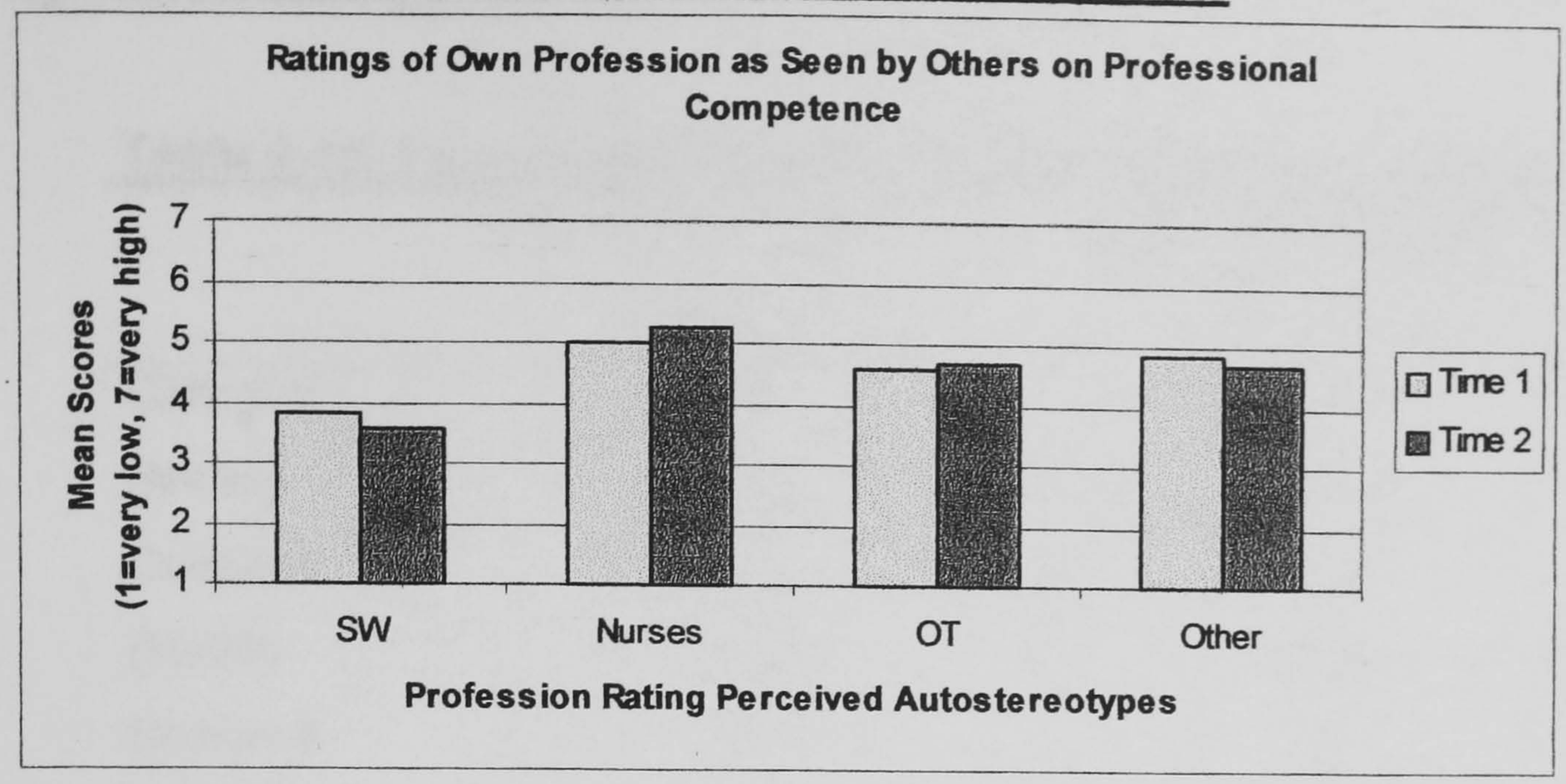
The professions differed significantly in their perception that "Others" saw them in relation to ***breadth of life experience*** (ANOVA, p=0.015, K-W, p=0.016) (Figure 6-28). "Others" expected that they would be rated highly on this (above 6). Whilst nurses, social workers and occupational therapists thought they would be seen as moderately high on this attribute (between 4 and 5). The difference between professions was also significant at Time 2 (ANOVA, p=0.001, K-W, p=0.004).

Figure 6-28: Mean Rating of Perceived Autostereotypes of Breadth of Life Experience at Time 1 and Time 2



Social workers believed that they would be seen as fairly low on ***professional competence*** (mean 3.8) whilst nurses thought that other professionals would rate them quite highly (mean 5) (Figure 6-29). At the end of the programme the social workers' were even more negative about other professionals views of social workers (mean 3.6). However, nurses were more confident of others' positive opinions (mean 5.3). This difference between professions in their perceptions of how others saw them in relation to professional competence was significant at Time 2 (ANOVA, p=0.01, K-W, p=0.02).

Figure 6-29: Mean Rating of Perceived Autostereotypes of Professional Competence at Time 1 and Time 2



Comment: The professions differed significantly on their ratings of two perceived autostereotypes – breadth of life experience (at Time 1 and Time 2) and professional competence (at Time 1). The "Others" on the programme thought that they would have been seen as having greater breadth of life experience than social workers, nurses and OTs considered their professions would be rated. Nurses believed that they would be seen as much more professionally competent, especially compared to social workers who thought their professions would be seen as having relatively low professional competence. None of the perceived autostereotypes changed significantly over time, indicating that perceived autostereotypes were stable.

6.3.5. Professional Identity.

This next section concerns identity and assesses the effect the programme had on professional and team identity. These scales were both highly consistent (alphas from 0.87 to 0.95).

Differences by cohort and overall

Course participants identified quite strongly with their own profession at the start of the programme (Table 6-16). Scores remained high at the end of the

programme, although students in Cohort 2 and the students overall showed a significant reduction.

Table 6-16: Professional identity scores by cohort and overall

	Professional Identity T1 Mean (SD)	Professional Identity T2 Mean (SD)
Cohort 2[1] (N=34)	3.99 (0.49)	3.84 (0.48)
Cohort 3 (N=20)	4.02 (0.55)	3.91 (0.65)
Cohort 4 (N=25)	3.83 (0.48)	3.81 (0.36)
All[2] (N=79)	3.94 (0.5)	3.85 (0.49)

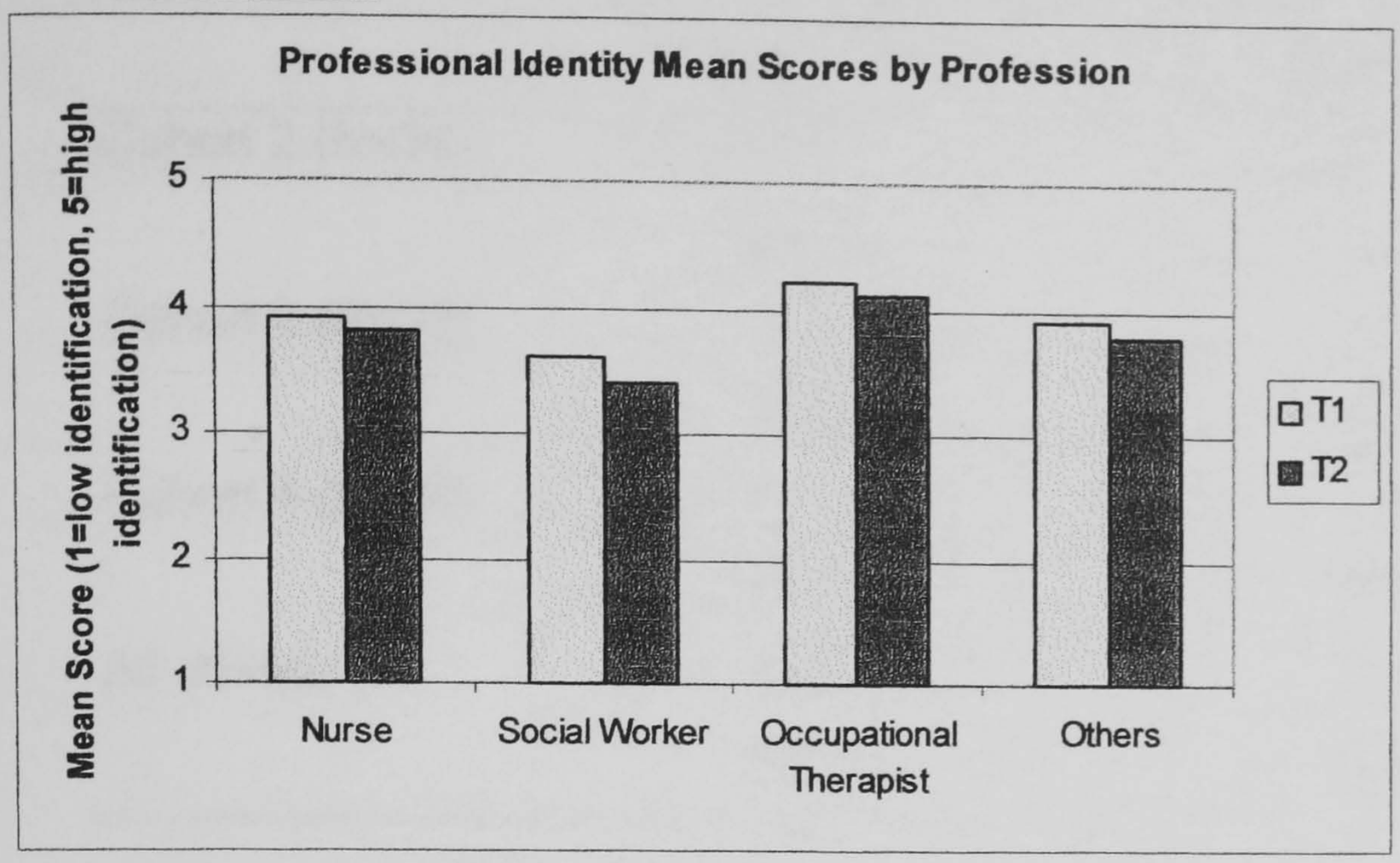
[1] cohort 2 (Paired *t*-test, p=0.01, Wilcoxon, p=0.014)

[2] overall (Paired *t*-test, p=0.02, Wilcoxon, p=0.02)

Differences between professions

At the start of the programme all professions showed quite high levels of identification with their profession (Figure 6-30). There were no statistically significant differences between the professions. At the end of the programme, OTs continued to show the highest level of identification to their profession (mean 4.11) and social workers continued to show the lowest (mean 3.4). This time the difference between the professional groups was significant (ANOVA, p=0.021, K-W, p=0.032). Although ratings of professional identification decreased for each of the professional groups over time this difference was not significant.

Figure 6-30: Mean Ratings of Professional Identity Over Time by Profession



6.3.6. Team Identity

Differences between cohort and overall

Participants identified more strongly with their teams than they did their profession. This was statistically significant at Time 1 (Paired t-test, p=0.001, Wilcoxon, p=0.000) and Time 2 (Paired t-test, p=0.007, Wilcoxon, 0.003). While team identification did not change significantly across time for any of the cohorts taken individually, there was a non-significant decrease from the beginning to the end of the programme for all cohorts taken together (Table 6-17).

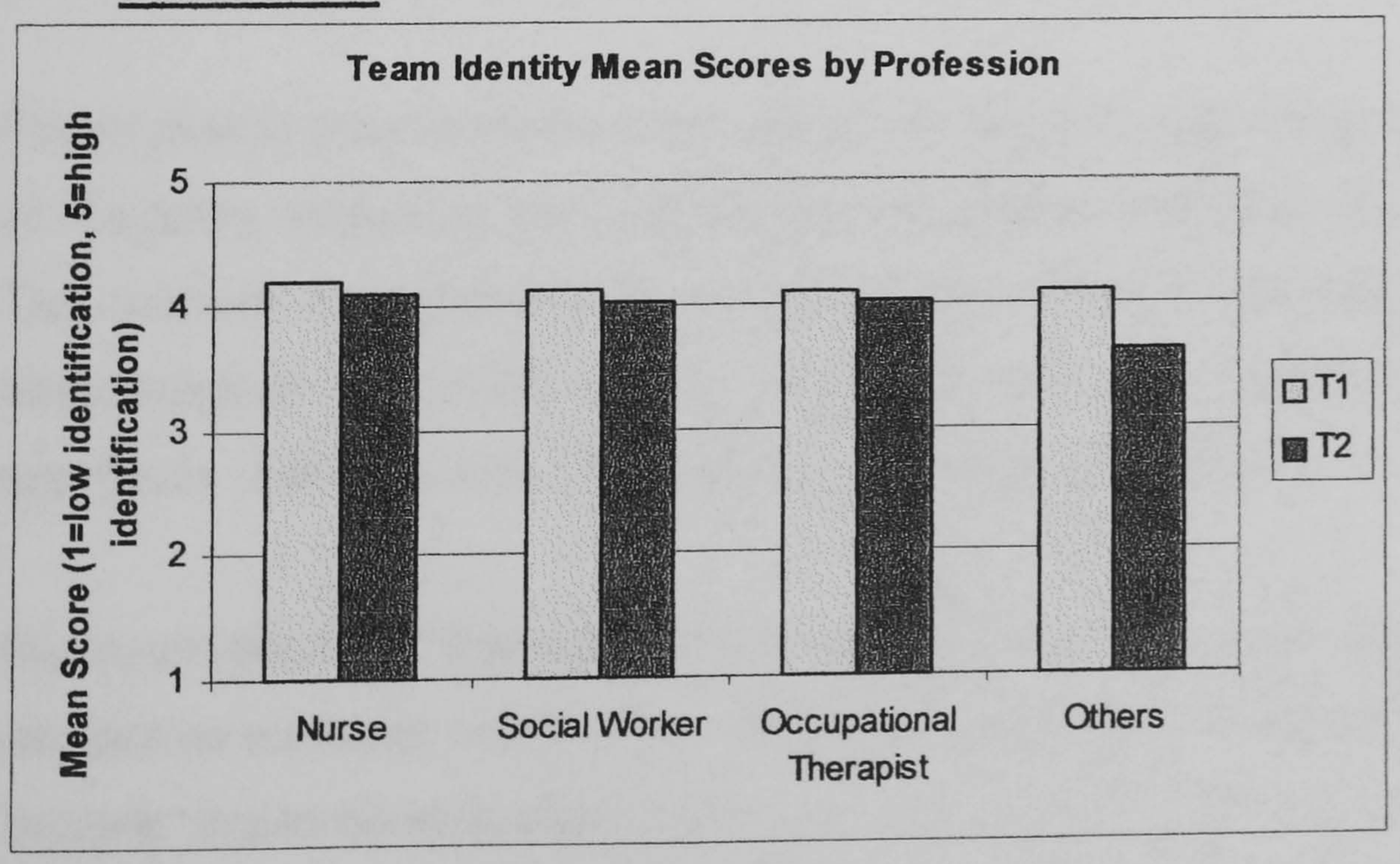
Table 6-17: Team identity mean scores by cohort and overall

	Team Identity T1 Mean (SD)	Team Identity T2 Mean (SD)
Cohort 2 (N=34)	4.25 (0.48)	4.13 (0.5)
Cohort 3 (N=20)	4.17 (0.64)	3.91 (0.82)
Cohort 4 (N=26)	4.02 (0.6)	3.96 (0.68)
All (N=80)	4.16 (0.57)	4.02 (0.65)

Differences between professions

All professional groups scored highly on team identification and all mean scores were above 4 at the start of the programme (Figure 6-31). Nurses showed the highest levels of identification with their team (mean 4.19) and OTs and "Others" showed the lowest levels (mean 4.09). The variation between professional groups in their levels of team identification was not significant.

Figure 6-31: Mean ratings of Team Identity scores over Time by Profession



Nurses continued to show the highest levels of team identification at the end of the first year of the course. "Others" felt the lowest level of identification with their teams rating an average of 3.61. The difference between professional groups was not significant at the end of the programme.

All professional groups showed a decrease in their levels of identification with their teams from the start to the end of the programme. "Others" showed the biggest decrease with average scores falling from 4.09 to 3.61. This reduction in scores by professions over time was not significant, suggesting that team identity is stable.

6.4. Psychosocial Interventions

The following section will address the second research question:

> "How do students learn about and implement psychosocial interventions in their work with people with severe and enduring mental health problems?"

This research question will be answered with data from the quantitative questionnaires (the Implementation Scale and the Barriers to Implementation Scale), group and individual interviews and participant observation.

Psychosocial interventions were taught to the first year students in a number of modules, including the module "Psychological Interventions in Psychosis". The module concentrated on teaching the students the basic principles of psychological interventions in psychosis, from a cognitive behavioural approach. I observed teaching in this module with Cohort 2.

My observations of this module revealed that didactic presentations and some interactive methods were used. Students were shown video presentations of 'experts' implementing techniques and they then put the techniques into action by working with another course member in role-play. The experience of this was then discussed within the larger year group. The information presented in

the module was based upon published research studies in the field of psychological interventions, especially cognitive behavioural therapy (CBT). It was presented as very specialised and technical, with details of research methodology and statistical analyses. In this way propositional knowledge (Eraut, 1992) was the main type of knowledge used. Process knowledge was also used where the students learnt 'how to do' psychological interventions such as monitoring a users' symptoms and developing a relapse plan, involving users, carers and other professionals. A high status member of a high status profession - a professor of psychology-presented the module.

From my observations, the students appeared to respond positively to this module. During the teaching students listened attentively, there was no chattering with fellow students, as I had observed on other occasions, attendances were high and students would ask questions during presentations. Additionally, discussions during coffee and lunch breaks revealed that the students, as a whole, were enjoying the module and considered it valuable. Further evidence for this came from the semi-structured interviews with students from all disciplines.

"I enjoyed the skills stuff the best." (Nurse Co2 Yr1)

"I really liked the CBT stuff." (OT)

"I enjoyed the skills-based stuff. Lots of the students preferred the skills-based stuff." (Nurse Co1 Yr3)

Not only was the skills element of the programme seen as enjoyable it was also seen as significant.

"CBT was seen as important by the other students" (Nurse Co1 Yr3)

Whilst the skills-based teaching was enjoyed by most of the students, and seen as important, some students reported difficulties with it. Many felt that

there was too much information to absorb, that it was pitched at too high a level and it was not given enough time to cover all aspects in sufficient detail.

> *"I would like to see modules stretched out. For example, CBT spread over a longer time." (Nurse Co2 Yr3)*

A student expanded on how the content of the psychosocial interventions sessions made her feel.

> *"I felt vaguely dazed by CBT." (OT)*

> *"CBT was too deep. I found it very difficult and there was too much use of figures." (Nurse Co2 Yr3)*

> *"CBT is good but you needed to know some knowledge of it before coming on the course. There is a lot of responsibility on yourself to learn" (Nurse Co3 Yr1)*

There was also some concern about the teaching methods, e.g.:

> *"CBT was good but there was too much lecturing, it was all in a samey style." (Nurse Co2 Yr2)*

and a suggestion that a more practical approach was required:

> *"In many sessions you are talked at. In CBT you need much more practice." (Nurse Co2 Yr2)*

6.4.1. Change in Behaviour: Implementing PSIs

Changes in the use of a number of psychosocial interventions were measured using the Implementation Scale. There were no significant differences between the cohorts in their use of any of the ten interventions at the start or at the end of the programme. Considering changes over time students in

Cohort 2 significantly increased their use of Optimising Medication (Table 6-18). Cohort 3 reported a significant increase in their use of Family/ Carer Interventions and there was a significant decrease in their use of Meeting Social, Recreational and Spiritual Needs from the start to the end of the programme. Cohort 4 demonstrated a significant increase in their use of CBT. Overall, two of the ten interventions showed significant increases in reported use between the start and the end of the programme: these were CBT and Family/ Carer Intervention.

Table 6-18: Implementation of Psychosocial Interventions by Students on Successive Cohorts (Implementation Scale)

(Range 1=never, 2=rarely, 3=sometimes, 4=frequently, 5=extensively)

	Co2 (N=34) Mean (SD)		Co3 (N=18) Mean (SD)		Co4 (N=24) Mean (SD)		All (N=75) Mean (SD)	
	Time 1	Time 2	Time 1	Time 2	Time 1	Time 2	Time 1	Time 2
Assessment and care planning	4.09 (0.88)	4 (0.97)	4.11 (1.13)	4.28 (0.89)	4.04 (0.75)	4.13 (0.9)	4.08 (0.9)	4.11 (0.92)
Care co-ordination	4.09 (0.67)	4.21 (0.91)	4.28 (0.67)	4.28 (0.83)	4.04 (0.69)	4.13 (0.74)	4.12 (0.67)	4.2 (0.83)
Advice giving	3.91 (0.79)	4.09 (0.87)	3.84 (1.01)	4 (1.05)	3.92 (0.78)	4.25 (0.9)	3.9 (0.84)	4.12 (0.92)
Optimising medication	3.24 (1.58)	3.68[1] (1.17)	3.61 (1.33)	3.5 (1.34)	3.65 (1.15)	3.83 (1.03)	3.45 (1.4)	3.68 (1.16)
Psychotherapy and counselling	3.36 (1.17)	3.48 (1.03)	3.28 (1.07)	3.17 (1.15)	3.29 (1.04)	3.38 (1.21)	3.32 (1.09)	3.37 (1.11)
CBT	3.03 (0.97)	3.03 (0.97)	2.79 (1.23)	3.32 (1.11)	2.54 (1.1)	3.17[4] (0.7)	2.82 (1.08)	3.14[5] (0.93)
Family/ Carer intervention	2.68 (1.27)	2.65 (1.18)	2.39 (1.04)	3[2] (1.24)	2.5 (1.14)	2.88 (0.85)	2.55 (1.17)	2.8[6] (1.1)
Group Therapy	2.29 (1.36)	2.15 (1.35)	2.22 (1.35)	1.94 (1.06)	1.88 (1.03)	2 (1.02)	2.14 (1.26)	2.05 (1.18)
Occupation, education or training	2.79 (1.23)	2.88 (1.3)	3.61 (0.98)	3.83 (0.92)	2.79 (1.22)	3.08 (1.02)	2.99 (1.21)	3.17 (1.18)
Meeting social, recreational or spiritual	3.76 (0.89)	3.71 (0.8)	4.17 (0.99)	3.72[3] (1.13)	3.46 (0.98)	3.67 (0.96)	3.76 (0.96)	3.7 (0.92)

[1] Optimising medication (Paired t-test=P=0.034, Wilcoxon, P=0.025)

[2] Family/ Carer intervention (Paired t-test, P=0.021, Wilcoxon, P=0.032)

[3] Meeting social, recreational and spiritual needs (Paired t-test, P=0.016, Wilcoxon, P=0.021)

[4] CBT (Paired t-test, P=0.004, Wilcoxon, P=0.007)

[5] CBT (Paired t-test, P=0.015, Wilcoxon, P=0.011)

[6] Family/ Carer intervention (Paired t-test, P=0.038, Wilcoxon, P=0.033)

At the start of the programme, there were significant differences between the professions in their use of four interventions (Table 6-19). These included Optimising Medication, which was used most by nurses and least by social workers. Group Therapy and Providing Occupation, Education or Training were both used most by OTs and least by social workers. Finally, Meeting Social, Recreational or Spiritual Needs was most commonly reported by OTs and social workers and least often reported by nurses.

