

Better prepared to care

The training needs of non-specialist staff
working with older people with mental ill health



Report of a study conducted by Ros Levenson and Nikki Joule

Mental Health Foundation

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SUMMARY

Background

The aims of this project were to understand more about the training needs of non specialist health and social care staff working with older people who have mental ill health and in particular understand:

- Specific skills, knowledge and understanding of staff working in this arena
- Contextual factors that will need addressing in order to maximise the effectiveness and sustainability of any training provided
- Management and institutional factors
- Practice development factors.

A range of methods were used to gather information: principally interviews with a large number of care staff, and some managers, working in a range of settings. We also looked at relevant literature, met with a group of carers for older people with dementia and interviewed some key individuals. (A full account of the methods used is in Appendix One).

Historically little attention has been paid in the literature and in policy and practice to the training needs of non-professionally qualified and non-specialist health and social care workers who have the most contact with older people in all care settings. However, this group of staff provide the majority of care, with the least training and, at times, without direct supervision. This lack of attention probably reflects the low policy profile, until very recently, of mental health services for older people and the low status of care staff.

Recently there has been some evidence, and some speculation, that training for this group might lead to improvements in the care of older people with mental health problems and would make a substantial contribution towards the promotion of person-centred care.

It is generally assumed to be good practice to involve a range of stakeholders in assessing the training needs of those caring for people with mental health problems, including service users and carers, health and social care professionals and managers. There are some differences in the priorities highlighted by different groups, though some commonality, and this raises some issues about who should set and define training needs.

Training needs of non-specialist health and social care staff working with older people who may have mental illness

This study focused primarily on the views of care workers, and some managers, in three local authorities in a variety of settings. Most had received little specific mental health training, but recognised a need and would welcome such training. They identified a range of issues that would be useful including:

- Mental health awareness training
- Recognition of mental health problems in older people
- Communication skills
- Person-centred care
- Dealing with aggression and difficult behaviour
- Risk management.

In addition, the need for task oriented training, such as moving and handling, to be applied to the mental illness context, was identified.

A range of learning styles was discussed and there were some differing views about what was most appropriate, but on the whole, care staff preferred workplace based training that was practical and helped them to do their job better. There was less enthusiasm for theoretical training. Where they had experience of it, staff particularly valued: workplace based support to learning, such as mentoring; and the input of mental health specialists to short courses on mental health issues. The potential for making training part of staff meetings and team meetings was under-exploited and it was felt more space might be made for learning and reflection in these situations.

Increasingly, training is centred around the attainment of NVQs and many had found their NVQ training helpful to some extent. However, as the NVQs focus on competencies within a current job, care staff reported that they had not necessarily covered issues pertaining to older people with mental health problems as it was not considered to be a significant part of their remit. This reinforces the circular nature of the problem; that low awareness of the mental health aspects of the work with older people may result in inadequate training in these issues.

The interviewees identified some factors that supported their access to training which were also largely reflected in the literature. The key factor appeared to be a supportive and skilled manager. Some barriers were identified; including the sources of finance for training non-professional staff, and this too was reflected in the literature in addition to the need for a more strategic approach to training for this group of staff.

BACKGROUND AND CONTEXT

Profile of older people with mental health problems

The extent of mental health problems in older people is only recently being recognised. The Department of Health estimate that 40% of older people attending their GP and 50% older people who are general hospital in-patients will have a mental health problem (most commonly depression, dementia or acute confusion). In addition 60 – 70% of care home residents have some form of dementia and 40% have depression. Within the general community depression is present in about 15% of older people and 5% of those over 65 years will be affected by dementia¹. Up to 23% of older people seen by medical staff have an alcohol problem². Finally, there are up to 60 per 100,000 population of older people with enduring or relapsing mental illness (most commonly chronic schizophrenia or relapsing mood disorder). Many of these people will be in residential or nursing homes and some living at home with care packages³.

Older women have twice the levels of depression as men and higher levels of anxiety⁴. Women over the age of 55 account for over a third of all suicides in women⁵.

The large increase in the numbers of older people in the next few years will include a substantial increase in the numbers of minority ethnic older people. In 2004 nearly a third of the minority ethnic population in the UK were over 65 years (including 11% of Black-Caribbean people and 7% of Indian people) this is set to rise further⁶.

There tends to be a lack of awareness generally about the mental health of older people and a tendency not to intervene. Mental health problems in older people are often unrecognised and, even if recognised, left untreated⁷. Older people over the age of 75 years are much less likely to be asked if they feel depressed than a younger person and far less likely to be referred to a mental health specialist⁸. Consequently, older people with mental health problems are very likely to be cared for by staff who do not have a specialist mental health background and who have little or no training in mental health care⁹.

What older people with mental health problems want from care staff

The overwhelming thrust of the literature on what older people consider important from care services stresses a “person-centred” approach that is characterised by older people being treated as individuals who can be involved in decisions about their care. The importance of not viewing mental illness in older age as inevitable and untreatable is stressed, as is the importance of human contact and social interaction. Older people

¹ Department of Health, 2005, Everybody's business – Integrated mental health services for older adults: a service development guide, Department of Health

² Mental Health Foundation, accessed September 2006, Adults in later life with mental health problems, <http://www.mentalhealth.org.uk/page.cfm?pageurl=mhilli.cfm>

³ Royal College of Psychiatrists, 2002, Caring for people who enter old age with enduring or relapsing mental illness, RCP, London (Report to Council, October 2002)

⁴ Milne A and Williams J, 2000, “Meeting the mental health needs of older women: taking social inequality into account”, Ageing and Society 20: 699-723, Cambridge University Press

⁵ Samaritans, 2006, Information Resource Pack, www.samaritans.org

⁶ NIMHE / Department of Health, 2005, Facts for champions – older people's mental health, Department of Health

⁷ NIMHE / Department of Health, 2005, Facts for champions – older people's mental health, Department of Health

⁸ O'Connell et al, 2004, “Recent developments: suicide in older people”, British Medical Journal 329 (895-99)

⁹ Department of Health, 2005, Everybody's business – Integrated mental health services for older adults: a service development guide, Department of Health / Audit Commission, 2000, Forget me not – Mental Health Services for older people, Audit Commission

identify friendship, conversation and activity as an important part of promoting mental wellbeing¹⁰.

Mind's *Access all ages* campaign summarises what older people with mental health problems state as their expectations:

- *To be treated with equal respect*
- *To have access to the same level and quality of support and treatment as other age groups*
- *To be supported by professionals who have expertise and training in mental health*
- *To be offered a choice of treatments*
- *To be given sufficient appropriate information in order to make an informed choice*
- *To be fully involved in planning, monitoring and reviewing any care needed.*

Mind notes that for many people these are currently false expectations¹¹.

Older people with mental health problems – the policy context

It is generally acknowledged that health and social care provision for older people with mental health problems has historically been poor and, until very recently, was rarely included in health and social care policy initiatives and discussions¹². The National Service Frameworks (NSFs) for older people and mental health respectively did not adequately address the needs of older people with mental health problems¹³. Where there has been a limited focus on this area the tendency has been to concentrate on dementia whereas depression is at least as significant an issue for older people¹⁴.

The (then) Commission for Health Improvement report into events on Rowan Ward, and the subsequent review of all in-patient services for older people with mental health problems, highlighted this area as a key policy issue for the first time and raised a number of issues that required addressing¹⁵. Amongst these issues were low staffing levels, lack of training and lack of leadership. It was also noted that there was a lack of clarity at Strategic Health Authority level about where responsibility for older people's mental health services lay; and that the lack of targets for this area of work meant that it risked being neglected¹⁶.

¹⁰ Bowers H, Eastman M, Harris J and Macadam A., 2005, *Moving out of the shadows*, Help and Care Development Ltd; Help and Care Development Ltd, 2005, *Spotlight on older people's mental health and wellbeing in London*, Help and Care Development Ltd; Andrew G, Gavin N, Begley S and Brodie D, 2003, *Assisting friendships, combating loneliness: users' views on a befriending scheme*, *Ageing and Society* 23, 346-362, Cambridge University Press; UK inquiry into mental health and well being in later life, 2006, *Promoting mental health and wellbeing in later life*, Age Concern and Mental Health Foundation

¹¹ Mind, 2005, *Access all ages – Campaign report*, Mind, London

¹² Department of Health, 2005, *Securing better mental health for older adults*, Department of Health; Department of Health, 2005, *Everybody's business – Integrated mental health services for older adults: a service development guide*, Department of Health; Bowers H, Eastman M, Harris J and Macadam A., 2005, *Moving out of the shadows*, Help and Care Development Ltd; Mind, 2005, *Access all ages – Campaign report*, Mind, London

¹³ Department of Health, 2005, *Securing better mental health for older adults*, Department of Health

¹⁴ Bowers H, Eastman M, Harris J and Macadam A., 2005, *Moving out of the shadows*, Help and Care Development Ltd

¹⁵ Care Services Improvement Partnership, 2005, *Moving On: Key learning from Rowan Ward – working to improve in-patient services for people with mental health problems*, CSIP / Department of Health

¹⁶ Care Services Improvement Partnership, 2005, *Moving On: Key learning from Rowan Ward – working to improve in-patient services for people with mental health problems*, CSIP / Department of Health

In addition to concern about in-patient services, there has recently been increasing awareness of the need to promote mental health in older people, and to provide both specialist mental health and other health and social care services for older people in a way that facilitates mental wellbeing¹⁷.

Workforce development for non-professional and non-specialist staff who work with older people who may have mental health problems

The health and social care workers who have the most contact with older people in residential and nursing care, hospital in-patients and in the community are non-professionally qualified and non-specialist staff. It has been observed that this group provide the majority of care with the least training and at times without direct supervision¹⁸. In particular, the majority of these staff have little or no training in mental health care¹⁹. In many parts of the country most or all of these staff are employed by private or voluntary organisations²⁰, and many work on an agency basis.

