(INSIDE COVER)

HAVING YOUR SAY 2
2001

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CONTENTS

PRAXIS MENTAL HEALTH

Praxis is a voluntary organisation which aims to improve the quality of life of people who experience, or are vulnerable to experiencing mental ill health through promoting the independence for such individuals, and encouraging their integration into the local community. In order to provide full and integrated services to people experiencing mental ill health, Praxis is committed to collaboration with other statutory and voluntary agencies.

PRAXIS SERVICES

Praxis provides 4 main types of services:

Accommodation: Around 190 people are housed and supported in Praxis services in 16 towns throughout Northern Ireland and the Isle of Man. There are 4 types of Praxis accommodation:

- Residential Care Home (RCH) – service users have their own 'bedsitting' room and share facilities such as the dining room and T.V. room with other service users. 24-hours staff support is provided.
- Residential Flat Cluster (RFC) – service users live in a single person flat which is grouped together with other flats. 24-hour staff support is provided.
- Flat Cluster (FC) – service users live in a single person flat which is grouped together with other flats. Staff members are based onsite for part of the day.
- Dispersed Intensively Supported Housing (DISH) – service users live in individual houses or flats and receive support from staff to facilitate independent living.

Home Response: This is a domicillary model of care where a support worker visits and provides support to an individual experiencing mental ill health within his/her own home. Praxis provides over 25,000 home response staff hours per year throughout Northern Ireland and the Isle of Man.

Volunteer Befriending: The volunteer befriending scheme recruits and trains volunteers to support individuals who have experienced mental ill health. Currently there are around 160 Praxis volunteers providing a befriending service throughout Northern Ireland.

Workskills/Day Care: Praxis is involved in a workskills initiative in liaison with the Training and Employment Agency (TEA) Action Project. The scheme offers retail skills to service users through shops in Newtownards, Bangor and Belfast. Praxis is also involved in an information technology training project called Planet Ballymena. The project is available for young people who have difficulty integrating into society due to health or social problems. In addition, a drop-

in facility and a support service for female service users (the Butterfly Group) are offered within the Larne/Carrickfergus area.

PRAXIS TRAINING

Praxis has a training department, which undertakes training for staff in relation to care issues (e.g. calming/diffusing and breakaway techniques). The department also provides NVQ opportunities to staff in the areas of care, retail and management; and offers NVQ retail training to service users. Members of the training department were involved in devising and implementing most of the training offered during the course of the HYS 2 project.

PRAXIS RESEARCH

The Praxis research department is responsible for undertaking research and the evaluation of projects that inform and promote understanding of mental health, and related health and social care issues. The department is involved in a number of research projects including the assessment of community health needs; the extent, nature and value of volunteer befriending across Northern Ireland; the opportunity for cross-border co-operation in the provision of day care services for individuals with a learning disability; the evaluation of a 'without walls' day care service; and the evaluation of the first year of operation of the Praxis home support service in the Isle of Man.

Having Your Say 2 was a joint project between the Praxis Training Department and the Research Department.

BACKGROUND TO HAVING YOUR SAY 2

The Having Your Say 2 project came about as a direct result of research carried out by Praxis during 1995/1996 with service users and staff. The main focus of this research (called Having Your Say) was on service user self-advocacy and how it could be promoted within Praxis accommodation services (Mawhinney & McDaid, 1996). The Working Group for this project, made up of staff and service users, defined self-advocacy as:

'The art of making choices and decisions and speaking up for yourself to bring about change'.

Based on the findings of the research, several recommendations were made to further promote service user self-advocacy. These included:

- *Ways need to be explored to promote service user self-confidence. This may involve offering formal training in social skills and confidence building, developing social activities and/or long-term one-to-one work between service users and staff.*

- *Further research should be carried out to take a closer look at the factors that help and prevent service users from asserting their views in situations outside of mental health services.*

- *Specific training needs for staff should be identified in order for staff to deal effectively with the changes which could come about if service users begin to speak out more for themselves.*

In furtherance of these recommendations Praxis sought funding to offer training to service users, staff and befriending volunteers. The training for service users aimed to provide an opportunity for individuals to explore the issues around user empowerment and to develop confidence building and assertiveness skills. The training for staff members and befriending volunteers aimed to explore the issues around service user empowerment and to identify the role they played in further promoting self-advocacy skills amongst Praxis service users. The research aimed to elicit the views of individuals who participated in the training and to determine the effectiveness of the training provided.

Staffing: A full-time research officer was appointed to take forward the research element of the project. This was a contracted post for 3 years. The training officer position was part-time and contracted for 2 years. Due to staff turnover, three training officers were recruited throughout the duration of the project. Each training officer took on the responsibility for co-ordinating and delivering the HYS 2 training. The difficulties in retaining the training officer post had several knock on effects on the overall project. These will be discussed in the final section of the report.

Steering Group: A steering group was set up at the outset of the project with the remit of overseeing the overall direction of the project and the project timescale. The group comprised service users, staff members, volunteers, the training officer and the research officer.

Funding: The HYS 2 project received funding from the National Lottery Charities Board, Comic Relief and the Gulbenkian Foundation.

BACKGROUND

The original Having Your Say project had two main recommendations relating to service user empowerment. These were:

- *Ways need to be explored to promote service user self-confidence. This may involve offering formal training in social skills and confidence building, developing social activities and/or long-term one-to-one work between service users and staff.*

- *Further research should be carried out to take a closer look at the factors that help and prevent service users from asserting their views in situations outside of mental health services.*

The Having Your Say 2 project offered training in assertiveness and self-confidence to Praxis service users. The research aimed to assess the effectiveness of this training in improving service user skills and abilities.

RECRUITING SERVICE USERS

At the time of the Having Your Say 2 project, Praxis was providing accommodation and support to 151 individuals across 13 schemes located throughout Northern Ireland. The project was open to all individuals using the accommodation services, but not to those using Home Support services. Home Support is a domicillary model of care where a support worker visits and provides support to an individual experiencing mental ill-health within their own home. At the time of the HYS 2 project, Praxis was providing home support to 140 individuals. It was agreed by the steering committee that the project did not have the time or resources to offer training to these individuals. However, depending on the outcome of the project, it was anticipated that similar training could be provided at a later time.

A range of methods was used to promote the HYS 2 project and encourage participation from Praxis service users. An information session was held with all managers of the accommodation and support schemes. This session served as an opportunity to inform managers of the overall aims of the project, the direction in which the project would be taken, the time commitment required from both staff and service users and the perceived outcomes of the project. The managers were asked to use appropriate methods to rely this information to staff and service users within their scheme.

A poster advertising the project was designed and placed in key locations within the accommodation schemes, including communal areas, notice boards and the Praxis office.

Each individual living in Praxis accommodation was sent a personal letter and information leaflet explaining the project and inviting his/her participation.

Finally, a notice advertising the project was placed in the Praxis Team Briefing (a bi-monthly circular detailing organisational developments). This notice remained in the circular throughout the first year of the project.

Each of these publicity efforts resulted in a poor response from service users. Therefore, the training officer and research officer attended a tenant/resident meeting[1] within each scheme to explain the project in greater detail, answer queries and address any concerns service users may have had regarding the project. This method of 'personal recruitment' had a significant impact on service user participation and resulted in two training groups being set up, involving 22 individuals from across 4 of the Praxis accommodation schemes.

HYS 2 TRAINING PROGRAMME

The training officer was responsible for the design and implementation of the HYS 2 service user training programme. A series of focus group discussions were held with service users and Praxis care staff to elicit information on what they regarded to be the key training issues around advocacy and empowerment. In addition, a wide range of training materials were reviewed and relevant information and training tools extracted. Based on these two sources of information a training programme was devised and piloted. A summary of the programme is outlined in Table 1. Two training groups were set up and hosted in two Praxis accommodation and support schemes that could be easily accessed by the service users. Eleven individuals were allocated to each group. The training was delivered over six weekly sessions (each lasting approximately 2 hours) and culminated in a graduation ceremony for all participants. Each session included periods of information giving and practical exercises. Frequent 'time outs' were built into the programme.

[1] Tenant/residents' meetings are held within accommodation schemes. They include service users and staff and provide an opportunity to discuss social events, developments within the scheme, and to raise any issues of concern.

Table 1: Outline of Service User Training Programme

Session 1	**Introduction to Assertiveness** ▪ Introducing the idea of assertiveness and personal strengths. ▪ Assessing confidence levels.
Session 2	**Communication** ▪ Verbal and non-verbal communication skills. ▪ Understanding of body language, tone and pitch of voice.
Session 3	**Listening Skills** ▪ Dealing with situations when it is hard to listen. ▪ Practical guidelines on improving listening skills. ▪ Practice listening to others.
Session 4	**Assertiveness Techniques** ▪ Identifying various assertive techniques. ▪ Practice in using these techniques.
Session 5	**Expressing Feelings / Negotiating** ▪ Skills around negotiation. ▪ Role-play and applying newly learned skills.
Session 6	**Evaluation and Graduation** ▪ Review and evaluation of programme. ▪ Graduation ceremony with certificates presented.

These 'time outs' were aimed at ensuring service users did not feel overloaded and that they had adequate time to digest the information, mix socially with the other participants and enjoy the whole training experience.

HYS 2 RESEARCH

The research officer was responsible for taking forward the research, which aimed to elicit service users' views on their experience of the training; the value of the training; and the impact the training had on self-advocacy skills. The research used both quantitative and qualitative methodologies. The research was carried out over 3 time periods:

- Prior to training (Baseline)
- 2 months post training (+ 2 months)
- One year post training (+1 year).

<u>Having Your Say 2 Questionnaire</u>

An initial task for the researcher was to construct a HYS 2questionnaire for service users to complete at the 3 time points. A comprehensive literature review was carried out on topics around advocacy, empowerment, assertiveness and confidence in order to identify the key issues to be included within the questionnaire. In addition, information from the focus groups (which were set up as part of developing the training package) was taken into account when constructing the questionnaire. A draft questionnaire was drawn up and piloted with 4 service users. Several changes were made as a result of feedback regarding difficult to answer items, problems with

layout and question order. The revised questionnaire was administered to the 22 individuals who participated in the training programme. The HYS 2 questionnaire comprised 3 main sections:

Complaints: Part of the original HYS questionnaire asked service users about their ability to make various complaints (Mawhinney & McDaid, 1997). Some of these items were included in the current HYS 2 questionnaire. The items selected asked individuals to rate the extent to which a range of factors would prevent them from making complaint; their ability to complain about a range of individuals as well as their Praxis accommodation; and the extent to which they spoke out in various social situations.

Empowerment: The Empowerment Scale, developed by Rogers et al. (1997), was included to provide an overall measurement of empowerment. This American scale was developed with the assistance of an advisory group of ex-service users with the aim of measuring the personal construct of empowerment as it applies to mental health service users. The scale demonstrates a high level of internal consistency (alpha = 0.86) indicating that it is a reliable measure. The scale consists of 28 items each scored on a 4-point Likert scale ranging from 'strongly agree' to 'strongly disagree'. The scale provides an overall empowerment score, which is broken down into five sub-scales (see Table 2): self-efficacy/self-esteem; optimism; power-powerlessness; righteous anger and community activism. During pilot testing it was found that Praxis service users had difficulty understanding one of the items from the scale, largely because of its American focus. The item, included under the power sub-scale, '*You can't fight city hall'*, was adapted to read *'You can't beat the system'* which was considered to be an acceptable alternative. Data collection demonstrated that service users had no difficulty responding to this item.