Nurses reported using the following interventions most frequently during the three months prior to the start of the course; Optimising Medication, Assessment and Care Planning and Care-Co-ordination. Social workers also reported frequent use of Assessment and Care Planning and Care Co-ordination as well as Advice Giving and Meeting Social, Recreational or Spiritual needs. Occupational therapists' most commonly used interventions before the course were Providing Occupation, Education or Training, Meeting Social, Recreational or Spiritual needs and Assessment and Care Planning. Students in the "Others" category only reported using two of the interventions frequently, these were Advice Giving and Meeting Social, Recreational or Spiritual needs

Table 6-19: Implementation of Psychosocial Interventions by Students in Professional Groups at Time 1 (Implementation Scale)
(Range 1=never, 2=rarely, 3=sometimes, 4=frequently, 5=extensively)

	Nurse (N=50) Mean (SD)	SW (N=6) Mean (SD)	OT (N=12) Mean (SD)	Others (N=8) Mean (SD)
Assessment and care planning	4.18 (0.72)	4.5 (0.55)	4.08 (0.9)	3.13 (1.46)
Care co-ordination	4.18 (0.65)	4.33 (0.52)	3.83 (0.83)	3.63 (1.19)
Advice giving	3.88 (0.86)	4.33 (0.52)	3.5 (0.8)	4.25 (0.71)
Optimising medication [1]	4.2 (0.8)	1.17 (0.41)	2.17 (1.11)	2.13 (1.25)
Psychotherapy and counselling	3.49 (0.9)	2.5 (1.38)	3.25 (1.22)	2.75 (1.49)
CBT	2.82 (1.03)	2.33 (1.03)	3.42 (1.08)	2.25 (1.16)
Family/ Carer intervention	2.67 (1.11)	2.83 (1.6)	1.83 (0.83)	2.5 (1.51)
Group Therapy[2]	1.88 (1.05)	1.33 (0.82)	3.33 (1.37)	2.5 (1.51)
Occupation, education or training[3]	2.8 (1.08)	2 (0.89)	4.33 (0.65)	2.63 (1.51)
Meeting social, recreational or spiritual[4]	3.55 (0.92)	4.33 (1.03)	4.33 (0.65)	4 (1.2)

[1] Optimising medication (ANOVA, p=0.000, K-W, p=0.016),
[2] Group therapy (ANOVA, p=0.000, K-W, p=0.003),
[3] Providing occupation, education or training (ANOVA, p=0.000, K-W, p=0.000)
[4] Meeting social, recreational or spiritual needs (ANOVA, p=0.024, K-W, p=0.024)

At the end of the programme, there were significant differences between the professions on seven of the ten interventions (Table 6-20). Assessment and Care Planning was most frequently reported by social workers and least often utilised by "Others". Social workers reported extensive use of Advice Giving and the variation between the professional groups was highly significant. Nurses remained the profession with the highest use of Optimising Medication at the end of the programme. OTs, social workers and "Others" all reported an increase in Optimising Medication but mean scores remained at or below 3 indicating they only used this intervention "sometimes". This variation between nurses and the other professional groups was highly significant. The professions also differed significantly in their use of Family and Carer Interventions at the end of the programme. Social workers reported using this the most and OTs reported using it the least, rating that they used it "rarely". Group Therapy was used most often by occupational therapists and least often by social workers. OTs also provided the most Occupation, Education and Training and social workers the least. Finally, there was a statistically significant difference between the professions in their reports of Meeting Social, Recreational and Spiritual Needs. Social workers reported the most frequent use of that intervention and nurses the least.

Table 6-20: Implementation of Psychosocial Interventions by Students in Professional Groups at Time 2 (Implementation Scale)

	Nurse Mean (SD)	SW Mean (SD)	OT Mean (SD)	Others Mean (SD)
Assessment and care planning [1]	4.2 (0.83)	4.86 (0.38)	3.75 (0.97)	3.5 (1.31)
Care co-ordination	4.25 (0.76)	4.71 (0.49)	3.67 (1.15)	4.14 (0.69)
Advice giving [2]	4.04 (0.93)	5 (0)	3.58 (0.9)	4.63 (0.52)
Optimising medication [3]	4.2 (0.8)	2.86 (1.07)	2.33 (0.89)	3 (1.29)
Psychotherapy and counselling	3.51 (0.99)	2.86 (1.07)	3.33 (1.23)	2.86 (1.57)
CBT	3.21 (0.87)	3 (1)	2.83 (1.03)	3.13 (1.13)
Family/ Carer intervention [4]	2.98 (1.02)	3.29 (1.5)	2 (0.95)	2.71 (1.11)
Group Therapy [5]	1.92 (1.12)	1.57 (1.13)	2.58 (1.44)	3 (0.58)
Occupation, education or training [6]	3 (1.12)	2.71 (1.7)	3.92 (0.79)	3.57 (0.98)
Meeting social, recreational or spiritual [7]	3.44 (0.92)	4.29 (0.49)	4.08 (0.79)	4.29 (0.76)

[1] Assessment and care planning (ANOVA, p=0.014, K-W, p=0.016).

[2] Advice giving (ANOVA, p=0.003, K-W, p=0.002)

[3] Optimising medication (ANOVA, p<0.000, K-W, p<0.000)

[4] Family and carer interventions (ANOVA, p=0.027, K-W, p=0.035)

[5] Group therapy (ANOVA, p=0.032, K-W, p=0.024)

[6] Occupation, education and training (ANOVA, p=0.044, K-W, p=0.034)

[7] Meeting social, recreational and spiritual needs (ANOVA, p=0.006, K-W, p=0.006)

6.4.2. Barriers to the Implementation of Psychosocial Interventions

In order to assess the extent and source of difficulties in using the psychosocial interventions taught on the course in their work setting, the Barriers to Implementation Scale was used. All subscales of this measure were reliable (alphas for Time and Resources, 0.77-0.91, Support and Interest, 0.83-0.89, Belief in Psychosocial Interventions, 0.87-0.97, Knowledge, Skills and Supervision, 0.81-0.92, User and Carer Beliefs 0.88-0.91).

Differences between cohorts and overall

The Barriers to Implementation Scale revealed that there were no significant differences between the cohorts at the start or the end of the programme (Table 6-21). However, Time and Resources did increase significantly for Cohort 4 and Knowledge, Skills and Supervision increased significantly for Cohort 3, from the start to the end of the programme. Three of the five subsections reduced significantly for Cohort 2. Ratings over time fell for Support and Interest, Knowledge, Skills and Supervision and User and Carer Beliefs. None of the subsections changed significantly over time for the students as a combined group.

Table 6-21: Perceived Barriers to Implementation Mean Scores (SD) by Cohort and Overall

	Time and Resources		Support and interest		Belief in Psychosocial interventions		Knowledge, supervision and skills		User and carer beliefs	
	Time 1	Time 2	Time 1	Time 2	Time 1	Time 2	Time 1	Time 2	Time 1	Time 2
Co2	2.36 (0.92)	2.26 (0.9)	0.98 (0.72)	0.66[1] (0.66)	0.41 (0.46)	0.38 (0.49)	1.46 (1)	1.1[2] (0.75)	1.46 (0.86)	1[3] (0.93)
Co3	1.79 (1.21)	2.16 (0.9)	0.79 (0.66)	1.09 (1)	0.52 (1.1)	0.83 (1.06)	1.14 (0.85)	1.88[4] (1.23)	1.14 (0.99)	1.41 (1.11)
Co4	2.43 (1)	2.85[5] (0.78)	1.27 (1.27)	1.19 (1.1)	0.81 (0.98)	0.9 (0.9)	1.8 (1)	1.91 (1.06)	1.38 (0.89)	1.41 (0.78)
All	2.24 (1.05)	2.43 (0.9)	1.03 (0.94)	0.94 (0.93)	0.57 (0.85)	0.66 (0.83)	1.49 (1)	1.56 (1.06)	1.36 (0.9)	1.24 (0.94)

[1] Support and Interest (Paired t-test, P=0.029, Wilcoxon, p=0.028)

[2] Knowledge, Skills and Supervision (Paired t-test, P=0.024, Wilcoxon, P=0.035)

[3] User and Carer Beliefs (Paired t-test P=0.001, Wilcoxon, P=0.002).

[4] Knowledge, Skills and Supervision (Paired t-test, P=0.004, Wilcoxon, P=0.002)

[5] Time and Resources(Paired t-test, P=0.01, Wilcoxon, P=0.01)

Differences between professions

There were no significant differences between the professions on their ratings of perceived barriers to implementation at the start of the programme. All barriers were rated as quite low with all scores falling below 3, a "modest barrier", (Table 6-22). Time and Resources were seen as the largest barrier by all professional groups, except "Others" who rated Knowledge, Skills and Supervision as their largest barrier to the implementation of psychosocial interventions.

Table 6-22: Perceived Barriers to Implementation at Time 1. Mean Scores by Profession

	Nurses Mean (SD)	SW Mean (SD)	OT Mean (SD)	Others Mean (SD)
Time and Resources	2.24 (1.01)	2.41 (1.13)	2.19 (0.79)	2.18 (1.51)
Support and interest	0.85 (0.83)	0.87 (0.53)	1.15 (0.72)	1.91 (1.42)
Belief in Psychosocial Interventions	0.4 (0.52)	0.5 (0.64)	0.42 (0.34)	1.68 (1.7)
Knowledge, skills and supervision	1.36 (0.96)	1.69 (1.34)	1.3 (0.71)	2.3 (0.99)
User and carer beliefs	1.23 (0.91)	1.64 (1.09)	1.4 (0.61)	1.78 (0.98)

At the end of the programme, there was a significant difference between the professions in the way that they perceived Support and Interest as a barrier (Table 6-23) "Others" rated this highest while social workers perceived this as a lower barrier than any of the other groups. None of the changes in scores between Time 1 and Time 2 were significant.

Table 6-23: Perceived Barriers to Implementation by Profession at Time 2

	Nurses Mean (SD)	SW Mean (SD)	OT Mean (SD)	Others Mean (SD)
Time and Resources	2.45 (0.82)	2.05 (1.27)	2.6 (0.74)	2.39 (1.25)
Support and interest[1]	0.74 (0.81)	0.55 (0.66)	1.42 (0.88)	1.66 (1.26)
Belief in Psychosocial Interventions	0.51 (0.58)	0.48 (0.78)	0.88 (0.54)	1.33 (1.66)
Knowledge, skills and supervision	1.4 (1)	1.51 (1.56)	1.75 (0.53)	2.24 (1.25)
User and carer beliefs	1.2 (0.84)	1 (1.09)	1.4 (0.79)	1.48 (1.51)

[1] support and interest (ANOVA, p=0.009, K-W, p=0.009)

Students reported some difficulties in learning about psychosocial interventions; they also reported difficulties in implementing the learning in the workplace. This is not to say that they did not implement their learning. Students reported changes in practice including creating care plans and implementing CBT. However, students voiced concerns about the level of skills to which they were trained and many considered that they had only a basic understanding of the interventions taught.

> *"Some skills have been assimilated into my work and I feel I have dabbled in all but I am an expert in none." (Nurse Co4 Yr1)*

Their fears were often magnified by the fact they were expected to apply their skills in the field of psychosis, e.g.:

> *"I thought CBT was very good but it was missing the support to implement the skills. It was the first time I had done it and I did it with someone who hears voices. It was scary." (Social worker Co4 Yr1)*

Students reported a number of barriers to the implementation of their learning. One of the most common was the lack of time. Many students did not receive a reduction in their caseloads despite working one day a week less:

> *"I lose a days work in time but I do not lose a days clients." (Nurse Co1 Yr3)*

> *"I have to cram five days work into four so it has been a nightmare for the last six to seven months. I cannot delegate because we cannot recruit." (OT)*

The lack of time as a barrier was linked to the lack of resources in many of the organisations in which the students worked.

> *"I have big problems fitting psychosocial interventions into my work. It is a major frustration. Before going on the course I wanted to have psychosocial skills, then when I was on the course I felt like I had gained the skills but I did not have the resources." (Nurse Co2 Yr1)*

Other students felt that the interventions taught on the programme were not suitable or desired by the people they worked with.

> *"I work less with people with psychoses but the course pushes working with psychoses which is more difficult. It doesn't fit with real life." (OT)*

And some students had users on their caseloads that they did not think suitable for PSIs:

> *"I am desperately trying to take on new ideas but it is frustrating to hear about ideal clients because my clients are not ideal. I have been working with some people for three years now. They either die or move to another area, that is the only way they are discharged." (Nurse Co4 Yr1)*

The lack of support at an organisational level was identified as another barrier to the implementation of learning.

> *"They are good at sending you on courses but they don't support you in cascading down." (Nurse Co3 Yr1)*

> *"I think there is more the trust could do. They could reduce caseloads and maybe think about structured clinical support." (Nurse Co1 Yr3)*

A certain amount of cynicism was evident, e.g.:

> *"The trust was not supportive. There has now been a change of management structure. Before they paid lip service to the support needed for the course." (Nurse Co2 Yr2)*

Even if time was granted, the difficulties were not necessarily solved:

> *"As always the trust were going for quantity not quality. I was given study days very informally. I was told to take time off when I needed it. I took a few days before assignments were due but the more time you take off the more there is for you to do when you come back." (Nurse Co2 Yr1)*

6.4.3. Factors that Facilitate Implementation of Psychosocial Interventions

Students described many barriers to the implementation of psychosocial interventions however they also identified factors that helped them in their implementation of PSIs. Team colleagues were often reported to be such a source of support.

> *"Although the team were struggling at times they never made an issue of it. They were helping us get the support we needed from managers." (Nurse Co2 Yr1)*

This support took a variety of forms, from taking an interest to providing practical support, such as taking cases from a caseload.

> *"Generally I do feel supported by the team. We support each other." (OT)*

The course had an impact not only on the individual students but also on their team colleagues.

> *"The team encourages me to implement my learning. There are a lot of changes in the team because of courses. Learning is coming back and having an impact on the team." (Social worker Co2 Yr2)*

However, as one participant pointed out, much depended on the students themselves, and in some cases on the support they could give each other:

> *"I did feel supported by the team but the course is about individual sacrifice. Having someone else from the team on the course helped, we support each other through it and share our experiences." (Nurse Co2 Yr3)*

Team colleagues were not the only source of support for students in their implementation of the skills that were taught on the programme. The group interviews held during the end-of-year evaluations revealed other sources of support that helped students to implement psychosocial interventions (Table 6-24). These included supervision, the use of assessment tools, information gleaned from the course and one's own personal belief in psychosocial interventions.

Table 6-24: Students' reports of factors that help the implementation of PSIs

Source of Support	Example
Assessment tools	Utilising questionnaires and assessment tools
Course factors	Guidelines given in the folder provided by the course Increased knowledge and skills from the taught sessions Doing the assignment
Personal factors	Own personal belief in psychosocial interventions
Supervision	Having a supervisor who is a psychologist Having a supervisor who is flexible in the application of CBT to allow the incorporation of values Talking with a supervisor at work
Work factors	Support from the team

6.4.4. Role Clarity

This section reports on the clarity and conflict participants may have experienced in their roles. These scales were reliable (alphas from 0.78 to 0.87).

Differences by cohort and overall

Role clarity was measured on a seven-point scale, where 1 indicated that participants were very unclear about their role at work and 7 indicated that they were very clear about what was expected of them at work. At Time 1 participants in all cohorts appeared to be quite clear about what was expected of them. By the end of the programme, participants in Cohort 2 appeared to be clearer about their role than at the start and there was also a slight increase for Cohort 4. However, Cohort 3 were less clear about what was expected of them at the end of the programme, showing a reduction from their mean score at the start of the programme of 5.13 to 4.88 at the end. Overall, there was a slight increase for participants on the programme from the start of the programme (mean 4.99) to the end (mean 5.06). None of the changes

over time between the cohorts or for participants overall were significant (Table 6-25).

Table 6-25: Role clarity scores by cohort and overall

	Role Clarity T1 Mean (SD)	Role Clarity T2 Mean (SD)
Cohort 2 (N=34)	4.99 (0.83)	5.28 (0.83)
Cohort 3 (N=20)	5.13 (0.95)	4.88 (1.2)
Cohort 4 (N=26)	4.9 (1.18)	4.93 (1.07)
All (N=80)	4.99 (0.97)	5.06 (1.01)

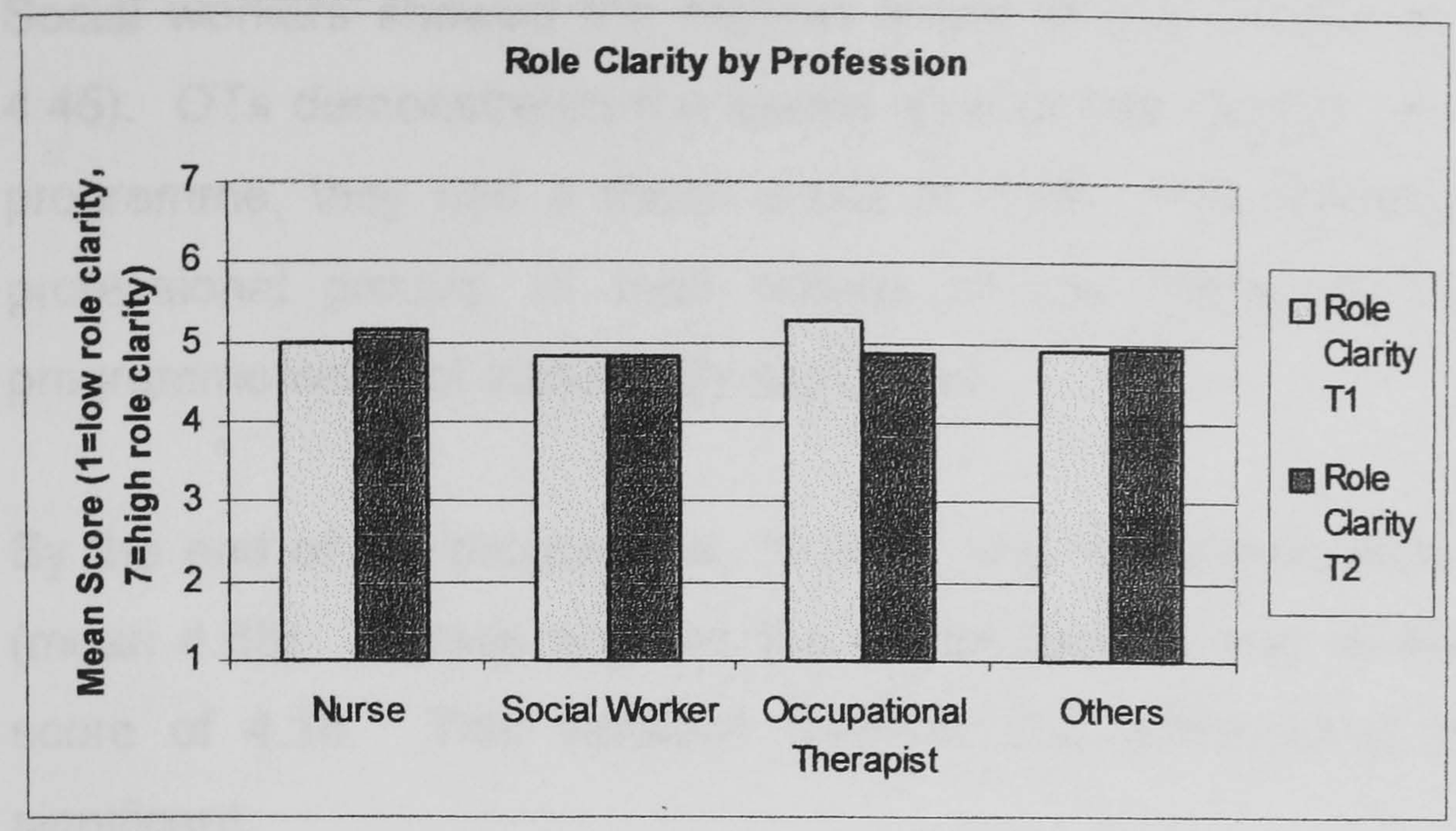
Differences between Professions

Occupational therapists showed the highest level of role clarity at the start of the programme (mean 5.28) and social workers showed the lowest level (mean 4.83). This difference in role clarity between professional groups was not significant.

By the end of the programme nurses showed the highest level of role clarity (mean 5.17) and social workers continued to show the lowest level (mean 4.83). This variation between the professions was not significant.

Nurses and "Others" demonstrated an increase in their role clarity scores from the beginning to the end of the programme (Figure 6-32). Nurses showed the largest increase with their average ratings rising from 4.97 to 5.17. Social workers' ratings of role clarity remained stable but OTs showed a decrease in their levels of role clarity. Average ratings fell from 5.28, at the start of the programme, to 4.86, by the end of the programme. These variations were not significant.

Figure 6-32: Mean Scores of Role Clarity by Profession at Time 1 and Time 2



6.4.5. Role Conflict

Differences by cohort and overall

Cohort 4 showed the highest levels of role conflict at Time 1 and Time 2 (Table 6-26). There was an increase in role conflict scores for all cohorts and overall. The increase in role conflict was significant for cohort 3 (Paired *t*-test, p=0.001, Wilcoxon, p=0.003), where scores increased from 3.86, at the start of the programme, to 4.44, at the end. The increase in scores was also significant for all of the participants overall, (Paired t-test, p=0.01, Wilcoxon, p=0.01).

Table 6-26: Role conflict scores by cohort and overall

	Role Conflict T1 Mean (SD)	Role Conflict T2 Mean (SD)
Cohort 2 (N=34)	3.74 (0.99)	3.95 (1.12)
Cohort 3 (N=20)	3.86 (1.32)	4.44 (1.18)
Cohort 4 (N=26)	4.27 (1.14)	4.56 (1.18)
All (N=80)	3.94 (1.14)	4.27 (1.17)

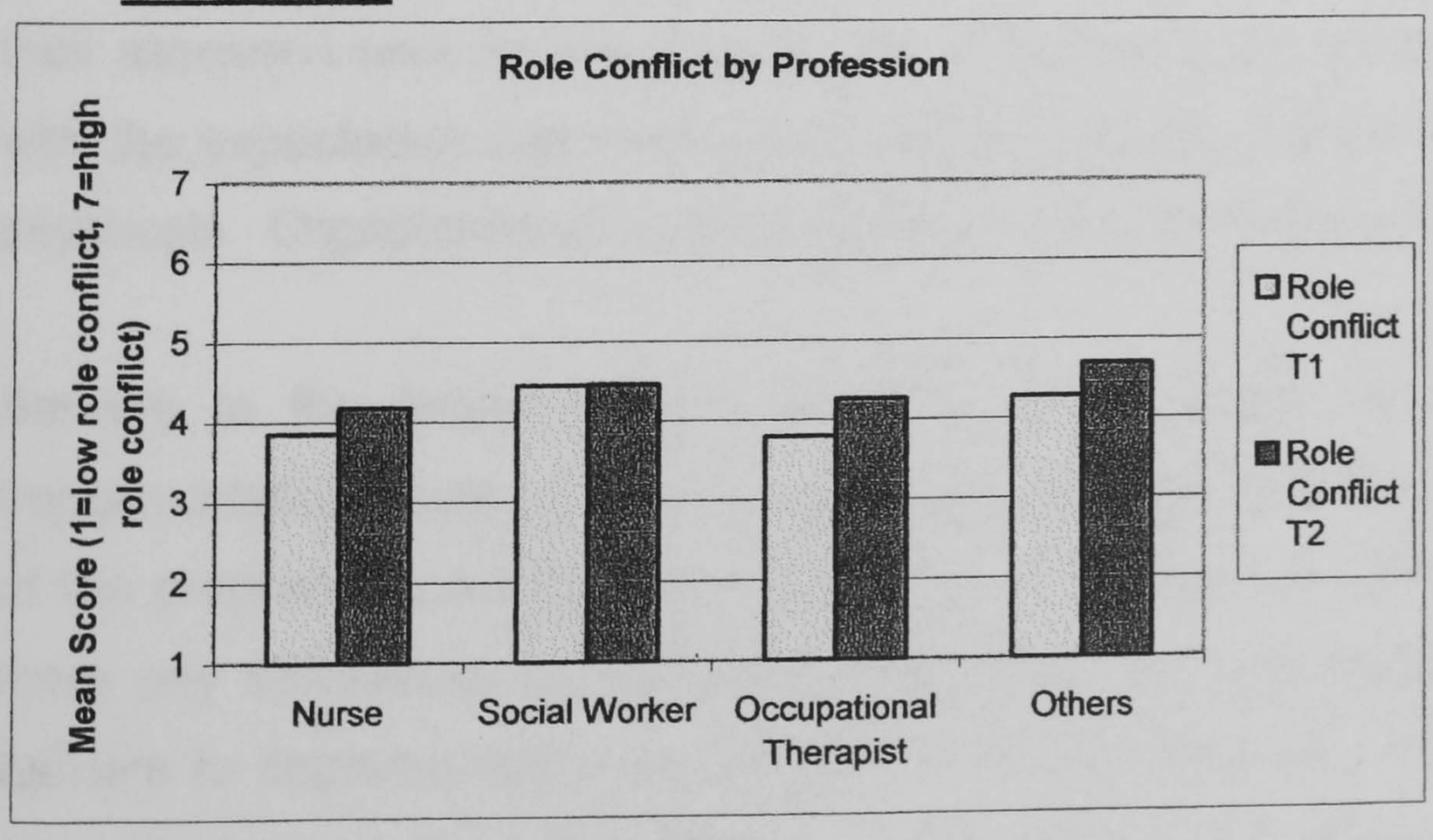
Differences between professions

Social workers showed the highest levels of role conflict at Time 1 (mean 4.45). OTs demonstrated the lowest level of role conflict. At the start of the programme, they had a mean score of 3.79. The difference between the professional groups, in their ratings of role clarity, at the start of the programme was not statistically significant.