Historically there have been concerns about the morale within this workforce; the low social status of older people in society has tended to be reflected in the workforce who care for them²¹. One commentator describes “a complex interplay between structural factors, systems failures and fatalistic assumptions”²².

Workforce policy relating to this group has tended to focus on the recruitment and retention of staff with little attention to education and training needs²³, whilst approximately 80% of social care workers have no formal qualifications or training²⁴. There has been more recently a recognition of the need to develop mental health training for non-professionally aligned and non-specialist staff²⁵, though the focus of mental health training strategies is still largely focused on the specialist workforce and there is no coherent strategy which specifies what mental health training should be provided to the mainstream workforce who care for older people²⁶.

¹⁷ Department of Health, 2005, Everybody's business – Integrated mental health services for older adults: a service development guide, Department of Health; Bowers H, Eastman M, Harris J and Macadam A., 2005, Moving out of the shadows, Help and Care Development Ltd; Mind, 2005, Access all ages – Campaign report, Mind, London; Care Services Improvement Partnership, 2005, Moving On: Key learning from Rowan Ward – working to improve in-patient services for people with mental health problems, CSIP / Department of Health; UK inquiry into mental health and well being in later life, 2006, Promoting mental health and wellbeing in later life, Age Concern and Mental Health Foundation

¹⁸ Thompson R, 2005/6, HCA Clinical Support Project – Older adult service CNWL Mental Health NHS Trust – Executive Summary, Central and North West London Mental Health Trust

¹⁹ Audit Commission Audit Commission, 2000, Forget me not – Mental Health Services for older people, Audit Commission

²⁰ Tarpey L, 2004, Round Pegs – Round holes? Recognising the future of human resources management, Association of Director of Social Services

²¹ Drennan V, Levenson R, Goodman C and Evans C, 2004, “The workforce in health and social care services to older people: developing an education and training strategy”, Nurse Education Today, 24, 402- 408; Presentation slides from Anthony Harrison, Consultant Nurse Liaison Psychiatry, Bristol Older people and mental health care: How can we understand the general hospital experience?

²² Presentation slides from Anthony Harrison, Consultant Nurse Liaison Psychiatry, Bristol Older people and mental health care: How can we understand the general hospital experience?

²³ Drennan V, Levenson R, Goodman C and Evans C, 2004, “The workforce in health and social care services to older people: developing an education and training strategy”, Nurse Education Today, 24, 402- 408

²⁴ McFarlane L and McLean J, 2003, “Education and training for direct care workers”, Social Work Education, Routledge.

²⁵ Mental Health Care Group Workforce Team, 2004, National Mental Health Workforce Strategy, Department of Health; Bowers H, Eastman M, Harris J and Macadam A., 2005, Moving out of the shadows, Help and Care Development Ltd; McFarlane L and McLean J, 2003, Education and training for direct care workers, Social Work Education, Routledge.

²⁶ Personal communication, Ian McGonagle, Centre for Clinical and Academic Workforce Innovation, University of Lincoln.

The National Minimum Standards for registered care services, introduced as part of the implementation of the Care Standards Act, 2000, set out that a minimum ratio of 50% of care staff should be trained to NVQ level 2 or equivalent by the end of 2005²⁷. The applicability and content of National Vocational Qualifications (NVQs) for some parts of the social care workforce has been questioned by some and there is some concern that there is a tendency to focus on the technical aspects of providing a service, and avoiding risk, to the detriment of the “human touch”²⁸.

It has been suggested that, within the NHS, there is a natural affinity between those things that matter to patients and the crucial role of support staff. Work to develop person-centred services, therefore, should be more clearly focused on the role of support staff and recognise their potential contribution to promoting person-centred care. It is further proposed that learning programmes for support staff should focus on this role²⁹. Others have also recognised the role of front line workers in promoting person-centred care³⁰.

²⁷ See, for example, Department of Health, 2003, Care homes for older people – National Minimum Standards - Care Home Regulations, 3rd Edition, Department of Health

²⁸ Bowers H, Eastman M, Harris J and Macadam A., 2005, Moving out of the shadows, Help and Care Development Ltd; Innes A, Macpherson S and McCabe L, 2006, Promoting person-centred care at the front line, Joseph Rowntree Foundation; Booker C and Curran J, 2005, National Continuous Quality Improvement Tool for Mental Health Education – Handbook and Implementation Guide, Northern Centre For Mental Health / Centre for Clinical and Academic Workforce and Innovation, University of Lincoln; Personal communication, Ian McGonagle, Centre for Clinical and Academic Workforce Innovation, University of Lincoln; Taylor L, Read K and Jolley D, 2004, Scoping the development of a certificate on mental health and later life – literature review, University of Wolverhampton – Dementia Plus Centre

²⁹ Gilbert, D, 2006, What patients think of healthcare support staff, Report for the Widening Participation in Learning Unit, Department of Health

³⁰ Innes A, Macpherson S and McCabe L, 2006, Promoting person-centred care at the front line, Joseph Rowntree Foundation

TRAINING NEEDS

The literature on the mental health training needs of non-specialist health and social care staff who may work with older people is sparse, though there is some evidence to suggest that intervention by appropriately trained staff who do not have a background in mental health can effect a change in the level of depression in older people and improve detection rates of mental ill health³¹. One study found that care staff thought the most useful parts of the training were those that increased their understanding of depression in the residents which had made them more tolerant, less judgmental and more able to make sense of their behaviour and the problems; for some caring had become “more enjoyable”³². Though there is little evaluation of the effect that training care staff has on the quality of care delivered, there is some evidence that suggests the main benefits are a greater willingness to promote autonomy and independence for older people, and improved communication between the care workers and older people³³.

The mental health related training needs explicitly identified in the relevant literature are³⁴:

- Valuing and respecting older people (Practising ethically, recognising people's rights)
- Supporting older people following bereavement or other stressful life changes
- Dementia care (signs, symptoms, types and causes, interaction with depression)
- Communication (with older people with dementia and other mental health problems and with their carers and family)
- Promoting independence and enhancing quality of life through meaningful activities
- Promoting good health and recovery (physical and mental)
- Managing challenging and aggressive behaviours, including handling risk and promoting safety
- Abuse (including recognising and reporting abuse)
- Person-centred approaches to care (working in partnership, patience, compassion, sensitivity and empathy)
- Working with a diverse client group (including respecting diversity, challenging inequality and practical issues such as working with interpreters).

Within the literature, training needs for the non-professional workforce are identified by a range of stakeholders including the care staff themselves. This raises an issue about who should determine the training needs of this group. The tendency, and assumed good practice, is to involve service users and carers, health and social care staff and their managers in determining training needs, though one study noted differences in the training needs prioritised by the different groups. Record keeping skills for instance were

³¹ Moxon S et al, 2001, “Mental health in residential homes: a role for care staff”, *Ageing and Society*, 21 Issue 1 71 – 93, Cambridge University Press; Eisses et al, 2005, “Care staff training in the detection of depression in residential homes for the elderly”, *British Journal of Psychiatry*, 186, 484 - 409

³² Moxon S et al, 2001, “Mental health in residential homes: a role for care staff”, *Ageing and Society*, 21 Issue 1 71 – 93, Cambridge University Press

³³ Taylor L, Read K and Jolley D, 2004, *Scoping the development of a certificate on mental health and later life – literature review*, University of Wolverhampton – Dementia Plus Centre

³⁴ UK inquiry into mental health and well being in later life, 2006, *Promoting mental health and wellbeing in later life*, Age Concern and Mental Health Foundation; Thompson R, 2005/6, *HCA Clinical Support Project – Older adult service CNWL Mental Health NHS Trust – Executive Summary*, Central and North West London Mental Health Trust; North West Dementia Centre, 2004, University of Manchester, *Dementia Care Training Needs analysis*, <http://www.medicine.manchester.ac.uk/pssru/nwdc/training/>; Bowers H, Eastman M, Harris J and Macadam A., 2005, *Moving out of the shadows*, Help and Care Development Ltd; NIMHE / The Sainsbury Centre for Mental Health / NHSU, 2004, *The Ten Essential Shared Capabilities – A framework for the whole of the mental health workforce*, Department of Health; Innes A, Macpherson S and McCabe L, 2006, *Promoting person-centred care at the front line*, Joseph Rowntree Foundation

highly prioritised amongst managers, but not amongst healthcare assistants, service users and carers. Whilst promotion of therapeutic activities, understanding the needs of carers and physical health needs were prioritised by service users and carers and by managers, but not by healthcare assistants themselves³⁵.

At the discussion group we held with carers of older people with dementia, the participants identified training needs that were largely related to the enhancement, or encouragement, of personal qualities of care staff, such as patience, tolerance and communication skills. They also stressed the need for training that would help staff to better support and involve family carers.

The overwhelming majority of care staff that we interviewed felt that they needed additional training to help them to work with older people with mental health problems and they would welcome such training. This view was shared by their managers. Managers usually felt that they too would benefit from further training on at least some topics and issues. Training was valued for increasing the skills and competencies of care staff and for building their confidence.

Some managers, and one or two basic grade staff, were aware that more mental health training and different kinds of training courses might be necessary in the future as the dependency level of clients in all settings was set to change. Older people living in their own homes were increasingly likely to be physically and mentally frail. In day centres, older people were in future likely to have a higher level of dependency as those whose needs were purely social would be using mainstream community leisure facilities. Two care staff and their manager in a day centre noted:

They have changed our criteria and we will now only accept people with “substantial to critical” level of need. So our client group will change – verging on nursing needs and they will be a lot frailer. We might need more nursing-care training, more moving and handling, medication training.

In residential care, it was already the situation that many residents had dementia, and it was recognised that this might increase, as might the number of older people with other mental health issues. Therefore their training needs for the future were different from those of the past, in so far as a greater level of training on mental health issues, of all kinds, would be indicated.