Table 2: Empowerment Scale

Sub-Scale	**Sample of Items**
Self-efficacy/ Self-esteem	*I have a positive attitude towards myself.* *I am able to do things as well as most other people.*
Optimism	*I can pretty much determine what will happen in my life.* *I am generally optimistic about the future.*
Power-Powerlessness	*Experts are in the best position to decide what people should do or learn.* *I feel powerless most of the time.*
Righteous Anger	*People have no right to get angry just because they don't like something.* *Making waves never gets you anywhere.*
Community Activism	*People have more power if they join together as a group.* *Working with others in my community can help to change things for the better.*

Quality of Life: The Lancashire Quality of Life Profile (LQOLP), developed by Oliver et al. (1996), has been used and tested with long-stay patients, clubhouse users, and individuals using residential services (Oliver et al., 1996). The scale demonstrates a high level of internal consistency (alpha = 0.87) indicating that it is a reliable measure. Items include a mix of 'yes/no' responses and ratings on a 7-point satisfaction scale. The scale includes objective and subjective ratings on 9 life domains. Four of these life domains were included in the HYS 2 questionnaire - leisure, living situation, legal/safety and social relations. The self-concept scale and a question on life satisfaction that make up part of the LQOLP, were also included in the HYS 2 questionnaire.

Written consent was obtained from each individual involved in the research and demographic information was collected. The demographic information included gender, age, accommodation type, length of time living with Praxis, previous living situation, attendance at day-time activity, and other forms of advocacy training they had previously been involved in. The questionnaire was administered via a face-to-face interview with the researcher. Visual response cards were used to aid responses where appropriate.

Semi-Structured Interview

In addition to completing the HYS 2 questionnaire at the 3 time points, service users were also asked to participate in a semi-structured interview, prior to taking part in the training and 2 months after training. The interview aimed to explore the views of service users about the HYS 2 training they received, and about general empowerment issues. A topic guide was devised to assess individuals' reasons for participating in the training; their experience of assertiveness; and perceived benefits of the training. Each interview was recorded with the service users' consent.

Data Analysis

Following data collection, data input and screening, quantitative data from the questionnaires were analysed using the statistical package SPSS (Ver. 10). Service user interviews were transcribed and analysed using Nvivo, a qualitative software package which enables analysis of text according to grounded theory guidelines (Miles & Huberman, 1994).

RESULTS

Overall, 22 of the 151 service users who were living in Praxis accommodation schemes took part in the HYS 2 training, representing a response rate of 15%.

Demographics

Demographic information was available for 16 of the 22 individuals who completed the HYS 2 training. Of these 16 individuals, the majority (N=12) were male. Service users had an average age of 42 years, ranging from 25 years to 57 years. Service users were either living in a Flat Cluster (FC) Scheme (N=9) or Dispersed Intensively Supported Housing (DISH) (N=7). There was no representation from individuals living in a residential group home. On average, service users had been living in Praxis accommodation for 4 years, ranging from 1-8 years. Prior to moving into Praxis accommodation, service users had come from a range of living situations, including living on their own or with other family members (N=6); living in hospital (N=5); and living in a hostel setting (N=5). Nearly two-thirds of service users (N=10) were involved in organised daytime activity, with the majority attending sheltered employment (N=5). Others attended a daytime activity offered by their local Health Trust (N=3) or Community Mental Health Team (N=2). Service users were also asked about other forms of training they had received. The majority of individuals (N=11) indicated they had received no prior advocacy or empowerment training. Of those individuals who had participated in other types of advocacy training (N=5), this had been made available to them while they were in hospital.

HYS 2 Questionnaire

Due to a variety of reasons (such as illness and being re-hospitalised) not all participants completed the questionnaire at each time point. Sixteen participants completed the questionnaire at baseline, 10 at the 2-month follow up, and 9 at the 1-year follow up. However, only 5 individuals completed the questionnaire at all 3 time points. The results of these 5 individuals are reported below. Given the small sample size, it was not appropriate to carry out statistical analysis to identify significant differences across time. The results are mostly reported as individual scores. In addition, where appropriate, overall group mean scores are computed using the completed questionnaire data from the 16 individuals at baseline, 10 individuals at the 2-month follow-up and 9 individuals at the 1-year follow up.

Complaints: Individuals were asked to rate the extent to which a range of factors would prevent them from making a complaint within Praxis. The items listed included lack of confidence, being seen as a troublemaker, feeling unwell, not being listened to, not knowing who to go to and being afraid of losing their room/flat if they made a complaint. Lack of confidence was identified as the principle factor preventing individuals from making a complaint at all 3 time points (mentioned by 4 of the 5 individuals). Not wanting to be seen as a troublemaker and feeling unwell were

mentioned by 3 of the individuals as preventing them from making a complaint across each of the 3 time points.

Individuals were also asked how easy or difficult they would find it to complain about particular individuals and their Praxis accommodation. The greatest level of difficulty experienced was related to professional mental health staff, particularly the Praxis scheme manager (this represented the greatest level of difficulty for all 5 service users). Table 3 displays the combined mean score for each individual, representing the overall ease/difficulty of complaining about personnel and their accommodation. A higher score indicates greater difficulty in making a complaint. The symbol ⇩ represents a reduction in the mean score one year after training compared to the baseline score. Two service users (SU2, SU4) reported slightly lower scores 1 year after taking part in the training (i.e. they found it easier to make a complaint) compared to baseline. The other 3 service users (SU1, SU3, SU5) had higher scores at the 1 year data collection stage (i.e. they found it more difficult to speak out about personnel and their accommodation) compared to baseline. However, overall there was a minimal change in scores over the 3 time periods with scores varying less than one point (range -0.4 to +0.8) from baseline to 1 year follow-up.

Table 3: Complaints about Personnel and Accommodation

	Baseline	+2 Months	+1 Yr	
SU1	1.80	2.40	2.60	⇧
SU2	3.20	3.00	2.80	⇩
SU3	2.80	2.60	3.00	⇧
SU4	3.60	3.20	3.20	⇩
SU5	2.60	2.60	2.80	⇧

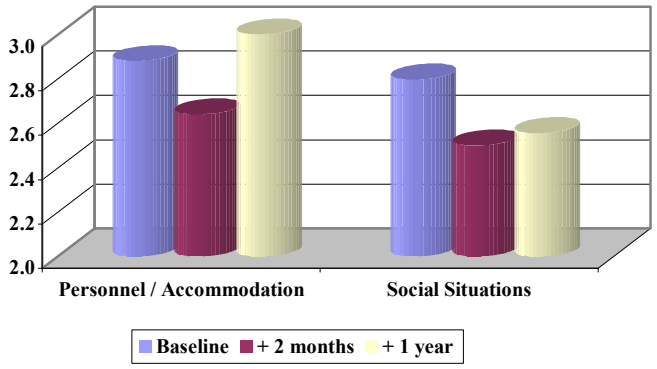
Finally within the complaint section of the questionnaire, individuals were asked to rate how easy or difficult they would find it to speak out in a range of common social situations outside their accommodation setting. A higher score indicates greater difficulty in speaking out. The symbol ⇩ represents a reduction in the mean score 1 year after training compared to the baseline score. As can be seen from Table 4, all but 1 service user (SU3) had lower mean scores 1 year after training (i.e. they reported that it was easier to speak out in social situations) compared to baseline.

Table 4: Speaking out in Social Situations

	Baseline	+2 Months	+1 Year	
SU1	2.50	2.00	2.00	⇩
SU2	2.50	2.00	2.00	⇩
SU3	2.50	2.00	2.50	-
SU4	3.75	3.00	2.75	⇩
SU5	3.00	2.75	2.75	⇩

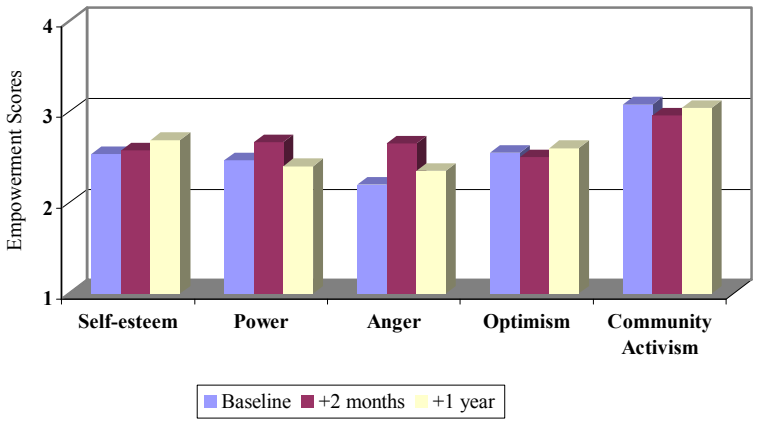
Group Mean Complaint Scores: As previously stated, data was available for 16 individuals who completed the questionnaire at baseline, 10 individuals at the 2-month follow up, and 9 individuals at the 1-year follow up. This information was used to compute an overall group mean score at each of the 3 time points (Fig 1). With regard to speaking out about personnel or Praxis accommodation, the group mean score was reduced 2 months after taking part in the training (i.e. individuals found it easier to speak out 2 months following training compared to baseline). However, at the 1year follow-up stage, the group mean score rose to slightly higher than the baseline score. The group mean score for speaking out in a range of social situations was lower 2 months following training compared to the baseline score. This increased only slightly 1 year after training, but remained lower than the baseline score (i.e. individuals found it easier to speak out in a range of social situations 1 year after training compared to baseline).

Fig 1: Making A Complaint (Group Mean Scores)



Empowerment Scale: Service user responses were obtained across 5 sub-scales: self-efficacy/self-esteem; optimism; power-powerlessness; righteous anger; and community activism. Higher scores indicate a greater level of empowerment. From Figure 2 it can be seen that over the three testing points there was minimal fluctuation in the scores for the 5 individuals who completed the questionnaire at the 3 times points. The power, anger and self-esteem sub-scale scores increased slightly 2 months after

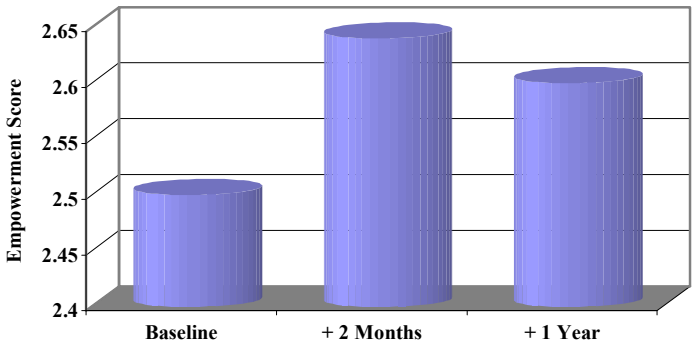
Fig 2: Empowerment Sub-Scales (Mean Scores)



training. For power and anger the scores had returned to approximately baseline levels at the 1 year follow-up stage. There continued to be a slight increase in the mean self-esteem score after 1 year. The community activism sub-scale was higher compared to the other sub-scales, suggesting that individuals recognised the importance of a group or community in effecting change.

