'Take a picture of this…'

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View-from-above

What's the difference between the Sahara desert and the UK mental health system? If you spent 15 years in each, the likelihood is that you would have a better grasp of the process of change occurring in the Sahara. When taking a wide-angled view-from-above, the desert appears as a vast never-changing entity.

However, the up-close view on the ground, examined through the zoom lens, shows change is always happening, slowly and in a way that maintains the ecological balance. Now contrast the same perspectives of the mental health landscape – the wide-angled view is similarly one of a vast entity of constantly shifting sands. However, the detail afforded by the zoom lens does little to clarify the picture for the service users or mental health practitioners – there appears to be little stability and balance afforded by the ever-changing patterns and textures.

One issue at the centre of mental health service delivery appears to be the obsession of management with large-scale policy change; but the focus tends to be on the broad landscape much more than the detailed portraits. We are provided with the National Service Framework (Department of Health, 1999) and the NHS Plan (Department of Health, 2000) drawing our attention to the need for comprehensive and integrated mental health systems characterised by assertive outreach teams, crisis response teams, and early intervention teams. This has merely moved the spotlight away from the community mental health team and the in-patient unit, despite these remaining the 'bread-and-butter' heart and soul of the whole system.

Does this drive for change bring about any real difference? Yes, it does, but arguably at the margins, or at least small isolated pockets of the whole entity that constitutes the complex web of the mental health system. The training initiatives commonly aligned to the push for this type of change rarely manage to bring about anything more than a marginal difference in the 'knowledge base' of individual practitioners and managers, with little if any impact on the difference in skill base.

Unfortunately this thinking has more to do with 'credentialing' through a narrow focus on bringing staff out of their workplace into the workshop, and plying them with monologues on service configurations and lists of research evidence, without a true connection to the realities of their practice experience (Morgan and Juriansz, 2002a). This approach to training has its place, and is frequently evaluated very highly, but we should not allow it to mask the needs for practice development initiatives, which are more specifically targeted to individuals and teams. The 'big picture' generates expectations, but the difference lies in the close detail, and changing this is only possible through

presence *in the workplace* beyond the artificial reality of the workshop (Morgan and Juriansz, 2002b).

A sharper image

We have previously described a *process* for implementing a model of practice development in community mental health teams (Morgan and Juriansz, 2002b). This article reports the impact of this work, through an evaluative process identified by the practitioners and team managers themselves. The model is rooted in practitioner empowerment, and uses practice-based evidence to measure change across a broad range of mental health practice issues.

We devised a measurement tool with 15 positively framed statements (See Table 1) addressing specific aspects of mental health care, to be rated individually by practitioners on a 5-point Likert scale. These responses were rated as an 'agree-disagree' response in relation to where the person felt the whole team practice was currently. The responses to each statement were amalgamated to give a mean response, a measure or team 'snapshot' of where it was currently, against each of the 15 statements. Using the same method 6-9 months later enabled a further two snapshots to be compared, differences to be identified, and the impact of the intervening practice development initiatives to be estimated.

Table 1: Creative Capability Evaluation Statements.

Ethical Practice:
1. Service users determine the priorities in the care plan.
2. We actively promote the use of ordinary community resources.
Care Process
3. Time for creative approaches to engagement is a priority.
4. Our assessment of needs includes the identification of service user strengths.
5. We identify and manage the broad range of risks reasonably and effectively.
6. Our interventions draw on a broad range of bio-psycho-social and practical approaches.
7. We implement the Care Programme Approach effectively in line with local policy.
Team working
8. I am clear about the priority functions of the team.
9. The referral and allocation processes function well.
10. We have good systems of support and supervision.
11. The team decision-making process works well.
12. We have efficient systems of administration and documentation.
13. We link effectively with other parts of the mental health system (including primary care).
Knowledge in practice
14. I utilise the diversity of knowledge and experience within the team.
15. My current knowledge adequately equips me to do my job.

The authors devised this structure to compliment another part of the practice development process - a confidential semi-structured practitioner interview. It extended and modified previous work; a national framework mapping the practitioner capabilities needed to implement the National Service Framework (Sainsbury Centre for Mental Health, 2001). The statements target positive aspects of the details of practice, from some of the attitudes underpinning our approach to our work, the focus of the work within a therapeutic relationship, the functioning of the team to support individual practice, and the knowledge base needed to support the work. Many of these represent the detail that is rarely addressed by training programmes, but which are vital to making a difference to the quality of service delivery to the service user.

Emerging pictures

Baseline evaluation and post-practice development measures have now been achieved for three community mental health teams. This is a sample of 39 responses at baseline and 44 responses at time 2. The initial findings are promising. They demonstrate positive shifts of opinion in the mean response to all 15 items in all three teams over the first 6-9 months of implementing the model of practice development. These changes are presented here as a percentage opinion shift (where the number 35 denotes a 35% shift in opinion towards greater agreement with the statement). Table 2 lists the 5 highest % opinion shifts.