Differences in training needs

Many of the views expressed by interviewees across the range of care settings showed a similar range of opinion on training needs, regardless of the setting in which the interviewee currently worked. Some interviewees had previously worked with older people in different settings in previous jobs (e.g. home carers and day centre workers had worked in residential care, and some who were currently in the employment of a local authority had also worked in the independent sector etc) and in some instances they were able to reflect on training needs in their present and past roles. As well as having much in common, there were suggestions that the different work settings and job descriptions also gave rise to some differences in training needs. For example, a home care worker suggested that home carers had more responsibility as they tended to be lone workers. In case of violence or aggression, there would probably be no-one around to help them, unlike other care settings. On the other hand, in other settings, such as care homes, the 24-hour presence of clients also created specific operational challenges and consequent training needs.

³⁵ Thompson R, 2005/6, *HCA Clinical Support Project – Older adult service CNWL Mental Health NHS Trust – Executive Summary*, Central and North West London Mental Health Trust

Discussions with the English Community Care Association, which is the largest representative body for independent care homes in England, suggested that, for the most part, training needs were similar whether staff worked for NHS organisations, local authorities, not-for-profit organisations or commercial companies. However, it was suggested that the size of an organisation is relevant, and within the independent sector training needs may be addressed differently by large corporate organisations and small providers of care for older people. Larger organisations see training as important and understand that it develops their business. Smaller organisations, working on tight financial margins, might be less able to undertake a comparable amount of training.

There were also variations in training needs depending on how often care workers cared for older people with particular mental health needs. For example, in residential care, there was a greater likelihood of caring for large numbers of older people with dementia than was the case in home care, where caseloads might include significant numbers of younger people with disabilities. Where care workers encountered a particular kind of mental health problem less frequently, they tended to report difficulties in assimilating knowledge unless they had opportunities to apply it in practice. Other variations in perceived training needs reflected the age and experience of the interviewees.

Particular training needs

A number of particular training needs were identified - these are described and discussed below, including how the training might help the staff to do their jobs better. In summary these were:

- Mental health awareness training
- Recognition of mental health problems in older people
- Communication skills
- Person-centred care
- Dealing with aggression and difficult behaviour
- Understanding when to refer on
- Promoting better mental health and preventing deterioration
- Training to take a broader role
- Increasing self-knowledge
- Risk management
- Cultural issues.

Mental health awareness training

Awareness of mental health in older people varied across different settings as well as between different individual care staff. In general, there was a greater level of awareness about the prevalence and implications of dementia than about functional mental illnesses. Understandably, those settings where staff cared for significant numbers of people with dementia were more aware of dementia and also more aware of the need for training to enhance their skills. However, this raises the possibility that other settings (such as a rehabilitation centre, whose clients are generally selected as not having any obvious dementia or mental health problems) may be less aware of the possibility that some of their clients do, nevertheless, have mental health needs. A home care manager, whose home carers did not necessarily have many clients with identified mental health needs, favoured compulsory awareness training.

In most care settings, training was seen as having the potential to increase awareness and understanding of mental health in general. Awareness training was needed:

To understand the whole concept of mental health. It's always "people with mental illness are there, and we're here". They need to be trained to see the person behind the illness.

Training was thought to help to encourage care staff not to make assumptions about behaviour and about disability. As a day centre manager observed:

It's also about them becoming more aware of mental health and that it's not just a "geriatric illness".

Training could also increase awareness of physical illness in people with dementia and about the impact of acute physical illness on the mental health of older people. One home carer said:

It could be helpful to know more about what causes the problems. For example, they might get hallucinations if they are dehydrated or have a water infection. ... But that's different to a mental health problem. You do learn as you go, but courses and updates are brilliant.

An awareness of mental health was seen as a means of improving the ability of staff to be patient and to control negative feelings towards clients, and not to take things personally:

When you don't know how these people feel and why they behave like that, you can become very angry with them. Training could help you to understand them, and know how to persuade them to wash, or to eat.

A basic level of awareness of mental health was seen as particularly important to home carers. Even if they did not have a significant mental health element to their current caseloads, some were aware that they might have to cover for another home care worker at short notice and it was not possible to predict what they might need to know.

Training to recognise mental health problems in older people

Most of the interviewees articulated a desire for more training in recognising mental health problems in the individuals they cared for. In a minority of interviews, the interviewee did not feel that this was necessary. There is no way of knowing whether those views reflected their higher level of skill in recognising mental health problems, or whether these interviewees may have needed training, but not recognised the need. There were no obvious patterns in the kind of staff (e.g. by age, gender or workplace) to correlate with the responses given. Generally, staff were more confident of their ability to recognise dementia than they were of their ability to recognise functional mental health problems. Several people mentioned that their confidence in recognising a mental health problem would depend on how well they knew the person. They felt much more confident about this when they knew the person well and could see whether a person's behaviour or mood had changed.

Some staff wanted help in recognising the seriousness and significance of what they observed, for example:

How do you know when they are depressed and when they are lonely. And how to know when they are crying for help. They say: I'm going to put my head in the gas oven. How can we know when they are joking and when they are serious?

For instance, if a lady started swearing, has she got a mental health problem or not? So we'd like an idea of possible symptoms. If we understood something was a symptom of mental illness we'd be more confident.

Training on what to look out for would be good – e.g. is she getting dementia if she keeps putting her purse in the fridge?

A home care manager felt that recognition in what to look for was “the number one priority” for her staff as it opened the door to talking to the person, and also enabled staff not to take it personally if the person was not easy to work with. She also felt that staff need to be able to understand some medical terms, such as “depression” and “schizophrenia”.

An experienced home care worker felt that most of her colleagues would not recognise either dementia or functional mental illness. She felt she owed her own deeper knowledge to experience of mental illness in her family, and to personal experience as a volunteer in a mental health setting. She emphasised to other home care workers that it was important to be open to the possibility of suspecting dementia. Other home care workers sometimes felt that the doctor would be bound to diagnose it, but she felt that as home carers saw clients every day, they would very likely notice significant changes in behaviour first. Training could make care workers more sensitive to picking up on significant changes.

Two managers agreed that staff were more likely to recognise mental health problems in some circumstances than in others, but they needed to increase their recognition skills across the board:

They expect mental health problems at certain times e.g. around bereavement, they'd be sympathetic then. But if further down the line, then maybe not.

It was suggested that, without adequate training, care staff might also fail to recognise the mental health component of a client's needs as families sometimes played down problems. They might fear that a non-residential service might not be provided if the problem was known, while they might be much more explicit when they were wanting, for instance, to access respite care, when the severity of a mental health problem might be seen as a way to make the case for a service.

Staff often wanted to know more about different types of mental illness, personality disorders and also about different types of dementia. Some staff also wanted more training on alcohol-related mental health issues, both in dementia and in other mental health problems. A day centre manager explained:

Staff are asking for an understanding of different forms of mental illness and a general awareness of the differences. We have 3 people with similar problems and one is aggressive, one is sensitive and one is challenging. So we want to know how to deal with them. We deal with them according to our personalities, but we need to know more, in-depth.

Others said:

I'd recognise some signs of depression, but some put on a brave face so you might not know. Training might help.

We need to know about mental illness other than dementia. We have had people with schizophrenia and we have managed. More training would help us more than “just manage”.

Staff generally had more confidence in recognising dementia than functional mental health problems, and saw their training needs as being greater for the latter. Care staff and their managers agreed that there was a greater chance of recognising a mental health problem where the older person was behaving bizarrely. However, the risk of overlooking

depression when staff were busy with physical care was considerable, particularly if the person was quietly “fed up” and was not causing problems for others.

Learning the language of mental illness was also seen as important, particularly by the managers who were interviewed. They wanted staff to have some training in report writing and in recording accurately their observations of clients. As one home carer said:

We may not have the words for it.

The idea of “not having the words”, or lacking a vocabulary to discuss mental health, came up in relation to oral communications too. This was an area where training was thought to be necessary to formalise what some care workers already knew to some degree, but without the appropriate skills to communicate with others about their observations and concerns.

Communication skills

Whilst communication skills are clearly highly valued by service users and carers as evidenced in the literature and in the discussion group we conducted with carers of people with dementia, opinion varied on whether training might help staff to communicate better with older people with mental health problems. Several staff in different settings felt that the main obstacle to better communication with older people with mental health problems was not training, but time to talk to people.

The balance between training and experience in improving communications was a recurrent theme. Several people saw a need for training, but felt that communication came naturally, or grew as a result of life experiences:

Communication – it’s just talking to people. You’ve either got it or you haven’t. It’s the sort of person you are.

But if you are a decent human being and have brought up children and have a feel for people, you know something of how to do it. There are some carers and you think – will it ever come? But usually such a person would leave the job.

Even so, some who felt that they were natural communicators recognised the need for training on specific areas of communication, or felt that they could have been taught things that they had learned the hard way:

It would be good to learn communication skills with people with dementia. I see one man and mostly he is very distressed. And it would be good to know how to communicate if people don’t understand – when to explain and when not to, what to do if they don’t understand the idea of time, how much to enable them to be independent or when to do things for them etc.

You mustn’t pressure a person – you have to calm them down first or they’ll get worse. I have learned on the job, but you could be taught e.g. thinking about what to do in certain situations to calm the service user quickly.

Also, some staff wanted very practical training on communication, such as what to say and how to say things in certain situations.

How to answer someone with mental health problems e.g. do you say: You’ve told me that 3 times already? It could stop staff getting agitated.

One manager was concerned that training could result in regimenting staff to the point where they lost their individuality, and that would impair their communication skills.

One person who wanted communication training related the need to being better able to defuse potentially threatening situations:

How to talk, what physical position I should take. For a long time no one has held their hand to talk to them. Training can help in what to observe and what to say that will not aggravate them. You have to watch your body language.