By the end of the programme, "Others" had the highest level of role conflict (mean 4.68). Nurses showed the lowest level of role conflict with a mean score of 4.18. This variation between the professional groups was not significant.

All the professional groups showed an increase in role conflict scores between the start and the end of the programme (Figure 6-33). However, there was only a very slight increase for social workers who had a mean score of 4.45 at the start and a score of 4.46 at the end of the programme. OTs, who had a score of 4.26 at the end of the programme, showed the largest increase in role conflict. At the start of the course, they had a score of 3.79. However, none of the differences of professions over time were statistically significant.

Figure 6-33: Mean Ratings of Role Conflict by Profession at Time 1 and Time 2



6.4.6. Summary of Findings: Learning about and implementing psychosocial interventions

Students appeared to enjoy the module that introduced them to psychosocial interventions (Psychological Interventions in Psychosis). However, students also reported difficulties with the teaching of this module, amongst which was that it was pitched at too high a level, was too "scientific" and was not long enough.

Changes in the use of psychosocial interventions, as measured by the Implementation Scale, revealed that there were statistically significant increases in the use of the two main PSIs taught on the course, Cognitive Behavioural Therapy and Family/ Carer Interventions for all students (with the cohorts combined). At the start of the programme the professions differed significantly in their use of four interventions. By the end of the programme there were statistically significant differences between the professions on seven of the ten interventions.

Students also reported, in the individual and group interviews, on the implementation of psychosocial interventions. Findings from the interviews showed students felt they did not have enough time to implement their learning, many were trying to do five days work in four as well as complete their assessed work for the programme. Other students did not feel confident with the expectation that they should begin their use of skills with people with psychosis. Organisational support was also reported to be lacking.

Barriers to the implementation of PSIs as measured by the Barriers to Implementation Scale showed no significant changes from the start to the end of the programme overall (with all cohorts of students combined). Nor were there any differences between the professions on their ratings of perceived barriers to implementation at the start of the programme. At the end of the programme the professions differed significantly in their ratings of Support and Interest as a barrier. The group classified as "Others" saw this as a barrier to a greater extent than the other professional groups. Social workers saw this

as less of a barrier. Students reported sources of support from five areas; supervision, course related factors, work related factors, personal factors and the use of assessment tools.

6.5. User Involvement

This section will answer the third research question of the study:

> "How do students' attitudes and behaviour change during and after attending a programme with a focus on service user involvement?"

Changes in the students' attitudes towards user involvement and changes to their practice of working with service users were explored during the group and semi-structured interviews. Additional information about user involvement and the students' attitudes and behaviour came from my observations of the teaching programme. User involvement on the programme took three forms, values emphasised throughout the programme and the involvement of users as trainers and students.

User involvement was an integral part of the value-base of the programme and it was an underlying thread of the programme, which was emphasised throughout all teaching. For example, the Student Handbook (University of Birmingham, 1997, p.58) outlines the aims of the teaching in the "User Participation and Self-Help" module, for students, as:

- To promote user involvement in the planning and development of services.
- To acquire background knowledge of the development of the 'user movement'.
- To establish ways in which users and carers can influence multi-disciplinary decision-making processes, and
- To develop the skills for auditing the quality of 'user involvement' within statutory and voluntary sector provision.

Service users were involved in the programme as trainers. Some service users facilitated one-off sessions offering a user-perspective, whilst other more established "user consultants" took a more involved approach to the programme, leading a whole module (User Participation and Self-help). Service users became students on the programme. The first service user joined the programme as a student in the third cohort and four service users became students in the fourth cohort.

6.5.1. Learners' Reactions to User Involvement on the Programme

The focus on user involvement during teaching had a mixed reception. Some students responded very positively to this element of the course. For example one nurse simply stated:

> *"It was the best thing I got from the course." (Nurse Co2 Yr2)*

Another student thought it was not only a pleasant part of the programme but that it was well structured and well supported by cooperative facilitators.

> *"I really enjoyed the service user element. I was very impressed with the organisation on the course and everyone was helpful." (Nurse Co3 Yr1)*

Reasons for such a positive reception to the user focus of the programme varied. One participant felt the programme's emphasis on user involvement was helpful for reflecting on their working practice:

> *"I liked the user focused stuff because it helped to reflect on practice. (Nurse Co2 Yr2)*

It was also valued because it was viewed to support the needs and wishes of service users the students worked with.

> *"Users are wanting more, they hear about interventions and services and they, quite rightly, want them. The expectations of users are changing." (Nurse Co2 Yr2)*

Students thus felt that the programme was addressing areas that were important to their professional practice in mental health services. However, this was not universally so. The students in the group and individual interviews sometimes reported the principles of user involvement as being too basic.

> *"I think user involvement should have been accepted as a given." (OT)*

In both the individual and group interviews some participants voiced their view that the values of the programmes were values they held prior to joining the course.

> *"The course reflects our existing value base." (Co2 Yr1)*

The values of user involvement were felt to be so basic that some students felt they had already demonstrated their ownership of them by applying to the programme.

> *"By coming on the course we already had the value base. The course has reinforced that." (Co3 Yr1)*

Other students felt that whilst they agreed with the values there were still some values that they would have liked challenged but the programme did not go deep enough.

> *"Lectures did not offer us more than we already had. I'm a reasonably PC person, open-minded, it did not challenge the edges of my prejudices. It was pitched at a very low level." (OT)*

Others felt that whilst they agreed with the values of the programme, the values had been forced upon them:

> *"The course was not difficult to "sign up" to. The value base was imposed but we agree with it." (Co2 Yr2)*

The students seemed to judge the sessions according to the nature of knowledge. From my observations of the User Participation and Self-help module, it seemed to concentrate on personal and process types of knowledge, according to Eraut's (1992) classification. Personal knowledge was the main type of knowledge used in this module and involved service users speaking about their experience and suggesting ways they would like to see services improved. Process knowledge involved discussions of 'how to' find out what users of services want, and how to provide this within the services the students worked. Some students voiced a desire for more process knowledge. For example, one OT who was interviewed said:

> *"There are practical things to do such as how you actually involve service users, rather than just talking about it." (OT)*

Many students felt that the values of the programme were a good starting point, but it was also a point many students felt they were already at. What many students wanted to know was how it could make a practical difference to their work. They would have liked more suggestions on how to improve their practice rather than hearing why it was important they changed.

6.5.2. Service Users as Trainers

It was not only the students' reactions to the user involvement element of the programme, and the User Participation and Self-help module that varied from the rest of the programme. The programme had input from users as trainers, or presenters, in three of the four modules I observed with cohort 2. Contemporary Approaches to Psychiatric Treatment (CAPT) was the only module I observed which did not involve service users in the delivery of

teaching. Students also reacted differently to users as trainers. Most students reported positive reactions to the use of users as trainers. As one student put it:

> *"I think it is very positive to have service users as presenters." (OT)*

One reason why users as trainers were seen in a constructive way was that many students recognised the expertise they had through their experience of using mental health services. Benefits of users as trainers, included changing the way the students thought about issues:

> *"It was good to have service users on, and teaching on the course. There was one session on risk and I realised that I had never thought of it from a service user perspective before." (Social worker Co4 Yr1)*

The above social worker describes how the use of a service user as trainer made them think differently and reflect that sometimes a user's view is not considered. This was an encouraging reflection. Unfortunately, evidence from my observations of the teaching sessions with Cohort 2 revealed that students' did not always value the input from service users as much as other sessions facilitated by professionals. Students treated user-led sessions differently to those held by mental health professionals. For example, I missed one session of the User Participation and Self-help module and the following week I asked one of the students what had happened. She replied, "Oh, you didn't really miss anything". When I asked in more detail what had happened she told me it was a session with some service users, which was "interesting but nothing new". In my observations I also noted a reduced attendance at such sessions and talking during such sessions when presenters were speaking. Students, in the semi-structured interviews also commented about the differences in the status of service users as trainers compared to professionals. Some students felt that this reflected a lack of respect for service users.

"Service users certainly did not get the same sort of respect as others teaching on the course. I don't know what it was, maybe it was because they weren't qualified or maybe some of the presentations I saw were a bit woolly and you weren't really sure what was going on." (Nurse Co1 Yr3)

Some students noted that it could be awkward when such lack of respect was shown.

> *"Users were not always given the same level of respect and at times this was quite embarrassing." (Nurse Co2 Yr2)*

Another student reflected on the different ways that lack of respect was shown for users as trainers and reasons for this.

> *"I did not feel that service users were always respected. People would often leave before or during sessions by service users. Also sometimes people were insensitive within the groups. People would leave and go home. Some people thought they had heard it all before." (Nurse Co3 Yr1)*

The students however, distinguished between individual service users and their presentations. So not all service users were considered to be less able as trainers. Indeed, some were held in high esteem and shown much more respect.

"Some of the service users we have had as presenters have been very articulate and presented their sessions very well. It has left me thinking I wish I was working with a client like this." (Nurse Co4 Yr1)

An OT reflected on reasons for such variation in the way users as trainers were received:

> *"One service user was very good. He was more in your face and extremely well read. He gave lots of references and knew history and different schools of thought but he was able to put his own views into context. He was so in your face that you did not have to adopt the egg shell approach." (OT)*

The above student obviously valued the knowledge of the user who was able to put forward more than one perspective. The students appeared to place greater emphasis on more "propositional" knowledge as opposed to personal knowledge, which many of the sessions facilitated by users concentrated on. For example, the above OT considered it important that references and historical events were discussed. Another participant also valued the presentation of a clear argument, which takes account of different perspectives.

> *"I think status issues were mixed. One woman, the user trainer consultant, was very good. I felt she had more status. She is an excellent trainer. She has really thought things out and is very clear about where she is coming from" (Social worker Co2 Yr2)*

The fact that service users as trainers were rarely challenged was also notable in my observations. On one of the occasions that I observed, one service user trainer was particularly critical of professionals he had encountered. The tension in the room was very noticeable, I observed this in the form of muttering amongst the students, and disapproving facial expressions, when this service user was speaking. Yet, none of the students challenged him. Instead they made it clear they did not agree with him once they left the session at lunchtime, when they expressed vocally how unhappy they had felt.

Reasons for the reluctance to challenge service users emerged during the semi-structured interviews and included a perception that service users were vulnerable, unlike professionals. The personal nature of the stories service users told also affected the way students perceived they could challenge, or not challenge them. There was a perception that it had happened to the individual so they had a right to tell their story. There was also a perception amongst some students that it was not "politically correct" to challenge service users. Indeed one student felt challenging a service user could have very dramatic and negative effects:

> *"You can challenge professionals but not service users when you could undo interventions and shatter a person's quality of life" (Nurse Co1 Completed Yrs1 and 2)*

Another student felt it was not the outcome of challenging that was the issue but it was the power relations between a professional and a service user that made such a challenge inappropriate.

> *"Individually service users can be critical and quite aggressive - therefore the rest of the group shut up. You could argue that we should get past that but there is something about an argument with a service user that makes it unequal." (OT)*

That students did not feel able to challenge service users led to some negative feelings, which were expressed during the interviews with the students in their workplace. Students reported feeling 'vulnerable' themselves and would have liked someone else to protect them. For example, one interviewee expressed:

> *"Service users were good but they give a subjective story and it is subjective in the past tense so you feel criticised and attacked and there is no one there to defend us. I felt 'got at'." (Social worker Co2 Yr2)*

The feeling of being attacked led some students to become 'defensive' and the power relations between students and users were altered. In this case professionals felt like they were the ones who needed protecting.

> *"We were stereotyped and I felt like we did not have a voice. My experience of the user module was that it got peoples' backs up. I felt attacked. We became very defensive, we were seen as oppressive. The users were stereotyping us" (Nurse Co1 Yr3)*

Learners' reactions to the user involvement focus of the programme were generally positive. The majority of students accepted, and indeed claimed to already hold, the values promoted by the programme. However, some disagreed with the way the values were 'force' upon them. The inclusion of service users as trainers was also well received, in principle at least. However, some students did not receive service users as trainers with the same respect that was accorded to 'professional' presenters. Many students were reluctant to challenge such user trainers, which brought to the fore issues of equality. Users were seen to be less equal in terms of power, compared to professionals. Yet this belief also caused students in turn to feel powerless when they could not challenge the trainers.

6.5.3. Changes in attitude

Whilst the above shows that the service user element of the programme was not always well received this is not to say it did not achieve positive outcomes. Several students reported that the programme's emphasis on service user involvement had changed their attitudes, especially with regards to the way they interacted with service users they worked with. One nurse thought that her attitude change was clear:

> *"The user involvement aspect has shifted my thinking, obviously so." (Nurse Co2 Yr2)*

Another nurse reflected upon how she was now able to see a person rather than just the mental health problem:

> *"It [the course] has not really changed the way I work with other professionals but it definitely has with service users. Before I was only the nurse and they were the service user. Now they are no longer just the illness." (Nurse Co3 Yr1)*

Attitude change was not just limited to personal beliefs but also encompassed beliefs about service organisations and educational environments.

> *"I mean if there is one thing that has changed for me it is that I have a much greater commitment to user participation than I ever had before and I would like to see more user involvement in the teaching really." (Nurse Co1 Yr3)*

One student commented on how their beliefs about being a professional had been completely turned around:

> *"I now see users as the expert and I see myself as a resource to them rather than seeing myself as the expert." (Nurse Co2 Yr2)*

Others felt that the course had not so much changed their attitudes about user involvement as much as strengthened it.

> *"It has consolidated my view that collaborative work with service users is needed" (OT)*

Some students perceived the programme as positive reinforcement for the attitudes they already held and the way they were already working.

> *It confirmed what I was doing and that was why I liked it. It was a relief." (Social worker Co2 Yr2)*

This reinforcement was particularly valued when students felt that others worked in a different way. They appreciated the confirmation that their practice was 'good'.

> *"The course has confirmed my practice with service users. I have always been user directed and I used to feel at odds with others." (OT)*

Many students reported that they had changed their attitudes towards service user involvement since starting the programme. This was despite students not always feeling they needed the values of the programme forced on them so heavily. Those in favour of user involvement spoke about how the programme had consolidated and confirmed their beliefs about the importance of user directed ways of working.

6.5.4. Changes in Behaviour

As well as changes in attitudes, some students reported changes in their working practice. During my observations with Cohort 4 a nurse told me about the changes going on in her workplace and how the service was becoming much more user focused and she was taking ideas back to the workplace from the programme. Further evidence of changes in the workplace following the focus on user involvement were reported in the group interviews. These included:

> *"I have been able to look at further developments into services, especially user involvement into plans for next year." (Co3 Yr1)*

A different student told me about how her role had changed at work so that users now had more control.

> *"Two groups are now user led at the centre. One is a discussion group and the other a support group. Whereas before I was running them both, I am now just there as a back up and am invited in sometimes when they want to talk about relevant issues, such as medication." (Co2 Yr1)*

A student in the same year reported how they had made changes to empower service users in their workplace:

> *"I found that the work assessment was designed by an OT and conducted through observation. There was no scope for users' own assessment. Now it has been redesigned to become a self-assessment form, completed by the user." (Co2 Yr1)*

During the group interviews with Cohort 3 one nurse explained the difference he felt the programme had made to his practice. He had piloted a user satisfaction survey and was shocked by how little actual involvement of service users there was where he worked. He had found this quite hard hitting and commented that he was surprised by the change the course had made to his work. He described how prior to the course, he had considered a good day at work as one where you gave out tablets, no one disappeared and there were no fights. He went on to say how he was much more committed to user involvement. Other reported changes in working practices emerged from the semi-structured interviews. These included working more closely with users and carers and developing relapse plans.

> *"I work closely with users and carers. I now take in their issues more than I did, or thought I did." (Nurse Co1 Yr3)*

> *"I am doing more service user focused work. For example, I am developing people's relapse symptoms." (Nurse Co3 Yr1)*

One student who had been on the programme for three years still used the material from the teaching of user involvement and self-help in the first year.

"I still refer to stuff on users and I now tell users about self-help groups." (Nurse Co1 Yr3)

Information, such as leaflets was frequently mentioned as a way students found to give users more insight in to mental health problems, treatments and services.

"Yes, the course has changed my practice. With service users, I have collated leaflets and I am developing symptoms plans." (Nurse Co2 Yr1)

The above student also put the symptoms plan into operation after being taught about it on the programme. This demonstrates that the programme had equipped students with new knowledge and skills that were applicable to mental health services. Others felt that it had changed their outlook for those with severe mental health problems:

"Recovery was never a word I used with clients. Now I use it all the time." (Nurse Co3 Yr1)

Whilst many students reported changes to their practice some reported that whilst their attitudes had changed they had not been able to change their practice in the workplace.

"The course has broadened my view and I did reflect on the way I work with service users. However, I have not changed due to the environmental conditions of the organisation." (Nurse Co1 Yr3)

Organisational factors were identified as those that prevented changes to involve users in mental health services.

> *"Change with our service user group here has been very sporadic. We have had service user reps elected. Two or three people have wanted to be more involved but it is harder to get people involved as we do not have a service user involvement worker." (Social worker Co4 Yr1)*

Factors that helped students to put user involvement into practice were identified during the group interviews held at the end of the year evaluation days. The students identified sources of support ranging from their team colleagues to their own personal commitment (Table 6-27).

Table 6-27: Factors Students Identified as Helpful to Increasing User Involvement in the Workplace

Source of support	Example
Work factors	The support of team colleagues and managers. Going back to the workplace and discussing issues of user involvement with service users.
Course factors	Reading around the subject for assignments (this demonstrated the lack of progress of service user involvement and the need for further development). Information and literature from the teaching sessions. Users teaching on the course and sharing their personal experience. Encouragement from fellow course members.
Values	Being confronted with prejudices of which they were not previously aware. Increase in confidence that user involvement is the "right thing" to do.
Policy	The increased importance attached to user involvement in local and national policy.

Many students were able to provide examples of changes they had made to their practice, which they attributed to the programme's emphasis of user involvement. The examples were many and wide raging. For example, some students listened more to users and carers, other began using new tools and some gave users more power by letting them facilitate their own groups and change their own role to one of a resource, to be used at the users' request. There were many factors that enabled students to make such changes to their practice and these included the importance given to user involvement in national policy, which in turn gave credence to their attempts to introduce change to the support of their course members, team members and managers. The programme's aim to increase user involvement amongst the practice of students appeared to be very successful. Of course, there is one final area where the user focus of the programme is evident: the inclusion of service users as students.

6.5.5. Users as students

Learning alongside service users as fellow students was a new experience for the majority of students on the programme. The students' reactions to this were usually best described as wary. Students in the individual interviews voiced how they were usually surprised to discover users on the programme.

> *"Initially I was shocked that users were on the course." (Nurse Co3 Yr1)*

One student described how he had overcome his discomfort with service users as students by making a deliberate effort to get to know them.

> *"Some users are really good. Initially I was very uncomfortable with them being on the course so I made a deliberate effort to sit beside them to get over this." (Nurse Co4 Yr1)*

Other students wanted to know what was the value of the programme for service users and how they would use the skills acquired. Others questioned

how users would meet the demands of the programme considering so much of the assessments were related to the workplace.

> *"I have some reservations about service users as students because it limits how comfortable you are about talking about some things. It would make me more conscious about what I say. I want to know what service users are going to use the course for and what are the benefits for them. Many of the assignments are practical so how will they do them?" (Nurse Co2 Yr3)*

Other students shared the confusion of how a service user would meet the demands of the programme, especially considering the programme's emphasis on psychosocial interventions.

> *"How do you do joint training with service users? For example, how are they doing CBT and risk assessment, of course it is different for service users who work for a Trust." (OT)*

Other students reported feeling uncomfortable challenging service users as students, as they had users as trainers.

> *"There was only one service user in my year. I found this really problematic. I would find it easier to disagree if there was more than one person. I would have felt like I was singling him out if I had to disagree with him." (OT)*

Thus, the vast majority of students with a professional affiliation voiced public support for the inclusion of users on the programme as students. Yet, many were perplexed as to what role they would play. During the days I spent with Cohort 4 observing the teaching on the module Working In Community Teams I had some informal discussions with three of the service users who were students on the programme. They told me that whilst they were all positive about the opportunity they had been given to start the programme they also had encountered several difficulties. The two service users who did not have

paid employment in a mental health service identified one of the main difficulties in meeting the requirements of the programme. The third service user was on the course in her role as an advocate, the other two service users did not have such a role. This created a difficulty in meeting the requirements if the programme in relation to assessed work, especially in relation to assignments for the skills-based modules.

The programme staff had created a flexible system for those who did not have a caseload and placements were created in order for those individuals to implement their learning in a mental health service. The two service users who had used the placement system reported slightly different experiences and one viewed the placement system in a more positive light. However, difficulties in making it clear what their role was during the placements with the staff who worked in the service and those who used the services were reported. The service user with the more positive experience thought that she had been responsible for making it work by persevering with an initially awkward situation. Her colleague felt that his situation was much more difficult and he could not continue with the placement.

All three service users who were studying on the programme reported that they were enjoying the programme and had received excellent support from the programme staff to enable them to overcome many obstacles to meeting the learning objectives. They also all reported that the programme was demanding academically. Thus, the involvement of service users as students presented some problems for the students with a professional role, as well as for the service users as students themselves. However, no student, either in the semi-structured interviews, group interviews or during my observations was entirely negative about service users becoming students on the programme.

6.5.6. Summary of findings: User Involvement

Learners' reactions to the programme's focus on user involvement in the value-base and the teaching were generally positive, although some students did report finding it too basic. Reactions to users as trainers were generally reported as positive but my observations of teaching sessions with users as trainers did not support this. In the observations, it appeared that users as trainers were treated differently to high-status presenters. There was a difference in the form of knowledge presented in the user sessions, as opposed to the psychosocial interventions sessions. Additionally several students voiced a desire for more process knowledge, such as 'how to' actually involve service users in their practice. This may reflect that whilst almost all students reported that the programme's emphasis on service user involvement had changed their attitudes many reported that it had not changed their practice, as much as they would have liked.

The role of service users as students on the programme did cause some concern from many students who took part in the semi-structured interviews. This concern was often related to anxiety that they may say something that would cause offence. Additionally there was confusion over why someone who did not have a professional role would want to take part in the programme and how he or she would meet the requirements of the programme. The service users who were students reported meeting the demands of the programme as problematic. However, they reported that the programme staff worked flexibly to enable them to overcome obstacles and as a result they were enjoying the programme.

This chapter has presented the evidence from the study in terms of the three research questions I aimed to address. How well the study has answered these questions, what the findings mean and what remains uncertain will be addressed in the following chapter.

7. DISCUSSION

7.1. Introduction

The implications of the findings from this study will be discussed in this chapter. The first section will examine the interprofessional nature of the programme, including the professional mix of students. This will lead on to the second section, which will return to each of the nine hypotheses and discuss what the findings mean and how well the three research questions have been answered. Finally, lessons that can be learnt from the evaluation of the programme will be drawn and put into the context of current policy issues.

7.2. The Interprofessional Nature of the Programme

One of the most noticeable findings from the study concerns the changing interprofessional nature of the programme. Over time the programme has been less successful in attracting and retaining members from the five main mental health professions. The majority of students on the programme were from a nursing background. It is unsurprising that nurses were the largest professional group on the programme considering they make up the largest sector of the mental health workforce. This finding replicates that by Brooker *et al.* (2002) in their survey of university-accredited, post-qualifying training and education for mental health professionals. Brooker and colleagues found that 85% of those who were trained on relevant courses between 1995 and 1998 were nurses. Whilst nurses do make-up the largest proportion of the mental health workforce Brooker and colleagues found that they were over represented in training programmes for people who work with those with severe mental health problems.

Only one psychiatrist and two psychologists were recruited to the programme on the three cohorts considered. The psychiatrist and one of the psychologists left the programme before completing the first year, resulting in only one

psychologist and no psychiatrist completing the Certificate level of the programme.