Group Mean Empowerment Score: Based on all the questionniares completed, a group mean empowerment score were computed at each the 3 time points (Fig 3). There was an increase in the empowerment scores 2 months following training compared to baseline (i.e. individuals were more empowered 2 months after training compared to baseline). This score dropped slightly 1 year following training, but remained higher than the baseline score. The original American sample reported an overall mean empowerment score of 2.94 (Rogers et al., 1997). A sub-group of this sample, who were based in American community hospitals, had a mean score of 2.29. The Praxis group mean empowerment score at all time points (2.5, 2.64, 2.6) fall between these two comparison figures.

Fig 3: Empowerment (Group Mean Scores)



Quality of Life (LQOLP): Information was collected on 4 life domains (leisure, living, legal/safety, and social relations), which included both objective and subjective ratings. Information was also obtained on self-concept and life satisfaction. This information was available for the 5 individuals who completed questionnaire at the 3 time points.

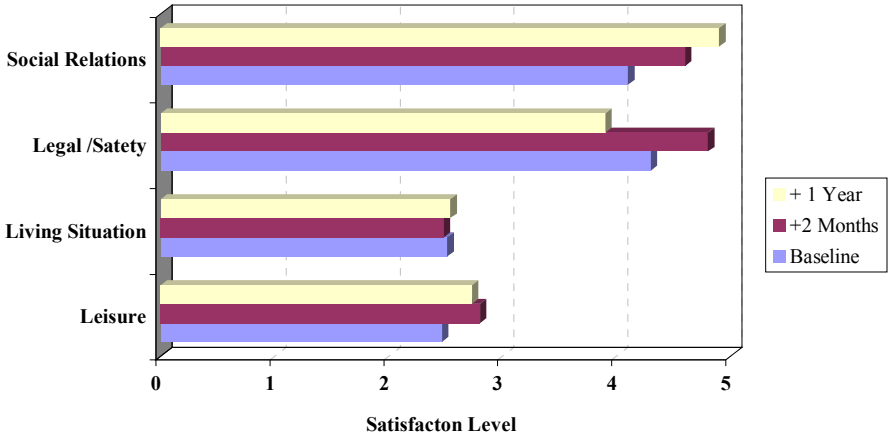
Leisure: Individuals were asked whether they had participated in a range of leisure activities within the 2-weeks prior to the interview. Almost all service users (4 of the 5 individuals) engaged in general community and social activities, such as shopping, going out in the bus or car, or watching TV at each of the 3 time periods. Fewer individuals were involved in sporting activities (ranging from 1 to 3 individuals). When individuals were asked if they would like to participate in more leisure, at the 1 year follow-up stage all but 1 stated that they would, but felt they were unable to.

Living: Across the 3 time points, between 1 and 3 individuals stated they would like to move house or improve their living conditions, but felt they were unable to do so.

Legal/Safety: None of the individuals had been accused of a crime. However, throughout the course of the year 2 individuals had been victims of crime and 1 individual required police/legal advise, but had been unable to receive any.

Social Relations**:** A series of questions was used to assess the extent of service users' network of friends. Two of the 5 individuals considered that they could manage without friends completely. The number of service users who had a close friend increased over the time of the project, from 1 individual to 4 individuals. Four of the 5 individuals stated that they had a friend they could turn to for help. The number of individuals who visited a friend in the week prior to the interview was quite low, with only 1 or 2 individuals through the year stating they engaged in this social activity.

Fig 4: Subjective Ratings on 4 Life Domains



Life Satisfaction Scale Midpoint = 4

A subjective rating on each of the 4 life domains was calculated for individuals across each of the 3 time points (Fig 4). Higher scores indicate a greater level of satisfaction, with a score of 4 being the midpoint. Overall, individuals reported higher satisfaction scores with social relations and legal/safety issues. Individuals reported dissatisfaction (scores below 4) with their living situation and leisure activities. There was a slight improvement in scores 2 months after training compared to baseline in 3 of the life domains (social relations, legal/safety, leisure). Scores continued to increase 1 year after training on the social relations sub-scale and the leisure activities.

Self-Concept: The final series of questions for service users focused on self-concept, which was measured using a series of 5 positive and 5 negative statements requiring a yes/no response. An improvement in self-concept is represented by an increase in the frequency of service users expressing self-enhancing attitudes (e.g. '*You feel you have a number of good qualities*') and by a

decrease in the frequency of self-detracting attitudes (e.g. *'You feel you do not have much to be proud of').* Overall, individuals improved in 6aspects of self and remained constant on 4 aspects of self 1 year after training compared to baseline.

Life Satisfaction: Finally, service users were asked to rate their overall life satisfaction at 2 points during the interview using a 7-point scale. The two ratings were used to construct a mean life satisfaction score. There was little change in the mean life satisfaction scores across the 3 time points. A mean score of 4.2 was reported at both the baseline and 2-month follow-up period. This increased slightly to 4.4 one year after the training.

Summary of HYS 2 Questionnaire Findings

- Lack of confidence was a principle factor in preventing individuals from making a complaint prior to taking part in the HYS 2 training. This continued to be a major factor 2 months and one year following training.
- Based on the group mean scores, individuals found it easier to speak out about mental health professionals and their accommodation 2 months after taking part in the training compared to baseline. However, by the 1-year follow-up the group mean score had returned to approximately the baseline mean score.
- With regard to speaking out in social situations, the group mean scores indicate that individuals found it easier to speak out in these situations 2 months after training compared to before training. Although the mean score increased at the 1 year point, individuals did not rate it as difficult to speak out in these situations 1 year after training compared to baseline.
- Individuals indicated that they were dissatisfied with both their living situation and their leisure activities.
- On the whole there was some improvement in self-concept over time, with individuals improving in 6 of the 10 aspects of self 1 year after training.

Semi-Structured Interviews

In addition to completing the questionnaire, service users were also asked to participate in a short semi-structured interview. Twelve of the 22 individuals who participated in the training agreed to take part in a short interview prior to the training. Nine individuals were available for interview 2 months after having participated in the training.

Reasons for Taking Part: Individuals were asked about their main reasons for participating in the training course. Some individuals regarded it primarily as an opportunity to learn or re-learn skills to encourage them to be more confident and assertive:
'*…before I had my breakdown I used to be a very assertive person, I wouldn't let people walk over me. But sometimes I wouldn't speak up for myself, and I should. And that's why I want to go to this group and improve those skills'.*

'I shut up about things I should speak out about. Like people saying things and me not answering them back'.

'I told staff I would have a go at it because I need to build up a bit of confidence and get things out in the open'.

For 1 individual it was anticipated that being more assertive would have a beneficial effect on their mental well-being:
'I think that it would improve my mental health a lot better..it would improve me when I would be able to speak up for myself and talk to different people'.

Other individuals highlighted the social aspect of taking part in the training, in terms of meeting people and taking a break from normal routine, stating *'Just being in the group and talking to people'.*

'It's something to do. Here I just see what is on T.V. and go back to bed again. It's a very dull existence'.

Preventing Speaking Out: Individuals were asked what they felt prevented them from speaking up for themselves. Reasons included lacking confidence, being concerned that they would hurt another person's feelings, feeling bound by the past and being afraid (Table 5).

Some individuals referred to specific occasions or situations in which they found it difficult to be

Table 5. Preventing Speaking Out

'I'm not very good on confidence, having confidence in myself. I'm not confident at shopping, I'm not confident at cleaning up the house'.

'It's just fear of offending people or maybe hurting somebody in some way or another, or hurting someone else's feelings'.

'Your confidence gets better, but then you start reflecting on the past and it's the past that makes you nervous'.

'Sometimes I'm afraid to speak out'.

confident and assertive. For some, this was going about their daily chores:
'Whenever I've been going shopping, I've been taking panic attacks and I need to get confidence in order to do that and let myself know that I am as good as others'.

Another individual referred to the difficulty of speaking out during appointments with his/her G.P:
'When it's me and the doctor and I don't want to get angry or anything like that, but you know he's talking to me about what I feel and all and sometimes I wouldn't speak up'.

Benefits of the Training: Two months after individuals had participated in the training programme, they were asked how they felt they had benefited as a result of taking part. For some individuals, feeling more confident and in particular being able to say 'no' to certain individuals or requests was regarded as the main outcome (Table 6).

Table 6: 'Saying No'

'It's helped me to say no…before that I was able to give in to [family member], but now I can say no…about money, I just said no'.

'It made me fit to talk to people a bit better...I was fit to tell people to get away from the door that were annoying me and things like that'.

'Saying no, not making excuses, but just saying no.'

Individuals also referred to a number of other specific outcomes from attending the course:

Achievement: One individual referred to a sense of achievement from participating in the course, stating: *'I enjoyed getting the certificate and am waiting for a frame for it'.*

Self-image: Another individual stated that the course had played an important role in developing a stronger self-image:
'I wouldn't be ashamed of speaking out. In one way it has made me think better about myself, which is a step in the right direction'.

Independence: For another individual, being an active participant on the programme offered the hope of becoming more independent:
'It genuinely did help me…it's helped me understand my own behaviour and made me aware that maybe in a year or two I'd be fit to cope on my own, that bit more independent.'

New Interests: One individual stated that as a result of having been involved in the training, he/she had the confidence to pursue a new interest:

'Going to the group gave me confidence. Because at the Day hospital I'm talking to one of the OT's [Occupational therapists] about doing a course in calligraphy or photography. Now I wouldn't have been able to do that. Going to that group gave me confidence to try different things'.

Skills: Another individual referred to the practical tool learned during the training course of writing things down prior to attending an important meeting. The individual felt that putting this skill into practice before attending a Praxis review meeting aided him/her to feel less anxious and have their say at the review. *'I usually get really worked up about the reviews here, but I don't get worked up as much'.*

Although individuals mentioned very positive outcomes as a result of having taken part in the training, some were also aware that feeling empowered and confident is a process that develops over time: *'You can sort of see progress, you do feel a bit more confident. Even if it helps you a wee bit that's a start if you feel a wee bit better after it, which I do'.*

Although feeling more confident in a general sense, some individuals identified a number of areas of their life in which they still felt vulnerable and disempowered
'I feel a bit more confident, but there's things I'm not confident in…'.

'I'm a lot more confident talking to people now, but sometimes if somebody says something nasty to me I'd dwell on it'.

Reflecting on the benefits of the course, one individual felt that the newly acquired skills would only be fully realised if they were rehearsed and affirmed on a regular basis, stating, '*you need to do it every now and again to keep up the practice of it'.*

Enjoyment: In addition to these perceived benefits, some individuals mentioned how much they actually enjoyed attending the course, as it afforded them the opportunity to get out and about and meet others. One individual stated, *'I enjoyed the course that much because it got me out and about'.*

POINTS FOR DISCUSSION

The questionnaire results are mostly based on the responses of 5 individuals who completed the HYS 2 questionnaire at each of the 3 time points. Given the small sample it is difficult to draw

conclusions as to the benefits of the HYS 2 training in terms of service users being more empowered to 'have their say'. The benefits of the training are more easily evident by service user comments elicited during the semi-structured interviews. However, based on the findings some general comments can be made.

Uptake of Training

- Although a range of methods was used to inform service users of the training and encourage their participation, overall there was a low uptake with only 15 % of all individuals living in Praxis accommodation taking part. A lot of time and effort was given to designing the training programme, setting up the training groups, and delivering the programme for a small number of individuals. In future, it would be beneficial to gauge the interest of service users in a group-training programme prior to the training being designed and delivered. In addition, the reasons as to why the majority of service users did not take part in the HYS 2 training were not explored. It would be beneficial to ascertain service users' reasons for not taking part in training. Such information could be used to make a decision as to whether to proceed with the group training or to explore alternative methods of training.