A manager noted:

It would help to train carers that it's not so much what you say as how you say it. And learning not to wind someone up. A lot is common sense.

Several staff noted the importance of non-verbal communication, including sensitive body language and the use of music. They felt training on communication with older people with mental health problems could include these broader aspects:

Communication is one of the key things. You need to get them to understand you. They will bond and get closer to you and you can help them better. I try to sit with them, spend some time talking and I sing with them. Some of them love music and it can be an effective way of communicating. Sometimes, when I wash a lady, we sing together.

You can help a situation by word or touch. With verbal communication you have to know how to talk – the older person may say something mid sentence like they have been talking to you for hours and you need to know how to talk and continue in that situation. And not allow yourself to become concerned or upset. It is important to know when and how to use touch.

Some carers pointed out the link between training in communications and training to recognise, assess and handle a difficult situation

Training helps you know what you are looking for. And you know that if they say go away, they may not mean it. They may have poohed themselves and feel embarrassed.

People can have behavioural problems or depression and you need to get through to them that you are not there to harm them, only to help them. And it is good to learn other ways to communicate, anything that will make it easier to communicate without it being a threat to them, or to yourself.

A manager observed that her staff were not trained on communicating with someone with suicidal thoughts.

Training was also seen as helpful in communicating about sensitive subjects, such as sexuality or continence.

For some, training was seen as a potential aid to improving the quality of communication:

You can sometimes ask how they are feeling and they say “Up and down like Tower Bridge” but that’s not a proper answer and you want to get beyond that.

You might ask: do you want to go to the toilet and she'll say no, although she wants to go. Or she won't open her mouth for dinner - she can't say what she wants.

Some home carers were particularly attuned to the possibility of training helping them to communicate more effectively. They saw this as very important as they were aware that the older person may not see anyone apart from their home carer.

Some staff wanted training on communicating with people with hearing difficulties, including training in basic signing, and on the communication difficulties associated with strokes and partial sight. A senior manager also mentioned that some staff do not speak good English, and this added to communication difficulties.

As with all training, staff may not always know what they do not know. One care worker observed that when she went on courses, she realised that other staff had been telling her "the wrong way" to communicate.

One manager pointed out that staff working with older people with mental health problems also needed training to help them communicate effectively with relatives of those being cared for, and with each other in the staff team. As noted above, this was also raised by the carers group we spoke to.

Dealing with aggressive or difficult behaviour

There was an enormous amount of concern about the need for further training on dealing with violent, aggressive or difficult behaviour, especially when that was possibly related to the client's mental health problems. The great majority of staff had had some general training in this area, but it often lacked particular application to older clients with mental health problems.

Insufficient training seemed to result in staff feeling frightened and sometimes being unable to continue working with clients.

I had a lady who boxed me in the face. I had to walk out. I was frightened. I tried to calm her down but it wasn't working. I'd like training to deal with those situations. I was so scared I won't go back there.

Another person noted that new staff are particularly frightened:

They are not sure if they can touch the patients as they have a mental health problem. You have to say: they won't hurt you. They are worried it is a disease and you mustn't touch them. You have to explain you can talk to them. At first, they don't know what to do. Training can help them.

Training was seen as having the potential to help staff to act quickly to defuse a difficult situation. As well as benefiting the older people, this was seen as reducing stress on the care staff.

Staff felt that training in dealing with aggression, violence and difficult behaviour would help them (or other staff) to be more patient and tolerant. Some staff suggested that it could reduce the incidence of abuse.

Staff experience of handling difficult behaviour included having to look after people who expressed racist opinions. Staff were very understanding of this, particularly in older people, whom they saw as having grown up in a racist society, but nevertheless, it was hard to deal with.

Racism is common. I had a lady who knew my name was [xxx] and when I turned up she was expecting a white English carer. I managed to calm her down. A younger person wouldn't have. Training would help greatly – how to deal with these situations and not lose your temper.

Sometimes you can be trained in anger management and this was useful. Like, you might have to deal with someone who says: I can't understand how they send a black man to wash a white person. You learn to say: I'm here to do a job. You need to understand their situation, that they are not completely responsible for their actions.

Person-centred care for people with mental health problems

Some interviewees felt that training would lead to better and more person-centred care. Two residential care workers agreed that staff needed training:

About dignity and respect – what's best for the lady and what's best for us.

In particular, training could help staff to see things from the older person's point of view:

Training helps to understand people who say they're not staying here, they have got to find their children. It helps you understand the older person's point of view.

A senior manager noted that the wards where older people were cared for were very task-focused and the skill mix of staff made it difficult to rise above this. She planned a number of organisational changes to address this, and she also favoured Dementia Care Mapping as a training tool to enhance patient-centred care. She added:

My priority is embracing and understanding patient-centred care. If you get that right, everything else falls into place.

Staff tended to think that it was staff other than themselves who needed more training in delivering person-centred care:

I don't feel I could learn a lot at my level – I have built up over the years. But the day centre staff would, yes. They need more understanding of person-centred care. And particularly on the wards, they need that too. They could do with more insight into mental health. There is a lack of understanding of why people behave as they do, so their tolerance is not as it should be. They think they are deliberately behaving as they do. They don't recognise that they are ill. This can make staff frustrated if they don't understand. Staff are so used to it that they don't stop and think.

Promoting better mental health and preventing deterioration

Whilst person-centred care in itself might promote mental well-being, some managers and their staff aspired to a greater role in promoting better mental health. They hoped that training would better equip them for that role. One manager (himself unqualified) said:

We had an old boy here and he was sexually active, and made a nuisance of himself to others. With proper medications we could maybe have kept the service going. How could we have seen the situation arising and dealt with it better?

A home care manager felt that better trained home carers could play a greater part in prevention of mental ill health. He noted that they had a high number of clients taking overdoses. He felt that more knowledge on depression might lead to mental health professionals stepping in earlier. A home care worker stated:

Training helps us help the clients get the help they need. Maybe avoid them not eating, or doing something silly. Getting help sooner rather than later. If we can get

the client sooner they won't have to go into hospital. Prevention of deterioration is what matters, and training would help that.

Some interviewees saw training as having a role in preventing a deterioration in an older person's mental health. This might be through better recognition of the problem, or as a result of knowing how to deal with an already identified mental health problem.

It would be good to spot problems earlier. It might stop them having to go into hospital if it was treated earlier.

Understanding when to refer on

Most interviewees were very clear that it was not part of their job to make decisions about when the older people in their care needed specialist referrals or access to specialist help and advice in relation to their mental health. On the contrary, most felt that it was their job to report any changes or concerns to their manager or superior, whose job it was to consider what action to take. The interviewees all felt well supported by their managers in this respect, and so they usually did not feel the need for training on what resources might be available for onward referrals. However, some carers felt that training:

... would help be more aware of what to look for, to take note and pass on to the line manager and see what we can do.

Another wanted training as she said:

I'd be properly qualified and would know more about the service users and could liaise with the families more. Or I could make a referral, to [name of hospital] and I could be the main one if there was a query and I could help more.

However, it is interesting that this person had been a manager elsewhere, and although she no longer wanted or held managerial responsibilities, she construed her role more widely than most of her colleagues and therefore perceived some additional training needs.

One home care manager particularly wanted the home carers to be trained to recognise when there was a mental health issue that they needed to pass on to specialist care.

Training to take a wider role

One day centre manager – herself unqualified – wanted training to enable her to play a greater part in working therapeutically with clients:

And personally I want to go into the therapeutic side of helping – what we can do to help. I had a situation and a lady turned on me, verbally and it took ¾ hour to defuse the situation. Her CPN said in that situation just get out the paints and paper and it calms her down.

A healthcare assistant valued training as she had to have knowledge and credibility when she acted in place of qualified staff:

If we haven't got two qualified staff on, I go to ward meetings and have to tell the doctors about the patients, their medications etc. I have to discuss all these things. I act in place of the qualified staff. We deal with the patients more than the qualified staff – they do the paperwork.

Increasing self-knowledge

One day centre worker felt that training was helpful in gaining a better understanding of oneself and one's own emotions.

As a child, I was carer to my mother, and I was fearful about the emotion in this kind of work. Training has given me more understanding of how people feel and how to be gentle with them, how to allow them to be themselves

A home care worker also felt that training would help to set boundaries:

I can get too involved. The training would help with that. I tend to say: you sit there and I'll do it, instead of getting them up. But really that's not on and it's not helping them. I'm too soft and you can make a rod for your own back. They can take advantage.

Risk management

Care staff wanted more training on understanding and managing risk, and on balancing risks with individual choice and autonomy. They were aware of what they were supposed to do, but did not always feel that this equipped them to do the job as they wished to do it, and sometimes, different policy imperatives conflicted, and they wanted training to help them negotiate these dilemmas.

More training on confidentiality. Clients want confidentiality, but there's a risk, so what do you tell the office? And we need more on choice. What can they [clients] choose, when risks are too great? The NVQ says we are there to do the client's choice. But we are "not allowed" to visit them in hospital in case we get too familiar, but the client might want us to go. And one man went into hospital and wanted me to feed his fish. I wasn't supposed to go in, but he wouldn't have been pleased to come home and find his fish dead! What to do? You have to use your initiative sometimes. The question is how to help clients make a choice while they are safe and we're safe, and everyone's happy.

A care assistant in a residential care home said:

Occasionally you give personal care or have to change a pad and they say no. They have choice, but how can you leave someone who is soiled? So you have to be properly trained. If you don't take care of them it is negligent and if you do, you may be going against the standard. So you need to be trained in how to reconcile these things – their rights and their needs.

Staff were also worried about the consequences of simply walking away from threatening situations:

There are certain issues that need to be addressed that I don't know about – like, if the client becomes aggressive, what do I do next? I know I should call the office, but what else? I don't want to come in to the office and say I don't want to work with them. Someone needs to be there for them. But I need to know what to do when both parties are in danger.