Table 2 – Opinion Shifts in Creative Capability Statements

No.	Statement	% opinion shift
11.	The team decision-making process works well.	35
9.	The referral and allocation processes function well.	27
12.	We have efficient systems of administration and documentation.	24
10.	We have good systems of support and supervision.	22
14.	I utilise the diversity of knowledge and experience within the team.	22

Four out of five of these items fall under the ‘team working’ category, focusing on the details of daily practice through decision-making processes, managing referrals and allocations of work within teams, and examining systems that support the efficient functioning of team processes. In reality, these positive shifts reflect specific attention on restructuring team meetings, and the impact they have on other team processes and systems. This type of work requires attention to detail and availability of support within teams – a challenge that ‘training’ frequently fails to achieve (even training focused on specific teams), but which has provided the most fertile arena for practice development initiatives.

Utilising the diversity of knowledge and experience within the team (statement 14) is the most frequently reported area for change in the semi-stuctured interviews with practitioners. Anecdotally, it appears that the specific caseload and general workload demands on individual practitioners draws attention away from the positive potential of team-working, and recognition of

the diverse skills, knowledge and experience immediately at hand within the team. It becomes an issue of 'time' and 'priority', which has improved across these teams through a specific focus of attention at the beginning of each team's away-day. These team days take on a new and essential function in the evolving process of practice development.

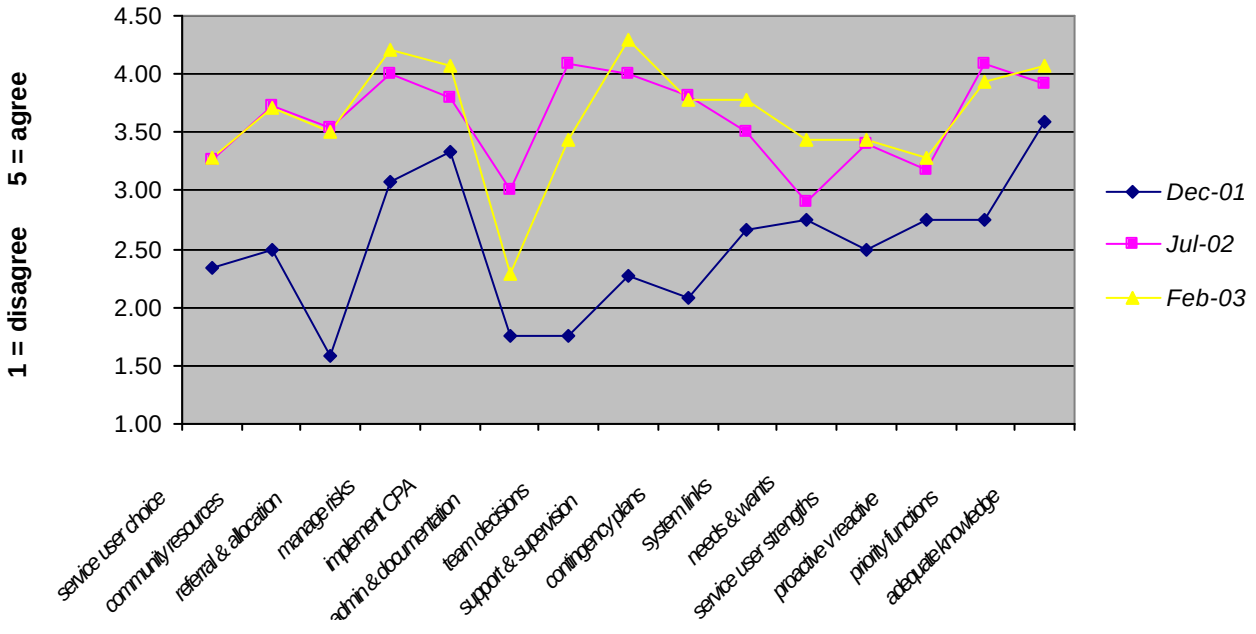
Interestingly, of all 15 items, the one with the lowest amalgamated opinion shift is statement 15 - *My current knowledge adequately equips me to do my job*. (8% shift).

In discussion, Clare Johnstone (Joint Head of Nursing) and Erville Millar (Chief Executive) of Camden & Islington Mental Health and Social Care Trust, identified this as a very significant finding. It signifies that practitioners are broadly less concerned about the gaps in the knowledge base to do their jobs, than they are about some of the systems, procedures and interventions in place. Yet training initiatives most frequently prioritise 'knowledge' as the area for change. It is our belief that knowledge can be addressed in many highly effective ways, not just through the training workshop. We need to radically rethink the use of resources that currently flow into training, and how closely aligned practice development initiatives can make them more cost efficient and practice effective.

Indeed, many organisations are paying their employees to attend courses only to see successful completion of the training resulting in people moving away to other jobs. A few practitioners even see the training course as their ticket out! We need to establish a stronger basis for sustainability of changes that make a difference, and a radical rethink of what support mechanisms in the workplace can help to promote greater practitioner satisfaction and staff retention. These aims can reasonably be expected to have positive benefits for service user satisfaction with the services being delivered.