Psychiatrists and Psychologists

The other students regretted the lack of participation by psychiatrists and psychologists on the programme. It was felt that their absence reduced the interprofessional aspect of the programme and was a missed opportunity for psychiatrists and psychologists who they believed would benefit from the programme. Exploration of possible reasons for the lack of involvement of psychiatrists and psychologists involves the consideration of what would attract these two professional groups to the programme. The factors that motivated the nurses, OTs and social workers to apply for the programme included the opportunity to gain a Master's degree without incurring financial costs and consequently (perhaps) improve career prospects. Additionally, the programme was seen as an opportunity to increase skills and improve the services they were able to offer service users, in a context that was linked specifically to severe mental health problems and community-based care. There is obviously a professional difference in motivation as a Master's level qualification would be unlikely to make a difference to the career progression of a psychologist or psychiatrist who is already qualified to that level or above. Thus, other elements of the programme must be considered attractive to psychiatrists and psychologists if their presence on the programme is to be increased.

It is also questionable whether the skills element of the programme would be relevant to the two professions. Clinical psychologists may feel that they already have a good understanding of psychosocial interventions from their uniprofessional training. Psychiatrists may feel that they do not have time to implement psychosocial skills, which are often time consuming and require the reorganisation of one's working arrangements, in their role as responsible medical officer. Thus, roles and initial training are factors that will influence attendance on an interprofessional education programme.

The specialist versus generic debate in post-qualification education may also play a role in the lack of participation of psychiatrists and psychologists. The programme teaches skills, knowledge and attitudes which are common to all professions. However, whilst these may contribute to the career development of social workers, OTs and nurses, more specialist training may be more likely to lead to the professional advancement of psychiatrists and psychologists. For example, a psychologist with a basic understanding of psychological interventions may prefer to complete a training programme with a focus on just one intervention, such as CBT in more detail, thereby deepening their knowledge and specialist skills.

Support for the hypothesis that psychologists and psychiatrists may prefer to undertake more specialist rather than generic forms of training can be found in the study reported by Ashworth *et al.* (1999). This study, which is explained in more depth in Chapter 4, assessed outcomes for students on a one-year post-qualification course in cognitive therapy. Between the years of 1990 and 1995 (across four cohorts), the programme taught 13 clinical psychologists and 12 psychiatrists. Clinical psychologists made up 25% of participants and psychiatrists 23%, with other medics contributing to a further 10%. This suggests that psychiatrists and psychologists are interested in skills-based programmes that are one-year in length. The programme's main difference to the Birmingham programme appears to be its specialisation on one therapeutic intervention. However, caution should be applied to this hypothesis since the finding from the Birmingham programme that it is hard to attract psychologists and psychiatrists is supported by other studies.

The finding that very few psychiatrists and psychologists were recruited to the programme reflects the findings by Brooker and colleagues (Brooker *et al.*, 2002). They reported that the *target* intakes, on programmes for mental health professionals, for psychiatrists and psychologists were 5% and 4% respectively, for single module courses between 1998 and 1999. However, in reality the courses surveyed only recruited one psychiatrist and no psychologist (out of a total of 338 individuals). Thus, the Birmingham programme did

relatively well to recruit one psychiatrist and two psychologists to the programme in the three academic years studied. Brooker and colleagues reported that the problem of under recruitment was even worse at Master's level.

Whilst the lack of psychiatrists and psychologists in the programme as students is obvious there are also some more rather hidden aspects of the interprofessional nature of the programme. The participation of both social workers and OTs on the programme shows some interesting patterns.

Social workers

Social workers showed a particularly high drop out rate on the programme across the three cohorts studied. From a total of 21 social workers that started the programme 9 (43%) left before the end of the first year of the programme. This is compared to a 19% drop out rate for OTs and a 21% drop out rate for nurses. Possible reasons for such a high drop out rate may be related to the role of social workers in the workplace. Social work, since the NHS and Community Care Act 1990, has become increasingly focused on the task of care management. This is reflected by the findings of this study which found the interventions social workers reported using most frequently were: Assessment and Care Planning, Care Co-ordination, Advice Giving and Meeting Social, Recreational or Spiritual Needs. The focus on skilling students in psychosocial interventions may therefore be of less relevance to social workers, as opposed to nurses or OTs. Nurses and OTs both reported using more therapeutic interventions than social workers at the start of the course. For example, nursing was the profession that reported using Psychotherapy and Counselling most often and OTs were the profession that reported using Group Therapy and CBT most frequently.

Some social workers also take on additional training and become 'Approved social workers' with specified duties and responsibilities in relation to the compulsory admission of patients to hospital. This role has consequences for any therapeutic relationships social workers would need to create in order to

implement the psychosocial interventions such as CBT and Family Intervention taught on the programme. Therapeutic relationships depend on trust, empathy, respect and genuineness (Rogers, 1957), however the compulsory powers held by Approved Social Workers can diminish a trusting relationship (Perkins and Repper, 2001). An additional problem social workers may have encountered is that the programme was funded by NHS trusts in the West Midlands region. Whilst this does not seem to be a considerable problem, especially as places were allocated to social services employees free of charge, there remained the cost to social services of replacing a member of staff for one day per week. Thus, managers may have been less supportive of the social workers' attendance on the programme once the full effect of their absence on a regular basis was noted. Unfortunately, no social worker from a social services department was interviewed during the semi-structured interviews. This was due to the sampling procedure adopted, which involved choosing teams to visit from NHS trust services. The two social workers who did take part in the semi-structured interviews were employed by NHS trusts. A recommendation for future work would be that it should examine the experiences of those who come from minority professions, or organisations on interprofessional programmes.

Occupational therapists

On the first two cohorts examined in this study (Cohorts 2 and 3) OTs were well represented, in equal numbers with social workers at the start of the programme. However, only one OT was recruited to the programme in Cohort 4. Reasons for this may be linked to the smaller size of the profession of occupational therapy in mental health, as compared to nursing. Thus, all those OTs in the region who wanted to take part in the programme may have done so in the earlier cohorts. Additionally, one OT in the semi-structured interviews referred to recruitment difficulties in her locality for OTs. If this is a region wide or national problem for occupational therapy it may reduce opportunities for OTs already in post to undertake training, especially such long-term training. The shortage of OTs does seem to be a national problem with 15% of OT posts reported as unfilled (Sainsbury Centre for Mental Health, 1997).

Questions still to be answered

The apparently diminishing interprofessional nature of the programme raises a number of questions. For example, is it appropriate to try to recruit more psychiatrists and psychologists to the programme as students? Does the programme meet their needs and what will they add to the learning experience? Why do social workers have such a high drop-out rate? Is it just a temporary problem or does it require addressing? Is the drop in attendance by occupational therapists a long-term problem or just a "one-off" for Cohort 4? What does the large number of nurses on the programme mean, for nurses themselves and the other "minority" professions? These questions will require a longer-term evaluation that explores participation on the programme. They also underline the importance of the programme staff monitoring their own student intake and paying attention to the professional mix on an interprofessional programme. Of course, once the students are on an interprofessional programme the next question is, what effect does it have?

7.3. Interprofessional Attitudes

The first research question aimed to examine the changes in attitude that may occur on an interprofessional education programme and to explore processes that may improve interprofessional working. The research question and the related four hypotheses were underpinned by the social psychological theory of the contact hypothesis, which outlines certain conditions necessary for attitude change in an intergroup context. The contact hypothesis was the basis for the first hypothesis of this study, which was that all conditions of the contact hypothesis would be present on the programme.

The findings of this study revealed that, from the students' perspective, a number of the conditions of the contact hypothesis were met. With regard to the first condition, institutional support, they strongly agreed that they had been given support for their participation on the programme from their team members, members of their profession and their employer. Next, according to

the contact hypothesis all participants should have positive expectations about taking part in an intergroup encounter. Students, across all cohorts, had positive expectations about working alongside members of other professions at the start of the programme. Similarities and differences between the professional groups should both have been discussed if attitude change is to occur. Students across all cohorts felt that similarities and differences were emphasised to some extent on the programme. Participants showed agreement with the statements that the professions had worked together as equals on the programme and when they had worked together the outcome had been successful. Participants also reported that the atmosphere on the programme was much more co-operative that competitive. Thus the quantitatively measured conditions of the contact hypothesis were generally met.

However, there was additional and contradictory evidence about the extent that the conditions of the contact hypothesis were met on the programme. As shown from the participant observations much of the teaching in Cohort 2 did not allow for intergroup interactions reducing opportunities for successful joint work and the need for co-operation. In addition, similarities were emphasised at the expense of explorations of differences between the professional groups. There was little opportunity for students to get to know their fellow students, as participants tended to interact with their team or trust colleagues who they already knew well. Thus the programme's "acquaintance potential", where individuals get to know each other as individuals, rather than as stereotypical members outgroup members (Hewstone and Brown, 1986), was poor.

After feed back from the external evaluation team changes were made to the structure of the programme for Cohort 4. Teaching, in the one module observed, became much more interactive and an attempt was made to explore professional differences as well as consider "core" values, knowledge and skills of mental health professionals. Thus, similarities and differences were both emphasised and the atmosphere, as witnessed by myself, was co-operative. An explicit effort was made by the teaching staff to encourage students to work

with those students they did not know, this may have increased the acquaintance potential of the programme. It is therefore possible that the same study of more recent cohorts of the programme, who have experienced the changes to the teaching, would find evidence of positive attitude change.

A wider variety of teaching methods were employed in the module observed with Cohort 4. These included simulation-based learning, with the use of role-play, and exchange-based learning where, in this case, students joined together in their professional groups and shared with the 'outgroup' their views about professional roles and values. Barr (2002) suggests that didactic learning has a place in interprofessional education. However, he advises it should be used sparingly to reinforce interactive learning. Thus, whilst the students reported enjoying the more didactic style modules there is evidence to suggest more interactive learning methods should be employed to promote learning from and about other professionals rather than simply learning with them. Adult learning theories (e.g. Freire, 1981; Knowles, 1980; Boud, 1988) have criticised the traditional pedagogic approach to adult education and learning, suggesting learners should become empowered and self-directed in order to become independent and interdependent. The aim of such approaches to adult learning is that once knowledge has become outdated students will retain the skills to update the knowledge themselves. These skills have particular relevance to continuing professional development. Additionally, more interactive learning methods have been advocated for interprofessional education so students can learn to work together. For example, McMichael *et al.* (1984) used exchange-based learning, where participants are encouraged to express their opinions, exchange experience and compare assessments and treatment plans in an interprofessional context.

A further condition of the contact hypothesis is that if attitude change is to generalise beyond the intergroup encounter, members of the outgroup (students from other professions) must be perceived as typical. However, evidence from the semi-structured interviews suggests that students were perceived as more forward thinking and more enlightened than typical

members of community mental health services. For example, nurses on the programme may have been seen to have high levels of academic rigour but if the other professionals feel that they are not representative of the nurses whom they work with on a daily basis ratings of the academic rigour of nurses in general over time would not change.

The contact hypothesis suggests that programmes should try to achieve the dual aim of creating an intergroup and an interpersonal environment. Thus, the students should see each other as individuals but also as typical and representative members of their profession (Hewstone *et al.*, 2002). The programme, as I observed it, with Cohort 2 advocated a Common Ingroup Identity (Gaertner *et al.*, 1993). This is where instead of stressing the individuality of group members, a superordinate identity is emphasised (in the Birmingham Programme this was that of a "community mental health worker" rather than a social worker or a nurse). This model has been criticised for failing to take account of the psychological and physical limitations of such an approach in the real world, where identities have many purposes (Brown, 2000). There is a danger with this approach that minority groups become assimilated with the larger ones. This can be seen as a potential hazard for programmes of interprofessional education if a single profession dominates them.

A further problem with the absence of the high status professions, psychiatry and psychology, may be that opportunities to challenge some strongly held attitudes regarding these professions were not available. Furthermore, the absence of these two professions from the programme may have served to reinforce negative stereotypes of these groups. This is especially so given that their participation in the programme was not as students but as presenters of modules. Presenters on the programme were usually individuals who had published widely in their field and were introduced as "experts" in the area they were about to lecture in. Their role in the sessions, which usually consisted of didactic presentations where the psychiatrist or psychologist shared their

propositional knowledge with the students, may have reinforced the stereotypes of the two professions as high in academic rigour and leadership.

The numerical domination of nurses on the programme and in the study may also have hidden some effects on attitude change. Sample sizes for social workers, occupational therapists and "Others" were small compared to nurses and thus evidence of attitude change in the smaller groups may not have emerged as significant. The professional composition of the programme was mainly nurses, occupational therapists and social workers. These are the three professions in mental health that are considered to share many similarities including role and status levels. Indeed, the levels of status on the course, as rated by the students did not show any differences between the three groups. Social identity theory proposes that intergroup relations between status groups will tend to be stable until the low status group perceives opportunities to change the status relations. Thus, the participation of the higher status professions might have produced more intergroup differentiation over time.

There is therefore evidence that not all conditions of the contact hypothesis were present on the Programme in Community Mental Health. This is despite evidence from the students on the quantitative scales that they felt the conditions were met. This disparity between the qualitative and quantitative data may be due to the greater depth of the qualitative methods. It is also likely to be influenced by the interpretations of the conditions. Whereas the students rated that the programme was much more co-operative than competitive this is likely to be because they did not have to interact in their professional roles with each other and therefore co-operation and competition did not emerge to a great extent. The finding from the qualitative methods that the conditions of the contact hypothesis were not met is not surprising given that the programme was not designed with the contact hypothesis in mind. This is unlike the Bristol studies (Carpenter, 1995 a & b, Carpenter and Hewstone, 1996), which were specifically designed in light of the contact hypothesis and demonstrated reasonably strong evidence that the conditions were actually met.

7.4. Changing Attitudes for Interprofessional Working

The second hypothesis of the study was that ratings of heterostereotypes would become more positive from the start of the programme to the end, as students recognised the skills of other professionals. In other words, as different professionals interacted on the programme they would consider members of other professions (the outgroup) in a wider and more diverse way. Findings from the Interprofessional Attributes scales and the interviews with the students showed that students on the programme held professional attributes, or stereotypes and there was very high agreement about the attributes shared by professions. For example, psychiatrists and psychologists received the most negative ratings. They were seen as having low levels of practical skills and less breadth of life experience. In addition psychiatrists were seen as having particularly low levels of interpersonal skills. Psychiatrists and psychologists did, however, receive high ratings for academic rigour and leadership. Ratings of high academic rigour may be reflective of the lengthy training programmes for both professions and competitive entry criteria to such professional courses. It also shows intergroup differentiation. Social workers were generally seen as having considerable breadth of life experience but received low ratings for leadership. Occupational therapists were rated highly for practical skills and interpersonal skills. Nurses were also seen as having good interpersonal skills. None of the heterostereotypes changed significantly over time for any of the professional groups on the Interprofessional Attributes Scale.

Findings from the interviews with students confirmed the findings of the Interprofessional Attributes Scale that professional stereotypes were firmly held. Participants spoke about OTs as "basket weavers", nurses as "medically dominated" and social workers as "politically correct". Psychiatrists were also seen as being constrained to a medical viewpoint with no understanding of 'talking therapies' and psychologists were seen as aloof and to be able to "cherry picking" in their work with people with mental health problems. Whilst stereotypes appeared firmly held few participants reported that their attitudes

had not changed whilst on the programme. Most participants felt they were relatively open-minded about other professionals and the programme had not impacted on that. This was not the case for all participants though. A few participants did report that their attitudes to other professionals had changed on the programme and this was mostly attributed to a greater understanding of the roles of other professions.

Perhaps rather worryingly, a most common response of participants was that they still did not know what the roles of other professions were. Thus with few examples of attitude change in relation to stereotypes held about other professional groups from the interviews and with no evidence of change on the Interprofessional Attribute Scale the second hypothesis was rejected. Possible reasons for the lack of attitude change demonstrated on the programme are discussed below, after an examination of the findings concerning the related hypotheses about autostereotypes and perceived autostereotypes.

The third hypothesis was that ratings of autostereotypes would become less negative from the start to the end of the programme as students no longer saw their profession as their ingroup. In other words, professions would change the way they saw their own professional group whilst on the programme. The data from the Interprofessional Attributes Scale did not show any significant change in the way participants saw their own professional group during the programme. For example, social workers considered their profession to have the greatest 'breadth of life experience' at the start of the programme and they did not change that perception during the time they spent on the programme. OTs rated their own profession highest for 'practical skills' at Time 1 and again at Time 2. Similarly, there was no evidence from the interviews with students that participants had changed the way they perceived their own professional group. In light of these results Hypothesis 3 was rejected.

One interesting feature of the results was that the heterostereotypes corresponded with the autostereotypes suggesting that mutual intergroup differentiation (Tajfel, 1981) was in existence and professions were seen, by

others, as they wished to be seen. However, it must be remembered that no data on autostereotypes was available for two of the five professional groups (psychiatrists and psychologists). Thus it cannot be determined from this study whether other saw psychiatrists and psychologists as they wished to be seen.

The fourth hypothesis was that perceived autostereotypes would become more positive during the programme. This hypothesis was built on the prediction that attitudes about the other professions would improve during the programme and the students would become more confident that other professionals recognised their wide range of skills and abilities. Whilst there were some variations between the professions on their ratings, on the Interprofessional Attributes Scale, of two perceived autostereotypes there were no significant changes over time in the way the professions thought they were seen by others. Again, the participants own reports confirmed this finding. Students in the interviews discussed how OTs were still seen as "basket weavers" and it was a source of amusement on the programme, which was wearing thin with some of the OTs. As a result of the findings the fourth hypothesis was rejected.

All three hypotheses (hypotheses 2,3, and 4) related to the contact hypothesis were rejected since there were no significant changes in heterostereotypes, autostereotypes and perceived autostereotypes. One possible reason for the lack of attitude change demonstrated in this study may be that all the conditions outlined by the contact hypothesis were not present. As seen above the programme was not designed to include all the conditions of the contact hypothesis and whilst the students reported that many of the conditions had been fulfilled this conflicted with what was observed in the teaching sessions of cohort 2.

One alternative explanation for the stability of the stereotypes is that they are actually a reflection of "real" professional differences. Unlike the Bristol studies of pre-qualification students reported by Carpenter and colleagues (Carpenter, 1995 a & b, Carpenter and Hewstone, 1996) this study involved professionals who had been working in their chosen profession for at least two years. The

attitudes of those on pre-qualifying courses may be largely made up of popularly held stereotypes built up from exposure to media images and other influencing factors rather than exposure to the particular professions. However, many of the students on the Birmingham programme had worked in mental health services for many years and thus had considerable experience of working alongside other professionals. Their attitudes may therefore reflect stereotypes built up from differences in attitudes between the professions from their earlier socialisation.

Support for this explanation can be found in the work of Skevington (1981) who investigated intergroup relations between high and low status nurses. Skevington found that, unlike participants in the minimal group studies (discussed in Chapter 4), participants in her study worked with outgroup members as a necessary part of their job. Thus she concluded that the outgroup ratings reflected real and considered differences, rather than the more simplistic impressions obtained in laboratory experiments. A comparative study between the attitude change of those on pre-qualifying programmes and those on post-qualifying programmes would help to shed light on whether the lack of attitude change found in this study was due to "real" professional differences or some other possibility. This finding suggests that there may be differences between pre-qualifying and post-qualifying programmes in their ability to positively change attitudes.

Identity

The study's fifth hypothesis was that professional identity would decrease and team identity would increase as a result of participating on a programme that emphasised multidisciplinary teamworking as opposed to uniprofessional working in community mental health services. This was not so; neither professional identity nor team identity changed significantly over the academic year measured. However, team identity was significantly higher for the students on the programme than professional identity (as rated using the Professional Identity and Team Identity Scales). My observations supported these data and I made several observations of teams appearing to play an

important role in the students' identification. Discussions with the students commonly referred to their team environment, more so than their profession.

Possible reasons why teams were considered so important included the fact that they varied in the amount of support they gave students and this obviously impacted on the students' workload. As a result students often felt appreciative or regretful of the support their team did or did not provide. Brewer (1991) puts forward an alternative view. She uses social identity theory to argue that there are various bases for self-categorisation available to an individual at a particular time. She contends that social identity derives from a fundamental tension between our need as human beings for validation and similarity to others, and a countervailing need for uniqueness and individuation. In other words, group identities allow us to be the same and different at the same time. Brewer develops the theory from the basic tenet that social identification will be strongest for social groups that meet an individual's needs for differentiation of the self and assimilation with others. Brewer summarises her argument by contending, "groups that become overly inclusive or ill-defined lose the loyalty of their membership or break up into fractions or splinter groups" (1991, p. 478).

If Brewer's argument that individuals choose the social identities of groups with clearly defined boundaries, in order to feel distinctive and at the same time similar, is accepted then the lack of professional identification observed could be attributed to the ill defined nature of the professions. It is indeed interesting to note that the students on the programme were from three professional groups that have been criticised for having ill-defined boundaries. Thus, a possible explanation for the favouring of team identity over professional identity could be that teams offer a clearer sense of inclusion. This is not, however, solely due to the boundaries of a profession, it may be that factors on the programme made team identity more important. This is not unreasonable considering that there was a large focus from the programme about implementing learning back in the workplace. However, Carpenter et al (in press) also found that team identity was higher than professional identity for

staff in mental health services across four districts. This strengthens the hypothesis that it is teams in themselves that lend to stronger identity rather than some element of the programme.

In relation to the first research question, the findings from the study indicate that change in attitude is not a necessary outcome of interprofessional education and improved interprofessional working will necessarily follow such an educational venture. This study has shown that didactic teaching methods do not enable interprofessional interactions in order to address the conditions the contact hypothesis outlines as necessary conditions of attitude change. This underlines the importance of training those who are to deliver interprofessional education to facilitate intergroup interactions and make use of interactive teaching methods. There was clear evidence that professional stereotypes were held but these did not change over the one-year of the programme. It is not clear whether this is due to a 'failure' of the programme to meet the necessary conditions of attitude change or if they are simply a reflection of realistic professional differences that are reinforced in the workplace.

7.5. Psychosocial Interventions

The second research question of the study was concerned with how students learn to implement psychosocial interventions in their work with people with severe mental health problems. Three hypotheses were related to this question. The first hypothesis (hypothesis 6) was that students' reported use of psychosocial interventions would increase from starting the course to completing the Certificate level at the end of the academic year. This hypothesis was based on the preposition that because the students had learnt about psychosocial interventions on the programme then they would use them more frequently at work.

The programme focused on two main psychosocial interventions - cognitive behavioural therapy (CBT) and family intervention. Psychosocial interventions

were introduced in the foundation module and covered in other modules. However, the main teaching took place in the module 'Psychological Interventions in Psychosis'. A high status presenter – a professor of psychology, led the module. Learning about PSIs was a complex area in the Birmingham programme. Students reported they enjoyed the skills-based teaching, and my observations supported this, but they also reported difficulties with the teaching. Amongst these was the complaint that teaching was condensed into too short a period of time and as such, issues could not be explored in the depth needed. They also considered that the presentation of material was too "scientific". There was a call for more practical learning methods. This perhaps reflects the argument of adult learning theories that didactic teaching is not the most effective method for skilling learners. Thus whilst students reported enjoying the didactic sessions, when it came to implementing their learning they did not feel confident enough to do so.

The importance of teaching psychosocial interventions in a way that meets the needs of learners has been identified by an evaluation of a one-year interprofessional training programme that taught psychosocial interventions (Repper, 2000). In Repper's study students reported using a greater range of psychosocial skills after the training programme. However, they did not use advanced or highly specialised skills because they reported teaching had been inadequate, amongst a number of other reasons. This highlights the need to develop teaching that equips learners with skills, and with confidence in their skills, rather than just equipping them with knowledge.

Students, from the three cohorts combined, showed statistically significant increases in the use of the two main interventions taught on the programme – CBT and family intervention, from the start to the end of the programme. Thus the sixth hypothesis of the study is accepted. This is positive considering reports in the literature of the poor implementation of skills following training. For example, Fadden (1997) found that after training in Behavioural Family Therapy (BFT) the average number of families seen was only 1.7 and a large number of families (40%) were seen by a small number of students (8%).

Fadden's results were very similar to those of Kavanagh *et al.* (1993) who found that following training in cognitive behavioural family intervention, 70% of those trained used the interventions with only one family.