Some staff also wanted general training on legal issues regarding older people with mental health problems, including consent, confidentiality and what care workers were and were not allowed to do. As two home care workers agreed:

We do feel vulnerable. The job is high risk. If anything goes wrong, we could get into trouble.

Cultural issues

There were differences of opinion on how necessary training on cultural issues was in relation to older people with mental health problems. In part, this reflected the fact that even though interviews were carried out in ethnically diverse areas, there were relatively few people from Black and minority ethnic (BME) communities using mainstream older people's services, particularly in day and residential care settings. In one area, we interviewed staff in a day centre for African-Caribbean older people and it may well be the case that the existence of this service had an impact on the use of other day services by the African Caribbean community.

In another area, where we interviewed home care staff, a similar pattern of low numbers of BME clients was reported. This raises interesting training issues. Although staff clearly saw a need to equip themselves to work equally well across all communities, some staff felt they did not need this training to help them do so as they currently had few clients whose cultures they were not familiar with. The question is, to what extent might a better trained workforce encourage further use of services by BME older people, and to what extent would a better trained workforce be able to respond more appropriately to BME older people with mental health problems?

The significance of this question is increased by the nature of some of the comments from those staff who were doubtful about the need for training in relation to cultural competency. It was sometimes the case that staff were not aware of what they did not know, and they saw cultural issues simply in relation to basic communication:

We have had people in here from other cultures and we do communicate. We use picture boards.

Some staff observed that they had had general equal opportunities training, but had not had any training that related both to equalities (particularly race and ethnicity issues) and mental health.

We have equal opportunities in NVQ, but don't deal specifically on mental health.

Those staff who saw a need for more cultural training made a number of observations:

I know a carer who is African and she can't get on with one man who is Jamaican. I am Jamaican and I can get through to him. I know what my granddad would have liked. But you need training to understand other cultures.

If you get a Caucasian who goes into a West Indian person, they might have different phrases, or looks and something might be misinterpreted as mental illness when it is not.

Within the context of the African Caribbean day centre, training on the cultural aspects of mental health were seen as important:

We all need to understand cultural needs. We have Africans and African Caribbeans and there are many different cultures. It is good to know where people come from. African Caribbeans can be loud and might be thought to be upset and can be misinterpreted.

One manager felt that she and her staff might benefit from training about the cultural aspects of mental health issues for older people in ways she could only infer from her previous experience:

When I was a youth worker, we had a course on gender and sexuality. And it was amazing how different it was – different cultures had different views. The same might be true for mental health.

Several care workers mentioned that they were aware that different cultures might have different attitudes to mental illness. They could see that understanding stigma and taboo in different cultures would be useful in their work, particularly in dealing with relatives.

Some of the staff who felt that they did not need training in cultural issues felt that they had acquired the necessary knowledge and sensitivity from living and working in ethnically mixed communities, and sometimes from their own personal experiences.

Medication

Day centre and residential care staff saw a need for more training on medications. This view was shared by senior managers in another borough who related the need for medication training with the changing clientele that they anticipated.

We need to be aware of the different medications. We don't give medications, but we do prompt. Our policy is to promote their independence and to support and advise them. We need to give the correct advice.

A home carer pointed out that medication training was important for home carers too, as they might need to be aware of the possible signs if someone was not taking their medication.

Application of generic training to working with older people with mental health problems

Mandatory training was generally seen as helpful, although in its present form it did not necessarily relate to the specific issues that staff encountered in working with older people with mental health problems. For example, while virtually all the staff who were interviewed mentioned that they had had training in moving and handling, this training had been applicable to all care settings and had not been specific to caring for older people with mental health problems. However, as a manager in a residential care setting observed:

We have good moving and handling policy and training, but we need ways of moving and handling people with dementia as they don't remember what a hoist is and can lash out. So we need applied moving and handling for people with dementia. And if people have a mental health problem, they may have been in a straight jacket years ago, so imagine what being put in a sling must be like for them.

Similar issues applied to other kinds of training. For example, training on dealing with aggression and violence was not necessarily geared to the care of older people.

Training for staff who are not primarily care workers

In addition to the varied training needs of care staff, the interviews elicited some views on the importance of training on mental health issues for other staff who come into contact with older people. This could apply to administrative, catering, cleaning, portering and transport staff. One manager noted:

Non-care staff don't get any relevant training, but they should do. ... Some of the non-care staff will argue with patients, and have no idea about privacy and dignity. So they might say: I need to clean, so get out! Domestic staff should be seen as part of the team. Why shouldn't contactors be part of mandatory training [in addition to more obviously relevant areas such as food hygiene]?

In some settings, such as voluntary sector day centres, staff may carry out a range of duties. Although they may not primarily be care staff, they may come into contact with older people with mental health problems. Moreover, the person's mental health may have a bearing on how the worker does their job. For example:

You need to recognise the signs. Like when I do escort, you need to know that some clients might try to undo their seat belts. Mental health has a bearing on that.

Whether you are a carer or a kitchen worker, you need training as you don't know what you are up against. Users and staff can have mental health problems.

Agency staff – training needs

The majority of interviewees who volunteered an opinion on agency staff did so in order to say that they felt they were less well trained than established staff, although one manager saw no difference. One home carer observed:

Some carers need more training, especially agency staff who often have no training at all. Agency staff are very different. You notice that if you double up.

They say they have been trained, but we don't see it. If they are here for a few weeks, they learn. But we don't let them write in the notes.

STYLE/DELIVERY OF TRAINING

Background

The literature suggests that frontline care workers feel there is a lack of recognition of the skills that they gain through experience and that this may be an increasing problem as the focus of training is shifting to towards the attainment of qualifications³⁶. One study found that, although there was a high level of interest amongst care workers in training to improve skills and the quality of service, not all workers were interested in obtaining qualifications³⁷.

A strong theme in the literature is the need to involve service users and caring in training programmes, both in delivering the training and in planning and evaluating it³⁸.

A number of reports recommend greater use of buddying, peer and self assessment, mentoring, individual learning accounts and other workplace based learning³⁹.

Two studies found that care staff appreciated specific mental health training (on recognising and dealing with depression). They particularly liked the specialist input from mental health workers⁴⁰.

The need for a range of training methods and approaches

In general, motivation to participate in training was high amongst the staff we interviewed, although occasionally staff nearing retirement were less enthusiastic, particularly about NVQ training. However, the degree of motivation and commitment to training was related to whether the style and content of the training was seen as appropriate and relevant. As suggested by the literature⁴¹, we found that the style and delivery of training to unqualified staff working with older people with mental health problems has to take account of a variety of factors and preferences, and a number of practical and logistical issues. One of the fundamental issues is a range of views on the relative value of training, work experience and life experience.

³⁶ Innes A, Macpherson S and McCabe L, 2006, *Promoting person-centred care at the front line*, Joseph Rowntree Foundation

³⁷ McFarlane L and McLean J, 2003, "Education and training for direct care workers", *Social Work Education*, Routledge

³⁸ Taylor L, Read K and Jolley D, 2004, *Scoping the development of a certificate on mental health and later life – literature review*, University of Wolverhampton – Dementia Plus Centre; Booker C and Curran J, 2005, *National Continuous Quality Improvement Tool for Mental Health Education – Handbook and Implementation Guide*, Northern Centre For Mental Health / Centre for Clinical and Academic Workforce and Innovation, University of Lincoln; Thompson R, 2005/6, *HCA Clinical Support Project – Older adult service CNWL Mental Health NHS Trust – Executive Summary*, Central and North West London Mental Health Trust; Tew J, Gell C and Foster S, 2004, *Learning from experience*, York Higher Education Academy / NIHME West Midlands / Trent WDC

³⁹ Brunt J, 2006, *Getting started – Towards a Patient-centred workforce – Implications for learning*, Unpublished paper for Widening Participation in Learning Strategy Unit – Department of Health; Tarpey L, 2004, *Round Pegs – Round holes? Recognising the future of human resources management*, Association of Director of Social Services; Care Services Improvement Partnership, 2005, *Moving On: Key learning from Rowan Ward – working to improve in-patient services for people with mental health problems*, CSIP / Department of Health; Thompson R, 2005/6, *HCA Clinical Support Project – Older adult service CNWL Mental Health NHS Trust – Executive Summary*, Central and North West London Mental Health Trust

⁴⁰ Moxon S et al, 2001, "Mental health in residential homes: a role for care staff", *Ageing and Society*, 21 Issue 1 71 – 93, Cambridge University Press; Eisses et al, 2005, "Care staff training in the detection of depression in residential homes for the elderly", *British Journal of Psychiatry*, 186, 484 - 409

⁴¹ Taylor L, Read K and Jolley D, 2004, *Scoping the development of a certificate on mental health and later life – literature review*, University of Wolverhampton – Dementia Plus Centre; McFarlane L and McLean J, 2003, "Education and training for direct care workers", *Social Work Education*, Routledge

As one home care worker stated:

When it comes to caring – it has to be in yourself. They can tell you what to do, but if it's not in you.... But you can be taught to communicate better.... What to do is common sense. But training can show a better way of dealing with it and different approaches.

Training might need to be targeted to deal with particular situations, especially if a mental health issue presented only rarely. A home care manager noted that he had to provide a service to some clients with personality disorders, and he had sent three carers on courses to equip them to deal with that situation (albeit with limited success). There was also an issue about how to apply training if it was about a situation that was rarely encountered. As one home care worker expressed it:

Yes, training is fine. But you need the experience. You understand the training only if you can put it into practice.

Above all, training needed to be enjoyable and convenient as well as practical and relevant. One care worker mentioned that the provision of lunch as part of a training course was a helpful incentive. For workers who may need to fit in training between attending to daily duties before and after courses this is no small matter. For one worker, it was even more important:

On courses, I have to check if I'll get anything to eat as I am a diabetic and this is not always taken into account. Especially on a short course, they won't think you need a meal. More information is required on what will be provided.