- The most successful method of recruiting service users was a 'personal approach' where the research and training officers visited the schemes and engaged directly with the service users. It is unclear as to whether this was the only significant influence encouraging individuals to take part, or whether it was a culmination of all the other recruitment methods employed.

- Of those individuals who participated in the HYS 2 training, none were living in a residential group home. Individuals were using DISH and FC models of care. In general, these individuals have greater coping skills and engage in more independent living than individuals within residential group homes. Therefore, in addition to the training attracting a small number of service users, it is likely that those who took part were more independent and confident than individuals who did not participate. It is essential that innovative ways of engaging with more dependent and less assertive service users and are considered.

Longitudinal Research

- Only 5 individuals completed the questionnaire at all 3 time points. This highlights the difficulties of conducting longitudinal research within mental health services where there can be a range of factors affecting the follow through of service users. This can include

individuals moving on to more independent living; individuals being unable to participate due to ill health; and individuals being re-hospitalised.

Impact of Training

- On the whole, individuals stated that they enjoyed the training experience and highlighted areas where they felt they benefited. These interviews took place 2 months after the training. Unfortunately due to the time scale of the project and the difficulty of following-up clients, interviews were not conducted 1 year after training. It would have been useful to explore service users' views of the training and its perceived impact one year on.

- Based on the group mean scores, there was an increase in levels of empowerment 2 months following training compared to baseline. However, these scores were not maintained at the 1-year follow-up. This raises the issue of 'refresher training' and the importance of providing opportunities to reinforce and refine the skills learned on an initial training course. Indeed, as stated previously, one of the participants themselves emphasised the need to '*do it every now and again to keep up the practice of it'*.

Individual Approach to Empowerment

- Participating in a group training programme may in itself be one step too far for some service users. Several prior stages of development may be required, in terms of confidence building and assertiveness, before individuals may feel able to embark on a group training exercise. In such cases, a more individual approach to developing self-advocacy skills may be more effective. A small case study was carried out to explore a more individual based approach towards user empowerment. The case study addressed the issue of user participation in care plan development within a Praxis housing scheme. The case study is outlined in the next section of the report.

BACKGROUND

As stated in the previous section, only 22 service users (15% of individuals living in Praxis accommodation services) participated in the HYS 2 group training. It was felt that for many service users, accessing group training in itself was a step too far and some would benefit from one-to-one work to develop confidence and assertiveness skills. In response to this, a small-scale case study was initiated focusing on service user participation in care plan development within one of the Praxis accommodation schemes.

PRAXIS CARE PLANS AND REVIEW MEETINGS

The care programme approach was introduced to improve the delivery of services for people with serious ongoing mental health problems (DOH, 1992). This approach was designed to ensure that the multiple needs of such individuals are met, that care from different agencies and personnel is co-ordinated and that the risk of a person losing contact with services is minimised (Kingdom, 1994). The approach involves compiling a written care plan based upon an assessment of the service users' health and social needs. The enactment of the care plan is co-ordinated by a named key worker (Perkins, 1996).

Praxis is committed to care programming with all service users. Praxis operates a system where an Individual Care/Support plan is drawn up for each service user when they first move into Praxis accommodation. The support plan is drawn up between the service user, Praxis scheme manager and the statutory referral agent. The plan is based on the needs of the service user in relation to their day-to-day living requirements. These plans are formally monitored and reviewed during Praxis Review meetings, which take place every 3 months during the first year and on a yearly basis thereafter. In addition, an emergency review can be called at any time to discuss any immediate issues or concerns. The original Having Your Say study found that, overall, service users were unfamiliar with their Care Plan and did not attend their own review meetings, which they found to be stressful and/or intimidating. Interviews with service users early on in the current HYS 2 project reinforced these findings. Therefore, care planning was selected as an area for further exploration through a case study. It was hypothesised that enabling service users to have greater involvement in creating their own Care Plan would have a beneficial effect on their advocacy skills and confidence. This hypothesis is supported by findings from the literature with different user groups, including psychiatric patients (Youssef, 1984); the elderly (Vallerand et al., 1989); and patients in long-term care (Rodin, 1986). Following a review of the literature the Avon Mental Heath Measure (AMHM), developed by MIND in England, was identified as being an appropriate assessment tool for this study.

AVON MENTAL HEALTH MEASURE (AMHM)

The AMHM was developed between 1993-1996 by a multi-agency group of current and ex-service users and mental health professionals from health services, social services and the voluntary sector in the south-west area of England (Avon/Bristol). It was co-ordinated by Bristol social services, and the development was supported by MIND, the National Schizophrenia Fellowship and local health trusts. The measure was designed to assist:

- Mental health service users – in assessing their own need
- Carers – in ensuring the person they care for receives the most appropriate care
- Mental health professionals – in understanding individual need and delivering care programmes that reflect these needs.

The measure consists of 6 key headings (Table 7).

Table 7: AMHM Key Headings

Physical	Food, Accommodation, Physical health, Self-care, Ill effects of treatment
Social	Social support, Discrimination, Daily Routine, Community Involvement
Behaviour	Sleep Disturbance, Risk to self, Substance misuse, Suicide, Anger
Access	Transport, Information, Communication, Income, Managing money
Mental Health	Mood swings, Depression, Unusual thoughts & experiences, Anxiety/fear, Obsessive compulsive thinking/activities, Problems forgetting / understanding
Other	Contact names and numbers, qualifications and work experience, areas of work/training interested in

The measure asks a series of questions under each of these headings where service users are asked to rate themselves on a 5-point descriptive scale ranging from A (indicating severe problem) to E (no problem). Opportunity is given to provide a rating on both a 'good day' and a 'bad day'. As part of the 'Changing Minds' programme, southwest MIND has 13 projects pilot-testing the AMHM in a variety of settings. With the permission of southwest MIND, this is the first time the measure has been used in Northern Ireland.

Selecting a Scheme: Following an information meeting and discussion with Praxis senior management, agreement was reached to carry out the case study within a Praxis DISH scheme where tenants were relatively independent and well settled into their accommodation. The Research Officer visited the scheme and explained the nature of the case study. Three staff members agreed to participate and identified 3 service users who were interested in taking part. The staff members were matched to a service user for whom they did not act as key worker, in order to make it easier for them to act in the role of an advocate rather than a professional.

Informing Service Users: The researcher met with the 3 service users to explain their involvement and answer any queries. Service users were informed that their involvement would be on a confidential basis and that they could end their participation at any time.

Staff Training: A training workshop, which lasted $2^{1/2}$ hours, was organised for staff members. The workshop covered the background to the measure and how to complete it, potential difficulties which could arise when completing the measure and general information around advocacy and service user empowerment.

Completing the Measure: Each staff member arranged an appropriate time to meet with the Praxis service user to complete the AMHM. Staff were advised that the procedure should not be hurried and that the service user should dictate the pace. Once the measure was complete, staff wrote a report on their experiences of using the measure.

Interviews: Approximately 2 weeks after completing the measure, staff and service users were invited to take part in a short individual interview to explore in greater depth their feelings about using the measure and their evaluation of its usefulness.

KEY FINDINGS

One individual completed the majority of the measure by him/herself and then met with the staff member to complete the remainder of the questions. The other 2 individuals completed the measure with the staff member present throughout. Table 8 provides a brief extract from a completed AMHM.

Table 8: Extracts from a completed AMHM

AREA	RATING	COMMENTS	HELP REQUIRED
SOCIAL			
Social Support	E	*I visit my family daily; I have a lot of support from my family. Would have occasional drinks with friends*	*Do not feel the need to change anything*
Discrimination	E	*Do not experience any discrimination*	
Daily Routine	E	*Socialise with family on a daily basis. Play snooker and go to Leisure Centre and walks*	*I would like to attend the Leisure Centre more often*
MENTAL HEALTH			
Mood Swings	E/E*	*I do not experience any kind of mood swings*	
Depression	C/C	*Sometimes I drift into a small bout of depression*	*Don't need any help as I can control this*
Anxiety / Fear	C/C	*When I am in a crowded place I would panic and feel that I have to get out*	*This happens rarely and I can usually cope*
(good/bad day)*			

Information from the AMHM was compared with the information included within each of the service user Praxis Care Plans. The key differences between the 2 measures are summarised below:

Completing the Form

- Instructions on completing the measures indicate that the measures are written for 2 different groups – the AMHM is directed towards service users, whereas the Praxis Care Plan is aimed at mental health professionals.
- The AMHM recognises that there may be disagreement between the service user and staff member on their chosen response to the various categories and allows space for this to be recorded in a summary sheet.

Categories and Response Ratings

- The AMHM addresses Work Experience and Training as a key topic whereas this is included within the Day Activity section of the Praxis plan.
- The mental health section of the AMHM is more comprehensive, covering a wide range of typical symptoms and recognising that symptoms can vary depending on the type of day the individual has had. In addition, other aspects of mental health are contained within the Behaviour category.
- The AMHM offers service users the option of five detailed responses to each category, with a secondary level reflecting the situation on a good or bad day. The Praxis plan allows for two levels of response (advice or help required / not required), followed by a description provided by the staff member as to the type of advice/help required.

Depth of Information

- The AMHM provides greater depth of information and gives a clear insight into the service user's daily life and activities, pyhsical and mental well being, coping strategies, areas of concern and support needs. The responses provided by the service user are very personal and give a practical insight into how they are dealing with their mental illness on a day-to-day basis.

- The use of a 5-point descriptive rating scale in the AMHM allows for a more subtle monitoring and detection of change in skills and behaviour over time than does the 2-level response format of the Praxis Care Plan.

- For all service users, regardless of their communication ability, the information provided by the AMHM was of a superior quality in terms of depth and scope, compared to that included within his/her Praxis Care Plan.

INTERVIEWS – SERVICE USER VIEWS

Each service user was interviewed before and after the implementation of the AMHM in order to assess their experiences of being involved in the case study and to elicit their views on the usefulness of the measure.

Praxis Care Plans and Review Meetings: None of the service users remembered completing or seeing a copy of their Praxis Care Plan. With regard to the Praxis review meetings, two individuals had previously attended a review where each stated that they felt intimidated and unable to speak up. This was largely attributed to the fact that they felt there were too many people present at the meetings:

'I didn't get anything out of it…I don't like that…answering a lot of questions and there was a lot of people there'.

'You don't have much say at it; it's more staff telling you what to do. Even two or three people can be intimidating, but sometimes there's like 6 people, and some wouldn't even know you.'

AMHM: During the interview prior to completing the AMHM, individuals did not voice any fears or anxieties about completing the measure. Some were looking forward to the opportunity of getting to know another member of staff. Individuals were unclear about the benefits they might receive from completing the measure. One individual felt the information required was quite personal, particularly in relation to the medication they were taking, while another was concerned the information could be used to reduce the level of benefits they received. One individual regarded the experience as enjoyable and felt it allowed him/her to reflect on different areas of their life:

'It's hard to be a judge of yourself, but I actually enjoyed doing some of it….it just keeps you thinking….It made me realise how much of a social life I have….it does get you thinking about yourself.'