Whilst it is positive to note statistically significant increases in reports of the two interventions used, one must also be extremely cautious about interpreting the results. Unlike Kavanagh *et al.* (1993) and Fadden (1997), I did not measure the number of users or families that students used the interventions with. Those figures may be similarly disappointing. Furthermore, Kavanagh *et al.* (1993) found that reports of implementation may be exaggerated after finding that 70% of those trained could not recall enough cognitive therapy material to allow them to use it competently. Since more than one third of respondents did not complete the knowledge section of the questionnaire, Kavanagh and colleagues advise that the true figure may be even higher. Thus without an assessment of knowledge it is not possible to claim that the programme resulted in the 'competent' implementation of the intervention. Fadden (1997) assessed the use of behavioural family therapy after a training programme and expressed concerns about the degree to which the intervention had actually been delivered as intended (the treatment "fidelity" or "integrity"). This highlights the need for assessments of competence as well as reported use.

A further note of caution needs to be applied to the student group on the Birmingham programme when considering generalising findings from this study. The students on the programme had made a deliberate choice to attend a programme with a strong psychosocial value base with an interprofessional emphasis. Those with strong prejudices against a psychosocial view of mental health problems or interprofessional teamworking are unlikely to have made such a decision. This accords with evidence from the studies on the contact hypothesis where one of the major flaws of attempts to promote attitude change through inter-group contact has been identified as being that those who have strong negative views will avoid the contact situation. Thus it is likely that initial positive attitudes of students towards psychosocial interventions played a role in the increased use of family intervention and CBT.

Studies of the implementation of skills after training in psychosocial interventions have generally been carried out with small groups of highly motivated students. For example, students in the study reported by Brooker *et al.* (1992) travelled to Manchester from all over the country to be interviewed before getting a place on the programme, and nine students were selected to take part in the course after interviews. The students on the Manchester programme had therefore demonstrated high levels of motivation before even securing a place on the programme.

Several studies concerned with training have found that that students' motivation to learn and attend training has an effect on their skills acquisition, retention and willingness to apply the newly acquired knowledge, skills and attitudes in their work (Martochhio and Webster, 1992; Mathieu *et al.*, 1992; Quinones, 1995; Tannenbaum and Yukl, 1992). This suggests that different results may be found with students who were not so motivated. For example, if training was compulsory for a whole team or organisation outcomes may vary between individuals according to their motivation. This is further supported when the finding by Fadden (1997) is considered, that a small number of students saw a large proportion of the families. This leads Salas and Cannon-Bowers (2001), in their review of the training research literature, to conclude that a deeper understanding of training motivation is needed because it is crucial for learning and has direct implications for the design and delivery of training. Hence, motivation appears to be one factor that facilitates the implementation of learning but there are many factors that may act as barriers to the implementation of learning.

Barriers to the use of psychosocial interventions

The seventh hypothesis of the study (the second hypothesis related to research question 2) was that perceived barriers to the implementation would decrease from the start to the end of the programme. Perceived barriers to implementation were measured using an adapted version of the Corrigan et al. (1992) scale.

Findings from this scale revealed that the largest barrier to the implementation of psychosocial interventions for social workers, nurses and OTs was "Time and Resources". This barrier, which was rated between a small and modest barrier, by all the professions, relates to items such as having too many service users on one's caseload and no allowance from the service for time in lieu or overtime for the out of hours work which is required to do the intervention. This subscale did not change significantly as a reported barrier for any of the professional groups but it did increase significantly between the start and end of the programme for Cohort 4. This may suggest that services are becoming less supportive of students on the programme in terms of flexible working hours and reduced caseloads. This may be reflective of some services having staff on the programme over the whole three years of the programme, concurrently, resulting in a reduced workforce for that service. Services may therefore not have the capacity to support students rather than not having the desire to support them. This suggests that the barrier of time and resources may need to be addressed at a level higher than team managers.

"Support and Interest" concerns items such as "my manager will not support me if I use psychosocial interventions" and "my colleagues are not interested in the use of specialist psychosocial interventions". Social workers and nurses reported that this was less than a slight barrier, suggesting that they do not perceive it to stop them implementing their learning. However, "Others" reported this as a significantly higher barrier at the end of the programme. This may reflect differences in the level of support given and interest shown to non-professionally aligned workers. Whether this is due to a perception, by managers or colleagues, that those without professional training are unsuitable to carry out PSIs is an area that is as yet unclear. It does however suggest hat this barrier could be addressed at a team manager level.

Social workers, nurses and OTs, in general, reported that their 'Belief in Psychosocial Interventions' was less than a slight barrier to implementation. This suggests strongly that they agreed with the philosophy of the course and

that they believed the methods taught on the programme were suitable for use with users on their caseload. Some students in the interviews did suggest that they did not believe the interventions were suitable for their service users but this was not the response from the majority of students. This finding supports the earlier discussion that the students on the programme held positive beliefs about PSIs and were highly motivated in their learning and implementation of the interventions taught on the programme. "Knowledge, Skills and Supervision" relates to the extent that teaching on the programme is of an appropriate depth, there is adequate supervision and students feel sufficiently skilled to implement the psychosocial interventions taught on the programme. At the start of the programme "Others" perceived that this would be their largest barrier to the implementation of their learning. Ratings of this subscale did not change significantly over time for any of the professional groups but did increase significantly for Cohort 3. Conversely, Cohort 2 reported a decrease over time for the perceived barrier of knowledge, skills and supervision. Variations between the cohorts may reflect differences in the teaching of PSIs. As observations were not carried out with Cohort 3 it cannot be assumed that the methods used in the teaching of psychosocial interventions remained the same.

The final subscale of the Barriers to Implementation Scale is "User and Carer Beliefs". This relates to the perceptions of students about the benefits of PSIs for users and carers and users' desire for such interventions. Students across all cohorts rated this as a slight or small barrier. There were no statistically significant differences between the professional groups about this perceived barrier. This suggests that on the whole students were very positive about users and carers' views on psychosocial interventions.

Thus, most students felt that the greatest barrier to their implementation of psychosocial interventions was "Time and Resources". This is consistent with findings from the literature. Kavanagh *et al.* (1993) and Fadden (1997) both found that students reported difficulties in gaining an allowance of time from their organisation to do interventions and integrate the new methods into their

caseloads. Attempts to improve the implementation of behavioural innovations in the US are reported by Corrigan *et al.* (1997) who used a method called Interactive Staff Training to improve attitudes about using behavioural innovations. Their eight-month programme resulted in staff reporting fewer institutional constraints to setting up behavioural innovations. Whilst attitudes improved in the study reported by Corrigan and colleagues, they did not examine whether implementation was more frequent or effective. Thus, there are still many questions about how to improve the implementation of PSIs.

The findings of this study along with the findings of Kavanagh *et al* (1993), Fadden (1997) and Corrigan *et al.* (1997) suggest that many of the barriers are at an organisational level. This suggests a need for organisational change if students are to implement their learning from training. Repper and Brooker (2002) report on the first year of a two-year organisational development project to address implementation issues for students on three training programmes. The project aims to support services in their development of an organisational context that increases the uptake and delivery of evidence-based practice for people with psychosis. The project started with meetings with teams and managers to discuss the proposed process for organisational support. So far, Repper and Brooker report that service users and carers are interested in information about evidence-based practice approaches. Barriers to implementation they identified include resources to support the release of staff, clarity of purpose, and function of CMHTs.

The report by Repper and Brooker (2002) highlights areas of development, in order to improve the integration of skills learnt in training. These include the assessment of training needs for evidence-based practice in psychosis and consideration of "backfill" for seconded students, whereby locum staff cover part of the students work. The suggestion of backfill is in order to conquer the problem of students trying to squeeze five days work into four when on training programmes. Repper and Brooker report that several services were taking up large numbers of places on training programmes and these were stretching resources. They found that psychology and psychiatry had particular problems

at a senior level because of the scarcity of staff to cover, even if funding is available. Additionally, they identify the need for short course training for managers so that they can help students implement their learning.

Role clarity and conflict

The eighth hypothesis of the study was that role clarity would increase and role conflict would decrease from the start of the programme as students learnt new skills. There was no evidence of a significant increase in role clarity, which was already high. This means that learning with other professionals in a common curriculum did not increase students' understanding of their tasks and roles within community mental health services. However, contrary to what was predicted, role conflict did increase for Cohort 3, and for the students overall (with all cohorts combined). The increase in role conflict may have been related to attempts to integrate new interventions into a working role not designed for such ways of working.

The second research question asked how students learn about psychosocial interventions and how they are then implemented in the workplace. This study has shown that learning about psychosocial interventions in a traditional didactic fashion does not help the student when they come to implement the interventions with real service users and families. The students on the programme asked for teaching to be more practice-based suggesting that experiential learning would improve the competence of students.

The implementation of psychosocial interventions was helped by the motivation of students. They demonstrated significant increases in the use of the two interventions taught on the programme. However, they also reported problems in the implementation of their learning. Notably, insufficient time and resources was the largest barrier to implementing psychosocial interventions. This is a barrier that requires change at the organisation level and is not simply a matter for individual students or their team managers. Implementing PSIs also appeared to have an effect on role conflict for students. The significant increase in role conflict from the start of the course to the end suggests that

PSIs do not fit into the traditional roles of nurses, occupational therapists and social workers. As such those who are trained to implement PSIs should be given a flexibility of their role if the use of such evidence-based interventions is to be increased in mental health services. Without adaptable roles that allow practitioners to work outside of office hours and to claim time off in lieu, learning from training programmes of PSIs will not be transferred back into practice.

So far this chapter has examined the implications of the professional mix of students on the programme and the effect this has had on attitude change to improve interprofessional working. It has also examined the findings of the study in terms of the psychosocial interventions that were such a large focus of the programme. This therefore leads to the third and final research question, about user involvement.

7.6. User Involvement

The third research question was concerned with the changes in students' attitudes whilst attending a programme that had an explicit service user focus. The research question had only one hypothesis (Hypothesis 9), which was that students' attitudes would become more positive towards user involvement after completing the Certificate level of the programme. This hypothesis was investigated during the participant observation sessions, the semi-structured interviews with individual students and group interviews with students. Interviews included service users who were students as well as those students with a professional affiliation. The programme had a strong emphasis on user involvement at a number of levels; as the underlying value-base of the programme, by involving users as trainers and having service users studying on the programme.

7.6.1. User Involvement - the value-base

The value-base of the Birmingham programme emphasised working in partnership with service users throughout all aspects of teaching. Most students welcomed the focus on the inclusion of users although some thought that such principles should be accepted as a "given" for people who attended the programme. Whilst students never overtly objected to the value-base, several complained that it was forced upon them and they objected to their perceived lack of choice about accepting it rather than the actual values. In the interviews several students claimed that the value-base of the programme had made a major impact on the way they worked with service users. They also reported that it had helped them develop the confidence and the skills to argue for more user involvement in the workplace. Thus not only did they claim it had helped to change their attitudes; they also maintained that it had actually helped them to change their practice.

User involvement in health and social care has been exhorted by numerous government policies, such as the National Service Framework for Mental Health (Department of Health, 1999), which has user involvement as a fundamental principle. However, the survey of post-qualifying training in mental health by Brooker *et al.* (2002) found that partnerships between education/ training providers and service users are generally less well developed than in service setting. They found that whilst the clear majority of courses involved service users in the planning of courses and in direct teaching on programmes, very few collaborated with service users in the evaluation of programmes, student assessment or the actual management of courses. The Birmingham programme was a noted exception to this. Service users were involved in the design and delivery of the programme and their role in doing so is described elsewhere (Barnes *et al.*, 2000a). This study adds to the work of Barnes et al. (2000a) by examining the impact the value-base of the course had on students, the role they played as trainers as well as exploring the inclusion of service users as students on the programme.

7.6.2. Users as Trainers

The programme had input from service users as trainers, or presenters, in three of the four modules I observed with Cohort 2. Contemporary Approaches to Psychiatric Treatment (CAPT) was the only module I observed which did not involve service users in the delivery of teaching. It is unusual for service users to be so involved in training mental health professionals, as shown by the literature review in Chapter 4. Only one paper in the literature search of post-qualifying training programmes in mental health reported the use and evaluation of service users as trainers. Cook *et al.* (1995) describe a study of training that involved a service user as a trainer. They found that the use of service users had positive benefits for staff who took part in the training. Findings also indicated that those trained by a service user felt more positive about service users as service providers and trainers and expressed more nonstigmatizing attitudes than those trained solely by a non-user. The authors report that the user, while in a trainer role "invested with competence and authority" impressed students with her training skills. Some students believed that the user as trainer was a rare example of a high-achieving person with severe mental health problems whilst others were inspired by her insight.

These findings are similar to those of the present study, which found that some students on the Birmingham programme found it frustrating to keep hearing about "ideal clients". They also did not consider the service users who took on a role of trainer were representative of the people they worked with. They felt that the people they worked with had much more disabling "symptoms" of either mental health problems or institionalisation. As such they felt that some ideas about ways of working were "idealistic". Most students, however, did appreciate the insights that users shared and, on the whole, they found sessions led by a user a positive experience. Of course the personal characteristics of users were also important.

In the Birmingham programme many service users acted as trainers and students distinguished between them; they were not viewed as a homogeneous group. For example, they particularly valued users as trainers who were aware

of historical developments, theoretical approaches and who could put forward more than one perspective. They did not value or respond positively to those users as trainers who appeared aggressive and did not take into account the opinions of others. When students did not respond positively to users as trainers they did not always feel able to express their opinions.

Challenging Service Users

Whilst the students may have disagreed with several service users as trainers, I observed, and they reported, a reluctance to challenge service users. This was often in contexts where they would have challenged a "professional" they disagreed with. This finding is not peculiar to the Birmingham programme. Taylor (1997) discusses this problem in her work on professional education. She states "In my experience, students who would not hesitate to challenge a lecturer, are often reluctant to challenge or critically reflect on material presented by users." (Taylor, 1997, p.177). She also found that students perceived users as more vulnerable and weaker and they expressed a fear about harming them. Some of the Birmingham students apparently shared this view. This suggests there is still a long way to go before users are seen as 'equal' to professionals in the role as trainers in mental health.

The involvement of service users is put forward by government policy but there is little clarity about the role service users as trainers play. Taylor (1997) saw that the involvement of users was, in part, to enable students to hear the voice of the user who will represent his or her experience in a particular way. However, this poses a dilemma for the educator who must decide if the experience can speak for itself. If the educator decides that experience cannot speak for itself they can suggest a critique of a particular theory. However, this can be seen as oppressive. The inclusion and support of service users as trainers appears to be an area which still requires some clarity about how best to involve users. Taylor suggests training for users as trainers in order to explore issues such as skills in developing process knowledge to enable personal knowledge to be heard. Many of the difficulties Taylor found when users are used as trainers have been replicated in this study. In order to

improve the situation, service users should be prepared for what is expected of them if they are asked to contribute to an educational programme. A training programme to prepare them could be seen as one way of valuing them for their contribution and may improve the experience for both users and students. It also seems that training is needed for the programme staff in order to help them to prepare users properly to lead sessions: this could cover situations where the programme staff member may be unsure whether they should intervene or let the user control the session in their own way.

As mentioned, the Birmingham programme is unusual in its inclusion of service users in the design and delivery of the programme. It is also unusual in relation to most mental health training programmes by including those who have experience of using mental health services as students on the programme, even if they do not have a professional qualification or role.

7.6.3. Users as Students

Learning alongside service users as students on a training programme was a new experience for the majority of students in the study. Many students reported that at first they were surprised by the inclusion of service users in the programme in this role but no student overtly objected to this. Instead students reported feeling a little uncomfortable with this. Some students felt that it prevented them from saying exactly what they thought, in case they caused offence. However, while this may have caused discomfort for some of the students it may also have helped them reflect on some of their assumptions about service users. Barnes *et al.* (2000a) used the term "saliency effect" to describe the increased awareness that user involvement can create, so that orientations accommodate to a user perspective when it is brought to their attention. Thus learning alongside users as students may have forced the students to constantly consider a user perspective and may have challenged some of assumptions about users.

Whilst the "professional" students reported that they welcomed service users on the programme, there was a lack of clarity about the purpose of the

programme for users. Many students understood the programme to be a practice-based programme, which would lead to new skills they could implement in their work. However, whilst many students accepted that the principle of user involvement was a reason for users to join the programme there remained a concern about how users would meet the requirements of the programme. Indeed users did report difficulties in meeting the practice-based element of the programme, especially the skills element. Users who were students said that programme staff members were flexible and understanding in making changes to the course requirements for users. Yet, some professionally affiliated students considered the programme might not be the right choice for service users without another role in which they could implement their learning. This suggests, that like any change, it will take some time for those involved to adapt. However, the programme could help to alleviate some of the anxieties of students by discussing the role of service users as students on the programme. They could also discuss the ways in which they will adapt to the need of these students so they can meet the requirements of the programme. Again, this would be in line with the contact hypothesis, which suggests that differences should not be ignored. Mental health professionals and mental health service users both have valuable knowledge about mental health services and although they may come from different perspectives the need for collaboration remains.

The findings from the study have shown that, in answer to the third research question, students can change their attitudes towards service users and many of the students on the programme did indeed report that they had become more user-focused. However, the programme has put considerable time and effort into promoting user involvement in a multitude of ways. There are still some problems, such as how to enable users as trainers to effectively communicate their experience, knowledge and perspective to students and how best to help service users as students on such a work-based programme. It would seem appropriate to draw upon intergroup theory and adult–based learning models for ways of managing these situations. For example, by encouraging participants to discuss differences as well as similarities and

promoting equality between participants on the programme, regardless of their background

The three research questions of this study have been addressed. I will now consider the wider implications of the study in terms of what it means for training health and social care professionals, for university-based education as opposed to work-based initiatives. Finally I will examine the methodological issues of this study before drawing conclusions and recommendations for further areas of research.

7.7. Implications of the Programme

This study has examined a post-qualifying training programme in community mental health in order to establish the extent to which it addresses the problems that face community mental health services. One of the major problems of community mental health services is the need for teams of different professionals to work together. The emphasis has been on learning together in order to improve working together. This remains the aim of government policy for all health and social care professionals.

7.7.1. Training for Health and Social Care

In 2000, the NHS Plan (Department of Health, 2000b) was published. This set the context for the modernising of education, training and professional development in the NHS. It outlined core values and core skills and knowledge that would apply to all staff. Amongst these was the value that all involved in the NHS were working together to provide a seamless service. Core skills included that all NHS staff should work effectively in teams. This involved appreciating the roles of other staff and agencies involved in the care of patients. The emphasis on "working together" enshrined in the core values, knowledge and skills was reinforced by a "new core curriculum". The NHS Plan outlined measures to support common learning on pre-qualification programmes for all health professionals. For example, by providing joint

training in communication skills. The reforms sought to make the transition between health care careers and training paths easier.

Proposals for improving workforce planning and development were spelt out in the NHS workforce strategy *A Health Service of All the Talents* (Department of Health, 2000a). This document again emphasised the importance of training and education across professional boundaries to improve collaboration between professions, agencies and with patients. Changes to education and training were further consolidated in *Working Together – Learning Together (Department of Health, 2001),* which put the innovations in education and training into the context of a framework of lifelong learning. *Working Together – Learning Together* clearly outlines the move towards interprofessional education, especially at a pre-qualifying level. It sets a target that all pre-registration students will take part in common learning with other professions by 2004. It also notes that common learning with other professions should run from under-graduate and pre-registration programmes through to continuing professional education (Department of Health, 2001, p. 32). The Birmingham programme can be used as an example of common learning at the continuing professional education level. One of the lessons that can be taken from this study of the Birmingham programme is that such broad aims of training may make it difficult to deliver effective training.

The broad aims of the Birmingham programme reflect calls from policy. Brooker *et al.* (2002) identify a number of problems with training requirements as outlined in policy documentation. Amongst these was the lack of centres that provide post-qualifying, multidisciplinary, evidence-based, skills-focused training. The need for such training is demanded by the National Service Framework for Mental Health (Department of Health, 1999) which advises that all training and education should be: evidence-based, stress team, interdisciplinary and interagency working, and involve users and carers in the planning, provision and evaluation of the training or education. The Birmingham programme can be seen to fulfil the requirements of the NSF and as such it is one of the few courses in the country to do so (Brooker *et al.*,

2002). Brooker and colleagues found that only 32% of current provision, identified in their survey, met the requirements of the NSF. However, whilst policy may call for such ambitious training it is not yet clear whether it is suitable for it to be delivered simultaneously by one programme.

7.7.2. University-based education

This thesis has evaluated a university-based post-qualifying programme, however, the suitability of university-based education has been questioned. Tarrier *et al.* (1998) identify a number of weaknesses with training that takes place away from the work place. Amongst these is the need for staff to leave their place of work in order to attend the training. This necessarily reduces the student's input to the team. Additionally, the current programme requires that students leave behind most of their colleagues.

An alternative solution to this would be whole-team learning as discussed by (Miller *et al.*, 2001). Miller and colleagues suggest that one of the benefits of whole team learning is that it enables learning to be focused on the specific clinical context in terms of geography, organisation, resource and function (Miller *et al.*, 2001, p.174). In this way, interprofessional communication can be learnt with colleagues who interact on a daily basis. It also offers an opportunity to develop a shared team philosophy and culture and identify the roles of each profession. However, whole-team training also has its disadvantages and many teams could not afford to train together. This could mean the closure of the service for the duration of training or the replacement of staff with locums, which has obvious resource implications. Evidence can be found in Repper and Brooker's report (Repper and Brooker, 2002) that cites examples of the stretching of resources when several team members attended training together. Thus, whilst university-based training may have its drawbacks it enabled individual's from a wide geographical base to attend the training. Additionally, it also offered students the opportunity for "time and space" away from the work place to reflect on their professional practice and the working of their organisation.

7.8. Methodological Issues

This study has attempted to use multiple methods to measure outcomes for students attending an interprofessional post-qualifying programme in community mental health. It measured outcomes in terms of changes in attitudes, skills and practice for three successive cohorts of the programme. The inclusion of three cohorts enables change to be measured over a longitudinal period and reduce the likelihood that reported changes were due to some factor other than the training programme. Thus, any change that is consistent across the three years increases the confidence that can be attached to the claim that the change is due to the programme. The evaluation was independent, unlike many evaluations of interprofessional education, which are often carried out by the teachers and trainers themselves (Barr *et al.*, 1999). Additionally, the evaluation has been guided by previous evaluations of interprofessional education (e.g. Carpenter, 1995a & b; Carpenter and Hewstone, 1996) and evaluations of training for health and social care staff (Corrigan *et al.*, 1992).

Whilst the study has many methodological strengths, it also has a number of weaknesses. Firstly, there was no observation of Cohort 3, thus it is not possible to generalise about their experiences on the programme, with the exception of those students interviewed. Secondly, sample sizes for the semi-structured interviews were quite small, especially for professions other than nursing. Only two social workers were interviewed. Additionally the response rate to the questionnaire sent to those students who dropped out of the programme was very poor and the data is not reported. The drop-out rate of the programme was quite high, 23% overall, and especially high for Cohort 3, 33%. It cannot be assumed that these students had the same experience as the students who continued with the programme. Two of the students who dropped out of the programme before the end of the first year were interviewed during the semi-structured interviews, which gave the opportunity for some of their opinions to be considered. However, this data should not be considered

to be representative of those who left the programme before achieving the certificate level.

Finally, there is an over-reliance on the self-report data of the students. This reduces the strength of evidence gained from this study, since it cannot be assumed that students' reports of changes in their attitudes, skills and practice are accurate. Students may have under or over-estimated changes following the training. The absence of a validated measure of competence means that reported changes in the level of skills in psychosocial interventions cannot be supported by evidence.

Future work should concentrate on the assessment of students' competence in applying the methods following training and the benefits to users and carers. Milne and colleagues advise that ideally competence should be assessed with multiple assessment methods, including well-validated instruments, applied to determine the adherence, skilfulness and interpersonal effectiveness with which students apply the skills they have been trained in (Milne *et al.*, 2000, p. 98). Competence should be independently assessed, perhaps with audiotapes of skills, which are assessed by an independent rater, blind to the timing of the tapes. As well as the systematic measurement of outcome there should be a thorough assessment of the integrity of the training process. This necessitates accurate and reliable observation, referred to in the psychotherapy literature as a "manipulation check". Such an analysis would clarify whether the training did indeed conform to the specification, thus providing an audit function that may itself improve the effectiveness of training (Milne *et al.*, 2000).

7.9. Recommendations

In light of the findings of this study a number of recommendations can be made which may prove useful for future programmes and evaluations in the areas of interprofessional education, psychosocial interventions and service user involvement. I will make recommendations for each area in turn and then make some general recommendations and reflections about the study.