The balance between practical and theoretical training

Most care workers wanted training to be very practical and obviously related to their jobs. Most did not want to have training that was too academic or theoretical. One manager stated:

Anything structured at a high level, they won't concentrate. It needs to be basic and down to earth. Sometimes trainers are too academic and use too many long words.

Unease and mistrust of theory was not restricted to care staff. A manager in a day care setting expressed herself strongly, saying:

There is a limit to academic courses. You can't smell shit on a page.

As levels of literacy and academic achievement varied, not everyone was comfortable with courses that required a lot of reading and writing, although many people valued printed handouts. While much of the necessary training can be delivered without too much reliance on the written word, some managers pointed out that having a very low level of literacy could now be a problem, as, for example, home care workers needed to be able to write in the client's communication book (client-held record). It was therefore suggested by some managers that literacy courses would be helpful for those staff who were least proficient in this area. A manager of a residential home felt that a good carer should not be discriminated against because of a low level of literacy. In one instance a member of her staff with literacy problems had been nominated for an NVQ course, but was going to undertake preparatory training. In another establishment a supervisor remarked:

The best carer I ever worked with – give her a pen and paper and she's lost. It's very much paperwork now, but that doesn't make you a good carer. Some carers get very worried about NVQ but they are excellent carers.

A small minority of interviewees wanted a more theoretical approach to training, and some saw training as a route to career advancement or development.

Training methods

There was widespread agreement that the least successful courses were those where a trainer talked or lectured for a long period. The lecture format was not popular. Almost everyone preferred opportunities for discussion and participation. Some people saw case studies as a good way to learn. Several people liked group work. One person said:

I like group work. It is more laid back and not so much pressure. It is easier to ask questions if it is with people like you that you are working with.

An experienced supervisor recalled:

Trainers mustn't talk over people's heads. I've been to some like that and they make you feel like an imbecile. I didn't dare open my mouth, that's when I first started. You don't want to show yourself up, but as you get older, you get more confident to ask. I'd say now: oy, what are you talking about. But some staff wouldn't.

Interviewees tended to enjoy opportunities for discussion and learning from others. They also liked to be able to ask questions and get answers to actual problems they were encountering at work:

It can be useful to discuss things and say, like: If I went to a client who was hitting me, what should I do?

Several people expressed a dislike of role play, though others said they found it useful, and a manager observed that her staff enjoyed it if they had to do it. A day centre worker spoke with some feeling of her dislike of certain approaches to training:

I don't like role play. Or introducing yourself. Or having to say who you would take to a desert island!

In one of our fieldwork sites, an enhanced home care project had been implemented. As part of this approach, nurses and therapists worked alongside home carers, and were available for specialist advice and assessments. They also took a major part in running training workshops for home carers. These workshops were immensely popular. They were valued as the health professionals had taken on board what the care workers needed, and they delivered the kind of practical reality-based training that staff needed. In general, interviewees were appreciative of training delivered by doctors and nurses, who were seen as credible and expert in their fields.

While most interviewees were very enthusiastic about training, this was not necessarily construed in terms of attending training courses.

New carers need more training than long-term carers. No [type of] training is better than learning on the job though.

Several people suggested that they might learn about older people's mental health by spending some time in a more specialised setting, and learning by observation.

Although mentoring and other support within the workplace were very under-developed, there was some enthusiasm for seeing these approaches as useful and practical adjuncts to formal training. It was suggested that it would be good to incentivise and reward people for mentoring, and it was pointed out that in nursing, mentoring is much more organised. It was also suggested that a buddying system, whereby experienced home care workers accompanied newer workers could be beneficial. Some care staff mentioned that support was important, in addition to training. This could come from managers or peer colleagues.

The potential for making training part of staff meetings and team meetings was under-exploited. Most people who expressed a view felt that that team meetings were geared towards business and practicalities. It was seen as difficult to have time in team meetings for training in work environments where the clients were always there during working hours, such as day and residential care. However, one day centre manager said:

We do workplace/on-the-job training e.g. in team meetings. It's about how we treat people.

Another person felt that it was important for training to take place away from the workplace in order to avoid distractions.

The role of supervision

Managers and supervisors told us – and their staff agreed – that training needs were discussed within supervision and as part of an appraisals process. There was also some evidence that supervision sessions were used to discuss specific issues, and to reflect on problems encountered in relation to particular clients. It is not entirely clear how far these sessions also provided opportunities for unqualified staff to broaden their knowledge of mental health issues and to apply theory to practice. However, given that the working relationship between care staff and their immediate line managers is often close, and they often work side-by-side, there may be further potential to use supervision and on-the-job support more systematically to better equip unqualified staff to care for older people with mental health problems. It is particularly important to extend this approach to staff who are not currently engaged in an NVQ programme.

Duration of training courses

The great majority of care workers preferred short courses. Day courses were popular, but some preferred shorter courses, lasting half a day or even two hours. The reasons for this included the difficulty of concentrating for a lengthy period, as well as practical and logistical issues such as delivering a service to clients. One carer said:

I like a course that goes straight to it, not too much jabbering. And not too many notes – they are not relevant.

A home care manager said:

What hits home is a 1-day course, dealing with things they understand, giving them the opportunity to raise issues about service users. If they can see examples of what a trainer is talking about, like on a video, that helps. They recognise something and can learn about it... The worst training is for a trainer to talk at them all day. It needs to relate to their experiences.

It was also important to have time to digest the material that was covered on courses. For this reason, a series of short modules was generally preferable to a single, longer course.

Refresher training

Many staff wanted regular updates and refresher courses. These were useful to update knowledge and to remind care workers of what they should know. This was all the more important on areas of practice that were carried out infrequently. This had particular application to the mental health field as some care workers had relatively little contact with older people with mental health problems, and it could therefore be argued that their need for refresher training was particularly great as they had fewer opportunities to reinforce and consolidate what they learned. This issue also raised concerns about what kinds of training should be offered, and to whom. One supervisor explained:

It is a bit of a dilemma whether to train everyone although they may not need it (and therefore may forget what they have learned) and how much to target mental health training on those actually doing the work with mentally ill people. But they all need some training as anyone can be thrown in if a carer doesn't turn up.

A care assistant in a rehabilitation centre stated:

You need refresher courses once in a while. Two years down the line, you don't remember it, especially if you don't do it every day. And you pick up bad habits.

Induction training

Induction training was seen as important in all work contexts. Several staff commented that they had acquired a greater level of mental health awareness as their experience grew. However, training at an earlier stage would have been beneficial:

We are skilled at picking up as we go, but what about new staff? And what did we miss as we were picking it up? For instance, we had a lady with a stroke and I could see there was more mental health stuff. I could see, but how did I know? And would a new member of staff see it?

A young care worker confirmed this concern:

It would be good to know what you are dealing with. I hardly know anything – how to deal with them.

Another care assistant recalled:

The first day... I freaked out! I had no idea what was going on. You expect every client would be hitting you.

Joint training

Joint training could involve training for care workers across a range of care settings. This was generally favoured as it gave opportunities to learn about how others approached their work.

I'd feel better about it if all our staff did it together, so if I didn't take something in, someone else could. And it could lead to closer teamwork.

However, it was generally agreed that care workers preferred not to have their managers present during training courses.

Courses are getting better. They are putting people together who should be together (not managers and care assistants in a group, as you assume the manager is there to check up on you).

There were mixed views on whether it was a good idea for unqualified care workers to be trained with qualified health and social care professionals. It appears that some managers were more cautious about this approach than were the care workers themselves, though some managers felt that joint training would help to break down barriers. Managers were aware of the possibility of care staff feeling unable to ask questions, or being somewhat intimidated by professional colleagues. While some care workers agreed that they preferred to be trained with their peers, others welcomed exposure to training with other workers, including those with professional qualifications.

On one course, we had people from home care, day centre and the health centre. It was good to hear other people's ideas - we can learn about each other's roles.

Certificated training

Increasingly, NVQ is becoming a requirement for care workers, with targets set for the proportion of staff required to hold an NVQ. Many care staff had completed courses for NVQ level 2 and some were doing or had completed level 3. Attitudes to NVQ varied as the following quotations illustrate:

I am going to start the NVQ – because I have to. I wouldn't bother otherwise. I've been doing the job for so long, what's the point? But I suppose it's useful. It's always good to learn something new.

NVQs are a lot better now. They do cover what we do every day. They used to be too book-y.

All do NVQs which are practice-based, so they remember it.

NVQ is a load of old bull. It's too easy to fake it. They use each other's work, maybe not intentionally. Only when you get to level 4 does it get good. Then it is more individualised and you have to prove what work you have done.

One person specifically said that her GNVQ and NVQ had been enjoyable and had made her want to go on studying. Although in her fifties, she was pursuing a pre-nursing course and hoped to go on to qualify.

Many staff had found their NVQ training to be helpful. However, as NVQs concentrate on competencies within a job, care staff reported that their NVQ had not necessarily covered issues pertaining to older people with mental health problems, if this was not a significant part of their current remit.

The NVQ did cover mental health a bit. I had to find things myself, but there was no teaching or training on it as such.

This reinforces the circular nature of the problem; that low awareness of the mental health aspects of the work with older people may result in inadequate training in these issues.

ACCESS TO TRAINING

A major concern of the literature is the need for a more structured approach to training for non-professionally aligned care staff. The need to develop an integrated programme, rather than a series of stand-alone sessions, and the need to introduce development pathways for staff and develop links to the Knowledge and Skills Framework⁴² (for NHS staff) are stressed⁴³.