Another individual stated that he/she found the questionnaire quite demanding but felt it would be beneficial to have the information on record for further reference:

'I suppose you opened up a bit more about things....it was a pretty heavy, informative form. Well personally I don't like disclosing information but I was honest, I disclosed it anyway you know…I'm sure it will help me in the long run.'

INTERVIEWS - STAFF VIEWS

The 3 staff members were invited to offer their views on the process of completing the measure, the advantages and disadvantages of the measure and its perceived usefulness in recording service user needs.

Completing the Measure: Reporting on the tenants' experience of completing the AMHM, staff stated that it was demanding in terms of time and attention. In retrospect, staff felt they may have needed more sessions to complete the measure more effectively:

'By the end of the last session it was noticeable (SU) was getting slightly bored with the efforts and although the plan was completed, I felt that a fourth session would have been more beneficial.'

'(SU) was very forthcoming in the responses and gave me a lot of information…(SU) didn't mind co-operating at all although found it quite long and intense, and once started (SU) wanted to finish as quickly as possible'.

User Focus: Staff referred to the benefit of the measure in terms of its focus on the service user. Staff felt that rather them, as staff members, imposing their views and opinions the AMHM measure provided a vehicle for users to be actively involved in making decisions about their own care. One staff member commented:

'I think it was very good, I think it gets you more involved with the tenant…we're not actually telling them what we want to do, we're asking them what they want out of the scheme'.

Confidentiality: Staff also recognised that some of the more personal information was difficult for tenants to reveal. Stressing confidentiality emerged as an important element when completing the measure:

'During the session (SU) remained in a calm state of mind but on each occasion voiced concerns regarding giving telephone numbers to contact'.

'I don't think (SU) actually minded so much answering the question, although confidentiality became a big question'.

'(SU) did not find the questions too difficult, but admitted they did feel a little bit uncomfortable answering some of the more personal questions'.

Relationship Building: The capacity for building closer relationships while completing the AMHM was commented on by all staff members as one of the clear advantages of the measure:
'I feel the AMHM was very useful and worthwhile…the measure gave me an opportunity to really get to know the individual better and give the service users an opportunity to voice their own views and concerns'.

Advocate v Professional: The conflicts inherent in being a staff member and acting as an advocate emerged when one of the staff members disagreed with the letter/ rating chosen by the service user. In order to continue working with the service user, the staff member felt the need to suppress their disagreement (which could be indicated on the Summary Sheet) with the service user's view:
'I found there were one or two points where I disagreed with (SU's) decision / letter, however, I felt unable to indicate this on the summary sheet in the space provided because (SU) is entitled to see the summary and would become distressed at my disagreeing with the letter they chose'.

Timing: The issue of when the AMHM should be completed resulted in a unanimous view that it should wait until service users have settled into their accommodation and are comfortable with the staff and surroundings:
'Definitely I think there should be a delay between the whole moving in procedure and before doing the plan (AMHM). You know maybe do an initial one like the one we have at the minute, the shorter one, just so as we have a basic idea, but definitely at a later stage, a month after they have moved in.'

'I certainly think that you should give them a bit of time to settle in rather than do it when they're coming into the scheme…obviously they need to get to know you a bit more'.

Overall: In general, despite the length of time it took to complete the measure and the greater amount of effort involved, staff considered the AMHM a superior method of devising care plans for service users. The benefits of using the measure included the range and depth of information generated, the focus on the service users' perspective and the added bonus of building up a personal relationship with the service user:
'I felt the AMHM was very useful and worthwhile, and a vast improvement on the care plans which are currently being implemented.'

'I think it was very worthwhile, it got to the nitty-gritty and it was so much more valuable information than if you had done just the ordinary care plan…and you're getting much more valuable feedback'.

POINTS FOR DISCUSSION

The AMHM has been used in other community mental health services and found to be valuable. However, this is the first time an attempt has been made to incorporate the measure into residential services and its first use in Northern Ireland. Although only 3 individuals were involved in the study, some general conclusions can be drawn from their experience and the experience of the 3 staff members who assisted individuals in completing the form. Overall, while the AMHM was more time consuming and demanding to complete, it was reported as having the distinct advantage of being user focused. It actively engaged the service user in the assessment process, giving ownership to the individual. Additionally the measure enabled detailed information to be generated and provided an opportunity for the development of relationships between service users and staff.

Positive Profiling

- Overall staff viewed the AMHM more favourably than the current Praxis Care Plan. Staff felt that due to the design and focus of the Praxis plan, service user responses were restricted. Only basic information on behavioural and skills deficits was elicited, with no real sense of the individual emerging from the process. In contrast, staff stated that the AMHM facilitated a depth and quality of response that resulted in a more meaningful and holistic view of the individual. In addition to illuminating areas where support was required, the AMHM provided an opportunity for the positive profiling of skills and behaviour.

Action Plan

- Designed as a comprehensive assessment tool, the AMHM does not result in a concise plan of action for the service user. While a great deal of valuable information is generated there needs to be a reduction of this into a manageable size, summarized into a format outlining clear goals for the service users to achieve; the individual(s) responsible for implementing such plans; and a time scale for completion, evaluation and review. Such an action plan (similar to the Praxis Care Plan) could form the basis for ongoing rehabilitative work with the individual service user. Therefore, rather than substituting one form for another, each could be used to compliment the other with the AMHM being used initially as a comprehensive assessment tool from which information is extracted and submitted to a Praxis Care Plan.

Praxis Policies and Procedures

- Although only 3 service users and 3 staff members were included in the case study, the findings have some implications for future Praxis practices and policies in relation to service user empowerment. The findings can be used as a catalyst to further address issues around the efficacy of the current Praxis plans, staff training, the potential benefits of the AMHM, and the role each of these plays in the empowerment of service users. However, part of taking this forward will involve piloting the measure in other models of Praxis care, particularly within Praxis residential group homes. It will be important to determine how useful the measure is with individuals who have greater levels of dependency. This is an area for further study.

Staff Role

- Central to the successful completion of the AMHM was the skill and sensitivity exercised by the staff members. Staff had to continually affirm confidentiality, be diplomatic when they disagreed with the rating chosen by the service user, and encourage the service user to open up through building a personal relationship. The skills and attitudes of staff members play a vital role in empowering individuals to 'have their say' in the support and services they receive. However, the mere existence of the care plan alone does not guarantee that the care delivered will be appropriate to the service user's needs. Once this care plan it devised, staff continue to play a crucial role in ensuring the care delivered matches that which has been documented. The way in which the information from a care plan translates on the ground will in large part be influenced by the attitudes and abilities of the front line staff workers. The attitudes of Praxis care staff are addressed in the following chapter.

BACKGROUND

Findings from the original HYS study concluded that Praxis staff members were generally positive about service user empowerment (Mawhinney & McDaid, 1996). However, staff raised concerns regarding situations which they felt could arise if service users were further encouraged to speak out for themselves. For example, staff mentioned the potential for manipulation of staff members by more assertive service users, and they highlighted the potential for conflicting views between staff and service users becoming more evident. Staff also felt that the development of self-advocacy amongst service users could lead to changes in staff roles and consequently staff training needs. In response to the finding concerning staff training needs, one of the recommendations from the report stated:

- *Specific training needs for staff should be identified in order for staff to deal effectively with the changes which could come about if service users begin to speak out more for themselves.*

The HYS 2 project aimed to take forward this recommendation by identifying staff training needs around the topic of user empowerment, and implementing a HYS 2 training programme to meet staff needs.

RECRUITING STAFF

The training was open to all grades of care staff [*] working within the accommodation and support schemes. Staff grades range from grade I, grade II, and grade III, to deputy project manager and project manager. An information session was held for managers of the accommodation and support schemes. The session was attended by Praxis senior managers who reinforced the value of the training and encouraged scheme managers to arrange for their care staff to participate in the project. Provision was made to fund staff travel expenses to and from the training, and to employ relief staff to enable other staff members to attend. Overall 86 staff members participated in HYS 2 training. Two separate training programmes were delivered; one for scheme managers, deputy managers and grade III staff; and one for grade II and grade I staff members.

HYS 2 STAFF TRAINING

Training for scheme managers, deputy managers and grade III staff members was the first programme to be delivered. It was designed and facilitated by a trainer, who was also an ex service-user, from Pavilion Training in Brighton. The training included information giving

[*] Care staff refers to staff members who have regular face-to-face contact with service users. It excludes administrative staff members.

sessions, case study analysis and group exercises. The training had 4 main objectives. These were for staff to:

- Understand disempowering experiences that service users and carers have, and be aware of possible changes that assist empowerment.
- Understand the types of advocacy and the characteristics of effective advocacy.
- Be aware of what users and carers want from mental health services.
- Understand and be able to apply skills that enable advocacy to flourish, and be aware of the staff member's position of power within this.

Training for grade I and grade II staff members was designed by the training officer. The training programme was developed using information obtained from the staff focus groups (referred to in the service user section of the report) and from a review of the training literature (Table 9). Members from the Praxis training department delivered the training.

Table 9: Outline of HYS 2 Training Programme (Grades I and II)

Session 1
- Understanding self-advocacy and advocacy.
- Advantages / disadvantages of self-advocacy.
- Advantages / disadvantages of being an advocate.
- Implications of service user self-advocacy for staff.
- Understanding basic needs (Maslow's hierarchy of needs).

Session 2
- Communication skills.
- Models of empowerment / disempowerment.
- How to start a self-advocacy group.
- Legal implications.
- Evaluation of programme.

Two training groups were set up and hosted in schemes that could be easily accessed by staff members. The training was delivered over 2 sessions, each lasting approximately 2 hours. It included periods of information giving, role-play, group exercises and discussion. The training focused on issues around promoting service user empowerment and the challenges this presents to frontline staff.

RESEARCH

At the time of HYS 2 project, Praxis employed 136 care staff throughout the accommodation and support schemes. The organisation did not have accessible information on the gender, age, level of education, and years of experience of their care staff team. An initial task of the HYS 2 research was to generate a demographic profile of Praxis care staff. In addition, the research aimed to determine staff attitudes towards user empowerment and community care initiatives, and to find out how empowered they felt as staff members working within the overall organisation. The research was carried out over 3 time periods:

- Prior to training (baseline)

- 2 months post training (+ 2 months)
- One year post training (+1 year).

HYS 2 Staff Questionnaire

Based on a review of the literature, 3 scales were selected to comprise the HYS 2 questionnaire.

Community Attitudes to Mental Illness Scale (CAMI): This scale, developed by Taylor & Dear (1981), was designed to provide an assessment tool for the systematic description of community attitudes towards the mentally ill. The scale comprises four sub-scales:

- **Authoritarianism** refers to a view of the mentally ill person as someone inferior who requires coercive handling. A higher score indicates a less authoritarian approach to people with mental illness.
- **Benevolence** refers to a paternalistic and sympathetic view of the mentally ill individual. A higher score on this sub-scale indicates a more benevolent approach to people with mental illness.
- **Social Restrictiveness** refers to the belief that mentally ill individuals are a threat to society and should be avoided. A higher score indicates a less socially restrictive approach to people with mental illness.
- **Community Mental Health Ideology** (CMHI**)** refers to the acceptance of mental health services and mentally ill patients in the community. A higher score indicates more support for a community care orientated approach to the care of people with mental illness.

The CAMI questionnaire consists of 40 statements, 10 statements on each sub-scale (5 express a positive sentiment and 5 express a negative sentiment). Individuals are requested to rate their level of agreement with each statement on a 5-point Likert scale ranging from 'strongly agree' to 'strongly disagree', with a 'neutral' option included.