7.9.1. Interprofessional Education

This study has evaluated an interprofessional education programme for community mental health practitioners. It has examined ways of promoting collaborative working with the five main mental health professions as well as collaboration with service users and carers. The major premise of this study has been that by learning together the professions would learn to work together. Interprofessional education is often built upon the assumption that by bringing together groups they can learn about each other and reduce negative attitudes that may impede interprofessional working. As such this study has examined changes in interprofessional attitudes and assessed conditions of the learning environment according to a social psychological theory, the contact hypothesis. There were no significant interprofessional attitude changes on the programme and as such the following recommendations are made:

1. Programme staff should realise that positive attitude change is not an automatic outcome of interprofessional education.
2. Programmes of interprofessional education should therefore be designed with conditions of the contact hypothesis in mind.
3. Teaching methods should be interactive rather than relying on didactic methods alone. As such they should meet the conditions identified by the contact hypothesis.
4. The proportion of participation by different professional groups should be examined to determine what the effect (if any) is of the domination of one professional group and how this translates to the experience of participation from minority and majority professions.
5. Differences in attitude change of pre-registration and post-registration students on interprofessional education programmes should be compared. Post-registration students have experience of working alongside other professionals and as such it may be more difficult to change interprofessional attitudes later in a professional's career.
6. The appropriateness of university-based programmes versus work-based programmes for post-registration students should be investigated.

7.9.2. Psychosocial Interventions

The programme evaluated in this study also aimed to skill the students in psychosocial interventions, specifically cognitive behavioural therapy and family intervention. The results of this study show that the use of CBT and family intervention can be increased following training. However, this was with a highly motivated group of students who were interested in psychosocial interventions. This may have implications if employers decide to increase the number of their staff trained in psychosocial interventions and staff are selected for training because of their role rather than their levels of motivation. The study also showed that time and resources are the largest barriers facing students trying to implement their learning.

The following recommendations are made in the light of the findings of this study:

1. Appropriate time is allocated for the teaching of psychosocial interventions and issues are explored in depth.
2. Teaching sessions use practical learning methods rather than employing only lectures and presentations. Didactic teaching methods do not help students to feel confident enough to implement their skills.
3. Future studies of the outcomes of training programmes of psychosocial interventions should measure how many users and families benefit from the implementation of psychosocial interventions. They should also measure the 'fidelity' that the intervention delivered relates to the intervention taught.
4. The role motivation in students' learning should be examined.
5. Organisational changes are made to enable students to implement their learning. For example, they are enabled to work time in lieu in order to meet families out of usual hours.
6. Students should also be supported in other ways to implement their learning since significant increases in role conflict suggest that psychosocial interventions do not fit into the traditional roles of the mental health professionals in this study.

7.9.3. User Involvement

Students can benefit from a training programme in terms of more positive attitudes towards user involvement. However, the study has shown that there are still many issues to be resolved in the involvement of service users in training programmes and in mental health services. Students felt that values were forced upon them, when they already held many of the same values as the programme promoted. Additionally the role of service users as trainers, whilst mainly welcomed, did encounter some problems. Finally, the role of service users as students on a programme designed for those who work in mental health services caused some confusion.

Recommendations for future training programmes for mental health professionals include:

1. Programme staff members need to be sensitive to the values many students bring to a training programme. Whilst, there is a role to ensure all work from a common value base it can be offensive for students if it is assumed they do not already hold those values.
2. Service users as trainers should be supported when involved in a training programme for professionals. Perhaps a short training programme on what their role is and the audience they will be speaking to would help service users who may not have undertaken such a role previously.
3. Finally, the role of service users on a programme for those who work in mental health services should be articulated to all students by the programme staff. This should increase clarity about what service users can bring to the programme and how they will be assessed.

7.10. Conclusion

This study has investigated an interprofessional, post-qualifying programme for staff who work in community mental health services. Interprofessional education and training in psychosocial interventions are both increasingly prominent in Britain and it is no longer uncommon for students to learn new interventions with colleagues from other professions. Calls for evidence-based practice and the inclusion of service users at all levels of training and service provision are to be commended. However, the implementation of new skills and calls to alter working practices require change beyond the level of individuals. As such, responsibility for implementing changes to mental health services cannot be left solely with those individuals who undertake training courses. This is not to doubt that individuals who commit to post-qualifying training, such as the programme studied, are likely to be amongst the individuals who most wish to see change.

Mental health services are currently asked by government, service user groups, professional bodies and the media to meet a number of different needs. The individuals working in such services are often doing their best to provide effective services under the extremely difficult conditions of staff shortages, large caseloads and limited resources. Training can help to change people's attitudes, to increase their knowledge and improve skill levels but ultimately organisational changes must be made if these individuals are to be permitted and supported to put their newly acquired skills, knowledge and attitudes in to operation. Without such changes the commitment, vision and expertise of the professionals, trainers and service users who wish to improve services for some of the most socially de-valued people in our society will be wasted.

REFERENCES

Albanese, M. A. & Mitchell, S. (1993) Problem-based learning: A review of the literature on its outcomes and implementation issues. *Academic Medicine*, 68, 52-81

Allport, G.W. (1954) *The Nature of Prejudice*. Reading, Mass: Addison-Wesley.

Amir, Y. (1969) Contact in ethnic relations. *Psychological Bulletin*, 71, 319-342.

Anciano, D. & Kirkpatrick, A. (1990) CMHTs and Clinical Psychology: The death of a profession. *Clinical Psychology Forum*, 26, 9-12.

Anderson, J. & Adams, C. (1996). Family interventions in schizophrenia: An effective but underused treatment. *British Medical Journal*, 313, 505-506.

Annandale, S., J., McCann, S., Nattras, H., DeBere, S.R., Williams, S. & Evans, D. (2000). Achieving health improvement through interprofessional learning in southwest England. *Journal of Interprofessional Care*, 14, 161-174

Areskog, N-H. (1994). Multiprofessional education at the undergraduate level-the Linköping model. *Journal of Interprofessional Care*. 8, 279-282.

Areskog, N-H. (1995). Multiprofessional education at the undergraduate level. In: K. Soothill., L. Mackay. & C. Webb (Eds.). *Interprofessional Relations in Health Care*. London: Arnold.

Ashworth, P., Williams, C. & Blackburn, I. M. (1999). What becomes of cognitive therapy trainees? A survey of trainees' opinions and current clinical practice after postgraduate cognitive therapy training. *Behavioural and Cognitive Psychotherapy*, 27, 267-277.

Audit Commission (1986) *Making a Reality of Community Care*. London: HMSO.

Bachrach, L. L. (1991) Community mental health centers in the USA. In D. Bennett, & H. L. Freeman (Eds.), *Community Psychiatry: The Principles*. London: Churchill Livingstone.

Bailey, D. (2002a). Training together: An exploration of a shared learning approach to dual diagnosis for specialist drugs workers and approve social workers (ASWs). *Social Work Education*. (In Press).

Bailey, D. (2002b). Training together part two: An exploration of the evaluation of a shared learning programme on dual diagnosis for specialist drugs workers and approved social workers. *Social Work Education*. (In Press).

Banks, M. H., Clegg, C. W., Jackson, P. R., Kemp, N. J., Stafford, E.M., Wall, T. D. (1980). The use of the General Heath Questionnaire as an indicator of mental health in occupational studies, *Journal of Occupational Psychology*, 53, 187-194.

Barnes, D., Carpenter, J. & Bailey, D. (2000a). Participation with service users in interprofessional education for community mental health. *Journal of Interprofessional Care*, 14, 189-2000.

Barnes, D., Carpenter, J. & Dickinson, C. (2000b). Interprofessional education for community mental health: attitudes to community care and professional stereotypes. *Social Work Education*, 19, 565-583.

Barr, H. (1996). Ends and means in interprofessional education: towards a typology. *Education for Health*, 9, 341-352.

Barr, H. (1998). Competent to collaborate: towards a competency-based model for interprofessional education. *Journal of Interprofessional Care*, 12, 181-188.

Barr, H. (2000). Interprofessional Education: 1997-2000. A Review. London: CAIPE

Barr, H. (2002). *Interprofessional Education: Today, Yesterday and Tomorrow.* London: LTSN (Learning and Teaching Support Network for Health Sciences and Practice).

Barr, H. and Shaw, I. (1995). Shared learning: Selected examples from the literature. London: CAIPE.

Barr, H. and Waterton, S. (1996). *Interprofessional education in health and social care in the United Kingdom.* Report of the survey commissioned by the Centre for the Advancement of Interprofessional Education. London: CAIPE.

Barr, H., Hammick, M., Koppel, I. & Reeves, S. (1999). Evaluating interprofessional education: A United Kingdom review for health and social care. BERA/ CAIPE.

Barris, R. & Kielhofner, G. (1986). Beliefs, perspectives and activities of psychosocial occupational therapy educators. *American Journal of Occupational Therapy*, 40, 535-41.

Barrowclough, C. & Tarrier, N. (1984). Psychosocial interventions with families and their effects on the course of schizophrenia. *Psychological Medicine*, 146, 629-642.

Barrowclough, C., Tarrier, N., Watts, S., Vaughn, C., Bamrah, J. & Freeman, H. (1987). Assessing the functional knowledge about schizophrenia: a preliminary report. *British Journal of Psychiatry*, 151, 1-8.

Bassoff, B. Z. (1983). Interdisciplinary education as a Facet of Healthcare Policy: The Impact of Attitudinal Research. *Journal of Allied Health*, 6, 280-6.

Becher, T. (1993). Academic Tribes and Terriorities: Intellectual Enquiry and the Culture of Disciplines. Buckingham: SHRE and Open University Press.

Becher, T. (1999). Professional Practices: Commitment and Capability in a Changing Environment. London: Transaction Publishers.

Becher, T. (Ed) (1994). *Governments and Professional Education*. Buckingham: Open University Press.

Beck, A. T. (1952). Successful out-patient psychotherapy of a chronic schizophrenic with a delusion based on borrowed guilt. *Psychiatry*, 15, 305-312.

Berkowitz, R., Eberlein-Fries, R., Kuipers, L. & Leff, J. (1984). Educating relatives about schizophrenia. *Schizophrenia Bulletin*, 10, 418-429.

Bernstein, B. (1996). Pedagogy, Symbolic Control and Identity Theory: Theory, Research, Critique. London: Taylor and Francis.

Bines, H. (1992). Issues in course design. In: H. Bines & D. Watson (ed). *Developing Professional Education*. Buckingham: SHRE & Open University Press.

Birchwood, M. (1983). *Family coping Behaviour and the Course of Schizophrenia*. Unpublished PhD Thesis: University of Birmingham.

Birchwood, M. (1996). Early Intervention in psychotic relapse. In: G. Haddock & P. Slade (Eds.). *Cognitive-Behavioural Interventions for Psychotic Disorders*. London: Routledge.

Birchwood, M., Smith, J., Cochrane, R. *et al.* (1990). The development and validation of a new scale of social adjustment for use in family intervention programmes with schizophrenic patients. *British Journal of Psychiatry*, 157,853-859.

Birchwood, M., Smith, J., Macmillan, F., Hogg, B., Prasad, R., Harvey, C. & Bering, S. (1989). Predicting relapse in schizophrenia: the development and implementation of an early warning signs monitoring system using patients and families as observers: A preliminary investigation. *Psychological Medicine*, 19, 649-656.

Blackburn, I. M., Milne, D. L., & James, I. A. (1997). How are therapeutic competencies evaluated? Heriot-Watt University; Edinburgh. Annual

conference of the British Psychological Society (Division of Clinical Psychology).

Bonder, B. R. (1987) Occupational therapy in mental health: crisis or opportunity. *American Journal of Occupational Therapy*, 41, 495-99.

Boud, D. (1988). Moving towards Autonomy. In: D. Boud (ed.). *Developing Student Autonomy in Learning* (2nd edn). London: Kogan Page.

Brennan, G. & Gamble, C. (1997). Schizophrenia family work and clinical practice. *Mental Health Nursing*, 17, 12-15.

Brewer, M. (1991). The social self: On being the same and different at the same time. *Personality and Social Psychology Bulletin*, 17, 475-482.

Brewer, M. B. & Miller, N. (1984). Beyond the contact hypothesis: theoretical perspectives on desegregation. In: N. Miller & M. B. Brewer (Eds.). *Groups in Contact: The Psychology of Desegregation*. New York: Academic Press.

Brooker, C. & Brown, M. (1986). National follow-up survey of practising nurse therapists. In. *Readings in Psychiatric Nursing Research* (Brooking, J. ed.). Wiley and Sons, Chichester.

Brooker, C. & Butterworth, T. (1993). Training in psychosocial intervention: the impact on the role of community psychiatric nurses. *Journal of Advanced Nursing*, 18, 583-590.

Brooker, C. (1990). A six-year follow-up study of nurses attending a course in community psychiatric nursing. In: C. Brooker (ed.) *Community Psychiatric Nursing: A Research Perspective*. Chapman and Hall, London.

Brooker, C. (2001). A decade of evidence-based training for work with people with serious mental health problems: Progress in the development of psychosocial interventions. *Journal of Mental Health*, 10, 17-31.

Brooker, C., Falloon, I., Butterworth, A., Goldberg, D., Graham-Hole, V. & Hillier, V. (1994). The outcome of training community psychiatric nurses to deliver psychosocial intervention. *British Journal of Psychiatry*, 165, 222-230.

Brooker, C., Gournay, K., O'Halloran, P., Bailey, D. & Saul, C. (2002). Mapping training to support the implementation of the National Service Framework for mental health. *Journal of Mental Health*, 11, 103-116.

Brooker, C., Saul, C., Robinson, J., King, J. & Dudley, M. (2001). Is Training in Psychosocial Interventions Worthwhile? Report of a psychosocial intervention trainee follow-up study. ScHARR, Sheffield.

Brooker, C., Tarrier, N., Barrowclough, C., Butterworth, A. & Goldberg, D. (1992). Training community psychiatric nurses for psychosocial intervention: Report of a pilot study. *British Journal of Psychiatry*, 160, 836-844.

Brown, A. & Bourne, I. (1996). *The Social Work Supervisor.* Buckingham: Open University Press.

Brown, G. W., Birley, J. T. L. & Wing, J. K. (1972). Influence of family life on the course of schizophrenia: A replication. *British Journal of Psychiatry*, 121, 241-58.

Brown, G. W., Carstairs, G. M. & Topping, G. (1958). Post hospital adjustment of chronic mental patients. *Lancet*, ii, 685-9.

Brown, R. & Gardman, K. (2001). Two forms of intergroup discrimination with positive and negative outcomes: explaining the positive-negative asymmetry effect. *Personality and Social Psychology Bulletin*.

Brown, R. (2000). Social Identity Theory: Past achievements, current problems and future challenges. *European Journal of Social Psychology*, 30, 745-778.

Brown, R., Condor, S., Matthews, A., Wade, G. & Williams, J. (1986). Exploring intergroup differentiation in an industrial organisation. *Journal of Organisational Psychology,* 59, 273-286.

Brown, R., Vivian, J. & Hewstone, M. (1999). Changing attitudes through intergroup contact: the effects of group membership salience. *European Journal of Social Psychology*, 29, 741-64.

Busfield, J. (1986). Managing Madness: Changing Ideas and Practice. London: Hutchinson.

Busfield, J. (1996). Professionals, the state and the development of mental health policy. In T. Heller, J. Reynolds, R.Gomm *et al.* (Eds.), *Mental Health Matters: A Reader*. Basingstoke: Macmillan Press.

Butterworth, T. (1995). The current status and future challenges of psychiatric/ mental health nursing. *International Journal of Nursing Studies*, 32, 353-365.

Caine, T., Smail, D., Wijesinghe, O. & Winter, D. (1982). *The Claybury Selection Manual.* NFER-Nelson, Windsor.

CAIPE (1997). Interprofessional Education-A Definition. London: CAIPE.

Campbell, A. (1999). *Behavioural Family Therapy: A Regional Evaluation*. West Midlands Partnership for Developing Quality, Birmingham.

Carpenter, J. & Hewstone, M. (1996). Shared learning for doctors and social workers: evaluation of a programme, *British Journal of Social Work*, 26, 239-257.

Carpenter, J. (1995a). Doctors and nurses: stereotypes and stereotype change in interprofessional education, *Journal of Interprofessional Care*, 9, 151-161.

Carpenter, J. (1995b). Interprofessional education for medical and nursing students: evaluation of a programme, *Medical Education*, 29, 265-275.

Carpenter, J., Barnes, D. & Dickinson, C. (1999). *Birmingham University Programme in Community Mental Health: Progress Report from the External Evaluation Team.* Centre for Applied Social Studies, University of Durham, Durham.

Carpenter, J., Barnes, D. & Dickinson, C. (2000). *Birmingham University Programme in Community Mental Health: Progress Report from the External Evaluation Team.* Centre for Applied Social Studies, University of Durham, Durham.

Carpenter, J., Ring, C., Sangster, A., Cambridge, P. & Hatzidimitriadou, E. (2000). From the asylum to the community: A longitudinal study of staff involved in the transition from Tone Vale Hospital to community-based services, *Journal of Mental Health*, 9, 211-230.

Carpenter, J., Schneider, J. *et al.* (in press). Working in multidisciplinary community mental health teams: the impact on social workers and health professionals of integrated mental health care. *British Journal of Social Work.*

Carrier, J. & Kendall, I. (1995). Professionalism and Interprofessionalism in health and social care: some theoretical issues. In: P. Owens, J. Carrier & J. Horder. (Eds). *Interprofessional Issues in Community and Primary Health Care.* London: Macmillan.

CCETSW. (1992). *Multidisciplinary Teamwork.* London: CCETSW.

Clark-Carter, D. (1997). *Doing Quantitative Psychological Research: From Design to Report.* Hove: Psychology Press.

Clauser, C. J. & Wise, K.F. (1958). Tranquillising drug effects on the schizophrenic patient in occupational therapy. *Occupational Therapy*, 21, 18-23.

Cook, J. A., Jonikas, J.A. & Razzano, L. (1995). A randomized evaluation of consumer versus nonconsumer training of state mental health [providers. *Community Mental Health Journal*, 31, 229-238.

Cook, S. W. (1985). Experimenting on Social Issues: The Case of School Desegregation. *American Psychologist*, 40, 452-424.

Cooper, D. (1968). *Psychiatry and Anti-psychiatry*. London: Tavistock.

Cooper, J. & Fazio, R. H. (1979). The formation and persistence of attitudes that support intergroup conflict. In: W. G. Austin & S. Worchel (eds). *The Social Psychology of Intergroup Relations*. Monterey: Brooks/ Cole.

Coppock, V. & Hopton, J. (2000). *Critical perspective on mental health*. London: Routledge.

Corney, R. (1995). Mental Health Services. In: P. Owens, J. Carrier & J. Horder (eds), *Interprofessional Issues in Community and Primary Health Care*. Macmillan: London.

Corrigan, P., Holmes, E. P., Luchins, D, Basit, A., Delaney, E., Gleason, W., Buican, B. & McCracken, S. (1995). The effects of interactive staff training on staff programming and patient aggression in a psychiatric inpatient ward. *Behavioural Interventions*, 10, 17-32.

Corrigan, P.W., Kwartarini, W.Y & Pramana (1992). Barriers to the implementation of behavior therapy. *Behavior Modification*, 16, 132-144.

Corrigan, P.W., McCracken, S.G., Edwards, M., Kommana, S. & Simpatico, T. (1997). Staff training to improve implementation and impact of behavioral rehabilitation programs. *Psychiatric Services*, 48,1336-1338.

Craik, C., Chacksfield, J. D.& Richards, G. (1998). A survey of occupational therapy practitioners in mental health. *British Journal of Occupational Therapy*, 61, 227-234.

Dahle, L. O., Forsberg, P., Svanberg-Hard, H., *et al* (1997). Problem-based Medical Education: development of a theoretical foundation and science based professional attitude. *Medical Education*, 31, 416-424.

Davis, J. R., Rawana, E.P, & Copponi, D.R. (1989). Acceptability of behavioural staff management techniques. *Behavioural Residential Treatment*, **4** (1), 23-44.

Denzin, N. K. & Lincoln, Y. S. (1994). *Handbook of Qualitative Research.* Thousand Oaks, CA: Sage.

Department of Health (1989a). *Caring for People: Community Care in the Next Decade and Beyond.* London: HMSO.

Department of Health (1989b). *Working for Patients.* London: HMSO.

Department of Health (1990). *Community Care in the Next Decade and Beyond: Policy Guidance.* London: HMSO.

Department of Health (1991). *The Patient's Charter.* London: HMSO.

Department of Health (1994). *Working in Partnership: A Review of Mental Health Nursing.* London: HMSO.

Department of Health (1995). *Building Bridges: A guide to arrangements for inter-agency working for the care and protection of severely mentally ill people.* London: HMSO.

Department of Health (1996). *The Spectrum of Care: Local services for people with mental health problems.* London: HMSO.

Department of Health (1998a). *Modernising Health and Social Services: National Priorities Guidance 1999/00 – 2001/02.* London: Department of Health.

Department of Health (1998b). *Modernising Mental Health Services: Safe, Sound and Supportive.* London: HMSO.

Department of Health (1999). *National Service Framework for Mental Health.* London: Department of Health.

Department of Health (2000a). *A Health Service of all the Talents: Developing the NHS Workforce.* London: Department of Health.

Department of Health (2000b). *The NHS Plan. A Plan for investment. A Plan for Reform.* London: Department of Health.

Department of Health (2001). *Working Together – Learning Together: A Framework for Lifelong Learning for the NHS.* London: Department of Health.

Department of Health (2002). *Reform of Social Work Education and Training.* http://www.doh.gov.uk/swqualification/index.htm

Department of Health and Social Security (1975). *Better Services for the Mentally Ill.* London: HMSO.

DHSS (1977) *The Role of Psychologists in the Health Service (Trethowan Committee).* London: HMSO.

Donat, D.C., McKeegan, G.F. & Neal, B. (1991). Training inpatient psychiatric staff in the use of behavioural methods: A program to enhance utilization. *Psychosocial Rehabilitation Journal*, 15, 69-74.

Dyer, J. & Hoffenberg, M. (1975). Evaluating the quality of working life. In: *The Quality of Working Life*. Vol 1. New York: Macmillan/ Free Press.

Endicott, J. *et al.*, (1976). The Global Assessment Scale. *Archives of General Psychiatry*, 33, 765-771.

Engel, C. (1994). A functional anatomy of teamwork. In: A. Leathard (ed.) *Going Interprofessional: Working Together for Health and Welfare.* London: Routledge.

English National Board for Nursing, Midwifery and Health Visiting. (2000). *Education in Focus: Strengthening Pre-Registration Nursing and Midwifery Education*. London: ENB.

Eraut, M. (1992). Developing the knowledge base: a process perspective on professional education. In: R. Barnett (Ed) *Learning to Effect.* Buckingham: SHRE and Open University Press.

Eraut, M. (1994). *Developing Professional Knowledge and Competence.* London: The Falmer Press.

Etzioni, A. (ed.) (1969). *The Semi-Professions and their Organization: Teachers, Nurses, Social Wo*rkers. New York: Free Press.

Fadden, G. (1997). Implementation of family interventions in routine clinical practice following staff training programs: A major cause for concern. *Journal of Mental Health*, 6, 599-612.

Fadden, G. (1998). Family Intervention. In: C. Brooker. & J. Repper (Eds.), *Serious Mental Health Problems in the Community: Policy, Practice and Research*. London: Balliere Tindall.

Falloon, I. R. H., Boyd, J. L. McGill, C. W., Williamson, M., Razini, J., Moss, H. B., Gilderman, A. M. & Simpson, G. M. (1985). Family management in the prevention of morbidity in schizophrenia: Clinical outcome of a 2 year longitudinal study. *Archives of General Psychiatry*, 42, 887-896.

Fernando, S. (1992). Psychiatry. *OpenMind*, 58, 8-9.

Ferrier, B. & Woodward, C. (1987). Career choices of McMaster medical graduates and contemporary Canadian medical graduates. *Canadian Medical Association Journal*, 136, 39-44.

Festinger, L. (1957). *A Theory of Cognitive Dissonance.* Stanford: Stanford University.

Foucault, M. (1967). *Madness and Civilisation.* London: Tavistock.

Freeman, H. (1999). Psychiatry in the National Health Service. *British Journal of Psychiatry*, 175, 3-11.

Freiheit, S.R. & Overholser, J.C. (1997). Training issues in cognitive-behavioral psychotherapy. *Journal of Behavioral and Experimental Psychiatry*, 28, 79-86.