How staff are encouraged/enabled

The literature also stresses the importance of having managers skilled in identifying training needs and supporting learning for care workers. It is suggested that the quality of management in terms of supporting the learning of care workers is variable across organisations and in different parts of the country and that there is a need to focus on the development of managers in their learning support role⁴⁴. Whilst, on the whole there is no suggestion that managers are actually antithetical to training for care staff, one study found that some managers believe training leads to greater staff turnover⁴⁵ and this may mean that they are less likely to fully support and encourage care staff to train, given that retention is a prime concern with this group of staff.

It was very encouraging to note that almost all staff, across all our interview sites, felt that they were encouraged to participate in training and enabled to do so. Usually, this extended beyond the mandatory training that they were required to attend on a regular basis. Managers and supervisors were generally very positive about mandatory training, and as one person explained:

Mandatory training is fantastic as managers can't say they have no time and staff can't say: I'm only here for 2 more years.

Managers and supervisors all stated that they included a discussion of training needs as part of regular supervision and appraisal processes. Training also features in each individual's Personal Development Plan. They used these mechanisms as opportunities to direct staff towards mandatory training and to suggest and encourage other training. This might be in response to the care worker's own request, or in response to the manager's perception of where the worker needed additional training, or it might be in response to a particular client's needs (e.g. where an unusual situation had arisen, requiring a more specialised service to be offered).

While managers and supervisors were enthusiastic and proactive about training, their ability to encourage and enable care staff working with older people with mental health needs to access training might be limited in two ways. First, the managers' own levels of knowledge about mental health issues in older people were, on their own assessment,

⁴² Department of Health, 2004, *The NHS Knowledge and Skills Framework and the Development Process*, Department of Health

⁴³ Care Services Improvement Partnership, 2005, *Moving On: Key learning from Rowan Ward – working to improve in-patient services for people with mental health problems*, CSIP / Department of Health; Thompson R, 2005/6, *HCA Clinical Support Project – Older adult service CNWL Mental Health NHS Trust – Executive Summary*, Central and North West London Mental Health Trust; Mental Health Care Group Workforce Team, 2004, *National Mental Health Workforce Strategy*, Department of Health; Tarpey L, 2004, *Round Pegs – Round holes? Recognising the future of human resources management*, Association of Director of Social Services

⁴⁴ Thompson R, 2005/6, *HCA Clinical Support Project – Older adult service CNWL Mental Health NHS Trust – Executive Summary*, Central and North West London Mental Health Trust; Brunt J, 2006, *Getting started – Towards a Patient-centred workforce – Implications for learning*, Unpublished paper for Widening Participation in Learning Strategy Unit – Department of Health; Tarpey L, 2004, *Round Pegs – Round holes? Recognising the future of human resources management*, Association of Director of Social Services

⁴⁵ Innes A, Macpherson S and McCabe L, 2006, *Promoting person-centred care at the front line*, Joseph Rowntree Foundation

variable, and none were mental health specialists. Secondly, they were usually untrained in assessing training needs, although one had relevant experience from a previous job and others had done some work on training as part of NVQ at level 4. Nevertheless, we came across quite a lot of systematic attempts to take stock of the training needs of unqualified staff. For example, in one area, residential care homes did an annual training needs analysis. One manager in a health setting acknowledged that the NHS Key Skills Framework had been very helpful in defining core skills for which everyone had to demonstrate competencies and on which they might require training.

Barriers to accessing training

The literature highlights the lack of a protected budget in order that training for care staff can be continual and planned⁴⁶. It is noted that when NHS training budgets are cut, support staff are particularly vulnerable as they have no professional body or institution to lobby for them⁴⁷. This is particularly worrying currently as NHS training budgets are reportedly being cut by up to a third in some parts of the country⁴⁸. It is also pointed out that priority tends to be given to practical, safety related, issues such as moving and handling when budgets are tight⁴⁹.

The other barriers mentioned in the literature are a lack of NVQ assessors⁵⁰, the need for paid time for staff to develop portfolios⁵¹ and some problems with fitting training around workloads and shifts⁵².

The great majority of staff we interviewed and their managers felt that there were few significant barriers to accessing training. However, the following issues were mentioned by some.

Cost

Few care workers mentioned cost as a barrier, although one said that she was aware that if a course was not in the “booklet and guidelines”, she would have to pay for it herself. One person, now employed by a local authority, reported that when she worked for an agency, she was not paid for attending training.

However, while the cost of training was an issue, for the most part, it would be overstating it to see it as a barrier to accessing training. However, cost was an issue in terms of how training needs could be met.

One home care manager said:

Learning and development have a limited budget so we are looking at economies of scale. They need fairly big groups and I can understand that. But sometimes we need small groups and tailor-made training.

⁴⁶ Brunt J, 2006, *Getting started – Towards a Patient-centred workforce – Implications for learning*, Unpublished paper for Widening Participation in Learning Strategy Unit – Department of Health; Innes A, Macpherson S and McCabe L, 2006, *Promoting person-centred care at the front line*, Joseph Rowntree Foundation; Care Services Improvement Partnership, 2005, *Moving On: Key learning from Rowan Ward – working to improve in-patient services for people with mental health problems*, CSIP / Department of Health

⁴⁷ Brunt J, 2006, *Getting started – Towards a Patient-centred workforce – Implications for learning*, Unpublished paper for Widening Participation in Learning Strategy Unit – Department of Health

⁴⁸ *Health Service Journal*, 5th October 2006, “Training cuts average at 10pc”, page 6

⁴⁹ Innes A, Macpherson S and McCabe L, 2006, *Promoting person-centred care at the front line*, Joseph Rowntree Foundation

⁵⁰ Thompson R, 2005/6, *HCA Clinical Support Project – Older adult service CNWL Mental Health NHS Trust – Executive Summary*, Central and North West London Mental Health Trust

⁵¹ Brunt J, 2006, *Getting started – Towards a Patient-centred workforce – Implications for learning*, Unpublished paper for Widening Participation in Learning Strategy Unit – Department of Health

⁵² Moxon S et al, 2001, “Mental health in residential homes: a role for care staff”, *Ageing and Society*, 21 Issue 1 71 – 93, Cambridge University Press

In the health setting, there was some concern about how and when funds were allocated from the Workforce Development Directorate.

Distance

A single interviewee felt that the location of training courses was problematic as some staff could not drive. However this concern was not raised by other staff.

Computerised booking

One interviewee was extremely concerned about the introduction of computerised booking, which he perceived as a major obstacle to finding out about courses and to securing places on them. It must be said that this concern was not shared by others. Also managers were aware of the potential difficulty and had taken steps to mitigate it. However, the strength of feeling expressed deserves some attention:

You don't know where to find it and where to go, even for mandatory training. It's a matter of finding out the dates. It's on the computer and a lot of people don't have access to the computer. And I can't use a computer and we have to book courses on the computer now. It is very stressful. It is the most stressful part of the job. I think I have done less training since it was computerised.

Cover

Providing cover for staff in training courses was an issue, but usually it was dealt with by managers who saw it as their business to keep the service running while enabling staff to attend training. One manager said:

If someone is off sick it may be hard to cover. But I say to the home carer: you will attend the course and I will get agency staff.

Other positive moves to ensure that staff could be free to attend training included grouping three mandatory courses in one day to make staff release and cover easier to manage.

Attitude

While most staff were very positive about training, a small minority were less so. Some – though by no means all – older workers felt that there was less point in training as they neared retirement. One forthright manager said:

There's no barrier from an external point of view, but there is a block in the minds of some of the staff. It's about change. So sometimes you have to dictate. It can be difficult to get them to buy into it.

Another said:

Older staff can be set in their ways and need to learn to change. Training can help but it is still difficult for them. You just chip away.

Agency staff – access to training

As we have seen, some interviewees expressed concern about the quality of care offered by agency staff and felt that they may have particular and additional training needs. This raises questions about how accessible training is to agency staff:

When I was doubling up (for the agency) I saw that some carers were not patient as they didn't get the training and didn't know how to handle themselves.

One home care manager was generally satisfied with her agency staff, who had been working in her borough for many years. If she had any concerns, she sent them on courses, paid out of the same source as in-house staff.

Night staff – access to training

In one authority we were assured that night staff have the same access to training as do day staff. NVQ assessors came in at night when required.

The quality of training

The evaluation of the training available on mental health needs of older people that is provided to care staff was largely beyond the scope of the fieldwork, but some of the literature and other sources suggested there were some problems with this. There is a published tool to evaluate mental health training in all settings for all groups, but this is not widely used⁵³. In addition there is no comprehensive plan for training non-specialist staff in mental health issues or a core curriculum to draw on. Finally, it is not clear where responsibility lies for assuring funding, standard setting and auditing of this training⁵⁴.

⁵³ Booker C and Curran J, 2005, *National Continuous Quality Improvement Tool for Mental Health Education – Handbook and Implementation Guide*, Northern Centre For Mental Health / Centre for Clinical and Academic Workforce and Innovation, University of Lincoln

⁵⁴ Personal communication, Ian McGonagle Centre for Clinical and Academic Workforce and Innovation, University of Lincoln

CONCLUSION AND RECOMMENDATIONS

As we have seen, there is a considerable amount of literature which documents the lack of attention paid to the training needs of care staff and some available information on the training needs of unqualified staff working with older people in relation to the mental health needs of older people. There is also some recent and developing literature about the need to develop a structured training programme for care staff. Our findings from interviewing unqualified non-professionally affiliated staff and their managers are consistent with the views of the carers we spoke to, and reinforce many of the themes that appear in the literature.

Taking all these sources into account, there is a wide consensus that unqualified staff (and in many cases, their managers too) would benefit from a more comprehensive and ongoing approach to increasing their awareness of mental health in older people. This would assist them in recognising possible mental health problems and in promoting mental wellbeing, which would, in turn, lead to better understanding of the needs of older people, better communication, better care and improved health outcomes.