Attitudes to Community Care Questionnaire (ACCQ): The ACCQ was developed to measure attitudinal support for community care (Haddow & Milne, 1995). The questionnaire consists of 23 statements referring to people with mental health problems and the provision of mental health services. A sample of items in the questionnaire includes:

- *People with problems should be helped to live in ordinary houses in the community, regardless of the severity of their illness.*
- *It is possible to prevent mental health problems occurring in vulnerable members of the community.*
- *Where I work is open and responsive to change.*

- *People with problems are very vulnerable and need others to represent them.*

Individuals are asked to rate their level of agreement with each statement on a 4-point Likert scale ranging from 'strongly agree' to 'strongly disagree'. A higher score indicates greater support for a community care approach for people with mental illness.

Work Powerlessness Scale: Developed by Guilbert (1979), the scale is based on the premise that power is formulated as the amount of control an individual can exert over his/her work situation; powerlessness is construed as the opposite of this. The scale assesses how much control individuals feel they have over their working environment and the extent to which they feel they can contribute to decision making within the organisation. It consists of 14 sets of paired items, one indicative of control and one of powerlessness. An example of one of the paired statements reads:

- *It doesn't do much good to try to think of ways to improve conditions at work: you usually can't try new ideas anyway.*
- *If you have a good idea about some way of improving conditions at work, you can usually get the backing you need to try it.*

Scores from the scale range from 0 to 14. A higher score indicates greater feelings of powerlessness and lack of control over the working environment.

Prior to staff members taking part in the HYS 2 training, staff received a questionnaire pack. The pack included a copy of the HYS 2 questionnaire and instructions for its completion; a letter outlining the project and affirming staff confidentiality; and a pre-paid return envelope marked for the attention of the researcher. Three weeks after the initial questionnaire was mailed, a reminder letter was sent to those who had not responded. Two weeks later a notice was placed in the Praxis Team Briefing to serve as a final reminder to those who had not responded and to thank individuals who had returned their completed questionnaire. The same procedure was followed at the 2-month and 1-year data collection times.

RESULTS

Overall, 86 of the 136 Praxis care staff took part in the HYS 2 training, representing a response rate of 63%.

Profile of Praxis Care Staff

Staff members who took part in the HYS 2 training (N=86) completed a demographic questionnaire. This provided information on their gender, age, education, years of experience and previous training they had attended on the topic of service user empowerment. Although

the questionnaire was not completed by all Praxis care staff (N=136), those who completed it can be regarded as being fairly representative of Praxis care staff as they represented all grades of staff and included all models of Praxis care. Therefore, this information was used to generate a demographic profile of the Praxis accommodation staff care team.

Gender and Age: Over three-quarters of Praxis care staff are female (78%), most of whom hold grade I posts. Although there are fewer males within the organisation, of all males employed 47% occupy positions of grade III or above. This is in contrast to just over one third of females (34%) holding the equivalent positions. Overall, Praxis has a young care staff team with 60% of staff aged less than 40 years. The average age of a Praxis care staff employee is 37 years, with a range of 22 years to 67 years. Over one third of grade III staff members (38%) are included within the youngest age category (18-29 years).

Scheme Type: 42% of female staff work within residential group homes, whereas over half of the male staff group (53%) are employed within DISH schemes.

Staff Hours: There is almost a 50:50 split between full-time staff members (53%) and those employed on a part-time basis (less than 20 hrs per week, 47%). However, this varies widely across staff grades. As seniority increases, the number of individuals employed on a part-time basis decreases. Whereas over 90% of grade 1 staff are employed part-time, only a small proportion of grade III and project managers (7.5%) are classified as part-time employees.

Qualifications: With regard to academic and professional qualifications, one quarter of staff members have obtained a degree or higher degree. Also, almost half of all care staff (45%) hold a professional qualification, with RMN (Registered Mental Nurse) being the most frequent. RMN was the most likely qualification for Project managers. A greater percentage of grade 1 staff are educated to degree level (26%) compared to either grade III staff (19%) or Project Managers (9%). However, the majority of grade I staff (80%) possess no professional qualifications.

Time Employed with Praxis: Praxis care staff have been employed by the organisation for an average of $2^{1/2}$ years. One in 5 employees have been recruited within the past year, reflecting the growth and expansion of the organisation. Twenty percent of individuals have been Praxis employees for 5 years or more.

Previous Training: 70% of staff members had not received previous training on the topic of service user empowerment.

HYS 2 Questionnaire

Due to a variety of reasons (such as sick leave, annual leave and staff turnover) not all staff members completed the HYS 2 questionnaire at the 3 time points. Eighty-six individuals

completed the questionnaire at baseline, 81 at the 2-month follow-up, and 69 at the 1-year follow-up. Overall, 65 individuals completed the questionnaire at all three time points. Mean scores are reported for these individuals. A repeated measures non-parametric test (Friedman test) was used to determine if there was a significant difference between the mean scores across the 3 testing points. Analysis was also carried out (using the Kruskal-Wallis test) to determine if there were significant differences between the mean scores reported by the different grades of staff and staff with different levels of academic qualifications.

CAMI: Table 10 details the mean scores for each of the 4 sub-scales over the 3 time points. Overall, there was minimal change in the mean scores, with scores varying less than one point (range -0.1 to 0.6) from baseline to 1 year follow-up.

Table 10: Mean Changes in CAMI Scores at the 3 Time Points

	Baseline	+ 2 Months	+ 1 Year
Authoritarian	4.01	4.00	3.99
Benevolence	4.14	4.02	4.06
Soc Restrictiveness	4.13	4.00	4.19
C.M.H Ideology	3.98	3.87	3.86

There were no statistically significant differences across the 3 time points, indicating that staff attitudes towards individuals experiencing mental illness did not change following the HYS 2 training.

Further analysis was carried out to determine if staff members holding different levels of academic qualifications (none, O-level, A-level, degree or above) reported significantly different CAMI mean scores. A significant difference emerged on the social restrictiveness sub-scale one year following the HY2 training. There was a significant difference between the mean scores of individuals who had no qualifications (3.77) and individuals who had 'O-levels' (4.38) [z=-2.661, p=0.008]; and between individuals who had no qualifications and individuals with 'A-levels' (4.20) [z=-2.368, p=0.018]. Individuals with no qualifications had a significantly lower mean score, indicating that they held more socially restrictive attitudes towards individuals with mental illness in comparison to individuals who had attained either 'O-levels' or 'A-levels'.

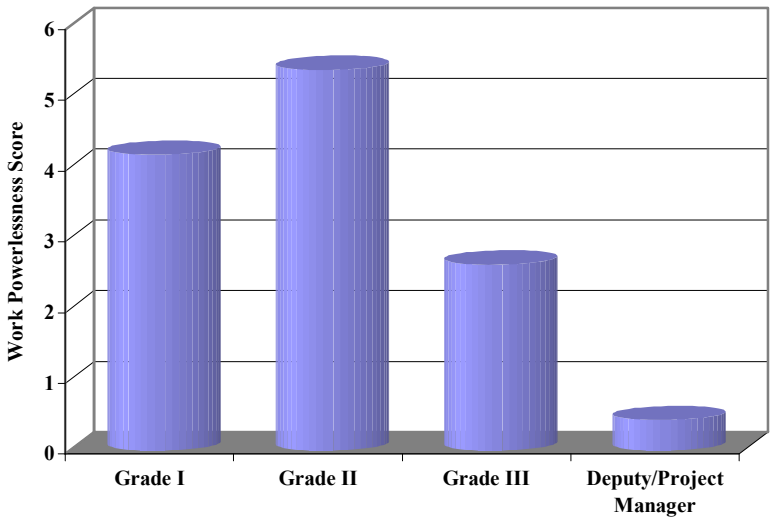
ACCQ: Praxis care staff reported a mean ACCQ score of 2.83 at baseline, 2.82 at the 2-month follow-up and 2.75 at the 1-year follow-up. There was no significant difference across time on the ACCQ mean scores, indicating that staff attitudes regarding community care initiatives did not change following the HYS 2 training.

Work Powerlessness Scale: Data analysis indicated a significant difference in the work powerlessness mean scores over time, with the mean score increasing over the 3 time points. There was a significant difference between the baseline mean score (2.41) and the mean score at the 2 month follow-up (3.54) [z=-2.926, p=0.003]. There was also a significant difference between the baseline mean score (2.41) and the mean score 1 year following the HYS 2 training (3.57) [z=-2.712, p=0.007]. Although the mean score increased between the 2 month and 1 year follow-up time period, this difference was not statistically significant.

A higher score on the work powerlessness scale indicates greater feelings of powerlessness. Therefore, it can be concluded that 2 months after the HYS 2 training, staff members felt they had less control over their working environment and were less able to contribute to decision making within the organisation compared to baseline. These feelings of powerlessness and lack of control remained 1 year after the HYS 2 training.

Further analysis was carried out to determine if feelings of work powerlessness differed significantly between the different staff grades. Deputy/project managers had the lowest mean score (Fig 5), indicating that they experienced more control over their working environment and felt able to contribute to decision making within the organisation. A series of Mann-Whitney U-tests revealed significant differences between grade I staff and deputy/project managers (z=-3,014, p=0.003); between grade II staff and deputy/project managers (z=-2.721, p=0.007); and between grade III staff and deputy/project managers (z=-2.174, p=0.030). Grade II staff members had the highest mean score indicating they experienced the greatest feelings of powerlessness and lack of control.

Fig 5: Work Powerlessness Scores Between Staff Grades



POINTS FOR DISCUSSION

The questionnaire results provide some interesting information on the makeup of the Praxis care staff; the attitudes held by staff members; and the impact of the HYS 2 training on staff attitudes. Some of these issues are discussed below.

Training Uptake

- Almost two-thirds of Praxis care staff working in the accommodation and support schemes took part in the HYS 2 training. This was a good response from staff given the difficulties that can be involved in arranging time and cover for staff members to participate in training, particularly for schemes providing 24-hour staff support. For staff members to be encouraged and supported to attend the training, the managers of the accommodation schemes had to be committed to the project. The managers' high level of commitment is evident in that 11 of the 14 managers participated in the HYS 2 training. Their personal commitment, the endorsement of the project by the Praxis senior management, and the fact that travel expenses and staff cover expenses were reimbursed from the HYS 2 budget were all contributory factors in ensuring a good uptake of the training.

- However, not all care staff members participated in the training. It is important that similar training opportunities are available for:
    - Care staff within the accommodation schemes who did not participate in the HYS 2 training
    - Staff members who were excluded from the HYS 2 project (i.e. those who were involved in administrative duties and relief staff)
    - Care staff who have been recruited since the HYS 2 project.

Staff Qualifications

- Praxis has a highly qualified care team, with almost half of all staff holding a professional qualification. Having such a qualified workforce is a great asset to the organisation. In order to encourage staff members to remain with the organisation and contribute their skills and expertise to it, it is important that Praxis continues to offer attractive terms and conditions for staff members; that it provides opportunities for career development; and that it facilitates staff to obtain work based qualifications.

- Although a greater percentage of grade 1 staff was educated to degree level compared to other staff grades, the majority did not hold a professional care qualification. It is

important that Praxis continue to provide work-based training opportunities to enable grade I staff to obtain their professional care qualifications.