Freire, P. (1981). *Pedagogy of the Oppressed* (2nd edn). New York: Herder and Herder.

Funnell, P., Gill, J. & Ling, J. (1992). Competence through interprofessional shared learning. In D. Saunders & P. Race. (Eds). *Developing and Measuring Competence*. London: Kogan Page.

Gaerther, S. L. (1999)Reducing Intergroup Bias: elements of intergroup cooperation. *Journal of Personality and Social Psychology*, 76, 388-402.

Gaertner, S. I., Dovidio, J. F., Anastasio, P. A., Bachman, B. A. & Rust, M. C. (1993). The common ingroup identity model: recategorisation and the reduction of intergroup bias. *European Review of Social Psychology*, 4, 1-26.

Galvin, S. W. & McCarthy, S. (1994). Multi-disciplinary community teams: Clinging to the wreckage. *Journal of Mental Health*, 3, 157-166.

Gamble, C., Midence, K. & Leff, J. (1994). The effects of family work training on mental health nurses' attitude to and knowledge of schizophrenia: A replication. *Journal of Advanced Nursing*, 19, 893-896.

Glaser, B. and Strauss, A. (1967). *The Discovery of Grounded Theory*. Chicago: Aldine.

Goble, R. (1994). Multiprofessional education in Europe: an overview. In: A. Leathard (ed.) *Going Interprofessional: Working Together for Health and Welfare*. London: Routledge.

Goldberg, D. & Hillier, V. (1978). A scaled version of the general health questionnaire. *Psychological Medicine*, 9, 139-146.

Gournay, K. & Brooking, J. (1994). Community psychiatric nurses in primary care. *British Journal of Psychiatry*, 165, 231-8.

Gournay, K. (1986). A pilot study of nurses' attitudes with relation to post-basic training. In. *Readings in Psychiatric Nursing Research* (Brooking, J. ed.). Wiley and Sons, Chichester.

Gournay, K. (1995). Mental health nurses working purposefully with people with serious and enduring mental illness: An international perspective. *International Journal of Nursing Studies*, 32, 341-352.

Gournay, K., Denford, L., Parr, A. & Newell, R. (2000). British nurses in behavioural psychotherapy: a 25-year follow-up. *Journal of Advanced Nursing*, 32, 343-351.

Griffiths Report (1988). *Community Care: An Agenda for Action.* London: HMSO.

Grove, E. (1988). Working Together: The Casson Memorial Lecture, 15 April 1998. *British Journal of Occupational Therapy*, 51, 150-156.

Haddock, G., Tarrier, N., Spaulding, W., Yusupoff, L., Kinney, C. & McCarthy, E. (1998). Individual cognitive-behavior therapy in the treatment of hallucinations and delusions: A review. *Clinical Psychology Review*, 18, 821-838.

Haddow, M. & Milne, D. (1995). Attitudes to community care: development of a questionnaire for professionals. *Journal of Mental Health*, 4, 289-296.

Hammersley, M. & Atkinson, P. (1995). *Ethnography: Principles in Practice.* London: Routledge.

Hammick, M. (1998). Interprofessional education: concept, theory and application. *Journal of Interprofessional Care*, 12, 188-198.

Hannigan, B. (1999). Joint working in community mental health: Prospects and challenges. *Health and Social Care in Community*, 7, (1), 25-31.

Hartley, J. (1998). *Learning and Studying: A Research Perspective*. London: Routledge.

Haworth, N. & MacDonald, E. M. (1946). *The Theory of Occupational Therapy.* London: Bailere, Tindall and Cox.

Hewstone, M. & Brown, R. (1986). Contact is not enough: An intergroup perspective on the contact hypothesis. In M. Hewstone & R. Brown (Eds.), *Contact and Conflict in Intergroup encounters*. Oxford: Blackwell.

Hewstone, M. (1996). Contact and Categorisation: Social psychological interventions to change intergroup relations. In. C. N. Macrae., C. Stangor & M. Hewstone. (Eds.). *Stereotypes and Stereotyping*. New York: Guilford.

Hewstone, M., Carpenter, J., Franklyn-Stokes, A. & Routh, D. (1994). Intergroup contact between professional groups: Two evaluation studies. *Journal of Community and Applied Social Psychology*, 4, 347-363.

Hewstone, M., Rubin, M. & Willis, H. (2002). Intergroup bias. *Annual Review of Psychology*, 53, 575-604.

Hopton, J. (1994/ 1995). 'User involvement in the education of mental health nurses: An evaluation of possibilities. *Critical Social Policy*, 42, Winter, 47-62.

Horder, W. (1996). Structures, cultures and undertows: inter-agency training for community care. *Journal of Interprofessional Care*, 2, 121-132.

Hunter, D. (1992). The move to community care with special reference to mental ill. In E. Beck (Ed.), *In the Best of Health*. London: Chapman and Hall.

Johnson, D. W., Johnson, R. T. & Maruyama, G. (1984). Goal interdependence and interpersonal-personal attraction in heterogeneous classrooms: a meta analysis. In: N. Miller & M. B. Brewer (eds). *Groups in Contact: The Psychology of Desegregation*. New York: Academic Press.

Johnson, T. J. (1972). *Professions and Power*. London: Macmillan.

Joint Council of Occupational Therapists in Great Britain (1962). Code of Ethics and Rules of Professional Conduct. *Scottish Journal of Occupational Therapy*, 49, 23-24.

Kavanagh, D. J., Clark, D., Manicavasagar, V., Piatkowska, O., O'Halloran, P. & Rosen, A. (1993). Application of cognitive-behavioural family intervention for schizophrenia in multidisciplinary teams: what can the matter be? *Australian Psychologist*, 28, 181-188.

Kendell, R. E. (1998). The National Health Service celebrates its 50th birthday. *British Journal of Psychiatry*, 173, 1-3.

Kirkpatrick, D. L. (1967). Evaluation of training. In: R. Craig & L. Bittel (eds). *Training and Development Handbook.* New York: McGraw Hill.

Kleinman, B. L. (1992). The challenge of providing occupational therapy in mental health. *American Journal of Occupational Therapy*, 46, 555-57.

Kline, P. (1993). *The Handbook of Psychological Testing.* London: Routledge.

Knowles, M. (1980). *The Modern Practice of Adult Education: From Pedagogy to Andragogy.* Chicago: Follett.

Krawiecka, M., Goldberg, D., Vaughan, M. A. (1977). A standardised psychiatric assessment scale for rating chronic psychotic patients. *Acta Psychiatrica Scandinavica*, 55, 299-308.

Krueger, R. A. (1994). *Focus Groups: A Practical Guide for Applied Research* (2nd ed). Thousand Oaks, CA: Sage.

Lam, D. H., Kuipers, L. & Leff, J. P. (1993). Family work with patients suffering from Schizophrenia-the impact of training on psychiatric nurses' attitude and knowledge. *Journal of Advanced Nursing*, 18, 233-237.

Lancashire, S., Haddock, G., Tarrier, N., Baguley, I., Butterworth, C.A. & Brooker, C. (1997). Effects of training in psychosocial interventions for community psychiatric nurses in England. *Psychiatric Services,* 48, 39-41.

Laporta, M. & Falloon, I. (1989). *The Behavioural Family Therapy Skills Measure (BFTSM).* COMMEND Training Agency, Buckingham.

Leary, J. & Brown, D. (1995). Findings from the Claybury study for community psychiatric nurses. In J. Carson, L. Fagin, & S. Ritter (Eds.), *Stress and Coping in Mental Health Nursing*. London: Chapman and Hall.

Leff, J. & Gamble, C. (1995). Training of community psychiatric nurses in family work for schizophrenia. *International Journal of Mental Health*, 24, 76-88.

Leff, J., Sharpley, M., Chisholm, D., Bell, R. & Gamble, C. (2001). Training community psychiatric nurses in schizophrenia family work: A study of clinical and economic outcomes for patients and relatives. *Journal of Mental Health*, 10, 189-197.

Lehman, A. F. (1983). The well-being of chronic mental patients: assessing their quality of life. *Archives of General Psychiatry*, 40, 369-373.

Leiba, T. (1996). Interprofessional and multi-agency training and working. *British Journal of Community Health Nursing*, 1, 8-10.

Loxley, A. (1980). A study of multidisciplinary in-service training in the interests of health care. *Social Work Service*, 24 September 1980.

MacDonald, K. (1995). *The Sociology of the Professions*. London: Sage.

Mackay, L. (1993). *Conflicts in Care: Medicine and Nursing*. London: Chapman and Hall.

Mari, J. J. & Streiner, D. (1996). The effects of family intervention on those with schizophrenia. In: C. Adams, J. Anderson & J. J. Mari. (Eds.). *Schizophrenia Module, Cochrane Database of Systematic Reviews*. London: Cochrane Library.

Martin, J. P. (1985). *Hospitals in Trouble*. Oxford: Basil Blackwell.

Martocchio, J. J. & Webster, J. (1992). Effects of feedback and cognitive playfulness on performance in microcomputer software training. *Personality Psychology*, 45, 553-78.

Maslach, C. & Jackson, S. E. (1986). *Maslach Burnout Inventory Manual.* 2nd ed. Palo Alto Calif, Consulting Psychologists Press.

Mathias, P. & Thompson, T. (1992). Interprofessional training – learning disability as a case study. *Journal of Interprofessional Care*, 6, 231-41.

Mathieu, J. E., Tannenbaum, S. I. & Salas, E. (1992). Influences of individual and situational characteristics on measures of training effectiveness. *Academic Management Journal*, 35, 828-47.

May, P. (1996a). Joint training for mental health key workers: Part 1. *Nursing Standard*, 43, 39-42.

May, P. (1996b). Joint training for mental health key workers: Part 2. *Nursing Standard*, 44, 38-41.

McCarthy, B., Lesage, A., Brewin, C., Brugha, T.S., Mangen, S. & Wing, J.K. (1989). Needs for care among the relatives of long term users of day care: A report from the Camberwell High Contact survey. *Psychological Medicine*, 19, 725-736.

McKeegan, G. F., & Donat, D. C. (1988). An inventory to measure knowledge of behavioural methods with inpatients adults. *Journal of Behaviour Therapy and Experimental Psychiatry*, 19, 229-236.

McMichael, P., Irvine, R. & Gilloran, A. (1984). *Pathways to the professions: Research Report.* Edinburgh: Moray House College of Education.

Midence, K., Marshall, L., Bell, R. & Leff, J. (1995). Research in brief. Community psychiatric nurses: their role as trainers in schizophrenia family work. *Journal of Clinical Nursing*, 4, 335-6.

Miller, C., Freeman, M. & Ross, N. (2001). Interprofessional Practice in Health and Social Care: Challenging the shared learning agenda. London: Arnold.

Miller, N. & Brewer, M. (Eds.) (1994). *Groups in Contact: The Psychology of Desegregation.* New York: Academic Press.

Milne, D. L. (1984). Skill evaluations of nurse training in behaviour therapy. *Behavioural Psychotherapy*, 12, 142-150.

Milne, D. L. (1985). A review of the in-service training of nurses in behaviour therapy. *Behavioural Psychotherapy*, 13, 120-131.

Milne, D. L., Baker, C., Blackburn, I-M., James, I. & Reichelt, K. (1999). Effectiveness of cognitive therapy training. *Journal of Behavior Therapy and Experimental Psychiatry*, 30, 81-92.

Milne, D. L., Keegan, D., Westerman, C. & Dudley, M. (2000). Systematic process and outcome evaluation of brief staff training in psychosocial interventions for severe mental illness. *Journal of Behavior Therapy and Experimental Psychiatry*, 31, 87-101.

Mistral, W. &Velleman, R. (1997). CMHTs: The professionals' choice? *Journal of Mental Health*, 6, 125-140.

Moos, R. H (1990). In D. L. Milne, *Coping responses inventory*. Windsor: NFER-Nelson.

Muijen, M. & Ford, R. (1996). The market and mental health: Intentional and unintentional incentives. *Journal of Interprofessional Care*, 10, 13-22.

Murphy, E. (1991). *After the Asylum*. London: Faber.

Myles-Kelly, P. (2001). *Process and outcome evaluation of a brief shared learning programme in cognitive behaviour therapy*. Unpublished MPhil Thesis, University of Newcastle, Newcastle–Upon-Tyne.

National Health Service and Community Care Act (1990). London: HMSO.

Newell, R. & Gournay, K. (1994). British nurses in behavioural psychotherapy: a 20-year follow-up. *Journal of Advanced Nursing*, 20, 53-60.

Newnes, C. (1999). Histories of psychiatry. In: C. Newes, G. Holmes. & C. Dunn. (Eds.). *This is Madness: A Critical Look at Psychiatry and the Future of Mental Health Services*. Ross-on-Wye: PCCS.

Norman, I. J. & Peck, E. (1999). Working Together in Adult Community Mental Health Services: An interprofessional dialogue. *Journal of Mental Health*, 8, 217-230.

Nuechterlein, K. H. & Dawson, M. E. (1984). A heuristic vulnerability-stress model of schizophrenic episodes. *Schizophrenia Bulletin*, 10, 300-312.

Nuechterlein, K. H. (1987). Vulnerability models: State of the art. In: H. Hafner, W. Gattaz, & W. Jangerik (Eds.). *Searches for the Cause of Schizophrenia*, Berlin: Springer-Verlag.

O'Boyle, M., Paniagua, F. A., Wassef, A. & Holzer, C. (1995). Training health professionals in the recognition and treatment of depression. *Psychiatric Services*, 46, 616-617.

Office of National Statistics (1997). *1995 Mortality Statistics: Cause, England and Wales Series DH2 no 22.* London: HMSO.

Oliver, J., Huxley, P., Bridges, K. & Mohamad, H. (1995). *Quality of Life and Mental Health Services.* London, Routledge.

Onyett, S. & Smith, H. (1998). The structure and organisation of community mental health teams. In: C. Brooker & J. Repper (Eds.). *Serious Mental Health Problems in the Community: Policy, Practice and Research.* London: Bailiere Tindall.

Onyett, S. (1995). Responsibility and accountability in community mental health teams. *Psychiatric Bulletin*, 19, 281-285.

Onyett, S. (1998). Case Management in Mental Health. Cheltenham: Stanley Thornes.

Onyett, S. (1999). Community mental health team working as a socially valued enterprise. *Journal of Mental Health*, 8, 245-251.

Onyett, S., Heppleston, T. & Bushnell, D. (1994). A national survey of community mental health team structure and process. *Journal of Mental Health*, 3, 175-94.

Onyett, S., Pillinger, T. & Muijen, M. (1995). *Making Community Mental Health Teams Work.* London: Sainsbury Centre Publications.

Onyett, S., Pillinger, T. & Muijen, M. (1997). Job satisfaction and burnout among members of community mental health teams, *Journal of Mental Health*, 8, 231-242.

Overall, J. & Gorham, O. (1962). The Brief Psychiatric Rating Scale. *Psychological Reports*, 10, 739-812.

Padgett, D. K. (1998). Qualitative Methods in Social Work Research: Challenges and Rewards. London: Sage.

Pai, S. & Kapur, R.L. (1981). The burden on the family of a psychiatric patient: development of an interview schedule. *British Journal of Psychiatry*, 138, 332-335.

Parsons, S. & Barker, P. (2000). The Phil Hearne course: an evaluation of a multidisciplinary mental health education programme for clinical practitioners. *Journal of Psychiatric and Mental Health Nursing*, 7, 101-108.

Paterson, C. F. (1997). Rationales for the use of occupation in 19th century asylums. *British Journal of Occupational Therapy*, 60, 179-183.

Paterson, C.F. (1998). Occupational therapy and the National Health Service. *British Journal of Occupational Therapy*, 61, 311-315.

Patmore, C.& Weaver, T.(1992). Improving community services for serious mental disorders. *Journal of Mental Health*, 1, 107-115.

Paul, S. (1996). Mental health: an endangered occupational therapy speciality. *American Journal of Occupational Therapy*, 51, 65-68.

Payne, M. (1995). *Social Work and Community Care.* London: Macmillan.

Peck, E. & Barker, I. (1997). Users as partners in mental health: Ten years of experience. *Journal of Interprofessional Care*, 11, 269-278.

Peck, E. & Norman, I. J. (1999). Working together in adult community mental health services: Exploring inter-professional role relations. *Journal of Mental Health*, 8, 231-243.

Peck, E. (1994). Community mental health centres: challenges to the new orthodoxy. *Journal of Mental Health*, 3, 151-6.

Peck, E. (1995). Mental health: On the team. *Health Service Journal*, 105, 28-9.

Peck, E. (1999). Introduction to special section on community mental health teams. *Journal of Mental Health*, 8, 215-216.

Perkins, R, E. & Repper, J. M. (2001). *Working Alongside People with Long Term Mental Health Problems*. Cheltenham: Nelson Thornes.

Pettigrew, T. F. (1998). Intergroup contact theory. *Annual Review of Psychology*, 49, 65-85.

Pietroni, C. (1992). Towards Reflective Practice-The Language of Health and Social Care. *Journal of Interprofessional Care*, 6, 7-16.

Pietroni, P. C. (1991). Stereotypes or archetypes-A study of perceptions among health-care students. *Journal of Social Work Practice*, 5, 61-69.

Pilgrim, D. & Rogers, A. (1997). *A Sociology of Mental Health and Mental Illness*. Buckingham: Open University Press.

Pilgrim, D. & Treacher, A. (1992). *Clinical Psychology Observed*. London: Routledge.

Pilgrim, D. & Waldron, L. (1998). User involvement in mental health service development: how far can it go? *Journal of Mental Health*, 7, 95-104.

Pirrie, A., Wilson, V., Elsegood, J., Hall, J., Hamilton, S., Harden, R., Lee, D. & Stead, J. (1998). *Evaluating Multidisciplinary Education in Health Care*. Edinburgh: Scottish Council for Research in Education (SCRE).

Porter, R. (1987). *Mind-forg'd Manacles*. London: Athlone.

Prior, L. (1993). *The Social Organisation of Mental Disorder.* London: Sage Publications.

Quinones, M. A. (1995). Pre-training context effects: training assignment as feedback. *Journal of Applied Psychology*, 80, 226-38.

Rawson, D. (1994). Models of interprofessional working: likely theories and possibilities. In: A. Leathard (ed.) *Going Interprofessional: Working Together for Health and Welfare*. London: Routledge.

Read, J. & Barker, S. (1996). *Not just Sticks and Stones. A Survey of the Stigma, Taboos and Discrimination Experienced by People with Mental Health Problems.* London: MIND.

Reeves, S. (2001). A systematic review of the effects of interprofessional education on staff involved in the care of adults with mental health problems. *Journal of Psychiatric and Mental Health Nursing*, 8, 533-542.

Repper, D. & Brooker, C. (2002). Avoiding the Wash Out: Developing the organisational context to increase the uptake of evidence-based practice for psychoses. Durham: Northern Centre for Mental Health.

Repper, J. (2000). Translating Policy into Practice: An Evaluation of a Multidisciplinary Training in Psychosocial Interventions for Working with People who have Serious Mental Health Problems. Unpublished PhD thesis. University of Manchester.

Richards, L. (1999). *Using NVivo in qualitative Research.* London; Sage.

Ritchie, L., Dick, D. & Lingham, R. (1994). The Report of the Inquiry into the Care and Treatment of Christopher Clunis. London: HMSO.

Rizzo, J., House, R. & Lirtzman, S. (1970). Role conflict and ambiguity in complex organisations, *Administrative Science Quarterly*, 15, 150-163.

Robson, C. (1993). *Real World Research: A Resource for Social Scientists and Practitioner-Researchers.* Oxford: Blackwell.

Rogers, A. & Pilgrim, D. (1991). 'Pulling down churches': accounting for the British mental health users' Movement. *Sociology of Health and Illness*, 13, 129-148.

Rogers, A. & Pilgrim, D. (1996). *Mental Health Policy in Britain*, (First edn). Basingstoke: Macmillan.

Rogers, A. & Pilgrim, D. (2001). *Mental Health Policy in Britain*, (Second edn). Basingstoke: Palgrave.

Rogers, A., Pilgrim, D. & Lacey, R. (1993). *Experiencing Psychiatry: Users Views of Services*. London: MIND Macmillan.

Rogers, C. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Counselling Psychology*, 21, 95-103.

Rosen, A. (1989). The Life Skills Profile. *Schizophrenia Bulletin*, 15, 325-337.

Rothbart, M. & John, O. P. (1985). Social categorisation and behavioural episodes: a cognitive analysis of the effects of intergroup contact. *Journal of Social Issues*, 41, 81-104.

Rothbart, M., Evans, M. & Fulero, S. (1979). Recall for confirming events: memory processes and the maintenance of social stereotypes. *Journal of Experimental Social Psychology*, 15, 343-55.

Sackett, D. L., Richardson, W. S., Rosenberg, W., & Haynes, R. B. (1997). *Evidence-Based Medicine: How to Practice and Teach EBM*. London: Churchill Livingstone.

Sainsbury Centre for Mental Health (1997). *Pulling Together: The Future Roles of Training of Mental Health Staff*. London: Sainsbury Centre for Mental Health.

Sainsbury Centre for Mental Health (2000). *Finding and Keeping: Review of recruitment and retention in the mental health workforce*. London: Sainsbury Centre for Mental Health.

Sainsbury Centre for Mental Health (2001). *The Capable Practitioner: A framework and list of the practitioner capabilities required to implement The National Service Framework for Mental Health*. London: Sainsbury Centre for Mental Health.

Salas, E. & Cannon-Bowers, J. A. (2001). The Science of Training: A Decade of Progress. *Annual Review of Psychology*, 52, 471-99.

Sarason, I.G., Levine, H. M., Basham, R. B *et al* (1983). Assessing social support: the Social Support Questionnaire. *Journal of Personality and Social Psychology*, 44, 127-139.

Sayce, L. (1989). Community mental health centres-rhetoric and reality. In: A. Brackx & C. Grimshaw (Eds.). *Mental Health Centres in Crisis*. London: Pluto.

Sayce, L. (1998). Stigma, discrimination and social exclusion: What's in a word? *Journal of Mental Health*, 7, 331-343.

Sayce, L., Craig, T. & Boardman, A. (1991). The development of community mental health centres in the UK. *Social Psychiatry and Psychiatric Epidemiology*, 26, 14-22.

Schon, D. (1987). *Educating the Reflective Practitioner: Towards a New Design for Teaching and Learning in the Professions*. San Francisco: Jossey-Bass.

Schon, D. A. (1983). *The Reflective Practitioner: How Professionals Think in Action*. USA: Basic Books.

SCOPME (1999). *Equity and Interchange: Multiprofessional Work and Le*arning. London: The Stationery Office.

Scull, A. (1977). *Decareration: Community Treatment and the Deviant-A Radical View*. New York: Prentice-Hall.

Seebohm Report (1968). *Report of the Committee on Local Authority and Allied Personal Services*. London: HMSO.

Shaw, I. (1993). The Politics of Interprofessional Training-Lessons from Learning Disability. *Journal of Interprofessional Care*, 7, 255-262.

Sheppard, M. (1990). Social Work and Community Psychiatric Nursing. In: P. Abbott & C. Wallace. (Eds.). *The Sociology of the Caring Professions*. Basingstoke: The Falmer Press.

Shorter, E. (1997). *A History of Psychiatry*. New York: Wiley.

Silverman, A. & Corbin, J. (1990) *Basics of Qualitative Research*. Thousand Oaks, CA: Sage.

Silverman, D. (1993). *Interpreting Qualitative Data: Methods for Analysing Talk, Text and Interaction*. London: Sage.

Silverman, D. (1998). *Qualitative Research: Theory, Method and Practice*. London: Sage.

Silverman, D. (2000). *Doing Qualitative Research: A Practical Handbook*. London: Sage.

Skevington, S. M. (1981). Intergroup relations and nursing. *European Journal of Social Psychology,* 11, 43-59.

Smith, M., Buckwalter, K. C., Garand, L., Mitchell, S., Albanese, M. & Kreiter, C. (1994). Evaluation of a geriatric mental health training program for nursing personnel in rural long-term care facilities. *Issues in Mental Health Nursing*, 15, 149-168.

Smith, R. (1990). *Mental Health: The Social Worker's Role*. Bristol: School of Applied Social Studies, University of Bristol.

Snyder, M. (1981). On the self-perpetuating nature of social stereotypes. In: D. L. Hamilton (ed). *Cognitive Processes in Stereotyping and Intergroup Behaviour.* New York, Erlbaum.