It is also apparent that while there is a considerable amount of training currently available, it does not always adequately address the needs of unqualified staff who care for older people. We were particularly impressed with the need for training to deliver person-centred care, and we suggest that a great deal of the training required by unqualified staff needs to be re-oriented so that it contributes more obviously to providing such care. Supporting and enabling staff to deliver care with kindness, respect and compassion is at the heart of effective training.

We also note that while most staff were enthusiastic for training, there was also a degree of doubt amongst some staff as to whether some of the things that were most important – including kindness and good communication – were likely to be enhanced by the training opportunities with which they were familiar. For this reason, while we accept the need for training that enables staff to carry out defined tasks in a safe and effective manner, we also suggest that this approach, by itself, fails to change attitudes and practice in ways that meet the needs of older people and those caring for them.

We also note significant limitations to what any individual employer can do to make the changes that are required. The fieldwork sites we visited all took training very seriously, and did a great deal to promote access to training for their staff. However, many of the issues that need to be tackled will need a concerted approach involving the Department of Health, and a range of stakeholders. This is complicated by what appears to be a very diffuse and fragmented picture of who is responsible for what. Different organisations carry responsibility for part of the business of training for unqualified staff, but there is no apparent overall strategy for ensuring that training for these staff is planned, quality-controlled, accredited, delivered, funded and audited in an integrated manner.

Therefore, while there are a number of immediate changes and improvements that can be made to improve the quality of training for unqualified staff working with older people in all settings, we also recommend a more fundamental review of training for these staff. We therefore make one key recommendation, and a number of other recommendations which can begin to be implemented, pending a more systematic review.

1. Key recommendation

The Department of Health should undertake a comprehensive review of training for unqualified, non-professionally aligned staff caring for older people.

- This review should pay particular attention to training needs in relation to older people's mental health, including both dementia and functional mental health problems of all levels of severity.
- The review should include a consideration of the role of unqualified staff in promoting better mental health for older people and preventing deterioration of older people's mental health.
- The review should look at how training needs are identified and met, with particular reference to curriculum-setting, standards and quality of training, accreditation of training and audit of training programmes.
- The review should look at the costs of training for unqualified staff and should clarify where the responsibilities for funding training for this group lie.
- The review should engage a wide range of stakeholders including commissioners and providers of care, strategic health authorities and their workforce development directorates, employers' organisations, trades unions, regulatory and inspection bodies, providers and accreditors of education and training and, of course, service users and their paid and unpaid carers.
- The review should look at training for unqualified staff working with older people in all sectors and all settings, and should include the training needs of all staff who come into contact with older people, and not only those whose jobs are primarily or exclusively concerned with the direct delivery of personal care.

2. Other recommendations – for immediate action

2.1. Improve access to awareness training

There should be an immediate increase in mental health awareness training for all staff who work with older people, in all settings, including staff who are not primarily care staff (e.g. cleaners, drivers, cooks, porters, receptionists). This training should include basic awareness of both dementia and functional mental health problems, and should be mandatory.

2.2. Apply generic training to the needs of older people with mental health problems

Ensure that generic training given to all those caring for older people (e.g. moving and handling, dealing with violence and aggression) is enhanced by the specific application of the training to the needs of older people with mental health problems.

2.3. Enable unqualified staff to have a wider role in promoting the mental health of older people

Recognise the potential of unqualified staff to play a greater part in promoting good mental health for older people and preventing deterioration of older people's mental health by offering appropriate support and access to relevant training.

2.4. Training methods

Ensure that training methods are appropriate by:

- Offering short, practical training rather than longer, theoretical training.
- Making available regular updates and refresher training, particularly to those staff who have irregular contact with older people with mental health problems.
- Developing more inter-disciplinary training e.g. including nurses, health professionals etc, alongside unqualified care workers.
- Enabling unqualified staff to learn from a range of methods in addition to formal courses, e.g. mentoring, observation placements.

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APPENDICES

Appendix One

METHODOLOGY

The methods used for the project consisted of:

- A brief review of the relevant literature
Focusing on workforce development issues for non-specialist, and non-professionally aligned health and social care workers, the identified training needs of this group and what may facilitate or hamper the training of non-specialist staff. The review also looked at evidence of the benefits of training for this group in terms of improvement of quality of care and outcomes. The literature review was designed to contextualise the fieldwork and to amplify findings where relevant. Sources are referenced in the footnotes and at the end of the report.
- A discussion with 13 people attending a support group run by the Norwich and District Alzheimer's Society
This discussion explored the experiences of people who were current or recent carers of older people, mostly with dementia. In the light of their experiences, they gave their views on the skills and attributes needed by those who delivered care to older people, both at home and in hospital, residential and nursing home care. We used this material to inform the interview schedule used for interviews with care staff and their managers. We also noted that a number of themes were common to both family carers and paid carers. For example, material from all sources agreed on: the need for greater awareness of mental health issues in older people; the importance of good communication; and the importance of staff being patient and tolerant.
- Interviews with a wide range of staff and their managers in a variety of settings
In the smaller workplaces all available staff were interviewed. In larger workplaces (e.g. home care sections of local authorities), managers approached staff to be interviewed, ensuring that they asked men and women, new and experienced workers and people from a wide range of ethnic backgrounds (See appendix two for details of the interviewees). The interviewees were given a written information sheet about the project, and were asked to sign a consent form. It was made clear that their participation in the project was entirely voluntary. Staff who agreed to be interviewed were released on a paid basis by their employers; the voluntary sector home care workers were given a token payment from project funds. All the interviews were conducted face-to-face and, in the great majority of interviews, each interviewee was seen alone. In three of the interviews two or three staff were interviewed together for operational reasons. Interviews were semi-structured, and the key questions are set out in the appendix three.
- Additional material was obtained from a small number of in-depth interviews and personal communication with experts on the training needs of staff caring for older people.

ABOUT THE INTERVIEWEES

In this section, we set out information on the types of care staff and their managers/supervisors who were interviewed.

Information by workplace setting and gender

Local authority home care staff

Number: 20 (including 6 supervisors/managers)

Gender: 15 women, 5 men

Independent (voluntary) sector home care staff

Number: 5

Gender: 5 women, 0 men

Local authority day centre for older people

Number: 5 (including 2 supervisors/managers)

Gender: 4 women, 1 man

Local authority African-Caribbean elders' day centre

Number: 3 (including 1 manager)

Gender: 3 women, 0 men

Independent (voluntary) sector day centre for older people

Number: 4 (including 1 manager)

Gender: 3 women, 1 man

Local authority residential care home

Number: 4 (including 2 supervisors/managers)

Gender: 3 women, 1 man

Local authority residential care home (rehabilitation)

Number: 2 (including 1 manager)

Gender: 2 women, 0 men

NHS Healthcare assistants

Number: 2

Gender: 1 woman, 1 man

NHS managers (including clinician-managers)

Number: 4

Gender: 3 women, 1 man

Total

Number: 49

Gender: 39 women, 10 men

Information about interviewees by age

Age band	Home care staff and their supervisors/managers		Other staff and their supervisors/managers	
	Male	Female	Male	Female
16-19	0	0	0	0
20-29	0	0	0	2
30-39	1	4	0	1
40-49	2	4	3	2
50-59	2	6	0	7
60+	0	2	0	1
Not given	0	4	2	6
Total	5	20	5	19

INTERVIEW SCHEDULE FOR STAFF INTERVIEWS

Introduction

- Summarise project and purpose of interview
- Check consent given and recorded

Interviewee's background and role

1. What is your name and age? (This will be destroyed once notes have been written up)
2. What is your job title and what does your job consist of?
3. How long have you been working in this job in this organisation?
4. Have you done similar work or had related experience elsewhere? (if so what)

Training to date

5. What training have you had that you consider to be relevant to your present job?
(If possible record year, nature of training, and whether it led to a qualification of any kind)

Further training

6. In general, would it be helpful to have further training in working with older people with mental health problems?
7. If yes, what training do you think you most need?
8. How would that training help you to do your job?
9. Do you feel you need further training in recognising mental health problems in older people?
10. Do you feel you need further training in communicating with older people with mental health problems?
11. Do you feel you need further training in understanding the needs and preferences of people from cultural backgrounds other than your own?
12. Do you feel that you need further training in knowing when to suggest a referral of an older person to a specialist mental health worker on account of their possible mental health problems?
13. Do you feel you need further training about possible sources of support and information for older people with mental health problems?
14. How would you like to take part in future training? (pick as many options as you wish)
 - a) Go on short courses (up to 3 days in total)
 - b) Go on courses lasting 4-6 days in total
 - c) Go on longer courses, (more than 6 days in total) but not including assessments and not leading to qualifications
 - d) Go on courses leading to qualifications
 - e) Learn from colleagues (observing their work)
 - f) Learn from colleagues (discussion e.g. at team meetings)
 - g) Workplace-based learning (with supervision in the workplace)

- h) Private study
- i) Other (please specify)

15. Do you feel encouraged/enabled to take part in further training?

16. Are you aware of any obstacles that prevent you receiving the training that you feel you need?

Other

17. Is there anything else you would like to add?

About the Mental Health Foundation

Founded in 1949, the Mental Health Foundation is the leading UK charity working in mental health and learning disabilities.

We are unique in the way we work. We bring together teams that undertake research, develop services, design training, influence policy, and raise public awareness within one organisation. We are keen to tackle difficult issues and try different approaches, many of them led by services users themselves. We use our findings to promote survival, recovery and prevention. We do this by working with statutory and voluntary organisations, from GP practices to primary schools. We enable them to provide better help for people with mental health problems or learning disabilities, and to promote mental well-being.

We also work to influence policy, including Government at the highest levels. And we use our knowledge to raise awareness and to help tackle the stigma attached to mental illness and learning disabilities. We reach millions of people every year through our media work, information booklets and online services. We can only continue our work with the support of many individuals, charitable trusts and companies.

To support our work, please visit our website or call our fundraising team on 020 7803 1121.

If you would like to find out more about our work, please contact us.

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