Staff Attitudes

- Other research has reported a relationship between educational level and attitudes towards individuals with mental illness. For example Woff et al., (1996) found that a greater percentage of individuals who had a lower educational attainment believed that the mentally ill might be more aggressive compared to individuals with a higher educational level. Also, a study by Brockington et al. (1993), found that individuals who had a higher level of education reported less authoritarian and less socially restrictive attitudes, and more benevolent attitudes toward the mentally ill in comparison to individuals with a lower level of education. In looking at the differences in CAMI mean scores between Praxis staff grades, individuals with no qualifications held more socially restrictive attitudes towards individuals with mental illness in comparison to individuals who had attained 'O-levels' or 'A-levels'. Individuals were more likely to agree with statements such as 'the mentally ill are a danger to themselves and those around them', and 'the mentally ill are very unpredictable and should not be given any responsibility', than more educated staff members. However, the mean scores from staff members with no qualifications on each of the other sub-scales were comparable to the other staff mean scores, indicating that their attitudes were not more authoritarian, less benevolent, or less supportive of community care approaches than more qualified members of staff.

- There were no significant changes in the overall CAMI scores over the 3 time points. It may have been expected that scores would have increased following the HYS 2 training. However, scores fluctuated less than 1 point between baseline and 1 year after training. In looking at the mean scores obtained it is evident that of the 12 scores obtained (one score at each of the 3 time points on each of the 4 sub-scales), 8 had a mean score of 4.00 or above. The scale was scored on a 5-point scale with 5.00 being the highest score possible. The fact that staff members had mostly reported a mean score of 4.00 indicates that they already held positive attitudes towards individuals with mental ill health at the baseline stage and these were maintained over the year. The HYS 2 training had no significant effect on further improving these attitudes.

Work Powerlessness

- The work powerlessness scale produces a score ranging from 0 to 14, with a higher score indicating greater feelings of work powerlessness and lack of control over the work situation. Over the 3 time points, staffs mean scores ranged from 2.4 and 3.6. Therefore,

overall the scores reported were within the bottom third of the scale, indicating that overall they did not experience feelings of work powerlessness or lack of control.

- In looking at the experience of work powerlessness over time, the findings indicate that staff members felt they had less control over their working environment and were less able to contribute to decision making within the organisation 2-months after taking part in the HYS 2 training compared to before training. Obviously this raises the question regarding the impact the training had on producing greater feelings of work powerlessness. The literature is in agreement that empowerment can mean different things to different people (Farrell & Gilbert, 1996). For example a manager's definition of empowerment may not be the same as a patient advocate's definition. Professionals often regard empowerment as a matter of 'giving over' power, where they confer power on a service user who, by definition, previously lacked it. One possible suggestion for staffs' increased feelings of work powerlessness is that in dealing with issues around empowering service users, staff re-evaluated their role in terms of relinquishing power to service users and in the light of this considered their position to be less empowered and lacking in control. Testing this hypothesis would require further exploratory research.

- Deputy managers and managers were more likely to feel empowered and in control over their work situation, whereas grade II staff were more likely to feel disempowered and lacking control over their work. This is in line with other research, which finds that role ambiguity, and feelings of powerlessness decrease as seniority increases. However, grade I staff reported a lower mean score than grade II indicating that they did not feel as powerless as grade II staff members. It is important to look at the specific role of the grade II staff member within the organisation; to compare their role with other grades of staff; to identify the factors that contribute to their feelings of powerlessness; and to positively address these factors.

BACKGROUND

A volunteer befriending service was one of the initial projects set up when Praxis was first established. Befriending is essentially a '*relationship between a volunteer and an individual that is supported by an organisation'*. At the time of the HYS 2 project Praxis was supporting 37 volunteer/service user relationships. There were an additional 36 volunteers and 68 service users on the waiting list. The Praxis befriending scheme aims to:

- Provide practical and emotional support to individuals who experience, or are at risk of experiencing, mental ill-health.
- Provide a regular focus and friendship for those who are socially isolated.
- Encourage the development of personal interests and social activities for service users in the community.
- Act as a link between the service user and the statutory services.

Recruiting and Training Volunteers: Praxis volunteers are recruited primarily through advertising campaigns and word of mouth. Potential volunteers submit an application form and attend a panel interview. If successful, individuals are invited to participate in an induction-training programme. The training programme includes information on Praxis and the role of the organisation; issues relating to mental illness and available treatments; confidentiality; and boundaries within the volunteer/ befriendee relationship. Volunteers consent to a minimum 6-month commitment to the befriending scheme. The befriending co-ordinator then introduces the volunteer to an individual who has been referred the service[*]. The befriending relationship is always made on the basis of the volunteer and service user having the same gender and, where possible, a similar age and shared interests. Volunteers receive individual support from a Praxis member of staff who is responsible for the befriending scheme within their local area. In addition, volunteers are encouraged to attend monthly support and development meetings. These meetings contain elements of skills training, mental health awareness, personal development and peer support.

Befriending Relationship: An evaluation of two Praxis befriending schemes found that service users valued having a volunteer befriender (Doherty et al., 1994). Service users stated that they valued the friendship offered by their volunteer; they were able to get out and about with the support of their volunteer; they had someone to talk to; and that they enjoyed the

[*] Referrals can only be accepted from professionals working within the statutory services.

company provided by the volunteer befriending relationship. As stated by one service user, *'she [volunteer] is my best friend and is there when I need her'.* Given the important role a volunteer can play in the life of the service user they befriend, it was decided that it would be beneficial to include volunteers in the HYS 2 project.

HYS 2 VOLUNTEER TRAINING

The HYS 2 training was open to all Praxis befriending volunteers. Volunteers were sent a personal letter and an information leaflet explaining the project and inviting their participation. The HYS 2 training programme, delivered to grade II and grade I staff members (described in the previous section of the report), was adapted for volunteers (Table 11). The training aimed to inform volunteers of the issues around advocacy and user empowerment. It also aimed to encourage volunteers to recognise the role they could play in promoting the self-advocacy skills of the service user they befriended. Two training sessions were set up, one in Belfast and one in Derry.

Table 11: Outline of HYS 2 Volunteer Training Programme

- Understanding self-advocacy and advocacy.
- Advantages / disadvantages of self-advocacy.
- Advantages / disadvantages of being an advocate.
- Understanding basic needs (Maslow's hierarchy of needs).
- Communication skills.
- Models of empowerment / disempowerment.
- Empowering service users to become self-advocates.

RESEARCH

HYS 2 Volunteer Questionnaire: The research aimed to assess volunteers' attitudes towards service user empowerment and to determine the impact of the training on their views and attitudes. The HYS 2 staff questionnaire (described in the previous section) was adapted for the volunteer group. Individuals completed the questionnaire prior to participating in the training and approximately two months after training. The questionnaire included:

- Personal Demographics
- Community Attitudes to Mental Illness Scale (CAMI; Taylor & Dear, 1981)
- Attitudes to Community Care Questionnaire (ACCQ; Haddow & Milne, 1995).

RESULTS

Overall, 24 volunteers participated in the HYS 2 training programme. Demographic information and baseline questionnaire data were available for 18 of the individuals; 11 from

the Belfast training group and 7 from the Derry group. Twelve volunteers completed the questionnaire 2 months after taking part in the training.

Demographics: Based on the demographic information available for 18 individuals, the majority of volunteers (N=13) were female. Volunteers had an average age of 43 years, with a range of 19 years to 66 years. Almost half of the volunteers (N=8) were employed. The remainder were unemployed (N=4), retired (N=3), or in full-time education (N=3). In general, the volunteers were well educated with 50% (N=9) being educated to degree or postgraduate level. Volunteers had been befriending with Praxis for an average of 3 ½ years. Four individuals (3 females, 1 male) had been a Praxis befriender for over 10 years. On average, individuals were involved in volunteer befriending for 3 hours per week. Only 4 of the volunteers stated that they had previously participated in other forms of advocacy training.

The following information is based on the 12 volunteers who completed the questionnaire prior to training and 2 months after training. The results are reported as mean scores and where appropriate they are compared to staff mean scores from the previous section.

Community Attitudes to Mental Illness Scale: The CAMI scale comprises 4 sub-scales: authoritarianism; benevolence; social restrictiveness; and community mental health ideology. Table 12 details volunteers' mean score for each sub-scale across the 2 time periods. Higher scores were reported across each of the sub-scales 2 months after training compared to baseline. Higher scores are indicative of attitudes which are less authoritarian, more benevolent, less socially restrictive, and more support of community care approaches towards the mentally ill. However, a series of non-parametric tests indicated that the difference in scores between baseline and 2 months after training were not statistically significant.

Table 12: CAMI Sub-Scale Mean Scores

	Baseline	+2 Months	Change
Authoritarianism	4.14	4.18	↑
Benevolence	4.27	4.40	↑
Social Restrictiveness	4.20	4.27	↑
C.M.H. Ideology	4.04	4.14	↑

Volunteer mean scores at baseline and 2 months following training were compared to Praxis staff mean scores at the same time points. In comparison to grade I and grade II staff members, volunteers reported a higher mean score on each of the sub-scales at the two time

points. The volunteer mean scores also compared favourably to the grade III and project manager mean scores at the 2-month time point, with volunteers having a higher mean score on each of the sub-scales compared to managers and grade III staff members. This indicates that volunteers' attitudes towards individuals experiencing mental ill-health were less authoritarian, more benevolent, less socially restrictive, and more supportive of a community care approach compared to paid members of staff.

Attitudes to Community Care Questionnaire (ACCQ): At baseline volunteers reported a mean score of 2.94. Two months after training, the ACCQ score had increased slightly to 3.00 indicating greater support for a community care approach compared to baseline. A non-parametric test indicated that the difference in scores between baseline and 2 months after training were not statistically significant. In comparison to staff members, volunteers reported a higher mean score 2 months following training compared to all grades of staff at the same time point. This indicates that volunteers are more supportive of a community care approach for people with mental illness.

POINTS FOR DISCUSSION

Impact of Training

- Volunteers' scores on each of the scales included within the HYS 2 questionnaire were higher 2 months after taking part in the training compared to baseline. Although these differences were not statistically significant, the findings indicate that volunteers were more supportive of user empowerment and community care approaches towards the mentally ill 2 months after training compared to baseline.

- There was some slippage in the overall HYS 2 training timescale. This resulted in training for the volunteers being provided towards the end of the project, with insufficient time available to collate 1 year follow-up data. Completion of questionnaire 1 year after the training would have been beneficial in terms of assessing the longer-term impact of the training.

- Due to the time limitations, volunteers were not invited to take part in a semi-structured interview. This would have been beneficial in order to explore in greater detail volunteers' views on user empowerment. Volunteer interviews would also have been useful in terms of providing qualitative information on their perceived benefits of the HYS 2 training.