Soskis, D. (1972). A survey of psychiatric opinion about schizophrenia. *Comprehensive Psychiatry*, 13, 573-580.

Spaniol, L., Jung, H., Zipple, A., *et al.* (1987). Families as a resource in the rehabilitation of the severely psychiatrically disabled. In *Families of the Mentally Ill* (Eds. A. Hatfield & H. Leffley). London: Cassell Educational.

Spratley, J. & Pietroni, M. (1994). *Creative collaboration: interprofessional learning priorities in primary health and community care*. London: Marylebone Centre Trust.

Stephan, W.G. & Stephan, C.W. (1984). The role of ignorance in intergroup relations. In N. Miller & M. B. Brewer (eds), *Groups in Contact*. New York: Academic Press.

Strauss, A. & Corbin, J. (1990). *Basics of Qualitative Research*. Thousand Oaks, CA: Sage.

Szasz, T. S. (1961). The uses of naming and the origin of the myth of mental illness. *American Psychologist*, 16, 59-65.

Tajfel, H. & Turner, J.C. (1986). The social identity of intergroup behaviour. In: S. Worchel & W. Austin (Eds.), *Psychology of Intergroup Relations.* Nelson Hall, Chicago.

Tajfel, H. (1981). *Human Groups and Social Categories: Studies in Social Psychology*. Cambridge: Cambridge University Press.

Tajfel, H., Billig, M.G., Bundy, R. P., Flament, C. (1971). Social categorisation and intergroup behaviour. *European Journal of Social Psychology*, 1, 149-178.

Tannenbaum, S. I. & Yuki, G. (1992). Training and development in work organisations. *Annual Review of Psychology*, 43, 399-441.

Tarrier, N. (1996). Family Interventions and Schizophrenia. In: G. Haddock & P. D. Slade (Eds.) *Cognitive-Behavioural Interventions with Psychotic Disorders*. London: Routledge.

Tarrier, N., Haddock, G. & Barrowclough, C. (1998). Training and dissemination: research to practice in innovative psychosocial treatments for schizophrenia. In: *Outcomes and Innovation in Psychological Treatment of Schizophrenia* (Eds. Wykes, T., Tarrier, N. & Lewis, S.), John Wiley & Sons, Chichester.

Taylor, I. (1997). *Developing Learning in Professional Education: Partnerships for Practice*. Buckingham: SHRE and Open University Press.

Thrackway, B. (1997). *Effective Evaluation of Training and Development in higher Education*. London: Kogan Page.

Timms, N. (1964). *Psychiatric Social Work in Great Britain (1939-62)*. London: Routledge and Kegan Paul.

Titmuss, R. M. (1963). Community Care-Fact or Fiction? In: H, Freeman & J. Farndale (Eds.). *Trends in Mental Health Services*. Oxford: Pergamon.

Turner, J. C. (1981). The experimental social psychology of intergroup behaviour. In: J. C. Turner & H. Giles (eds) *Intergroup Behaviour*. Oxford: Blackwell.

Turner, T. (1988). Henry Maudsley: psychiatrist, philosopher, and entrepreneur. In: W. F. Bynum., R. Porter & M. Shepard (eds). *The Anatonomy of Madness: Essays in the History of Psychiatry*, Vol 3. London: Tavistock.

University of Birmingham (1997). *Programme in Community Mental Health: Course Portfolio*. Birmingham: Department of Social Policy and Social Work, University of Birmingham.

University of Southampton. (2001). The New Generation Project Partnership: Taking forward Interprofessional Education. http://www.mhbs.soton.ac.uk/newgeneration/newngp/about.htm

van Knippenburg. A. & van Oers, H. (1984). Social identity and equity concerns in intergroup perceptions. *British Journal of Social Psychology*, 23, 351-361.

Van Oudenhouven, J. P., Groenewoud, J. T. & Hewstone, M. (1996). Co-operation, ethnic salience and generalisation of inter-ethnic attitudes. *European Journal of Social Psychology,* 26, 649-662.

Vaughn, C & Leff, J.P. (1976). The measurement of expressed emotion in families of psychiatric patients. *British Journal of Social and Clinical Psychology,* 15, 157-165.

Vaughn, C. E. & Leff, J. P. (1976). The influence of family and social factors on the course of psychiatric illness: A comparison of schizophrenic and depressed neurotic patients. *British Journal of Psychiatry*, 129, 125-137.

West, M. (1994). *Effective Teamwork*. Leicester: BPS Books (the British Psychological Society).

White, E. (1991). *The 3rd Quniquennial National Community Psychiatric Nursing Survey.* Manchester: University of Manchester.

Williams, R.M., Moorey, S. & Cobb, J. (1991). Training in cognitive-behaviour therapy: pilot evaluation of a training course using the Cognitive Therapy Scale. *Behavioural Psychotherapy*, 19, 373-376.

Wilmot, S. (1995). Professional values and interprofessional dialogue. *Journal of Interprofessional Care*, 9, 257-265.

Wing, J., Curtis, R. and Beevor, A. (1995). *Health of the Nation Outcome Scales*. Royal College of Psychiatrists, London.

Wing, J.K., Cooper, J.E. & Sartorius, N. (1974). *The Description and Classification of Psychiatric Symptoms: An Instruction Manual for the PSE and CATEGO System*. London: Cambridge University Press.

Woodward, C. A. & Ferrier, B.M. (1983). The content of the medical curriculum at McMaster University: graduates evaluation of their preparation for postgraduate training. *Medical Education*, 17, 54-60.

Worchel, S. W., Wong, F. Y. & Scheltema, K. E. (1989) Improving Intergroup Relations: Comparative effects of anticipated cooperation and helping an attraction for an aid-giver. *Social Psychology Quarterly*, 52, 213-210.

Young, J. & Beck, A. T. (1980). *Cognitive Therapy Scale: Rating Manual.* Unpublished manuscript. Philadelphia, PA: Center for Cognitive Therapy.

Zeiss, R. A. (1997). Interdisciplinary treatment and training issues in the acute inpatient psychiatry unit. *Journal of Interprofessional Care*, 11, 279-286.

Zubin, J. & Spring, B. (1977). Vulnerability: a new view of schizophrenia. *Journal of Abnormal Psychology*, 86, 103-26.

Zwarenstein, M., Atkins, J., Barr, H., Hammick, M., Koppel, I. & Reeves, S. (1999). A systematic review of interprofessional education, *Journal of Interprofessional Care*, 13, 417-424.

APPENDIX A

Interview Schedule from Semi-Structured Interviews

EVALUATION OF BIRMINGHAM UNIVERSITY PROGRAMME IN COMMUNITY MENTAL HEALTH

INTERVIEW QUESTIONS FOR STUDENTS

1. What is your professional background? (e.g. social work, nursing)
2. When did you qualify?
3. Do you currently work in a multidisciplinary team?

Professional roles and Identity

4. What is your experience of interprofessional working on the course? For example :

- Did the different professional groups co-operate well?'
- Were similarities and differences discussed?
- Do you feel that professional differences were considered important or was a generic mental health worker role adopted?
- Were all professions considered equal?

5. What were your views of other mental health professions before you went on the Birmingham course?
6. Has the course changed any of these views? If so how?
7. Do you think that those on the course were typical of their profession?
8. Do you feel that the course has complicated or clarified your role at work? (e.g. with the teaching of psychosocial interventions)

Teaching

9. Do you think some modules were considered, by the students, to be more important than other? (e.g. was information about medication considered more important than information about user involvement or vice versa?). If so, why do you think this was?

- Difference in information
- Difference in presentation
- Difference in presenters
- Information was new
- Information was relevant to practice.

10. What was the status of service user, as presenters, on the course?

Groups

11. Groups appeared to be used a lot as a way of learning on the course. What groups did you take part in?

- Did you choose to be in these groups?
- Was profession ever used as a factor to form groups?

12. Did you find these groups useful?

- Did everyone have the chance to participate equally in the groups?
- Were the groups too big, small? Did some members dominate the groups?
- Were the group tasks interesting?

Teams and Trusts

13. How were you selected to go on the course?
14. What was your motivation for going on the course?
15. What did you see as the personal outcomes of the course for yourself? (e.g. promotion, more skills, an opportunity to learn)
16. Do/ did you feel supported by your team?

- Do you have a reduced caseload?
- Do you receive study days?
- Does the team encourage you to implement your learning?

17. Is the trust supportive?

Practice

18. Do you feel that the course has helped improve the way you work with: a) other professionals, b) service users?
19. Has the changed your practice? (e.g. Do you use the new skills you have learnt?)
20. What did you enjoy most about the course?
21. What did you enjoy least about the course?
22. Any other comments

Thank you for your time

APPENDIX B

Professional Identification Scale

Professional Identification

Please put a cross ☒ in the box as appropriate.

What is your profession? I am a _____

Q2 a) I am a person who identifies with my profession.

Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Very Often ☐

Q2 b) I am a person who makes excuses for belonging to my profession.

Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Very Often ☐

Q2 c) I am a person who feels held back by my profession.

Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Very Often ☐

Q2 d) I am a person who considers [my profession] important.

Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Very Often ☐

Q2 e) I am a person who criticises my profession.

Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Very Often ☐

Q2 f) I am a person who is glad to belong to my profession.

Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Very Often ☐

Q2 g) I am a person who sees myself belonging to my profession.

Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Very Often ☐

Q2 h) I am a person who is annoyed to say I'm a member of my profession.

Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Very Often ☐

Q2 i) I am a person who tries to hide belonging to my profession.

Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Very Often ☐

Q2 j) I am a person who feels strong ties with [my profession]

Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Very Often ☐

APPENDIX C

Team Identification Scale

Team Identification

Please put a cross ☒ in the box as appropriate.

Q3 a) **What is your team? My team is called the** _____

I am a person who identifies with my Team.

Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Very Often ☐

Q3 b) I am a person who makes excuses for belonging to my Team.

Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Very Often ☐

Q3 c) I am a person who feels held back by my Team.

Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Very Often ☐

Q3 d) I am a person who considers my Team important.

Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Very Often ☐

Q3 e) I am a person who criticises my Team.

Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Very Often ☐

Q3 f) I am a person who is glad to belong to my Team.

Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Very Often ☐

Q3 g) I am a person who sees myself belonging to my Team.

Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Very Often ☐

Q3 h) I am a person who is annoyed to say I'm a member of my Team

Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Very Often ☐

Q3 i) I am a person who tries to hide belonging to my Team.

Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Very Often ☐

Q3 j) I am a person who feels strong ties with my Team.

Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Very Often ☐

APPENDIX D

Role Clarity and Role Conflict Scales

Personal role clarity and conflicts

When answering this question, imagine a scale running from one to seven and cross the box [X] that measures how much you think each statement applies to your job. Try to think about the actual nature of your job.

Q11 a) I am certain about how much authority I have.	Very False	☐	☐	☐	☐	☐	☐	Very True
Q11 b) Clear, planned goals and objectives exist for my job.	Very False	☐	☐	☐	☐	☐	☐	Very True
Q11 c) I know that I have divided my time properly.	Very False	☐	☐	☐	☐	☐	☐	Very True
Q11 d) I know what my responsibilities are.	Very False	☐	☐	☐	☐	☐	☐	Very True
Q11 e) I know exactly what is expected of me.	Very False	☐	☐	☐	☐	☐	☐	Very True
Q11 f) Explanation is clear of what has to be done.	Very False	☐	☐	☐	☐	☐	☐	Very True
Q11 g) I have to do things that should be done differently.	Very False	☐	☐	☐	☐	☐	☐	Very True
Q11 h) I receive an assignment without the staff to complete it.	Very False	☐	☐	☐	☐	☐	☐	Very True

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APPENDIX E

Conditions of the Contact Hypothesis

Interprofessional Attitudes

We are interested in how different professionals see each other and the extent to which interprofessional issues are experienced on the Course.

First some background questions about the Course.

Q14 a) To what extent do you feel that:

There is institutional support (i.e. from your employer) for your participation on the Course?

☐ ☐ ☐ ☐ ☐ ☐ ☐

Not at all — Some — Great deal

Q14 b)

There is support from members of your <u>own profession</u> for your participation on the Course?

☐ ☐ ☐ ☐ ☐ ☐ ☐

Not at all — Some — Great deal

Q14 c)

There is support from members of your <u>community mental health team</u> for your participation on the Course?

☐ ☐ ☐ ☐ ☐ ☐ ☐

Not at all — Some — Great deal

Q14 d)

Your own expectations about working on the Course alongside members of other professions are:

☐ ☐ ☐ ☐ ☐ ☐ ☐

Very Negative — Neutral — Very Positive

Now some questions about the Course:

Q14 e) To what extent do you feel that:

Similarities between mental health professionals have been emphasised?

☐ ☐ ☐ ☐ ☐ ☐ ☐

Not At all — Not Sure — A Great Deal

Q14 f) Differences between mental health professionals have been emphasised?

☐ ☐ ☐ ☐ ☐ ☐ ☐

Not At all — Not Sure — A Great Deal

Q14 g) Participants work together as equals?

☐ ☐ ☐ ☐ ☐ ☐ ☐

Not At all — Not Sure — A Great Deal

Q14 h) The atmosphere between the members of different professions has been <u>co-operative</u>?

☐ ☐ ☐ ☐ ☐ ☐ ☐

Strongly Disagree — Not Sure — Strongly Agree

Q14 i) The atmosphere between the members of different professions has been <u>competitive</u>?

☐ ☐ ☐ ☐ ☐ ☐ ☐

Strongly Disagree — Not Sure — Strongly Agree

Q14 j) Members of the different professions have tended to stick together?

☐ ☐ ☐ ☐ ☐ ☐ ☐

Strongly Disagree — Not Sure — Strongly Agree

Q14 k) Members from the same mental health teams have tended to stick together?

☐ ☐ ☐ ☐ ☐ ☐ ☐

Strongly Disagree — Not Sure — Strongly Agree

Q14 l) There has been successful joint work between members of the different professions?

☐ ☐ ☐ ☐ ☐ ☐ ☐

Strongly Disagree — Not Sure — Strongly Agree

APPENDIX F

Interprofessional Attributes

Q15 a) Please rate your views on the status of the different professions in society, including your own. Please rate each professional group by giving a number between 1 (= very low status) and 7 (= very high status). A score of 4 would indicate neither high nor low status.

Status	Social workers	CPNs	OTs	Psychiatrists	Psychologists
in society	☐	☐	☐	☐	☐
on Course	☐	☐	☐	☐	☐

Q15 b) Now please indicate your views on the professions, including your own. Again please rate, using a number between 1 (very low) and 7 (very high), the following qualities or attributes of each profession. A score of 4 = don't know. Please rate your own profession and how you think other professionals see your profession.

	Social workers	CPNs	OTs	Psychiatrists	Psychologists	Own prof as seen by others
Academic rigour	☐	☐	☐	☐	☐	☐
Interpersonal skills (e.g. warmth, empathy)	☐	☐	☐	☐	☐	☐
Communication skills	☐	☐	☐	☐	☐	☐
Leadership	☐	☐	☐	☐	☐	☐
Practical skills	☐	☐	☐	☐	☐	☐
Breadth of life experience	☐	☐	☐	☐	☐	☐
Professional competence	☐	☐	☐	☐	☐	☐

APPENDIX G

Implementation Scale

Implementation Questionnaire

We would like to know about your use of psychosocial interventions before coming on the Course, what obstacles you have encountered, what support you have received, and about any strategies which you hav found successful.

These first questions concern the use you have been able to make of specific forms of intervention. **In relation to people with severe and enduring mental health problems**

Please rate the extent to which you used the following interventions in the last three months.

5 = extensively 4 = frequently 3 = sometimes 2 = rarely 1 = never

Interventions **In last three months**

Assessment and Programming Care

Includes assessment of: users' psychiatric, psychological, or social needs, problems and strengths; risk assessment; users' family relationships and support systems. Includes collating contributions of colleagues in the team and other agencies. All activities necessary to formulate a care or treatment plan e.g. arranging, attending CPA meetings. Reviews of care plans with users, carers and professionals

Care Co-ordination

Ensuring users have access to the services they require (e.g. referral, liaison, advocacy with other organisations,including police, GPs, general hospital, monitoring.

Advice Giving (to user)

(e.g. accommodation, managing money, benefits, legal affairs, complaints)

Optimising Medication

Prescribing, administering, monitoring and advising on psycho-pharmacological medication. Excludes: cognitive approaches to psychoses.

Psychotherapy and Counselling

Interventions where the focus is on the individual user, i.e. supportive counselling, psychotherapy, art therapy. Excludes: skills training CBT and family interventions.

Cognitive Behavioural Therapy

Individual focus, including cognitive approaches to managing psychotic symptoms. Excluding family based interventions.

Family/Carer Intervention

Including family/couple therapy, psychoeducation, carers groups.

Group Therapy

Including group psychotherapy, social group work, art therapy groups. Excludes: self help groups and carers groups

Providing Occupation, Education or Training

Aimed at coping with existing impairments. Includes all form of skills training and personal development.

Meeting Social, Recreational or Spiritual Needs

Includes encouragement to use community facilities

APPENDIX H

Barriers to Implementation Scale

Q17 a) Now, please rate the extent to which you think the following statements are true in your experience. All refer to the extent to which you believe psychosocial interventions can be implemented in your routine work.

There are too many service users on my caseload.

Not a barrier at all	Slight barrier	Small barrier	Modest barrier	Large barrier	Insurmountable barrier
☐	☐	☐	☐	☐	☐

Q17 b) There are too few staff to carry out psychosocial interventions.

Not a barrier at all	Slight barrier	Small barrier	Modest barrier	Large barrier	Insurmountable barrier
☐	☐	☐	☐	☐	☐

Q17 c) There are insufficient resources to help users.

Not a barrier at all	Slight barrier	Small barrier	Modest barrier	Large barrier	Insurmountable barrier
☐	☐	☐	☐	☐	☐

Q17 d) There is too much bureaucracy, forms and procedures.

Not a barrier at all	Slight barrier	Small barrier	Modest barrier	Large barrier	Insurmountable barrier
☐	☐	☐	☐	☐	☐

Q17 e) There is no allowance of time from the service to undertake specialist interventions.

Not a barrier at all	Slight barrier	Small barrier	Modest barrier	Large barrier	Insurmountable barrier
☐	☐	☐	☐	☐	☐

Q17 f) The service does not allow time in lieu or overtime for out of hours work which is required to do the interventions.

Not a barrier at all	Slight barrier	Small barrier	Modest barrier	Large barrier	Insurmountable barrier
☐	☐	☐	☐	☐	☐

Q17 g) It is difficult to combine psychosocial interventions with my own outside interests and responsibilities (e.g. to my family).

Not a barrier at all	Slight barrier	Small barrier	Modest barrier	Large barrier	Insurmountable barrier
☐	☐	☐	☐	☐	☐

Q17 h) Management tasks and responsibilities prevent me from doing direct work with service users.

Not a barrier at all	Slight barrier	Small barrier	Modest barrier	Large barrier	Insurmountable barrier
☐	☐	☐	☐	☐	☐

Q17 i) My colleagues are not interested in the use of specialist psychosocial interventions.

Not a barrier at all	Slight barrier	Small barrier	Modest barrier	Large barrier	Insurmountable barrier
☐	☐	☐	☐	☐	☐

Q17 j) Colleagues will not support me if I use psychosocial interventions with users.

Not a barrier at all	Slight barrier	Small barrier	Modest barrier	Large barrier	Insurmountable barrier
☐	☐	☐	☐	☐	☐

Q17 k) There is poor teamwork and communication between staff such that interventions with users are not sustained or followed through.

Not a barrier at all	Slight barrier	Small barrier	Modest barrier	Large barrier	Insurmountable barrier
☐	☐	☐	☐	☐	☐

Q17 l) My manager is not interested in the use of specialist psychosocial interventions.

Not a barrier at all	Slight barrier	Small barrier	Modest barrier	Large barrier	Insurmountable barrier
☐	☐	☐	☐	☐	☐

Q17 m) My manager will not support me if I use psychosocial interventions with users.

Not a barrier at all	Slight barrier	Small barrier	Modest barrier	Large barrier	Insurmountable barrier
☐	☐	☐	☐	☐	☐

Q17 n) The responsible medical officer (consultant psychiatrist) does not approve of my using psychosocial interventions.

Not a barrier at all	Slight barrier	Small barrier	Modest barrier	Large barrier	Insurmountable barrier
☐	☐	☐	☐	☐	☐

Q17 o) The responsible medical officer (consultant psychiatrist) interferes in the user's treatment when I use psychosocial interventions.

Not a barrier at all	Slight barrier	Small barrier	Modest barrier	Large barrier	Insurmountable barrier
☐	☐	☐	☐	☐	☐

Q17 p) Personally, I don't believe that the psychosocial interventions taught on the course will work with users in my service.

Not a barrier at all	Slight barrier	Small barrier	Modest barrier	Large barrier	Insurmountable barrier
☐	☐	☐	☐	☐	☐

Q17 q) There are insufficient users on my caseload for whom psychosocial interventions are appropriate.

Not a barrier at all	Slight barrier	Small barrier	Modest barrier	Large barrier	Insurmountable barrier
☐	☐	☐	☐	☐	☐

Q17 r) The approaches taught on the course conflict with ways of working which are important to me.

Not a barrier at all	Slight barrier	Small barrier	Modest barrier	Large barrier	Insurmountable barrier
☐	☐	☐	☐	☐	☐

Q17 s) The philosophy of the course conflicts with my approach to working with service users.

Not a barrier at all	Slight barrier	Small barrier	Modest barrier	Large barrier	Insurmountable barrier
☐	☐	☐	☐	☐	☐

Q17 t) Psychosocial interventions are not applicable to the needs of users on my caseload.

Not a barrier at all	Slight barrier	Small barrier	Modest barrier	Large barrier	Insurmountable barrier
☐	☐	☐	☐	☐	☐

Q17 u) Psychosocial interventions are too complex.

Not a barrier at all	Slight barrier	Small barrier	Modest barrier	Large barrier	Insurmountable barrier
☐	☐	☐	☐	☐	☐

Q17 v) The teaching on the course is not of sufficient depth to enable me to use the methods.

Not a barrier at all	Slight barrier	Small barrier	Modest barrier	Large barrier	Insurmountable barrier
☐	☐	☐	☐	☐	☐

Q17 w)At present I do not have sufficient skills to implement psychosocial interventions.

Not a barrier at all	Slight barrier	Small barrier	Modest barrier	Large barrier	Insurmountable barrier
☐	☐	☐	☐	☐	☐

Q17 x) At present I do not have sufficient confidence to implement psychosocial interventions.

Not a barrier at all	Slight barrier	Small barrier	Modest barrier	Large barrier	Insurmountable barrier
☐	☐	☐	☐	☐	☐

Q18 a) I do not have adequate clinical supervision to undertake specialist psychosocial interventions.

Not a barrier at all	Slight barrier	Small barrier	Modest barrier	Large barrier	Insurmountable barrier
☐	☐	☐	☐	☐	☐

Q18 b) Psychosocial interventions are too demanding of my time and energy.

Not a barrier at all	Slight barrier	Small barrier	Modest barrier	Large barrier	Insurmountable barrier
☐	☐	☐	☐	☐	☐

Q18 c) Psychosocial interventions take too long to achieve positive benefits for service users.

Not a barrier at all	Slight barrier	Small barrier	Modest barrier	Large barrier	Insurmountable barrier
☐	☐	☐	☐	☐	☐

Q18 d) Service users do not favour psychosocial interventions.

Not a barrier at all	Slight barrier	Small barrier	Modest barrier	Large barrier	Insurmountable barrier
☐	☐	☐	☐	☐	☐

Q18 e) My clients also do not understand psychosocial interventions.

Not a barrier at all	Slight barrier	Small barrier	Modest barrier	Large barrier	Insurmountable barrier
☐	☐	☐	☐	☐	☐

Q18 f) It is difficult to engage users in psychosocial interventions.

Not a barrier at all	Slight barrier	Small barrier	Modest barrier	Large barrier	Insurmountable barrier
☐	☐	☐	☐	☐	☐

Q18 g) Family members or carers do not favour psychosocial interventions.

Not a barrier at all	Slight barrier	Small barrier	Modest barrier	Large barrier	Insurmountable barrier
☐	☐	☐	☐	☐	☐

Q18 h) Family members or carers do not understand the specialist psychosocial interventions.

Not a barrier at all	Slight barrier	Small barrier	Modest barrier	Large barrier	Insurmountable barrier
☐	☐	☐	☐	☐	☐