While these findings are promising, we are keen to ask questions about the sustainability of the practice development work. At the time of writing, one of the three community mental health teams had recently completed its *third* time point evaluation. The figures for these 3 points of evaluation over a 15 month

Fig. 1. Camden Town CMHT: Creative Capability 1, 2 & 3 (Dec 01 - Feb 03)



period (November 2001 – July 2002 – February 2003) are represented in **Figure 1 (Camden Town CMHT: Creative Capability 1, 2 & 3)**. [N.B. The order of the 15 statements in the Camden Town evaluations does not exactly correspond to the list in Table 1, as this team was the pilot and subsequent changes were made to the tools].

The graph depicts strong gains made in all 15 items between the baseline measure (Dec. 01) and the second point evaluation (July 02). Between the second point and third point evaluations (July 02 & Feb. 03) there is a variable picture of small improvements and some slight regression across different items. Overall, sustainability of gains is achieved when we compare the third point to the baseline established in the first evaluation. However, the identified regressions can be isolated and explained, largely through shifting attention of practice development implementation onto other items, and through failure to yet achieve the expectations established in areas such as administrative systems and decision-making processes. As an evolutionary process, practice development can more flexibly respond to these identified changes than would be the case with a training response.

In addition to the statistical details of the practice development evaluation, it is important to hear the voices of the practitioners, particularly if this model of practice development is to achieve the aim of being a more practitioner empowering approach. Anecdotal evidence of change for practitioners is briefly reflected in the following selection of comments:

"Before this, away-days would never make sense."
"We feel more empowered to say what needs to and can change."
"I've been on some really good training workshops, but I don't remember what I am supposed to do with the information. This practice development stuff is much more focused on what I do."

Refining technique

This approach to practice development can be summarised as:

clearly articulated '*process'* + practice sensitive '*tools'* = 'difference' through positive *outcomes.*

Every sustainable process needs a basis in sound principles. In Table 3 we offer 12 steps for grounding a model of practice development, in order to achieve real difference within the changes services are continually required to train their lenses on:

Table 3 – Principles in Practice.

Principles of 'practice based evidence' and 'creative capability'		
1.	**Philosophy**	Maintain belief in the intrinsic creative capability of practitioners and communicate the principles regularly.
2.	**Presence**	Regular involvement in group forums (team meetings). Being there and being seen to be there. Being in their office, not in some distant place.
3.	**Participation**	Emphasise active participation in decision-making. Listen; collate everything said; value and encourage all team members input.
4.	**Presentation**	Non-expert stance. Informal, but with 'clout'. Emphasise the expertise inherent in practice.
5.	**Position**	You are not in the team yourself, but can be seen to be part of the team. Work in the gulf. Engage people's trust.
6.	**Priorities**	Include these in planning for all away-days. Let people know that their priorities inform the work. Base all implementation on team priorities.
7.	**Practical**	Set achievable goals to implement small and sustainable changes (to make a difference).
8.	**Pace**	Follow through. Give information back rapidly. Keep information simple, clear and on as few pages as possible. Surprise people with the speed of your responsiveness.
9.	**Practitioner -led**	Fit in with the needs of practitioners – work around their diaries. Follow their interests. Take an informal and flexible approach (like applying assertive outreach principles to teams).
10.	**Process**	Make it transparent.
11.	**Package**	Present ideas in an accessible form. Process is the key, but we still need good products. Simplicity is the key.
12.	**Practice what you preach**	Keep your promises. Avoid 'all talk and no action'. Remain close to the realities of practice.

Future composition

The findings are preliminary, and need further detailed investigation in order to be more specific about the different factors influencing the positive results, and the ways in which teams rapidly respond to regression in evaluation of individual items. Practice development work has now commenced with a fourth team, which will add power to our sample and subsequent analysis. We also need the impact of the developments to be identified in relation to subsequent benefits for service users, through an additional focus on the delivery of care. However, we have an opportunity to celebrate the *difference* in the detail before demanding the *changes* to the bigger picture.

Failure to sustain good ideas and initiatives often results through:

- not venturing beyond the scope and remit of 'training' interventions;
- not offering or employing sufficient 'skilled' supervised practice development;

- superficial acceptance of a good idea, but failure to drive it deeper.

We believe that sustaining local capability to implement an effective process of practice development is a further necessary challenge. Hence we have commenced a new phase, to train practitioners who have participated in the process and are interested in being involved in this work. This next stage of 'practice based evidence' within Camden & Islington is one of developing a local capability to deliver, through:

- identification of motivated and talented staff;
- a practical programme of 'training' in the approach to practice development;
- supervised implementation of the approach across other parts of the Trust.
- Independent management of a locally grown 'practice development team'.

One of the most wonderful aspects of the desert landscape is the subtle change that goes on in microdetail, often invisible to the eye. We hope, through this work, to shift the focus to the detail of such changes to teams, practitioners and ultimately, service users. Otherwise we'll be swept away by the hot winds of UK mental health policy.

References

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