Volunteer Views Compared to Staff Views

- Although grade I staff members within Praxis are not required to have formal mental health education before they are employed by Praxis, they undergo an intensive induction training programme and receive on-going training in mental health issues. Volunteers are not afforded the same training opportunities within the organisation, and so it would be expected that grade I staff members would be more supportive of user empowerment and have a greater awareness of community care issues. The only training volunteers receive from Praxis is through the monthly support meetings. As previously stated, these meetings are focused on skills training, mental health awareness, personal development and peer support. However, volunteers reported higher scores across each of the scales in comparison to grade I staff members, indicating that volunteers are more supportive of user empowerment and community care initiatives towards the mentally ill. In addition, volunteers' scores from most of the scales compared favourably with scores from the Praxis managers. Other research has found that mental health professionals rate outcomes of mental health care more negatively than members of the public (Jorm et al., 1999). This has been interpreted that the negative attitudes of health professionals have a basis in reality, in that they have much greater contact with mental disorders and may be more realistic in their assessment of long-term outcomes. In applying this explanation to the findings between volunteers and staff members, it could be suggested that staff members have a greater level of contact with individuals with mental ill health compared to volunteers; that the individuals who staff are in contact with have more severe mental ill-health compared to individuals the volunteers would befriend; and that staff have more experience of dealing with situations when service users re-lapse and require hospitalisation. These experiences may have the effect of staff being more realistic in their attitudes towards the care and control of individuals with a mental illness in comparison to volunteers.

Further Research

- Findings from the HYS 2 project reflect well on the Praxis befriending service. It indicates that those individuals who are involved in a one-to-one relationship with a service user have a sympathetic attitude regarding care in the community initiatives and are supportive of the principles around user empowerment. However, this is based on the information provided by those individuals who participated in the HYS 2 training programme and it is not known if their views reflect the views of all Praxis volunteers. It would beneficial for volunteers who did not take part in the training to complete the HYS 2 questionnaire to determine their attitudes towards user empowerment and community care initiatives.

CONCLUSION

Having Your Say 2 was an ambitious training-research project. It aimed to provide training to all individuals living in Praxis accommodation schemes, to all Praxis care staff; and to individuals who volunteered with the Praxis befriending service. In addition, the project aimed to elicit the views of individuals who participated in the training and to determine the value of the training provided. Finally, the project aimed to assess the impact of the HYS 2 training on service users' level of empowerment; and the impact of the training on staff and volunteers' attitudes towards individuals with a mental illness and community care initiatives. Based on the findings detailed in the preceding sections of the report, it can be concluded that the aims of the project were partially achieved. Some of the issues are discussed below.

Staffing of HYS 2 Project

One of the main factors that had an overall impact on the project was the recruitment and retention of the training officer. Throughout the duration of the project, 3 separate training officers were recruited. Each time a training officer left the project, this involved a lengthy process of re-advertising the post, short-listing, interviewing, and appointing a new member of staff. The training officer then completed an induction programme prior to settling into the post and delivering the HYS 2 training. This process was repeated on 2 separate occasions. The time involved in this whole process had obvious knock-on effects for the overall time scale of the project and also the continuity of the training provided. However, it was a situation that was beyond the control of the project.

Service User Training

There were several important findings related to the service user training and its impact on user empowerment. Two months after the HYS 2 training, service users stated that they would find it easier to make a complaint about their Praxis accommodation and mental health professionals, and that they would find it easier to speak out in a range of social situations (for example, if someone jumped a queue in front of them, or if they had to return a faulty item to the shop where it was purchased). In addition, 2 months after training service users reported increased levels of empowerment. However, not all of these improvements were evident 1 year after the training. This raises the issue of providing 'refresher training' and the importance of providing opportunities to reinforce and refine the skills learned on an initial training course. Service users also mentioned a number of benefits of attending the HYS 2 training. These included feeling more assertive, having a sense of achievement, developing a stronger self-image, finding new interests, and putting into practice newly learned skills. In addition, for those who participated in the training it was regarded as an enjoyable experience.

Such findings highlight the benefits and the positive impact of the HYS 2 training. However, only a small percentage (15%) of individuals living in the Praxis accommodation and support schemes participated in the training. Also, those individuals who did take part were using the more independent models of Praxis care (i.e. DISH and FC). Therefore, in addition to attracting a small number of service users, it is likely that those who participated were more independent and confident that those who did not take part. It is vital that Praxis examines innovative methods for encouraging the involvement of more dependent service users in confidence-building and empowering initiatives. This may involve exploring more individual approaches towards user empowerment

Service User Care Plan

One way in which individuals can be involved at a more individual level is through their active engagement in developing their own care plan. The Avon Mental Health Measure (AMHM) was used as a pilot exercise for engaging individuals in devising their own care package. This was the first time the measure had been used within mental health services in Northern Ireland, and the results were very encouraging. Overall, while the AMHM was more time consuming and demanding to complete, it was reported as having the distinct advantage of being user focused. Additionally, the measure provided an opportunity for the development of relationships between service users and staff. To determine the full benefits of the measure, it is necessary for the measure to be more widely piloted within Praxis services.

Staff Training

The HYS 2 project aimed to generate a demographic profile of the Praxis accommodation staff care team. The findings concluded that Praxis has a young, highly qualified care staff team, with almost half of all staff holding a professional qualification. Having such a qualified workforce is a great asset to the organisation. In order to encourage staff members to remain with the organisation and contribute their skills and expertise, it is important that Praxis continues to offer attractive terms and conditions for staff members; that it provides opportunities for career development; and that it facilitates staff to obtain work-based qualifications.

Prior to taking part in the HYS 2 training, staff members held positive attitudes towards individuals with mental ill health and towards community care initiatives. These positive attitudes were maintained over 1 year, however they were not further improved following the HYS 2 training.

In order for staff members to be involved in the process of empowering service users, it is important that they feel empowered in their staffing role. The project assessed feelings of work powerlessness before and after staff participated in the HYS 2 training. Results from the questionnaire indicated that overall staff did not experience feelings of work powerlessness or lack of control. However, there was a significant change over time in that staff members felt they had less control over their working environment and were less able to contribute to decision making within the organisation 2 months after taking part in the HYS 2 training compared to before training. One possible suggestion for staffs' increased feelings of work powerlessness is that in dealing with issues around empowering service users, staff re-evaluated their role in terms of relinquishing power to service users and in the light of this considered their position to be less empowered and lacking in control. Alternatively, these greater feelings of powerlessness could be attributed to a range of other factors that were not controlled for during the study. For example, the changes could have been in response to organisational developments at the time when the project was carried out; staff changes; or the introduction of a new policy or procedure. Any of these factors may have played a role in contributing to greater feelings of powerlessness amongst care staff. As stated in the literature, attitudes are not only individual characteristics. They are influenced by the culture within which an individual works (Jorm, et al., 1999). Data was not collated on the culture or organisational climate within which staff members carry out their role. This is a potential area for further research.

Volunteer Training

Volunteer attitudes towards individuals with a mental illness were assessed prior to and after taking part in the HYS 2 project. Findings confirmed that volunteers had more positive attitudes towards individuals with a mental illness 2 months after taking part in the training compared to before training. In fact, the volunteers reported more favourable attitudes compared to grade I staff members, and their attitudes were similar to those held by project managers. Such findings reflect well on the Praxis befriending service. It indicates that individuals who are involved in a one-to-one relationship with a service user have a sympathetic attitude regarding care in the community initiatives and are supportive of the principles around user empowerment. Given the important role a volunteer can play in the life of the service user they befriend, it is important that Praxis continue to provide training and support for volunteers to ensure that these positive attitudes are transferred into action in the way in which they interact with their Praxis friend.

Overall Conclusion

The HYS 2 project highlighted some positive findings (i.e. service users reported increased levels of empowerment following the HYS 2 training); some areas for concern (i.e. staff members expressed greater feelings of work powerlessness and lack of control over their working environment following the HYS 2 training); and identified further areas of study (i.e. to explore the value of the Avon Mental Health Measure as an assessment tool with individuals who have greater levels of dependency).

Empowering users of mental health services is a complex process, involving a combination of various factors. The HYS 2 project was an important initiative in addressing several of the factors involved in this process, including providing training for service users; involving service users in devising their own care plan; and providing training to promote supportive attitudes towards user empowerment amongst staff and volunteers. This has provided a good base from which to move forward. However, the real benefits of the HYS 2 project will only be fully realised if the issues raised by the project are addressed and other innovative initiatives aimed at empowering users are pursued. Such action is necessary to ensure that the gap between the 'ideal' of user empowerment and the 'reality' of everyday practice is reduced.

- Brockington, P., Levings, J. & Murphy, C. The community's tolerance of the mentally ill. *British Journal of Psychiatry, 1993, 162, 93-99.*
- DOH. (1992). Health of the Nation. HMSO: London.
- Doherty, H., Graham, C., McDaid, C., Mawhinney, S. & Dignan, G. (1994). Volunteer Befriending. An Evaluation of the Derry City and Belfast Befriending Schemes. Praxis: Belfast.
- Farrell, H. C. & Gilbert, H. (1996). Health Care Partnerships. Kings Fund.
- Guilbert, E. K. (1979). Health Care Work Powerlessness Scale (revised): Instruments for measuring nursing practice and other health care variables. Public Health Service, U.S Department of Health, Education and Welfare, 1, 37-40.
- Haddow, M., & Milne, D. Attitudes to community care: Development of a questionnaire for professionals. *Journal of Mental Health, 1995, 4, 289-296.*
- Jorm, A., Korten, A., Jacomb, P., Christensen, H. & Henderson, S. Attitudes towards people with a mental disorder: A survey of the Australian pubic and health professionals. *Australian and New Zealand Journal of Psychiatry, 1999, 33, 77-83.*
- Kingdom, D. Care Programme Approach: Recent government policy and legislation. *Psychiatric Bulletin, 1994, 18, 68-70.*
- Mawhinney, S. & McDaid, C. (1996). Having Your Say: Self-advocacy and Individuals Experiencing Mental Ill-Health. Praxis: Belfast.
- Miles, M. B. & Huberman, A. M. (1994). Qualitative Data Analysis. Sage: London.
- Oliver, J., Huxley, P., Bridges, K. & Mohamad, H. (1996). Quality of Life and Mental Health Services. Routledge: London.
- Perkins, R. & Fisher, N. Beyond mere existence: The auditing of care plans. *Journal of Mental Health, 1996, 5, 3, 275-286.*
- Rodin, J. Ageing and health: Effects of the sense of control. *Science, 1986, 233, 1271-1276.*
- Rogers, E.S., Chamberlin, J., Langer Ellison, M. & Crean, T. A consumer-constructed scale to measure empowerment among users of mental health services. *Psychiatric Services, 1997, 48, 8, 1042-1047.*
- Simpson, A. Creating alliances: The views of users and cares on the education and training needs of community health nurses. *Journal of Psychiatric and Mental Health Nursing, 1999, 6, 347-356.*
- Taylor, S. M. & Dear, M. J. Scaling community attitudes towards the mentally ill. *Schizophrenia Bulletin, 1981, 7, 2, 225-240.*
- The Avon Mental Health Measure: A User Centred Approach to Assessing Need. South West MIND: Bristol.

- Vallerand, R., O'Connor, B. & Blais, M. Life satisfaction of elderly individuals in regular community housing, in low cost community housing and high and low self-determination nursing homes. *International Journal of Ageing and Human Development, 1989, 28, 227-283.*
- Woff, G., Pathare, C. T. & Leff, J. Community knowledge of mental illness and reaction to mentally ill. *British Journal of Psychiatry, 1996, 168, 191-198.*
- Wowra, S.A., & McCarter, R. Validation of the empowerment scale with an outpatient mental health population. *Psychiatric Services, 1999, 50, 959-961.*
- Youssef, F. A. Adherence to therapy in psychiatric patients: An empirical investigation. *International Journal of Nursing Studies, 1984, 21, 51-57.*